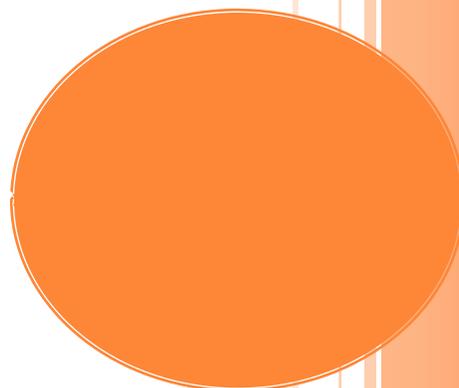


*AFFORDABLE CARE ACT
(ACA)
STRATEGY BRIEFS*

November 12, 2015



5. POTENTIAL ACA STRATEGIES

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Potential Strategy 5.1 Health Home Benefit

I. Description of the Proposed Strategy

Prepare homeless and health care systems in Los Angeles County for the new Medi-Cal Health Homes benefit by:

- *Creating a public-private partnership between the Department of Health Services (DHS) and Medi-Cal managed care/health plans; and*
- *Developing the capacity of health home teams “Community-Based Care Management Entities” (CB-CMEs) to be ready by July 1, 2016.*

Health homes funding will provide a new Medi-Cal benefit that funds care/case management and other services for beneficiaries with chronic medical and behavioral health conditions. Homeless beneficiaries who meet State-established health home program eligibility criteria would be eligible for the benefit. The Affordable Care Act (ACA) included the health home benefit (Section 2703) as an optional benefit which states may offer Medicaid beneficiaries with two or more chronic conditions, and provides states with enhanced federal funding (90% funding) for the first two years. The federal Centers for Medicare and Medicaid Services (CMS) provided some guidance to states on taking advantage of this option, but has not issued regulations, giving states considerable flexibility in crafting a health home benefit.

Successful case management programs serving homeless and frequent user populations, such as those funded under the DHS Housing for Health (HFH) program, use evidence-based models of multidisciplinary treatment, such as outreach and engagement using motivational interviewing, frequent face-to-face contact, connection to housing, and housing stability services (i.e., life skills and money management training, community integration, etc.). Study after study shows this package of services dramatically improves health outcomes and reduces Medicaid costs.

The California Department of Health Care Services (DHCS) is working on a State Plan Amendment (SPA) to create a Medi-Cal health home benefit. DHCS intends to submit the SPA at the end of 2015. DHCS is now preparing to release a draft SPA and updated concept paper on December 4, 2015 and to roll out the benefit in initial counties on July 1, 2016.

Managed care organizations will administer Health Home Programs (HHP) in specified counties. DHCS recently sought non-binding Requests for Information from health plans across the state. Within each county, all Medi-Cal managed care health plans that have contracts with the State must agree to implement health home in order for that county’s Medi-Cal beneficiaries to be eligible.

The health home benefit will offer a monthly per member, per month rate to health home providers, which DHCS has termed “Community-Based Care Management Entities,” or CB-CMEs. Under the ACA option requirements, DHCS will establish eligibility based on a combination of chronic medical health and behavioral health conditions identified by DHCS. DHCS will also define the services funded in the benefit. CB-CMEs serving homeless beneficiaries would need to include a housing navigator to help beneficiaries complete housing applications, provide housing search assistance, and connect beneficiaries to the appropriate coordinated entry system. DHCS could also define services to include services that promote housing stability. However, the benefit will not fund start-up costs, such as costs necessary to build the infrastructure or to build a Countywide health home network.

The County could join with Medi-Cal managed care plans to create partnerships to ensure the health home benefit is accessible to Medi-Cal beneficiaries experiencing homelessness, and to determine what role the County could play in the administration of the benefit.

A. County-Health Plan Partnership to Administer HHPs

DHS and other health departments could play a leading role in administering and supporting implementation of the health home benefit. Several options exist to create County-health plan partnerships:

1. DHS could convene and lead a County-health plan work group on health homes. A work group could address capacity-building, data-sharing, plan contracting, and other issues in preparation for the roll-out of a health home program in Los Angeles County. DHS could coordinate with health plans in decision-making regarding request(s) for proposals, health plan requirements of CB-CMEs serving homeless beneficiaries, metrics, and data reporting and sharing.
2. DHS’s Housing for Health (HFH) division is well-poised to take a leadership position and play an important role in administering the benefit. One potential option would be for HFH to apply to be a lead CB-CME for homeless services and healthcare providers providing health home services in the County.
3. The Department of Mental Health (DMH) is in the process of establishing Health Neighborhoods in several communities of the County. DMH could also explore whether Health Neighborhoods could become CB-CMEs in some communities.

B. Capacity-Building for CB-CMEs Serving Homeless Beneficiaries

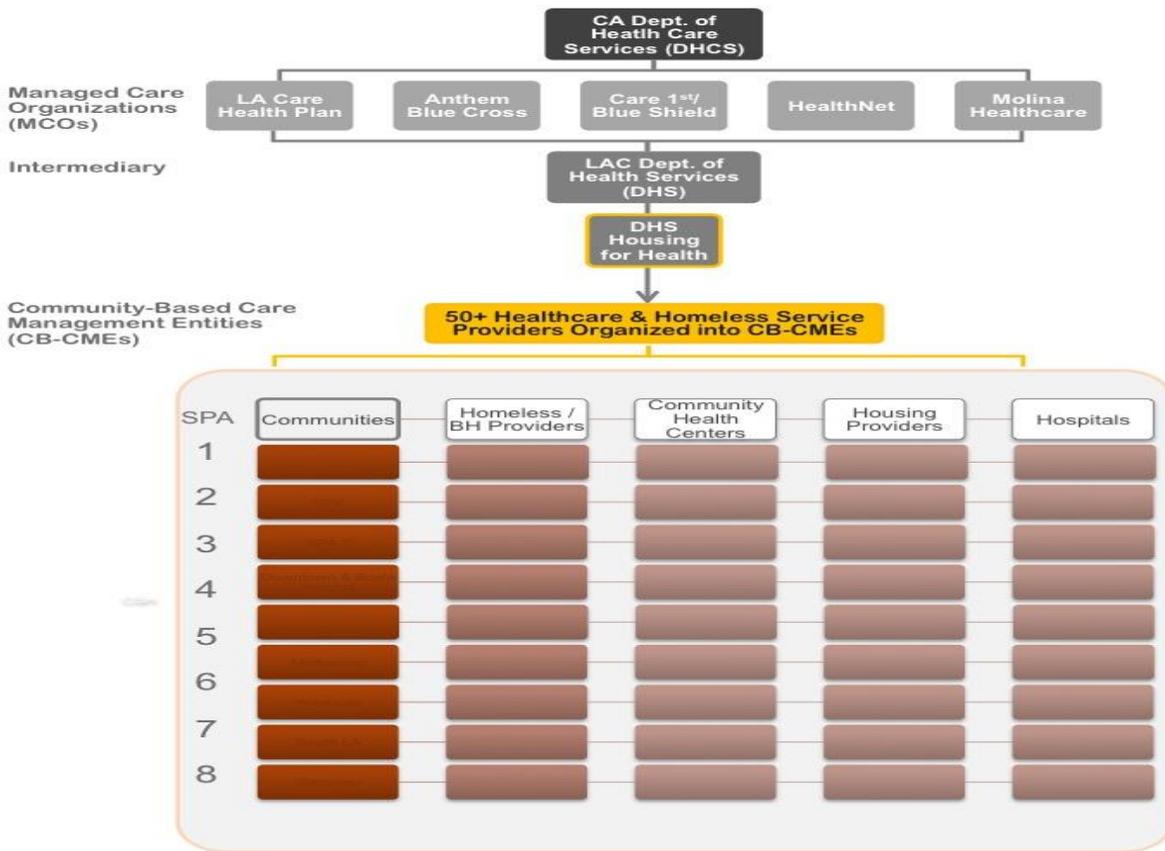
As the potential launch of health homes approaches, one significant concern is the current capacity of agencies with the greatest experience serving homeless beneficiaries. The next 12 months are critical in preparing providers across the County for the new health home benefit. With the appropriate level of resources, DHS could help potential CB-CMEs to prepare, which could include in-person training and support for CB-CMEs to build the infrastructure necessary to comply with administrative requirements, to help CB-CME team partners to share data and address HIPAA and health care privacy requirements, and to

“scale and staff up” to serve a significant number of homeless beneficiaries who will become eligible for a health home benefit.

