Building on CalAIM's Housing Supports

Strengthening Medi-Cal for People Experiencing Homelessness

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About Corporation for Supportive Housing

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. CSH is a 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. 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. Learn more at www.csh.org.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system. 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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Executive Summary

While the health care system cannot by itself solve homelessness, it has a crucial role to play in providing access to services critical to the welfare of people experiencing homelessness. Across the state, organizations and communities help people exit homelessness every day. But the story behind each success is often a long journey through layers of administrative barriers and siloed programs. Navigating access to meaningful care by people experiencing homelessness, who are already facing trauma and struggles to survive, requires a person-centered approach to care.

California's Medicaid program, Medi-Cal, is undergoing an ambitious transformation known as CalAIM (California Advancing and Innovating Medi-Cal).[1] A key focus of this transformation is removing barriers to care for populations who struggle to access services, including people experiencing homelessness. A critical goal of CalAIM is a more person-centered approach to publicly funded health care.

This paper rests on a foundation of extensive research and examines the successes, challenges, and opportunities in providing person-centered care to people experiencing homelessness. In **Part 1**, the authors describe in detail how homelessness undermines a person's health. When people live outdoors or without reliable shelter, existing health issues are made worse, and people develop new ones. Californians experiencing homelessness die in large numbers from causes directly related to their lack of housing. Homelessness cuts lives short: People experiencing homelessness die on average 20 to 30 years younger than their housed counterparts.[2] Homelessness also exacerbates existing racial health disparities, with Black and American Indian / Alaska Native people being significantly more likely to experience homelessness.[3] Decades of racism in housing and institutional policies contribute to these disparities, leading to untreated chronic health conditions and other behavioral and physical health problems that contribute to chronic patterns of homelessness and early mortality.

The primary driver of homelessness is a lack of affordable housing. **Part 2** describes opportunities in CalAIM, in the Providing Access and Transforming Health (PATH)[4] initiative, and in the Home and Community-Based Services Spending Plan[5] to fund housing support services that connect people to housing and help keep people stably housed. This section also includes explanations of CalAIM's Enhanced Care Management benefit (PDF)[6] and Community Supports (PDF),[7] seven of which specifically focus on people experiencing homelessness.

Despite the promise of CalAIM and related programs, CalAIM's impact has been limited to date. **Part 3** describes the challenges providers and managed care plans face in implementing CalAIM and the provision of housing support services. Health care and social service providers offering services under CalAIM must navigate differing reimbursement rates — which may not be enough — and differing requirements set by each managed care plan, even among plans operating in the same county. Managed care plans may not know how best to identify and reach people experiencing homelessness, and to connect people to housing and housing support services. Meanwhile, people who are unhoused must still find and access the care and services they need by navigating complex systems of care and fragmented provider networks.

Recommendations

The substantial research cited in this report highlights the need for a well-designed Medi-Cal benefit for housing support services that would make the integration of housing and support services funding possible and sustainable.

The report offers these seven recommendations California policymakers can take now to implement Medi-Cal housing supports and achieve person-centered care for people experiencing homelessness:

1. Seek federal approval by the end of 2024 for a housing support services Medi-Cal benefit to provide a comprehensive range of services to all Medi-Cal members experiencing homelessness.
2. Set provider rates that adequately support housing-related services, covering the full costs of evidence-based programs.
3. Fund evidence-based homeless outreach and engagement strategies through sustainable funding sources.
4. Build the capacity of community-based organizations to implement housing-related services.
5. Develop a plan for integrating inter-agency health and housing policies, aligning funding models and resources effectively.
6. Establish equity benchmarks to address health disparities and reset eligibility criteria based on need.
7. Create a process for referrals that begins with the homeless response system, allowing for smoother access to housing support services.

These recommendations can help advance our health care system toward evidence-based, comprehensive, person-centered care that can help people with the most complex needs find and access housing, obtain needed care, stabilize, and thrive.

Foreword: Bob's Story

Unable to manage his diabetes and clinical depression after a difficult divorce left him unable to afford rent, Bob sought emergency treatment at Oakland's Highland Hospital about 12 times a year.

In his 50s, Bob had nowhere to shower or store his medication. Following a healthy diet was almost impossible. He spent most days hunkered in De Lauer's, a downtown Oakland newsstand, in an effort to stay safe. He could not rest because the shelters were noisy and the streets dangerous. As Bob focused on day-to-day survival, his conditions worsened. Like many Californians experiencing homelessness, Bob qualified for Medi-Cal coverage, but he did not know his insurance plan, had no primary care physician, and lacked transportation.

On one visit to Highland's emergency department (ED), Bob met Maria, a social worker with Project RESPECT, a "Housing First" program providing intensive case management services[8] to people frequently visiting hospitals due to acute conditions. Project RESPECT had partnered with the hospital to identify and provide outreach to people experiencing homelessness and visiting the ED. Maria began establishing a trusting relationship with Bob. She worked with him to plan for his care and make sure he got what he needed: medical care, mental health treatment, new teeth, and assistance finding a place to live. After a few months of working together, Maria found Bob a small apartment and a subsidy from the local housing authority that prioritized Project RESPECT clients.

Bob said he felt "human for the first time in years." He was able to remain in his own apartment for about five years, when he died from his chronic illnesses.

After Bob moved to his new home, Maria continued to work with him to improve his health. Eventually, he stopped visiting the ED, no longer used drugs, reestablished relationships with his kids, and even began volunteering at a veterans' hospital. He said he felt "human for the first time in years." Bob was able to remain in his own apartment for about five years, until he eventually died from his chronic illnesses.

Meaningful access to health care is elusive for people experiencing homelessness, like Bob. People like Bob bear the burden of navigating administratively complex and uncoordinated health, housing, and social services systems, leaving them to access care in acute care settings or not at all. The result is relentlessly poor outcomes and unnecessary suffering for those affected, as well as the grossly inefficient use of resources.

California's Potential to Address Homelessness

In responding to homelessness and its health ramifications in California, the Department of Health Care Services (DHCS) is taking a leading role (described in detail in Part 2 of this report) through the following programs and initiatives:

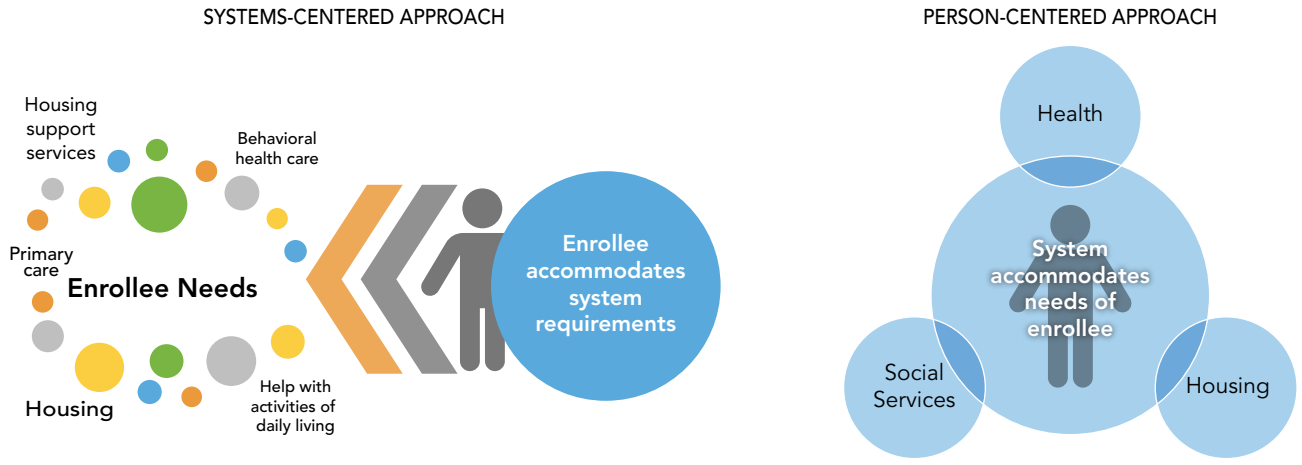
- California Advancing and Innovating Medi-Cal (CalAIM)
- Providing Access and Transforming Health (PATH)
- Home and Community-Based Services (HCBS) Spending Plan

Importantly, state leaders are working to make Medi-Cal an integral component in solving homelessness through bridging two major systems — housing and health care — with a goal of creating a person-centered approach to receiving care. A person-centered approach seeks to accommodate the unique needs of the person, rather than requiring the person to accommodate the way the system operates (Figure 1). In a person-centered approach, the person drives their care, and systems coordinate to meet the person's needs.

This report provides research findings and background on the current system, opportunities, and challenges associated with integrating housing and health care systems, and specific recommendations for creating a housing support services benefit that does the following:

- Reliably funds evidence-based services to help people access housing and remain stably housed.
- Coordinates and aligns with housing and homeless response systems.
- Includes people with lived experience in all aspects and components of the health care sector, including policymaking, program design, delivery system, service delivery, financing, and research.
- Increases access to people with the greatest barriers to receiving care.

Figure 1. Current Systems-Centered Approach to Care vs. Person-Centered Approach to Care



Sources: *What Is People-Centered Care?*, World Health Organization, YouTube video, June 21, 2017; and "Person-Centered Care," Centers for Medicare & Medicaid Services.

Part 1. Background: Homelessness Complicates Care

How Homelessness Undermines Health

For Californians without housing, the traditional approaches to health care fail under any typical measure — access to care, health outcomes, equity, or costs.[9] The consequences are often lethal; every year, thousands of Californians die from causes directly attributable to homelessness.[10] A literature review showed that people experiencing homelessness die, on average, 20–30 years younger than housed people with similar health conditions.[11] An Alameda County study revealed that the health conditions of people without housing were akin to those of housed people 25 years their senior.[12]

A relatively small number of Medi-Cal members experience homelessness — an estimated 273,500 Californians, or less than 2%[13] — but their needs are complex. People experiencing homelessness encounter a combination of health risk factors, such as exposure to communicable disease, extreme temperatures, unsanitary conditions, poor nutrition, sleep deprivation, physical and emotional trauma, and long periods of standing and walking. They face extreme danger of physical and sexual assault and are far more likely to be victims of violence than people who are housed.[14] They develop a more complex array of medical and behavioral health conditions while homeless. They are more likely to suffer debilitating skin and foot conditions, as well as heart and lung disease.[15] The stress of homelessness can bring on or exacerbate behavioral health conditions such as complications from stimulants (which many people use to stay awake and vigilant), major depression, anxiety, or post-traumatic stress.[16] Further, research shows that people cannot significantly improve their health without housing and that, in fact, health conditions continuously worsen during episodes of homelessness.[17]

Homelessness exacerbates existing racial health disparities. In California, Black people are more than five times more likely to experience homelessness than the population as a whole, while American Indian and Alaska Native (AIAN) populations are over four times more likely.[18] Decades of racism in housing and institutional policies underpin today's housing inequities,[19] which are consistent with health disparities seen in Black and AIAN populations with regard to preventable hospitalizations, hospital readmissions, and untreated chronic conditions.[20]

Although California spends two to three times more on people who are unhoused than on other Medi-Cal members, people experiencing homelessness still have far worse health outcomes.

Homelessness is also costly to public health care systems. Although California spends two to three times more on people who are unhoused than on other Medi-Cal members, the former have far worse health outcomes. For the costliest 10%, the public health care system spends more than $75,000 per person annually,[21] often because hospitals keep people longer than medically necessary when they lack a safe and stable place to recover. Also, people without housing are often admitted to nursing homes for conditions that could be managed at home with nursing support.[22]

Housing Affordability

A lack of affordable housing for people with the lowest incomes is the leading driver of the homelessness crisis in California, where renters need to earn almost three times the state's minimum wage to comfortably afford the average rent for a two-bedroom apartment,[23] and people with the lowest incomes pay a far higher portion of their income for housing than is sustainable.[24] Substantial research points to the critical role of housing in solving homelessness

when said housing does not limit length of stay ("permanent housing")[25] and is affordable to someone in deep poverty.[26] Health and social services are far more effective when provided to a person living in housing rather than to someone living in a shelter, a vehicle, or on the street.[27] When people experience homelessness, they are focused on survival: where to sleep or how to stay awake so as to avoid abuse, how to access food and water, how to store medication or access medication, how to avoid the elements. This instability does not allow people to recover from or evade illness. Health stability is only possible with housing stability.[28]

Data show that people who have experienced homelessness and complex health challenges can thrive with housing and services offered through a "Housing First" approach.[29] Grounded on American psychologist Abraham Maslow's hierarchy of needs[30] theory of human motivation, Housing First is a recovery-oriented model developed about 30 years ago to address the needs of people experiencing both homelessness and serious and persistent behavioral health conditions. Housing First programs result in high rates of housing stability,[31] decreased emergency room visits and inpatient hospitalizations,[32] reductions in incarceration,[33] and reduced substance use.[34]

This evidence-based model shows that people must have a safe and stable home before they can improve their health conditions.[35] The federal government[36] and the state of California[37] now require almost all housing and service programs receiving homelessness services funding to adopt the Housing First core components, which include harm reduction and helping people move into permanent housing as soon as possible without preconditions. Housing First uses a voluntary service approach that does not condition housing on participation in a program or services.[38] CalAIM's Community Supports, discussed in this report, also adopt these core components of Housing First.

The Role of Housing Subsidies in Supporting Someone to Exit Homelessness

People with little or no income often require "affordable housing," which is made possible through subsidies. "Tenant-based" subsidies allow a person to rent from a private-market landlord; "project-based" subsidies help developers of affordable housing pay for the costs of operating an affordable or supportive housing project (in a project, tenants do not take the subsidies with them if they move). Subsidies include the following:

- **Capital funding.** The federal government, the state of California, and local governments offer capital funding for developers of affordable housing to build a project that offers apartments affordable to people with low incomes.
- **Operating funding.** The federal government funds "project-based" subsidies to pay the costs of operating new affordable or supportive housing developments. The subsidy amount is the difference between the cost of operating and maintaining those apartments and 30% of the tenants' income. California sometimes pays the up-front operating cost for new projects through a "capitalized operating subsidy reserve" that developers can draw from over time.
- **Tenant-based rental subsidies.** The federal government and some counties in California offer tenant-based rental housing subsidies, which pay a private-market landlord (or a nonprofit that has leased apartments from private-market landlords) the portion of rent the tenant cannot afford to pay. The best-known and largest housing subsidy program is the federal Housing Choice Voucher program, also known as "Section 8."
- **Public housing.** The federal government also owns and operates "public housing," affordable apartments all in a single project (though California has little remaining public housing).

