CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
1115 WAIVER RENEWAL
HOUSING/SHELTER EXPERT STAKEHOLDER WORKGROUP

Wednesday, January 14, 2015
10:00am – 3:00pm
USC State Capitol Center, Room E, 1800 I Street, Sacramento

MEETING SUMMARY

Members present: Lisa Bates, California Housing Finance Agency; Kelly Brooks Lindsey, California State Association of Counties; Cindy Cavanaugh, California Housing and Community Development; Vitka Eisen, HealthRight 360; Dave Folsom, St. Vincent de Paul Village Family Health Center; Dena Fuentes, County of San Bernardino; Courtney Gray, San Francisco Health Plan; Jonathan Istrin, Libertana Home Health; Marty Lynch, Lifelong Medical Care; Ed Ortiz, Health Plan of San Mateo; Shirley Sanematsu, Western Center on Law and Poverty; Ben Schwartz, California Tax Credit Association; Cathy Senderling, County Welfare Directors Association; Doug Shoemaker, Mercy Housing California; Ann Warren, Community Health Group; Carol Wilkins, ABT Associates.

Members on the phone: Peter Lynn, Los Angeles Homeless Services; LaCheryl Porter, Skid Row Housing Trust; Neal Richman, Westside Center for Independent Living; Kathy Moses, CHCS

Members Not Attending: Clayton Chau, L.A. Care Health Plan; Ann McLeod, California Hospital Association; Rusty Selix, Mental Health Association of California; Marc Trotz, Los Angeles Department of Health Services.

Others Attending: Hannah Katch, DHCS; John Shen, DHCS; Rebecca Schupp, DHCS; Efrat Eilat, DHCS; Urshella Starr, DHCS; Wendy Soe, DHCS; Kiyomi Burchill, CHHS; Rachel McLean, CDPH; Bobbie Wunsch, Pacific Health Consulting Group; Sharon Rapport, Corporation for Supportive Housing (CSH).

Members of the public attended the meeting.

Welcome, Purpose of Today's Meeting and January 28 Meting, Feedback on Summary Meeting #2, Introductions of Workgroup Members
Bobbie Wunsch, Pacific Health Consulting Group
Bobbie Wunsch reviewed the agenda. Clayton Chau from LA Care also was invited to present information on health plan efforts to address housing in the afternoon session today but due to a meeting conflict he is not able to join the agenda. Ms. Wunsch provided an overview of the six other waiver workgroups. The final waiver will integrate the ideas from across the workgroups. It will be difficult to discuss what the overall waiver includes until the workgroups

have concluded their meetings. A discussion of the preliminary draft of the integrated waiver proposal will be discussed at the Feb. 11th meeting of the Stakeholder Advisory Committee (stakeholder group for the current waiver). There will be a presentation of budget neutrality and Federal/State Savings on January 30th.
(http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Wrkgrp_DL_1-21-15.pdf)

DHCS Goals for Waiver Component on Housing: What Can Be Included in 1115 Waiver Renewal and What Can't Be Included
John Shen, Department of Health Care Services

John Shen offered introductory comments and his appreciation to the workgroup for the interest and ideas they are contributing. You are helping DHCS learn and explore strategies for how to address housing in a health care context. We have learned there are potential savings if we implement a different way organizing services. One topic that is coming forward is care coordination/care management and the need to focus on the individuals who are not able to maintain stable housing without support services. We also hear that support services improve the operation of the housing. If Medi-Cal is tapped for support services, there is potential that more local funding, such as the Shelter Plus Program, may be shifted to support access to housing units. The 1115 waiver, by itself, will not solve housing problems. There are many constraints such as the five year time frame of the waiver and the need for capital funding. The waiver is about using existing health dollars in a creative way that will generate savings that can be channeled toward development of additional housing. There can be conversations beyond the workgroup and the waiver renewal proposal timeframe to solve some of those constraints, like access to capital funding. Gradually, the entire Medi-Cal system will be managed care. Currently 8 million of the total 9+ million are in managed care and this means the state has a long term commitment to using health care financing in the most cost effective way. The 1115 waiver is a tool the state uses to move toward its overall goals.

