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Housing Deposits, and Housing Tenancy and Sustaining Services

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SPEAKERS

Jill Donnelly
Neha Shergill
Katie League
Tyler Brennan
Cheryl Winter
Kyle Stefano
Ann Milton
Sarah Mahin
Tracee Roque

Jill Donnelly: Good afternoon. I see that folks are still joining, so we'll give it one more moment before we get started.

Hi there. My name is Jill Donnelly and I'd like to welcome everyone to our sixth CalAIM Community Support Spotlight webinar. Before we begin a few housekeeping notes, all participants will be on mute during the presentation. We'll have some time reserved for Q&A at the end of the webinar, but no need to wait till the end to submit your questions. Please feel free to submit any questions you have for the presenters via the Q&A feature on Zoom at any point. We ask that all questions be submitted through that Q&A feature rather than chat. The PowerPoint slides and all meeting materials will be available soon after this webinar on the DHCS website within the next couple of weeks. We'll share details on where to access that information in the chat and a recording of the webinar will be sent out as well. Additionally, we do have captioning available for this webinar. If you'd like to use this feature, click on the closed captioning button at the bottom of your screen and select subtitles.

All right. Today, we'll be hearing about three different Community Supports, including housing transition, navigation services, housing deposits and housing tenancy and sustaining services. We'll start with some introductions. We'll hear about these Community Supports and promising practices from presenters. We'll also have Q&A time at the end, as I mentioned. And without further ado, let's get it started. I'll turn things over to Neha at DHCS to introduce these Community Supports.

Neha Shergill: Thanks so much, Jill. So today on the DHCS side of the house, we'll begin with a brief overview of CalAIM Community Supports. So Community Supports are medically appropriate, cost-effective alternatives to services. Medi-Cal managed care plans may provide in lieu of services traditionally covered by Medicaid. Community support services are designed to potentially decrease utilization of other Medi-Cal benefits, such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. Managed care plans are strongly encouraged, but not required to provide Community Supports. CalAIM currently includes a robust menu of 14 pre-approved Community Supports to address the health needs of members. The list of these pre-approved Community Supports is informed by the work and lessons learned under the Whole Person Care Pilot and the Health Homes Program. Managed care plan selected Community Supports to offer when CalAIM went live on January 1st of 2022 and have the option to add new Community Supports every six months. Managed care plans in all counties are encouraged to offer at least one community support by January 1st of 2024. We can go to the next slide please.

So the Community Supports are in lieu services, which are medically appropriate and cost-effective services or settings offered by a managed care plan. And these are as substitutes for Medicaid state plan covered service or setting. Under our regulatory requirements in lieu of services must be authorized and identified by plan contracts and offered at plan and enrollee options. This allows for Community Supports to cover a broad range of social and support services for eligible populations. These are financed through capitated rates to plan in the same way as state plan services and do not require 1115 waiver savings.

So this slide that you're looking at now outlines the 14 pre-approved Community Supports and today's webinar is intended to provide information about the housing

transition navigation, housing deposits and housing tenancy and sustaining services, and help inform you as you consider offering these supports to plan members and patients. And at this time, at least one plan in 56 out of 58 California counties have elected to offer all three of the housing supports by January 1st of 2024. All counties will have at least one community support by 2024. I'll pass it over to Katie League, clinical policy manager at the National Healthcare of the Homeless Council, who will now take us through the guidance on housing transition navigation. Thank you.

Katie League: Thank you, Neha. Hello, everyone. It's great to be with you. We're now going to provide a little bit of a summary of guidance on the housing transition navigation services support. There are a lot of elements that can be included in housing transition navigation services and a range of services that may be offered as part of this community support. There are lots of definitions covered more thoroughly in the community support policy guide, which we're going to link to in the chat, but we're going to talk through a few today. And my work in homeless services has been for over a decade in the Baltimore City area of Maryland. And so many of these I hope to bring to light for you a little bit on how essential they are in transitioning a person into housing.

These can include tenant screening and housing assessment, developing an individualized housing support plan. I can't emphasize enough the word individualized there. It is so easy to try and be prescriptive with these, but everyone is unique in their needs and their wants and their likes. Assisting members with their housing search and then assisting with applications and benefit advocacy. Next slide please. Other services included include identifying resources to assist members with securing resources to help with rent and move-in expenses and helping members to make requests for reasonable accommodations and accessibility adaptations.

So thinking of how to keep somebody in a house starts long before they actually get the keys. There are a lot of steps and a lot of costs that are not covered even when somebody holds one of those vouchers. You think of times that you've moved in your life or relocated. That is an incredibly expensive endeavor. It is even more so for somebody who has very limited income and knowing that those HUD resources or housing resources often don't include those supplemental costs. And planning an advance for those reasonable accommodations will help create an environment where the person is more likely to be able to thrive and be successful. This service can also include helping members with landlord engagement and communication, helping resolve disputes and addressing issues that could impact housing stability.

This may be a first time a person has lived independently on their own. So some of the skills of like engaging with a landlord or even knowing how to talk the lingo of housing may be new to them and can be very overwhelming. All transitions are stressful even when they're incredibly positive. Next slide please. Additional services can include supporting the details of move in and coordinating non-emergency, non-medical transportation to access housing options, helping members to retain housing and ensuring that homes are safe and ready for move in. Oftentimes when somebody finds housing, it is not in the community that they are used to being in. So how to get around, where things are located, where the grocery store is, where public transportation is, laundry facilities may be new to them. They may have lived in a place where all of those things were within walking distance or close access or on a shuttle line or a bus line that they were familiar with.

In more rural areas, things can be spread out and it can be very challenging for somebody to navigate a new area. This can cause them to actually want to give up on housing, because there's a whole lot of day-to-day things that become overwhelming. So planning for those, engaging in those conversations. This is all about making a personalized housing plan. The services provided should be based on an individual assessment of need and documented in the individual housing support plan. Members may require an access only a subset of the services listed here. So not everything is for everyone. And when we talk about members, it may include an individual or a family system. So lots of things to take into consideration when developing that housing plan for that member, because in order for them to be successful, you want to have these conversations from the very beginning,, knowing that this is going to be an exciting but also potentially a very stressful time as they transition to all of these new things and new normal in their days. Next slide please.

There are some service limitations and exclusions for this community support. Services under housing transition navigation do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and support. So no matter how expedited housing is, there is a time when the person may go from being unhoused to having those keys and that transition can be incredibly stressful and a person may want to know where they're able to stay. Looking for Community Supports will not only provide them support during this time, but also may identify valuable resources for them as they progress through their housing period. So you want to also be thinking of other supports that should be in place for them once they are housed, that making these community connections will, one, give them resources they can turn to if things change in their living situation or an unexpected cost comes in.