Given significant overlap between the objectives of DMH’s Health Neighborhoods and a health home program, DMH could play a role in facilitating partnerships between Health Neighborhoods and CB-CMEs serving beneficiaries experiencing serious mental illness.

While a number of homeless service providers could expand to offer services to homeless beneficiaries, additional work would be needed to partner homeless services and mental health providers with health centers and hospitals serving residents in many places in the County. This work would involve setting up and conducting meetings with potential health home partners, including hospitals, health centers, and behavioral health providers. In this work, DHS and DMH are important partners to the health plans to design and implement a robust health home benefit in Los Angeles County.

Health Home Program (HHP) Network Structure in Los Angeles County



C. Target Population(s)

DHCS has not yet identified populations eligible for the health home benefit. Under the ACA, DHCS must identify specific chronic conditions which could trigger beneficiary eligibility. For purposes of this brief, the target population would be homeless beneficiaries

who are eligible for the health home benefit, though the benefit would be available to a much larger population, and not all homeless beneficiaries would be eligible. The new benefit would be an entitlement, so all who are eligible in participating counties would be entitled to receive health home services, provided the provider infrastructure is in place. Based on rough estimates of the number of homeless beneficiaries who would be eligible statewide, which is based on the number of chronically homeless people and the number of homeless people with disabilities, Los Angeles CB-CMEs could potentially enroll and serve an estimated 12,000-17,000 homeless Medi-Cal beneficiaries eligible for health home benefits.

D. Estimated Costs Per Person to Establish Public-Private Partnerships

Investing upfront in infrastructure, such as data sharing platforms, encryption software, etc., could result in avoiding significant County costs. Potential costs are not yet determined.

II. Opportunities That Make This Proposed Strategy Feasible

As noted above, DHCS is in the process of crafting a new health home benefit. DHCS is planning on submitting a State Plan Amendment (SPA) by December 31, 2015, with an early draft released for public comment on December 4th.

In drafting their SPA, DHCS is implementing Assembly Bill 361, which passed the California Legislature and was signed into law in 2013. AB 361 authorized DHCS to take advantage of Section 2703 of the ACA. The bill further required DHCS to craft a health home benefit in a way that would address the needs of Medi-Cal beneficiaries experiencing chronic homelessness and beneficiaries frequently visiting hospitals for avoidable reasons. The bill included several provisions to ensure DHCS creates a benefit that homeless people could access, such as a requirement that CB-CMEs (or health home providers) have experience addressing needs of homeless beneficiaries and have experience connecting beneficiaries to permanent housing, that CB-CMEs be allowed to provide health home services in places most accessible to beneficiaries, including in a beneficiary's home, and that CB-CMEs include relationships with permanent housing providers and homeless systems to serve homeless beneficiaries.

Since the legislation passed, DHCS has proposed several concepts specific to health home beneficiaries experiencing homelessness, including the following:

- A tiered rate structure that would include an additional per member, per month rate if the beneficiary is homeless or formerly homeless and living in housing for less than one year (a "homelessness modifier");
- A "housing navigator" as part of the CB-CME team, who would assist beneficiaries with finding and securing interim and permanent housing; and
- An "engagement rate" to allow CB-CMEs to receive payment while working to engage beneficiaries, prior to a beneficiary's consent to participate in a health home program.

The Centers for Medicare and Medicaid Services has approved health home SPAs in 19 other states. Several states have received approval of multiple SPAs. Most are intended to address the needs of Medicaid beneficiaries with mental health conditions, but states approach the health home benefit differently. Because CMS has not yet issued regulations on the health home benefit, states have great flexibility in defining and funding services that make up the health home benefit. New York is the only state that has intentionally targeted homeless beneficiaries through a health home benefit; however, the New York SPA does not include requirements specific to homeless beneficiaries.

To administer the New York health home program, which began in 2011, New York City's leaders in medical, behavioral health, rehabilitation and supportive housing service systems, came together to launch a nonprofit health home fiscal intermediary, Coordinated Behavioral Care (CBC). CBC was created with government and philanthropic support, including the New York City Department of Health and Mental Hygiene. CBC is now comprised of over 50 organizations that provide case management, supportive services, supportive housing, and neighborhood-based clinical treatment for medical, mental health and substance abuse disorders. Through the unprecedented joint effort of its members, CBC is enabling community agencies to participate with managed care organizations and hospitals in large-scale, city-wide health care initiatives, including Health Homes. CBC is responsible for: governance, contracts for MCOs, establishing provider networks, consumer outreach and engagement, a 24/7 call center, care coordination standards, central IT for billing, data analytics and performance metrics, technical assistance and consulting, and the learning collaborative. CBC provides the infrastructure for CBOs across the city to provide health home services.

Because multiple agencies in Los Angeles have significant expertise in improving health care and access to homeless beneficiaries and do not have contractual relationships with MCOs, Los Angeles could benefit from a lead fiscal intermediary. The County HFH program could be an ideal intermediary, should the County decide to pursue this function.

Because the HFH program currently dedicates resources to pay for services for homeless County hospital patients, as well as for rental subsidies for these patients, the health home benefit could pay for a substantial portion of costs for HFH services, though it could not fund any costs of housing. Funds saved could then potentially be diverted to the Flexible Housing Subsidy Pool.

III. Barriers to Implementing the Proposed Strategy and Recommendations on How they can be Resolved

In order for Los Angeles County to take advantage of the Health Home benefit a number of system changes would help remove existing barriers to implementation.

A. Use of Health Information Technology

The implementation of Health Homes will require enhancements and changed methods of data entry and changes in how data is shared. Historically, managed care plans have not documented who is experiencing homelessness in Electronic Health Records (EHR). To date, managed care plans cannot cross-reference Medi-Cal billing to identify beneficiaries who are homeless. In order to address this concern, it is recommended that managed care plans use the International Classification of Diseases (ICD-10) code to indicate homelessness in the EHR. The ICD-10 is the standard clinical catalog system to indicate any factors influencing health status that are not otherwise coded through the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Z59.0 is the ICD-10-CM code used to indicate homelessness. EHRs could include functionality in which to capture ICD-10 codes. Ideally, managed care plans would cross-reference Medi-Cal beneficiaries to this code and then have greater access to information indicating who is homeless in the health plans.

Because ICD-10 codes may not offer the health plans the most accurate data regarding a beneficiary's homeless status, health plans could help create a referral system that would allow for presumptive eligibility and expedited approvals of referrals from CB-CMEs serving homeless beneficiaries.

The HUD Continuum of Care services utilize the Homeless Management Information System (HMIS) as administered by the Los Angeles Housing Services Authority (LAHSA) in order to gather the HUD required data elements for individuals receiving homeless services. HMIS is a web-based application designed to collect information on the characteristics, service needs, and target achievements of clients. Los Angeles Homeless Services Authority (LAHSA) administers HMIS. In 2015, HMIS incorporated the Coordinated Entry System (CES). CES is now used to match homeless individuals to housing. CB-CMEs serving homeless beneficiaries should know how to access CES to identify housing options for homeless beneficiaries. In fact, CES could also incorporate health home program eligibility criteria into CES assessments of housing need to prioritize health home participants for supportive housing.

