Brown Bag Series

Home Safe and CalAIM Housing Supports

February 20, 2025

Presenters:

Baljit Hundal
Gretchen Schroeder

CFPIC
Celebrating 20 Years

OUR AGENDA

01. Overview of Home Safe and Current Status

02. CalAIM: Medi-Cal Transformation

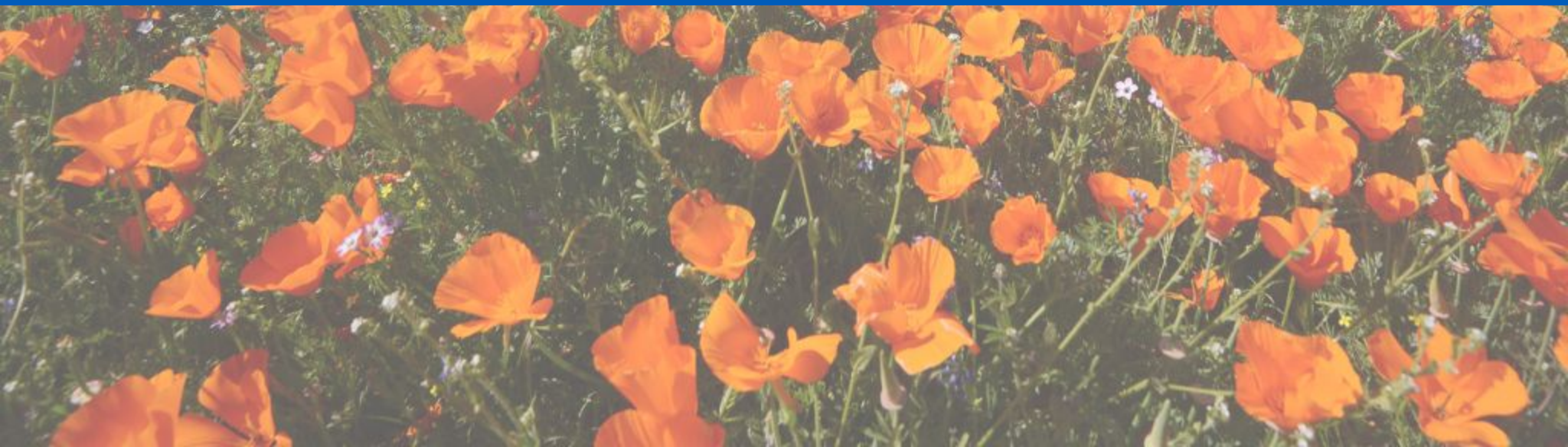
03. Enhanced Care Management

04. Community Supports

05. Transitional Rent

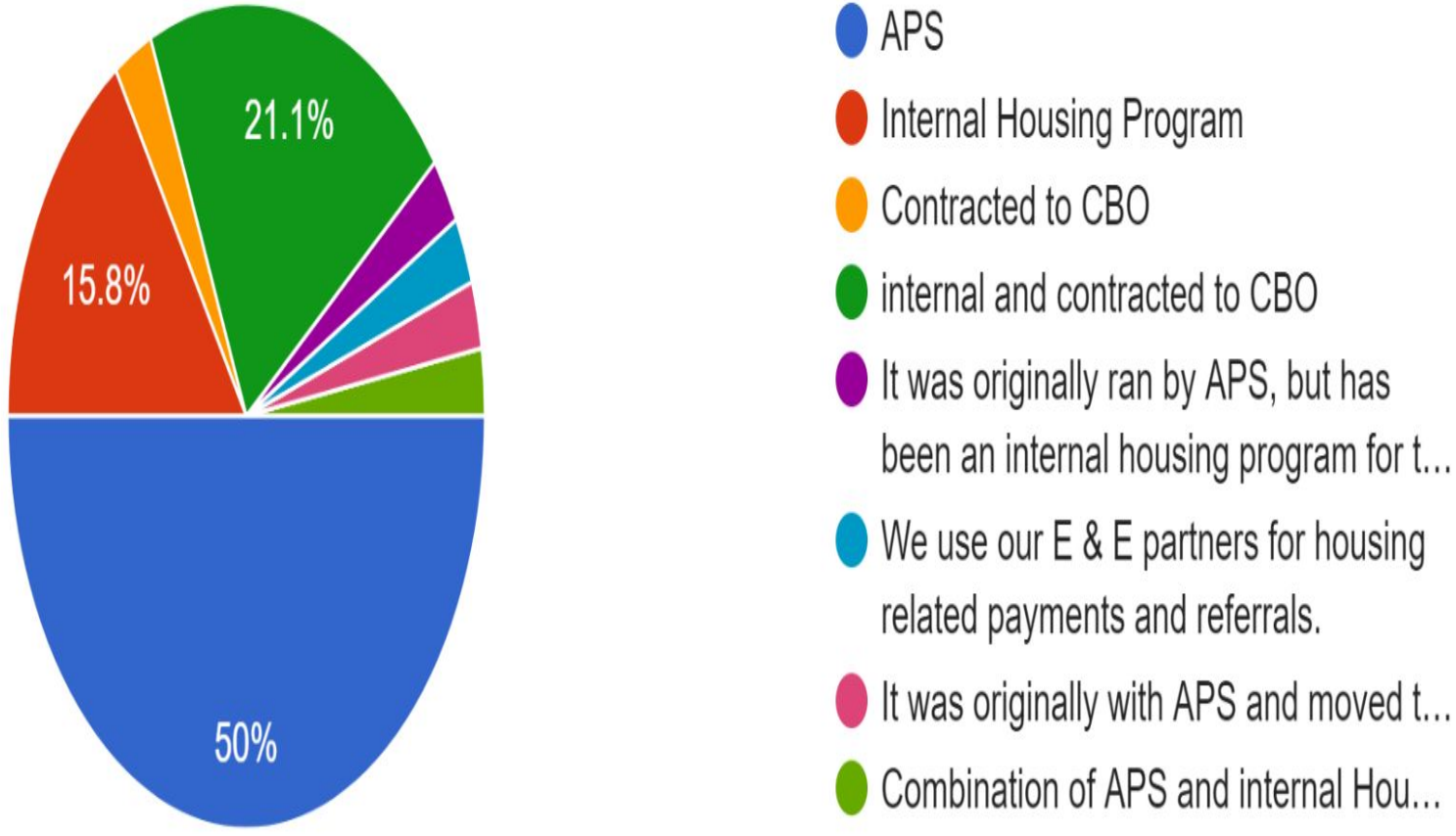
06. County Practices

Overview of Home Safe Survey and Current Status



