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

Wednesday, January 28, 2015
10:00 am – 3:00 pm
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; Dave Folsom, St. Vincent de Paul Village Family Health Center; Dena Fuentes, County of San Bernardino; Jonathan Istrin, Libertana Home Health; Rachel McLean, CDPH; Ed Ortiz, Health Plan of San Mateo; Shirley Sanematsu, Western Center on Law and Poverty; Ben Schwartz, California Tax Credit Association; Doug Shoemaker, Mercy Housing California; Rusty Selix, Mental Health Association of California; Ann Warren, Community Health Group; Carol Wilkins, ABT Associates.

Members on the phone: Clayton Chau, L.A. Care Health Plan; Courtney Gray, San Francisco Health Plan; LaCheryl Porter, Skid Row Housing Trust; Neal Richman, Westside Center for Independent Living; Wendy Soe, DHCS; Kathy Moses, Center for Health Care Strategies (CHCS); Marc Trotz, Los Angeles Department of Health Services.

Members Not Attending: Vitka Eisen, HealthRight 360; Peter Lynn, Los Angeles Homeless Services; Marty Lynch, Lifelong Medical Care; Ann McLeod, California Hospital Association; Cathy Senderling, County Welfare Directors Association.

Others Attending: Hannah Katch, DHCS; John Shen, DHCS; Rebecca Schupp, DHCS; Efrat Eilat, DHCS; Urshella Starr, DHCS; Kiyomi Burchill, CHHS; Bobbie Wunsch, Pacific Health Consulting Group; Laura Hogan, Pacific Health Consulting Group; Sharon Rapport, Corporation for Supportive Housing (CSH); Maria Funk, LA County Mental Health.

8 Members of the Public Attending

Welcome, Purpose of Today's Meeting
Bobbie Wunsch, Pacific Health Consulting Group
Bobbie Wunsch reviewed the agenda and announced a meeting presentation on January 30th on budget neutrality and Federal/State Savings. 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). Wunsch encouraged all members of the workgroup to fill out the evaluation surveys on the workgroup process.

Confirm Revised Target Populations
Sharon Rapport, Corporation for Supportive Housing and John Shen, DHCS

Presentation slides available at: at http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Housing.aspx

Sharon Rapport presented updated definition of the eligible populations based on input from the workgroup. The biggest change was to expand the definition to include those who had experienced homelessness and incarceration. The focus is homeless individuals who are the highest cost to the health care system, such as inpatient and ED visits. She also presented a clarified definition of who among skilled nursing facility residents will be eligible – those who have no identified need to remain in the SNF but who have an extended stay.

John Shen addressed other input previously received from the workgroup about populations, such as individuals already housed but at risk of skilled nursing facility placement. This population is certainly in need and benefits from intensive case management. However, the 1115 waiver will focus on those with poor health status plus homelessness. High cost populations where we have some evidence that stable housing can lower cost.

Ann Warren, Community Health Group: Is the population either one of the populations or do you need to be both?

Sharon Rapport, Corporation for Supportive Housing: Either.

Dena Fuentes, County of San Bernardino: I am reviewing the definitions with county staff in various departments and there are questions about the choice of the definition. There are differences between the definitions that HUD uses vs. the definition from Department of Education. What is the rationale for using the more narrow HUD definition?

Sharon Rapport, Corporation for Supportive Housing: Yes, in the federal system HUD has a definition that identifies those eligible for homeless assistance housing programs. The Department of Education definition is for the purpose of ensuring no child falls through the cracks and has a home school. This is broad so that children are not excluded based on homelessness or moving among different addresses. The HUD definition is more narrow because that definition identifies who will be eligible for scarce housing resources. We don't see those with unstable housing who are the target of that broad Department of Education definition as a high cost to the health care system. They are certainly worthy of housing but are not the priority for this health care intervention.

Ed Ortiz, Health Plan of San Mateo: I want to understand the decision about the narrow scope of the eligible populations. Some decisions have been made since the last meeting and I want to understand the rationale better.