LAHSA has met with managed care plans to work through the process of addressing legalities inherent in HIPAA and effective data sharing. This process needs to continue to move forward in order to connect people experiencing homelessness to managed care plans and to connect homeless patients to housing resources.

B. Partnerships

Health Homes will require managed care plans to be the "Lead Entity" to contract with CB-CMEs. CB-CME's and managed care plans may require additional support for capacity building in order to meet the requirements of service delivery through a Health Home. Many

providers who have cultural competency to address the needs of homeless beneficiaries do not have the current infrastructure to become a health plan contractor. As noted above, the County could support capacity-building efforts, as well as work in partnership with managed care health plans to help with the process of contracting with agencies who are not currently health plan contractors.

The 10th Decile Project, administered by the Corporation for Supportive Housing, is a collaborative effort in Los Angeles County to connect frequent users of emergency health services to housing and appropriate care. More than 25 organizations, including five Health Center Program grantees, are involved in six neighborhood networks throughout the county to address the needs of the top 10% highest-cost, highest-need individuals experiencing homelessness in the community. This model has resulted in improved housing stability, enhanced health outcomes, and a significant reduction in per person cost to the health care system. In addition to the 10th Decile Project's model of partnership, the DHS' HFH program has become the standard of excellence in terms of partnership, resulting in ending homelessness for nearly 1,000 individuals in less than three years. The County could build on and expand significantly these existing partnerships that have successfully demonstrated effective case management and care coordination support for the Health Home population.

C. Availability of Adequate Housing

As housing is critical to improved health outcomes, available subsidized housing will be critical to the success of the health home benefit. Potential funding sources could include:

- Use a portion of HFH funding now dedicated to services to pay for rental subsidies through the Flexible Housing Subsidy Pool, if cost of services could be covered through Health Home funding or other sources.
- Reallocate McKinney-Vento Homeless Assistance funding now used for services to fund housing costs, if the cost of services could be covered through Health Home funding or other sources.

D. Timing of Implementation

The intended start date for Health Homes is July 1, 2016, DHCS' current planned implementation date for initial counties participating in the benefit. Because the financial model and final required outcomes have not yet been finalized by DHCS nor approved by CMS, the intended start date may be ambitious. Although there is a strong desire for managed care plans to take advantage of the Health Homes benefit option, there is not enough information yet to move forward with initial planning and full implementation.

E. Rate

The County could advocate with DHCS to ensure that DHCS designs the health home benefit to provide an adequate per member, per month rate to offer intensive services to homeless beneficiaries, limit administrative burden, and allow for services promoting housing stability.

F. Sustainability

The health home benefit would be funded through California's Medicaid program (Medi-Cal), typically funded in California at 50% federal funding and 50% state funding. Section 2703 of the ACA allows for 90% federal funding in the first two years of the benefit, and The California Endowment has offered to pay the State's share of costs for these first two years. After the first two years, the federal share of funding for the benefit will drop to 50% for categorically-eligible beneficiaries (on SSI or Social Security benefits) and 100% for Medicaid expansion population beneficiaries (indigent adults).

DHCS has indicated a commitment to administer this benefit beyond the first two years of enhanced federal funding. However, DHCS has also stated the State will not pay the State's share of costs for continuing the benefit *unless* an evaluation completed in the first two years demonstrates Medicaid costs decrease sufficiently among the participants to justify the costs of the benefit. Should the evaluation fail to demonstrate sufficient cost savings, the program would not have a sustainable source of state funding.

IV. Potential Performance Measures

- Number/percent of eligible clients enrolled in Health Home Benefit;
- Patient experiences of improved satisfaction in care;
- Reduced per capita cost of health care via reduced readmissions;
- Improved population health outcomes;
- Among beneficiaries who were homeless when they entered the health home program, percentage now living independently in their own apartments;
- Quality measures, based on state eligibility criteria; and
- Number/percent of health home participants matched to all eligible benefits to which they are eligible.

V. Potential Funding Streams

As noted above, studies show providing services in combination with housing dramatically decrease the health care costs of those experiencing homelessness. If the evaluation of the first two years of the Health Homes Program examines the impact of the benefit on specific populations, and if the benefit is administered in a culturally-competent manner following evidence-based practices, the State is expected to realize sufficient cost savings to fund the benefit for homeless populations on an ongoing basis.

In the event the State fails to achieve cost savings sufficient to pay for the ongoing costs of the benefit, the County would be required to: (1) fund the State's share of costs; (2) identify an alternative funding stream; or (3) allow the program to end. Relative to option 2, Mental Health Services Act funding could act as a potential funding stream, as could County DHS contributions to the HFH program.

The County could also advocate to the State to allow the County and health plans to create a “risk-savings pool” to draw on these funds for state matching funding. Federal guidance allows for using Medi-Cal money saved under a health home option to fund ongoing state matching requirements under the health home benefit.

Potential Strategy 5.2

Placeholder for the 1115 Medicaid Waiver

Los Angeles County should explore developing a proposal for a Whole Person Care Pilot program which includes services and some housing assistance (if allowable) for people who are experiencing or at high risk for homelessness. A portion of County and City funding that is available to invest in solutions to homelessness could be used to qualify for matching federal funds through the terms of California's new 1115 Medicaid waiver.

California's Department of Health Care Services is currently negotiating with the federal government (Center for Medicare and Medicaid Services, or CMS) the terms of a new 5-year 1115 Medicaid waiver, which will replace the current, expiring waiver by the end of the calendar year. One of the waiver provisions, which has been proposed by the state and is supported by CMS, would authorize Whole Person Care Pilots. These pilots would be county-based programs to provide more integrated care for high-risk, vulnerable populations. The waiver will authorize up to \$300 million statewide, annually for five years, to be matched by an equal amount of non-federal funds. Counties will be invited to submit applications for funding through a statewide, competitive process. Participation by a county is voluntary.

Between now and December 31, 2015, the state and CMS will negotiate Special Terms and Conditions (STCs) for the waiver and these STCs are expected to provide more details about the proposed Whole Person Care Pilots, including pilot program design, potential target populations, allowable uses of federal matching funds, requirements for non-federal funds, and performance measures/evaluation design.

Potential Strategy 5.3
Drug Medi-Cal Organized Delivery System (DMC-ODS) for Substance Use Disorder
Treatment Services

I. Description of the Proposed Strategy

How the DMC-ODS Can Expand Services for Homeless Individuals

The approval of the California Department of Health Care Services (DHCS) Drug-Medi-Cal Organized Delivery System (DMC-ODS) waiver by the Federal Centers for Medicaid and Medicare Services (CMS) allows counties to voluntarily opt-in to expand reimbursable services under the DMC program. This opportunity includes a fuller continuum of care and appropriate support services, standardizes level of care placements based on the American Society of Addiction Medicine (ASAM) Criteria and medical necessity, ensures effective and appropriate care through quality assurance and utilization management efforts, more fully integrates physical and mental health services with the SUD service system, and transforms the overall treatment of SUD from an acute care model to a chronic care model.

This waiver, coupled with the expansion of Medi-Cal eligibility to include single childless adults with incomes up to 138 percent of the Federal Poverty Level (FPL), greatly expands opportunities for individuals, including the homeless, to access substance use disorder (SUD) services. Furthermore, DMC waiver services will be an entitlement for all Medi-Cal beneficiaries who qualify based on medical necessity, and DMC will become the primary payer for most individuals seeking publicly funded treatment services. The program will soon include a more robust benefit package (as described in the next section), which will allow SAPC to shift other SUD financing sources that currently support these services to be utilized to provide services to the un/under insured and undocumented individuals, as well as to provide other necessary services not covered by Medi-Cal (e.g., room and board rate for residential services, sober living).