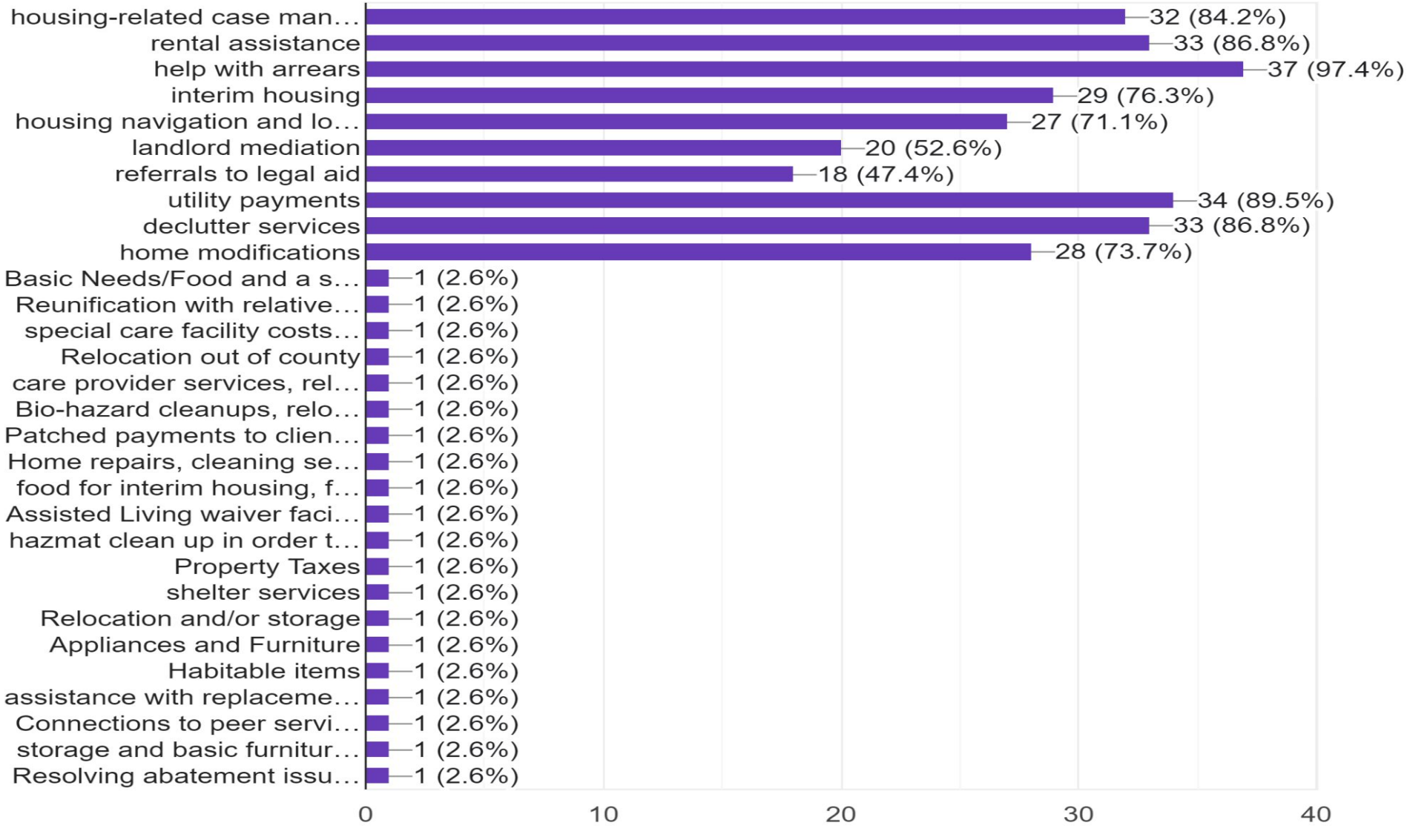
1. How was your Home Safe Program structured in your county?

38 responses

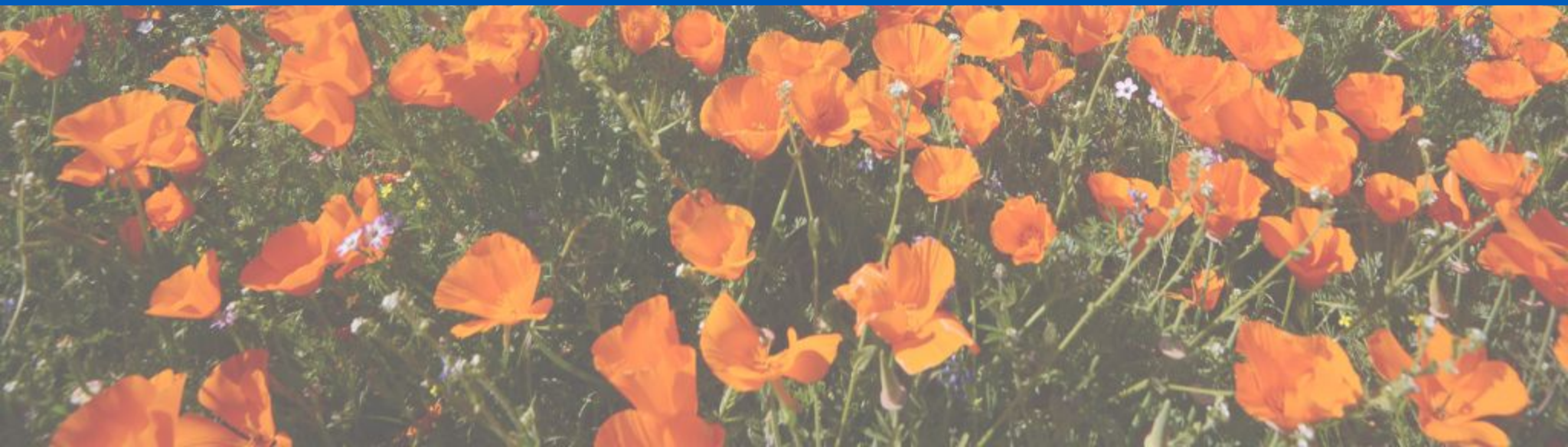


3. What were the needs of your Home Safe clients?

38 responses



CALAIM: MEDI-CAL TRANSFORMATION



WHAT IS MEDI-CAL?

Medi-Cal is **California's Medicaid program** which is public health insurance that provides needed health care services for qualifying individuals.