And recognizing that people who are experiencing homelessness often have very complex health conditions that need to be continued to care for even after housing is identified. You're not going to be able to provide all those without those layers of support. Housing transition and navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan. And service duration can be as long as necessary. Many of these services do not end as soon as the person is housed. In fact, the process of housing may identify a whole new layer of services that are necessary in order to keep them successfully housed. Engaging in these personalized housing plans, you are building that trustworthiness. You are demonstrating your investment in helping them get housed and, more importantly, helping them stay housed. That early tenancy is a very vulnerable time for somebody and as it gets closer, they can feel some of that anxiety and have lots of questions that are going to require some patience. Next slide please.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy. Housing navigators coordinate with many different types of entities, including some of the county and legal entities that you'll see listed here. Oftentimes, there are things in a person's past that may serve as a barrier towards accessing housing. And so thinking of these in advance and planning for them and creating a non-judgmental environment in where you can have honest and candid conversations with the individual is going to set them up for housing success.

I cannot overemphasize the importance of this. As we've moved to this system of

coordinated entry where we are prioritizing the most vulnerable people for housing, we also need to recognize that the things that make those individuals vulnerable need supports in order to provide them with successful opportunities to remain housed. So there is a reason here that we always say housing is healthcare and that these are ways in which we can address some of these complex needs, but they're not all solved just by housing.

For members who will need rental subsidy supports to secure permanent housing, the services will require close coordination with operators of local rental subsidies. These funds often vary in their availability and may need significant application time in advance prior to move in. You'd hate to get to the point of lease signing and not have that security deposit and prevent the individual from being able to move in at that time. That can cause a lot of frustration, disheartened feelings and feeling like it's never going to happen. Some housing assistance is also funded by county behavioral health agencies, Medi-Cal, managed care plans and their contracted community support providers should expect to coordinate access to housing resources throughout the county behavioral health when appropriate.

There are a lot of different ways in which these services are available, particularly when it comes to financial resources. They often have their own application process and different things that need to be in place and demonstrated to show that the individual is eligible. And helping somebody walk through that process and actually being prepared with the information can really ease the process for them. As you do it, this may be the 10th, 20th, 200th person you've helped through this process. It's probably their first time. So approaching it with the excitement, the nerves, and the anticipation of all that it will bring, as though it's a new thing each time, it's very, very exciting. Next slide please.

The eligibility definition for this community support is lengthy and we recommend that you consult the guide for complete definitions and we're going to include that link in the chat. At a high level, folks who meet some of the criteria listed here may qualify for this community support. Next slide. This service can be provided by any of the provider types you see here. This may include vocational service agencies, providers of service for individuals experiencing homelessness and other social service agencies, county agencies, public hospital systems, housing providers, federally qualified health centers, also known as FQHCs, rural health clinics and mental health, behavioral health or substance use disorder providers, including county and behavioral health agencies. I'm going to now hand it over to Tyler Brennan from DHCF who will take us through the guidance on housing deposits.

Tyler Brennan: Hi. I'm sorry about that. I was muted. We'll now go through the guidance and provide a summary of all the guidance on housing deposits. Next slide please. So how does the housing deposits community support work? The housing deposits community support is intended to assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household and which do not constitute room and board. Like housing navigation, the services provided should be based on an individualized assessment of needs and documented in the member's individualized housing support plan and individuals may require an access only a subset of the services that are offered. Next slide please.

So in terms of service offerings, housing deposits can be used to cover any of the items you see here, including security deposits and first and last month's rent, fees

and deposits for utilities, first-month coverage of utilities, services to improve habitability, like pest control and cleaning before move in, and goods like air conditioners and heaters or other medically necessary items. Next slide please. Eligible populations. Members who are eligible for housing deposits may include those who have received the housing transition and navigation community support, those who have been prioritized for a permanent supportive housing unit, and some individuals who meet the HUD definition of homeless and require additional services. Next slide please.

In terms of allowable providers, there are a few types of entities that can offer this service. The entity that is coordinating an individual's housing transition navigation services or the Medi-Cal managed care plan case manager, care coordinator or housing navigator may coordinate these services and pay for them directly, or also they may subcontract out the services. Providers must have demonstrated or have verifiable experience and expertise providing these unique services. Next slide please. Service limitations and restrictions. Services covered under the housing deposits community support do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's rent coverage.

Housing deposits are available once in an individual's lifetime, but can be approved one additional time with relevant documentation supporting why an additional time would be both medically appropriate and cost effective. Plans are expected to make a good faith effort to review of information available to them to determine if the individual has previously received services. These services must be identified as reasonable and necessary in the member's individualized housing support plan and individuals must receive also the housing transition navigation in conjunction with this service. With that, I'll pass things over to Cheryl Winter, a senior program manager from the Corporation for Supportive Housing. We'll cover housing tenancy and sustaining services. Cheryl?

Cheryl Winter: Thank you, Tyler. As Tyler mentioned, my name is Cheryl Winter, I work with CSH. To save on time, I'll put a little bit more about CSH in the chat after my section, but I'll be giving us a summary of the guidance on housing and tenancy sustaining services. You can go to the next slide. Thank you. So what are housing and tenancy sustaining services? So this service provides tenancy sustaining services with the goal of maintaining safe and stable tenancy for someone once housing has been secured. So after they've moved into housing. And like the other supports covered today, the services provided should be based on an individualized assessment of needs and documented in that person's individualized housing support plan.

Individuals may require and access just a subset of the services, so there are a number of activities that fall under these services that we'll review today. And like housing navigation, those services may involve coordination with other entities, like landlords and other community service providers, to ensure that a person has access to the supports needed to stay successfully housed. Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless service to members experiencing homelessness once housed and entering housing tenancy and sustaining services. So just as Katie mentioned earlier, these services do not include the provision of room and board or payment of rental costs. Next slide.

There are many services offered as a part of this community support. They're shown on this slide and the next. I recommend looking at the chat to find the link for the

thorough definitions of these Community Supports. Some that I do want to highlight are those related to coordination and advocacy. So coordinating with a landlord or other case management entities to support an individual in remaining successfully housed and providing advocacy and linkage to other community resources to help someone avoid eviction are two of these services that you'll see on this slide here. We can go to the next slide please.

Some of the additional services offered are here on this slide. And I do want to highlight that, as Katie mentioned, identifying potential barriers to remaining successfully housed starts when someone is being supported in housing navigation and transition. But not everyone who is going to be receiving tenancy sustaining services may have been enrolled and authorized for housing navigation and transition services. So, again, with these services, it's important to provide early identification and intervention for behaviors that could jeopardize someone's housing. You want to provide a crisis support plan in addition to your housing supports plan. And then review that regularly with the member to reflect any changes and their needs and preferences. Next slide please. The eligibility definition for this community support is also lengthy, so we'll put a link in the chat where you can review the eligible populations. But at a high level here, you can see that people who meet some of the criteria listed here may qualify for this community support. Next slide. And as with the housing navigation and transition services-

Cheryl Winter: And as with the housing navigation and transition services, this is the list of allowable providers for this support service. And I do want to mention that providers must have demonstrated or have verifiable experience or expertise with providing housing related services and supports. When enrolled in enhanced care management as well, community support should be managed in coordination with enhanced care management providers. And when members receive more than one of these services, the managed care plan should ensure coordination by an enhanced care management provider whenever possible. So that would be to minimize the number of care transitions, and to improve overall care coordination and management. Next slide.