What will and will not be included in the waiver? There is a CMS and DHCS concern that health care resources cannot become housing – rental subsidies or capital financing. This process is exploring how to push the boundaries on these constraints but the red line does exist. These are unlikely to be approved by CMS, however, we can talk about how to be more creative with local partners and how we can figure out the overall need for housing. First, we can include in our proposal to CMS services--case management and support services, that reduce hospital admissions and emergency room visits. Second, if Medi-Cal services can fund part of the picture, what are the local partnerships that will produce housing units because of the new support services through Medi-Cal? Third, what are the incentives/incentive pools for health plans to spur the creation of more housing? Much of the discussion indicates that communities and local partnerships are unique to each place and they vary across the state. We are looking at how we might start with pilots in specific locations and expand over the five year timeframe.

Member Questions and Comments

Shirley Sanematsu, Western Center on Law and Poverty: To set a timeframe for the waiver proposal, when will you submit? Do you engage stakeholders after the end of the workgroups?

Bobbie Wunsch, Pacific Health Consulting Group: The proposal will be submitted to CMS in late February/early March and then a six month period of negotiation begins which can change the proposal substantially. The waiver approval needs to be in place by end of October 2015. There will be periodic updates on the process with the negotiation. It is unlikely the workgroups will be reconvened but there will be ongoing communication. Phase 1 is the stakeholder workgroups; Phase 2 is writing the proposal; Phase 3 is negotiation with CMS; Phase 4 is finalizing terms and conditions; and, Phase 5 is implementation of the waiver.

Marty Lynch, Lifelong Medical Care: Communication is a good thing. Even if you are not planning to reconvene the workgroup, letting us know where the housing issue lands will be appreciated, so we have information about our efforts here. I want to confirm what I heard in your comments about what will and will not be considered?
John Shen, DHCS: Care management will improve outcomes so we will consider basic coordination and case management. Second, what is freed up through Medi-Cal financing of care management? MSHA and other local dollars fund some of this currently – so what are the opportunities to substitute Medicaid and use those "replacement" funding sources differently. Finally, how do we structure incentive ideas?

Doug Shoemaker, Mercy Housing California: What is the role of the legislature in the waiver process?
John Shen, DHCS: Much of what we pursue requires legislative authority, such as Cal MediConnect. There will be a set of initiatives that we will seek legislative support for.

Kyomi Burchill, CHHS: The process is a contract between CMS and DHCS. The legislature is an integral partner and they have been receiving ongoing updates.

Doug Shoemaker, Mercy Housing California: Your description of what is possible sounds very reasonable. Lacking specifics on the incentives and the specific structures for making this work, it is harder to understand how to advise on this aspect. What is the role of the workgroup in developing concepts that go beyond the waiver and may require legislative support?

John Shen, DHCS: This should be a major discussion today. On incentives, what is the source of the incentive funding and how do we structure this, so it is not one time. The pool of incentives is the savings achieved by what the cost would have been without a change vs the actual cost based on a new way of providing support. Let's think broadly about the Medi-Cal system.

Confirm Target Populations for Housing Efforts in 1115 Waiver Renewal Proposal and How Other States Have Addressed These Populations in Waivers
Rebecca Schupp, DHCS
Presentation slides available at: at http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Housing.aspx

Rebecca Schupp presented information to begin to define target populations. Skilled Nursing Facility (SNF) and Chronically Homeless Population. We estimate there are about 7,000 beneficiaries currently in nursing homes who do not have to be in SNF. The exact target population and the numbers for the waiver are unknown. Using some proposed criteria, chronically homeless high utilizers statewide are estimated to number 60,000.

Jonathan Istrin, Libertana Home Health: Can you clarify the chronic homeless definition?
Sharon Rapport, Corporation for Supportive Housing: This number uses the HUD definition. This refers to those in supportive housing and need ongoing services to remain in housing who were previously chronically homeless. This does not include those housed in institutions, like a SNF but the SNF population is included under the first target population.

Vitka Eisen, HealthRight 360: Does this includes those incarcerated?
Rebecca Schupp, DHCS: It excludes them.
Sharon Rapport, Corporation for Supportive Housing: They would be included if they were in jail less than 90 days and were homeless prior to incarceration.
Vitka Eisen, HealthRight 360: If they are incarcerated for longer, what category would they quality under?
Sharon Rapport, Corporation for Supportive Housing: They would not qualify.
Rebecca Schupp, DHCS: They could quality under chronic homelessness if they meet the target population definition there.