This system transformation will provide opportunities to better serve homeless adults needing SUD treatment services, and improve care coordination with physical and mental health, and other health/social services. It is anticipated that costs associated with providing SUD treatment services for homeless adults will largely be covered by DMC and the cost per individual will vary depending on what services are required and for what duration.

II. Opportunities That Make This Proposed Strategy Feasible

The DMC-ODS and Expanded SUD Benefits for Medi-Cal Eligible Beneficiaries

Los Angeles County intends to submit the DMC-ODS Implementation Plan by January 2016. Once the plan is approved by DHCS and CMS, and the new County contract with the State is executed by the Board of Supervisors, the expanded services can be provided and reimbursed. The DMC levels of care (LOC) would then include withdrawal management (formerly detoxification services), residential treatment, and medication-assisted treatment, in addition to already available outpatient, intensive outpatient, and narcotic treatment programs. Additional services will also include a 24-hour toll-free access line to place individuals in the appropriate LOC, case management, recovery support, and coordination with physical and mental health. Placement at a particular LOC and service duration will be based on medical necessity, except for residential services for which the maximum service duration for adults is 90 days with a one-time 30-day extension if medically necessary and a limit of two non-continuous 90-day episodes annually (standards vary for perinatal beneficiaries and adolescents). Criminal justice populations may be eligible for an extension of up to three months past the 90-day episode, for a total treatment length of six months if medically necessary; however, SAPC would not receive federal funding for treatment after the first 30-day extension for residential treatment, and would have to utilize other SUD funding for treatment after that point. DMC does not reimburse for sober living homes, but limited slots are available through AB 109 and Adult Drug Court Treatment Program funding for these populations.

Substance Abuse Prevention and Control (SAPC) is targeting a launch date toward the end of 2016 for the new waiver services, but this timeline is dependent on County, State and Federal approvals. With the aim of expanding network adequacy, SAPC is currently reaching out to providers to encourage them to become DMC-certified. SAPC intends to provide training and technical assistance to providers seeking State DMC certification. Network adequacy is also dependent on the ability of DHCS to certify new providers and LOCs, particularly residential treatment facilities.

III. Barriers to Implementing the Proposed Strategy and Recommendations on How They can be Resolved

SUD System Barriers to Effectively Serving Homeless Individuals

The SUD treatment system, even with the expanded DMC-ODS benefit, does not fund transitional or permanent housing except for a limited number of sober living facility slots. Furthermore, residential treatment services are time-limited and require eligibility based on medical necessity and not housing status. Therefore, while homeless individuals with SUD treatment needs could receive services at the appropriate LOC, SAPC and its provider

network need to collaborate with other agencies to secure long-term housing. The County should align the DMC-ODS benefit with the Health Homes efforts of the local Medi-Cal managed care plans, as well as any potential provisions in the Section 1115 waiver that focus on homelessness. The availability of housing is particularly important for individuals transitioning from short-term residential programs who need a stable residence post-discharge to support treatment gains.

At this time, SAPC anticipates that there will be a need for additional residential treatment slots and additional network capacity more generally across LOCs. SAPC is in the process of engaging a consulting service to assist providers in the DMC certification process and developing the capability to deliver the continuum of services in accordance with the ASAM criteria and the DMC-ODS waiver requirements. It will also be important that existing residential treatment facilities receive DMC certification from DHCS so that currently unfunded beds not currently eligible for Medi-Cal reimbursement can be filled with DMC beneficiaries. This shift is essential since it can be time- and resource-intensive to receive local and State approvals for new facilities.

While it is possible for non-residential service providers to repurpose their facilities for residential SUD treatment, that process would require substantial changes. Those facilities would have to develop many capacities, including 24-hour staffing and the ability to provide and document individual, group, case-management, and recovery support services using evidence-based practices; assessing clients using approved tools and determining placement and on-going services based on medical necessity; and the ability to comply with other State and County requirements. Partnering with an established residential treatment agency may provide a better opportunity to leverage the appropriate resources and expertise in the earlier phases of waiver implementation.

One significant change in service provision with the waiver is the ability to provide and receive reimbursement for care delivered in the field, rather than strictly at certified locations. This provision opens the door for service providers that specialize in serving the homeless to provide services such as assessment, individual counseling, case-management, and recovery support in non-traditional settings. This flexibility would also allow practitioners to more effectively engage clients and introduce them to clinic-based services over time, both SUD and other health/social services.

SAPC's DMC provider network development activities will prioritize contracting with agencies with specialized expertise and unique approaches to providing services, including those who focus on services for individuals who are homeless.

- ***Recommended Strategy 1: Utilize SAPC network to provide the full continuum of DMC-ODS waiver services in a culturally competent manner to people experiencing homelessness.***

- *Recommended Strategy 2: Leverage new flexibility through the DMC-ODS waiver to increase access to SUD services by providing mobile services in the community for people experiencing homelessness.*

IV. Potential Performance Measures

SUD Performance Measures

- A. X% of homeless individuals with a positive SUD assessment who were referred to and initiated treatment at the ASAM-designated level of care.
- B. X% of homeless individuals who remained engaged in treatment after initiating treatment (i.e., after 4 or more treatments within 30 days).
- C. X% of homeless individuals transitioned down to the next appropriate level of care (e.g., withdrawal to residential, residential to outpatient, and outpatient to recovery services).

V. Potential Funding Stream(s)

Funding for SUD Services

DMC will be the primary funder for SUD treatment services for Medi-Cal eligible beneficiaries. Until Los Angeles County's DMC-ODS Implementation Plan is approved and the new contract executed, new services (e.g., withdrawal management, residential, recovery support) will not be reimbursable by DMC, but may be available under other funding sources.

SAPC anticipates no Net County Cost as a result of the DMC waiver implementation. Existing financing streams (i.e., Realignment funds, Federal Financial Participation, the Federal Substance Abuse Prevention and Treatment Block Grant, and the State General Fund) will support the newly-available services. Further, while the administration of the new organized SUD delivery system will require additional SAPC full-time employees, SAPC is eligible to receive Federal matching funds for administrative expenses for up to 15% of County DMC program costs, and the Federal matching rate is 75% for the cost of the administrative capacity that SAPC is building to operationalize an organized delivery system. SAPC expects that this Federal financial participation and other available funds will offset the cost of additional staffing items.

Potential Strategy 5.4
Creating Partnerships for Effective Access and Utilization of ACA Services by Persons Experiencing Homelessness

I. Description of the Proposed Strategy

Develop effective partnerships between health plans, health care providers (including health, mental health and substance use disorder), and homeless service providers to: A) Identify and share information; B) Emphasize case management for health care services; C) Promote health literacy education; and D) Connect the homeless to health care and services, as described below.

