Addressing Homelessness and Health in California

CA Association of Health Plans Annual Conference

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Outline for today

1. Understanding homelessness in CA
2. State and federal efforts to end homelessness
3. Opportunities for MCPs
   - CalAIM
   - Home and Community Based Services
4. How to build collaborative efforts in your county
5. Q and A

Why are people homeless?

Homelessness is an interaction between:

- **Structural Factors** (i.e. affordable housing, jobs for low wage workers, income inequality)
- **Individual vulnerabilities** (i.e. mental health disabilities, substance use disorders, adverse childhood experiences)

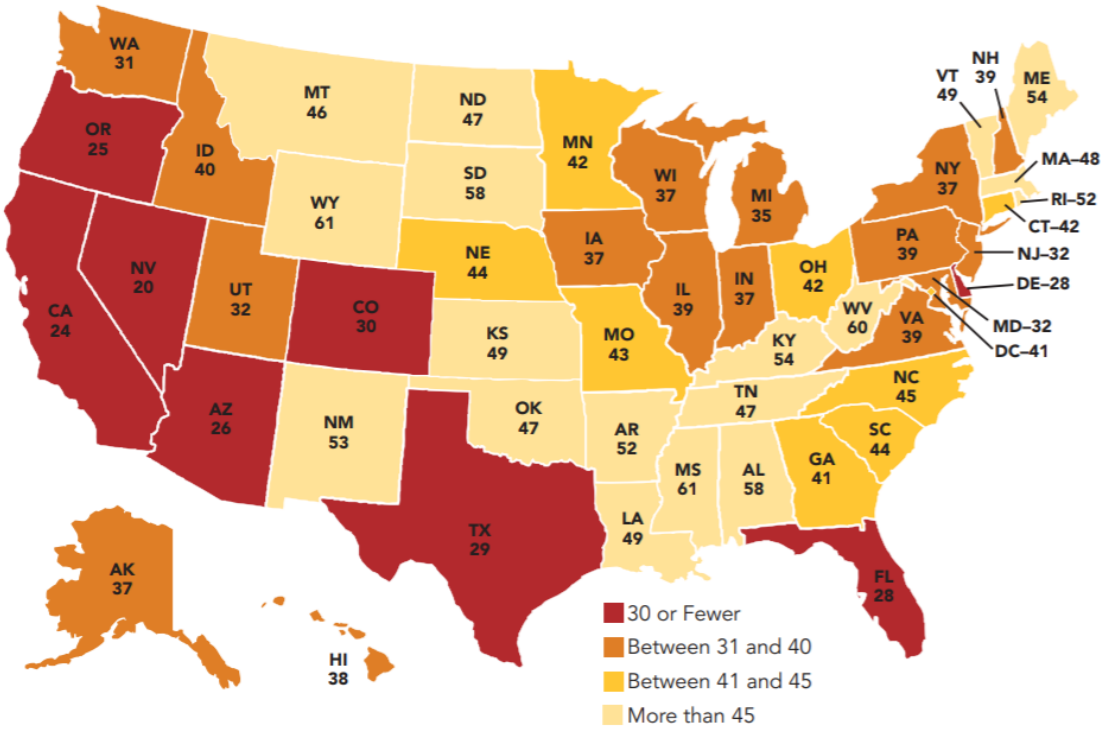
And the **presence or absence of a safety net** (i.e. income support, safety-net healthcare, subsidized housing).

The less favorable the structural factors and availability of safety net is, the fewer individual vulnerabilities one needs to become homeless