Two Definitions

Housing Versus Shelter

"Housing" is distinguished from temporary places to stay (often referred to as "shelter" or "interim housing"). In this report, "housing" refers to a place to live without time limits ("permanent housing"). Such housing is:

- A permanent structure, usually with a foundation and access to what makes a home healthy, such as running water and a bathroom in the unit.
- A decent, safe, healthy place to live, typically an apartment or rental home, with the requirements of an apartment in California (i.e., hot water, electricity, and heat).
- Subject to the same landlord-tenant protections and laws as other California renters.
- Not a licensed setting.

Tenancy-Sustaining Services

Tenancy-sustaining services help people adjust to living in housing and address behaviors that could lead to eviction. People receiving voluntary services who are paired with assertive engagement — the process of using interpersonal skills and evidence-based practices to engage someone who is distrustful — are more likely to participate in services, to receive treatment,* and to be satisfied with their services than people in programs that require them to participate in services or "comply" with a program.†

* Min Hwa Lee and Mi Kyung Seo, "Perceived Coercion of Persons with Mental Illness Living in a Community," *International Journal of Environmental Research and Public Health* 18, no. 5 (Mar. 2021): 2290; Angela A. Aidala et al., *Frequent Users Service Enhancement 'FUSE' Initiative* (PDF), Columbia Univ. Mailman School of Public Health, 2014; and Daniel Gubits et al., *Family Options Study: 3-Year Impacts of Housing and Services Interventions for Homeless Families*, US Dept. of Housing and Urban Development, October 25, 2016.

† *Evaluating Your Program: Permanent Supportive Housing* (PDF), Substance Abuse and Mental Health Services Administration (SAMHSA), 2010.

"Supportive housing" is affordable housing with intensive tenancy-sustaining services designed to help people with disabilities remain stably housed (see more information about evidence-based tenancy support services below). Such housing is most appropriate for people with multiple disabilities and is strongly associated with reductions in acute care use and costs. Tenancy-sustaining services are critical to the success of supportive housing.

Resources for Housing Subsidies

California has recently increased investments to local governments and to developers to build housing and temporary/interim stays in shelter or other temporary settings. California does not directly invest in rental housing subsidies for people experiencing homelessness, but some counties have recently created programs that pay subsidies for rental apartments in the existing private market.

The state has invested in capital funding to convert existing structures into housing or temporary places to stay (non-congregate shelters) and to build new permanent housing projects. Yet the scale of funding needed to build projects offering permanent housing is nowhere near what it would take to allow even 15% of California's homeless population to exit homelessness.[39] What's more, waiting lists for federal rental housing subsidies, like Housing Choice Vouchers (Section 8), in California can be 10 years long or closed altogether, as demand for subsidies is far higher than supply, with only four in 10 households eligible for a rental subsidy receiving one.[40]

However, several programs prioritize resources for people experiencing homelessness, and many housing authorities establish preferences that allow them to more quickly access federal housing rental subsidies such as Housing Choice Vouchers. When a household no longer needs a subsidy, that subsidy "turns over," and housing authorities, which run most federal rental subsidy programs, can prioritize people experiencing homelessness for these turned-over subsidies. Even with these preferences

and some local funding for rental housing subsidies, people experiencing homelessness typically wait nine to 12 months (or longer) before receiving a subsidy.

California has homeless response systems covering every county (often serving people across multiple counties) that homeless Continuums of Care navigate, working within or alongside a county agency or agencies, and sometimes city agencies funding housing. These entities often collectively control resources for housing, though they do not always coordinate effectively.

See Appendix B for more information on housing and housing resources.

Housing Support Services

Housing support services include finding and engaging people experiencing homelessness, helping people move into housing, and offering individualized attention and services to stabilize people in housing. Services begin with meeting people where they are — often outside, in vehicles, or in shelters — and building trusting relationships. Services continue through an individual's tenancy. Most individuals need "light" services to navigate the homeless response system, such as help accessing housing vouchers, help completing housing applications, and some help moving into housing (pre-tenancy, housing navigation, or housing transition services).

Some people require intensive, individualized tenancy-sustaining services in supportive housing. Organizations managing rental housing subsidies or developers creating supportive housing projects partner with homeless service providers to offer services to tenants, preferably at provider-to-tenant ratios of between 1:10 and 1:20.[41] People needing supportive housing include people with disabilities or major long-term health care needs, those experiencing long-term (chronic) homelessness, and people who have significant barriers to housing stability, such as those who cycle between institutionalization and homelessness.

The Corporation for Supportive Housing (CSH) has created a Supportive Housing Services Budgeting Tool[42] to help agencies, communities, and project planners estimate costs for supportive housing services. It includes common evidence-based service models, along with ideal staffing for team-based and individual case management.

Assertive Engagement: Vikki's Story

Vikki is a case manager in Los Angeles who was formerly unhoused. She shared her story:

"A truly caring outreach worker, Darren, rescued me from homelessness. He would stop by and try to engage in conversation with me, but I did not want anything to do with him. This went on for two years because I was so distrustful of anyone saying they wanted to help me because of my previous experience of being forced to take medication that almost killed me.

When I became very ill from a respiratory infection, Darren offered me bus tokens and information about the Rose Family Clinic. Something inside me said, 'OK, you need the doctor.' About a month into antibiotic treatment for my respiratory infection, when I was living in an emergency shelter at Daybreak for Women, Dr. King of Rose Family Clinic referred me to Edelman Westside Mental Health. It took another 11 months before I was referred to permanent supportive housing.

My case worker in supportive housing was so incredible! Believe it or not, I could not fill out forms. She went through housing applications with me, line by line, question by question, and completed forms with me in this way. Thanks to her real caring, when I was given the opportunity to be a resident at the Downtown Women's Center, I accepted.

Today, I am a case manager for people who are elderly and disabled in South Central Los Angeles for the Aging and Disability Resource Center. I no longer need help paying for my housing."

California has a network of effective homeless service providers highly skilled at assisting people experiencing homelessness. They offer a range of services:

- Meeting people wherever they are located and asking them what they need, then working toward meeting those needs. These "outreach and engagement" services include returning to see people, again and again, and building trust over months or even years, using evidence-based techniques of assertive engagement.
- Helping people access the local homeless response and Coordinated Entry System (PDF)[43] to complete applications for housing and housing subsidies, as well as benefits, if eligible, and to connect them to treatment.
- Recruiting landlords willing to take housing subsidies.
- Transitioning people from living outside to tenancy in their own apartment, often with support from peers with lived experience of homelessness.
- Offering case management or tenancy-sustaining services to those needing supportive housing. Such services help people plan to meet goals, avoid behaviors that may lead to eviction (like hoarding), shop for groceries, pay rent, navigate relationships with neighbors and landlords, coordinate and advocate for tenants' health care, and connect tenants with community services.

Multiple studies show that tenancy-sustaining, housing navigation, and outreach and engagement services significantly improve the stability of people after they are housed.[44] For some specific study findings, see Table 1 on page 13.

Table 1. Findings from Eight Studies on Housing and Support Initiatives

STUDY	LOCATION	METHOD	FINDINGS
Daniel Flaming et al., *Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients*, Economic Roundtable, September 1, 2013.	Los Angeles	Pre-/post-housing one-year analysis of costs and outcomes among 163 of the costliest 10% of homeless hospital patients	People receiving outreach, engagement, and tenancy-sustaining services reduced hospital costs by 72% and reduced the days they spent in the hospital by over 65%.
Maria C. Raven et al., "An Intervention to Improve Care and Reduce Costs for High-Risk Patients with Frequent Hospital Admissions: A Pilot Study," *BMC Health Services Research* 11 (Oct. 13, 2011): 270.	New York City	Pre-/post-housing one-year analysis of costs and outcomes among hospital patients identified as high-risk for readmission	People receiving housing navigation and tenancy-sustaining services decreased their hospital admissions by 37.5% on average, with 73.3% of patients having fewer hospital admissions in the year after the intervention versus the prior year.
Debra Srebnik, *"Begin at Home": A Housing First Pilot Project for Chronically Homeless Single Adults: One Year Outcomes* (PDF), King County Dept. of Community and Human Services, October 15, 2007.	King County, WA	Comparison between high-cost chronically homeless adults who received supportive services in housing and those who did not, one year after tenancy	People connected to supportive housing, receiving tenancy-sustaining services, had 74% fewer hospital admissions than a comparison group receiving usual care.
Alvin S. Mares and Robert A. Rosenheck, "Twelve-Month Client Outcomes and Service Use in a Multisite Project for Chronically Homelessness Adults," *Journal of Behavioral Health Services & Research* 37, no. 2 (Apr. 2010): 167–83.	Multiple cities	Pre-/four-years-post-placement evaluation of 734 chronically homeless people	Formerly homeless tenants receiving tenancy-sustaining services were able to decrease their mental health crisis services costs by 79% and were able to decrease their total health costs by 73% after moving into housing.
Daniel Flaming, Patrick Burns, and Michael Matsunaga, *Where We Sleep: Costs When Homeless and Housed in Los Angeles* (PDF), Economic Roundtable, 2009.	Los Angeles	Los Angeles County public agency costs among 9,186 General Relief (GR) recipients experiencing homelessness versus 1,007 people who formerly experienced homelessness and are now receiving housing subsidies and services	Homeless GR recipients incurred county costs of $2,897 *per month* versus $605 per month for people now living in housing and receiving tenancy-sustaining services.
Laura S. Sadowski et al., "Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Trial," *JAMA* 301, no. 17 (May 6, 2009): 1771–78.	Chicago	Randomized control-group study of 405 chronically ill, chronically homeless adults receiving housing with services versus similarly sized group receiving usual care	People receiving housing and services had 29% fewer hospital days and 24% fewer ED visits within 12 months than control group, and 46% fewer hospital days within 18 months than control group.
Mary E. Larimer et al., "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems," *JAMA* 301, no. 13 (Apr. 1, 2009): 1349–57.	Seattle	Randomized control-group study of chronically homeless people with alcohol use disorder receiving intensive case management, using harm reduction in housing, versus control group receiving usual care	People receiving services in housing incurred $2,449 less in Medicaid costs per-person *per-month* than control-group participants after six months. They had 45% fewer arrests, 42% fewer jail days, and a 60% decrease in alcohol and substance use, compared to the group receiving usual care.
David Buchanan et al., "The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial," *Amer. Journal of Public Health* 99, suppl. 3 (Nov. 2009): S675–80.	Chicago	Tenants of housing receiving intensive case management for people with HIV/AIDS compared to control group receiving usual care	Tenants receiving services lived longer and were 63% more likely to have normal immune systems than the control group.

Homelessness is a traumatizing experience.[45] People who are unhoused often also have past experiences of trauma such as these:

- Involvement in the foster care system as children[46]
- Adverse childhood experiences, including physical and sexual assault[47]
- Experience of domestic or dating violence[48]
- High rates of previous accidents, severe injuries, and traumatic or life-threatening health conditions[49]

Trauma can cause fear, hopelessness, isolation, and disempowerment. It can impact the survivor's ability to trust others.[50]

Housing First service models offer trauma-informed care (TIC), an evidence-based approach both health care services and social services providers use. Housing First–oriented services incorporate six TIC principles: (1) safety, (2) trustworthiness and transparency, (3) multidisciplinary support, (4) collaboration and mutuality, (5) empowerment and choice, and (6) cultural, historical, and gender understanding. These principles are described in detail in Appendix C.

Some people with disabilities cannot live independently without regular services that help them with cooking, cleaning, dressing, or other activities of daily living. Once housed, people can access these services through the In-Home Supportive Services (IHSS) program, a Medi-Cal program to aid people with disabilities to find help with these tasks. In most counties, IHSS enrollees must find their own IHSS workers, who can also be friends or relatives. Many enrollees elect to have someone they know provide IHSS services to them; however, finding a worker can be more challenging for someone who has experienced homelessness (as homelessness is socially isolating) and may not have these relationships. Medi-Cal also funds personal care services through a number of programs intended to allow people to live independently if they are at risk of institutionalization, such as the Program of All-Inclusive Care for the Elderly (for people 55 and older), the Assisted Living Waiver, the Home and Community-Based Alternatives Waiver, the Multipurpose Senior Services Program, and Community-Based Adult Services.[51] However, people who are unhoused struggle to access these services because of their homelessness status; they are often not eligible because of requirements to literally receive services in a home. Most supportive housing does not offer help with personal care services. As a result, enrollees who need help with activities of daily living have no choice but to live in licensed settings, putting California at risk of violating federal law requiring states and local governments to offer housing in the least restrictive setting.[52]

A person's need for tenancy-sustaining services and help with activities of daily living tends to be cyclical, not linear. Someone who has experienced homelessness for years is likely to need two to three years of intensive, more frequent services to overcome long-term trauma before stabilizing into a lower level of services. They may need intensive housing-related services again when experiencing stressors, such as the loss of a family member or a deteriorating health condition. Some supportive housing tenants need services for the rest of their lives due to the acuity of their conditions. Crucially, a person who loses services is at risk of losing housing, and a formerly homeless tenant who loses housing often faces greater challenges getting rehoused. A tenant's ability to achieve and maintain successful outcomes is therefore directly related to their service continuity, and whether those services are available for as long as or whenever the tenant needs them.

Supportive Housing Services: Emily's Story

Emily, who was formerly unhoused, shared her story about receiving supportive housing services where she currently lives:

"At the apartments where I live, I have social services I would not receive in a conventional apartment. Some of these services include substance abuse programs, healing arts, cooking, gardening, and health care. I have a doctor and social worker from the Department of Mental Health who come to my apartment biweekly.

Recently, I suffered a financial setback. Without the support of the supportive housing services and staff at my apartment complex, I may have found myself in an institution or back on the streets. You may think this will never happen to you, but it happens to thousands of people every day."

Part 2. Opportunities for Funding Housing Support Services Through Medi-Cal

Several states, including California, have been looking to Medicaid to fund services to address health-related social needs. In its 2015 Informational Bulletin on Coverage of Housing-Related Activities and Services, the federal Centers for Medicare & Medicaid Services (CMS) indicated that states can use Home and Community-Based Services (HCBS) and demonstration programs to support Medicaid recipients to obtain and maintain housing stability.[53] Since then, states have begun funding services for people experiencing homelessness. CMS recently approved three states' Section 1115 Medicaid waivers to include funding for housing support services for people experiencing homelessness. While California's managed care plans can currently offer posthospitalization housing for up to six months for people discharged from hospitals and other institutional settings, Arizona and Oregon recently received CMS approval to fund housing for up to six months for people experiencing homelessness or leaving institutional settings.[54] California's recently approved state budget similarly includes funding for up to six months of rental assistance or temporary housing for people exiting institutional settings through a CalAIM Transitional Rent Waiver Amendment.[55]

See Appendix D for more information on federal and state action to fund housing support services.