Financing

Medi-Cal is financed equally by the state and federal government. (Medi-Cal Overview)

Eligibility

Medi-Cal covers low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and low-income people with specific diseases such as tuberculosis, breast cancer, or HIV/AIDS.

Enrollment

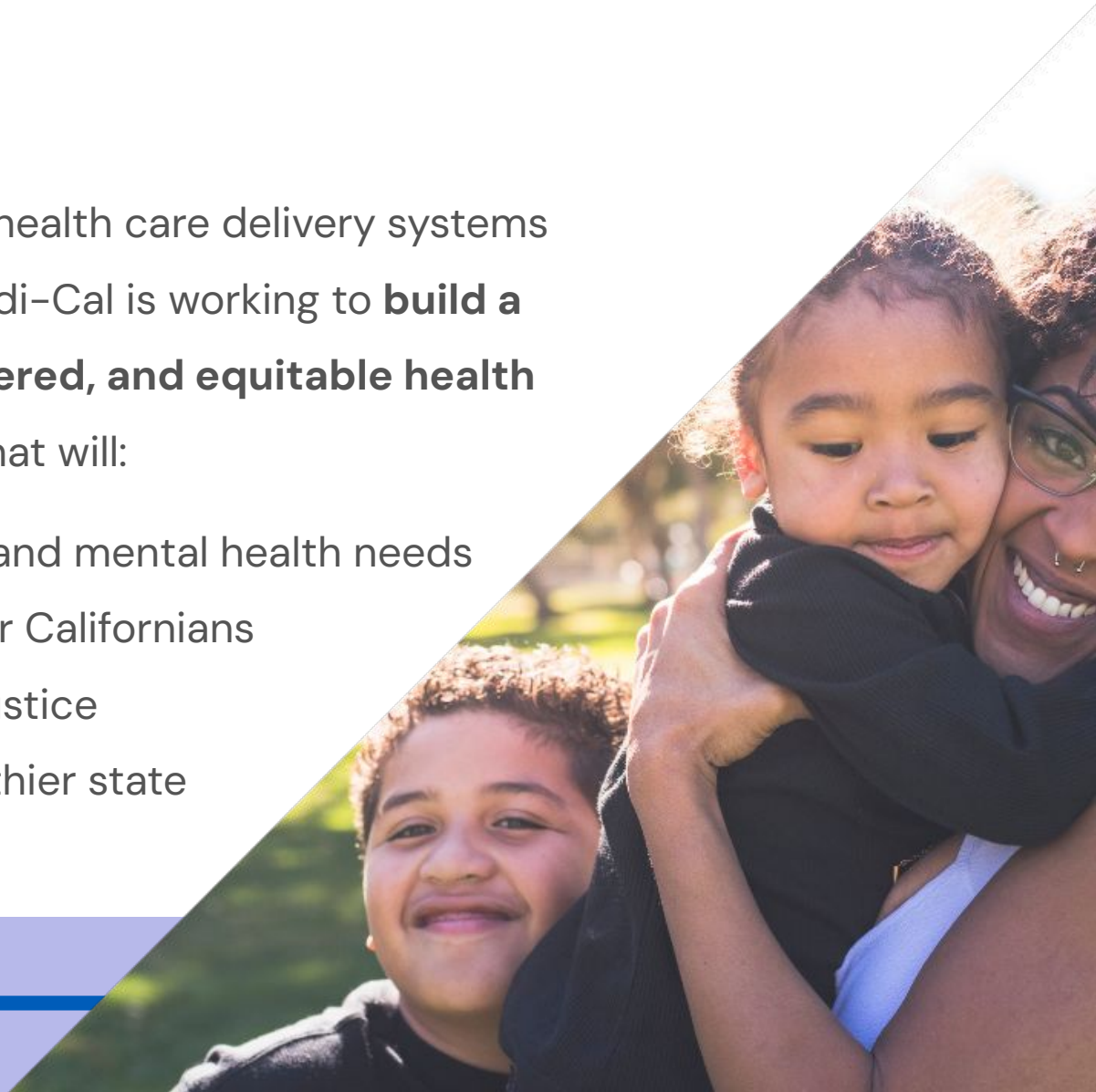
Medi-Cal enrollment hovers around 15,000,000. Medi-Cal managed care enrollment is 90-95% of the total Medi-Cal enrollment.

CALAIM: MEDI-CAL TRANSFORMATION

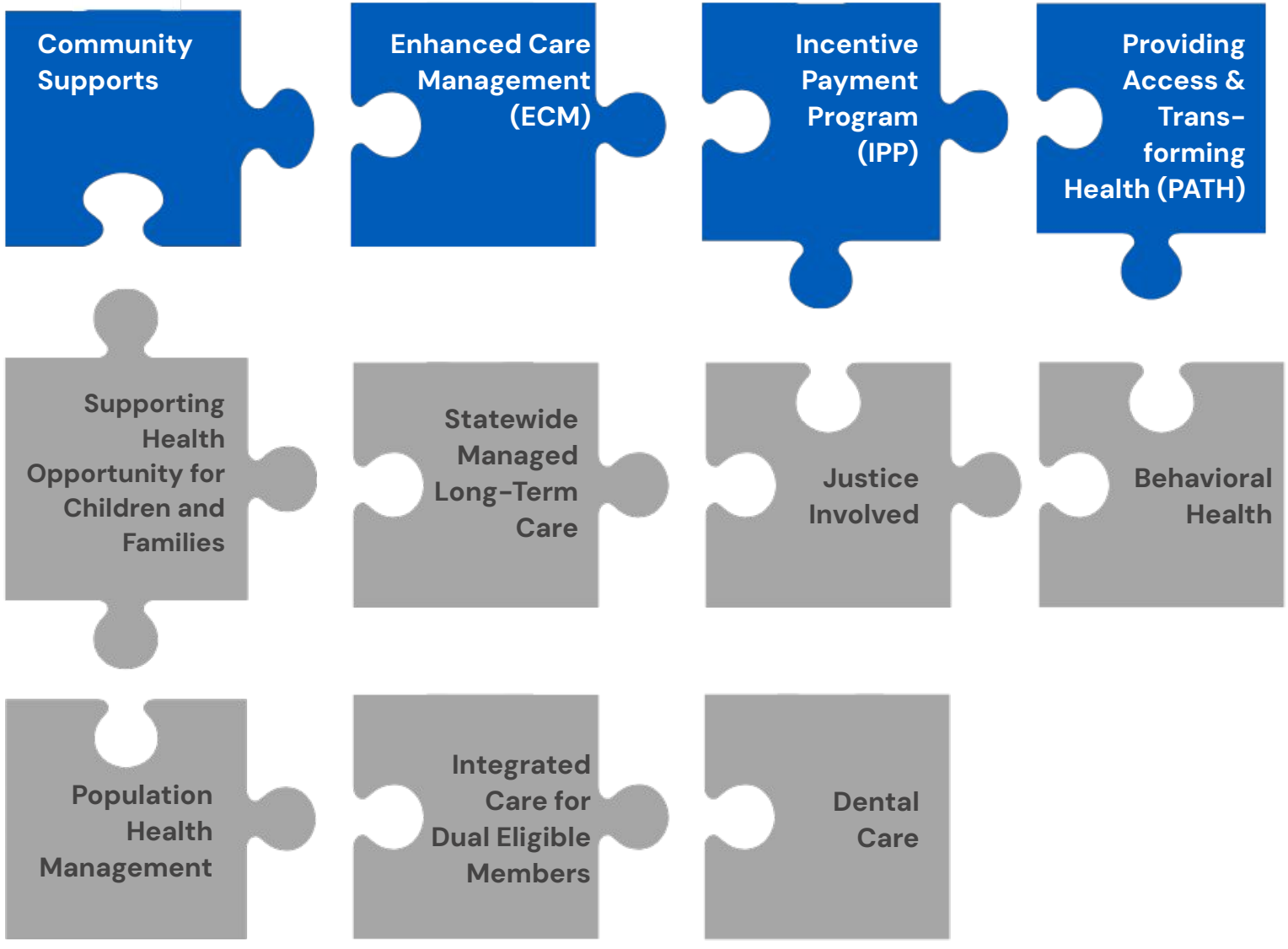
What is it?