The main driver of homelessness is housing affordability

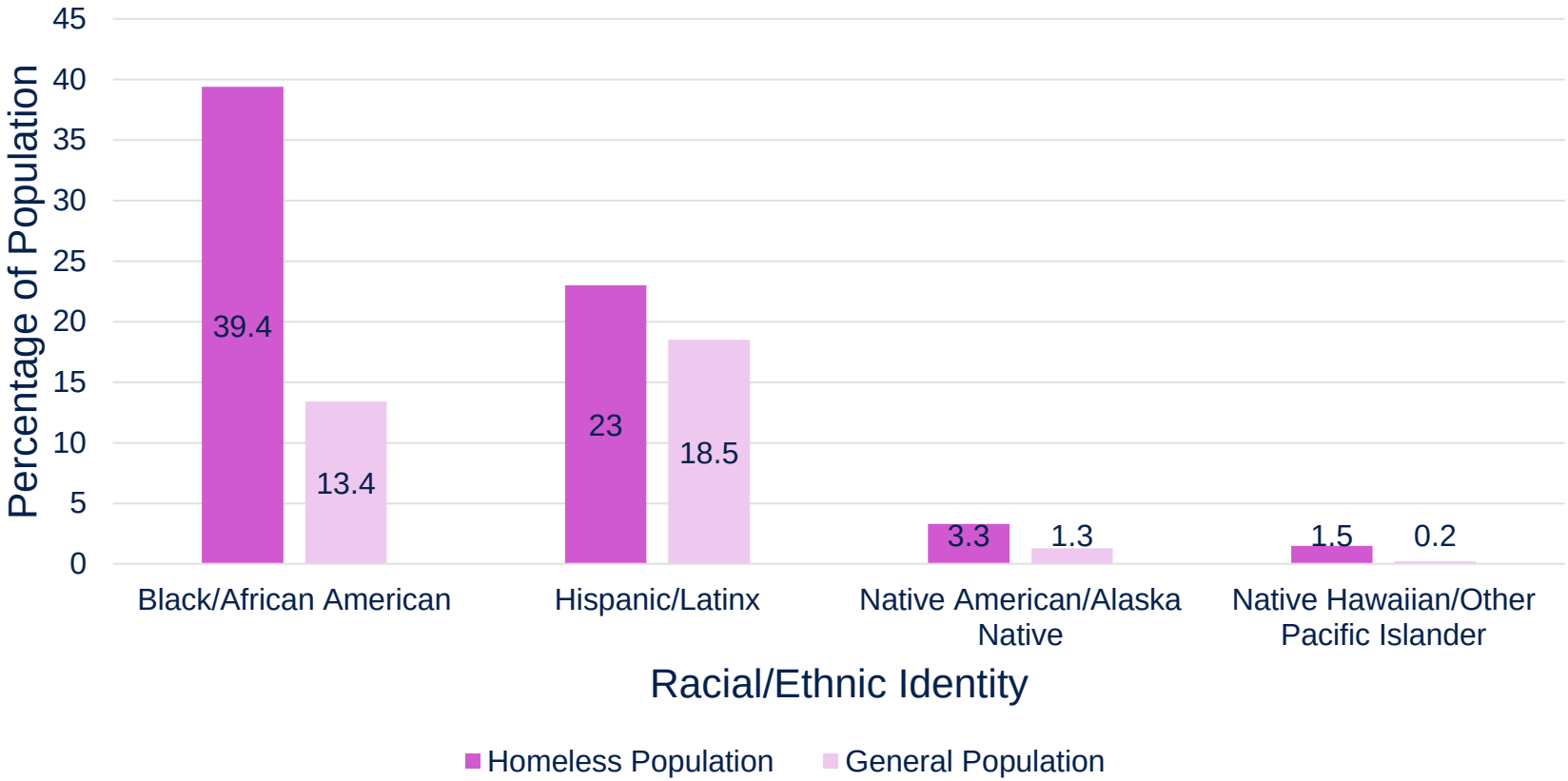
US has **36** units available for every 100 extremely-low-income households (CA has **24**)

FIGURE 7: RENTAL HOMES AFFORDABLE AND AVAILABLE PER 100 EXTREMELY LOW INCOME RENTER HOUSEHOLDS BY STATE



Note: Extremely low income (ELI) renter households have incomes at or below the poverty level or 30% of the area median income. Source: NLIHC tabulations of 2019 ACS PUMS Data.