CalAIM — Intended to Offer a Whole-Person Approach to Care

CalAIM seeks to build and expand on the successes and lessons of two previous programs, the Whole Person Care (WPC) Pilot and the Health Homes Program (HHP), with the goal of creating something more robust, permanent, and statewide.

CalAIM's goals include shifting the state's Medicaid program toward a more whole-person-oriented approach, integrating Medi-Cal benefits with social services, improving the outcomes for enrollees with complex or high levels of need, and standardizing and making more equitable services funded across the state. For people experiencing homelessness, CalAIM programs offer the following services:

- Outreach and care coordination, including referral for social services, through a new Enhanced Care Management (ECM) benefit administered by managed care plans (MCPs). ECM is designed to support people with multiple conditions and complex needs in navigating multiple health and social service systems. People experiencing homelessness or at risk of homelessness are among eligible populations for the ECM benefit. MCPs receive an additional capitation payment for ECM services.[56]

- Community Supports — provided through a Medicaid regulatory tool, In Lieu of Services — allow MCPs to cover services that address health-related social needs, in an effort to decrease preventable expensive acute care services such as emergency room visits, hospitalizations, and nursing home stays. These nontraditional services must be medically appropriate and cost-effective. MCPs may include the costs of Community Supports in their reported medical costs, requiring the state to consider these costs when it sets MCP rates in the future. Unlike ECM, MCPs do not receive increased payment for the ongoing costs of providing Community Support services to their members, unless the MCP was offering those services prior to CalAIM.

In addition, MCPs have begun receiving payments under the DHCS Incentive Payment Program (IPP) if and when they achieve specific outcomes defined by DHCS in their ECM and Community Supports programs.[57] These IPP payments will be available to MCPs over a 30-month period in part to help plans with additional costs incurred from providing Community Supports before new rates that include them go live.

CalAIM identifies 14 preapproved Community Supports, including seven that specifically focus on people experiencing homelessness:

- Housing navigation and transition services to help people access and move into housing[58]
- Housing deposits to pay for onetime costs of moving into housing, such as security deposits[59]
- Housing and tenancy support services to help people maintain housing stability[60]
- Short-term posthospitalization housing, providing an interim bed for people exiting a treatment facility[61]
- Recuperative care for short-term residential care and medical monitoring[62]
- Day habilitation services, including training in daily living skills, help moving into a home, settling disputes with landlords, managing money, and connecting to community services[63]
- Sobering centers, providing 24 hours of a safe environment for people who are publicly intoxicated[64]

However, MCPs are not required to offer all 14 Community Supports, resulting in a patchwork of Community Supports across counties and even within counties with multiple health plans that provide Medi-Cal coverage. If DHCS chooses to, it may ask that CMS allow DHCS to make a Community Support a Medi-Cal benefit, which would in turn make that Community Support available to all Medi-Cal members regardless of the MCP they are enrolled in.

With the combination of the ECM benefit and the optional Community Supports, CalAIM is a pathway for MCPs to offer services in new ways to members experiencing or at risk of homelessness.

PATH — Building Provider Capacity

The Whole Person Care (WPC) Pilot, which provided county-administered services for high-cost, high-need populations, ended in December 2021. To avoid service gaps during the transition from WPC to CalAIM, and to provide the up-front funding and capacity building for community-based organizations and county agencies to become providers, when they have not worked with Medi-Cal managed care in the past, DHCS created the Providing Access and Transforming Health (PATH) program. Approved under CalAIM, PATH'S purpose in regards to people experiencing homlessness is twofold:

- Ensure continuity of care for people receiving county-led Whole Person Care services
- Build administrative capacity among providers who have yet not contracted with MCPs or who are contractors but need to strengthen capacity, including their capacity to serve people experiencing homelessness

The PATH Capacity and Infrastructure Transition Expansion and Development (CITED) (PDF) initiative is aimed at building county and local government, public hospital system, tribal, and community-based provider capacity specifically for ECM and Community Supports.[65] PATH funding — which will total $1.85 billion over five years — offers an opportunity to build a network of homeless service providers that can bill Medi-Cal or coordinate smaller providers to work with or create an entity that can bill Medi-Cal.[66] PATH funding eligibility is limited to organizations actively contracted with MCPs or that have an attestation from an MCP they intend to contract. MCPs are not eligible to receive funds.

Opportunities for Using PATH or IPP Dollars to Strengthen Provider Networks

- Hiring staff to meet requirements of Medi-Cal billing, administration, or oversight, including a quality improvement manager, a compliance officer, or additional quality improvement staff
- Federal HIPAA (Health Insurance Portability and Accountability Act) and whistleblower and Medicaid fraud prevention training
- Acquiring software and licenses for electronic health records, and/or software for Medicaid billing and for email and data encryption
- Funding training for staff on working with MCPs or training for health center staff on working with homeless service providers who offer trauma-informed and evidence-based housing support services
- Creating a regional entity providing support to multiple community-based organizations in receiving payment from the Medi-Cal program for the provision of housing support services

HCBS Spending Plan — Connecting Services and Housing

The Home and Community-Based Services (HCBS) Spending Plan is California's plan to use savings achieved under the federal American Rescue Plan's enhanced federal match for Medi-Cal HCBS services. California's HCBS Spending Plan offers additional funding for PATH to build provider capacity to serve people experiencing homelessness. It also includes $1.3 billion for the Housing and Homelessness Incentive Program[67] (HHIP) to provide MCPs incentive payments for making investments and progress in addressing homelessness and achieving specific DHCS benchmarks. MCPs that opt in must show how they intend to invest their incentive dollars and identify the gaps in health access they intend to address for people experiencing homelessness they intend to address. Once an MCP earns an incentive by meeting specific HHIP benchmarks or milestones, the MCP may use these funds flexibly.[68]

Opportunities for MCP Investments Using HHIP Incentive Dollars

- Capitalized services reserves like an account holding 15 years' worth of tenancy support services that could be dedicated to funding services in affordable or supportive housing units within projects serving MCP enrollees
- Capitalized reserves for housing navigation offered to county agencies or homeless Continuums of Care to help MCP enrollees connect to Coordinated Entry Systems and move into housing
- Capitalized operating reserves to pay for costs of operating a housing unit set aside for MCP enrollees
- Staff time of housing authority, county agency, or Continuum of Care staff to establish preferences for federally or locally funded housing vouchers, plus landlord recruitment and incentive funding to help MCP enrollees move into private-market housing
- County and Continuum of Care staff and MCP time to develop data-matching process to identify MCP enrollees experiencing homelessness

Part 3. Challenges for Enrollees, Providers, and Managed Care Plans

Challenges for Enrollees

Housing support services are not universally available under CalAIM. DHCS has acknowledged that housing support services are a cost-effective intervention. However, an enrollee's access to housing support services under Community Supports depends on whether their assigned MCP decides to fund these services.

In July 2023, DHCS issued an updated Community Supports policy guide (PDF)[69] that will require all MCPs to align eligibility and service definitions with DHCS guidance by January 1, 2024. This critical guidance will significantly expand access to Community Supports. In the first years of CalAIM, MCPs have narrowed eligibility for housing support services out of concerns about demonstrating return on investment (ROI). The guidance promises to end differences in eligibility criteria between MCPs.

Though MCPs are not required to demonstrate the cost effectiveness of housing support services, they report setting policies, like narrowed eligibility, based on their ability to achieve ROI due to the upfront costs MCPs invest in services. MCPs have shared concerns that they will not meet all incentive payment requirements, and their upfront payment for services to all eligible members may exceed the incentive payments they will receive. These concerns may increase as eligibility for these services expands under the new DHCS guidance. MCPs have further shared that the Community Supports (services provided "in lieu of" other, more expensive services) approach to showing cost avoidance may work well for programs like recuperative care or sobering centers, as the plans can realize ROI quickly by avoiding hospital admission or readmission. However, they may not be able to adequately capture the ROI of housing-related services that take longer to materialize, considering the housing scarcity in California (see Figure 3 on page 25).

To achieve ROI for housing supports, MCPs report they have been narrowing eligibility to prioritize their members with recent histories of high-cost or frequent hospitalizations. Some MCPs are funding only one or two of the housing-based Community Supports rather than a more comprehensive package of services and are limiting the time period members can receive services. Members face the following challenges in accessing Community Supports:

Time limits. While DHCS guidance does not restrict how long members can receive housing navigation and tenancy-sustaining services, in the first year of CalAIM, MCPs have signaled that they are likely to fund services for a set duration, such as 12 or 18 months (in addition to authorization periods), again, to ensure MCPs are ensuring ROI or minimizing risk for ongoing costs of services. Some MCPs also set six-month reauthorization periods, with reauthorization requiring a higher level of documentation than initial authorization. People with complex health conditions may need services for multiple years or over multiple episodes. Someone who needs services and does not receive them may return to homelessness, putting their health at great risk.

Lifetime limits. DHCS guidance states that a member may receive tenancy support services for a single duration in their lifetime, with an option to approve the provision of those services one additional time.[70] This might mean that a person exiting chronic homelessness could lose services after six months if their MCP decides they no longer need those services. Should they need services again, they might not qualify. However, research shows that people typically need services cyclically, with varying intensity over time.

Potential Impacts of Lifetime Limits to Services: Lisa's Story

Lisa successfully moved into housing after experiencing years of chronic homelessness and received tenancy support services to help her stay housed for a period of time. After six months of stability, Lisa needs tenancy support services again and risks losing her housing without them. However, Lisa's provider can no longer offer Lisa tenancy support services via Community Supports because Lisa has met her lifetime limit. Although DHCS allows the managed care plan to offer a second additional period of service delivery, the provider must show that the second round of services will be "more successful" than the first, a high standard when Lisa's first round of services already resulted in good outcomes — housing placement and stabilization. Without being able to show a more successful outcome, the service provider will not be able to offer Lisa a second round of services. Lisa, like many others, may continue to need intermittent tenancy support services for many years beyond what is currently available.

Limited eligibility. DHCS guidance on eligibility for housing supports is not restrictive. However, in the first year of implementation, many MCPs have prioritized their highest-cost members for housing-related support services. This approach overlooks members with high levels of *need* who do not incur high health care or public *costs*. Two studies reviewing deaths of people experiencing homelessness in San Francisco found that a subset of them were not accessing care at their time of death:[71]

- Only 32% of those who died were among the top 5% most frequent utilizers of urgent or emergency health services in the city.
- 24% had no health care utilization in the year before their death (this increased to 36% during the pandemic).
- 10% had no health care or social services utilization in the year before their death.

Black and Indigenous people are less likely to be admitted to hospitals, visit emergency departments, or be admitted to nursing homes — all of which are high-cost services.[72] In fact, Black and Indigenous people experiencing homelessness in California represent a lower share of hospital emergency department patient encounters relative to their overall representation in the homeless services system.[73]

In July 2023, DHCS updated its policy guide to standardize eligibility and ensure MCPs authorize Community Supports equitably. People who were previously denied by MCPs should have the opportunity to receive Community Support services in 2024, necessitating provider and enrollee education or notification.

Siloed ECM and Community Supports. Studies show that care coordination for people who are homeless is not effective at improving care or decreasing costs until they are stably housed.[74] The ECM benefit funds outreach and relationship-building engagement services. Community Supports fund services that the homelessness sector provides in tandem, like housing navigation/transition services and tenancy-sustaining services. In practice, providing services like enhanced case management, housing navigation, and tenancy-sustaining services in a piecemeal way presents barriers to efficient service delivery and adds administrative barriers and costs for providers.

In addition, different provider types and organizations may offer the ECM benefit and Community Supports. A person's primary care provider is likely to offer ECM, whereas community-based homeless service providers primarily offer most of the housing-related Community Supports. Behavioral health providers, Federally Qualified Health Centers, vocational or life skills service providers, county agencies, public hospitals, social service agencies, and affordable or supportive housing providers may also provide these services.[75]

To add further complexity, an MCP may contract with multiple Community Support service providers, some of which may offer only housing navigation and some of which may offer only tenancy-sustaining services or housing deposits. In addition, members may have other case managers through different programs, exacerbating existing member complaints that they need a "case manager to manage their case managers" as they struggle to understand the role of each. Though DHCS encourages ECM providers to work with Community Supports providers, the siloed programs may require a member to work with more than three providers, in addition to their primary care provider, to receive a full array of services.

Members have remarked that they need a "case manager to manage their case managers" as they struggle to understand the role of each.

"Noncompliance" label. Language in DHCS guidance for Community Supports suggests that providers or MCPs may terminate or not offer services to members considered "noncompliant" or unresponsive.[76] However, many people experiencing homelessness appear to be unresponsive or noncompliant because of their entrenched distrust of health care systems and providers. Some have experienced forced treatment, had health issues long ignored, or been misdiagnosed or mistreated in health care settings. Some have been victims of crime and other violence while homeless and therefore are distrustful of strangers in general. The proven approach to people perceived as "services resistant" or "noncompliant" is to use continuous engagement techniques (i.e., reaching out again and again), consistently and reliably asking and providing what people report they need. Over time, this active engagement helps providers develop trusting relationships. This longer-term engagement approach may take months to bear results (it convinces people it is safe for them to accept and access services). Providers should receive compensation for the time and effort that goes into this work, as engagement and homeless outreach services are part of an essential package of care.[77]

Misaligned funding for supportive housing development and services. A person may be eligible for services (e.g., ECM or Community Supports) but not for a housing program, which would be an added barrier. Housing programs providing capital subsidies to developers to build supportive housing typically require the developer to identify and secure long-term funding commitments to cover service costs before the developer can access the capital subsidies. A service provider could not make those long-term funding commitments by relying solely on ECM and Community Supports, so developers could not count on Medi-Cal services to cover service costs for tenants in newly built supportive housing. Capital subsidy programs also typically require a staff-to-client ratio of at 1:20,[78] which Community Supports may also be unable to guarantee.

Only the ECM benefit can fund outreach, engagement, and care coordination services, and only Community Supports can offer housing support services.

