# Leveraging Resources to Build Partnerships between Health & Homeless Systems

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Homebase

# Introductions

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# Objectives

- ✓ Understand California's most recent Medicaid 1115 demonstration (CalAIM), its housing-related services, and efforts to incentivize Medicaid managed care plans to engage deeply in collaboration with long-standing homeless system through the Housing & Homelessness Incentive Program (HHIP)
- ✓ Identify challenges that arise when connecting two disparate systems – managed care and homeless systems.
- ✓ Apply insights emerging from early CalAIM and HHIP implementation to cross-system partnership efforts in your communities.

# Overview of CalAIM and HHIP

# CalAIM Overview

- CalAIM = California Advancing and Innovating Medi-Cal
  - New Medicaid initiative (Section 1115 demonstration) focused on improving health of Californians w/ the most complex needs
  - Populations of focus include people experiencing homelessness
- CA contracts with managed care plans (MCPs), which contract with networks of providers to deliver services.
  - 1+ Medicaid MCP in each county
  - MCPs only responsible for providing coverage to their members
  - MCPs receive payment from the state per member / per month

# Enhanced Care Management & Community Supports

- Two new CalAIM programs offering benefits and services for people experiencing or at risk of homelessness
- Enhanced Care Management (ECM): Medicaid benefit that MCPs are required to provide to eligible members
- Community Supports (CS)
  - MCPs are encouraged, but not required to provide
  - Key goal: allow members to obtain care in the least restrictive setting possible and keep people in the community

# Enhanced Care Management (ECM)

- Intensive care coordination and services across multiple systems of care
- Intended to help address both clinical and non-clinical needs
- ECM providers must meet members where they are, instead of just at the doctor’s office
- Enhanced care managers help members set clear goals, make sure they receive the full array of benefits they’re eligible for, and coordinate across systems to help members achieve their goals

# Community Supports (CS)

- New services MCPs can add to the package of services they offer
- MCPs are encouraged to provide as many of the 14 pre-identified services as possible

  - Housing Transition Navigation Services
  - Housing Tenancy and Sustaining Services
  - Recuperative Care (Medical Respite)
  - Caregiver Respite Services
  - Community Transition Services/Nursing Facility Transition to a Home
  - Environmental Accessibility Adaptations (Home Modifications)
  - Sobering Centers
  - Housing Deposits
  - Short-Term Post-Hospitalization Housing
  - Day Habilitation Programs
  - Personal Care and Homemaker Services
  - Nursing Facility Transition/Diversion to Assisted Living Facilities
  - Medically Supportive Food/Meals/Medically Tailored Meals
  - Asthma Remediation



For more details about each Community Support, see DHCS Community Supports Policy Guide

# CoCs and MCPs are critical partners

## CoCs

- Identify eligible MCP members
- Make referrals to ECM and CS
- Support people not yet enrolled in Medicaid to enroll and select their MCP
- Support CoC agencies to become contracted Community Support providers

## MCPs

- Leverage Medicaid funding to pay for housing-related services Community Supports (housing navigation, housing deposits)
- Preserve CoC funding for other needed services
- Support CoC agencies to become contracted Community Support providers

# Quick Questions

Who here has worked with your local cross-sector partners?

If you have, how would you describe your cross-sector/cross-system partnerships?

(exploring, previously partnered, extensively partner, something else?)

# Overview of Housing and Homelessness Incentive Program (HHIP)

- California state program funded with $1.3 billion in one-time American Rescue Plan Act (ARPA) funding
- Voluntary program for MCPs
  - Earn incentive funds by investing in addressing homelessness
  - Must work at the county-level with local community stakeholders (including Continuums of Care (CoCs))
- HHIP's stated goals:
  - Ensure Medicaid MCPs develop the needed capacity and partnerships to connect their members to housing services
  - Reduce and prevent homelessness

# HHIP Metrics

- State is using 15 metrics to evaluate MCPs & determine the effectiveness of their engagement and investments
- Metrics determine the amount of incentive funds each MCP will ultimately receive. Key metrics relate to:
  - Engagement with CoC and connection to HMIS
  - Data sharing – for client matching and care coordination
  - Connections to ECM & housing-related Community Supports
  - Connections to street medicine
  - Screening MCP members for homelessness
  - Housing placement and retention

# HHIP Funds

- Pre-determined maximum amounts that participating MCPs can earn in each county.
  - No guarantee to receive specific amount
  - MCPs must earn their allotted portion by meeting metrics
- Use of earned funds is not directed or restricted, but state agency administering the program:
  - Intends for HHIP to bolster housing- and homelessness-focused efforts and investments; and
  - Expects MCPs will maximize investment with local partners who are leading housing- and homelessness-related efforts.

# Collaboration Required, Partnership Incentivized

- MCPs must work w/ counties and CoCs to develop & submit:
  - Local Homeless Plan (June 2022)
  - Investment Plan (September 2022)
  - Reports in March 2023 and December 2023 to demonstrate they've met specific metrics
- Strategic and meaningful partnership between CoCs and MCPs increases the likelihood of meeting the metrics and earning maximum available incentive funds.

