Housing-Related Community Supports:
A Handbook for Managed Care Plans

JANUARY 2023

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About Corporation for Supportive Housing

The **Corporation for Supportive Housing (CSH)** is the national champion for supportive housing, demonstrating its potential to improve the lives of very vulnerable individuals and families by helping communities create more than 385,000 real homes for people who desperately need them. CSH funding, expertise, and advocacy have provided $1.5 billion in direct loans and grants for supportive housing across the country. Building on 30 years of success developing multiple and cross-sector partnerships, CSH engages broader systems to fully invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources, and ensure a better future for everyone.

CSH works to advance solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources, and build healthy communities.

About the Foundation

The **California Health Care Foundation** (CHCF) is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Introduction

CalAIM (California Advancing and Innovating Medi-Cal) is a far-reaching, multiyear plan with the ambitious goal to improve outcomes for the millions of Californians with complex needs, especially people experiencing or at risk of experiencing homelessness. While Medi-Cal has not historically paid for housing or shelter, CalAIM opens the door to a stronger whole-person approach to care and to address the social factors that impact the health of people experiencing or at risk of experiencing homelessness.

CalAIM's Enhanced Care Management (ECM) and housing-related Community Supports (CS) are avenues by which managed care plans (MCPs) can fund the care coordination and housing-related services many people need to stabilize after inpatient care and to locate, transition into, and remain healthy in permanent housing, which is essential to ending homelessness and meeting the complex health needs for unhoused Californians.

What Are the "Housing-Related" Community Supports Services in CalAIM?

The housing-related Community Supports services included in CalAIM that are particularly relevant to people experiencing homelessness are:

- Transition and navigation services
- Deposit assistance
- Tenancy and sustaining services

To accomplish its goals, CalAIM relies on MCPs to implement integrated care models at the community level. MCPs will need to seek out and collaborate with new partners in the homeless services, affordable housing, and supportive housing sectors (collectively referred to in this handbook as the "housing-related sector") to successfully deliver on the whole-person approach to care. Positive health outcomes for unhoused MCP members depend on access to permanent, affordable housing and the support services necessary to stabilize in housing.

The purpose of this handbook is to help MCPs navigate what may be unfamiliar territory and support MCPs in establishing and strengthening partnerships with housing-related sector partners. It provides key considerations, useful steps, and best practices that MCP staff will need to successfully implement the housing-related CS.

- **Chapter 1: What works.** Guidance for MCPs in understanding the evidence-based practices that support best outcomes for individuals experiencing or at risk of experiencing homelessness.
- **Chapter 2: Housing-related services providers.** Priorities, capacity, and opportunities in partnering with homeless response systems.
- **Chapter 3: Planning and execution.** The opportunities and challenges for MCPs as they build systems and programs with their new partners.
- **Chapter 4: Data sharing.** A model for MCPs to plan, develop, and get the most out of data sharing with their housing-related sector partners.

The guidance in the following chapters is based on research findings as well as conversations and extensive experience with California providers in health care and in the homelessness and housing services sector.

Who Should Read This Handbook?

Housing-Related Community Supports: A Handbook for Managed Care Plans can help MCP staff plan, develop, and implement new services provided under CalAIM. The content of this handbook is most relevant to MCP staff working in these areas:

- Medical management and clinical leadership
- Provider relations and/or network development
- Community supports leads / Leads for members experiencing homelessness
- Member services
- Population health team and data analytics

Additional CHCF Resources

To learn more about the homeless response system and opportunities for cross-sector collaboration, see: *Homelessness Response 101: For Health Care Providers and Stakeholders* and *Breaking Down Silos: How to Share Data to Improve the Health of People Experiencing Homelessness*.

CHAPTER 1

What Works — Evidence-Based Practices for Housing-Related Services

CalAIM enables managed care plans (MCPs) to support their members — especially those with complex needs — through partnerships with many types of organizations in the housing-related sector. Although likely new to MCPs, permanent supportive housing (PSH) providers have delivered housing navigation, transition, and tenant supportive services throughout California for nearly 30 years.

As the research compiled by the California Department of Health Care Services (DHCS) in *In Lieu of Services (ILOS) in CalAIM: A Summary of the Evidence-Base on Cost Effectiveness and Medical Appropriateness of ILOS* (PDF) shows, health outcomes improve and health care costs for unnecessary services decrease when someone is stabilized in permanent housing. Many studies cited in the DHCS summary measure individual housing outcomes and health care costs at 6-, 12-, 18- and 24-month intervals once that individual had moved into housing and was receiving ongoing housing tenancy and sustaining services. Given the important links between stable housing and improved health outcomes and lower health care costs, it is vital for MCPs to make housing tenancy and sustaining services available for their members and to work closely with homeless response systems to facilitate placements into housing and housing retention.

What Services?

DHCS offers the following definitions for the housing-related Community Supports (CS) services that MCPs have the option to cover through CalAIM:

- **Housing transition and navigation services.** "Services include a housing-focused needs assessment, development of service plan, securing rental assistance and move-in costs, acting as a liaison with property owners and other community supports and any other direct, hands-on care and assistance needed to obtain housing."
- **Housing deposit assistance.** "Services include one-time funding to assist with move-in related expenses. This can include security deposit, first and last month's rent, assistance with back utility bills, or other move-in related costs."
- **Housing tenancy and sustaining services.** "Services include assessment, service plan development, and any other direct, hands-on care and assistance needed to support continued tenancy."

Appendix A offers additional clarity and definitions on acronyms and terms that MCPs may encounter when partnering with homeless service providers.

Differentiating Permanent Housing from Short-Term Housing Programs

The US Department of Housing and Urban Development (HUD); California's Business, Consumer Services, and Housing Agency (BCSH); and the National Health Care for the Homeless Council (NHCHC) offer definitions to distinguish between permanent housing and short-term housing programs.

PERMANENT HOUSING PROGRAMS	SHORT-TERM HOUSING PROGRAMS
Permanent supportive housing (PSH). HUD defines PSH as "a CoC (Continuum of Care) program component type providing indefinite leasing or rental assistance combined with supportive services for disabled persons experiencing homelessness so that they may live independently." PSH is to be distinguished from other types of housing, such as board and care homes, residential treatment facilities, transitional housing, housing provided through rapid rehousing programs and by other tenant-based rental assistance programs.	**Shelter/Interim housing.** BCSH's California Interagency Council on Homelessness (Cal ICH) defines shelter/interim housing as "any program whose primary purpose is to provide a temporary shelter for people experiencing homelessness in general or for specific populations, and which does not require occupants to sign leases or occupancy agreements."
Tenant-based rental assistance (TBRA). HUD defines TBRA as "a rental assistance model in which program participants locate housing in the private rental market and enter into a lease with the property owner." By using TBRA to cover a part of the market-rate rental cost, participants can attain housing that is affordable to them, where they pay no more than 30% of their income in rent and the TBRA covers the rest.	**Transitional housing.** HUD defines transitional housing as housing "designed to provide homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing."
Rapid rehousing (RRH). HUD defines RRH as "a permanent housing solution emphasizing housing search and relocation services and short- and medium-term rental assistance to move homeless persons and families (with or without a disability) as rapidly as possible into housing." RRH rental assistance may last up to two years and while some households will be able to take over the full market-rate rent payment, others may need to transition into PSH or into TBRA programs.	**Medical respite/recuperative care.** According to the National Health Care for the Homeless Council, "medical respite care is acute and post-acute care for persons experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. Unlike 'respite' for caregivers, 'medical respite' is short-term residential care that allows individuals experiencing homelessness the opportunity to rest in a safe environment while connecting to medical care and other supportive services."

Sources: *CoC and ESG Virtual Binders Glossary of Terms* (PDF), US Department of Housing and Urban Development (HUD) Exchange, last modified 2022; "Permanent Supportive Housing (PSH): What Is Permanent Supportive Housing?" HUD Exchange, last modified 2022. "Medical Respite Care," National Health Care for the Homeless Council, last modified 2022; *Guide to Strategic Uses of Key State and Federal Funds to Reduce Homelessness During the COVID-19 Pandemic* (PDF), California Homeless Coordinating and Financing Council, last updated September 2020.

Evidence-Based Strategy for Use of Housing-Related Community Supports

Many studies have demonstrated the effectiveness of housing navigation and tenancy support services when linked with permanent housing.[2] The programs with successful client outcomes shared the following features:

Housing first approach. This model recognizes that stability in housing is necessary before health-care-related outcomes can be achieved. Therefore, the approach does not require sobriety, a high level of services engagement, or treatment compliance as a precondition for housing. It focuses instead on helping individuals navigate complex housing and health care systems, with attention to safety and individual autonomy. This model is particularly successful when supporting people living with disabilities, behavioral health conditions, and chronic illnesses.