Challenges for Providers

DHCS has worked to reduce barriers to community-based organizations (CBOs) interested in providing homeless services under Community Supports. DHCS has focused many of these efforts on making contracting with MCPs easier for providers who have not been Medicaid providers in the past. For example, DHCS took steps to guide providers through obtaining a National Provider Identifier (NPI) that is typically required to receive reimbursement under Medi-Cal. DHCS also directed MCPs to allow providers who normally do not have a

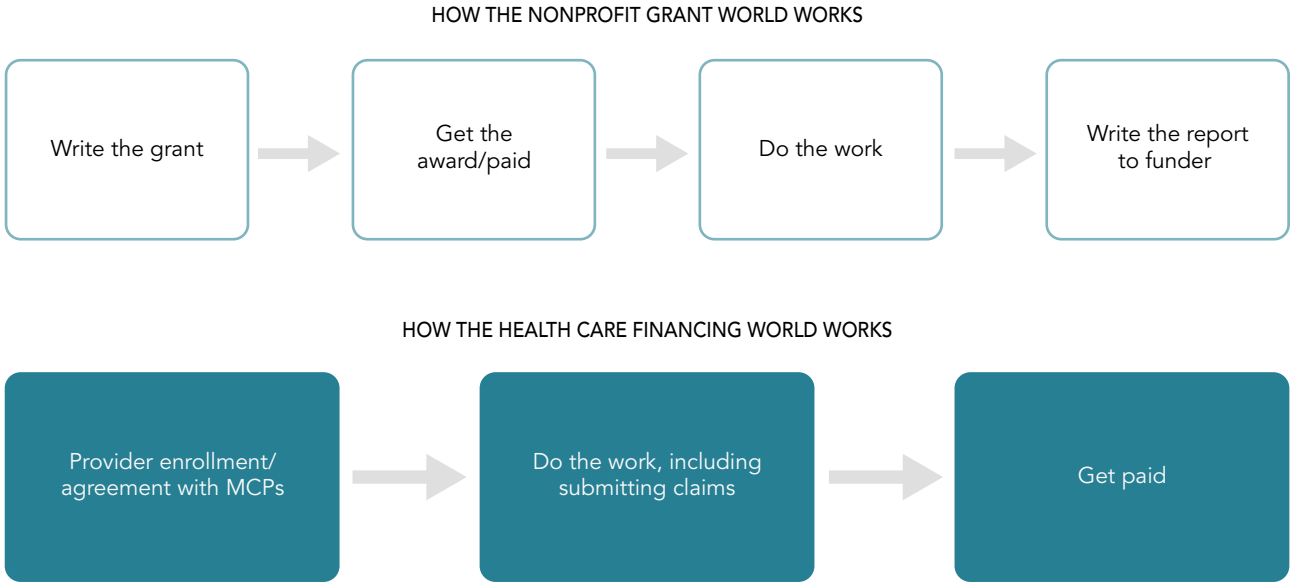
state-level pathway to credentialing to nevertheless contract with them, even if the provider does not have an NPI.[79] Also, DHCS received CMS approval to fund provider capacity building through both PATH and in the HCBS Spending Plan. And finally, DHCS has required MCPs to pay provider claims within 30 days, which is particularly important for smaller providers that operate without substantial reserves.[80]

Despite these mitigation strategies, CBOs face significant challenges participating in CalAIM as Community Supports providers. Community-based homeless service providers may be reluctant to engage with MCPs for a number of reasons, including those described below.

Steep learning curve for contracting with MCPs. Homeless service providers are typically less experienced at billing Medi-Cal for services and may lack the technical capacity and infrastructure to transition to a retrospective billing system (see Figure 2). Billing and reporting requirements for Community Supports may be too daunting and expensive for many homeless service providers to meet. While some access Medi-Cal funding through county behavioral health systems, most homeless service providers do not have sufficient reserves to wait to receive reimbursement well after service provision and lack cultural understanding of MCPs. Although PATH and the HCBS Spending Plan can help providers build capacity, they may be unable to invest time and money in becoming Medi-Cal billers without assurance of funding for services enrollees may need on an ongoing basis, and without knowing the number of referrals they may receive from MCPs.

Insufficient rates. Many providers report challenges negotiating adequate rates to pay for services provided to people with complex needs. In the first year of implementation, many plans have asked ECM providers to provide ratios of care manager to enrollee of 1:25 to 1:50. That ratio is insufficient to provide the type of assertive engagement strategies often required for people experiencing homelessness, particularly among people with complex health conditions. For people who recently exited homelessness, ideal case management ratios are typically between 1:10 and 1:20.[81] In addition, providers widely regard rates DHCS has suggested in Community Supports Pricing Guidance[82] as too low, based on a review of a range of case manager salaries.[83] Though DHCS suggested generous rates for housing deposits, and rate guidance accommodated potential costs of travel time to meet enrollees where they are, pricing guidance rates did not take into consideration the intensity of services required to achieve the outcomes the state believes it can achieve.

Figure 2. Administrative Differences Between the Nonprofit Grant World and the Health Care Financing World



Source: Stuart Butler and Marcella Maguire, "Building Connective Tissue for Effective Housing-Health Initiatives," Brookings Institution, May 3, 2022.

Administrative burdens. Each MCP may administer and offer ECM and Community Supports through different contracting requirements, rate structures, staffing plans, data sharing platforms, and programmatic structures, even across plans within the same county. Navigating these different structures and requirements is a significant undertaking for a community-based provider. This burden is particularly true for providers that have not previously billed Medi-Cal and already juggle programmatic requirements for different sources of funding. Many providers have never reported encounter data,[84] and most receive monthly payment for services through other programs. To offer people the full range of services they need, providers may have to submit multiple requests (for each separate Community Support). Also, in the first year of CalAIM implementation, providers report low referral rates from MCPs, frequent denials of authorization requests, and delays in payment. The administrative burden coupled with authorization denials or delayed payments may lead to delays in the provision of services, interrupting member trust and provider continuity,[85] and may dissuade additional providers from forming contractual relationships with plans.

DHCS published third-quarter ECM and Community Supports data that show that about 26,000 Californians at risk of or experiencing homelessness had enrolled in the ECM benefit. The data also showed that 23,000 Californians received at least one housing-related Community Support service by the end of September 2022.[86]

For more insights into CalAIM implementation so far:

- Diana Crumley, Kelsey Brykman, and Matthew Ralls, *Launching CalAIM: 10 Observations About Enhanced Care Management and Community Supports So Far*, California Health Care Foundation, May 2022.
- *How It's Going: Local Insights into CalAIM* (PDF), Insure the Uninsured Project, 2022.

Challenges for Managed Care Plans

MCPs and many of their contracted providers have long faced challenges identifying and effectively serving people experiencing homelessness. California's recent experience with the Health Homes Program (HHP) demonstrated this challenge. DHCS staff and contractors, philanthropies, and the Corporation for Supportive Housing spent over four years and millions of dollars preparing MCPs for HHP, including providing extensive trainings, and facilitated collaboratives between MCPs and homeless service providers, meetings with regional groups of stakeholders, and technical assistance on providing housing navigation and tenancy-sustaining services to members experiencing homelessness. Despite the effort, the final UCLA evaluation of HHP showed that only 8.2% of the 90,045 participants had experienced homelessness at some point during enrollment, even though people who are unhoused were a priority population under HHP.[87] Researchers noted inconsistencies in reporting homelessness/at-risk data due to providers' struggles identifying housing status. The majority of homeless enrollees received only one type of housing support service, usually housing navigation/transition services, and only 6% of HHP participants who were unhoused had exited homelessness by the last reported quarter.[88] HHP participants were among the first group to transition to the ECM benefit.[89] The Whole Person Care (WPC) Pilot, administered by counties, in contrast, offered services to over 124,000 consumers experiencing homelessness.[90]

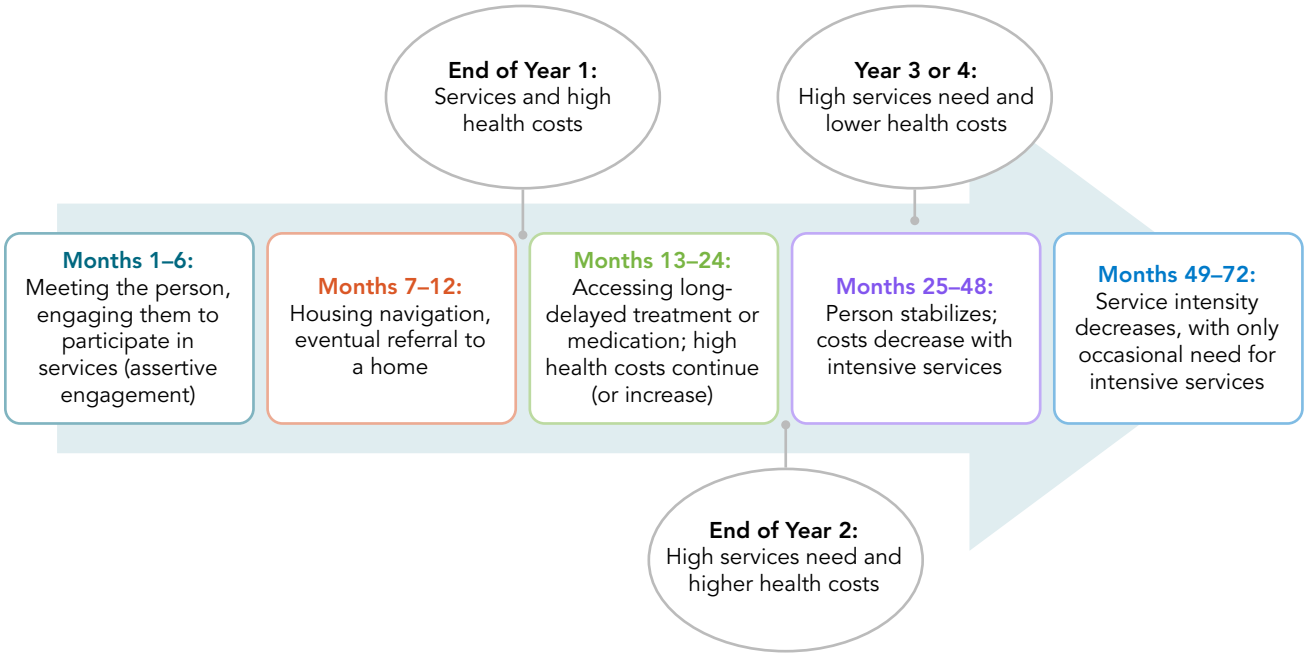
In the first year of CalAIM implementation, MCPs are experiencing the following challenges:

Member identification. MCPs do not have reliable ways to identify members experiencing homelessness. Though MCPs have begun partnering with some homeless Continuums of Care to identify eligible members, creating data use agreements can take years, and timely data matching remains difficult. Even among MCPs that have been working with Continuums of Care for some time, data matching has remained challenging due to lack of interoperability between data systems and differences in privacy standards.[91] Other ways of identifying people experiencing homelessness — through shelter addresses or ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) Z codes in the electronic medical record — are not always fully reliable.[92] MCPs may explore additional direct data collection strategies such as adding housing or homelessness questions, or both, to member intake surveys. However, adding such questions alone does not guarantee an accurate or timely reflection of members experiencing homelessness. Who asks these questions, and how the questions are asked matters, since many people often answer "no" when asked if they are homeless, even though they meet the formal definition of homelessness.

Calculating return on investment. Almost all MCPs in California decided to offer one or more housing-related Community Support services. Though DHCS does not require MCPs to document return on investment, MCPs could find these services yield an ROI through a reduction in expensive acute care services after members move into housing and can achieve health stability. However, achieving a positive ROI through housing supports may take significantly longer than MCPs expect (see Figure 3 on page 25). For example, people receiving housing navigation often wait well over a year for a housing subsidy. While waiting, those suffering from complex, chronic health conditions may see their conditions worsen and will continue to need frequent hospitalizations. Although once housed, their health conditions may begin to stabilize, reductions in costs may not be immediate. Often, these members begin long-delayed medications, treatment, and other high-cost interventions for a year or longer after they move into housing.[93]

Figure 3. Possible Scenario Timeline for an MCP's Return on Investment in Housing Supports

Based on the Frequent Users of Health Services Initiative Final Evaluation Report



Source: Karen W. Linkins, Jennifer J. Brya, and Daniel W. Chandler, *Frequent Users of Health Services Initiative: Final Evaluation Report (PDF)*, California Health Care Foundation, August 2008.

Adverse selection. MCPs operating in counties with more than one MCP may offer different Community Supports or have limited data documenting eligibility, potentially resulting in confusion around referrals and adverse selection, as providers will likely help people change MCPs to plans offering longer-term, more comprehensive, or higher-paid housing-based services. Adverse selection can lead to an atypical distribution of healthy and unhealthy people signing up for one MCP's coverage.

Member churn. Within and between MCPs, churn is well documented among those experiencing homelessness,[94] as people lose their benefits or change plans while seeking care from different providers. Churn causes members to lose and gain Medi-Cal benefits frequently, leading to higher administrative costs and less predictable federal funding for states.[95] When MCPs lack the partnerships or structures necessary to bridge gaps in enrollment and look back on authorizations and claims from other plans, it becomes difficult to ensure continuity of coverage and to make decisions about eligibility for ECM and Community Supports.

A deeper look at challenges can be found in Appendix E.

Part 4. Recommendations: Seven Steps Toward Greater Person-Centered Care

The following seven policy recommendations for DHCS and other California policymakers are based on data, analysis, expert consultations, and literature cited in this report. They are intended to support and promote a stronger focus on person-centered care that is operationally and financially viable , and to support the program improvement work DHCS already has underway.

1. Seek Federal Approval for a Housing Support Services Medi-Cal Benefit by the end of 2024

To meet the goals articulated in the CalAIM proposal to "provide a whole-person, interdisciplinary approach to care" and avoid challenges of inequitable access to services, **DHCS could move away from offering housing support services through an ECM benefit and separate optional Community Supports and instead seek federal approval and funds for a uniform housing support services benefit by the end of 2024**.

All Medi-Cal members experiencing homelessness (or who previously experienced homelessness and now live in housing), regardless of what county they live in or which MCP provides their coverage, should be eligible for a benefit covering a comprehensive range of services (housing navigation/transition, tenancy-sustaining, and supported employment services, all of which are described in Table C1 in Appendix C) rather than a siloed services approach requiring authorizations for each set of services. A benefit would also reduce the risk of adverse selection as well as the burden of multiple authorizations. DHCS could explore with CMS which Medicaid authority will work best to achieve the objectives of a sustainable benefit, including which authority would allow the state to require services to be offered statewide. A well-structured benefit would allow the state to fund, at scale, needed services and to receive substantial federal share of the costs. And, as DHCS previously set "by 2024" as a target for seeking federal approval of a benefit, it seems that "by the end of 2024" is a reasonable revision.[96] Also, plans and providers who know a benefit is coming will be far more eager to prepare for it.