There are some limitations and restrictions to these services. So these services are available from the initiation of services through the time that an individual's housing support plan determines they are no longer needed. So service duration can be as long as necessary. It needs to be identified in that individual's housing support plan. They are only available, however, for a single duration in an individual's lifetime. That being said, Housing Tenancy and Sustaining Services can be approved one additional time with documentation, and that documentation should include what conditions have changed to demonstrate how providing Housing Tenancy and Sustaining Services, again, would be more successful on the second attempt. And plans are expected to make a good faith effort to review information available that to them to determine if someone has previously received services. Next slide.

As with the housing navigation and transition services, the Housing and Tenancy Sustaining Services must be identified as reasonable and necessary in that individual member's individualized housing support plan. And are available only when it is demonstrated that the enrollee is unable to successfully maintain longer term housing without that assistance, so that that is necessary and reasonable assistance to be providing. So as I said earlier, someone may have also received housing transition and navigation services, but that is not a prerequisite for eligibility for Housing

Tenancy and Sustaining Services. At a minimum, the member must have an associated tenant screening, a housing assessment, and that individualized housing supports plan. And like previously mentioned, these services do not cover room and board or payment of rental costs. Next slide.

All right. So let's look at some of the benefits of providing these comprehensive housing supports by transitioning eligible individuals who would otherwise be experiencing homelessness into permanent housing, and then helping them to sustain that housing. Community Supports can improve health outcomes and reduce the inefficient use of costly unnecessary medical care. These are evidence based services. There are programs that we have the evidence from in New York State, here in Los Angeles where I'm located, that provided rental subsidies and wrap around housing navigation supports and tenancy sustaining case management services to high cost Medicaid members who were frequent utilizers of healthcare systems. And they found these reductions in inpatient days, reductions in emergency department visits, and inpatient psychiatric admissions. And then, cost avoidance of an average of 23,000 to $52,000 per person in that year when that person had been successfully housed and received those tenancy, ongoing tenancy sustaining case management services. Next slide.

So let's look now at what Tenancy Sustaining Services mean for an individual's health and healthcare experiences. So there are national surveys that report the rate of emergency department visits decrease significantly when you're comparing people experiencing homelessness to people who are housed. There was one Chicago housing program that provided intensive case management in Housing Navigation and Tenancy Sustaining Services to individuals that were HIV positive patients experiencing homelessness. And after those patients were housed and provided with tenancy sustaining case management, it resulted in increased lifespans among participants, intact immunity, and lower viral loads. And that was when compared to other individuals who were receiving usual care but still experiencing homelessness.

And then, we have extensive research, and the US Health and Human Services produced a literature review on the impact of permanent supportive housing. And that showed that there are multiple studies, evaluations, and pilot programs where supportive housing is associated with improved quality of life, reductions in substance use, and improved mental and physical health. So these studies illustrate just some of the ways that safe and stable housing can support the health of people currently experiencing homelessness, and how safe and stable housing in those tenancy sustaining services can reduce unnecessary healthcare utilization and costs over time. Next slide. There are best practice approaches associated with these tenancy sustaining services and they include, Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care. We don't have time to go into all of these in detail, but I'll say there are a number of excellent trainings on each of these. And progressive engagement means creative and assertive engagement with someone to build trust and rapport over time. Next slide.

Lastly, like with housing navigation and transition services, there is pricing guidance that DHCS has offered that outlines high-level per diem pricing approaches, reflecting typical staffing ratios, and service intensity. So for more information, the suggested pricing guidance for these three housing related Community Supports, take a look at the pricing guidance document in the chat. And I just want to note that the pricing guidance suggests a recommended maximum of $5,000 for housing deposits. There

is no upper limit established by DHCS for the service rate. The pricing guidance offers recommendations. However, if a managed care plan determines that it would be cost-effective to offer the service to a member beyond that limit, they can do so. And with that, I will hand it back to Jill to introduce our guest speakers for today.

Jill Donnelly: Thanks, Cheryl. All right. So now that we've gone through all of the guidance, we're going to move on to hear from some of our provider presenters. I want to note the folks who just presented are all really wonderful experts in the field, and will be staying on to answer questions and are available in the Q&A as well. So now we'll move on to provider presentations. We're going to start with Kyle Stefano, who's the Vice President of Clinical Programs at Sacramento Covered, and we'll talk about their Community Supports programs. Kyle.

Kyle Stefano: Thanks, Jill. Hi, everyone. My name is Kyle Stefano. Like Jill said, I'm the Vice President of Clinical Programs here at Sacramento Covered. I am a social worker by training and in my heart, so I am happy to be here to talk about some of the experiences my team has had doing Community Supports with our clients. So next slide, please. Just a little brief overview about our agency. So we are a community-based organization here in Sacramento, and we've been serving folks in our community for over 25 years now. And we started out really just focusing a lot on health insurance enrollment, connecting folks to Medi-Cal, also connecting people to other resources in the community like CalFresh or Primary Care, anything that individuals and families needed help just acclimating into their community. And then, I would say about six or so years ago, we branched out into working in housing services with our experience in the Whole Person Care program and Health Homes pilots. So we'll talk about that in a minute.

But we are really proud here of our peer driven and data focused approaches. And of course with our peer driven approach, what I mean by that is we take a lot of time in our hiring and recruitment for our staff to find folks who have lived experience that mirrors the individuals that we're serving in the community. We think that's really important, because it's challenging to navigate these super complicated systems of care, and it really helps to have someone walking through that with you who's had experience in that. So we take that really seriously. And then, in terms of data, we have a small but extremely mighty data team here at Sacramento Covered who I am very grateful for and rely on them daily for information to help us understand and see the services that we're providing, and how we can use those to improve practices going forward.

So we've even used outside consultants, for example, with our work in the Whole Person Care Pilot to do outside evaluations. So we could look at some of our outcomes and change our daily practices to be more efficient in the new CalAIM land. So in addition, so we have one of the largest field-based teams of community health workers here in Sacramento. We have about 75 pushing 80 now, I think, I'm looking at my board, staff, community health workers, patient navigators, and health navigators who are serving individuals in the community. And the biggest success that we've had in the formula that we believe in the most is having a field-based approach. I can't say enough how important that has been for us to have our community health workers be out in the community and not requiring people to come into our office, or creating another barrier to access services by having to come into us. We'll go to people in their encampments, if they may be housed, we'll go wherever they are, meet people in the hospital, the coffee shop, wherever they might need us to come.