John Shen, DHCS: We are looking at the Medi-Cal database to identify high utilizers for ER and hospital inpatient stays and we don't have information there about who is homeless. In the Medicaid waiver, we are looking at how to solve the high cost health care issue with new services in housing, we are not looking to solve housing overall.
Vitka Eisen, HealthRight 360: I would offer to you that they are receiving high cost care via the jail and are very high cost individuals.

Rachel McLean, CDPH: There are some incarcerated populations that do have health care billed to Medi-Cal and it seems useful to include at least that part of the incarcerated population. Does double-up housing or couch surfing qualify as homelessness?
Sharon Rapport, Corporation for Supportive Housing: No, they are not in the HUD definition and there is no indication that population is high cost to Medi-Cal. I like your point that high cost, incarcerated could be included.

Kelly Brooks Lindsey, California State Association of Counties: Counties are not able to claim for incarcerated individual who are sent out for hospitalization and billed to Medi-Cal now, however once there is a claiming protocol, we can offer data on that.

Cindy Cavanaugh, California Housing and Community Development: How does this expand services for SNF populations? Don't they currently quality for the services we are discussing?

Rebecca Schupp, DHCS: Not all SNF are eligible to receive waiver services and usually the services provided are more medical care coordination and habilitation services that are more medically oriented and do not include housing coordination and navigation.
John Shen, DHCS: Even though they are eligible for waiver services, there may not be housing for them.
Cindy Cavanaugh, California Housing and Community Development: This won't create housing.
John Shen, DHCS: We want to make them more able to be in stable housing.

Carol Wilkins, ABT Associates: I thought you were describing people staying in SNF who do not need to be there but have no housing for discharge. If they qualify for home and community based services (HCBS), isn't it required that they meet SNF-level of care? They don't need SNF for medical reasons, don't have a home to discharge to and also they may not quality for HCBS waiver services? Is that the gray area we want to target?
Rebecca Schupp, DHCS: Yes, there are 3 groups: those who need informal supports only – not daily; those who need help with daily living (IHSS eligible); and, those who need HCBS waiver services. Potentially this waiver could cover all three populations and they could continue to receive housing-based services to keep them housed.
Carol Wilkins, ABT Associates: Yes, these are folks that get stuck in hospital or SNF but don't have a medical reason to be there.

Ed Ortiz, Health Plan of San Mateo: I want to encourage a broader scope of population. There are a number of at risk populations in the community; frail elderly, incarcerated, those who have had acute events that increase their needs. All are at risk of institutionalization. It is a challenge to demonstrate cost savings vs cost avoidance but I think we should explore this more to broaden the scope beyond the two presented here.

Sharon Rapport, Corporation for Supportive Housing: There have been discussions about who is going to be high cost soon. How do we distinguish between those who will actually be high cost vs those who are in the risk category but do not become high cost?

Ed Ortiz, Health Plan of San Mateo: We can use profiles and data analytics to identify the actual number. We already segment populations by aid code and other ways. We need to drive to the next level to connect the clinical and social component to get to the target.

Doug Shoemaker, Mercy Housing California: A number of us in housing are asked to take over failed housing with many residents who have many needs and are unconnected to services. They are high cost individuals but they are housed. The ability to use health funding to offer services and retain housing seems useful from the savings aspect of the equation.

Bobbie Wunsch, Pacific Health Consulting Group: Maybe DHCS and CHS can think about how to address incarcerated and at-risk populations and how they can respond to this discussion.

Budget Neutrality

Rebecca Schupp presented a graphical depiction of budget neutrality trend lines in relation to housing case management being included in the waiver. She offered a framework for how budget neutrality works through a cycle of services producing savings over time.

Ann Warren, Community Health Group: Savings do take time and it can be a disservice to build in too much, too early. Over time we can change behaviors and utilization but this population will take high touch and time to accomplish the change. Is the spike here due to housing cost?
Rebecca Schupp, DHCS: The slide does include a spike of cost in the early years with savings in the later years. None of the actual housing costs are included. We need to nail down where the savings come from through our discussion.
Sharon Rapport, Corporation for Supportive Housing: Yes, there is a spike due to health care needs being identified. This shows break-even in year 3.

Kelly Brooks Lindsey, California State Association of Counties: How are you thinking about the seed money required upfront, perhaps for data mining with county mental health specialty plans or others?