Multidisciplinary team-based care. Social workers, housing specialists, skilled clinicians, and peers with lived experience collaborate with the individual experiencing homelessness to determine a plan of care. Early research studies on the cost effectiveness and health outcomes of housing and services focused on Assertive Community Treatment and other multidisciplinary team care models, paired with affordable housing rental subsidies. Daily coordination, shared supervision, and a single electronic record are three critical components of effective multidisciplinary team-based care. Multidisciplinary housing teams are unique from an Enhanced Care Management (ECM) or primary care team, in that all team members approach care with a focus on keeping the member housed. Additionally, all team members are required to coordinate together, communicate regularly with each other and the member, and report to the same supervisor. In this multidisciplinary team-based care model, coordination time is included in the total cost of care for all team members and is a part of every job description.

Staff with lived experience of homelessness. Hiring people with lived experience of homelessness as staff members is a part of several evidence-based staffing models in permanent supportive housing (PSH). MCPs are encouraged to support providers in hiring and training peers with lived experience of homelessness and of navigating housing services by providing financial incentives for providers to do so.

Trauma-informed approaches to care. Homelessness is a traumatic experience. Trauma-informed care seeks to understand the broad impact of trauma and paths for recovery; recognize signs and symptoms of trauma; integrate knowledge about trauma into policies, procedures, and practices; and actively avoid re-traumatization during the housing and services process.

Harm reduction. In working with people who use drugs or alcohol or who engage in other risky behaviors, the evidence-based model calls for the "harm reduction" approach. Strategies include education and training on overdose reversal, the provision of supplies to promote sterile injection, and linkages to disease prevention, testing, and treatment services, depending on the person's desires and needs. The model emphasizes "the dignity of individuals and their right to exercise self-determination and to collaborate in their own health care."

Smaller caseload, better outcomes. Trusting relationships and provider consistency made possible by small caseloads help members achieve better outcomes and higher satisfaction with services.

Linking housing and health care services. In the planning phase, stronger communication channels and data exchange processes must be established to ensure that eligibility criteria for housing

subsidies and CS services are aligned. The administrative burden of linking housing subsidies with housing-related CS services must be on the MCPs, Continuums of Care (CoCs), and housing systems, not on individual providers or participants.

Ongoing, proactive outreach and engagement. Effective outreach staff use creative, person-centered approaches to meet MCP members wherever they are in the community to provide program enrollment assistance and connections to services. On the ground, this means that refusal for assistance today signals the need for the outreach staff to come back tomorrow. Ongoing and proactive outreach takes abundant staff time and funding to cover travel into the community for multiple outreach attempts and relationship building to grow trust. In rural areas, these costs are more significant as unhoused members may be spread across hundreds of miles in remote areas.

In regions where such practices have not yet been enacted, MCPs can access the wealth of training, resources, and supports available through community-based organizations in their area. (See Appendix B for resources available to providers new to implementing evidence-based practice models when serving unhoused members.)

CHAPTER 2

Aligning MCP Efforts with Local Homelessness Response Systems

To realize CalAIM's potential, MCPs will need to coordinate and integrate plan services, such as housing-related CS and ECM benefits[3] with local agencies and programs that fund or operate housing-related resources. To support this work, plans will need strong, collaborative partnerships and networks with entities that receive federal and state housing and move-in assistance funds and manage rental subsidies and housing vouchers. This chapter provides useful resources for MCPs beginning the process.

The following agencies manage a variety of state and local funding sources, each with its own priorities, regulations, requirements, and geographical focus. Creating and sustaining partnerships with each of these agencies will present its own set of opportunities and challenges.

Local Homeless Continuum of Care (CoC) and Coordinated Entry System (CES). The US Department of Housing and Urban Development (HUD) requires that grantees coordinate their funding applications and responses to homelessness through local CoCs. These are often county based, though in rural areas, they may cover multiple counties, and some large urban areas have more than one CoC. CoC systems are primarily supported by yearly HUD McKinney-Vento funding grants awarded directly from HUD to CoCs and may also receive funding support through the state. Local governments can also provide city- and county-level funding support to CoCs. Within a CoC, a Coordinated Entry System (CES) serves as a single point of access for assessment and prioritization of its homeless system resources. Each CES has an established methodology to determine who is prioritized for housing resources, such as long-term affordable housing through a Housing Choice Voucher or time-limited subsidies like "rapid rehousing" since there are more people in need of housing than there are vouchers or subsidies. In addition to housing, supportive services like homelessness prevention, diversion,[4] and street outreach[5] comprise a large part of the services that CoCs offer.

Public Housing Authorities (PHAs). PHAs primarily manage federal funds that come directly to housing authorities for activities, such as overseeing housing vouchers or rental subsidies and managing public housing. Some PHAs are also affordable housing developers. PHAs are usually county based, though rural counties may band together to form a single housing authority. MCPs are advised to engage the PHAs that serve the same area. HUD provides a list of California housing authorities.[6]

County housing departments. Housing departments manage resources that affordable housing finance and development agencies use to build and operate affordable and supportive housing. By engaging with county housing departments, MCPs can learn what housing is being developed, how their members can access this housing, and how MCP CS can assist in that process. Many counties have a "pipeline" process and can share what affordable units are projected to be ready to lease over the next five years. Federal and state housing dollars flow to these departments, primarily for capital expenses.

The National Academy for State Health Policy (NASHP), together with the Corporation for Supportive Housing (CSH), published *Health and Housing: Introduction to Cross-Sector Collaboration*,[7] a report that elaborates on cross-sector partnerships and available federal funding resources.

State Housing Programs

California invests state funds to address homelessness. The California Business, Consumer Services, and Housing Agency (BCSH)[8] has created a strategic resource guide[9] listing many of these resources. The awards offer MCPs insights into potential housing partners in their communities. The State of California, through the Department of Housing and Community Development (HCD), funds and administers the following programs:

- **Project Homekey.**[10] California's Homekey program has $1.4 billion in fiscal year 2021-22 funds for housing capital and development. Building on the success of Project Roomkey, which housed persons experiencing homelessness during the COVID-19 pandemic in hotels and motels, many cities and counties are converting these sites to supportive housing.

- **Homeless Housing, Assistance and Prevention (HHAP) Grant Program.**[11] This $1.95 billion grant program awards funds to California CoCs, large cities, and counties to address homelessness. As of November 2022, HHAP has awarded three rounds of funding and a fourth is currently in process.

- **HOME American Rescue Plan Act Funds (HOME-ARP).** In 2022, California received $155 million in federal HOME-ARP funds, which can be used to develop and operate supportive housing for people experiencing homelessness or at risk of experiencing homelessness. Cities and counties throughout the state receive their own allocations of these funds; see federal allocation chart.[12] MCPs may elect to partner with local HOME-ARP funded housing development efforts.

- **HOME Investment Partnerships Program (HOME)[13] and CDBG Block Grant Program.** HCD as well as cities and counties across the state also regularly receive and distribute funds from the federal HOME and the Community Development Block Grant (CDBG)[14] programs to create and rehabilitate affordable rental housing, among other eligible activities.

- **No Place Like Home (NPLH).**[15] This program specifically funds permanent supportive housing (PSH), lending financing for new PSH projects to housing developers.

- **Multifamily Housing Program (MHP).**[16] This program lends funding to developers for new and rehabilitated affordable rental housing, which can include supportive housing. Some funding targets specific populations, such as seniors, veterans, or people experiencing homelessness. HCD has recently streamlined the developer application processes for several funding programs. Often, developers look for service providers in the predevelopment and planning phases to ensure that future tenants have the supportive services they need to thrive. MCPs can connect with developers and their contracted service providers to identify shared priorities and partnership opportunities.

Cities and counties that directly receive federal HOME or CDBG funds are required to create a countywide consolidated plan that brings together information about housing needs throughout the region for a variety of populations. HCD manages a statewide consolidated plan, while large counties and cities may have their own, as is the case of the City of Los Angeles, the City of Fresno, and Alameda County.

Coordinating with Housing Partners

Unlike many health care benefits, housing benefits like rental assistance, housing vouchers, and affordable housing are not entitlements. There is no requirement that every eligible household receive access to housing benefits. In California and most other states, only a small percentage of households eligible for rental assistance receive it, and many people spend years on wait-lists for affordable housing.

Therefore, it is important that MCPs coordinate housing-related CS eligibility with existing housing prioritization systems, such as coordinated entry systems, to ensure that members who are receiving Housing Navigation and Transition services can be prioritized for permanent, affordable housing. Data sharing between systems will be critical to this effort (see Chapter 4).

In coordinating with housing partners, MCPs need to be clear on their own strengths and needs. Their strengths may include covering a high percentage of the relevant target populations through Medi-Cal, offering a countywide perspective, having robust data analytics, and bringing resources for CS and ECM. A challenge for MCPs is their inability to directly fund housing long term.

In approaching partnerships, MCPs should be aware that their potential partners have their own networks of providers with their own strengths and challenges, and are accustomed to very different billing, reporting, and authorization processes.

Creating a Cross-Sector Referral System with Housing Partners

Each MCP will need to learn what the affordable and supportive housing options and pathways to those options are for their members in each service area in which they operate. While local homeless response systems and MCPs may have different priority groups, they must find alignment where possible to ensure positive and equitable health and housing outcomes for people served. See *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide*.[17]

MCPs will need to establish systems-level partnerships and cross-sector referral systems that help service providers to support individual clients navigating the housing and services sectors. The cross-sector referral system should be easy to access, transparent in its operations and priorities, and use sophisticated technology to make interactions as seamless as possible for end users. Any new data system should be paired with training for all users that includes the reasoning for why certain data are collected and how data are used. (Appendix C offers a structure and key questions to guide the creation of a cross-sector referral system.)