- A. Identify and Share Information: Establish practices to ease the ability for homeless service providers to share information on homeless clients to determine enrollment status, assigned health plan and health care provider. This could include a process such as granting access to this information for Service Planning Area (SPA) CES/HFSS Leads, establishing a hotline, or sharing data between established homeless and health care systems. Frequently, individuals experiencing homelessness who receive services from homeless service providers are asked questions about their insurance type and health plan provider. Many are uncertain of their enrollment status. Technology and consents allowing health plans to cross-reference enrollees with clients in the Homeless Management Information System (HMIS) and automatically update the client's health plan information in HMIS would be beneficial. On the health plan provider side, a report could then be generated for the health plans informing them of the homeless service program in which the client is enrolled and/or the most updated client contact information.
- B. Case Management for Health Care Services: The needs of many persons experiencing homelessness are complex and, for those with the greatest vulnerabilities, pro-active health care treatment can either be difficult to access or be a lower priority for the person, thereby leading to high costs in public and private systems. The positive impact on cost to the system of providing intensive case management services to high-need homeless individuals was clearly evidenced by a project carried out in Los Angeles County referred to as the 10th Decile Project conducted by the Corporation for Supportive Housing. Homeless individuals found to be in the costliest decile of spending were assigned a case manager from one of seven participating housing service providers who helped them find housing, medical homes, and other services. Preliminary results of a pilot test of this approach between 2011 and 2013 found

dramatically reduced service use including a 71 percent reduction in emergency department utilization, an 85 percent reduction in hospital readmissions, and an 81 percent reduction in in-patient days. The average cost-reduction per participant was \$59,415. This study and the work being performed in the Housing for Health (HFH) program, as well as outcomes reported by HFSS and CES, demonstrate that housing and homeless service providers are well-positioned to deliver the types of services recommended for inclusion in the Health Homes model, including housing navigation; care coordination; transportation; health education; etc. In essence, ensuring that persons with complex health needs, who are experiencing homelessness, are linked to supportive field-based case management teams increases the likelihood that they will proactively access needed health care services (i.e, public health, mental health, and substance use disorder services).

The process and infrastructure under which funding could be provided to enable homeless service providers to work closely with the health plans and health providers could take several forms. One option would be to build upon the success found in CES/HFSS by regionally delivering services via the 8 SPAs. One possible structure could include Federally Qualified Health Centers (FQHCs) applying to the health plans to act as regional leads and subcontracting with homeless service providers on a reimbursement basis.

C. Health Literacy Education: Create a health literacy education program for homeless clients by funding community-based organizations with experience in health consumer education to create and execute the education program. This program would focus on educating homeless clients and those working with homeless clients on both enrollment and renewing health coverage (Medi-Cal), and how to navigate the health care system and access care, in particular within managed care organizations. The education program will include the following components:

- Consumer-friendly trainings for homeless clients;
- Short consumer-friendly materials aimed at assisting homeless individuals with navigating the health care system;
- Train-the-trainer trainings, including webinars for agencies that work with the homeless population;
- Technical assistance to homeless service providers assisting clients with accessing health coverage and/or health care services; and
- Using existing peer navigators to assist with outreach, engagement and education.

Target Population(s):

Homeless clients, homeless services providers, health plans and health care providers, as well as staff at public agencies, such as the Department of Public Social Services and the Department of Health Services.

Estimated cost: per person - \$50–\$100

- D. Connect Homeless People to Health Care and Services: Utilize coordinated entry systems (CES/HFSS/SAM) to connect homeless people to health care providers, health plans, and housing resources. CES and HFSS assessment tools gather self-reported information about persons experiencing homelessness, including: insurance and health plan enrollment; physical health; mental health; substance use; and resulting impacts on housing stability. There is potential to gather more targeted information via these assessments (or brief supplemental assessments) that could assist housing providers, in conjunction with the health plans to confirm eligibility for health care services.

In order to ensure geographic coverage for persons experiencing homelessness throughout Los Angeles County, each SPA has a lead agency coordinating services for HFSS and CES. For CES, the SPAs have been subdivided to facilitate local collaboration and lead agencies have subcontracted with other established homeless service providers. Similarly, the Department of Public Health (DPH) has identified lead agencies to operate the Community Assessment Service Centers, which take primary responsibility for linkage to appropriate substance use services.

Promising practices already in place through HFH and SAM that could be expanded include adding requirements in the statement of work for Intensive Case Management Services providers to link clients to both health insurance and primary care providers. Providers could be required to report on health care progress regularly, including assessing individual client barriers to accessing primary care (e.g. transportation, shame/stigma, control issues) and to ensure that case management service providers actively address these issues.

II. Opportunities That Make This Proposed Strategy Feasible

1. Developing Partnerships: The development of partnerships between the health plans, health providers and homeless service providers, along with clear protocols for sharing data among the health care and homeless service systems, has proven to be effective in linking homeless clients to health care and reducing negative health outcomes and frequent ER use among homeless populations. A framework such as the Health Neighborhoods created by the Department of Mental Health (DMH) could be an aid in

supporting the development of these partnerships to promote the objectives mentioned above in strategies A and B. There are currently seven (7) Health Neighborhoods being piloted, which can be expanded to include homeless service providers and health plans. For the remaining areas, the process that has been established to develop Health Neighborhoods can be replicated to identify and build off of existing partnerships, and gather information about additional resources needed to achieve the strategies.

2. Health Literacy Education: DPH's Children's Health Outreach, Enrollment, Utilization and Retention Services currently funds at least two community-based organizations, Neighborhood Legal Services of Los Angeles County (NLSLA) and Maternal and Child Health Access (MCHA), to conduct comprehensive health program trainings for enrollment counselors, community-based organizations (CBOs), and other community partners. L.A. Care has previously provided funding to a community-based organization to conduct trainings on the transition of seniors and persons with disabilities into managed care organizations and the Coordinated Care Initiative. Programs such as these could support the development of Strategy C.

3. HFH: An effective homeless health care and housing service delivery program, such as HFH, serves as a model to support strategies B and D. The Department of Health Services (DHS) via HFH has established subcontracts with a number of established homeless service providers to deliver Intensive Case Management Services (ICMS) for persons experiencing homelessness with complex health care needs (health, mental health, and substance use disorders). Services provided by ICMS teams mirror those proposed under the potential Whole-Person Care Pilots referenced in the 1115 Waiver and the concept of Health Homes for clients with complex health and behavioral health needs. The HFH model has proven to be very effective in linking chronically homeless individuals with appropriate housing and health interventions.

III. Barriers to Implementing the Proposed Strategies and Recommendations on How They can be Resolved

Potential barriers to implementing the strategies discussed above include the challenges of identifying and conducting outreach to homeless clients, as well as the lack of mechanisms to track health outcomes and health coverage retention rates for homeless clients. To address this, organizations carrying out the education program could work in partnership with the Los Angeles Housing Services Authority (LAHSA) and County departments working closely with the homeless (such as, the Department of Public Social Services, DMH, DHS, DPH, etc.), health care providers, homeless service providers, and health plans, to identify and track homeless clients, conduct outreach, distribute consumer materials, and secure

transportation and training space. This could be done through the creation of a stakeholder advisory committee and the creation of a system to share information about homeless clients between County agencies, health plans, and other entities.

IV. Potential Performance Measures

- Survey results for participants of consumer and train-the-trainer education programs;
- Percentage of homeless clients attending education programs who are still enrolled in Medi-Cal the following year;
- Percentage of people attending education programs connected to primary care physicians (PCPs);
- Health outcomes of homeless clients participating in education programs;
- Survey of client wellness - similar to USC Transitions to Housing Study;
- Percentage of eligible persons enrolled in HMIS with a health care provider identified; and
- Attendance at an annual wellness evaluation with a PCP.