John Shen, DHCS: There is a lot of work to do here; data mining, changing provider behavior, setting up services. The slide is a general concept to demonstrate how we are looking at budget neutrality in a 5 year cycle.
Wendy Soe, DHCS: This slide is also specific to how we are looking at housing-related services to lower costs or be cost neutral. Waiver Budget Neutrality would demonstrate that we are looking for spending to be lower overall over the full five years in the entire waiver.

Carol Wilkins, ABT Associates: In my conversations with states, they build into models a lag time between enrollment in housing support services and savings – so they budget 12 months of services and 6 months of savings. For some individuals, they have spikes in care due to unmet needs, but we see that the aggregate costs of the group do go down. There is so much to be saved, that it offsets the unmet needs of individuals. The evidence is strong we will get there as a group.

Ann Warren, Community Health Group: I agree, we have seen that in our pilot.

Marty Lynch, Lifelong Medical Care: I agree as well. We have run Frequent User programs with the local hospital and in the first year, we saw fast savings due to reduced ER visits, etc.

Ed Ortiz, Health Plan of San Mateo: I want to point out we are discussing the beginning of a program where we have start up and are building services. It is a good idea to begin to build capacity in the nine months ahead of this.
Marty Lynch, Lifelong Medical Care: Yes, Ed is absolutely right. Once we roll out services, there will be savings.

Doug Shoemaker, Mercy Housing California: Two points: On the cycle of savings, there be a difference in who bears the cost and who saves. On the slide, the bubble should include both state and local savings included – SNF are not local costs. Second, on eligibility: we have a hard time of differentiating between the benefit of getting housing and services vs someone who is already housed and getting case management. We have lots of high utilizers in housing and don't have resources to give them services. The traditional case management services of phone support does not work for these. Going back to Ed Ortiz comment, we should want to include this population with a housing provider doing the case management services as a cost effective alternative. Being on-site brings advantages.

Dena Fuentes, County of San Bernardino: On the point of incentivizing future, new housing. There is a basic level of service in housing but it does not reach the level of intensive case management. If there is a way to incentivize a developer to set aside units for intensive services to gain points in a tie-breaker score plus gain access to services, we will leverage multiple state resources without actually providing additional dollars but through linking.

Ben Schwartz, California Tax Credit Association: I agree. We have top priority for homeless projects and we don't have a chronically homeless category. So, how might we take tax credits to encourage an incentive for chronic homeless?
Dena Fuentes, County of San Bernardino: Mostly, I am talking about a large project where you carve out a small number for chronic homeless, then you get points or go into a special category. It is much harder to get a 100% chronic homeless project approved locally. Cities that see the benefit for affordable housing are looking for a variety of resources to make up for lost resources through redevelopment.
Ben Schwartz, California Tax Credit Association: I agree. The concept of incorporating homeless units in a larger project is coming up more often.
Dena Fuentes, County of San Bernardino: The cities are more comfortable as well.

Marty Lynch, Lifelong Medical Care: Can the state talk about the elderly population issue where we would see savings in Medicare? I assume you are claiming calculations in the waiver for Medi-Cal, do savings from Medicare tie into the budget neutrality discussion with CMS? Is there any precedent in other states for claiming savings that are shared between federal and state?
Wendy Soe, DHCS: Only the cost to Medicaid is what we can include in the budget neutrality.
John Shen, DHCS: We are not aware of any precedent like this. CCI is the closest thing.

Options for Housing Supports in 1115 Waiver Renewal Proposal
Sharon Rapport, CSH and John Shen, DHCS
Presentation slides available at: at http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Housing.aspx

Sharon Rapport offered context and reiterated the need to be focused on the criteria for options that can be included in the waiver. The options discussion will include funding for services AND trying to identify ways to include funding for housing. Housing-based Care Management services may include tenancy supports and care coordination. She offered

advantages and challenges related to a monthly case rate funding mechanism paid to the health plans for services. Ms. Rapport then presented options for how the case management service funding might stimulate housing opportunities for the target populations. Other states are working on these concepts as well.

Carol Wilkins presented info on Massachusetts CSPEC. There are 10 providers serving 400 consumers and they are scheduled to double the number this year. Under managed care, the state contracts for diversionary services to stay out of the hospital. Community support services that are nonclinical services include linkage to services, navigation and others. These services were intended to link people to housing for a number of months while they are being connected to programs funded through other sources. The most recent waiver includes language that the health plan will be paid actuarially sound rates that include both cost of health care and the diversionary services.