Shen, DHCS: We know there are populations, like senior housing residents, that need intensive case management. For this waiver, we are looking at those that require housing as well as case management. We are trying to mesh housing with case management needs. We know that there are residents of low cost, affordable housing who are at risk or are high utilizers who need case management. All the saving concepts, the concepts of pooling local funding and other ideas to create housing units are a part of the proposed approach and therefore, we have focused on the eligible populations that brings this together.

Katch, DHCS: Also, we are looking at the highest need for this phase. In the future, it may be possible to expand beyond this population.

Lisa Bates, California Housing Finance Agency: What is happening on the preventative side. I know this is difficult to quantify but are there other workgroups that might be focused on that?

Katch, DHCS: Plans are required to provide case management to all managed care beneficiaries. The health home initiative will be a companion program that may prevent institutionalization. Also, we are focused on the formation and support of partnerships that will go beyond.

Ed Ortiz, Health Plan of San Mateo: The way we are looking at housing is to use it as a tool. When I look at the eligible population, it seems a narrow use of housing as a tool. As long as we have an opportunity to revisit this, let's focus on how to make housing as a tool work. There are other populations who fit these same parameters, who are discharged from institutions that would be important to include. Cost avoidance is a challenge but using housing as a broad tool would be helpful.

Katch, DHCS: We would love to do it all. This is an opportunity to pilot with a narrow definition and then evolve over time as we see it successful.

Dave Folsom, St. Vincent de Paul Village Family Health Center: San Mateo has been innovative in a way other places could benefit from. One upside of the narrow definition is that it keeps us focused on the hardest to reach. The more we can tie the target population definition to those that HUD defines for housing vouchers, the easier it will be to get their buy-in. On the high cost beneficiary, there is no cost savings specified.

Katch, DHCS: We will develop metrics for cost savings. This is only the eligibility definition portion.

Sharon Rapport, Corporation for Supportive Housing: I agree. Sometimes a broad focus results in more focus on higher functioning individuals at a cost to those who need the most support. NY has loosely defined high cost populations and they see the resources going to lower risk individuals – not the higher cost individuals. This may be a lesson for us in starting off.

Clayton Chau, L.A. Care Health Plan: Should the definition for people exiting institutions be exiting institutions OR homeless, not AND?

Sharon Rapport, Corporation for Supportive Housing: We included periods of homelessness to target those who cycle in through institutions and homelessness.

Clayton Chau, L.A. Care Health Plan: I would like to consider the group that is not homeless but are in an institution and we have a hard time placing them to discharge them.

Sharon Rapport, Corporation for Supportive Housing: Are you referring to jails, Instititutions for Mental Disease (IMD) folks?

Clayton Chau, L.A. Care Health Plan: Yes. I'm particularly interested in the IMD folks.

Bobbie Wunsch, Pacific Health Consulting Group: We will come back to this point.

Rachel McLean, CDPH: I have a similar question about the criteria. Would a health plan be restricted if a person had 4 ED visits instead of 5, can they target them? Will plans have flexibility within this?

Sharon Rapport, Corporation for Supportive Housing: I think it's difficult to figure out the exact cut-off. These definitions are based on algorithms to determine what defines a high-cost homeless person but DHCS staff can address the flexibility.

Shen, DHCS: We are still looking at the exact cut off point and how much flexibility will be included. Over the course of the waiver, we hope the conversation will continue and the program will continue to evolve. Over time, with experience we can begin to modify and expand the definitions and target populations. This is our beginning place for calculating cost savings.

LaCheryl Porter, Skid Row Housing Trust: I agree we need a cut off point. Aligning with local agencies, we use a definition of 2 ED visits per year so this is a high threshold.

Sharon Rapport, Corporation for Supportive Housing: This is based on what other programs have used to achieve outcomes for the highest cost homeless people. Some counties and programs do use definitions that are more flexible, but our definition does incorporate people experiencing chronic homelessness. I think there probably a lot of people in the LA program, for example, who would meet the definition by being chronically homelessness.

Dave Folsom, St. Vincent de Paul Village Family Health Center: I'm noticing the cost implications. We want to focus on those who are cycling in and out of the hospital, not someone who has a single very high cost episode in the hospital.