A multi-year effort to change the health care delivery systems within CA's Medicaid program. Medi-Cal is working to **build a more coordinated, person-centered, and equitable health system** that works for everyone that will:

- Address California's physical and mental health needs
- Improve and integrate care for Californians
- Be a catalyst for equity and justice
- Work together to build a healthier state



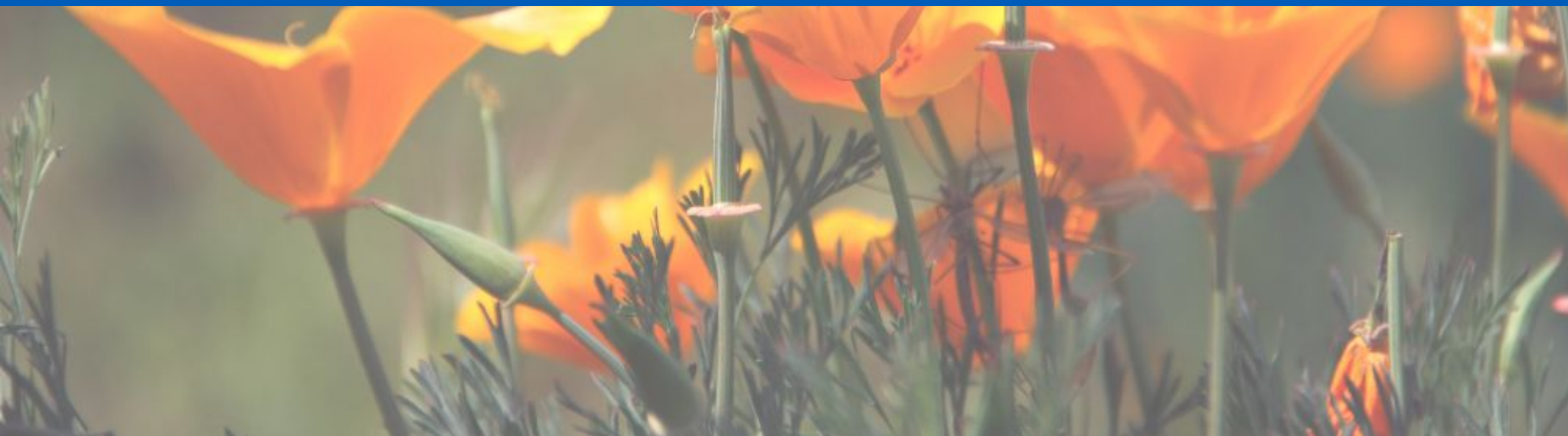
CALAIM MEDI-CAL TRANSFORMATION INITIATIVES



WHY DOES CALAIM MATTER?

- New revenue streams, which extend support and services
- New benefits and services available to vulnerable populations
- Opportunity to break down silos and create a more coordinated system of care

ENHANCED CARE MANAGEMENT



ENHANCED CARE MANAGEMENT (ECM)

A new statewide Medi-Cal benefit intended to:

- Break down the traditional walls of health care, and extend **beyond hospitals and health care settings into communities**;
- Provide high-need members with **in-person care management** where they live;
- Introduce a better way to **coordinate care**;
- Provide access to a single **Lead Care Manager** who provides comprehensive care management and **coordinates their health and health-related care and services**; and,
- Makes connections to the **quality care** they need, no matter where members seek care – at the doctor, the dentist, with a social worker, or at a community center.

Source: ECM Policy Guide – August 2024

WHAT IS ECM?

ECM is a statewide Medi-Cal Managed Care Plan (MCP) benefit to support comprehensive care management for Members with complex needs.

Medi-Cal MCP Care Management Continuum

ECM

Complex Care Management
for MCP Members with higher- and medium-rising risk

Basic Population Health Management
For all MCP Members

Plus: Transitional Care Services
For all MCP Members transitioning between care settings

Source: CalAIM Enhanced Care Management Policy Guide

WHO IS ELIGIBLE FOR ECM?

ECM is available to MCP Members who meet criteria for ECM "Populations of Focus" (POFs), which are launching in phases from January 2022 to January 2024.

	ECM Population of Focus	Adults	Children & Youth
1	Individuals Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization	✓	✓
3	Individuals with Serious Mental Health and/or Substance Use Disorder Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

ECM has been available for adults with intellectual or developmental disabilities (I/DD) and pregnant and postpartum individuals from the launch of ECM if they meet the eligibility criteria for any existing Population of Focus. In July 2023, children and youth with I/DD or who are pregnant/postpartum will also be eligible for ECM if they meet the eligibility criteria for any existing Population of Focus.

Source: ECM Policy Guide – August 2024

COMMUNITY SUPPORTS

COMMUNITY SUPPORTS UPDATE

Community Supports are services that address MCP Members' social drivers of health and help them avoid higher, costlier levels of care.