CHAPTER 3

Bringing Housing-Related Providers into Local Network

MCPs contracting for housing-related CS services will be collaborating with community-based organizations that have expertise working with people facing housing instability and homelessness. These housing-related providers (HRPs) bring several strengths to such partnerships and require significant support from the MCP to make the collaboration successful. This chapter itemizes some of the specific supports that HRPs are likely to require.

The HRPs that may become a part of a local partner network are:

- Permanent supportive housing (PSH) providers
- Local Homeless CoC lead agencies and contracted providers
- Homeless services providers, including homeless and domestic violence shelter providers, interim and transitional housing providers, Medi-Cal recuperative care or medical respite programs, rapid rehousing service providers, and outreach service providers

These HRPs will bring with them several strengths as collaborative partners, such as:

- Understanding how to connect people to affordable and supportive housing resources and how to operate within the local housing and homeless service systems
- Experience delivering proactive community-based outreach and engagement services through innovative approaches and partnerships
- Established networks and relationships with rental property owners/property managers that enable placements for people with rental subsidies
- Trusted relationships with people experiencing homelessness

New Payment Models and Cash Flow Changes

However, HRPs have previously operated in separate spheres from MCPs. They have not needed to be conversant in health care financing, language, Centers for Medicare & Medicaid Services (CMS) regulations, Medi-Cal contracting and MCP credentialing requirements, negotiations, or the day-to-day health care contracting and administrative processes.

Most HRPs have program budgets with small margins and are primarily familiar with grants rather than the retrospective payment model of Medicaid. Most of their funding comes through the local CoC program, which operates on a prospective payment model. In smaller communities, one agency may operate homeless programs and develop affordable and supportive housing, all of which rely on up-front funding that is prospective.

Partnering with MCPs presents a significant shift in cash flow and creates gaps in funding for HRPs. Restructuring service processes, documentation systems, billing, and cash flow requires that a variety of administrative activities occur prior to the provision of reimbursable direct services. As they ramp up the provision of services, HRPs will likely need start-up funding to cover compliance and contract planning, hiring new staff, training, and policy and procedure development as they wait for reimbursement. MCPs can use their CalAIM Incentive Payment Plan (IPP)[18] Gap Filling funding to address the start-up and capacity-building needs of HRPs.

What Is the Incentive Payment Program?

The CalAIM Incentive Payment Program (IPP)[19] is a three-year funding opportunity totaling $1.5 billion that will be awarded to MCPs as they meet targets and deliverables identified in their submitted IPP plans,[20] following required needs assessments. This funding will be available through June 30, 2024, and can support the uptake of CS services, capacity building, provider start-up costs, quality improvement, the addressing of health equity, and the fostering of cross-sector streamlining efforts.

New Tasks Requiring Support

HRPs will be responsible for many new activities as they shift their program model and operations to include Medi-Cal services. HRPs may need additional support from MCPs to source appropriate technical assistance and identify internal MCP staff to liaison with HRPs, address, and triage issues using plain language. Support will need to be ongoing and may benefit from a phased approach. It will not be enough for MCPs to offer web-based materials for agencies to read; they will require hands-on support and dialog. Specifically, HRPs are likely to need help mastering the following tasks:

- Initiating and completing referral/authorization request forms for CS services and other network services; and tracking referrals out, referral requests, and authorization status
- Appropriately receiving, triaging, and addressing referrals received from MCPs and health care providers for CalAIM services; and tracking referrals in, reporting timely responses to referrals, and connections to services
- Identifying, purchasing, and managing new data systems and processes (including HIPAA [Health Insurance Portability and Accountability Act] compliance measures) for coordinating care with ECM and other CS providers
- Credentialing with MCPs
- Understanding the various Medi-Cal documentation processes flows, such as:
  - Member consents and releases
  - Assessments and reassessments
  - Service plans and plan amendments
  - Progress notes
  - Incident reporting
  - Grievance/complaint documentation
  - Whistleblowing/fraud protection processes
  - Obtaining a National Provider Identification (NPI) number
- Tracking Medi-Cal enrollment and MCP membership for clients
- Tracking start and end dates for service plans and aligning those dates with authorization dates
- Adopting and implementing HIPAA-compliant privacy and security policies and procedures
- Handling continuous quality improvement and compliance processing and tracking Medi-Cal claims for reimbursement:
  - Utilizing new billing codes
  - Understanding clean claim requirements
  - Engaging with and knowing clearinghouse processes
  - Completing billing and claims reconciliation processes
  - Conducting internal claims reviews
  - Exchanging data with MCPs
  - Handling denied and rejected claims

Steps MCPs Can Take to Support HRP Transitions to Medi-Cal

Successful MCPs will make it simple and straightforward for HRPs to navigate, track, and meet plan requirements by standardizing processes organization-wide (especially MCPs operating within the same communities). Following are specific steps that plans can take to maximize the success of the collaboration:

1. **Standardize processes and document templates across all MCPs in the same location.** This will enable HRPs to handle referrals, document assessments, service plans and progress notes, and submit documentation and clean claims in timely ways. MCPs may opt to redevelop and/or realign their existing assessments, service plans, and document templates. The more processes can be standardized, the smoother the transition will be for all parties.

2. **Identify dedicated points of contact (individual or team) within their organization to liaison with HRPs and support them in navigating MCP departments, processes, and staff.** Appendix D includes recommendations on how MCP departments can communicate their organizational idiosyncrasies with HRPs.

3. **Create and train a dedicated internal team or single point of contact to work with HRPs on tracking enrollment, eligibility, and authorizations.** Help fund updates with data system vendors to create additional data fields/alerts and/or HIPAA compliance for the Homeless Management Information System (HMIS). These steps ensure continuous health care coverage and CS authorization.

4. **Align eligibility and processes for services and housing to save HRP staff the significant administrative burden of piecing together eligibility requirements for housing resources for each member.**

5. **Fund start-up costs.** Corporation for Supportive Housing (CSH) has found that onboarding to the contracting process to develop a Medicaid revenue stream requires significant resources and time — 12 to 18 months. HRPs must hire new staff, revise or create new workflow processes, change procedures, and train staff in all updates. MCPs can use incentive funding to support HRPs in making this shift. Some plans connect new providers to established agencies with similar staff size and budgets, paying for technical assistance and cross-provider learning.

Timeline for Housing-Related Provider (HRP) Onboarding

Following is an approximate timeline for HRPs engaging in the process of collaboration with MCPs.

Strategy development and business planning (4 months). After identifying their priorities, agencies make an organization-wide commitment to a collaboration process. They seek out funds for start-up assistance, communicate with current clients and staff, and develop a work plan that reflects the new business model and requirements for staff at all levels as well as for clients.

Start-up and initial implementation (6 to 8 months). Agencies begin implementing the changes needed to be a Medicaid billing agency. Start-up costs include staffing, revising policies and procedures, determining how to bill for services, and contracting with a billing service or implementing an Electronic Health Record. Throughout the implementation, agencies need consistent communication and regular access to the MCP staff with specific expertise in the areas being addressed.

Sustaining program administration and revenue (4 to 6 months and ongoing CQI). Agencies have basic processes in place but may need ongoing support around the billing process to ensure timely reimbursement and steady cash flow. For many HRPs, having staff who manage continuous quality improvement (CQI) and Medicaid compliance is unfamiliar. Successful MCPs often have open office hours or other opportunities for real-time dialog with agencies.

Note: CSH's Medi-Cal Academies will assist HRPs during each stage with tools, training, and technical assistance. All materials will be offered on the California Health Care Foundation website.

Funding to Support CalAIM Implementation

California has made it a high priority to effectively address homelessness in the state and has offered numerous funding opportunities to help the state reach this goal. To support the organizational changes that will be required by both MCPs and HRPs, DHCS launched multiple new funding programs and an accompanying Funding Opportunities Cheat Sheet,[21] to help explain these opportunities.

The Housing and Homelessness Incentive Program (HHIP)[22] is a voluntary program that enables MCPs to earn incentive funds for making progress in addressing homelessness and housing insecurity. Funded through California's Home and Community-Based Services (HCBS) Spending Plan, HHIP funding for MCPs may total up to $1.3 billion in one-time funding, which will be available through March 31, 2024.

HHIP Measurement Priority Areas

The three Housing and Homelessness Incentive Program (HHIP) measurement priority areas are:

1. Partnerships and capacity to support referrals
2. Infrastructure to coordinate and meet member housing needs
3. Delivery of services and member engagement

MCPs can earn incentive payments for "progress in addressing homelessness…and keeping individuals housed." The incentive funding can be used to equip HRPs to replicate and/or strengthen evidence-based practices and staffing models pioneered by PSH providers. To opt into HHIP, MCPs had to submit a Local Homelessness Plan (LHP) — developed in partnership with local homeless response systems — to DHCS by June 30, 2022. This LHP process was intended to align with the concurrent Homeless Housing, Assistance, and Prevention (HHAP) Grant Program[23] funding application process, which comprises the Local Homelessness Action Plan (LHAP).[24]

What Are the Differences Between an LHP and LHAP?