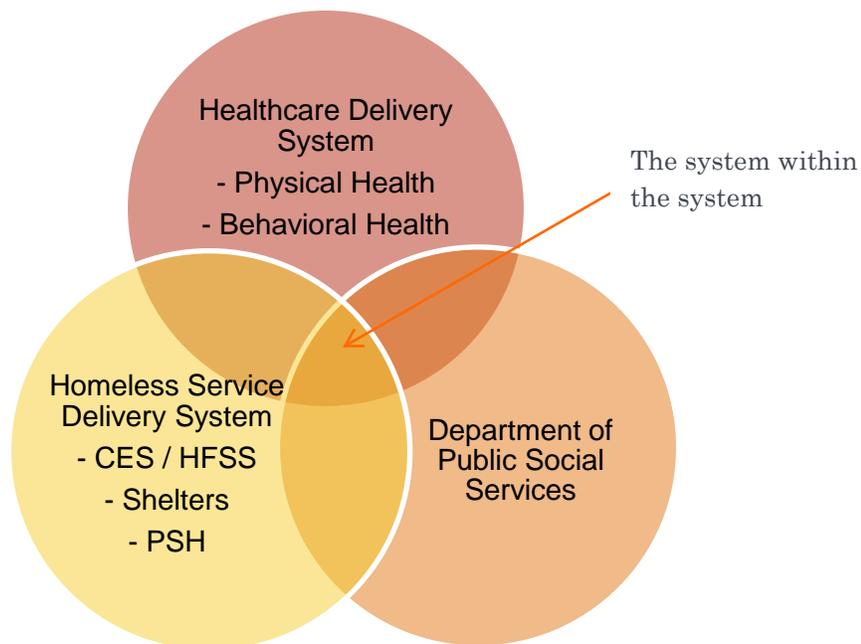
V. Potential Funding Stream(s)

- Funding from county agencies that have previously funded CBOs to carry out similar work such as DPH and DHS;
- Federal funding such as grants through the Department of Health and Human Services' Administration for Children and Families. Funding from private foundations such as the California Endowment, the California Wellness Foundation, Blue Shield Foundation, etc.;
- Funding provided by health plans; and
- Per capita reimbursement provided to organizations providing homeless case management via funds available through the 1115 Medicaid Waiver and/or Health Homes provided under the Affordable Care Act.

Potential Strategy 5.5 Creating a Homeless Health Care System within a System

I. Description of the Proposed Strategy

With few exceptions, the dominant systems of health care delivery fail to address the unique needs of the homeless population. To appropriately serve this population, new strategies of engagement and models of service delivery and care coordination are required to enable systems and individuals to intersect in meaningful ways. An integrated health system specifically tailored to the homeless population—a system within a larger physical health, mental health, and substance use disorder care system — is one key strategy to address these challenges.



To be successful, this health care system within a system must: 1) have no wrong entry points or ‘doors’ to care; 2) integrate an array of physical health, mental health, and substance use disorder (SUD) services; 3) remain sensitive to the unique realities and lived experiences by maintaining a level of ‘homeless cultural competence’; and 4) effectively

challenge public entities and community-based organizations to work together in unprecedented ways to maximize services to those who lack stable or secure shelter including new strategies, systems, and platforms to aggressively enroll and retain chronically homeless individuals on Medi-Cal.

Areas of work for the system within a system will include:

1. *Identifying and engaging* chronically homeless individuals entering the delivery system through “any door”;
2. *Assessing* their needs and navigating them to permanent housing and appropriate services across sectors – requires seamless referral and coordination between the homeless service and social service sectors and the physical and behavioral health delivery system;
3. *Ensuring* that each individual has *access* to a continuity provider – primary care provider or behavioral health provider;
4. *Supporting recovery and self-efficacy* and providing care coordination services (whether through improved coordination between existing case managers or assignment of new care coordination staff);
5. Developing successful *transitions of care* – e.g. hospital-to-community, emergency department-to-community, jail-to-community, etc;
6. Cultivating and developing a culturally competent *workforce* of specialty providers—including individuals with lived experience--skilled at providing and linking chronically homeless to services;
7. Mapping the *service landscape* (formal and informal) where the chronically homeless access care, wellness services, etc.

In order to create this system within a system, Los Angeles County could consider several specific changes to improve outcomes for chronically homeless people with significant health issues:

- Designate specific physical health, mental health, and substance use disorder providers to deliver treatment to the members of the target population;
- Fund additional supportive services (such as case management, housing navigation, and housing retention);
- Fund additional housing subsidies or prioritize access to existing housing resources;
- Expand existing specialized health access points and/or create additional access points;
- Create electronic infrastructure to facilitate communication between health and homeless services providers; and
- Modify Medi-Cal eligibility and/or renewal processes to facilitate continuous enrollment for qualifying individuals.

Target Population(s)

Many different groups of people experience homelessness. These include: chronically homeless adults, veterans, families, transition aged youth, and single adults. Understanding the different needs, eligibility for benefits and services, and receptivity to engaging in health care and other services, of each of these groups and the subgroups within them allows for tailored strategies and approaches.

While the L.A. County physical health, mental health, and substance use disorder (SUD) care system needs to serve all individuals experiencing homelessness, there may be a special role to play for individuals who are chronically homeless, or who are homeless and also have significant physical health, mental health, or SUD needs. A system within the health care system could provide specialized care settings and/or services to these individuals. If the system within a system did not include all homeless families and individuals, specific eligibility criteria would need to be defined (e.g. chronically homeless vs. homeless plus a specific diagnosis, including, for both categories, those with high utilization of ER & IP services). If homeless people meet appropriate criteria, they should be included, whether or not they receive Medi-Cal physical health services through the Department of Health Services.

Potential Target Population	Approximate # of People in L.A. County <i>(Based on 2015 Homeless Count)</i>
Chronically Homeless Individuals	12,300
Chronically Homeless Families	1,800
Chronically Homeless plus High Utilizers of ER & IP Health Services	4,400 (i.e. "10th Decile")
Homeless plus Serious Health Condition	14,000 - 18,000 (Rough estimate)
Homeless plus Serious Mental Illness	12,000
Homeless Plus Substance Use Disorder	10,000
<i>Please note: only rows 1 and 2 are mutually exclusive of one another. Otherwise, all rows overlap with one another to some degree.</i>	

II. Opportunities That Make This Proposed Strategy Feasible

- Medi-Cal eligibility for nearly all homeless people.
 - This new system will need new mechanisms and strategies to leverage financial resources to ensure sustainability. While an ideal system would serve all individuals regardless of their benefits, this system is best maintained - and homeless people's access to, and continuity of, quality health care fostered - when Medi-Cal penetration rates are maximized.
- Existing specialized physical health, mental health, SUD care settings for individuals experiencing homelessness.
- Existing specialized services available through the physical health, mental health, SUD systems for certain individuals experiencing homelessness.
- More organization and coordination within the homeless services sector (e.g. Coordinated Entry Systems (CES), Homeless Families Solutions Systems (HFSS)).
- More organization and coordination within the health care service delivery sector with the expansion of Health Neighborhoods, which can include homeless service providers.
- Upcoming expansion of SUD services through the Drug Medi-Cal waiver.

III. Barriers to Implementing the Proposed Strategy and Recommendations on How They can be Resolved

- Barrier: Designing a system that accommodates regional variation in the demographics of homeless people, and the regional variation of the current system of homeless services providers and their partner physical health, mental health, and SUD service providers.

Potential Approach: Develop regional approaches linked to CES in each Service Planning Area so that the “system within a system” is responsive to local needs and addresses the differences in available services in different regions of the county. CES is designed to assess housing needs. A system to assess health care needs linked to CES should leverage both the existing housing placement system and the health care system.

- Barrier: Funding the services needed to engage and link people experiencing homelessness with health care.

Potential Approach: Invest in the health of chronically homeless individuals by funding support services within homeless services agencies as well as within the health care system. Many homeless services case managers provide support in all aspects of a client's journey to housing (for example - Housing for Health Intensive Case Management Services). Intensive and on-going case management is essential to sustaining housing, which is an essential ingredient for improved health. Without it, a client can easily fall back into homelessness.

- **Barrier:** Homeless services providers in housing, legal, health care, and related services have various levels of knowledge about the Medi-Cal funded safety net health system, and should be educated about systems changes as they occur.