Carol Wilkins, ABT Associates: In a research study that focused on frequent users of emergency room services, those who were most likely to be frequent users year after year were people with 4 or 5 ED visits per year. Someone might have very bad year but go back to being stable

afterward. The folks who have 5 are more visits per year are likely to be those who are cycling through. In looking at notes from other workgroups, I see lots of efforts coming forward to expand the Medi-Cal managed care programs and give health plans the flexibility and financial incentives to improve the care of those individuals who fall outside of this definition but who still need support. I think this is the right target.

Sharon Rapport, Corporation for Supportive Housing: I want to clarify. The list includes those with one condition and ONE of the other criteria, like chronic homelessness.

Shen, DHCS: On Clayton's point about other institutions, we will want to use a broad definition of institutions like IMD are included. We will look at the language to ensure all are included.

Sharon Rapport continued her presentation with options for discussion, including incentives for health plans, counties and regional partnerships to provide housing-based case management services. This involves flexibility for health plans to include broad services as part of capitated costs. Under the county incentives, this would allow local funds to draw down federal funding for services not currently financed through Medi-Cal such as outreach and tenant supports. Partnership incentives would involve plans forming partnerships with housing providers, counties, philanthropy and others to develop shared data agreements, provide housing support, form savings pools and create recuperative care services. Recuperative care would use existing beds to be able to discharge individuals who do not require hospital care yet cannot be discharged to unstable or homeless situations. The savings pool allows local entities to contribute to a pool to fund rental subsidies, case management or recuperative care. We don't expect health plans to have the capacity to help people to move into housing, so we would hope there would be a third party to administer the savings pool. We also see this as a way to reassure CMS that the waiver proposal will not use Medicaid to produce housing.

Bobbie Wunsch, Pacific Health Consulting Group: The plan/provider incentives workgoup is discussing how health plans might "re-base" their rates so that savings could be utilized for services. We will not discuss that here but it is important to realize that discussion is ongoing.

Dena Fuentes, County of San Bernardino: One observation is that pre-tenancy supports seem to be missing such as utility and other deposits, personal care items. This is a difficult item to find funding for. In addition, it seems that rent subsidies would become an eligible use of savings that are generated from the approach. Is that correct?

Sharon Rapport, Corporation for Supportive Housing: We discussed at the last meeting how we might use savings for rental subsidies and have been trying to be creative to produce housing.

Katch, DHCS: We have had questions throughout about why not let the plans fund rental subsidies. We hear from CMS that we are not permitted to use any federal Medi-Cal dollars for direct rental subsidies. Using savings instead of direct federal funds is a creative approach to discuss with CMS.

Shirley Sanematsu, Western Center on Law and Poverty: My understanding is that recuperative care began because of hospitals “dumping” patients and it is funded by hospitals. What has been the role of health plans in funding recuperative care?

Sharon Rapport, Corporation for Supportive Housing: Yes, this is largely funded by hospital systems. Recuperative care is in short supply and the role of plans has been limited because they have not been able to include recuperative care in their costs. Currently, if they achieve savings by getting people out of hospitals and into recuperative care, they’re not able to include the costs in their rate costs so they are not benefiting from the savings.

Ann Warren, Community Health Group: On recuperative care, we do work with hospitals. It is case by case now to figure out alternative housing, beds available where home nursing can attend. I am excited to see this included to help with safe discharge.

Shen, DHCS: In the past, these folks were not Medi-Cal. Now we need to restructure the savings. There are structural transitions here. On the housing subsidies, we are looking at potential partnerships so that existing money spent through mental health or health care can be used for housing – not Medi-Cal. Medi-Cal will pick up certain aspects of care; the local partnerships pay for housing.

Ann Warren, Community Health Group: I agree we want to think in a new way, yet the savings pool still raises lots of questions, risk and potentially a new administrative layer. I am having difficulty knowing how this might work. Administratively, there will be a need to oversee the savings pool. We are looking at a narrow target so will I need to anticipate the savings to fund the pool and put out resources before we know the outcome?