Sharon then presented information from Minnesota where a housing stabilization services aspect that was proposed but dropped prior to CMS approval; Louisiana used a 1915i waiver option to contract for services; and, Texas used the 1115 waiver to create regional incentive structures to pay for housing based services.

Member Questions and Comments
Rachel McLean, CDPH: Can you specify "housing-based?" Does this include nonprofits doing outreach or have relationships with housing organizations but are not a housing agency?
Sharon Rapport, Corporation for Supportive Housing: Yes, it should include both housing organizations and other agencies who have expertise to reach the target populations.

Marty Lynch, Lifelong Medical Care: The link with community based organizations that have access to housing vouchers, like FQHCs, is important. We have relationships that give us access to consumers who are being discharged and have developed relationships with housing partners. It is important to link payments to the health plan with requirements to work with service organizations to ensure we encourage local, effective service providers and don't default to large, out of area providers.

LaCheryl Porter, Skid Row Housing Trust: Can you go into detail on the funding mechanism? Also, can you speak to how we make the connection to potential target populations if we don't have a relationship with the health care provider?
Sharon Rapport, Corporation for Supportive Housing: Our thinking is that a case rate goes to the health plan and they would contract with service organizations.
John Shen, DHCS: Yes, the health plan would contract with service organizations, with ACO organizations, with FQHCs, etc. An existing homeless service organization that is effective will be a new kind of provider in those systems. They may be contracted directly from the health plan or through subcontract with another at-risk entity.

Cindy Cavanaugh, California Housing and Community Development: Would the health plan identify the target client?

Sharon Rapport, Corporation for Supportive Housing: There will need to be overlapping loops and bi directional relationships for the referrals. The health plan will not be able to identify all those with chronic homelessness. There will need to be a be-directional mechanism where the service provider identify populations as well.
Doug Shoemaker, Mercy Housing California: We need to be clear about the tax credit implications to know if a health plan can be a referring agency. If there is private benefit gained, it has tax credit implication we have to address.

Shirley Sanematsu, Western Center on Law and Poverty: Can we also look at housing-based clinical services such as mental health, substance use services being included in the waiver to address a need for services onsite at housing as a "housing-based service?"

Lisa Bates, California Housing Finance Agency: How do we increase the conversation on the state level? Much of the discussion here is at the local level – but as Doug raised, how might we add a role for state housing programs to support incentives?
Sharon Rapport, Corporation for Supportive Housing: Perhaps the place is in the "more likely to lease to difficult to serve individuals" but there is a need for more discussion on that role.
Bobbie Wunsch, Pacific Health Consulting Group: Perhaps we can convene a small group to discuss this further.

Cathy Senderling, County Welfare Directors Association: I want to encourage flexibility on the case-rate mechanism to include county-based or regionally based entities for smaller counties or others who may need different mechanisms.
Hannah Katch, DHCS: DHCS is open to different options to meet unique needs of counties.

Dena Fuentes, County of San Bernardino: On the state agency and financing topic, we need a balance between how much we are weighting homelessness in the financing of housing units. The consequence will be building less affordable housing in the state so we need to discuss how to balance the options available.

Doug Shoemaker, Mercy Housing California: Ohio has come close to a relationship between DHCS and FHA. FHA would front the funding for housing of seniors coming from SNF if the state paid a share of the services. Kresge Foundation is funding this and could discuss the details.

Sharon Rapport presented the specifics of four funding methodology options developed from workgroup stakeholder input and from community input meetings hosted by CSH. Option one has several separate mechanisms and builds on related elements of the ACA for person centered care improvements.

Option 1: Integrated/Whole-Person Care" System

- Partnerships between health plans, counties, behavioral health plans, hospitals, housing providers, service providers.
- Incentive payments once partnerships created, based on responses to RFP for specific populations

- Savings pool with contributions from health plans, counties, and any others. Savings pool could be used for services or housing.
- Incentive payments to create interim housing & recuperative care programs with housing navigators.

Member Questions and Comments on Option 1:

Kelly Brooks Lindsey, California State Association of Counties: Other advantages to this option is that it builds on the Low Income Health Program local pilots from the previous waiver. I think the whole person care framework is useful to create an overarching narrative for CMS that isn't solely about housing.