So I think that that's been a really, really important piece of our success. So I think the field-based approach is extremely important. So next slide, please. Okay. So I've said this a couple of times, before CalAIM, I think we had admittedly maybe had a little bit of a leg up, because we were involved in both Whole Person Care and Health Homes. And as we know, those two programs laid the groundwork for what we're doing now in CalAIM with Community Supports. And our team is out there doing anything we need to do to get services started, whether that's just doing an initial psychosocial assessment to see a person's needs. One of the very first things we do is make sure that individuals have cell phones. We help people get phones, and of course IDs, and any documents they might need in order to start housing applications that come with the work in providing transition and navigation services.

So we'll start there, and then peel back the layers of what other things the individual or family might need, whether it's care coordination at the same time, or whatever's going on with that individual. So next slide, please, Kathleen. So now here we are in CalAIM land. And just another little bit about us here at Sacramento Covered, we work with all of the five health plans in Sacramento, which are Aetna, Anthem, Health Net, Kaiser, and Molina. And we do both ECM, and of course the Community Supports housing trifecta as we call it. So I'll skip over this slide. Next one, please. I wanted to spend most of my time talking about challenges and successes that we've experienced. So far here we are about three quarters in to the first year of CalAIM and Community Supports. And start with the bad news, the challenges first. So I think in the implementation of this in the first couple months of the year, one of the biggest challenges we had was flushing out how the plans were interpreting the nuances of the DHCS requirements a little bit differently.

And I think, admittedly we've all come a long way in working together with the plans. I know that our contacts at the plans, we've developed really good relationships with them, and they've taken a lot of feedback from us about how things have felt on the ground as the CBO working with the individuals versus how that information is trickling down to the state. So for example, the housing deposits are so important, it's where the resources are in order to secure housing security deposits for people to move into housing. And at the beginning plans we're paying for different things. So for example, just one small example might be that one plan might pay for home goods, whereas another plan may not pay for home goods, unless you could prove that it's medically necessary. So we might have one, for example, a couple experiencing homelessness and they both have different health plans, and we could pay for a bed or for pots and pans for one person in the couple, but the other person's plan wouldn't cover that, those home goods.

So little things like that have been challenging to describe to members. But again, I think the plans have been very receptive in hearing how that comes down on the ground. And now, some of the plans have changed the requirements and I know at least three of the five plans we work with will cover home goods, which has been super helpful for us in providing services and really getting people set up in a way that will help them maintain housing. And other things that have made it somewhat challenging to keep track of. For example, sometimes each benefit the length of time that people maybe authorized for a service, maybe different, sometimes they're authorized for six months, sometimes maybe authorized for 12 months. So we've had to work a little bit internally about how we track authorization timelines and when we need to make sure that those are extended if needed.

But these are all things I think that we anticipated that we were going to have to do a little bit of finessing and learning on the go. And I can't say it enough that the plans have been supportive to us in helping us work through some of those hiccups and we just keep getting better as we go. And the last two, the closest two little bubbles that I have on the slide there, these are the challenges where we stand now. And this is, I think I can summarize it in the biggest challenges we have are just around housing stock. Here in Sacramento, the housing market is extremely tight, as I imagine it is all over California. But I think that we really have been trying to lobby local housing authority as well as even elected officials to help us advocate to get more housing subsidies and vouchers for our clients. It's difficult enough for individuals who may have a steady, healthy job securing an apartment at the cost that they're at now.

So I don't want to say it's impossible for someone trying to pull themselves out of homelessness with a limited income to find a market rate apartment, but it's damn near close to impossible. So the voucher is just such an important tool. And back in the Whole Person Care days, our clients sometimes had expedited access to vouchers, which was amazing. And then, of course, during COVID, the Emergency Housing Voucher was released through HUD, and that was a finite number of vouchers. So now really, we don't really have any access to new vouchers, which is daunting for us to be frank, looking forward to housing people. And then, just the last thing that I wanted to mention, I think it's so inspiring to see DHCS and the plans, and all of the community partners coming together and acknowledging how important the housing Community Supports are.

And it just feels like there's a missing piece of, how do we get landlords on board to be the final step in this process? I know that there's been some incentives for landlords, one-time payment incentives to accept working with some of our folks. But it still feels like a challenge just in terms of stock. And I wish I had some creative solutions to present to the group about that. But that's still something that I think collectively we're trying to figure out how to just create more opportunities for people to move. So those are some of the challenges that we've come up to. But next slide, I want to share some good stuff. So here's just a picture of some of the housing placements we've been able to make in CalAIM since the beginning of the year through the three housing benefits. So 131 people we've got into permanent housing, which we're very proud of. And if you see the orange part of the graphic there, that's 33 people have gone into PSH, Permanent Supportive Housing, through the local continuum of care.

And then, the yellow and the blue side of the picture there adds up to about 62 folks that we placed in apartments, people and families in apartments with vouchers, whether it was the EHV or the HCV. And that's such a huge chunk of the placements that we made, which is why I was talking earlier about the importance of vouchers. And we even have a whole full-time staff, housing specialist, who she does not carry a caseload of clients. Her whole job is to go out into the community and, for lack of a better way to put it, court landlords to try to build relationships with folks who might want to be open housing individuals that are enrolled in our program. So we really are out there canvassing for landlords who will work with us, so that we can continue to make these awesome housing placements. And then, in the green graphic there, the 36 other, that would be people that maybe were in a family reunification situation, maybe folks who wanted to live in a room and board permanently, or even just a room for rent.

So that's a slice of picture of the folks that we've housed. And if I have time, a couple of minutes I wanted to speak on one particular success story that we walked through. We had a young woman who grandfathered into CalAIM with us from Whole Person Care. And when we met her way back in 2019, she was barely 35 and she had four children under 10, and she was working as an IHSS worker, so she had some earned income. But due to childcare and not having a steady place to sleep, she was not able to work enough, and she was just stuck in this cycle of just almost about to get housed, but things kept coming up for her in various challenges. And we were able to secure a housing choice voucher for her back when we had access to that in Whole Person Care. And just when we were about to house her, or try to find a placement for her, she had some setbacks in her life, she became pregnant again. And we were actually able to get her into a family shelter, a transitional family shelter.

And then, when we rolled over into CalAIM, I think that the ability for us to tap into the housing deposit for her really was a life changing situation for her. I can't say it enough how wonderful it is to be able to tap into those dollars, which we really need to go that extra mile and secure the housing for individuals. And I wish I could share this picture, but of course there's confidentiality issues. Back in June, she moved into a house, when she had the last baby, we were able to extend the number of rooms on her voucher, and we found housing for her through the help of CalAIM. And she recently sent us a picture on her two year old's birthday party, and it was just this wonderful picture of all of their friends and family, and balloons and signs in their house. And I just couldn't reflect enough on how wonderful that was.