Ed Ortiz, Health Plan of San Mateo: I agree it seems complicated and probably will need a local coordinating entity. One entity needs to coordinate and there needs to be clarity about the roles of all participating organizations. Each participating organization has a different focus in terms of housing, health care, and human services, so I’m trying to figure out how this would fit in an integrated system of care.

Clayton Chau, L.A. Care Health Plan: The complication here are the entities that serve many different populations. For example, the county does not serve only Medi-Cal; the plan does. How might we reconcile the admin costs for diverse populations? It does seem complicated.

Courtney Gray, San Francisco Health Plan: I am trying to understand how this will play out and agree it is very complicated.

Doug Shoemaker, Mercy Housing California: Homelessness is complicated. Health plans are new to this but the costs are coming to you. It seems useful to get ahead of this issue. This is an incredible opportunity to create networks to solve this problem. The problem is not going away so my plea is to hope we can overcome the complexity concern.

Katch, DHCS: This idea is our best thinking but we are very open to how it can be simplified. We had many conversations about other models or efforts already underway that can simplify or that we can augment to accomplish this.

Bobbie Wunsch, Pacific Health Consulting Group: Perhaps we can have a call after this meeting to discuss this further.

Ann Warren, Community Health Group: I appreciate that. Health plans know we need to scale up. I like the idea of customizing things already in place.

Maria Funk, LA County Mental Health: We have talked in mental health about how to do this. Many of our clients are enrolled in managed care but it is a carve-out. There is no case rate. In LA we have invested in housing solutions like vouchers and certificates and building housing through the MHSA program. How does mental health benefit from this approach? How do we bill for services not currently covered by Medi-Cal or workers not able to bill? We should include recuperative care in the target populations.

Dave Folsom, St. Vincent de Paul Village Family Health Center: I am wondering if the complexity is necessary to use funds within CMS requirements? Does it bring the advantage of rent subsidies? If so, it is important to include because other ways to accomplish that might be impossible.

Katch, DHCS: Yes, and in addition this leverages other resources like philanthropy or MHSA that are not currently included.

Sharon Rapport, Corporation for Supportive Housing: Yes, this is about integrating savings; bringing new resources, new partners.

Dave Folsom, St. Vincent de Paul Village Family Health Center: Counties vary quite a bit. In some counties, it can be difficult for MHSA and other resources to be used beyond the narrow mental health system. Especially where there is no county hospital or any robust county services may look at this very differently than other places where the county services are more robust.

Dena Fuentes, County of San Bernardino: This does involve getting many different departments to speak together at the county level. It relies a lot on the leadership of the counties. There needs to be flexibility for counties because they are each so unique. Need to include cities and League of CA cities. If you can figure out a weighted benefit to cities to helping the homeless get into housing, those cities that have an interest in building housing will figure out how to make that happen. This recently happened with the MSHA housing program. Ten units in a 100 unit setting, with wrap-around services was what made cities willing to do it.

Ed Ortiz, Health Plan of San Mateo: When you consider how to calculate cost saving, I ask that it align to other cost savings initiatives, such as Duals and CCI. These are very complex algorithms.

I appreciate the concept but we need to make it something the plans can operate. We definitely want to use housing as a tool to health and be part of the solution.

Kelly Brooks Lindsey, California State Association of Counties: There are different sets of incentives for different counties. Those with public hospitals seem straightforward. All counties have mental health plans and we need to think more about how smaller counties will participate. If we can allow some flexibility as the waiver proceeds, I know there is a lot of interest in the smaller counties to participate, even as regional collectives.

Rachel McLean, CDPH: Can you clarify the threshold of 50 people, and the requirement that we move into housing in 3 months? This could be difficult for a small county.

Sharon Rapport, Corporation for Supportive Housing: These are a starting point to think about how to scale up. The 50 number is to indicate that this is a healthy working partnership to allow scale-up to happen. The 3 month timeframe is taken from other states. This relates to wanting a fast track agreement being in place and not operating under the existing scenario of 9 months to get to housing.

Doug Shoemaker, Mercy Housing California: This is a heavy superstructure and if we don't have a significant number, we may not be able to make it work.