Importantly, a comprehensive housing support services benefit would accomplish CalAIM goals more efficiently than the current pairing of CalAIM ECM and optional Community Supports. These goals include a whole-person approach to services, greater standardization, and high-quality outcomes. See Appendix F for more information on achieving CalAIM goals through a housing support services benefit.

As with other recently approved waivers in Massachusetts and Arizona, covered services should be needs-based. In creating a benefit, DHCS could promote policies offering certainty that providers will be able to continue to offer services to people for as long as they need and want them, so long as federal financial participation continues and the state can fund its share of costs.

Because a benefit could achieve a more person-centered approach to care for people experiencing homelessness and addresses several challenges to the ECM and Community Supports structure, the following recommendations relate to creation of this benefit.

2. Set Rates That Adequately Support Housing-Related Services

California could offer a comprehensive rate structure to providers that includes the full costs of services. The rate would take into consideration staff time to travel community-wide to deliver services and coordinate with housing and other health and social service providers to ensure seamless access to services and should cover everyone in a team needed to offer a comprehensive person-centered approach, including licensed supervisory staff and peers with lived experience. Rates would initially reflect a provider-to-member ratio of 1:15.[97] Most important, rates would match the costs of services offered in evidence-based services programs, such as programs DHCS reported as improving health outcomes and decreasing Medicaid costs.

A benefit could pay a supplemental per-person per-month or per diem rate for housing support services provided to people experiencing homelessness and people formerly homeless living in supportive housing. A benefit could also offer providers payment incentives for moving a specific percentage of people into housing.[98]

Providers' capacity to deliver services cannot reach scale without simplifying a billing structure for a benefit, as several other states have done. Billing based on encounters requires administrative complexity and creates burdens beyond the capability of many homeless service providers. A per diem or per-member per-month rate saves providers from spending inordinate resources on administrative costs.

In the near term, for more effective CalAIM implementation, DHCS could update rate guidance for housing-based Community Supports to take into consideration that members accessing Community Supports often have complex needs and multiple health conditions, and they require intensive team-based services with lower provider-to-member ratios, such as 1:15. An adequate rate will also help attract more provider interest in Community Supports. DHCS has relied on studies that acknowledge that housing support services are cost-effective and supports an intensive, multidisciplinary structure that requires higher rates.

3. Fund Homeless Outreach and Engagement Services

Homeless "outreach" is typically far more extensive than outreach as MCPs traditionally understand it. Rather than a process for enrollment into a single program, homeless outreach involves locating, identifying, and building relationships with people experiencing homelessness. It often requires months or even years of persistent, assertive engagement.

New York, through a care management pilot, identified outreach and engagement strategies as a critical component to serving people experiencing homelessness. That pilot evaluation showed that failure to adequately fund outreach was a barrier to finding and engaging Medicaid enrollees who were unhoused.[99] In California, the Health Homes Program evaluation indicated that MCPs and providers similarly struggled to identify, reach, and enroll people who were homeless, a barrier to successful implementation of that program.

To effectively reach and connect with people experiencing homelessness, Medi-Cal could fund evidence-based homeless outreach and engagement strategies through a reliable, sustainable source of funding. California should consider including homeless outreach and engagement services as part of a bundled rate, but California may need to pursue a different Medicaid authority to fund these services if the state decides to pursue a Section 1915(i) State Plan Amendment for a housing support services benefit. CMS recently approved Arizona's request for coverage of a range of services for people experiencing homelessness, including outreach services, in its Section 1115 Medicaid demonstration waiver, though the waiver's Special Terms and Conditions did not define outreach in its approval.[100]

In the near term, to better support homeless outreach and engagement through the CalAIM structure, DHCS could consider revising the ECM benefit in the following ways:

- Require MCPs and their contracted providers to contract or subcontract with homeless service agencies to provide intensive, longer-term outreach and engagement services, even if these providers are not ECM providers.
- Adjust ECM rate guidance to reflect higher provider-to-member ratios for members experiencing homelessness who receive homeless outreach services (or offer incentives to MCPs specifically to contract for the provision of these services).

4. Build Capacity of Community-Based Organizations for Implementation of CalAIM

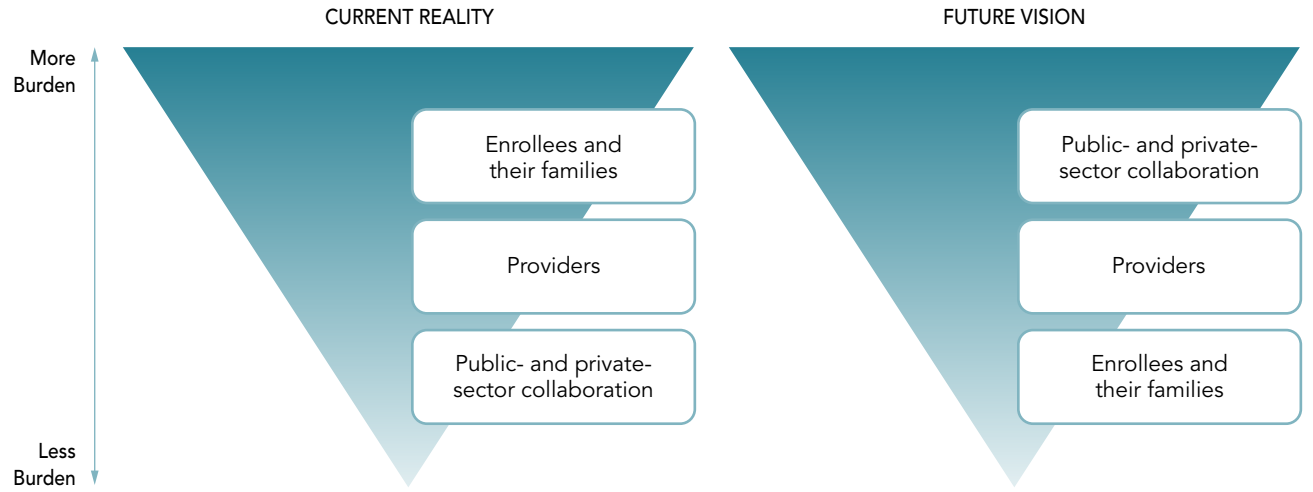
A DHCS commitment to seek federal approval for a housing supports benefit would offer providers incentives to build their capacity, potentially initially in partnership with MCPs under CalAIM, and then through a benefit. **DHCS could continue to help build a network of providers with experience using evidence-based models to help people who are unhoused move into permanent housing and remain stably housed and able to pursue meaningful care.** To achieve this objective, state departments could do the following:

- DHCS could target a portion of PATH CITED funds to strengthen implementation of housing-related Community Supports with the goal of building a sufficient network to implement a benefit. CITED funding for homeless service providers can help these providers obtain information technology systems, hire staff to take on Medicaid billing and reporting, and receive training and technical assistance to become agencies that can sustain themselves through a health care financing model of a benefit.
- DHCS, through HHIP or IPP, could offer incentive payments to foster partnerships between current billing entities — such as community health centers, Program of All-Inclusive Care for the Elderly (PACE) providers, and county agencies — and homeless service providers who will likely be unable to bill Medi-Cal but have expertise in providing housing support services. Current billing entities could help build a provider network through subcontracts paying adequate rates for services.
- DHCS could reduce administrative barriers to the extent that federal law allows, including removing the once-in-a-lifetime limits on services provision and authorization for each set of services, rather than for individual services.
- The California Interagency Council on Homelessness (Cal ICH) could assist DHCS staff in identifying criteria for providers to receive seed funding grants under CITED and HHIP to help build a robust network of competent providers. Cal ICH staff could reach out to providers well respected but not well resourced to recruit them in growing a network of providers.

5. Establish a Plan for Integrating Inter-Agency Health and Housing Policies

Providers that offer both health and housing services find it challenging to braid funding. For example, housing providers/developers interested in building a new supportive housing development must secure capital, operating, and services funding to get the project off the ground. To obtain capital funding through programs like the Multifamily Housing Program and the Low-Income Housing Tax Credit, developers must first secure ongoing and sustainable funding to cover the costs of operating the development (i.e., rental subsidies to cover the costs of operating and maintaining the building) and the costs of providing supportive services (e.g., tenancy support services). This financing model cannot rely on time-limited funding for services. Since MCPs often limit the period of coverage for housing support services under Community Supports, developers and financing institutions cannot rely on this source of services funding in creating supportive housing. As housing providers try to stitch together resources to offer housing and services for as long as people need to exit homelessness and remain stably housed, more can be done to align funding models so providers can effectively leverage capital, operating, and services resources.

Figure 4. Coordination of Health and Housing: Lessening the Burden for Enrollees and Their Families



Source: Stuart M. Butler and Marcella Maguire, "Building Connective Tissue for Effective Housing-Health Initiatives," Brookings Institution, May 3, 2022.

As noted above, members or providers typically bear the burden of accessing housing subsidies, finding landlords willing to take those subsidies, and then enrolling in whatever service program for which the member is eligible. A seamless approach would be challenging under any Medicaid authority. Still, the state can take steps to align state-funded housing with services offered under a benefit or CalAIM.

The state could further work with health, housing, and homeless sectors — at the provider, administrator, and government levels — to identify a shared vision of alignment, with the purpose of using each system's ability to assimilate provider networks and leverage each other's expertise and resources to address the challenges of homelessness. As a federal example, the US departments of Housing and Urban Development and Veterans Affairs partnered to offer veterans permanent housing vouchers along with VA-funded services. This program has successfully reduced homelessness among veterans by 55% since 2010.[101]

Although DHCS, in HHIP, requires MCPs to form partnerships with homeless Continuums of Care to receive incentive payments, CalAIM materials offer little guidance on how a member will be able to access both housing and services more seamlessly as a result. Materials should offer specific guidance. To clarify the way forward, DHCS could work with Cal ICH, now cochaired by the secretaries of Health and Human Services and Business, Consumer Services, and Housing (BCSH), to do the following:

- Collaborate on a suggested list of MCP uses of HHIP dollars to pay for services that could potentially make more housing units available for MCP members. For example, incentive dollars could fund capitalized service reserves that would allow a housing developer to draw from the reserve for 15–20 years to support the MCP members who live in the developer's housing project.
- Partner to offer technical assistance to MCPs and local homeless response systems on best practices in use of onetime HHIP or PATH dollars to braid services and housing funding.

- Encourage MCPs to use HHIP payments to establish a process (including a dedicated point person) for creating a referral pathway through Coordinated Entry Systems that already refer people to housing.
- In establishing a benefit, work with housing agencies to align eligibility for capital funding to build supportive housing units (through California's Homekey, Multifamily Housing, National Housing Trust Fund, and other state-administered programs) with eligibility for a housing support services Medi-Cal benefit. If, for example, eligibility for a percentage of Homekey units were based on eligibility for a housing support services benefit, developers and housing financers could rely on services funding (based on need) in Homekey-funded supportive housing. To secure public subsidies to build supportive housing, developers must typically secure funding commitments to pay for the "supportive services" that accompany the housing unit for 5–20 years. The option to pair housing-related service dollars with supportive housing (and spurring more supportive housing development) is only feasible through a sustained and reliable services funding source, like a benefit. Without this reliable funding source for services, housing providers cannot be certain their tenants will be able to access the supportive services they need and for as long as they need, through Community Supports.
- Create a state-level supportive services workgroup consisting of subject matter experts serving people experiencing homelessness, people with lived experience, and staff of DHCS, BCSH, the Department of Housing and Community Development, and Cal ICH. The workgroup would develop a blueprint for the following:
  - An ideal delivery system that ensures equitable access to a benefit, ease of access to services, an adequate and supported workforce, and alignment with housing at the systems levels
  - Services and cost models matched to the needs of people experiencing homelessness
  - Eligibility criteria to include people who are formerly homeless and living in supportive housing
  - Services requirements that align effectively with housing
  - Referral systems for cross-sector collaboration between health and housing sectors

6. Develop Benchmarks to Create a More Equitable Program

DHCS should set service goals toward achieving greater health equity and reducing health disparities. **DHCS could include specific equity benchmarks in HHIP benchmarks and should guide next steps for reform.**

Equity benchmarks might include resetting eligibility for programs based on need rather than cost. Evidence suggests that people experiencing homelessness who have had few or no connections to the health system often have substantial needs. These Californians may fail to get served under CalAIM.

Under Community Supports and ECM, MCPs (or any alternate future benefit administrators) should track outcomes and be required to course correct if the racial makeup of members accessing services or benefits is not consistent with the racial makeup of people experiencing homelessness in the county in which they are operating. Importantly, to establish equity benchmarks and outcome measures, and to complete course correction, DHCS and MCPs should include people with lived experience in policy development and benefit design.

7. Create a Process for Referrals That Begins with the Homeless Response System

The Coordinated Entry System (CES) assesses the housing and services needs of people experiencing homelessness and prioritizes those with the highest needs for supportive housing. CES protocols are intended to coordinate resources to offer a more seamless experience. Though these protocols are complex, state leadership is needed to support information exchange. **DHCS could promote identifying and referring people potentially eligible for Community Supports, or a new benefit, through the Coordinated Entry process. A benefit would make referrals through a coordinated entry process more feasible, if all experiencing homelessness are eligible for the covered benefit.**

In drafting HHIP benchmarks, DHCS included a benchmark of partnership with the homeless response system. DHCS should offer MCPs further guidance on using HHIP incentive payments to fund homeless Continuum of Care staff to help establish this referral process. Pilots for CES referral to Community Supports could work toward achieving the following design:

- MCPs within a single jurisdiction all align Community Supports referral and authorization procedures through work to achieve HHIP benchmarks
- MCPs support staff at homeless Continuums of Care to work with MCPs countywide to establish the following:
  - Systems for entering data and completing assessments, which would allow for hospital staff or other health providers to complete a Coordinated Entry assessment and enter information into a Coordinated Entry database after obtaining Homeless Management Information System (HMIS) licenses
  - Continuums of Care and MCPs communicate regularly through designated staff at each entity

When Coordinated Entry staff begin to assess housing needs, they may also identify eligibility for housing support services (or Community Supports under CalAIM). Identifying eligible members experiencing homelessness should include the following elements:

- CES, Continuum of Care, or county outreach staff receive training on eligibility and authorization criteria, so they can identify people who are potentially eligible, and receive payment for creating a referral process, including entering assessed people into their Homeless Management Information System (HMIS).
- CES, Continuum of Care, or county outreach staff obtain consent from people to share data with an MCP. If the person consents, designated CES staff receive data from the person's MCP.
- Within 24–48 hours, designated MCP staff could confirm eligibility, authorize for services, and assign a homeless service provider or work with Coordinated Entry staff to identify potential providers. Alternatively, MCPs can offer presumptive eligibility for Community Supports to people CES staff identify as eligible and high priority for supportive housing.