If anyone with kids knows that sometimes going to all these birthday parties can be taxing over and over again. But just to see it in the context of how long she waited to have a space for her family to do something as much as we would take for granted like a simple birthday party, and she was so proud in sending us a lot of pictures. So I think that that is a testament of how these resources can really take folks to the place they need to get to get them inside and get them stably housed. So I think that's the end for me. So thank you for allowing me to come on and present, and I appreciate it. Thank you.

Jill Donnelly: Thank you, Kyle. All right. We're going to keep moving along, and we'll now hear from Ann Milton, who's the Director of CalAIM at St. John's Community Health. I'll hand it to you, Ann.

Ann Milton: Hi, everyone. My name is Ann Milton. Again. I am the Director of CalAIM here at St. John's. A little bit about St. John's.

Ann Milton: Here at St. John's, a little bit about St. John's. St. John's is the second largest non-profit provider in LA County. We service people who are low income, the uninsured, underinsured in Central and South LA and some areas of Compton. We have 12 community health centers, six school-based health centers, three mobile clinics, and one homeless drop-in center. And this year, we've had about 450,000 primary care visits and we utilize eCW, I'm not sure if you all are familiar with it, I'm sure you are. But we utilized eCW to document our patient progress. Next slide.

And so our contracted Community Supports currently are housing transition navigation services, tenancy and sustaining services. We also are contracted with Anthem Blue Cross for asthma remediation services. And starting in January of next year via Health Net, we will embark on our housing deposit service. So that should be

fun. Next slide.

And so we rolled out Community Supports here at St. John's January of this year. We're contracted with Health Net and LA Care and Anthem Blue Cross. At the start of our our journey, we were grandfathered members from LA Care only and then were assigned all members from any health plan, for those health plans. And we also accept existing and non St. John's patients. Next slide.

And so our staffing model, this is what it looks like. So obviously I'm the director of both programs, ECM and CS. We have one program manager, Jaime Lopez, he's on the call now, so he's the program manager. We have one outreach specialist, which is a newer position. We used our IPP funds to gain access to a outreach specialist. We figured we really needed it once the caseloads of the housing care manager started to build. So right now we have seven housing care managers, and we are looking to add about six more to our team hopefully by mid next year. And so total enrollment, so when I did this slide, we had 323 patients, but we now have 347 patients. And so broken down into sections, our housing transition navigation patient enrollment is at 270 and our tenancy and sustaining services enrollment is at 77. Our case managers hold a caseload of 50 patients per caseload. Next slide.

And so here are some internal marketing strategies that we utilize. St. John's is very big, we have over 100 providers, medical assistants, LVN, so we wanted to get the word out. So our outreach specialist is stationed at our homeless drop-in center over on Avalon to conduct outreach for both CS and ECM. We have CS and ECM case managers that are stationed at our larger clinics, in heavily homeless populated areas. So that would be our Williams clinic, which is here over on Slauson and Hoover. We have our Avalon center. And then we also have our Rolland Curtis center, which is near USC. So our care managers attend community events that are hosted by St. John's for all different departments. And so in training everyone on what our program is and what we do, we make sure that we had individualized emails for both ECM and CS. And we also make sure that we have flyers at all locations in clinic lobbies, exam rooms, provider areas, and on the mobile clinics for ECM and CS. Next slide.

And so some integration. We noticed that at the beginning because we're so big, I was like, "How do we get the word out about our program?" We started to send monthly emails to all our providers, clinic managers regarding the eligibility and referral process, which really helped. Our program managers will go to different departments within St. John's and do presentations about the program. Our housing care managers and our program managers, again, they send monthly flyers to all clinics. And then we have in a collaboration with external agencies. Right now, our outreach specialist goes two times a month to a church who has a drop in center. So she's also there for outreach and support of the folks that joined those drop in centers over at the church. And so St. John's also has the monthly food pantry at two different locations. One at our Crenshaw location and at our Avalon location, we encourage our housing care managers to have their patients visit those food pantries, they get about two bags at each one and we make sure that our outreach specialist is there as well. Next slide.

And so we wanted to figure out how can we get the word out about our program and let others know that a patient is in our program. So we do utilize eCW and we have a global alert set for our patients. So if the patient is in Community Supports, when you

go to put a patient in, you will see housing navigation services and they'll know that that patient does have a case manager for housing here at St. John's. Next slide.

And so our housing navigation workflow looks something like this and you'll see the tools on the next slide, but we have our housing assessment tool that we utilize, our housing support plan. We have a housing navigator as well, and as she is very helpful in our community, she goes to different landlord events and she assists with credit repair, which is great. And then hopefully after all of these things we can give the patient housed, though it's easier said than done. Next slide.

And then I just wanted to show a small little summary of the different forms that we use. So the first form is our housing assessment tool. And this is done upon intake, before patient is enrolled into the program. We have our housing consultation form that we utilize that has things like the housing status of the patient, HMIS information, CHAMP information, if the patient has a voucher. And then we also, what I like the most about this form is it does include SMART goals. We want to have SMART goals for all of our patients because the road to housing is a road, and it's a long road so we want to make sure that we stay on task. The next slide.

And so for our tenancy and sustaining service, we have four goals here. So one would be our tenant and landlord relationship, we feel like that is the key to stable housing. Budget management, healthcare management, that's when our ECM coworkers come into play, and then social support. So we feel like these four goals will lead you to stable housing. Next slide.

And again, here you'll see our individual lives housing support plan that we utilize for all of our patients with things it does, like we do a thorough housing assessment. We have the medical summary here. Section five is most important to me, I like to have as much follow up as possible because this is a long row. We want to know what interventions worked, what didn't work. Also, referrals needed in section six. And next slide.

We have our proof of unit viewing form that we utilize when case managers are going to unit viewings with patients. We want to make sure that the patient signs whether they like the unit or not, we have our budget plan that they utilize. Next slide.

And our collaboration method, this is going back to our housing navigator. And so once a week our case managers meet with our housing navigator and they discuss different roadblocks that they have with the patient. Our housing navigator will come up with different leads that she may have, leads or connections within the community, which is helpful. We rely heavily on our housing navigator and we're trying to create many housing navigators within our case managers. But we really look to her for support because like Kyle said, the stock is so low and especially here in LA County. Next slide.

Alrighty. And so lessons learned, what's going well for us right now? CalAIM as a whole, we're starting to collaborate, the collaboration has increased. Our ECM and CS, I noticed that they are doing more case consults together, going to viewings together, making sure a patient comes for their appointment and things like that so that's increasing. Our provider and clinic staff support is increasing and I've noticed that our housing case managers, they feel more comfortable in their scope of work and their workflow so I'm happy to say that. Some things that we need help with, I'm

sure everyone on the call will say the same thing. Billing, claims, capitation, those type of things. And in a perfect world, our wish list, we'd have universal rules for all health plans and a streamlined system regarding like overpayment, claims needed reports, those type of things. Next slide.