Shen, DHCS: We are looking at pilots and will need to identify the critical mass to move forward. We don't need to focus on 50 but on momentum to accomplish the outcomes.

Dave Folsom, St. Vincent de Paul Village Family Health Center: I think it makes sense to have ambitious targets. This is to push new agreements to speed up the housing.

Revised Options for Inclusion in 1115 Waiver Moving Forward Health Homes AB 361
Hannah Katch, DHCS, John Shen, DHCS and Sharon Rapport, CHS
Presentation slides available at: at http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Housing.aspx

Hannah Katch observed that California did not receive the CalSIM grant, however DHCS is working to identify ways to proceed with concepts that were included there. One of these efforts is the Health Homes Initiative to be implemented January 2016. She offered background on Health Homes (AB 361) and how the waiver may intersect with this effort. Health Homes includes non-medical services to provide "whole-person care: Comprehensive case management, Care coordination, health promotion, Comprehensive transitional care, Individual and family supports, and Referral to community and social services. State legislation authorized the Health Home initiative and requires an evaluation. The target population specifically mentions homeless and frequent utilizers. Health plans will oversee the effort and pay for services locally through an augmentation to the premium. Financing includes 90% federal participation with the 10% match paid by The California Endowment. Following the baseline 8 quarters of this financing, services must be offset by savings.

Sharon Rapport, Corporation for Supportive Housing: Under federal guidance, the state can fund its share through risk savings pools. This is an option for the period beyond 8 quarters.

Rusty Selix, Mental Health Association of California: How does the money flow to mental health providers given they don't generally contract with health plans?

Katch, DHCS: A team is exploring the in-depth questions. The decision to start with CCI counties is that managed care organizations (MCO) does have a relationship with all providers.

Dave Folsom, St. Vincent de Paul Village Family Health Center: It is good news the state has decided to proceed with the Health Homes initiative.

Cindy Cavanaugh, California Housing and Community Development: Will there be additional opportunities beyond today to share and offer input?

Katch, DHCS: Yes, there is an email list and a website with resources. We will forward futures meetings on this topic to the workgroup members.

Ann Warren, Community Health Group: What is the requirement about the number of people to be served?

Sharon Rapport, Corporation for Supportive Housing: There is not a cap from the federal government. Some states have limited the number of people served but I'm not aware of it in California.

Carol Wilkins, ABT Associates: I encourage the state to consider other counties with readiness, such as Alameda.

Katch, DHCS: We have heard this from multiple areas and we are actively looking at this option.

Maria Funk, LA County Mental Health: In LA, discussion included a question of whether nontraditional providers will be able to participate? Do the services need to meet the regular Medi-Cal requirements?

Katch, DHCS: There are 3 categories, including MCOs, providers, and community and social supports. My guess is that "nontraditional providers" would fall into that third bucket and would still be able to provide those services.

Jonathan Istrin, Libertana Home Health: If the contract is between the state and the MCO, it is up to the MCO who the providers are. It is the MCO's responsibility for quality assurance on this

Katch, DHCS: The provider group will be responsible for a certain set of services. There are contractual requirements for MCOs in defining those providers and other community and social supports.

Sharon Rapport, Corporation for Supportive Housing: The state plan amendment has to delineate standards for providers, but MCOs would have discretion otherwise. The legislation Hannah mentioned does require, though, using community-based providers or county systems to offer the services. Locally, there will be room to contract with new providers.

Kelly Brooks Lindsey, California State Association of Counties: There is a lot on overlap between Health Homes and the waiver discussion in this workgroup. How can we influence how this will intersect?

Katch, DHCS: They are on parallel tracks and they are influencing each other. For example, the process of setting the eligibility criteria for the waiver was informed by the Health Home target population. This workgroup is already influencing Health Homes. Since it may not be in every county, we do need to ensure they operate independently.

Sharon Rapport, Corporation for Supportive Housing: We have discussed how we can supplement the waiver in counties that are not a target for Health Homes to create a holistic approach.