15 Pre-Approved DHCS Community Supports include :

- 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
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically-Tailored Meals or Medically-Supportive Foods
- Sobering Centers
- Asthma Remediation
- Transitional Rent*

Source: CalAIM All-Comer Webinar: Community Supports Implementation Progress and DHCS Policy Refinements

How Do Individuals Access Community Supports?

Access to Community Supports can occur in multiple ways:

- **Community-based service providers,** both in and out of MCP networks, may identify and refer eligible members for Community Supports Services.
  - DHCS expects MCPs to source most Community Supports referrals from the community.
  - Non health care agencies are encouraged to refer members for ECM.

- **Individuals** and their families can refer for community supports.

- **MCPs** can refer for Community Supports Services.

Community Supports Summary
Part 1 – Housing Services

Community Supports Service	Eligible Populations	Example of Services
Housing Transition Navigation Services	Homeless, at-risk of homelessness	Housing assessment, plan & search for housing
Housing Deposits (reimbursement-based; once in a lifetime benefit)	Homeless, received housing transition navigation services	Security deposits, first month utilizes, set-up fees
Housing Tenancy & Sustaining Services	Homeless, received housing transition navigation services	Advocacy & coaching to help maintain housing
Recuperative Care (Medical Respite)	Homeless, unstable living conditions	Interim housing for short-term residential care
Short-Term Post-Hospitalization Housing (up to 6 months; once in a lifetime benefit)	Existing recuperative care or other facility, homeless, at-risk of homelessness	Interim housing for recuperation and recovery

What are Housing Transition and Navigation Services?

- Conducting a tenant and housing assessment
- Developing an **individualized** housing support plan
- Searching for housing and presenting options

- Assisting in **securing housing**, including housing applications and required documentation
- Assisting with requests for reasonable accommodations
- Assisting with **benefits advocacy**

Source: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services (October 2022)

Housing Transition and Navigation Services

- Identifying and securing available resources to assist with **subsidizing rent**
- Identifying and **securing resources** to cover expenses such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses
- Supporting **environmental modifications** to install necessary accommodations for accessibility
- **Communicating and advocating** on behalf of Member's with landlords
- Assisting in arranging for and supporting the **details of the move**
- Supporting non-emergency, non-medical **transportation** to ensure reasonable accommodations and access to housing options
- Establishing procedures and contacts to **retain housing**
- Ensuring that the living **environment is safe** and ready to move in
- **Landlord** education and engagement

Source: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services (October 2022)

Housing Deposits

Service Offerings

- **Security deposits** required to obtain a lease on an apartment or home
- First month's and last month's **rent** as required by landlord
- **Set-up fees**/deposits for utilities
- **First-month** coverage of utilities

- Services necessary for the individual's **health and safety,** such as pest eradication and one-time cleaning prior to occupancy
- Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services

Source: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services (October 2022)

How do Housing Deposits Work?

Identify, coordinate, and **fund one-time** services and modifications

Based on an **individualized assessment** of needs

Documented in an individualized **housing support plan**

Source: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services (October 2022)

What are Housing Tenancy and Sustaining Services?

- Provides tenancy and sustaining services with a **goal of maintaining safe and stable tenancy** once housing is secured
- The services may involve coordination with other entities to ensure the individual has **access to supports needed** to maintain tenancy
- Based on an **individualized assessment** of needs and documented in the individualized housing support plan

Source: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services (October 2022)

Housing Tenancy and Sustaining Services

- Providing early identification and intervention for behaviors that may jeopardize housing
- Continuing assistance with lease compliance
- Other prevention and early intervention services identified in the crisis plan
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis
- Health and safety visits
- Providing independent living and life skills
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy
- Coordination with landlord and case management provider
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction
- Advocacy and linkage with community resources to prevent eviction
- Assistance with benefits advocacy
- Assistance with the annual housing recertification process

Source: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services (October 2022)

What is Recuperative Care?

Short-term residential care for individuals who no longer require hospitalization, but still need to heal

Allows patients to continue addressing care and social services

Addresses housing instability and promotes recovery after acute care

Source: Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing with WellSpace Health, People Assisting The Homeless San Diego, and the National Health Care for the Homeless Council (August 2022)

Recuperative Care in Context

- Bridge program between hospital and emergency departments and homeless shelters that do not offer medical care
- Part of the **continuum of care** for homeless services
- Broad program diversity
- Over 130 recuperative care programs in the US
- 41 recuperative care programs in California

Source: Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing with WellSpace Health, People Assisting The Homeless San Diego, and the National Health Care for the Homeless Council (August 2022)

Recuperative Care Services

Minimum Service Offerings

- Interim Housing
- Meals
- Medical and behavioral health monitoring

Additional Service Offerings

- Short-term assistance with Activities of Daily Living
- Transportation coordination for post-discharge appointments
- Connection to ongoing services
- Housing and benefits support
- Case management stabilization

Source: Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing with WellSpace Health, People Assisting The Homeless San Diego, and the National Health Care for the Homeless Council (August 2022)

Eligibility for Recuperative Care Services

Eligible populations include Individuals who:

- Are at risk of hospitalization or are post-hospitalization
- Live alone without formal supports
- Face housing insecurity or have housing that would jeopardize their health and safety without modification
- Who meet HUD definitions of "homeless" or "at risk of homelessness" and who are receiving Enhanced Care Management (ECM) or who have one or more serious chronic condition(s) and/or serious mental illness and/or is at risk of institutionalization as a result of a substance use disorder

Source: Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing with WellSpace Health, People Assisting The Homeless San Diego, and the National Health Care for the Homeless Council (August 2022)

What is Short-Term Post-Hospitalization Housing?