Ethnic and Racial Disparities in National Homelessness



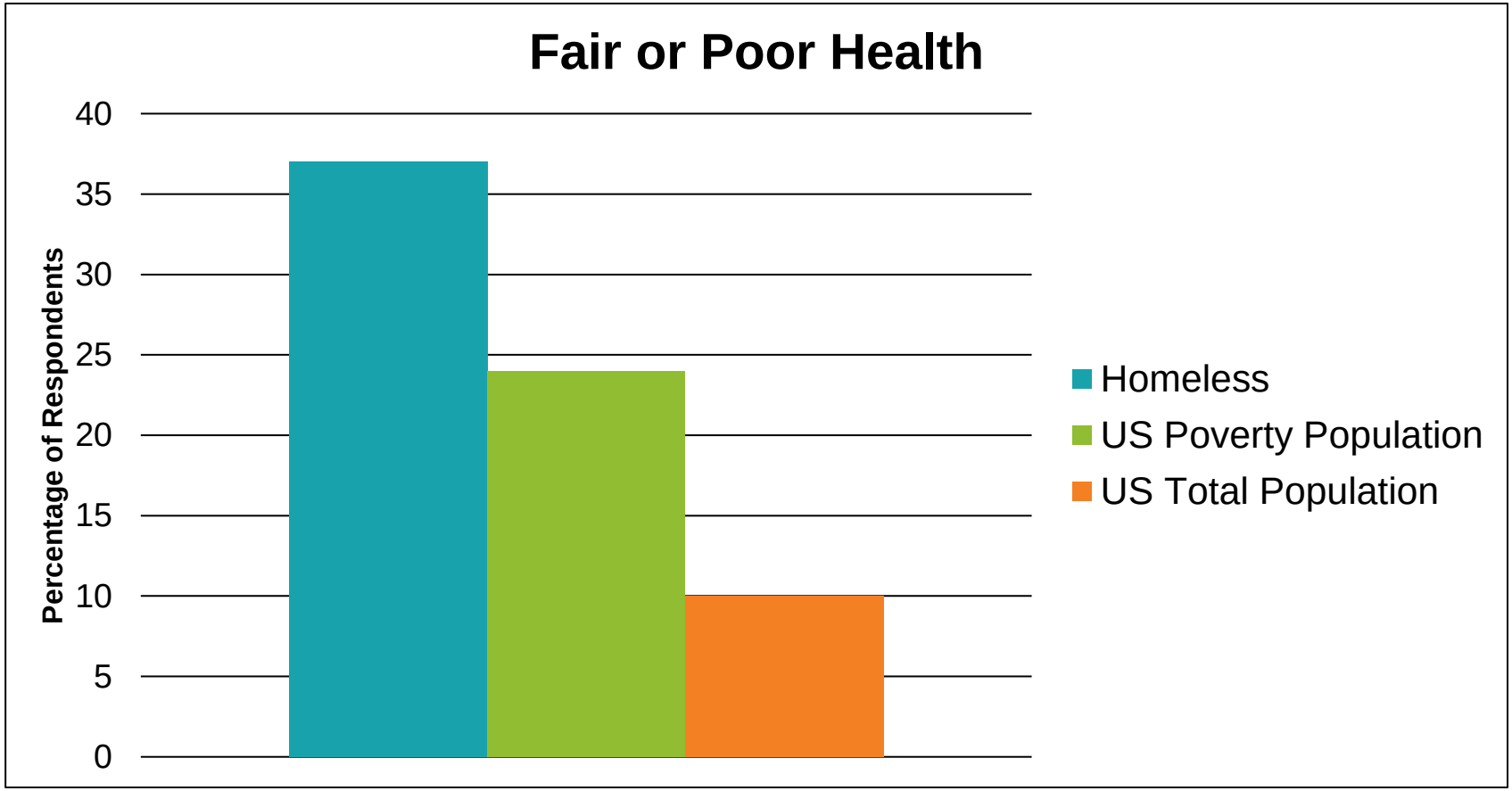
Henry, M., Sousa, T., Roddy, C., Gayen, S., Bednar, TJ., & Abt Associates. (2021). *The 2020 Annual Homeless Assessment Report (AHAR) to congress*. https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf

U.S. Census Bureau. 2019 Population Estimates. https://www.census.gov/quickfacts/fact/table/US/PST045219

How many people are homeless in CA?

- Over **161k people** experiencing homelessness in CA on any given night (2020 Point In Time count).
- At over **113k people living in an unsheltered setting**, California accounts for more that half of all unsheltered people in the US.
  - People experiencing unsheltered homelessness are far more likely to face health challenges, violence and trauma, and longer lengths of homelessness than people staying in shelters.
  - Unsheltered people also engage much more frequently with police and emergency health services than people staying in shelters.

Homeless persons report worse health status than US or poverty populations



Elevated age-adjusted mortality rates of homeless adults; causes vary by age

- Age 25 to 44
  - Drug overdose, heart disease, substance use disorders, HIV
  - Mortality rates 9x-10x higher than general population
- Age 45 to 84
  - Cancer, heart disease
  - Mortality rates 4x-5x higher than general population

Baggett TP, Hwang SW, O'Connell JJ, et al. Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. JAMA Intern Med. 2013 Feb 11;173(3):189-95. doi: 10.1001/jamainternmed.2013.1604. PMID: 23318302.

How homelessness affects health care utilization

- More frequent hospital stays
- Longer hospital stays
  - More hospitalization for potentially preventable causes
  - Lowered admission thresholds
  - More difficult to discharge
    - Homeless were 3x more likely to be readmitted (22.2 % versus 7.0 %)

Saab D, Nisenbaum R, Dhalla I, Hwang SW. Hospital Readmissions in a Community-based Sample of Homeless Adults: a Matched-cohort Study. J Gen Intern Med. doi:10.1007/s11606-016-3680-8.