And I just wanted to add our information here just in case anyone had any tips or tricks they'd like to send to me. And then if you had any questions for me or our program manager, Jaime Lopez, here's our contact information. Feel free to reach out. Thank you all for having me.

Jill Donnelly: Thanks so much Ann. And many of you are already using this, but just a reminder that the Q&A is live. We've got a lot of 31 questions answered so far and we've got folks on from DHCS as well as all of the great presenters you've heard so far answering in there. So feel free to throw questions in there. And now we will move on to Sarah Mahin. Sarah is the director of Housing for Health at LA County Department of Health Services. I'll hand it over to you, Sarah.

Sarah Mahin: Great, thanks so much. Really happy to be here with you all this afternoon. If you move to the next slide, it'd be great.

I'm here really to talk about a model where a county can step in and be a community support provider, but do so by directly providing services, but also through an established subcontractor network to help really facilitate connections between NCPs and our county's homeless system and the over a hundred non-profit homeless service providers that we have across LA County, all of which don't have capacity to directly enter into contracts and provide these services with plans. So happy to be here with you today to talk a little bit about what this type of model looks like.

A little bit about Housing for Health. Housing for Health is 10 years old. We were created in 2010. We are a program office within the LA County Department of Health Services. When we were initially created, our then director Mitch Katz said that we were created so that our doctors could write a prescription for housing, recognizing how important and critical housing is to the health of our patients. Over the last 10 years, housing for health infrastructure has really scaled significantly and been infused with other resources, including funding from other county departments to be able to serve their prioritized populations funding through Whole Person Care, now CalAIM. And most importantly, through Measure H, which was the local sales tax that has generated revenue that we can use to serve the over 70,000 people who are unhoused in LA County every night.

Our philosophy and approach at Housing for Health is really based on three principles, and they're really key because our services are really targeted to people who are experiencing homelessness and have complex health and behavioral health conditions. In partnership with Department of Mental Health, we really function as the high acuity arm of our local homeless services system and work really closely with our continuum of care leads as well as all of the, again, just amazing non-profit service providers. The three principles that we're based on is first, housing first and really that we're offering housing to people without any preconditions, that we're removing all barriers that we can for entry into housing, that we're operating under principles of harm reduction and ensuring that people are treated with respect, with dignity, with compassion, and that we're really embracing whatever it takes mentality.

So we ask our service providers to be really flexible and meet people where they're at and wherever that might be for as long as it takes. And we hold ourselves at Housing for Health to that same standard, both in terms of how we're directly interacting with our patients and with our clients. But really importantly, with our contracted service providers, it's really hard to do this work and there's a lot of different funding streams that come into homelessness that have different set time limitations, have different sets of eligibility, and the people we're serving are probably going to need services for the rest of their lives. And so we at Housing for Health do the work of trying to braid those time limited funding together in a way that creates long term solutions and in a way that our contracted service providers don't have to worry about it and they can focus on providing the services on the ground. And this has been really important for our approach with how we've approached CalAIM, and next slide please.

So this provides an overview of Housing for Health continuum. Again, we're not just serving DHS patients, we're serving really anyone who's homeless in LA County who has complex health and behavioral health conditions. Our services start with street-based outreach and engagement through contracts with community based providers. We have 70 multidisciplinary teams that are out on the street 7 days a week engaging with people who are homeless, helping to connect them to housing and to service opportunities. We also offer about 2,500 interim housing beds across LA County. About 800 of those beds are recuperative care beds that provide medical and psychiatric oversight. We also offer a range of permanent housing interventions. The first is a homeless prevention program that's actually very exciting, that uses predictive analytics to identify people who are likely to become homeless and provides time limited services to stabilize them in the housing, we're doing research on that.

Our largest program and continues to grow every year is our permanent supportive housing program. Thanks to Measure H, the county has made a commitment to match services to all housing subsidies that can become available to create as much permanent supportive housing as possible. We now braid in the CalAIM funding to make that a reality, and we have over 18,000 people who are connected to housing subsidies and in housing through our permanent supportive housing program. This is a lot of where our housing navigation and tenancy sustaining services is happening. And then we have an enriched residential care program that supports about 1,200 people and who are placed into adult residential facilities and residential care facilities and need daily supervision and care. We also have a county wide benefits advocacy system that connects people to social security, VA and CAPI benefits, and then some robust clinical services, including a medical clinic here in Skid Row, mobile medical clinics that rope around LA County to provide primary medical care to people who are unsheltered as well as other clinical supports that wrap around the programs above. Next slide please.

So Community Supports and Housing for Health progress. We have six plans in LA County and we are contracted with all six. We're currently contracted for our housing navigation services, for tenancy sustaining services, and for recuperative care. We're in process of expanding our contracts with our plans to include housing deposits and personal care, homemaker services. We offered all of these services plus more under Whole Person Care, which meant that on 1/1, we transitioned over 11,000 clients who were grandfathered into community support services. And as of a few weeks ago, we had already submitted over 10,000 referrals to local plans for Community Supports and provided community support services to 18,000 people in LA County. Next slide

please.

So talk a little bit about how we implemented Community Supports in the next slide. The first is that we really leverage our existing infrastructure. So as I mentioned, we have contracts with community based providers, over a hundred of them already. And we have expertise and how do we braid funding together to be able to ensure that that services are continuous for someone, that we're meeting someone's needs at all time, and really keeping things as simple as possible for our contracted service providers. So we absolutely had this structure that we were able to leverage and excited to do so for CalAIM. We had an existing data system that we used under Whole Person Care called CHAMP with [inaudible]. In anticipation of CalAIM, we built out functionality so that we could track services, which we have turned into claims where we can track care plans across our 100 different service providers, assessments across our 100 different service providers so that was in place on day one, before we even had contracts.

We also were able to leverage just in-house expertise that we have at Housing for Health in housing services, in really scaling large systems so that has been critical to our work. We also, knowing a lot more, particularly around documentation, a lot more requirements of our contracted providers to document the work that they're doing so that we can demonstrate that to the plan through claims and supporting documentation. So we have amped up our training team to support both our staff and our contracted providers. And then we have leveraged existing in-house staff that we have for data analytics and IT support so that we can really drive performance based on the things that are critical for our plan partners in terms of getting the supporting documentation and claims. Next slide please.

So some things that we did as a county entity that's using this subcontractor model, we have really centralized a lot of the CalAIM functions at our office so that the contracts and the services on the ground for our contract providers really look the same. And we do a really do the sort of things that are plan facing here at Housing for Health. So one of the key things that we did, we worked with all six of our plans and our continuum of care partners so that we really integrated Community Supports, particularly housing navigation and tendency support services into our existing workflows for the coordinated entry system. Housing for Health provides the case management services for 90% of the permanent support of housing in LA County so we were able to successfully integrate CalAIM into those workflows.