Courtney Gray, San Francisco Health Plan: We are trying to do this in a much smaller way with our pilots. If we had incentives and capital to do this, it would be helpful. Pushing the whole person aspect will be helpful.

Ed Ortiz, Health Plan of San Mateo: There are aspects that make sense and I want to think it through. I was thinking of simple ways to include housing in rate calculations – like a CPT code for housing?

Doug Shoemaker, Mercy Housing California: This option is important for several reasons. In order to get this moving at scale, we need upfront housing capital to get the system up and running. Most housing costs are upfront. I can imagine an appropriation or bond to get this operating and then Cal HFA can count on a repayment option thorough DHCS. I think this could be popular among housing groups and staff people within the capital.

Marty Lynch, Lifelong Medical Care: John mentioned wanting to include this model but not including direct housing. CMS has said no, so far. How do we push the ball a bit farther along with CMS even if they say no to us?
John Shen, DHCS: We are looking for that small piece that could accomplish what you mention. What kind of saving that CMS can participate in, such as Doug is suggesting, to advance the conversation? I think directly paying housing providers to develop housing is a no-go; allowing health plans to include direct housing costs in rates is also not likely. Beyond that, how can we create incentive payments to plans for saving health care dollars?

Cindy Cavanaugh, California Housing and Community Development: You list a challenge for option 1 being a delay. Can you speak more about that?
Sharon Rapport, Corporation for Supportive Housing: The option may be similar to an ACO, but without the complexity or delay of establishing a formal ACO. Creating partnerships is complex and may cause some delay but less than an ACO.

Sharon Rapport, Corporation for Supportive Housing Rapport presented additional options. Options are not mutually exclusive – we can take aspects from various options. The state is not likely to pursue option four here because CMS has rejected in the past, but it is important to

include for discussion and potential future development. A related option not outlined in slides is a pay for success initiative from the Governor of Massachusetts. This measure uses private investment to capitalize and start up and would use savings from Medicaid health funding to finance the repayment.

Option 2: Partnerships Between Housing-Based Case Management & Housing Agencies

- State & local housing entities.
- Targeting of eligible populations funding.

Options 3: Incentive Payment to Create Respite Care

- Incentive to achieve specific goal (i.e., reduction in hospital readmission).
- Accessing shelter/hospital beds to provide nurse care & housing navigator.
- For people exiting hospitals & needing nurse care
- Link to permanent housing.

Option 4: Creating a Housing Benefit

- Benefit for eligible members, limited by available money.
- Case rate for housing.
- Potential for Coordinated funding through partnership between DHCS & Housing & Community
- Development

Member Questions and Comments on Option 2-4:

Ann Warren, Community Health Group: It seems good to think of this as a combination of options. How do we maximize each pot of money, housing, health, state, federal, local, all combined to produce the better care and savings.

Hannah Katch, DHCS: As we think these options through, where do we already have infrastructure? We ask a lot of Medi-Cal managed care plans. How do we build on existing partnerships, relationships rather than adding a complexity on top? Is there a way to leverage existing relationships locally and partner with the state?

Ann Warren, Community Health Group: Yes, that is what plans do is take risk and develop systems of care. We so already have a lot of infrastructure in San Diego and every community has those partnerships to build on.

Hannah Katch, DHCS: Yes, so is there a way we can increase your ability to leverage relationships to develop the system of housing and partner with the state to fund support services. How do you see this working?

Ed Ortiz, San Mateo Health Plan: We are doing this in pilot scale now. We partner with the county, IHSS and the housing authority to collaborate and identify housing. We have reconfigured how care is delivered. This has been effective so far. This does take a lot of effort

to build this, change roles within the health plan and many other details that are needed to build a model that can support housing.

Carol Wilkins, ABT Associates: As we think about plans taking risk, it is very different to build this system in a county with a COHS, where members stay in the same health plan for longer periods. Other plans may be hesitant to do this where there is churning in enrollment. Given the difference in how managed care operates in different regions of California, we need different mechanisms for different localities. Perhaps the state can create a state level incentive pool to capture savings for some counties where that is beneficial. There should be models at the state level and at the local level.