LOCAL HOMELESSNESS PLAN (LHP)	LOCAL HOMELESSNESS ACTION PLAN (LHAP)
MCP-led, required as part of the Housing and Homelessness Incentive Program (HHIP)	CoC/city/county/tribal government-led, required as part of Homelessness Housing, Assistance, and Prevention (HHAP) Program Round 3
Administered by CA Department of Health Care Services (DHCS)	Administered by CA Interagency Council on Homelessness (Cal ICH)
One-time, $1.3 billion incentive funds	$1 billion noncompetitive block grant
Payments will be earned by each MCP based on the successful completion of four components and measures; there is a maximum amount that each MCP can earn	Allocations for each eligible CoC/city/county/tribal government are based on their proportionate share of the state's homeless population as reported by the 2019 HUD Point-in-Time (PIT) Count
Purpose is to enable Medi-Cal MCPs to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health; thus, improving health outcomes and access to whole-person care services for the Medi-Cal population	Purpose is to provide local jurisdictions, including recognized tribal governments, with flexible funding to continue efforts to end and prevent homelessness in their communities
Funding available through March 31, 2024	Counties must have funds contractually obligated by May 31, 2024. CoCs and large cities must have at least 50% of funds contractually obligated by May 31, 2024. All funds must be fully expended by June 30, 2026.

Sources: CHCF analysis of data from Homeless Housing, Assistance and Prevention (HHAP) Grant Program, State of California Business, Consumer Services and Housing Agency, 2022, and the Housing and Homelessness Incentive Program, DHCS, last modified September 15, 2022.

To encourage collaboration, DHCS required MCPs operating within a single county to submit a joint LHP that is aligned with LHAP efforts to offer one integrated plan to multiple state departments. (See slides from the January 2022 DHCS webinar on the HHIP.[25])

To effectively implement the plans as laid out in LHPs, MCPs and community partners will need to:

- Further develop detailed analyses of what services and service gaps exist
- Strategize over how MCPs can both collaborate and invest to fill gaps, such as:
  - Provider network adequacy for ECM and CS services
  - Additional training for current provider networks to support transitions to new workflows and partnerships
- Align various funding resources at the local level, particularly CalAIM IPP and PATH (Providing Access and Transforming Health) funding, by identifying and engaging with community-based organizations (CBOs) to leverage resources and avoid duplication of efforts. PATH funding is especially important given its aim to: "build up the capacity and infrastructure for CBOs, public hospitals, county agencies, tribes, and others to successfully participate in the Medi-Cal delivery system."[26]

Additionally, the state is also interested in data sharing efforts between MCPs and entities operating local data systems, such as HMIS. MCPs will need to leverage local housing-related referral systems to ensure access to safe, affordable, and often supportive housing for their members, which will be key to achieving the outcomes required by the state.

CHAPTER 4

Data Sharing with Community Partners

To implement housing-related CS services and meet criteria to earn incentive payments, MCPs will need to enable data sharing with community partners and develop workflows to support referral processes, align access, and coordinate funding across sectors. Data sharing will be required at both the system and individual levels.

Data sharing can provide significant benefits to both MCPs and CoCs. MCPs stand to gain access to timely and near real-time data on the percentage of their members and more specifically, which individuals are experiencing homelessness or housing instability. Homeless services providers stand to benefit from data sharing through improvements in service delivery, cross-sector referrals, and housing for those jointly served by the MCPs.

The data sharing process takes time to develop and necessitates significant collaboration across sectors. Because CoCs are not subject to compliance with the data security standards of HIPAA, they may not have expertise to negotiate a Business Associates Agreement (BAA). CoCs and HMIS administrators may have limited resources in terms of staff and funding to support analytic capacity. In California, some CoCs are housed within health departments and already meet HIPAA compliance standards, while others are separate entities and prioritize compliance with HUD and local CoC data standards. The state has worked to clear the regulatory and legal concerns by summarizing their analysis and prioritization of data sharing in a state issues brief[27] on the topic.

Therefore, MCPs will need to support data quality efforts on behalf of CoCs, identifying gaps in data and supporting CoC-led efforts to ensure data are accurate, timely, and entered consistently across all homeless service providers. MCPs may also need to fund additional data analyst positions within a CoC and support a system upgrade, such as adding HIPAA compliance.

What follows is a suggested six-step guideline for planning and executing a data sharing initiative:

1. **Establish long-term goals**
2. **Examine the landscape**
3. **Plan for training**
4. **Create processes and tools**
5. **Ensure partners are supported**
6. **Execute and sustain efforts**

Details on each step are described below.

1. Establish Long-Term Goals

MCPs will need to internally develop a specific vision of the data sharing they wish to achieve at both the aggregate and individual levels. MCP and CoC partners are encouraged to develop use cases for how data sharing will drive new interventions on each side to support members. CoC lead agencies will be the MCP's primary partners for system-level data sharing and the CoC's network of providers should be part of the planning efforts for day-to-day operations of data sharing. All parties should consider their shared priorities, long-term goals, and the cross-training support needed. The HUD *Homelessness and Health Data Sharing Toolkit*[28] cites long-term goals, including:

- System integration that includes regular exchange of information and integration of multiple data systems via a data warehouse. The goal is regular cross-system collaboration integrated into workflows across multiple systems.

- Real-time data exchange that includes alerts and cross-system collaboration at critical transitions, such as hospital admission or discharge, shelter admission or discharge, or release from long-term incarceration. Real-time data exchange can facilitate care coordination outside health care settings.

2. Examine the Landscape

Before creating a network, MCPs need to conduct a landscape assessment of the agencies and CoCs addressing homelessness and housing challenges for MCP members. (Note: Some agencies may not contribute data to the local HMIS data system.)

Questions to explore and document in an MCP landscape assessment and network development plan include:

- What are the HRPs that operate within the MCP's service area?
- Has the MCP previously collaborated with these agencies and what was learned from that process?
- Which providers have already shared data with the MCP, and what paperwork or agreements are in place?
- Is HMIS the primary method used by HRPs to document visits, assessments, service plans, and housing status updates? Will sharing data solely with the local HMIS system meet the MCP's data needs to successfully implement CalAIM's housing-related community support services?
- Does the local HMIS system meet HIPAA privacy and security rules standards for data security and sharing? Does the local CoC include a release of information so persons served can choose (or not) to have their data shared?
- Does the CoC have staff and capacity to negotiate or review the MCP's standard BAA?
- What are some opportunities to engage HRPs and support stronger data entry and quality assurance practices? (Agencies may have limited incentives to support the MCP's mission without direct support to do so. HHIP may be a helpful funding source in these cases.)
- What would HRPs need in order to apply HIPAA privacy and security standards using HMIS? What can the MCP do to support compliance in data collection, data sharing, and encryption?
- Can the MCP support the CoC in engaging with the HMIS vendor to design HMIS for HIPAA compliance?

In preparation for engaging with local networks, MCPs should have the following items drafted for potential partners:

- A one-page description of the MCP's vision and goals for data sharing.
- Simple use cases showing the benefits of data sharing for all parties and how new CalAIM services improve community-wide health and equity.
- A sample data use agreement to initiate discussion and negotiation.

MCPs will need to connect to CoCs operating in their service area to initiate conversations about data sharing. Every California community has data on who is experiencing homelessness in their local HMIS. Each HMIS system is administered by a local CoC lead agency. The lead agency can be a county office or a local nonprofit or other quasi-governmental agency and can cover one county or multiple contiguous counties. The CoC applies annually for a federal grant that establishes this network of homeless service providers within a geographical area. CoC lead agencies may also elect to contract out the management of their local HMIS to an external vendor.

3. Plan for Training

MCPs are advised to consider external partners on a variety of topics, including Medicaid compliance, documentation fields and forms needed, and data sharing practices typical for partnerships with managed care. IPP and HHIP funds can be used to support these efforts.

Internal MCP staff will require cross training on HMIS, homeless system data, homeless system terminology, and best practices. They will also need training on receiving data from the CoC and how this data should be utilized to support members and referrals. Finally, MCP staff will need to be educated about current prioritization processes and the training and support needs of homeless system partners. Important considerations during this part of the planning process include:

- What internal training and support will the MCP need?
- What do MCP staff need to learn about CoCs, their provider networks, and best practices in the homelessness services sector? They will need information to make appropriate referrals and resource decisions around CS and ECM.
- For plans that will gain access (i.e., read-only or writing access) to HMIS, MCP staff will need training on how to access member-specific information and pull reports.
- How will each department's staff use HMIS access in their operations? Who will train these staff and what will it cost?
- What do housing and homeless system partners need to learn about MCPs and their capabilities and constraints in terms of HIPAA and other data privacy standards? Who will train these agencies, what will it cost, and who will pay for this training?