- Site for patients to continue medical, psychiatric, or substance abuse disorder recovery
- For patients exiting inpatient and residential treatment facilities

- Supports recuperation, recovery, and transitions to other housing
- Individual and group housing setting

Source: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services (October 2022)

Eligibility for Short-Term Hospitalization Housing

Eligible populations include Individuals who:

- Are exiting recuperative care
- Are exiting an inpatient treatment stay who satisfy any of the following:
  - Meet the HUD definition of homeless and receive ECM, have one or more serious chronic conditions, or are at risk of institutionalization for substance use disorder
  - Meet the HUD definition of homelessness and receive ECM, have one or more serious chronic conditions, serious mental illness or are at risk of institutionalization, or are transition-age youth facing housing instability
- Must have medical/behavioral health needs that would likely result in hospitalization, re-hospitalization, or institutional readmission after experiencing homelessness upon discharge from care

Source: Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing with WellSpace Health, People Assisting The Homeless San Diego, and the National Health Care for the Homeless Council (August 2022)

Interim Housing Services in Context

- Builds on **housing-first** model
- Provides **case management and stabilization** for medically vulnerable individuals
- Links patients to long-term supports

Source: Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing with WellSpace Health, People Assisting The Homeless San Diego, and the National Health Care for the Homeless Council (August 2022)

Community Supports Summary Part 2

Community Supports Service	Eligible Populations	Example of Services
Environmental Accessibility Adaptations (home modifications) (reimbursement-based services)	Individuals at risk for institutionalization in a nursing facility	Ramps, stair lifts, grab-bars
Nursing Facility Transition/Diversion to Assisted Living Facilities (some reimbursement-based services)	Able and willing to live in assisted living setting *IHSS, APS*	Wrap around services to assist with ADLs/IADLs to keep living in home
Community Transition Services/ Nursing Facility Transition to a Home (up to a total lifetime maximum amount of $7,500)	Able and willing to live in community *IHSS, APS*	Security deposit, housing navigation, home modifications

Environmental Accessibility and Home Modification Services

- Ramps and grab-bars to ensure access at home
- Doorway widening for Members who require a wheelchair
- Making bathrooms and showers wheelchair accessible
- Stair lifts
- Installation of specialized electric and plumbing systems to accommodate medical equipment and supplies
- Installation and testing of a Personal Emergency Response System (PERS)

Source: Asthma Remediation & Home Modifications, also known as Environmental Accessibility Adaptations (July 2022)

Eligibility for Environmental Accessibility and Home Modifications

Eligibility Criteria Includes:

- Individuals at risk for institutionalization in a nursing facility
- Documented provider order for service or equipment
- Documented provider description of medical necessity for services and efficacy of equipment for member

Authorization Requirements:

- Physical or occupational therapy evaluation and report:
  - Member evaluation and equipment needs
  - Evaluation of provider-ordered services or equipment
  - Description of similar equipment used that has demonstrated to be inadequate for the Member
- Two itemized bids from service providers
- Suitability of service or equipment verified via home visit

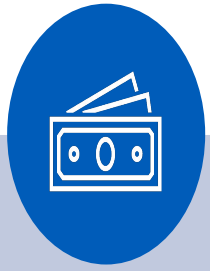
Source: Asthma Remediation & Home Modifications, also known as Environmental Accessibility Adaptations (July 2022)

Nursing Facility Transition/ Diversion Services

- Assess housing needs and presenting options
- Assess member service needs
- Assist in securing facility residence
- Help members retain facility housing
- Communicate with facility administration and coordinate move-in
- Coordinate with managed care plans to ensure appropriate delivery of Community Supports and Enhanced Care Management

Source: Nursing Facility Transition & Diversion to Assisted Living Facilities and Community Transition Services & Nursing Facility Transition to a Home (September 2022)

Nursing Facility Transition/ Diversion Services



The Nursing Facility Transition/Diversion Community Supports covers **ongoing expenses** for Members receiving it in an assisted living facility

For individuals who transition from a nursing facility to home, MCPs may elect to offer the "**Personal Care/Homemaker**" Community Supports to support ongoing ADLs/IADLs

Source: Nursing Facility Transition & Diversion to Assisted Living Facilities and Community Transition Services & Nursing Facility Transition to a Home (September 2022)

How Nursing Facility and Diversion to Assisted Living Works

Assisted living providers support individuals with Activities of Daily Living, meals, medications and transportation.

Wrap Around Services

- Activities of Daily Living and Instrumental Activities of Daily Living
- Companion services
- Medication oversight
- Therapeutic social and recreational programming
- 24-hour direct care staff on-site

Eligibility Nursing Facility Transition and Diversion Services

Nursing Facility Transition
Eligible populations include individuals who:

- Resided 60+ days in a nursing facility
- Are willing to live in an assisted living facility
- Are able to safely reside in an assisted living facility

Nursing Facility Diversion
Eligible populations include individuals who:

- Are interested in remaining in the community
- Are willing and able to safely reside in an assisted living facility
- Receiving medically necessary nursing facility level of care or meet minimum criteria to receive nursing facility services

Source: Nursing Facility Transition & Diversion to Assisted Living Facilities and Community Transition Services & Nursing Facility Transition to a Home (September 2022)

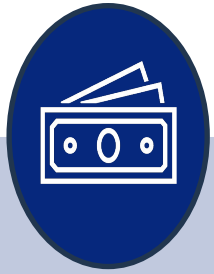
What are Community Transition Services/Nursing Facility Transition to a Home?

- Assessing member housing needs and presenting options
- Assisting in **searching for and securing** housing
- Communicating with landlord and coordinating the move
- Establishing procedures and contacts to **retain housing**

- Identifying, coordinating, securing, or funding non-emergency, non-medical **transportation** to assist Members' mobility
- Identifying the need for and coordinating funding for **environmental modifications**

Source: Nursing Facility Transition & Diversion to Assisted Living Facilities and Community Transition Services & Nursing Facility Transition to a Home (September 2022)

What are Community Transition Services/Nursing Facility Transition to a Home?



Non-recurring set-up expenses for transition from licensed facility to private residence

Designed to help members live in the **community** and avoid further institutionalization

Source: Nursing Facility Transition & Diversion to Assisted Living Facilities and Community Transition Services & Nursing Facility Transition to a Home (September 2022)

Community Transition Services/Nursing Facility Transition to a Home

- Security deposits
- **Set-up fees** for utilities or service access
- **First-month** coverage of utilities
- **Home modifications,** such as an air conditioner or heater

- Services necessary for the individual's **health and safety,** such as pest eradication and one-time cleaning prior to occupancy
- Medically necessary services, such as hospital beds to ensure access and reasonable accommodations

Source: Nursing Facility Transition & Diversion to Assisted Living Facilities and Community Transition Services & Nursing Facility Transition to a Home (September 2022)

Eligibility for Community Transition Services/ Nursing Facility Transition to a Home

Eligible populations include Individuals who:

- Are currently receiving medically necessary level of care (LOC) services and choosing to transition from a nursing facility or Medical Respite
- Lived 60+ days in a nursing home or medical respite setting
- Interested in moving back to the community
- Able to reside safely in the community

Source: Nursing Facility Transition & Diversion to Assisted Living Facilities and Community Transition Services & Nursing Facility Transition to a Home (September 2022)