Further, Cal ICH can play a leading role in encouraging local data matching between HMIS and MCP data to identify MCP members experiencing homelessness. Cal ICH and DHCS can also accelerate efforts to use the Homeless Data Integration System to match identified records with the state's Medi-Cal data, to identify Medicaid members who are unhoused.

Conclusion

Organizations and communities across the state engage in countless efforts to help Californians experiencing homelessness every day, but behind each success is often a long slog through layers of administrative barriers and complex, siloed programs. The process is unnecessarily complicated for those who are unhoused as well as for the providers working hard to help them. It is also far too expensive.

In recent years, California has made progress in acknowledging the need for housing support services through CalAIM, the HCBS Spending Plan, and PATH, as well as the need for specific, specialized processes for reducing barriers to care. These efforts represent significant state investment and commitment toward Medi-Cal redesign.

However, in the face of severe and growing need statewide, California must do more. Though the homeless population represents a relatively small percentage of Medi-Cal members, a program must be designed around the unique needs of Californians experiencing homelessness to achieve the results the state is seeking. California cannot accomplish equitable outcomes when erecting a system too complex for providers and people experiencing homelessness to navigate, and too focused on return on investment to reach scale, especially considering the health risks people experiencing homelessness face. Continuing a systems-centered approach, in fact, continues to allow people to die from homelessness.

> *"Once I got into housing and got the right services, I was able to stabilize, get regular appointments with doctors, and take care of my teeth. Now I seek care as soon as I start to feel sick."*
>
> — A person with lived experience of homelessness

At this moment, California policymakers and officials have an opportunity to redesign Medi-Cal housing supports toward approaches effective in helping people find and access housing, stabilize their health conditions, and thrive. Designing a housing support services benefit to fund what works — one that places people at the center of their health care and removes barriers to needed services — should be California's immediate next step. These policy advances would provide a foundation for success stories at scale. People like Bob (see foreword), along with the many thousands of Californians *without* high-cost needs, are waiting for bolder reforms.

Appendix A. Acknowledgments

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*Affiliation indicated was at time of expertise provided.

Appendix B. Housing for People Experiencing Homelessness

"Housing" under a Housing First approach is permanent, meaning that tenants can remain without time limits so long as they follow the terms of the lease. Tenants are subject to the rights and responsibilities of California's landlord-tenant law under that lease.[102]

People experiencing homelessness need a housing subsidy to fund the difference between what the tenant can afford to pay, considered 30% of the tenant's income, and what the apartment costs. When accessing housing that is affordable because a subsidy allows the tenant to afford the rent, the housing is "affordable housing." If the tenant is also receiving intensive services integrated in the housing to help them remain stably housed, the tenant is living in "supportive housing." The federal government, the state of California, and local governments offer subsidies for the following:

- "Capital" to build affordable apartments.
- "Operating costs" to operate buildings created through capital funds.
- "Rental assistance" or "rental housing subsidies" for tenants who rent apartments from individual private-market landlords or from a nonprofit that "master leases" multiple apartments from a private-market landlord.
- "Public housing" the federal government owns and operates. A new movement to reinvigorate publicly owned housing calls it "social housing."

Public funding exists for each type of subsidy, but not at anywhere near sufficient scale.

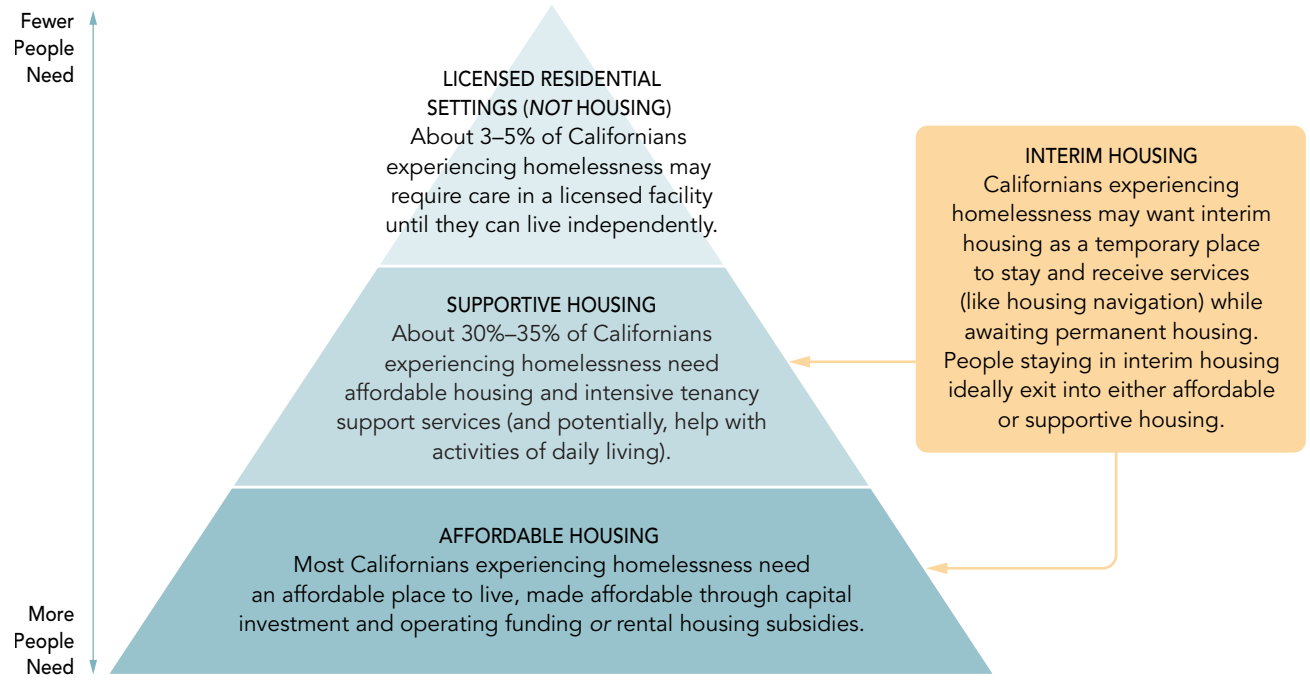
Creating supportive housing requires services to be available to residents who want and need them, in addition to housing subsidies.

Not all publicly funded places to stay are considered housing. Temporary places — often referred to as "emergency shelters" in the past — are part of a larger category called "interim interventions" or "interim housing"; these include tiny homes, navigation centers, and bridge housing. All are temporary places to stay, ideally where people can receive services to help them access the Coordinated Entry System, complete housing and benefits applications, connect to health care and service providers, and receive referrals to permanent housing. Congregate settings referred to as shelters are rarely funded in California post-COVID-19. But the state funds non-congregate interim interventions. In fact, since 2018, the state has trended toward more and more funding for these temporary interventions in response to the alarming number of unsheltered Californians. People living in interim interventions are still considered homeless.[103]

Licensed settings, like some "board and care" — Adult Residential Care Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs)[104] — are residential facilities providing care and supervision. They are not subject to landlord-tenant law and therefore are also not "housing."[105] As with other licensed residential settings, people stay in ARFs and RCFEs so long as they require some form of care and supervision, but then ideally move on to independent permanent housing. Other licensed residential settings provide treatment or personal care services with skilled medical care. They are not meant to provide a place to live, but instead to offer treatment to people who cannot live independently.

Federal and state laws require people to live in the most integrated setting possible, where people with disabilities are living with people without disabilities, and in the most independent setting possible.[106] As a result, any homeless response from a public entity receiving federal or state funding must do everything possible to refer people to independent housing of their choice, rather than referring people to licensed settings, so long as the individual can live independently with the right services.

Figure B1. Types of Interventions People Who Are Unhoused Need to Exit Homelessness



Sources: "Solutions," National Alliance to End Homelessness; and *All In: The Federal Strategic Plan to Prevent and End Homelessness*, US Interagency Council on Homelessness, December 2022.

The amount of a housing subsidy depends on the income of the tenant. Many affordable apartments built with state dollars in California do not house people experiencing homelessness. Our state dollars pay for housing for households with moderate, low, very low, and extremely low incomes, measures based on the tenant's income as a percentage of an area's median income (Table B1).[107] People with extremely low incomes, for example, have incomes up to 30% of an area's median income, and are typically working part-time or full-time but making minimum wage. People with low incomes are earning up to 60% of an area's median income.

Under California's programs funding capital to build housing, tenants typically pay 30% of their incomes on rent. People with low incomes or very low incomes cannot afford market rent in California on their incomes, but can rent in an affordable housing project and pay rent sufficient for the manager to operate and maintain the affordable housing property without an "operating subsidy," an additional housing subsidy to cover a portion of the tenant's rent. People with extremely low incomes and below, however, have incomes too low for the tenant to pay sufficient rent for a manager to operate an affordable or supportive housing project. To provide this level of affordability, the housing developer must also secure funding to operate the building, often through federal vouchers aligned with the project and sometimes through a onetime disbursement meant to last 15–20 years, paid for by California's state housing agency ("capitalized operating subsidy reserves"). Table B2 provides an overview of funding programs for people experiencing homelessness in California.

People experiencing homelessness typically have incomes well below the extremely low-income category, with the average income at about 14% of an area's median income. California's legislature recently created a new category of income, called "acutely low income," defined as 15% or less of an area's median income.[108] Most people experiencing homelessness fall into this category.

Table B1. Housing Affordability Under California's Capital Programs

HOUSEHOLD INCOME CATEGORY	THRESHOLD	DESCRIPTION	PERCENTAGE IN INCOME CATEGORY SPENDING OVER HALF THEIR INCOME ON RENT
Moderate	80%–120% of the area's median income (AMI)	Households making incomes consistent with what others are making in that area	6%
Low	60% of AMI	Households with more than one income or making low wages but not minimum wage	24%
Very Low	50% of AMI	Households with more than one income or making low wages but above minimum wage	53%
Extremely Low	30% of AMI	Households making minimum wage, working part-time or full-time	78%
Acutely Low	15% of AMI	Households making minimum wage, working part-time, or living on fixed incomes, like Supplemental Security Income, or no incomes	

Source: Danielle M. Mazzella and Lindsay Rosenfeld, *California Affordable Housing Needs Report 2021*, California Housing Partnership, March 2021.

Table B2. Funding Programs for People Experiencing Homelessness in California

FUNDING SOURCE	ADMINISTERING AGENCY	HOUSING FUNDED
Federal and State Homeless Assistance	Homeless Continuums of Care (CoCs)	CoCs contract with agencies to fund housing subsidies, interim interventions, onetime prevention assistance, and funding for people to move back in with family ("diversion"); this may include funding for capital to build supportive housing.
Mental Health Services Act / Proposition 63	County health agencies	Housing subsidies for people with serious mental illness who would benefit from intensive services (e.g., people eligible for "full-service partnerships").
Federal Housing Choice Vouchers ("Section 8")	Local public housing agencies	Subsidies to private-market landlords and affordable housing developers, often through "preferences" for people experiencing homelessness, allowing vouchers that turn over (when a current household no longer needs a voucher, it "turns over") to go to someone experiencing homelessness. Housing authorities may also set aside 20%–30% of their allocation of Housing Choice Vouchers to pay for project-based vouchers that attach to capital funds to create housing available to people with extremely low incomes or below (otherwise, Housing Choice Vouchers are tenant-based).
"Flexible Housing Subsidies" Through Mainstream Health or Justice Resources	Usually a county health or housing agency	Housing subsidies and services, or services combined with Housing Choice Vouchers that local housing authorities prioritize for eligible populations.
California's Capital Programs	State agency, usually the California Department of Housing and Community Development or the State Treasurer's Office	Loans to developers (e.g., Multifamily Housing Program, Homekey) or funding through tax credits that developers sell to investors to create affordable and supportive housing (state and federal Low-Income Housing Tax Credits).
State or Local Funds	Cities or counties	Capital to build housing and sometimes fund operating reserves (i.e., a onetime payment to operate the building for 15–20 years).

Source: *California State Homelessness Funding Programs* (PDF), California Homeless Coordinating and Financing Council, September 2018.

Appendix C. Trauma-Informed Housing Support Services for People Experiencing Homelessness

Homelessness is traumatic for all who experience it. And many people experiencing homelessness have past histories of additional trauma. Trauma can change a person's view of the world, impacting one's ability to trust others and to feel hope. On top of trauma, and often because of it, people experiencing homelessness have higher incidences of mental health and substance use disorders.[109]

Trauma-informed care (TIC) is an evidence-based approach to homelessness that requires service providers to have a deep, organization-wide understanding of trauma and awareness of impacts leading up to and resulting from homelessness. Staff providing TIC build a sense of trust and safety and are knowledgeable about potential triggers that could retraumatize people. Moreover, TIC providers are culturally aware of the marginalization people may have experienced. When offered through a trauma-informed approach, housing support services are transformational, allowing people with complex, often comorbid or trimorbid conditions, to recover and thrive.[110]

Housing First service approaches incorporate the following six TIC principles:

1. **Safety.** After initial interactions over a period of months, service providers promote a sense of safety by forming trusting, long-term relationships with people who likely have had past negative, sometimes traumatic, experiences with health care or social service providers, who may have turned over frequently. When providers pay attention to safety, people report feeling safe and satisfied with their housing location. Housing First service models promote safety when the provider offers all the following:
   - Provider-to-client ratios beginning at 1:10 to 1:15.[111]
   - Access to service providers 24 hours a day, seven days a week through a "warm line" for nonemergency support.[112]

   However, due to the traditionally low rates paid for service providers in California, provider-to-client ratios are typically 1:20 or 1:25, and no 24/7 line is offered.