Potential Approach: Build on trainings that have been offered to providers by the health plans and United Homeless Healthcare Partners (UHHP). Increase the frequency and fund the training.

- **Barrier:** A “system within the health care system” could be more complicated and more difficult to access than existing entry points into the health system.

Potential Approach: Create clear eligibility criteria that are aligned with existing tools (e.g. VI-SPDAT) and programs (e.g. federal definition of chronic homelessness). Create a simple entry and exit process. Build relationships amongst staff of local physical health, mental health, SUD, and homeless/social service providers.

- **Barrier:** Potential to increase health provider discrimination against people experiencing homelessness.

Potential Approach: Hold health providers accountable to provide non-discriminatory services using existing managed care and health regulation (e.g. EMTALA). Provide support to individuals experiencing homelessness as they navigate all parts of the health care system (e.g. using patient navigators).

- **Barrier:** Many health-related costs would not be counted in the Medi-Cal managed care rate setting process, even if they do result in overall health care savings.
 - **Background:** Medi-Cal managed care rates are based on health plans' reported costs and a variety of cost and utilization assumptions made by the state. Each year the plans submit an extensive Rate Development Template (RDT) that details all of their costs and service utilization for the reporting year, usually with a two-year delay. The state's actuary, Mercer, applies trend factors as well as policy changes impacting cost or utilization to the data. To the extent that a health plan is able to reduce health care costs or utilization, those reductions are reflected in the data submitted via the RDT and, thus, applied to the plans' rates through the rate setting process. The relationship between the plans' costs and the final rates are not directly correlated due to the variety of assumptions and factors applied during the rate setting process. The costs included in the RDT for medical services are limited to those costs considered Medi-Cal benefits. If a plan utilizes dollars for non-benefit costs, these initiatives must be paid for using administrative dollars. The plans' final rates do not reflect the plans' actual administrative costs. Instead, Department of Health Care Services (DHCS) adds a small percentage on top of the

medical costs for administration, profit and risk. If a plan's administrative costs are deemed too high by DHCS, the plan may experience further rate reductions.

Potential Approach: The County of Los Angeles could advocate that DHCS amend its Medi-Cal State Plan to include permissible housing-related costs for homeless people with significant health needs. (See CMCS Informational Bulletin re: Coverage of Housing-Related Activities and Services for Individuals with Disabilities, 6/26/2015)

IV. Potential Performance Measures

Service Provider Metrics:

- Percent of direct services provided in the field (or in other accessible settings);
- Respond to referrals within 72 hours; 24 hours if from an institutional setting;
- 15:1 client-to-direct service staff ratio for intensive case management;
- Maintain an integrated mental health, physical health and substance use care plan for 100% of clients;
- Refer clients to self-help, peer support and caregiver support groups;
- Hire some paid staff who are consumers and/or patient advocates within health care settings;
- Utilize evidence-based programs: Housing First, Harm Reduction, and Critical Time Intervention
 - Housing First: Housing First is an approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible – and then wrapping services around them, as needed.
 - Harm Reduction: A set of practical strategies and ideas aimed at reducing negative consequences associated with drug use, potentially including safer use, managed use, abstinence, and addressing conditions of substance use along with the use itself.
 - Critical Time Intervention: A structured, nine-month intervention that provides support to people during and after a transition to community living from shelter, hospital, or other institutional setting, with the primary goal of preventing a return to homelessness and other adverse outcomes.

Client Metrics:

- Percent of clients whose health, mental health and SUD treatment outcomes improved;
- Percent of clients satisfied with their services;
- Percent of clients connected to a primary physical care provider;
- Percent of clients with mental health or SUD needs who are connected to mental health and/or SUD treatment;

- Percent of clients completing recommended preventative services/screenings (e.g. receipt of influenza/pneumonia vaccines);
- Percent of clients who obtained housing;
- Percent of clients who retained housing for a minimum of 1 year;
- Reduction in rate of emergency room visits;
- Reduction in rate of incarcerations;
- Reduction in rate of hospitalizations (admissions and/or readmissions);
- Percent of clients who applied for benefits for which they qualify (CalFresh, SSI, General Relief); and
- Percent of clients who attained benefits.

V. Potential Funding Stream(s)

- Medi-Cal Managed Care Capitation Dollars: Medi-Cal managed care (MMC) plans are paid a fixed, monthly amount for each of their actively enrolled Medi-Cal members on a per member, per month (PMPM) basis.
 - In general, this amount varies based on the member's aid category (TANF program, Medi-Cal Expansion, Seniors/Persons with Disabilities, other) and their acuity level in terms of need for institutional or other intensive care (Community Well, Home and Community-Based Low, Home & Community-Based High, and Institutional). There are some modifiers based on health conditions (e.g. higher rates for members diagnosed with HIV/AIDS) but not for housing status or other social determinants of health.
 - MMC Plans must provide members access to all benefits defined in the plan's contract with the state DHCS, including physical health care, mild-to-moderate mental health care, and pharmacy coverage. MMC plans may elect to cover additional services and supports that promote improved member health and wellbeing; however, the costs of these additional services/ supports are not included in future rate-setting (see Barriers above).
 - Federal regulations prohibit states from using Medi-Cal dollars to pay for room and board, but allow for flexibility regarding housing-related services and activities. (See CMCS Informational Bulletin re: Coverage of Housing-Related Activities and Services for Individuals with Disabilities, 6/26/2015)
- ACA Section 2703 Health Homes: 8 quarters of Federal funding that will be used for intensive, in-person care coordination, including housing navigation.
 - Federal requirements state that eligibility criteria can be based on diagnosis and acuity level; while many homeless individuals will qualify, not all will, and homelessness is not an eligibility criterion in itself.
 - Start date, program design, and rates are to be determined.

- 1115 Waiver Whole Person Care Initiative: Up to five years of additional funding to California for cross-sector initiatives to improve health for vulnerable Medi-Cal populations.
 - Program requirements, eligibility criteria, program design, rates, and start date are to be determined.
- Potential Mental Health Funding Streams: When specialty mental health and other funding-specific criteria are met for the individuals receiving services:
 - Federal Projects for Assistance in Transition from Homelessness (PATH);
 - State Mental Health Services Act (MHSA);
 - Medi-Cal; and
 - County General Funds.
- Potential SUD Funding Streams: The new Drug Medi-Cal Organized Delivery System creates the potential for increased use of several funding streams for SUD treatment and services:
 - Federal Financial Participation (FFP, or matching funds);
 - County Realignment;
 - Substance Abuse Prevention and Treatment (SAPT) Block Grant; and
 - State General Funds for Intensive Outpatient Treatment.

Appendix A: Estimated Costs for Selected Health-Sector Programs, Per Person Per Year

Los Angeles County has a number of existing health-sector programs that serve chronically homeless individuals or other homeless people with significant health needs. These programs could potentially be expanded or replicated to create additional capacity for a “system within a system.” Costs below are *estimates* and vary depending on the services and programs to be expanded. Client counts below show the varied scale of the different programs.