We also are at Housing for Health directly screening, assessing and referring all members for community support to the health plans, and we're managing all the authorization and appeals processes so that our contracted providers don't have to worry about that. As I mentioned before, we're building out our data system, continuing to do that so that our providers can just enter what they're doing and we on the back end can pull out what we need for community support claims and supporting documentation and transform it into the right format and get it over to the health plans. And we're overseeing that entire claiming process, including submissions and reconciliation of claims. And we also support our service providers with helping people get connected and staying authorized with Medi-Cal, Medicare, various kinds of processes that are not always familiar to homeless service providers. Next slide please.

So the next slide, we'll talk a little bit about some things that we think at Housing for

Health.

Sarah Mahin: Talk a little bit about some things that we think at Housing for Health are opportunities for greater collaboration with health plans and with the state. There's really two primary buckets, and I think I'll be reiterating some of the things that were said before by my colleagues. The first really has to do with standardization, but in particular having a standardized member level information file. As of October 20th, we don't have common understanding with our plans around everyone who's enrolled and community support and who was grandfathered in, and this is because unlike ECM, you don't have a missed file. And so, we don't have a full confident list of everyone who we're serving that was grandfathered in or has been approved and services. The second is, and Kyle really spoke to this well earlier, but really opportunities for better alignment and workflows, so that we can increase efficiency when we're doing it at scale, particularly at the scale that we're doing it's really helpful.

It also helps to minimize risk for errors and it reduces time that people are spending doing redundant work. And, then the second piece around standardization is we're now in our first round of claims and realizing that while there's some guidance from the state that's really helpful, there could still be a room for more standardization on claim structure, on required data elements, on how HCPC codes are used, as well as what is appropriate supporting documentation, so that there's standardization across health plans and they can all feel confident that they're meeting the expectations of the state. And, then finally it really getting information on adjudicated claims, so that we understand if something is denied, why it's denied, so that we can remedy it if possible. That concludes my presentation. Thank you so much.

Jill Donnelly: Thank you so much, Sarah. All right, we'll now move on to Tracee Roque, who is the manager of community support services at Inland Empire Health Plan. Tracee?

Tracee Roque: Hi everyone, and thank you so much for having me. My name is Tracee Roque. I am the manager of Community Supports at Inland Empire Health Plan.

So, DHCS invited managed care plans begin offering a menu of community support services. As you're well aware, 14 of these services were pre-approved. IEHP chose to roll out with 11 of the services effective January 1st, and three of these services really focus on assisting our members with securing and maintaining a permanent home setting, and those services are housing transition, navigation, tendency sustaining and housing deposits. So, just a quick summary of the services. This is usually what we share when we are looking for providers to provide the services and/or discussing them with internal team members that may need to know how to access the services. So, housing transition navigation services, this is going to be where the provider is screening the tenants, performing a housing assessment, identifying the members' preferences, any barriers that may relate to successful tenancy, and then searching for the housing, assisting with advocation for benefits or for advocating on members' behalf with the landlord, engaging with that landlord, identifying vouchers, et cetera.

For housing deposits, these are meant to assist with coordinating and securing one time services or modifications. This should be modifications or services that are necessary to enable a person to establish those basic household items, and we do not pay for room and board. So, rent is not included in this. We will cover first and last month's rent if it's a requirement by the landlord in order for a member to secure that

home. Set up fees are included, deposits for utility, security deposits, et cetera. Housing tenancy and sustaining services, so this would be where our providers are identifying and intervening early on if they identify those behaviors that could jeopardize members' housing. So, perhaps they need to coach and develop them on establishing those key relationships with their landlords, their property managers, and again, advocating on behalf of member in an attempt for a member to remain in that permanent home.

So connecting our members, it took us some time before we figured out our best practices and how to really engage with our members. We wanted them to know about the services as well as our providers. So, the referral methods are pretty flexible. A member can be referred for these services via fax, via provider portal. We have a provider portal that our contracted providers have access to, as well as our ECM teams. So, they are able to go in and refer a member through that portal, and then of course, phone. So if someone was calling in, sometimes members call in and they can self-refer through member services. Referral sources, so this is where we see our referrals coming from. PCP, primary care providers for our members, specialists, it is open to even members' GI doctor if they're going to gastroenterology. It also is open to our behavioral health providers.

And, then of course our internal care teams. Excuse me, so for example, maybe somebody is already working with the care manager within ECM, or perhaps they're working with the care manager on our housing team. These members can be identified internally by IEHP teams and then referred over for evaluation. The chart to your right, I hope it's your right, it's my right, this is the total number of approved authorizations per community support service. This takes into consideration those that were first approved back from January 1st. Numbers are a bit outdated, so I wanted to give you those current measures right now. We have a total of 5,900 approved community support services. So, that shows you just how large this volume is. Housing services are the three main services approved for. I know deposits is a bit low, but again, you have to remember it's really dependent on those members that need it and those members that have successfully been housed at this point.

So as of today, I actually have 607 approved tenancy sustaining authorizations, so that number grew a bit. We have 2,680 approved transition navigation authorizations, that number has grown a lot, and for housing deposits, 100. So, the numbers continue to increase. Our referral workflow, I wanted to give you an idea of what we see internally for the referrals. So, obviously someone, somewhere submits the referral, whether it's a provider on an internal care team, it goes through a criteria check, either at our UM point of contact or within one of our internal teams in behavioral healthcare management.

So, they will run the members' documentations or the referral supporting documentation up against the criteria we've established as a health plan. Assuming member does meet criteria, we will then approve an authorization to one of our contracted providers. Currently, we have roundabout figure eight providers that are providing the housing services, and what we have found to be the best approach is that those providers provide each of the three services. So, it's that continuum of care consistency for the member. It hopefully alleviates that confusion. And the final thing, and probably the most important is really closing that loop. Did member in fact get those services during that month, even if member hasn't yet been housed? And, finding out which members have in fact been housed, and for those that have not

been housed, what step of the process are they in?

So again, just touching on best practices that we have found that work for us, and sometimes we found those retrospectively once the program was already fairly along the way. The first one would be confirming that contracted providers have the ability to provide all three housing services. So, initially we did have a couple of providers that would only contract for transition navigation. Well, I think best practice would be that they also contract for the deposit piece and the tenancy. They all go hand-in-hand, and again, to my point earlier, it just alleviates that confusion for a member. They build that trust with those providers and there's consistency for them. Secondly, open communication with our housing and CS team. So, we have an internal housing team, which is separate from my Community Supports team. However, because we are both very much so involved in Community Supports as a whole, it's very important that we remain in constant communication. What is working, what is not working? What does volume look like? Have we run into barriers? And, just keeping that open communication with our providers as well.