# Cross-System Connections

- Majority of people experiencing homelessness are eligible or already enrolled in Medicaid in California, but MCPs have historically not been engaged in efforts to address homelessness.
- CalAIM (ECM & CS) and HHIP have created opportunities for MCPs to better understand the homeless system of care & for homeless system partners to understand the role of MCPs and how Medicaid programs can support community efforts to address homelessness.

# Anything sounding familiar?

For those in California, are you aware of or involved with ECM/Community Supports or HHIP efforts in your county?

For those outside California, are you aware of anything similar to these programs in your state?

# Challenges in Connecting Disparate Systems

# Overarching Challenges

- Wide range of awareness, understanding, and ability to take advantage of CalAIM and HHIP from both sides
  - Clarity around purpose and opportunities
  - Capacity to fully partner
- Minimal understanding of each other's systems: funding, structures, processes, motivations, goals, language, etc.
- Interest in building long-term partnerships vs. taking advantage of this one-time opportunity

# There’s a will – Is there a way?

- Starting from scratch on a tight timeline
- Metrics as a highly motivating but also complicating
- Dependence on hyper local planning and implementation with insufficient cross-county learning opportunities
- Data sharing difficulties: privacy, capacity, quality, technology
- Short term vs. Sustainable
  - Flexible but one-time funds
  - Limited time for system change & demonstrating impact
  - Some MCPs leaving counties in 2024

# What are *your* challenges?

Do these sound familiar?

What other challenges have you experienced when attempting to collaborate with your cross-system partners?

# Insights Emerging from Initial Implement Efforts

# Community Case Study

- Big county with large urban center + suburban areas
- Lots of wealth but also very high numbers of people experiencing homelessness, especially unsheltered
- Robust CoC with established Community Plan to End Homelessness and coordinated providers
- Very dedicated MCPs: One local and one multi-county commercial
- MCP engaged a consultant with homelessness expertise and connections to CoC to facilitate planning process

# CalAIM & HHIP Implementation Barriers

- Initially: Trust and relationship-building
- Understanding each other's systems
- Contracting timelines
- Data matching: identifying shared clients, tracking referrals and services
- Care coordination: determining roles and avoiding duplication
- Long-term planning

# Success is Underway…

- Direct investments in homelessness prevention and street medicine
- Cross-system training: CoC & MCP 101, resources, referrals
- Coordination around referrals, tracking, and care coordination
- Continued focus on data-sharing and data system improvements
- Dedicated housing- and homelessness-focused MCP staff
- Collaborative expenditure planning → funding new, innovative programs and strategies
- Focus on sustainability (of programs and partnership), centered around improving health and housing outcomes for people experiencing homelessness

# Data Sharing Opportunities

- Direct HMIS access
- Targeted data matches/exchanges (one time or with agreed-upon frequency)
  - Identify shared clients/members
  - Supplement CoC and MCP data (e.g., what MCP members are known to be experiencing homelessness/connected to CoC, what CoC clients are connected to ECM and CS)
  - Monitor service connections and housing outcomes
- Investment in HMIS improvements or expansions
- Development of needed Application Programming Interface (API) to facilitate more automatic connectivity

# What's Helped

- Prior collaboration attempts (including MCP access to HMIS)
- Strong leadership and demonstrated commitment by MCPs
- MCP consultants and/or staff with homeless system expertise
- MCP embedding in CoC: attending existing meetings, presenting to a variety of CoC and county stakeholders, etc.
- Dedicated work group with staff from both MCPs and CoC
  - Focus on short-term needs to meet metrics/earn dollars and connect to existing resources like ECM and CS
  - Longer-term planning for funds
  - Building foundation for sustained partnership and collaboration

# Opening it Up

What questions do you have?

Which of these ideas might help in your own cross-system partnership efforts?

What cross-sector successes have you had?

What could you use help with?

# A few final lessons from the HHIP field…

- CoC meetings can be productive & mutually beneficial if health system partners understand the purpose & how to participate.
- Health system partners can do more than refer patients to homeless services. Share expertise with CoCs about health-related factors that should be incorporated into Coordinated Entry prioritization and assessment process to improve the overall equity.
- Consider ways to integrate referrals to housing-related health system resources into HMIS/Coordinated Entry.
- CoCs can educate health provider staff on effective, trauma-informed ways to screen people for homelessness/housing instability.
- Programs focused on serving people experiencing homelessness should be *designed specifically* for (and with!) them.

# Additional Resources

- About Section 1115 Demonstrations
- State Medicaid Waivers and Demonstrations List
- Resources for Building Health Care-Homeless Response System Partnerships (Homebase)
  - Suite of materials on understanding and leveraging CalAIM and HHIP
    - CalAIM Basics
    - CalAIM's Housing-Related Services
    - The Housing & Homelessness Incentive Program (HHIP)
    - Opportunities for Homeless Systems of Care under HHIP
    - HHIP Implementation Toolkit for CoCs
  - Data-sharing resources
    - Breaking Down Silos: How to Share Data to Improve the Health of People Experiencing Homelessness
    - How to Share Data: A Practical Guide for Health and Homeless Systems of Care
  - Homelessness Response 101 for Health Care Providers and Stakeholders

***Reach out with any questions: healthcare@homebaseccc.org***