COMMUNITY SUPPORTS SUMMARY PART 3

Community Supports Service	Eligible Populations	Example of Services
Respite Services (336 hours/year)	Live in the community - *IHSS, APS*	Episodic, short-term caregiver prevent caregiver burnout
Day Habilitation Programs	Homeless, exited homelessness in past 24 months -	Peer mentoring to improve socialization and adaptive skills provided in a non-facility setting.
Asthma Remediation (up to a total lifetime maximum of $7,500)	All populations	Air filters, pest eradication, mold removal
Sobering Centers	18 and above	Safe supportive environment to become sober
Medically Tailored Meals/ Medically- Supportive Food	All populations	Home-delivered meals and groceries
Personal Care & Homemaker Services	*IHSS, APS*	Caregiver to assist with ADLs/IADLs

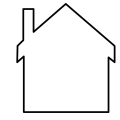
TRANSITIONAL RENT

Transitional Rent Eligibility Criteria

Eligible high-need members enrolled in an MCP may be eligible for up to 6 months of Transitional Rent if they meet the following criteria:

Clinical Risk Factors

- Meet access criteria for Medi-Cal SMHS OR
- Meet the access criteria for DMC-ODS services OR
- Have 1 or more serious chronic physical health conditions OR
- Pregnant to 12-months postpartum OR
- Have physical, intellectual or developmental disabilities



Homelessness

- Experiencing or at risk of homelessness
- As definition by HUD's current definition at 24 CFR part 91.5, with certain modifications.

Transitioning Pop

- Transitioning out of an institutional or congregate residential setting, OR
- Transitioning out of a carceral setting, OR
- Transitioning out of recuperative care or short-term post-hospitalization housing, OR
- Transitioning out of foster care, OR
- Unsheltered homeless, OR
- Eligible for Full Service Partnership (FSP)

Transitional Rent Populations of Focus

Transitional Rent (TR) Implementation Timeline

- **July 1, 2025**
  Optional go-live for MCPs for the BH POF and/or additional TR POFs
- **January 1, 2026**
  Mandatory launch for the TR Behavioral Health POF

POF 1 Behavioral Health POF

POF 2 Transitioning out of an institutional or congregate residential setting

POF 3 Transitioning out of a carceral setting

POF 4 Transitioning out of an interim setting

POF 5 Transitioning out of recuperative care or short-term post-hospitalization housing

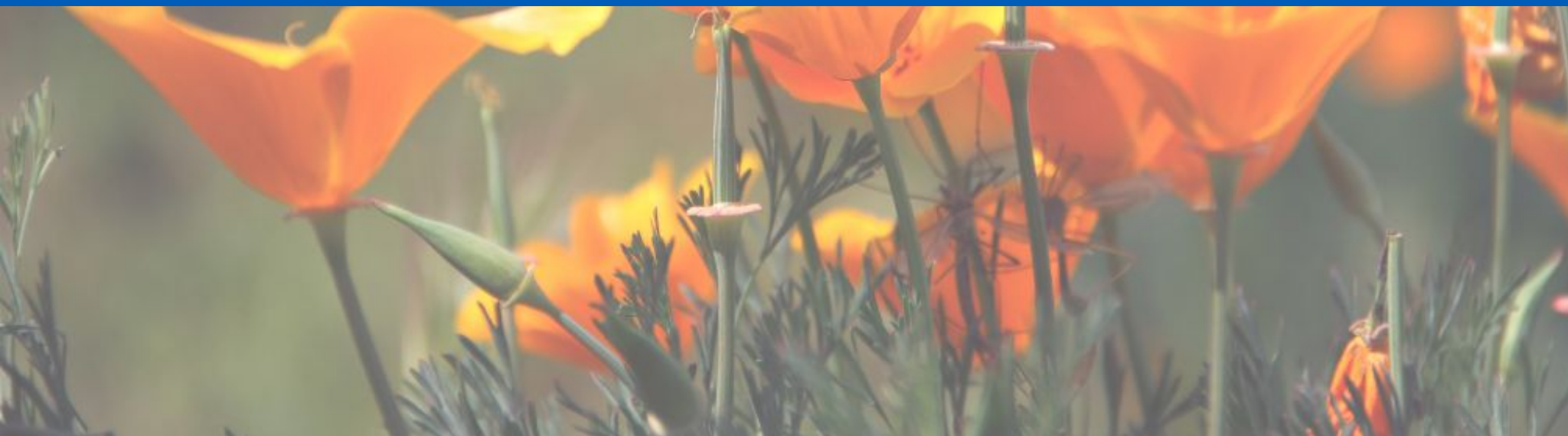
POF 6 Transitioning out of foster care

POF 7 Experiencing unsheltered homelessness

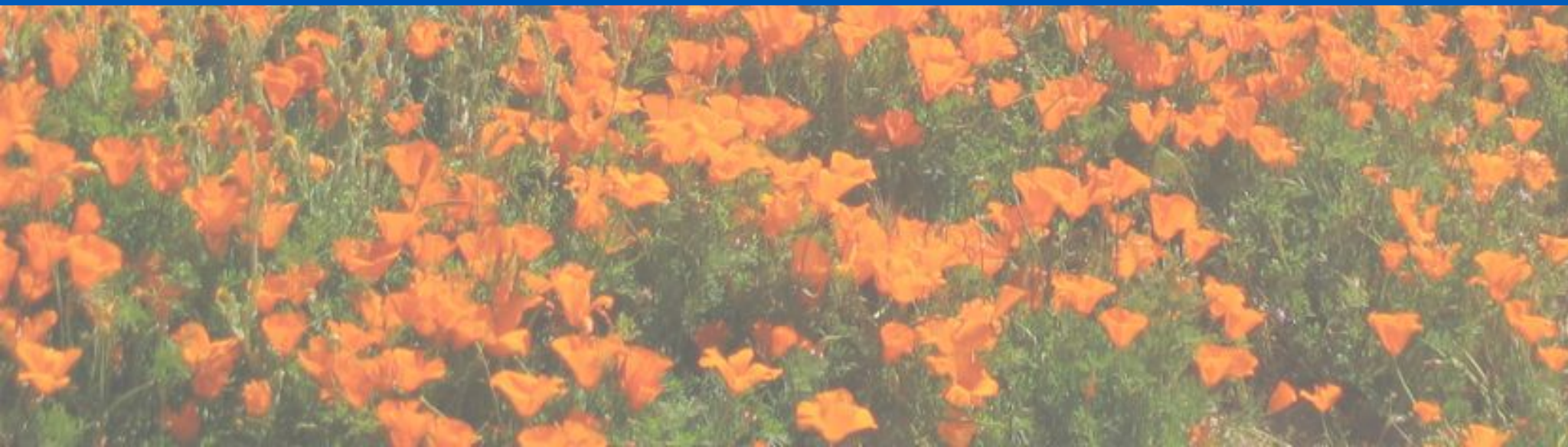
POF 8 Eligible for Full-Service Partnership (FSP)