How to end homelessness? Housing!

- Rapid Rehousing
  - Connects families and individuals to permanent housing via tailored package of assistance. Can serve as bridge to longer-term support (i.e. rental vouchers)
  - Targeted supportive services
    - Housing identification
    - Rent and move-in assistance (typically 6 months or less)
    - Case management and services

- Permanent supportive housing for those with chronic homelessness/disabling conditions
    - Subsidized housing
    - Linked supportive services that are voluntary
    - **Housing First** model – start with the housing
    - Shown to be highly effective at keeping people housed
    - Need to adapt for needs of older adults

Key State and Federal Investments

- Federal Investments
  - Emergency Housing Vouchers
- State Investments at $12B over the next 2 years
  - $5.7B in new infrastructure funding to create housing and behavioral health treatment settings
  - $2B in flexible funding to local governments with strong accountability metrics
  - Investments in social safety net and healthcare delivery system

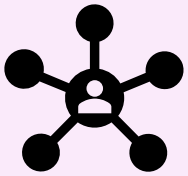
Key DHCS opportunities to address the needs of people experiencing homeless

- **CalAIM**
  - Enhanced Care Management
  - Community Supports (also known as In-Lieu of Services)

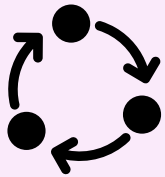
- **Home and Community Based Services**
  - Housing and Homelessness Incentive Program
  - Providing Access and Transforming Health (PATH)
  - Assisted Living Waiver expansion
  - Residential Continuum Pilots
  - Community Care Expansion

California Advancing and Innovating Medi-Cal (CalAIM)

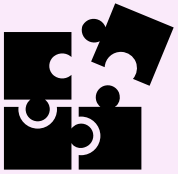
Moving from Pilot to Statewide Implementation: CalAIM will implement broad program, delivery system, and payment reforms statewide to advance <u>three primary goals</u>:



Identify and manage member risk and need through **whole-person care** approaches and addressing **social determinants of health (SDOH)**



Move Medi-Cal to a more consistent and seamless system by **reducing complexity** and **increasing flexibility**



Improve quality outcomes, **reduce health disparities**, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform

Enhanced Services to Promote Health Equity for the Most Vulnerable Medi-Cal Beneficiaries

Based on the success of the Whole Person Care (WPC) pilots and Health Homes Program (HHP), DHCS will launch ECM as a statewide benefit, as well as Community Supports (ILOS) at Medi-Cal health plan and member option to offer members cost-effective alternatives to Medi-Cal State Plan benefits.

Enhanced Care Management (ECM)

- ECM will be a **statewide service** available to **members with the most complex health and social needs** as defined by **Populations of Focus.**
- ECM Core Services will be defined in the **Medi-Cal Managed Care MCP Contract,** with MCPs expected to coordinate all carved out services (e.g., SMHS, DMC-ODS).

Community Supports (ILOS)

- Community Supports will focus on addressing **medical and SDOH needs to** avoid higher levels of care and associated costs.
- Specified in the **MCP Contract,** with MCPs **strongly encouraged,** but not required, to provide “in lieu of”/as substitute for utilization of other services or settings (e.g., hospital or skilled nursing facility admissions, discharge delays, or ED).

* ILOS launches statewide in **January 2022**. ECM implementation begins in **January 2022 and will occur in phases through July 2023**.

HHP/WPC Transition to ECM/ILOS

CURRENT STATE

WPC
- Pilot program supported by 1115
- Coverage agnostic (Medicaid MC, FFS or uninsured)
- Administered by county based “Local Entities”

HHP
- Benefit (state plan service) in select counties
- Managed care members only
- MCP administered with care management contracted out to providers

1915c Waivers
- Mix of statewide and county-specific programs
- Full Scope Medi-Cal members only
- Administered by Waiver Agencies located throughout the state

FUTURE STATE

ECM
- Care coordination contract requirement
- Managed care members only
- MCP administered with care management contracted out to community providers

ILOS
- Optional, but strongly encouraged
- Managed care members only
- MCP administered with care management contracted out to community providers