4. Create Processes and Tools

MCPs need to develop joint workflows, documentation, and policies/procedures between MCPs, CoCs, and HRPs. These may be part of a supported and negotiated BAA.

Useful questions to ask as this process unfolds:

- What entities are sharing data with what other entities? What data? How frequently is data shared? Which job roles involve execution of data sharing?
- How will the MCP engage people — especially local members — with lived expertise of homelessness? This will inform the best approach to obtaining assessments of housing status, language used for releases of information, and processes for collecting data using Z codes.
- What data on housing status does the MCP have internally through Z codes? How can the health care providers be incentivized to report this data consistently? Should plan processes be altered to update expectations and training for: care coordination, discharge planning, member outreach and engagement, network development and bringing on new providers, and analytics and reporting requirements?
- How will the MCP use the data tools to drive care planning and investment strategies? What regular reporting needs to be developed regarding housing status of members?

5. Ensure Partners Are Supported

MCPs will need to ensure that new network partners have the supports they need for administrative responsibilities to maximize their time and impact. Key considerations include:

- How can the health plan simplify processes to expand the network of potential providers? It is useful to create a map of internal process steps to identify complexities that might be simplified.
- Has the plan conducted an internal review to consider what processes are required for compliance and accreditations, and what other contracting processes can be simplified to expand the provider network to these agencies?

In developing and refining internal processes and tools, it will be important to ensure that the system reflects person-centered values. Questions to be considered include:

- What internal processes are being adapted and revised to address this new population and priority?
- Has the plan created a point of contact (along with backup points of contact) for homeless and housing systems, providers, and members? Has the plan created positions that connect to homeless and housing systems at the person, program, and systems level?
- Does the plan ensure that consent forms and assessments required of members are reviewed by persons with lived experiences of homelessness? This will reduce the risk of re-traumatization and needlessly requiring individuals to tell and retell their experiences.
- What data sharing risks are reasonable for the MCP to ensure that members are not retraumatized when assessments/data collection happen with multiple parties?

To enhance the results of collaboration, it is important to engage partners in data sharing goals as well as to demonstrate the MCP's commitment to addressing their priorities around housing stability and homelessness. To promote engagement, the MCP might:

- Offer short-term grants for agencies to fund system-level liaison positions with MCPs.
- Hold networking events for staff that will serve in cross-systems' roles.
- Develop trainings on MCPs and how agencies can partner with them to better assist people served by both systems.
- Create a leadership advisory group to prioritize data sharing goals internally for both systems. This group would include members with lived expertise of homelessness and would reflect the demographics of those served by the plan. The group would be compensated fairly and supported to be part of this process.

6. Execute and Sustain Efforts

The execution of data sharing efforts typically includes:

- Creating data use agreements and memoranda of understanding between partners.
- Technology upgrades (e.g., data fields, reports, and automation being added to existing or new electronic recordkeeping systems).
- Providing training and database access to staff, based on roles and the level of data they should have access to.
- Determining baseline data.
- Assessing the quality of initial data received.
- Setting goals for improvement across partner systems.

With early analytics knowledge in place, partners will be able to ensure that eligible members are receiving CS and ECM services, and access to PSH through connections to the housing and homelessness systems. It will now be possible to measure the return-on-investment that might be anticipated based on numerous pilot investigations.

Going forward, cross-sector teams will need regular meetings to discuss results, enhance collaborative systems, and develop a joint policy and advocacy agenda to address barriers and gaps. Fulfilling the potential of CalAIM to powerfully change the lives of unhoused Californians will require continuing energy and creativity in communities across the state.

Appendix A. Health and Housing Terms and Definitions

ACRONYM*	FULL NAME	DEFINITION
	Affordable Housing	Rent or mortgage payment that is no more than 30% of a household's income. For single people with disabilities, the threshold is less than 20% of area median income.
AHAR	Annual Homeless Assessment Report	Annual report to US Congress completed by HUD that provides nation-wide estimates on the number of individuals and families experiencing homelessness and housing/shelter capacity.
BCSH	Business, Consumer Services, and Housing Agency	State department that manages the Homeless Housing, Assistance, and Prevention grant program funds in California.
CDBG	Community Development Block Grant (HUD funding)	A flexible HUD funding program that provides communities with resources to address a wide range of unique community development needs.
	Chronic Homelessness	A federal definition that qualifies a person or household for unique assistance and in many communities, prioritizes them for permanent supportive housing.
CoC	Continuum of Care	Refers to a competitive HUD grant program and to community-based networks of homeless service providers funded by the grant program (grant recipients or "CoC leads" and their subrecipients). As networks, Continuums of Care operate as regional, year-round planning bodies of representative stakeholders that work toward addressing homelessness within a defined jurisdiction, typically led by single entities or a formal collaborative of entities (i.e., nonprofit organizations, states, and/or units of general-purpose local governments). CoCs create unified plans to organize and deliver housing and services, gather and analyze information to determine the local needs of those experiencing homelessness, implement strategic responses, and measure results.
CES	Coordinated Entry System	System to coordinate intake, assessment, matching, and prioritization to shelter and other housing resources.
DHCS	Department of Health Care Services	The California state department that administers Medi-Cal and funds health care services for Medi-Cal beneficiaries. DHCS also administers many other health care programs for Californians.
HCD	Department of Housing and Community Development	California state department that manages a variety of federal housing funding streams, including HOME and CDBG funds. The department also manages state programs, such as Project Homekey and No Place Like Home, among others.
ES	Emergency Shelter	Any facility whose primary purpose is to provide temporary shelter for people experiencing homelessness in general or for specific populations of people experiencing homelessness.
FMR	Fair Market Rent	Area rent levels published by HUD and used in determining Section 8 payment standards.

ACRONYM* / FULL NAME		DEFINITION
FPL	Federal Poverty Level	A measure of income level issued annually by the US Department of Health and Human Services. FPL is used to determine eligibility for certain programs and benefits.
HFA	Housing Finance Agency	State bond and tax credit allocating agency.
HHAP	Homeless Housing, Assistance, and Prevention Program	A state grant program that awards funds to CoCs, counties, cities, and tribal governments to address homelessness in their communities. This program is managed by the BCSH.
HIC	Housing Inventory Count	Report completed by a CoC in March and April providing an inventory of beds and units available to serve people experiencing homelessness as well as people in permanent supportive housing (PSH). Consists of three housing inventory charts for: emergency shelter, transitional housing, and PSH.
HIE	Health Information Exchange	An entity comprised of multiple stakeholders (e.g., providers, clinics, health departments, state actors, etc.) exchanging health information in a digital format.
HMIS	Homeless Management Information System	Refers to HUD-mandated local information technology systems to capture client- and program-level information on the characteristics and service needs of people experiencing homelessness by CoCs. CoCs are responsible for selecting an HMIS software solution that complies with HUD data collection, management, and reporting standards.
HOPWA	Housing Opportunities for Persons with AIDS	Established by HUD to address the specific needs of persons living with HIV/AIDS and their families. HOPWA makes grants to local communities, states, and nonprofit organizations for projects that benefit low-income persons medically diagnosed with HIV/AIDS and their families.
HRP	Housing Related Provider	Community-based organizations that have expertise working with people facing housing instability and homelessness.
	Housing First	A housing model whereby PEH are offered immediate access to permanent affordable or supportive housing, without clinical prerequisites (like sobriety or medication compliance) that formerly had been common in shelter or housing programs.
HUD	US Department of Housing and Urban Development	The federal agency responsible for national policy and programs that address America's housing needs that improve and develop the nation's communities and enforce fair housing laws. Established in 1965 with the mission to create strong, sustainable, and inclusive communities and quality affordable homes nationwide.
IPP	CalAIM Incentive Payment Program	IPP is a three-year funding opportunity from DHCS totaling $1.5 billion that will be awarded to MCPs as they meet targets and deliverables identified in their submitted IPP Plans following required needs assessments. This funding will be available through June 30, 2024, and can support the uptake of CS services, capacity building, provider start-up costs, quality improvement, the addressing of health equity, and the fostering of cross-sector streamlining efforts.