Source: CITED Round 4 Transitional Rent Webinar

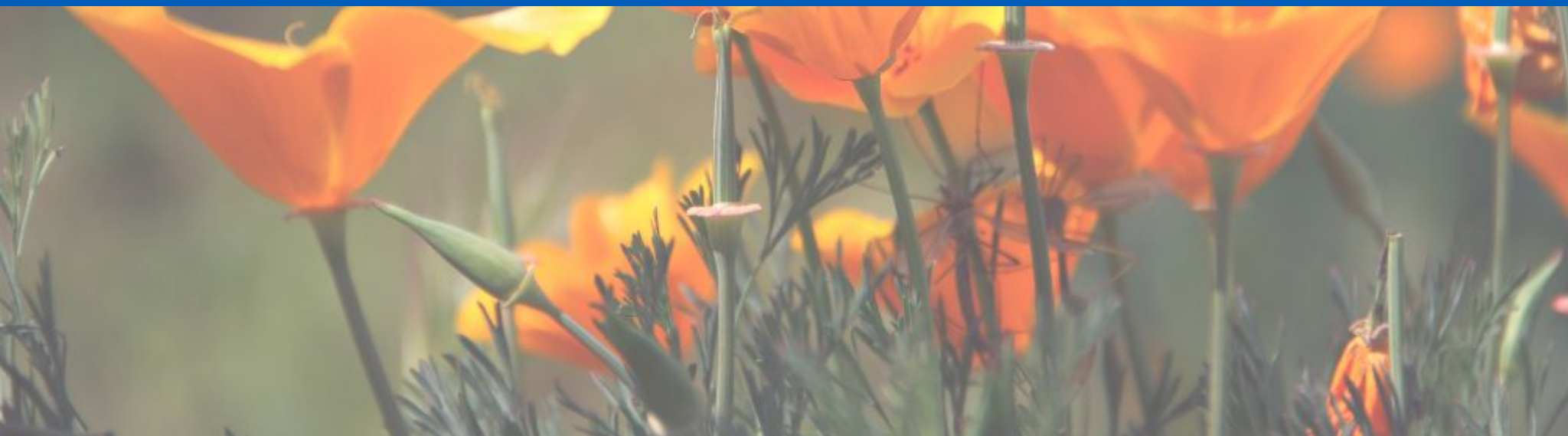
COUNTY PRACTICES



Share your experience with referring to CalAIM services such as ECM or Community Supports

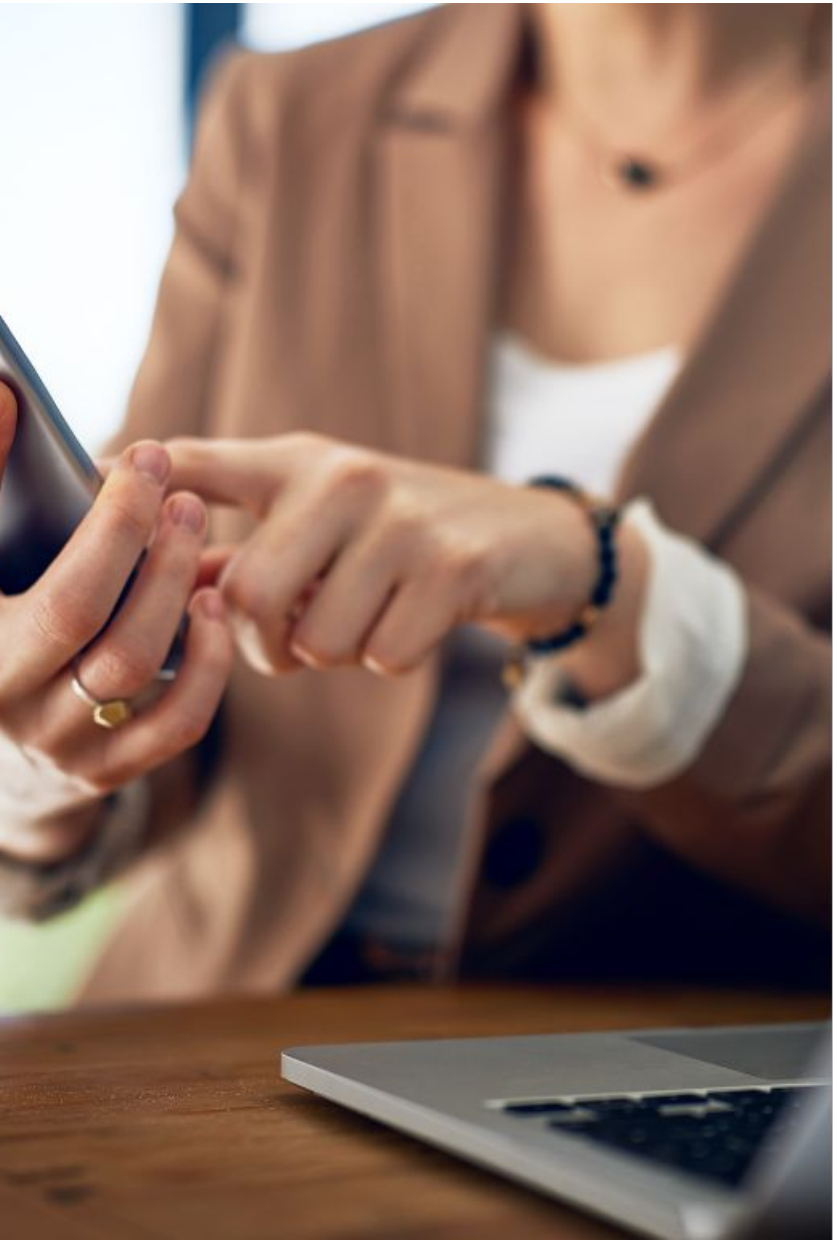


RESOURCES



ECM AND COMMUNITY SUPPORTS RESOURCES

- → ECM and Community Supports Policy Cheat Sheet
- → ECM Policy Guide
- → Community Supports Policy Guide
- → DHCS ECM & Community Supports Main Page
- → PATH Home Page



GET IN TOUCH

CFPIC

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- **Baljit Hundal, Consultant**
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THANK YOU!