Enhanced Care Management

ECM go-live will occur in stages, by Population of Focus

Populations of Focus	Go-Live Timing
1. Individuals and Families Experiencing Homelessness 2. Adult High Utilizers 3. Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)	**January 2022** (WPC/HH counties); **July 2022** (other counties)
4. Incarcerated and Transitioning to the Community 5. At Risk for Institutionalization and Eligible for Long Term Care 6. Nursing Facility Residents Transitioning to the Community	**January 2023**
7. Children / Youth Populations of Focus • Experiencing homelessness • High Utilizers • Serious Emotional Disturbance (SED) or Identified to be At Clinical High Risk (CHR) for Psychosis or Experiencing a First Episode of Psychosis • Enrolled in California Children's Services (CCS)/CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Qualifying Condition • Involved in, or with a History of Involvement in, Child Welfare (Including Foster Care up to Age 26) • Transitioning from Incarceration	**July 2023**

Community Supports

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

ECM is a Core Component of CalAIM's Justice-Involved Initiative

ECM is integral to CalAIM's initiatives to improve health outcomes and address health disparities among Medi-Cal eligible people involved in the justice system 90 days prior to release and reentry to the community.

The justice-involved initiative is **based on and builds upon ECM**, including (but not limited to):

- Coordinating an **initial care needs assessment** to evaluate medical, psychiatric, substance use, and social needs
- **Direct connections with community providers** to ensure continuity of care for their conditions (especially for medications) and to address any health care needs not treated while they were incarcerated
- Utilizing **housing-related community supports** to identify housing and prepare individuals for securing and/or maintaining stable housing
- **Coordinating and collaborating** with various health, behavioral health, and social services providers, as well as parole/probation, including sharing data (as appropriate) to facilitate better coordinated whole person care

ECM for justice-involved populations is expected to be fully implemented statewide in January 2023

Home and Community Based Services

- Housing and Homelessness Incentive Program
- Providing Access and Transforming Health (PATH)
- Assisted Living Waiver expansion
- Residential Continuum Pilots
- Community Care Expansion

Housing and Homelessness Incentive Program

- Medi-Cal managed care plans earn incentive funds for making investments and progress in addressing homelessness and keeping people housed.

- Funds allocated by Point in Time counts of homeless individuals and other housing related metrics.

- Managed care plans and the local homeless Continuum of Care, in partnership with local public health jurisdictions, county behavioral health, Public Hospitals, county social services, and local housing departments must submit a Homelessness Plan to DHCS. DHCS will make payments based on meeting goals or milestones identified in the Homelessness Plan.

Providing Access and Transforming Health (PATH)

- PATH funds for Homeless and HCBS Direct Care Providers to assist implementing CalAIM and HCBS Spending Plan initiatives

- Local governments, providers and community based organizations will need to recruit, onboard, and train a new workforce.

- Funding will support outreach efforts to publicize job opportunities, workforce development strategies to train staff in evidenced based practices, implement information technology for data sharing, and support training

Assisted Living Waiver Expansion

- The ALW is designed to assist Medi-Cal beneficiaries to remain in their community as an alternative to residing in a licensed health care facility.

- Adds 7,000 slots to the Assisted Living Waiver in an effort to eliminate the current waitlist while furthering the vision of the Master Plan for Aging.

Community Based Residential Continuum Pilots

- The pilots will provide medical and supportive services in the home, independent living settings including permanent supportive housing, and community care settings (home, ARFs, RCFEs, affordable housing) in order to avoid unnecessary healthcare costs, including emergency services and future long-term care placement in a nursing home.

- This program would ensure individuals are able to live in the least restrictive setting possible by ensuring access to home-based health and other personal care services for vulnerable populations, including seniors, people with disabilities, and people experiencing homelessness.

Community Care Expansion

- The Community Care Expansion (CCE) Program provides capital funding for the acquisition, rehabilitation, or construction of adult and senior care facilities that serve the SSI population to prevent and end homelessness.

Opportunities for Collaboration

What is a CoC?

- A homeless Continuum of Care (CoC) is a regional planning body that coordinates funding for people experiencing homelessness
- Key roles:
  - Oversee Homeless Management Information System (HMIS), HUD mandated data system
  - Manage the Coordinated Entry System to assess, prioritize, and connect individuals to appropriate housing interventions

CA has 44 CoCs covering all 58 Counties

Partners

- Get to know your homeless Continuum of Care and other local homeless programs
- Leverage WPC and Health Home providers
- Contract directly with experienced service providers
- Connect with homeless shelters, street based teams, mobile clinic providers, etc.

What questions do you have for us today?

For follow up questions, contact housing@dss.ca.gov and CalAIM@dhcs.ca.gov