Then, there's the sequence of events. So following the sequence, really starting with that transition navigation piece, assisting that member, making sure that you are finding the most appropriate setting for member. Again, addressing any barriers for that member, working towards the deposit piece, and then finally, the tenancy sustaining. How do we assist member with sustaining this permanent home? We do have at times where members maybe only have a piece of the transition navigation service, and then it goes into tenancy sustaining, but really understanding the flow of events and what works best for our members, and last but not least, internal tracking of deposits. As you know, there is a cap on housing deposits. We attempt to only work with one provider, although I'm sure you've run into the same thing where there may be more than one provider requesting this type of service. So, really having an understanding internally of how you're tracking those deposit amounts, and you're tracking who has received an authorization already and what you've been billed for.

And my favorite part is, of course, sharing our success story. We had a member that was living with their brother. The member had moved in with his brother because of a recent loss of mom and sibling due to COVID-19. Member's brother then decided to sell his home, and so that resulted in member living in his car. Member himself ended up becoming COVID-19 positive, which obviously led to some anxiety and fear of what were the next steps, how does he get better? And not only how does he get better, where is he going to live? Luckily, member was referred to ECM and the ECM team was already working with member on care management, identified that member could possibly benefit from a referral to Community Supports, and went ahead and processed that referral over for member.

Member was approved for housing transition navigation services. Under this service, we were able to provide temporary shelter at a hotel for the member. We also assisted member with applying for an emergency housing voucher and member was able to move into his new home on July 6th. And again, just the importance behind this is really watching our mission and our vision come to life with each story and each success of our members. So, I put here in the little purple boxes, "We will not rest until our communities enjoy optimal care and vibrant health." And, I feel like that's really what we are attempting to do under this umbrella of Community Supports.

Next steps for our plan, we're going to continue to evaluate the volume of referrals

and provider capacity or gaps in the network, just like with anything else. Sometimes you don't have appropriate access for members in specific regions, and so really looking at our expansion across zip codes and looking to make sure that our members all have consistent access regardless of demographics. We also want to consider incentives, whether it be through HHIP and/or the incentive payment program, so look at how we can kind of build a robust network when and if needed by utilizing these incentives that we've been given. We want to look at cost savings, so since January, it's really just been go, go, go. We've got to look at criteria and we've got to build processes and we've got to get these support services in front of members and providers, and now we're working with approvals and denials and that good stuff.

But, I think because it's been so fast-paced, we really need to step back. We need to take a deeper dive into those members that are being referred and look at, how are we saving cost and how are we really keeping members in the least restrictive setting as possible and keeping them in that community? Last but not least, we are looking at our closed loop process. Currently, it is very, very manual. So, it's a lot on the teams internally and then of course on our external partners. So, we are considering an automated approach to this, so that will definitely be... It's actually already in the works, so hopefully by end of year we have something solid.

Jill Donnelly: Great. Thank you so much, Tracee. We have a few minutes left for some Q and A. There's some robust conversation happening in the written Q and A, but we have some questions we can try to answer live here. So, I will throw this first question to Neha. Neha, there's a question around limitations for Community Supports. Can these services be combined with other Community Supports like environmental accessibility adaptations or asthma remediations, or any others?

Neha Shergill: Sure, Jill, I'd be happy to take this one. So, in instances where the member is eligible for multiple community support services and would benefit from receiving more than one community support, the member may receive those supports concurrently. So, something to note here is that not only can the supports be combined when the members are eligible, but some supports must be delivered together. So for example, members must be receiving housing navigation services when they are receiving housing deposits.

Jill Donnelly: Great, and I know that was something that was coming up in the written Q and A quite a bit is whether those had to be concurrent. Next question, maybe Tyler can answer. Tyler, we have a question about allowable uses for housing deposits. Can you clarify what's being covered in housing deposits? For example, are deposits just for setting up a lease for our residents, or can they cover utilities or other setup fees?

Tyler Brennan: Sure, I can answer that. So, the housing deposits community support not only covers the deposits required as part of a lease for an apartment or on a home, but they can also be used to cover deposit in first month coverage for utilities like phone service or gas or electricity based on the member's need.

Jill Donnelly: Great, and it sounds like that would also need to be cleared by the plan, is that right? That was a question we heard a bit as well.

Tyler Brennan: I'm sorry, can you just repeat that last part?

Jill Donnelly: Just that the MCP would also be involved in determining what's covered under the housing deposits.

Tyler Brennan: Absolutely, the MCPs are always involved and always responsible for making that medical appropriateness and cost-effectiveness determination.

Jill Donnelly: Great, there's another question here about limitations. Are all three of the supports we talked about today once-in-a-lifetime supports?

Tyler Brennan: Sure, I can take that as well. The answer to that is no, not all of these supports are subject to once-in-a-lifetime limitations. The housing transition and navigation services are available for as long as necessary as identified in the member's housing support plan. The housing deposits and the tenancy and sustaining services are available once in a lifetime, with the exception that they can also be approved one additional time under certain conditions.

Jill Donnelly: Great, and to find out more about those conditions you could look at the Community Supports policy guide that we've linked here, yes?

Tyler Brennan: That's correct, yes.

Jill Donnelly: Great, maybe I will throw one back to Neha. We've had a few questions in the chat about rates. Can managed care plans set rates above those listed in the pricing guidance or different from those listed in the pricing guidance?

Neha Shergill: So, the pricing guidance is designed to serve as a tool to support discussions regarding rates, but it is non-binding to managed care plans or community support service providers. So, the managed care plans may offer rates that are different from those outlined in the document, and then also, just to note here, that the reimbursement rates are not set by DHCS, but DHCS has provided non-binding pricing guidance for all Community Supports, and we can also share that link in the chat.

Jill Donnelly: Great, we'll drop that in, and regarding pricing guidance for deposits, the non-binding Community Supports pricing guidance document suggests $5,000 as a recommended maximum. I know we talked about this earlier, but are providers and plans able to negotiate that limit as well?

Neha Shergill: Good question, I'm happy to clarify that. So just like the rest of the non-binding pricing guidance, the suggested limit is just a recommendation. So, there is no set maximum for deposits in place from the state, but we have heard from plans and providers that the cost drivers and assumptions outlined in the pricing guidance have been helpful. And so for housing deposits, we do recommend MCP's review HUD's Fair Market Rents resource. It's a really handy tool where you can filter by state and county to find the most up-to-date rental information.

Jill Donnelly: Great. All right, well, I see we're at time. I want to just thank all of the wonderful experts and folks in the field who have presented today, and thank you everyone who has joined and stuck with us for 90 minutes. As we mentioned at the beginning, slides and a recording of this webinar will be available in the coming weeks on the DHCS website. So, thank you all, and I also wanted to remind you about an upcoming... The next one of these, the spotlight webinars will be at 1:00 PM on November 3rd on

personal care, homemaker services, and caregiver respite. Thank you all and have a good rest of the day.