ACRONYM* / FULL NAME		DEFINITION
LIHTC	Low-Income Housing Tax Credit	Federal tax credit to encourage investment in low-income housing.
MAGI	Modified Adjusted Gross Income	The figure used to determine eligibility for lower costs in the Marketplace/Exchange and for Medicaid and the Children's Health Insurance Program (CHIP). Generally, MAGI is your adjusted gross income plus any tax-exempt Social Security, interest, or foreign income you have.
NOFO	Notice of Funding Opportunity	An announcement of funding available for a particular program or activity. HUD is statutorily required to administer the CoC Program Competition (competitive grant program) each year. As one of the largest funding sources for homeless service programs in the US, the NOFO application is a critical and time-intensive activity that takes much of a CoC's capacity in the late summer and fall.
PEH	People experiencing homelessness[29] (HUD definition)	An individual or family who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution; people who are losing their primary nighttime residence within 14 days and lack resources or support networks to remain in housing; families with children or unaccompanied youth who are unstably housed; and people who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing.
PHA	Public Housing Agency or Public Housing Authority	Administer HUD's low-income and public housing programs, including Housing Choice Vouchers, such as Section 8.
PIT Count	Point in Time Count	Point in Time Count annually counts all sheltered and unsheltered people experiencing homelessness in a community on one single night in January.
PSH	Permanent Supportive Housing	An evidence-based housing intervention that combines non-time-limited affordable housing assistance with wraparound supportive services for people experiencing homelessness, as well as other people with disabilities. This type of supportive housing enables the special needs populations to live as independently as possible in a permanent setting. PSH can be provided in one structure or in several structures at one site or in multiple structures at scattered sites.
RRH	Rapid Re-Housing	The provision of housing relocation and stabilization services and short- and/or medium-term rental assistance as necessary to help an individual or a family experiencing homelessness move as quickly as possible into permanent housing and achieve stability in that housing.
SRO	Single Room Occupancy	A residential property that includes multiple single-room dwelling units. Each unit is for occupancy by a single eligible individual. The unit need not, but may, contain food preparation or sanitary facilities, or both. It provides rental assistance on behalf of individuals experiencing homelessness in connection with moderate rehabilitation of SRO dwellings.
TAY	Transition Age Youth	Youth aged 16 to 24 who are experiencing challenges on their path to a successful adulthood, including youth transitioning out of foster care or juvenile detention facilities, youth who have run away from home or dropped out of school, and youth with disabilities. Youth in this age group are sometimes also called "youth in transition" or "youth aging out."

ACRONYM* / FULL NAME		DEFINITION
TBRA	Tenant Based Rental Assistance	Rent subsidies that a tenant can take from unit to unit.
TH	Transitional Housing	A project that has its purpose facilitating the movement of individuals and families experiencing homelessness to permanent housing within a reasonable amount of time (usually 24 months).
	Unaccompanied Youth	Minors not in the physical custody of a parent or guardian, including those living in inadequate housing, such as shelters, cars, or on the streets. Also includes those who have been denied housing by their families and school-age unwed mothers who have no housing of their own.
USICH	United States Interagency Council on Homelessness	United States Interagency Council on Homelessness authorized in 1987 to coordinate and catalyze the federal response to homelessness by working in close partnership with Cabinet Secretaries and its 19 federal member agencies and supporting governors, mayors, CoC leaders and other local officials.
VASH	Veterans Affairs Supportive Housing	Veterans Affairs programs for veterans experiencing homelessness.
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool	Assessment tool used by many communities to determine chronicity and medical vulnerability of people experiencing homelessness to intake and case management with a standardized tool.

* Acronym is listed when applicable.

Source: Author-generated list of health and housing terms and definitions, 2022.

Appendix B. Expertise and Coordination Best Practice Resources for Housing-Related Community Supports Services, by DHCS-Named Activities

ACTIVITY	IN-PERSON CONTACT	PAIRED WITH TRANSPORT AND COMPANY* FOR APPOINTMENTS	RECOMMENDED EXPERTISE AND COORDINATION PARTNERS	FIDELITY TOOLS, EBP RESOURCES, AND HELPFUL GUIDES
Searching for housing and presenting options	✔	✔	Coordination with PHAs, CoCs, local housing development agencies, and HRPs	VA Housing Navigator Toolkit HUD Toolkit FT 1: SAMHSA PSH Fidelity Scale, Choice in Housing
Assisting in completing housing applications	✔	✔	Familiarity with reasonable accommodation and fair housing laws; coordination with local legal service programs and HRPs to advocate on behalf of those with poor rental history, poor credit, and criminal records to secure housing placements	HUD guidance AHP guide The Nifty 50
Assisting in obtaining ID and documentation for SSI	✔	✔	Familiarity with special state programs that facilitate no-cost IDs for PEH. Staff may seek specialized online training to become SAHMSA SSI/SSDI Outreach, Access, and Recovery (SOAR) specialists.	SOARWorks
Supporting SSI application process	✔	✔	Partner HRPs that are currently offering these services	SOARWorks
Identifying and securing housing resources to assist with rent, matching available rental subsidy/voucher	✔	✔	Partner with PHAs to access subsidies/vouchers.	CoC points of contact list
Identifying and securing resources to cover security deposit, moving costs, adaptive aids, environmental modifications, and other one-time expenses	✔	✔	Awareness of reasonable modifications laws and partner with CoCs, County human service departments, local Area Agency on Aging (AAA), local public housing authorities, and private funders to secure deposits, moving costs, assess for adaptive aids, environmental modifications, and one-time expenses.	HUD guidance HomeFit guide AAA locator

ACTIVITY	IN-PERSON CONTACT	PAIRED WITH TRANSPORT AND COMPANY* FOR APPOINTMENTS	RECOMMENDED EXPERTISE AND COORDINATION PARTNERS	FIDELITY TOOLS, EBP RESOURCES, AND HELPFUL GUIDES
Assisting with requests for reasonable accommodations	✔	✔	Familiarity with fair housing laws and the many examples of what falls under "reasonable" for accommodations, including emotional support animals, corner units if noise disturbance could be a concern, and accommodations that could support emotional and mental well-being. Coordination should include local legal service programs, local housing authorities, and community-based organization housing providers who are currently providing these supports.	HUD guidance AHP guide
Engaging and educating landlord/property management	✔		Cross-training for landlords and property management on Mental Health First Aid and Supportive Housing 101, tenant rights, and reasonable accommodations. Service providers operating in scattered-site PSH benefit from having a housing team for streamlined communication with private landlords with tenant-based vouchers.	HUD Landlord Outreach and Recruitment
Ensuring living environment in prospective unit is safe and ready for move in	✔		Staff identifying and showing units must have knowledge of subsidy provider home inspection requirement and HUD Housing Quality Standards. This can save significant time and enable repairs to a unit before inspection versus after a client views the unit and awaits inspection results.	HUD Quality Standards Move-in Checklist Safety Tips
Communicating and advocating on behalf of member to landlord/property management	✔		Advocacy and communication should happen hand-in-hand. Communication includes the service provider teaching, modeling, and coaching behavior/action. This requires trusting relationships and small caseloads.	FT 1: SAMHSA PSH Fidelity Scale, Indicator 7.4.a
Assisting in arranging for and supporting details of the move	✔		Service providers need access to funds for move-in kits (i.e., basic living items, groceries, and basic furniture needs); movers/transportation.	Furniture Bank Network Emergency Assistance fund

ACTIVITY	IN-PERSON CONTACT	PAIRED WITH TRANSPORT AND COMPANY* FOR APPOINTMENTS	RECOMMENDED EXPERTISE AND COORDINATION PARTNERS	FIDELITY TOOLS, EBP RESOURCES, AND HELPFUL GUIDES
Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is in jeopardy	✔		Stages of Change, motivational interviewing (MI), and treatment planning skills are needed to understand a person's stage of change, to develop mutually agreed upon housing plans (i.e., frequency of visits, location, duration, goal, and intervention), and understanding of Trauma Informed Care (TIC) to create crisis plans.	EBPR 1: Stages of Change EBPR 2: MI Center for EBPs EBPR 3: TIC, TIC in PSH
Identifying, coordinating, securing, or funding nonemergency, nonmedical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day	✔		Access to company vehicles or way to reimburse staff for mileage and use of personal vehicles with clients (e.g., funding for gas, seat covers, personal protective equipment, and car cleaning services); funds for Uber/Lyft or other nonmedical transport to assist clients in arriving to nonmedical appointments needed to meet housing plan goals. This support in mobility and access can be trauma-informed and person-centered.	
Identifying, coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility	✔		MCPs and providers will need to work together with county human service departments, AAAs, local public housing authorities, and legal aid to build relationships and coordination for assessments, funding, and installation.	HUD guidance HomeFit guide AAA locator
Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations	✔		The ability to deliver this service requires the completion of an individualized assessment and housing plan. These services should be delivered by using best practices to include Motivational Interviewing techniques, Harm reduction, Housing First, Person-Centered Care, and TIC.	EBPR 4: CDC harm reduction help EBPR 5: Person-Centered Care Planning CSH Training Center
Education and training on the role, rights, and responsibilities of the tenant and landlord	✔		Understanding local, state, and federal tenant rights. Ability to describe legal jargon in lease documents in plain language. Funding/coordination for interpretation/translation of legal documents.	CA Fair Housing Rights

ACTIVITY	IN-PERSON CONTACT	PAIRED WITH TRANSPORT AND COMPANY* FOR APPOINTMENTS	RECOMMENDED EXPERTISE AND COORDINATION PARTNERS	FIDELITY TOOLS, EBP RESOURCES, AND HELPFUL GUIDES
Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy	✔		Coordination and shared goal setting with partners, cross-training in fair housing and PSH 101, regular coordination meetings with property management, and provider receiving copies of all documents sent to tenants to help track changes in building, late rent, and any notices (with tenant permission at intake).	CSH Not a Solo Act
Coordination with landlord and case management provider to address identified issues that could impact housing stability	✔			HUD Tips for Housing Stability Rent Repayment Plan template
Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse actions, including developing a repayment plan or identifying funding in situations in which the member owes back rent or payment for damage to the unit	✔			
Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized	✔		Coordination with behavioral health services, legal aid to support accommodations and fair processes, and peer support to prevent escalation toward eviction. This may require transportation support or accompaniment to appointments.	FT 2: Service Array in Pathways Housing First Fidelity Scale (ICM)
Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skill set.	✔		The ability to deliver this service will require a specialized skill set from a SOAR specialist. This may require transportation support and/or accompaniment to appointments.	EBPR 6: Center for EBPs Benefits Advocacy