Perspectives of Health Plans on Housing: Implications for the Waiver
Facilitated by Bobbie Wunsch

Ed Ortiz, San Mateo Health Plan presented the Community Care Settings Pilot program targeting three high risk populations of beneficiaries: 1) existing long term care residents who can , 2) those at risk of long term care/skilled nursing diversion and at risk frail elderly/chronically homeless. The health plan contracts with two housing organizations and has partnered with county IHSS to develop an innovation on health and social services. This required having to realign with community partners and develop new internal capacities to make this work. Some services were happening but they were in separate departments and fragmented. It was a SNF closure that caused us to become strategic about our options.

Lessons:

- Rate determination does not recognize housing services in subsequent rate payments to Plan
- Targeting and screening participants requires new tools and extensive testing (Prioritization Factors & Case Mix Index)
- Successful placements require 3-6 months of pre-work
- Affordable housing partners are keenly interested in connecting with health care services (set-asides)
- Resource alignment and Health Plan role definition is key to delivering incremental services
- Building new network with non-traditional partners requires significant coordination
- Finding hard-to-reach members has required community partner participation (HRA's, etc.)

Dena Fuentes, County of San Bernardino: What was the impetus to develop the program?
Ed Ortiz, San Mateo Health Plan: The SNF closure was key. That together with the Duals Demonstration encouragement to look at the needs of the whole person.

Shirley Sanematsu, Western Center on Law and Poverty: What is the caseload ratio?
Ed Ortiz, San Mateo Health Plan: It is 20:1 and grows to 25:1. There are two levels of case management: the intensive level of case managers happens with Institute on Aging; following

the intensive level, there is a transition to retention level cases management with Brilliant Corners. The case load is higher than 25 for the retention level.
John Shen, DHCS: What do you mean by set asides and how did you finance them?
Ed Ortiz, San Mateo Health Plan: We worked with the housing authority to accomplish this. The health plan agreed to provide services on site; the housing authority worked with the developer for the set aside. There are two agreements in place so far. It took some time to work this out. We are trying to decrease the duplicative assessments and make sure everything aligns.

Hannah Katch, DHCS: Can you offer details about the 3-6 month timeline for placement?
Ed Ortiz, San Mateo Health Plan: This is the actual placement timing once enrolled in the program. Prior to this are discussions about whether they want to participate and is the person appropriate to the program, etc.

Cindy Cavanaugh, California Housing and Community Development: Did the VA contribute vouchers to make this affordable?
Preston Burnes, San Mateo Health Plan: We work with the housing authorities on vouchers to utilize project-based vouchers. The housing organization we work with already had project-based housing vouchers so we worked to have our participants slotted for those vouchers in return for services provided at the site. We knew that many at this housing site were already our members.

Jonathan Istrin, Libertana Home Health: Was that a new construction? For existing housing, you would have to jump over wait lists?
Ed Ortiz, San Mateo Health Plan: Yes one opportunity is for new construction. I am learning there may be opportunities for existing housing to obtain set asides through financing requirements.

Doug Shoemaker, Mercy Housing California: There are a variety of options. It may have to do with the fact that services are inadequate, needing an operating subsidy, mission or other reason. San Francisco recently opened up the wait list to homeless families only – no one else was able to register. The housing agency can create a preference.

Ed Ortiz, San Mateo Health Plan: in addition, the housing site has many health plan members who may be at risk of SNF. It will makes sense to target the site for both people we want to refer into the site and those already in the site who are at risk of SNF.

Jonathan Istrin, Libertana Home Health: We face challenges with moving people out of SNF because the housing agency is not willing to push the “reasonable accommodation” because of risk of law suits from housing advocates.
Dena Fuentes, County of San Bernardino: It could circle back to HUD also. There could be an equal worry of being scrutinized by HUD. If HUD offered guidance to allow flexibility, it could help.

Doug Shoemaker, Mercy Housing California: There are many areas within HUD and they are siloed. There is a component to the waiver process that could help in working with HUD to offer leadership that helps broaden opportunities.

Cindy Cavanaugh, California Housing and Community Development: There are various populations that want special access and preference. There are other regulatory agencies outside of HUD involved here.

Carol Wilkins, ABT Associates: HUD has issued guidance to say that the housing authority can open a wait list for certain populations, open them daily, and open them monthly. That is the mechanism to create access for a priority population.

Jonathan Istrin, Libertana Home Health: Yes, it is difficult to navigate the local variations in housing authorities and so we have gravitated to tax credit buildings as easier to access.