2. **Trustworthiness and transparency.** Unlike telephonic case management, homeless service providers offer frequent in-person contact when getting to know clients. A Housing First service approach promotes trust when the following conditions are met:
   - Throughout their relationship, a provider's level of contact is frequent enough that the client can identify their primary service provider. The first six months includes very frequent contact with the client and eventually tapers to two to three contacts per month.[113]
   - Case managers work closely with clients to ensure they can retain housing and avoid eviction once housed. Case managers also offer clients help orienting to their neighborhood, understanding how to build relationships with their landlords, creating a budget, going shopping, accessing mainstream services, and developing social roles and networks.[114]
   - Service teams provide the full range of services to maintain client trust and continuity, from initial outreach and relationship-building engagement, to housing navigation, to tenancy supports in housing, to rehousing those

who face eviction or want to relocate. When a service team cannot stay with the client to offer this full range of services, service providers can offer critical-time intervention, which offers intensive services for nine months after the client moves into housing, and then conducts a "warm handoff" to services the client can access from mainstream resources in the community. A warm handoff means service providers have relationships/linkages with multiple community service providers, match needs of clients with providers, directly introduce clients to new providers, and conduct ongoing follow-up with new providers and clients afterward.[115]

- Service providers also work to connect clients to permanent housing — housing without actual or expected time limits — ideally within one week to four months after program intake.[116] Services are far more effective when offered in housing than when offered while the person is still homeless,[117] and people are more likely to seek and receive services when housed.[118]
- Service providers and leaders at the organization reflect the life experiences and identities of populations served. Having service providers who have lived in the same communities where their clients are living can make a significant difference in empathy, trust building, and client satisfaction.[119]
- Service providers work to relocate clients to other housing when they are evicted or the housing is not the right fit. Connecting clients to housing takes longer than ideal in California due to limited affordable and available housing — often 9 to 12 months. Relocation of a client does not mean that the services provided or the client was "unsuccessful."

Role of Peer Providers

Peers with lived experience of homelessness play critical roles in providing outreach to people experiencing homelessness, helping people in adjusting to living in housing, and connecting them to resources in the community. People often trust peers more or feel a connection to peers more quickly. However, low rates for services have resulted in frequently underpaying peers as front-line staff.*

* Manuela Tobias, "Will Worker Shortage Disrupt California Homeless Strategy?," *CalMatters*, January 27, 2022.

3. **Multidisciplinary teams that include peer support.** Housing First services promote multidisciplinary services when they adopt these practices:
   - Because people experiencing homelessness may have multiple service needs, multidisciplinary teams offer partnerships through memoranda of understanding that connect clients to resources and other services in the community, like primary care and specialty care, and include clinical staffing (such as a psychiatrist, nurse, and/or mental health professional),[120] other health care providers, benefits advocates, and workforce development / employment services providers.[121]
   - Multidisciplinary teams have daily case conferences about all clients on their shared caseload.[122]
   - Peers with lived experience of homelessness are effective members of a multidisciplinary team in building trust with clients and helping them adjust to living in housing.[123]
   - Tenants in an affordable or supportive housing project also have meaningful leadership opportunities, such as tenant associations or positions on boards.[124]

4. **Collaboration and mutuality.**[125] Housing First services promote collaboration when providers tailor services based on tenant-stated wants and needs:

   - Services are voluntary for tenants but not for staff. Housing is functionally separate from services, meaning a tenant should still be able to access and maintain housing even if the tenant does not want to participate in services.[126]
   - Service providers meet clients where they are or in a location most convenient to the client — the streets, a shelter, a hotel, a car, an institutional setting, or a supportive housing project — rather than require the client to come to a clinic.[127]
   - Importantly, providers assertively engage clients to want to participate in services the client chooses. Providers regularly attempt to connect in meaningful ways with tenants, and then document those attempts. Services staff use a variety of proven interventions, like motivational interviewing and stages of change, to engage and support people.[128,129]
   - Service teams have regular team meetings to discuss emerging issues and strategies, and to identify resources to further assist clients.[130] Clients receiving voluntary services paired with assertive engagement are more likely to participate in services than clients with providers who expect them to seek services.[131] Program outcomes show that tenants in a voluntary-services model stay stably housed for longer periods, are more likely to receive mental health, substance use, and primary care treatment,[132] and are more satisfied with their services than people accessing programs that require services participation or evidence of compliance with a program.[133]

People are far more likely to remain stably housed and report feelings of satisfaction when they have choices.

5. **Empowerment, voice, and choice.** Housing First services empower people when providers emphasize choice:

   - When moving into housing, people choose between multiple apartments and view the apartment and building before moving in. Likewise, a provider does not force people to live with others, particularly others they don't choose to live with, and does not require people to share a bathroom with strangers.[134] People prefer living alone or with roommates or housemates of their choice. In fact, people are far more likely to remain stably housed and report feelings of satisfaction when they have choices.[135] Due to low availability of housing and the pressure to move as many people into housing as quickly as possible, people often do not receive these choices in our current homeless response systems.
   - Providers also work with clients to direct their own care. Services staff actively involve clients in the design and implementation of a services plan, and work with them to set realistic, measurable goals the client wants to meet, then update plans regularly with the client to meet their changing needs.[136] Clients participate in regularly scheduled treatment-planning meetings.[137]

- Providers do not terminate services unless the client demonstrates violence or threats of violence. Instead, providers work with clients to address behaviors related to their conditions, have formal policies and protocols to prevent eviction, and may have staff dedicated to eviction prevention.
- Providers use harm reduction, an evidence-based approach to working with a client to avoid risky behaviors, including behaviors that could lead to eviction, and can involve counseling clients on safer substance use.[138] Programs offer ongoing staff training in harm reduction and crisis intervention, and regularly educate clients on harm reduction principles.[139]

6. **Understanding of cultural, historical, and gender issues.** People experiencing homelessness have been persistently underserved by mainstream service systems. Housing First services promote cultural awareness when the following conditions are met:
   - Providers ensure low caseloads and diverse staff — staff who reflect the identities and experiences of people served. Both factors are critical for responding to clients' changing needs in flexible, trauma-informed, culturally appropriate ways.[140]
   - Staff work to support clients in developing and strengthening connections to their community, a community the client ideally chooses, to overcome the stigma and social isolation of homelessness.[141]
   - Providers have formal and informal processes for receiving input from clients on both housing and services they are receiving, including evaluations that seek their input.[142]
   - Housing providers offer housing options in "scattered-site" housing in the private market or in projects where apartments for people with disabilities are integrated with apartments not designated for people with disabilities, and offer housing in the least restrictive setting possible.[143]

People experiencing homelessness with multiple health conditions or disabilities may need and want all of the services or a variety of the services listed in Table C1 on page 43. Housing support services are related to each other: Housing navigation correlates to move-in assistance / housing deposits, which, for people with barriers to housing stability, leads to the need for tenancy support services. Offering one service without the others hampers a person's ability to access housing or remain stably housed. An important feature of all services is a single point of contact, often a case manager, whom the person experiencing homelessness knows and trusts in receiving a comprehensive range of services.

Table C1. Types of Services People Experiencing Homelessness May Need

TYPE OF SERVICE	DESCRIPTION	METHOD OF PROVISION (HOW / BY WHOM)	DURATION	MEDI-CAL COVERAGE	OTHER SOURCES OF FUNDING
Homeless Outreach	▸ Finding people (on the streets, in shelters or interim housing, in cars, etc.) and beginning to form a relationship	In person: paraprofessionals who are outreach workers, often peers with lived experience of homelessness	Depends on client needs, potentially months	Potentially funded under Enhanced Care Management (ECM) benefit. Community Health Worker benefit could help support staffing	Local, federal grant, and state Homeless Housing, Assistance, and Prevention (HHAP) grant program
Engagement	▸ Repeated visits over time — often months — to engage the person and form a trusting relationship	In person, wherever the person lives or in a location convenient to the person	Potentially months or years, ideally within four months while the person is homeless, ongoing after housed	Could be provided under ECM with experienced homeless service provider	Local, federal grant, and HHAP
Housing Navigation*	▸ Help navigating the homeless response system and applying for housing subsidies/vouchers ▸ Assessment of housing preferences/barriers related to tenancy ▸ Development of an individualized housing support plan with the client, including a crisis plan ▸ Landlord recruitment ▸ Help with collecting documentation ▸ Help with a housing search and completing housing applications ▸ Ensuring housing unit is safe and ready for move-in ▸ Help with move-in ▸ Orientation to the neighborhood	Primarily in person, some telephonically: paraprofessionals skilled in navigating the homeless response system	Month 1 to potentially month 12 or beyond	Under Community Supports (CS) of housing navigation and tenancy transition services	Local and HHAP

* Other states fund through a Medicaid benefit.

Table C1. Types of Services People Experiencing Homelessness May Need (continued)

TYPE OF SERVICE	DESCRIPTION	METHOD OF PROVISION (HOW / BY WHOM)	DURATION	MEDI-CAL COVERAGE	OTHER SOURCES OF FUNDING
Housing Stabilization or Tenancy Support Services*	▸ Establishing a services plan with tenant ▸ Early identification and intervention in behaviors that may jeopardize housing ▸ Education on tenant and landlord rights and responsibilities ▸ Harm reduction ▸ Eviction prevention planning and coordination ▸ Connecting the tenant with community resources ▸ Coaching on developing and maintaining relationships with landlords ▸ Assistance with credit repair activities and skill building ▸ Assistance with housing recertification process ▸ Continued training on tenancy and household management ▸ Benefits advocacy	Primarily in person, occasionally telephonically after a relationship has been established: case managers with a range of experiences (often under supervision of licensed clinicians)	Upon move-in, ideally with the same person who engaged with the tenant to ensure continuous engagement	Under CS of tenancy-sustaining services	Mental Health Services Act (MHSA) and Short-Doyle/ Medi-Cal (SDMC) funding for people with serious mental illness
Employment Services*	▸ Help with finding employment that meets tenant's preferences and strengths ▸ Support during challenging periods of employment ▸ Liaison between employer and tenant to address challenges and help align the tenant with employment opportunities	In person: employment specialists	When tenant expresses desire to work	No	Some workforce development grants and some federal grants
Tenant Satisfaction Surveys	▸ Identifying whether tenants are thriving, through surveys or assessments on health status	In person or telephonically	Upon move-in and periodically thereafter	Under CS of tenancy-sustaining services	MHSA and SDMC funding for people with serious mental illness
Health Advocacy*	▸ Health and wellness education ▸ Peer support ▸ Nonemergency transportation ▸ Case conferencing ▸ Advocacy with health professionals	In person or telephonically	Before move-in and afterward	Potentially under CS of tenancy-sustaining services. Community Health Worker benefit to support staffing	MHSA and SDMC funding for people with serious mental illness
Housing Navigation (for Rehousing)	▸ Same services as housing navigation (see above) should tenant need rehousing	In person and telephonically	If tenant needs to relocate	No, if used already in tenant's lifetime	Some local, state, and federal funding

* Other states fund through a Medicaid benefit.

Sources: *Housing First Model Fidelity Index for Providers*, Midwest Harm Reduction Institute; and *Community Supports Policy Guidance*, Dept. of Health Care Services.

Appendix D. What the Federal Government and Other States Are Doing to Fund Housing-Based Services

Other states are increasingly looking to Medicaid to fund housing support services for people experiencing homelessness.[144] Since a 2015 Information Bulletin on Housing-Related Activities and Services, the federal Centers for Medicare & Medicaid Services (CMS) has made clear, in both Republican and Democratic administrations, that Home and Community-Based Services (HCBS) and other Medicaid authorities can be used to support Medicaid recipients to obtain and maintain housing stability.[145] A more recent CMS state health official letter, in fact, encourages states to use existing Medicaid authorities to fund high-quality services sufficient in amount, duration, and scope to achieve goals of greater integration of social services into the health care system. The letter describes ways in which states can fund services to help enrollees secure housing, tenancy supports, nonmedical transportation, and individualized supported employment services. The letter identifies potential Medicaid authorities to fund these services, including Medicaid demonstration waivers under Sections 1905(a)(13) or 1915(b)(3), or State Plan Amendments under Sections 1915(c) or 1915(i) of the Social Security Act.[146]

The earliest state using Medicaid to fund housing support services was Massachusetts, which created its Community Support Program for People Experiencing Chronic Homelessness (CSPECH).[147] CSPECH expanded from a pilot serving 50 people to serving over 800. Louisiana similarly created a statewide permanent supportive housing program for people with serious mental illness, using the state's "Rehab Option."[148] Since the 2015 CMS Information Bulletin, more and more states have either implemented programs designed to scale up supportive housing services or are in the process of developing programs to fund housing support services at scale.

States have a variety of policy levers to fund housing support services. Similar to California's Whole Person Care Pilot, other states, like Hawaii (Community Integration Services), Massachusetts (Flexible Services), and Washington (Foundational Community Supports), have used Medicaid's Section 1115 research and demonstration waiver to implement housing support services demonstrations. Some states have submitted Section 1115 waiver requests to CMS to fund specific services for people experiencing homelessness, such as Arizona's request to fund outreach and engagement services, which CMS approved,[149] and Vermont's request for a permanent supportive housing pilot to fund tenancy support services for tenants in supportive housing.[150] Vermont remains in discussion with CMS around these requests. These Section 1115 Medicaid waivers, however, are commonly in place for only five years, making ongoing services commitments challenging.

Other states embraced a comprehensive strategy to add a long-term benefit to a state's Medicaid plan, most commonly via a Section 1915(i) State Plan Amendment (SPA). Using this Medicaid authority signals the state's long-term commitment to fund housing support services, as a Section 1915(i) SPA does not require renewal. It also does not require the state to prove federal budget neutrality. The Section 1915(i) SPA allows states significant flexibility to design the benefit's "needs-based criteria" to ensure that the population eligible for the benefit aligns with populations who need housing assistance. Minnesota used this authority to create its Housing Stabilization Services benefit,[151] and North Dakota used it to create its Housing Support Services benefit.[152]

A third strategy is a value-based payment (VBP). VBPs allow states and managed care plans to contract directly with providers, as North Carolina has done in designing a program intended to pay for specific health outcomes, rather than the volume or type of health care.[153] In this payment model, providers receive a per-member per-month rate to assist a person in maintaining health. This rate may cover inpatient care, outpatient visits, and pharmacy costs, as well as any Home and Community-Based Services.

VBPs are challenging to implement because providers must be sophisticated in their cost and revenue models, and one provider may pay for housing support services while another does not. Further, providers must accurately predict the total cost of care, which most providers find difficult to do.

Table D1 on page 46 shows a sampling of state approaches to fund housing support services.