ACTIVITY	IN-PERSON CONTACT	PAIRED WITH TRANSPORT AND COMPANY* FOR APPOINTMENTS	RECOMMENDED EXPERTISE AND COORDINATION PARTNERS	FIDELITY TOOLS, EBP RESOURCES, AND HELPFUL GUIDES
Assistance with the annual housing recertification process	✔		Knowledge of subsidy provider home inspection requirement and HUD Housing Quality Standards. Supporting tenant in repair requests.	HUD Quality Standards
Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers	✔		Assessment is ongoing. Reassessing goals and plan should occur every 6 months or time frame set by MCPs. Skills needed: Stages of Change, MI, person-centered treatment planning, harm reduction, and an interdisciplinary team approach.	FT 3: Housing First Model Fidelity Index
Continuing assistance with lease compliance, including ongoing support with activities related to household management	✔		Peer support, relationship building, having a copy of the lease document, receiving a copy from property management of lease violations to support client, regular coordination while protecting tenant privacy.	EBPR 7: SAMHSA Peer Support Services
Health and safety visits, including unit habitability inspections	✔		Understanding how to identify and help prevent common health and safety risks (e.g., falls, fires, water damage, hoarding, pests, unit being taken over by unwanted guests).	HUD Healthy Home Rating System (HHRS) and Hazards Chart
Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in)	✔		Receiving training in person-centered and client-authored housing crisis plans, WRAP training, use of MI techniques to teach ADLs, harm reduction.	EBPR 8: Wellness Recovery Action Plan (WRAP)

*Refers to a case manager or other support staff accompanying service recipients to appointments with other agencies, landlords, etc., to secure housing, documents, and other resources.

Acronyms: *ADLs* are Activities of Daily Living, *ATP* is At Home Program, *CDC* is Centers for Disease Control and Prevention, *CoCs* are Continuums of Care, *CSH* is Corporation for Supportive Housing, *EBPR* is evidence-based practice resource, *FT* is fidelity tools, *HRPs* are housing-related providers, *HUD* is US Department of Housing and Urban Development, *MCP* is managed care plan, *PHAs* are Public Housing Agencies/Authorities, *PSH* is permanent supportive housing, *SAMSHA* is Substance Abuse and Mental Health Services Administration, *SSI* is Supplemental Security Income, *SSDI* is Supplemental Security Disability Insurance, *VA* is Department of Veterans Affairs.

Source: Author analysis of expertise and coordination best practice resources for housing-related community supports services by DHCS-named activities, 2022.

Appendix C. Guide for Creating Cross-Sector Referral Systems and Resource Maps

Community Supports Leads/Leads for Members Experiencing Homelessness

A cross-sector housing and housing-related services referral system should have a number of key aligned aspects between systems. Ideally, systems will:

- Share data with each other to:
  - Identify members who are eligible for both Community Supports (CS) services and housing resources
  - Identify in Homeless Management Information System (HMIS) members previously connected to a specific CS contracted provider so that members can have continuity with the same provider
  - Inform equitable outcomes
  - Understand and plan for quality improvement efforts, and
  - Ensure ease of access to housing and services for members.
- Be knowledgeable enough about the other systems to troubleshoot issues between systems and for jointly held persons being served.
- Plan for cross-sector trainings as they will be necessary at all levels of the systems, including for direct service staff, supervisors, managers, and system leaders.
- Policy- and program-based liaison roles can be helpful to create these systems with each sector hiring a well-networked expert in the other sector for these liaison positions.
- Commonly, a person-centered process map exercise between sectors can create the materials needed to design the process. Including Persons with Lived Expertise (PLE) of homelessness will be an important part of successfully designing this process map.
- Include a process for case conferencing between systems that will identify challenges and disconnects early in the process and build toward resolutions at the person, program, AND system level.

First Questions to Ask

Local housing partners are very interested in developing additional supportive housing capacity for their communities, but their constant refrain is "Where is the services funding?" This is where managed care plans (MCPs) can be most valuable with their array of existing services and new investments in Enhanced Care Management (ECM) and CS. The trick will be to ensure that processes and populations match between systems. Two important questions cross-sector partners will need to answer include:

- Who manages housing access in the geographies in which we operate? and
- Where do our priorities overlap?

Before systems create their cross-sector referral systems, both systems need to jointly come up with access criteria that fit a sizable population in their communities and addresses priority for both sectors. Therefore, it is critical to outline how priorities overlap and what data are needed to include all those priorities. Matching data between systems to create a multi-sector priority list has occurred in many communities looking to end homelessness for people cycling between institutions and the street. These projects, called Frequent User System Engagement or FUSE projects[30] can serve as prototypes for the systems of scale that communities are looking to build.

First Steps in Coordinating Referrals and Resources

For each of their geographies, MCPs should answer the following questions:

Planning and Resource Mapping

- What planning efforts already exist around the Local Homelessness Action Plan (LHAP) (who is coordinating the LHAP efforts, who is involved, how do we get involved/support)?
- How can my MCP's Local Homelessness Plan (LHP) build on those efforts?
- What mapping, workflow charting, and coordination must occur to braid service funding in order to "supplement and not supplant services," as outlined by the California Department of Health Care Services (DHCS)?

Housing Access and Referrals

- What is the process for Coordinated Entry to the homeless programs in my community? For other non-homelessness programs what is their access process? Do members with disabilities receive any preferences? Do members who come with service packages receive any priority?
- For my local Housing Authority, is the wait-list open or closed? If open, how can I support members to sign up for the wait-list? If it's closed, does my Housing Authority have any "Special Purpose vouchers" for disabled populations that our priority members might be eligible for? What other conversations can my MCP have with a local Housing Authority?
- What is the access point for other affordable and supportive housing resources in my community, such as:
  - Project HomeKey
  - Homeless Housing, Assistance, and Prevention Program (HHAP) resources
  - Local resources
- What alignment mapping and business agreements are necessary for housing assistance to be aligned with CS Housing Deposits, when security deposits and other moving expenses are not covered in the housing program?
- In taking these first steps toward alignment, MCPs can create meaningful health and housing cross-sector referral systems that streamline access to affordable and supportive housing, a foundational social driver of health.

Action Plan Checklist for MCPs

- Identify staff member(s) who will outreach to housing partners at the City, County, Continuum of Care (CoC), Public Housing Authority (PHA), and developer levels to work collaboratively on the HHAP and any other coordination efforts. Identify how that person will gather information regarding housing partners that can be accessed by various members of your team, as needed. Build on MCP tools to gather information regarding your provider networks.
- Identify data leads who can work with homeless and housing systems to share data. Identify clinical liaisons to support this effort and ensure that the data shared are actionable and integrated into plan processes.
- Identify program leads who, with housing partners, can create a cross-sector referral system. Lay out eligibility criteria for all CS and Housing programs. Is there overlap? If not large enough, what entry criteria need to be reconsidered to ensure the MCP is having the level of impact committed to in the LHP.
- Develop planning documents for MCP Leadership Team implementing CS that:
  - Document the eligibility requirements for each housing program and how they align with your eligibility for CS in each County you serve, include which entity manages the housing assistance, and related contact information.

  - Document which eligibility criteria or population subset(s) do not align with housing resources and examine options for ensuring equitable care and access to housing.

- Common challenges and solutions to explore and document in your planning include:
  - Are there disparities in the systems and resource distribution that your MCP should note, as you work toward more equitable care?
  - Identify any eligibility criteria that need to change to ensure that members meet housing prioritization so that you can demonstrate outcomes and cost effectiveness?
  - Are there any possible members in your CS eligibility criteria who do not currently have housing resources aligned and prioritized for their housing affordability needs?
  - If there are eligible population subsets in your housing-related CS that need housing assistance and do not meet housing program eligibility due to limited resources or inequities, how will your plan's services create positive outcomes for the member without housing? And/or what flexible funds could fund housing assistance?

- Charge the cross-sector planning team with developing a process for referrals that begins with service assignment by MCPs but leads to housing referrals in the Coordinated Entry or other county-wide system. Ensure that the burden for coordination lies with the systems and NOT with those needing assistance or providing direct services.

Appendix D. Guidance for Managed Care Plan (MCP) Departments Interacting with Housing-Related Providers (HRP) to Deliver Community Supports

How MCP Departments Will Be Impacted and How They Can Support CBOs.

- Provider Relations/Network Development will be contracting with agencies, with little to no history in health care contracting and billing. Nevertheless, these agencies are needed in network to reach members; flexibility, compassion, and ongoing FAQ support will be necessary when partnering with the workforce.
- Member Services will be working with more members experiencing homelessness and those who support them — including homeless service providers. Plans will need to develop, with member consent, a way to coordinate with Community-Based Organizations (CBOs). Many members will not have a mailing address or a reliable phone.
- Clinical and Utilization Management will have to consider in their discharge-planning role, where people will live upon discharge. If not returning to a safe home, what are the options?