Program Name and Description	Estimated Costs	Notes
<u>Housing for Health</u> – Strives to end homelessness in Los Angeles County, reduce inappropriate use of expensive health care resources, and improve health outcomes for vulnerable populations. HFH provides intensive case management, permanent supportive housing, recuperative care, and specialized primary care to homeless people with complex physical and behavioral health conditions.	Average Cost of Case Management \$400-450 Per Member, Per Month (PMPM) Average cost of rental subsidy \$825 PMPM Total annual costs per client, including admin \$1,500 PPPM → \$18,000/year	Client Count = 1,000+ as of June 2015
<u>Full Service Partnerships</u> – The foundation of Full Service Partnerships is doing “whatever it takes” to help individuals on their path to recovery and wellness. Full Service Partnerships embrace client driven services and supports with each client choosing services based on individual needs. Unique to FSP programs are a low staff to client ratio, a 24/7 crisis availability and a team approach that is a partnership between mental health staff and consumers.	Annual service costs per client range from \$8,450-\$13,500 Annual housing costs per client, above/beyond vouchers, \$55-\$700 Annual Client Supportive Services (CSS) costs per client \$130-\$1,530 Total annual costs per client \$9,350-13,600 depending on age	These costs are based on information on FSP provided to children, TAY, adults and older adults. Costs vary widely depending on age. (costs rounded) Client Count = 10,924 (FY 2014/15)
<u>Project 50</u> – identified the 50 most vulnerable, long-term homeless individuals living on the streets in Skid Row. Begun in 2007 and has since expanded to other areas.	Annual service cost per client \$5,512 Annual HACLA housing costs per client \$8,170 Annual CSS costs per client \$85 Annual total cost per client \$13,767	Costs are based on DMH estimates for FY 2014/15. Client Count = 50

Program Name and Description	Estimated Costs	Notes
<p><u>Needs Special Assistance (LAC+USC)</u> - County of Los Angeles, Department of Public Health, Substance Abuse Prevention and Control (DPH-SAPC) awarded Social Model Recovery Systems, Inc. (SMRS) a grant to establish a community prevention project surrounding Los Angeles County + University of Southern California Medical Center (LAC+USC MC) entitled: Community Centered Emergency Room Project (CCERP). The project's two-pronged approach is to provide targeted outreach to the Needs Special Assistance (NSA) population to establish linkages and enhance community engagement in order to reduce risk factors. The program was also known as the LAC+USC Street to Home Project and is now operated through IMHT funding.</p>	<p>Annual program costs \$205,274</p>	<p>Client Count = 391 outreach recipients vs. 109 housed</p>
<p><u>Integrated Mobile Health Team</u> – A client-centered, housing-first approach that uses harm reduction strategies across all modalities of mental health, physical health, and substance abuse treatment. The service model is designed for individuals with a mental illness and their families, if appropriate, who are homeless or have recently moved into Permanent Supportive Housing (PSH) and have other vulnerabilities. Mental health, physical health and substance abuse services are provided by multi-disciplinary staff working as one team, under one point of supervision, operate under one set of administrative and operational policies and procedures and use an integrated medical record/chart.</p>	<p>Annual service cost per client \$20,839.77 Annual CSS cost per client \$2,670.18 Annual total cost per client \$23,509.94</p>	<p>Client Count = 300 (FY 2014/15)</p>
<p><u>10th Decile Project / FUSE / Social</u></p>	<p>\$15,159 One-time costs</p>	<p>Client Count =</p>

Program Name and Description	Estimated Costs	Notes
<p><u>Innovation Fund</u> - The FUSE (Frequent Users Systems Engagement) 10th Decile Project pilot helps hospitals collaborate with homeless service providers and community health centers to target and house the highest-cost, highest need individuals in supportive housing – and surround them with supportive medical and mental health homes.</p>	<p>to house each patient, including the first year of local subsidies for rent and supportive services \$3,518 Annual rent subsidy in the second and subsequent years, in addition to the Section 8 subsidy \$3,000 Annual cost for enriched supportive services in the second and subsequent years \$18,159 total cost per person for year one.</p>	<p>163</p>
<p>Estimated cost to provide housing, housing navigation, and care management for Integrated Recovery Network</p>	<p>Housing = \$1,000 PMPM SUD treatment, case mgmt, supportive svcs. = \$625 PMPM Average annual cost = \$19,500 / client</p>	<p>Client Count = 75</p>

Appendix B: Strategies to Facilitate Continuous Medi-Cal Eligibility for People Experiencing Homelessness

Current DPSS efforts to stay in touch at Medi-Cal renewal

DPSS efforts to stay in touch with homeless beneficiaries begin at initial Medi-Cal application. It is important that we attempt to have a valid mailing address to ensure beneficiary remains informed of case status at all times.

Individuals indicating that they are ‘Homeless’ are asked to provide a mailing address and a phone number, if available. The DPSS District Office address is used when an applicant is unable to provide a mailing address. In these instances, the individual is required to do a mail check at the District Office at least once a week.

MAGI Medi-Cal Only Beneficiaries

The Affordable Care Act (ACA) expanded the eligible Medi-Cal population to include single adults aged 19-64. Most homeless single adults are within this age group and are usually eligible under the ‘MAGI’ program. The renewal process for this age group is completed via an Electronic Health Information Transfer (eHIT) process, which includes automated ex-parte review. Based on existing information, the renewal process is seamless and is completed with minimal correspondence between DPSS and the beneficiary. Our long term goal is to obtain the necessary information from our MAGI population at initial application. This step will allow us to complete an automated renewal process without the need to contact the beneficiary. Based on this ‘Happy Path’ scenario, the beneficiary would receive a notice indicating their eligibility has been re-established for twelve months.

No Discrepancies

- Automated eHIT process is done 60 days before the renewal due date.
- If no discrepancies, the case is authorized and the Approval Notice of Action will be generated.
- Beneficiaries without a mailing address may obtain their Approval NOA based on the mail check process.

Discrepancies

Discrepancies during the eHIT process requires the mailing of the Pre-Populated Medi-Cal Renewal Form (MC 216).

- The MC 216 is mailed with a 60-day due date to beneficiaries with a mailing address.
- Homeless beneficiaries using the District Office as their mailing address are provided the MC 216 during their mail check.
- If renewal is not completed:

- Automated phone call reminder is made.
- Reminder notice is sent to beneficiaries 30 days prior to renewal due date.
- Termination Notice of Action is mailed 10 days before the termination date.
- Beneficiaries have up to 90 days from the date of termination to provide the information needed to re-establish eligibility.

Non-MAGI Medi-Cal Only Beneficiaries

The Non-MAGI renewal process requires annual verification of property and resources. This current information is needed to re-establish Medi-Cal eligibility. This is not an automated renewal process. This Non-MAGI program is mainly comprised of the Aged, Blind, and Disabled population. A minimal number of these Medi-Cal beneficiaries are identified as homeless.

- The Renewal packet is generated 60 days before the renewal due date.
- If renewal is not completed:
 - Automated phone call reminder is made.
 - Reminder notice is sent to beneficiaries 30 days prior to renewal due date.
 - Beneficiaries that use the District Office as a mailing address are provided the reminder notice during their mail check.
 - Termination Notice of Action is mailed 10 days before the termination date.
 - Beneficiaries have up to 90 days from the date of termination to provide the information needed to re-establish eligibility.

Note: Submitted incomplete renewal packets will require the Eligibility Worker to conduct an ex-parte review (LEADER, MEDS, IEVS, and mutual household member cases terminated within the last 90 days) in an attempt to obtain missing information to determine continued eligibility.

Opportunities:

Ex Parte Review: A thorough ex parte review can play a critical part in easing the renewal process for homeless clients who may lack regular access to phone or email. Even if DPSS is unable to verify continued eligibility, the ex parte review can also be used to locate individuals with whom DPSS has lost contact. In order to improve the ex parte review process' ability to help locate homeless clients, the County could consider conducting an assessment of the databases DPSS currently has access to and evaluate whether access to additional county, state, and federal databases is feasible.

Partnerships with Homeless Service Providers: Homeless service providers who have consistent contact with homeless clients can serve as authorized representatives allowing them to assist their homeless clients with contacting DPSS during the renewal process. The county could enter into an MOU that allows for information sharing between homeless service providers and DPSS to assist with the renewal process.