Table D1. Different State Approaches to Funding Housing Support Services

STATE	MEDICAID AUTHORITY	FUNDED SERVICES	ADMINISTRATION/PAYMENT METHOD	SOURCE
Arizona	Section 1115 Medicaid waiver	Housing and health opportunities coverage, to include rent / temporary housing for up to six months for people transitioning out of institutional or congregate settings, homelessness or risk of homelessness, or foster care. Pre-tenancy and tenancy supports, move-in costs, housing deposits, case management, and education for people experiencing homelessness.	Recently approved, still in planning process. Administered by managed care plans.	*Centers for Medicare & Medicaid Services Waiver List* (PDF), 11-W-00275/9, Arizona Medicaid Section 1115 Demonstration, Arizona Health Care Cost Containment System (pages 10, 26–27) (approved October 14, 2022).
California	Section 1115 Medicaid waiver	Whole Person Care Pilot (ended Dec. 31, 2021).	Twenty-five (out of 58) California counties administered and provided local funding to match federal funds of $1.5 billion. Each county established eligibility criteria for "high-need, high-cost populations." Counties established their own rates.	"Whole Person Care Pilots," California Department of Health Care Services (DHCS), last modified May 23, 2022.
California	Health Homes State Plan Amendment	Health Homes Program (funding ended for program on Dec. 31, 2021, in some counties as CalAIM began rolling out).	MCPs in 14 counties administered Health Homes Program services, including housing navigation and tenancy support services. Plans set their own rates to providers and negotiated different rates with DHCS.	"Health Homes Program," DHCS, last modified March 29, 2022.
Hawaii	Section 1115 Medicaid waiver	Community Integration and Transition Services, funding pre-tenancy and tenancy support services.	MCPs administer a per-person per-month supplemental rate.	Danielle Daly (director, Div. of Demonstration Monitoring and Evaluation) and Angela D. Garner (director, Div. of System Reform Demonstrations) to Judy Mohr Peterson (administrator, Med-QUEST Division, Hawaii Dept. of Human Services), QUEST Integration Medicaid Section 1115 Demonstration (PDF), October 14, 2020.
Maryland	Section 1115 Medicaid waiver	Assistance in Community Integration, funding tenancy support services and housing-based case management.	Counties administer based on a cost-based payment rate.	"Maryland Waiver Factsheet," Medicaid.gov, accessed January 3, 2023.

Table D1. Different State Approaches to Funding Housing Support Services (continued)

STATE	MEDICAID AUTHORITY	FUNDED SERVICES	ADMINISTRATION/PAYMENT METHOD	SOURCE
Massachusetts	Section 1115 Medicaid waiver	Community supports program for people experiencing chronic homelessness previously approved. In September 2022, the Centers for Medicare & Medicaid Services (CMS) approved an extension to provide housing supports — including outreach, education, and transportation to access housing supports — for people experiencing homelessness or involved with the judicial system.	Recently approved, still in planning process. Previous program funded services at $17 per person per day for housing-focused case management for up to 60 days.	*Massachusetts State Profile* (PDF), US Dept. of Health and Human Services.
Minnesota	Section 1915(i) State Plan Amendment	Housing Stabilization Services to fund tenancy-sustaining services.	MCPs administer, based on payment rate in 15-minute increments of $17.17.	"Housing Stabilization Services," Minnesota Dept. of Human Services, updated January 5, 2023.
Oregon	Section 1115 Medicaid waiver	Requires MCPs to fund housing-related services for people experiencing homelessness or at risk, and for people leaving institutional or congregate care settings, including short-term housing for up to six months.	Recently approved, still in planning process.	Chiquita Brooks-LaSure (administrator, CMS) to Dana Hittle (interim Medicaid director, Oregon Health Authority), Oregon Health Plan (OHP) (PDF), September 28, 2022.
Rhode Island	Section 1115 Medicaid waiver	Home Stabilization Services benefit, funding tenancy-sustaining services.	MCPs administer with a per-member per-month payment rate.	"Rhode Island Comprehensive Demonstration," Medicaid.gov, accessed January 3, 2023.
Washington	Section 1115 Medicaid waiver	Foundational Community Supports to pay for supportive housing and employment services.	Third-party administrator pays per diem rate of $112 (limited to 30 days every six months), amounting to $560 per person per month.	Angela D. Garner (director, Div. of System Reform Demonstrations) to MaryAnne Lindeblad (Medicaid director, Washington State Health Care Authority), Foundational Community Supports Program (PDF), November 21, 2017.

Appendix E. Additional Challenges with CalAIM Implementation

MCP Member Identification

To address the challenges managed care plans (MCPs) have in identifying members experiencing homelessness, CalAIM proposes that MCPs receive Whole Person Care enrollee data to help them identify some people experiencing homelessness. Also, some plans have secured (or are securing) licenses to Homeless Management Information Systems (HMIS), the data system Continuums of Care (CoCs) use to track services provided to people experiencing homelessness in the region. The California Department of Health Care Services is encouraging MCP partnerships that would allow CoCs to share identified HMIS data with MCPs.[154] Yet several factors hamper these efforts:

- Not every county implemented Whole Person Care.
- Mismatches in data platforms between MCP data and HMIS data can complicate attempts to use HMIS data effectively.
- HMIS tracks data only on people seeking services, rather than on every person experiencing homelessness.
- Most plans do not have licenses or partnerships with CoCs to begin the process of attempting a data match.

Some plans try to identify members experiencing homelessness by tracking those (1) without addresses, (2) with addresses of Department of Public Social Services (DPSS) offices, or (3) with addresses of homeless service providers. Yet the number of people experiencing homelessness at any one time is fluid, creating complexities in identifying those currently experiencing homelessness. These methods do not provide an accurate reflection of members experiencing homelessness and fail to capture most of them.

MCP Outreach

Even if MCPs know which members are experiencing homelessness, their customary method of communicating with members, a mailed letter, will by and large not reach members experiencing homelessness. For example, if an MCP identifies someone experiencing homelessness via a last-known address, a letter sent to that address is unlikely to reach them. Many who use a DPSS office address rarely pick up their mail, as wait times are exceedingly long.

Other common types of MCP outreach to members experiencing homelessness are likely to fare just as poorly. Robocall reminders for screening tests may not be heeded when people are focused on day-to-day survival. Even in-person outreach may be challenging for contracted providers when they do not know how to find people.

Provider Assignments

MCPS are likely to assign a treatment provider as the member's Enhanced Care Management (ECM) provider, and are often unaware that the member has a trusting relationship with a homeless service provider that is not a provider under ECM.[155] Many ECM providers, more likely to be traditional MCP providers, have not had training or experience in engaging people experiencing homelessness. The UCLA interim evaluations of the Health Homes Program (HHP) showed that over 84% of Community-Based Care Management Entities (CB-CMEs) — HHP providers who were primarily health centers, specialty providers, and primary care providers — used medically oriented in-house staff to provide housing support services. Among MCPs offering HHP, only two partnered with Whole Person Care providers to offer housing navigation services to people experiencing homelessness, and two partnered directly with homeless service providers by the time of the first interim evaluation. The results of the initial evaluations showed most providers struggled to know who among their members were homeless and to offer services to eligible members experiencing homelessness.[156]

Staffing

Staff capacity is a challenge statewide, for both health care and housing providers. In Los Angeles County, Community Clinic Association of Los Angeles County (CCALAC) members cited staff capacity as the most common barrier to contracting with MCPs under CalAIM, even among the providers who already have contracts with MCPs. Only 26 of the 64 members of CCALAC were planning to contract with MCPs to provide ECM services in the first year, the same providers who were CB-CMEs under the Health Homes Program. Only eight CCALAC members plan to provide Community Supports. While a number of incentive payments to MCPs are tied to building staff capacity, such payments may fail to offer community-based providers enough funding to boost capacity to provide ECM or Community Supports.

One of the biggest drivers of low staffing among homeless service providers and other social service providers is low pay. The rates offered by MCPs for Community Supports are too low to maintain adequate staffing levels or pay staff livable wages, and may result in high staff turnover, particularly given the intensity of services people experiencing homelessness require. If ECM capitated payments, incentives, or In Lieu of Services payments trickle down through delegation or subcontracts (MCPs to independent physician associations to health centers to subcontractors, or MCPs to counties to subcontractors providing services to people experiencing homelessness), rates will yield ratios of case managers to clients of 1:35 to 1:50, rather than ideal ratios of 1:10 to 1:15.

Medi-Cal Churn

For providers as well as for MCPs, churn presents challenges. People experiencing homelessness often lose Medi-Cal when they fail to get recertification notices or are unable to act on these notices. Churn creates holes in financial benefits to homeless service providers when people are no longer enrolled, or when people change MCPs and the provider does not contract with the new MCP in its region. MCP notification to providers that a former member has changed plans is currently slow. So a homeless service provider who has a contract with plan A may have spent months providing outreach and engaging someone who has changed to plan B, and may fail to get reimbursed for forming a trusting relationship with that person. Also, a person deemed eligible for Community Supports under one plan may not be eligible under a different plan.

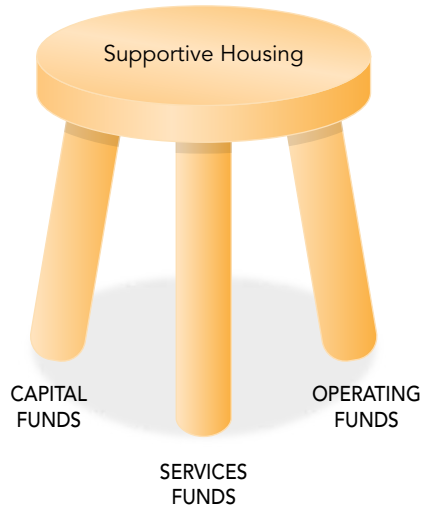
Funding

Most community-based nonprofits are grants based, with budgets and administrative structures built around the grants process. Much of the housing world also operates from that prospective payment model. The health care world, in contrast, operates on a retrospective payment model. Reporting in the homeless response system relies on general reports of services provided and outcomes achieved in housing placement and retention. Health care (Medi-Cal) requires billing and reporting in 15-minute increments, and many providers do not contract under Medi-Cal for this very reason. The start-up and transition costs (staff, technology) that organizations must incur to be able to bill Medi-Cal will prevent many community-based organizations working to respond to homelessness from participating in CalAIM.

Site/project-based supportive housing financing commonly requires a three-legged stool: (1) capital funds to build the housing, (2) operating funds to keep the property affordable to people with extremely low incomes, and (3) services funds to ensure assertive housing supports are available. Scattered-site or master-leased supportive housing uses rental housing subsidies to help a tenant lease an apartment from a private landlord. In this model, service providers offer services, ideally, where the tenant lives.

To align services resources from Community Supports with capital and operating funding for housing projects, services must be offered with certainty for as long as tenants want and need them. They must align, on a project basis, with the housing. To receive housing funding to build a housing project, developers must commit to funding services for the housing units they are creating for at least 15 years. Similarly, to house people with rental housing subsidies in private-market housing, particularly if the rental subsidies are prioritized for people experiencing homelessness, housing providers must put in place services funding that will persist for as long as the tenant wants and needs the services. Because MCPs could end Community Supports, and MCPs may limit time periods during which tenants could receive services, housing providers will face uncertainty about the stability of the services and how these services will align with housing. To create housing opportunities, all three legs of the stool must be in place (Figure E1).

Figure E1. The Three-Legged Stool of Financing to Create Supportive Housing



Source: *Dimensions of Quality Supportive Housing Guidebook* (PDF), Corporation for Supportive Housing.

Appendix F. Achieving the CalAIM Goals

Table F1. Using the Current CalAIM Structure versus a Housing Support Services Benefit to Achieve California's Goals

STATED CALAIM GOALS TOWARD PERSON-CENTERED CARE	MID-2023 USE OF COMMUNITY SUPPORTS AND ENHANCED CARE MANAGEMENT (ECM) TO FUND HOUSING-BASED SERVICES	WITH A HOUSING SUPPORT SERVICES BENEFIT, STRUCTURED AS RECOMMENDED
Ability to Identify and Manage Comprehensive Needs Through a Whole-Person Approach	▸ Services offered through separate lanes: ECM funds outreach, engagement, and care coordination, while separate Community Supports fund housing-based services. ▸ Managed care plans (MCPs) decide which Community Supports to offer; some MCPs decided not to offer the full range of housing-related Community Supports.	▸ If the California Department of Health Care Services (DHCS) creates a demonstration through a Section 1115 Medicaid waiver, a single homeless service provider could offer a full range of services, from outreach to tenancy supports, based on client needs. ▸ If DHCS creates a benefit through a Section 1915(i) State Plan Amendment, this authority may result in multiple providers offering different services. ▸ Enrollees receive services for as long as they need them.
Improve Quality Outcomes	▸ ECM care coordination may not improve outcomes without housing. ▸ Siloes between Community Supports and between ECM and Community Supports interrupt continuity of care.	▸ Improve access to a range of services with adequate rates. ▸ Potential to scale services to all who need them.
Consistent and Standardized Approach	▸ No standardization, as each MCP designs its Community Supports differently. ▸ Potential for adverse selection is high, as people may choose plans offering more comprehensive services.	▸ Standardized, consistent approach to funding housing support services statewide.
Seamless Access for Members by Reducing Complexity	▸ Extremely complex process for accessing services, with member navigating different programs. ▸ Funding for services based on MCP return on investment. ▸ Restrictions on members, such as lifetime limits, multiple assessments, and denied services if member is deemed unresponsive.	▸ Simpler funding, seamless to member if designed to reduce barriers.
Flexibility for Providers	▸ Providers must contract with different MCPs with potentially different rates, different programs, and different rules.	▸ Regular, ongoing payment for a range of services, for as long as the member needs them, ideally statewide.
Equity in Access	▸ In some cases, excludes members who have not accessed high-cost care, leading to disproportionate exclusion of people of color.	▸ As an entitlement, potential for greater scale and more equitable access to services.
Scalability	▸ In some cases, limited to high-cost members.	▸ As an entitlement, potential for scalability.
Coordination with Housing	▸ Not well coordinated or aligned with housing.	▸ Certainty of services funding could be coordinated with housing resources more easily, and housing providers can set aside units available to people eligible for the benefit (under a Section 1915[i] State Plan Amendment, tenants would have the ability to choose their providers, and services end if an assessment indicates a tenant no longer needs the services).

Source: "Guiding Principles," in *California Advancing & Innovating Medi-Cal (CalAIM) Proposal* (PDF), California Dept. of Health Care Services, January 2021.

Endnotes

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36. "Deploy Housing First Systemwide," US Interagency Council on Homelessness, last updated August 15, 2018. Some veterans programs require tenants of housing to participate in services, counter to the Housing First core components. Federal homeless programs otherwise require systemwide adoption of the Housing First core components.

37. California Welfare & Institutions Code § 8256 (2020).

38. California Welfare & Institutions Code § 8255(b) (2021) spells out the core components of Housing First that almost all state programs must follow. In 2022, the legislature passed trailer bill language that exempts specific California Department of Corrections and Rehabilitation programs from three of the Housing First core components (AB 197).

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