Community Supports Leads/Leads for Members Experiencing Homelessness

Community-Based Organizations (CBOs) will likely have no framework for collaborating with the range of MCP departments that handle Medi-Cal managed care. This appendix includes recommendations on how common MCP departments might prepare their operations for welcoming in new provider types, such as housing-related providers (HRPs).

These changes in operations and funding for HRPs are falling on organizations that are skilled and resourceful, but also that have been underfunded and stretched thin with worker shortages.[31] Low wages, lack of benefits and professional development, vicarious trauma,[32] and a lack of housing resources to meet the needs of all the people frontline workers serve, all lead to high turnover rates and burnout among homeless service providers. Now this workforce is also facing added challenges, having ramped up activities working on the frontlines of the COVID-19 pandemic to move vulnerable unsheltered members into hotels and non-congregate housing for the last two years.[33]

Homeless- and housing-focused CBOs will bring important strengths to your provider network and may also face challenges in executing the potential contracts offered by MCPs. CBOs will not be familiar with these contract types and may not have access to legal counsel or advice from agencies that have experience with these contracts. To contract with these agencies, MCPs should consider how to modify and simplify some administrative processes and dedicate resources to expanding their provider network and their partnerships. With focus on expanding their provider networks to homeless and housing services providers and some small modifications and extra support for those agencies, California's MCPs can be leaders nationwide in the movement to address Social Drivers of Health.

MCPs are advised to envision an enhanced process to support a network of agencies with no experience in health care contracting, which should include:

- Reviewing new provider contracting processes,
- Revisiting contract template language,
- Developing training material and supports, and
- Having one or more provider representatives on a team to quickly respond to provider questions.

The MCP teams working with homeless and housing providers should receive training and support on the MCP's goals around engaging HRPs, the HRPs' histories, strengths, values, and challenges. Members of this team will need to be excellent communicators who understand how to work with agencies that are outside traditional health care contracting language and processes.

Special Populations, Clinical and Utilization Management

HRPs will also have no history or understanding of working with any type of prior authorization process and will need to understand what the MCPs are requiring in this area. MCPs' Utilization Management teams need the same perspective as other MCP departments in working with HRPs. Guidance for agencies on working with Utilization Management or Clinical Management staff will need to be in simple, plain language and steer away from health care jargon. HRPs will welcome the support of Care Coordination staff but will need education on their role and how that role can complement the supports offered by the HRPs.

Finally, HRPs are likely to be sophisticated in data management and outcomes reporting related to housing status of members. MCPs can capitalize on this strength by collaborating with HRPs and systems, such as homeless Continuums of Care and Homeless Management Information Systems (HMIS) for outcomes and impact reporting. HRPs also are likely to have their own priorities from a data management perspective and therefore, support from the MCPs will be needed to be full partners in this process.

Teaching HRPs About the Need to Ensure Continuous Medi-Cal Coverage and Authorizations

Many HRPs are just learning to track Medicaid enrollment and eligibility for members. Counties operate the Medi-Cal enrollment system and MCPs are given information on who is enrolled from those county systems. MCPs will be advised to explain simply the Medicaid enrollment processes OR partner with county offices that do this work. HRPs will need to learn administratively simple ways to check enrollments and CS authorizations and know what to do before and after they have lapsed. The California Department of Health Care Services' (DHCS) guidance on information sharing[34] with HRPs can help MCPs develop materials and consider how to communicate with agencies that may or may not be an enrolled Medicaid program provider currently. MCPs' member-facing departments will need training and potentially a group of staff who specialize in working with these agencies through this process of tracking enrollment, eligibility, and authorizations.

MCPs will be taking time and resources to support this learning on the part of HRPs, but that learning will support stronger HRP networks in the counties that MCPs serve.

Appendix E. Framework for Data Sharing Dialogue Between Managed Care Plans (MCPs) and Housing-Related Providers (HRPs)

	USE CASES	CONSIDERATIONS
Individual member data	Shelter and outreach providers contacting plans to determine if the person they are working with has current services or is eligible for Enhanced Care Management (ECM) or other Community Supports (CS) services. MCPs have access to the local Homeless Management Information System (HMIS). Access can be "read only" or another job role where MCPS can have write access.	Plans need an information-sharing policy for homelessness system providers. Plans should have designated liaisons to these systems. Plans need to train internally and externally on the policy. Plans need to support the local homelessness systems to ensure this process is prioritized and has the needed capacity to operate.
Provider/Network data	Plans create Business Associates Agreements (BAAs) or other data sharing arrangements with homeless services providers to address their own network adequacy issues in addressing homelessness. Plans' care coordination staff collaborate with local homeless services providers to assist members who are currently homeless.	Homeless services providers will need incentives and capacity building to be full, effective partners. Homeless services partners often are able to find members more easily than health plans, particularly members with complex care needs. As plans build out their social determinants of health (SDOH) referral systems, having an adequate referral network that can manage capacity will be critical to health plan success.
Community/Systemwide/ Population health data	Regularly scheduled data sharing for joint community reporting. Population health data reporting that includes housing and homelessness analysis to drive plan strategy, investment, and community capacity-building efforts.	Continuums of Care (CoCs) and their provider networks are seldom covered entities or have the capacity needed to create or consider a BAA. MCPs should be aware of this and have strategies to address. Strategies could include funding for CoCs and providers, training, and other capacity-building support.

Source: Author analysis of framework for data sharing dialogue between managed care plans and housing-related providers, 2022.

Appendix F. Additional Resources on Health Care and Homelessness Data Sharing

Breaking Down Siloes: How to Share Data to Improve the Health of People Experiencing Homelessness.
California Health Care Foundation (CHCF)

Community Information Exchange Toolkit: Collaboration and Cross-Sector Data Sharing to Create Healthier Communities (PDF)
LeSar Development Consultants

Data Sharing Template for PHAs and Health Organizations
Council of Large Public Housing Authorities (CLPHA)

Guidance and legal analysis for MCPs needing to receive or share data with their local homelessness systems
California Department of Health Care Services (DHCS)

HMIS Data Standards
US Department of Housing and Urban Development (HUD)

Homelessness and Health Data Sharing: Why and How Communities Are Sharing Data to Improve Outcomes for People Experiencing Homelessness (PDF)
HUD

Homelessness Response 101
CHCF

How to Share Data: A Practical Guide for Health and Homeless Systems of Care
CHCF

Endnotes

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2. The California Department of Health Care Services cited several studies in their Evidence Library. Additional studies and literature reviews uphold several key program and service delivery components that contribute to successful outcomes. The studies listed in the DHCS Evidence Library Executive Summary and CSH's own research library demonstrate improved member health and cost effectiveness.
3. The Enhanced Care Management (ECM) benefit, made available through CalAIM, is intended to help Medi-Cal members who have complex or chronic conditions to navigate multiple health systems.
4. "Diversion," National Alliance to End Homelessness, last updated August 10, 2022.
5. "Street Outreach," HUD Exchange, last modified 2022.
6. "Housing Authorities on the Web: California," US Department of Housing and Urban Development (HUD), last modified 2022.
7. Marcella Maguire, Allie Atkeson, and Sandra Wilkniss, *Health and Housing: Introduction to Cross-Sector Collaboration* (PDF), Health Resources and Services Administration (HRSA), December 2021.
8. "Our Vision," State of California Business, Consumer Services, and Housing Agency (BCSH), 2022.
9. *Putting the Funding Pieces Together: Guide to Strategic Uses of New and Recent State and Federal Funds to Prevent and End Homelessness* (PDF), California Homeless Coordinating and Financing Council, last updated November 2021.
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17. *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* (PDF), DHCS, August 2022.
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20. "CalAIM Incentive Payment Plan (IPP) Program Year 1 Gap Filling Plans," DHCS, last modified June 30, 2022.
21. *Funding Opportunities Cheat Sheet* (PDF), DHCS, 2022.
22. "Housing and Homelessness Incentive Program," DHCS, last modified September 15, 2022.
23. "HHAP Grant Program," BCSA.
24. *Local Homelessness Action Plan and Application Template* (PDF), California Interagency Council on Homelessness, February 15, 2022.
25. *HHIP Stakeholder Kickoff Meeting* (PDF), DHCS, January 31, 2022.
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27. *CalAIM Data Sharing Authorization Guidance* (PDF), DHCS, March 2022.
28. *Homelessness and Health Data Sharing: Why and How Communities Are Sharing Data to Improve Outcomes for People Experiencing Homelessness* (PDF), HUD, September 2020.
29. *Homeless Definition* (PDF), HUD Exchange, 2022.
30. "FUSE," Corporation for Supportive Housing (CSH), last modified 2022.
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33. Joy Moses, *Responding to COVID-19: Conversations with Homeless System Leaders* (PDF), National Alliance to End Homelessness, August 2020.
34. *CalAIM Data Sharing*, DHCS.