Courtney Gray, San Francisco Health Plan, SF Health Plan presented information on the pilot. We are about the same size as SMHP but operate in a two-plan county. We have reorganized how we provide services for high cost individuals. Part of that is to offer wrap around services and organize housing through "golden tickets" that may be set asides. It was difficult to track down members and engage them, build trust to get them housed. This is our biggest learning. Another issue was that some people were ineligible due to previous criminal convictions. It takes time to learn about and work thorough the challenges. There is a partnership including the county, clinic provider and the health plan – the golden tickets are from public health, two clinics are on site. We do not contract at this point for housing navigation externally.

Vitka Eisen, HealthRight 360: What is an example of the previous eviction ineligibility?
Doug Shoemaker, Mercy Housing California: Assault or possession with intent to sell or firearms will scare a housing operator. We are used to evictions for other reasons but these are difficult.

Cathy Senderling, County Welfare Directors Association: What is the scale of the program?
Courtney Gray, San Francisco Health Plan: The 50 tickets were one-time opportunity. There are 450 total enrolled. Our caseload is 30:1 high risk/high utilizer individuals to a case manager.

Dena Fuentes, County of San Bernardino: We worked through many challenges in Shelter Plus - one issue was the pipeline of HUD-qualified applicants. It took three potential applicants for every one final client. Also, the expense for housing navigation does need to be built in.

Ann Warren, Community Health Group presented on a San Diego pilot.
Our health plan was founded as part of a community health center that separated about 10 years ago. We have 240K members. We have rapidly changed over the past five years from moms/babies to many high risk populations through SPDs and Cal MediConnect. We have added staff, used predictive modeling to identify individuals with avoidable ER visits and have begun to make home visits and expand high touch case management internally. We have changed the way we deploy nursing staff into SNFs. If they are able to transition from SNF, we work to find housing. I have spoken previously about our partnership with Doug Folsom at the Project 25 as a pilot program. This evolved from a single member with very high costs to the health plan. We used this case as a way to develop the program. Care is on site, mental health

services, clinical care on site, medications are managed, and there are no requirements about alcohol. We are adding 4 more members into program identified through an aid code of homelessness. We are at a very small scale but we plan to expand. We want to partner more closely at SNF to create a SNF-based clinician to evaluate readiness and coordinate care transitions. Our biggest lesson is to get out to community, to home, to SNF and partner more closely with community agencies, like 211.

Rachel McLean, CDPH: What is the threshold for knowing a member needs intensive services? Also, how much saving can we really pull from high utilizers? There must be a finite number.

Ann Warren, Community Health Group: We used inappropriate utilization plus did the individual require services we are having difficulty coordinating. It is often a referral based on health plan staff seeing a fit for the program. Were they asking for many different services beyond medical that were difficult to coordinate and obtain? To the numbers, there are many people with inappropriate ER at a middle tier we do need to assess.

Kelly Brooks Lindsey, California State Association of Counties: We need to design a program that does include the middle tier. We will need to balance the huge savings in a few individuals and the larger group with modest saving per person.

Hannah Katch, DHCS: We really need help with data to help make the case with CMS.

Kelly Brooks Lindsey, California State Association of Counties: Do we have a sense of how big the pilot should be?

John Shen, DHCS: Not yet. We will take the comments today and begin to refine the numbers. We welcome your input about the numbers and size. First, we need to identify the system and the services so we can scale up. The population is difficult to engage, local partnerships need to develop, care management services need to be implemented.

Ann Warren, Community Health Group: Also, partnering with county mental health has been key for us.

Public Comment

Lamar Turner with Elder Focus: I have a comment on the preferences discussion. I worked with a nonprofit housing that had project-based vouchers and wanted to bring people from a SNF into the program. They didn't have a vacancy and were concerned about legality. HUD has preference in housing authority programs but not in section 8 and tax credit properties. They asked us to submit information so that they might develop a legal opinion. That has not be issued yet but it speaks to the difficult of using section 8 vouchers for this population.

Next Steps

John Shen, DHCS and Bobbie Wunsch

Thanks to California Health Care Foundation, Blue Shield of California Foundation and The California Endowment for supporting the stakeholder process. Please reflect on the target populations, the options and the experiences the health plan shared to summarize proposals for the final meeting.

Housing Expert Stakeholder Workgroup Meeting Dates:

- January 28, 2015: USC State Capitol Center, Room E, 1800 I Street, Sacramento