Kelly Brooks Lindsey, California State Association of Counties: In counties, we are more focused on the wavier and I will help with education on Health Homes. There is value in having a larger group offer input.

Katch, DHCS: We are considering stakeholder outreach once it is more fleshed out.

Ben Schwartz, California Tax Credit Association: Will health homes funding be project based? Are there concerns about the federal funding overlapping?

Sharon Rapport, Corporation for Supportive Housing: This is person based, tenant based, not project based. The individual has to be a Medi-Cal beneficiary.

Doug Shoemaker, Mercy Housing California: There are solutions but this is really important. One of the challenges for us is having contingent money. By the time it gets to us, it can’t be as contingent as “potential savings.”

Carol Wilkins, ABT Associates: This is a service that would be delivered to eligible tenants. It is unlikely to be funding received by the developer. It will go to a provider. So I can’t imagine that this is part of project funding that would represent an overlap.

Ben Schwartz, California Tax Credit Association: It may still show up in the application under the services budget and will play a role in how feasible the project is.

Doug Shoemaker, Mercy Housing California: We do need to explore this.

Ann Warren, Community Health Group: These discussions point to the importance of flexibility.

Jonathan Istrin, Libertana Home Health: Is Health Homes a demonstration project or a waiver? Is there a cap?

Katch, DHCS: This is an entitlement so it has to be available to anyone who meets the criteria.

Dave Folsom, St. Vincent de Paul Village Family Health Center: Can we review the financing issues just discussed?

Ben Schwartz, California Tax Credit Association: For Health Homes – from an allocating agency stand point, I was concerned about how we would see this funding show up in an application. Would we have requirements or commitments for project partners that could result in them losing their funding because of an inability to meet those requirements?

Doug Shoemaker, Mercy Housing California: To the extent that we are signed up for long-term commitments to serve people – 30-50 years in housing. We will not have those timelines in this program so we need to be sure we are not disabling ourselves from using the very tools that we're creating here. To provide better regulatory language than we've seen to date that don't have the right escape clauses in them.

Rusty Selix, Mental Health Association of California: I think we are confusing rental subsidies and new housing development.

Doug Shoemaker, Mercy Housing California: When we approach rental subsidies, we attach long-term requirements although you are right in pointing out the new housing is even more restricted.

Ed Ortiz, Health Plan of San Mateo: We had this problem of timing of commitment to services with the health plan having a shorter timeline than the housing provider needed. I didn't realize this impacted scoring. We pushed hard not to have a 15-year agreements.

Ben Schwartz, California Tax Credit Association: Our requirement for services is directly with the applicant not with service providers.

Ed Ortiz, Health Plan of San Mateo: Our housing providers needed to know where their funding would come from in order to make those commitments. It took almost a year to figure this out.

Lisa Bates, California Housing Finance Agency: From the housing world, it is a rich resource we are providing and we expect to see outcomes. We are expected to demonstrate outcomes so

we are driving to have rich services available. I understand the difficulty in long term commitments.

Cindy Cavanaugh, California Housing and Community Development: This is an adaptive problem. If services are tenant based, we might be able to propose that the services will come with the tenant, not be required in the housing package.

Dena Fuentes, County of San Bernardino: Whether it's embedded in the application vs. the prioritization of projects that get competitive funding. At the state level, during the evaluation of the application, there may be tenant-based services that would allow a project to go to the top of the list.

Doug Shoemaker, Mercy Housing California: As a follow up to this meeting, we need to be specific and ensure this works. For example, fifteen years ago, the HIV expectations and regulations turned out to be wrong as HIV positive individuals lived long lives.

Katch, DHCS: We need your help with this.

Ben Schwartz, California Tax Credit Association: As things move more to tenant-based services, it makes it harder for us to evaluate a project.

Rachel McLean, CDPH: My understanding is that Health Homes is a 2 year project. What happens after the results of the evaluation are in?

Katch, DHCS: State law requires budget neutrality. So in order to continue the program after those two years, we would have to demonstrate budget neutrality.

Doug Shoemaker, Mercy Housing California: We need a way to adapt when things change.

Katch, DHCS: The Health Home is care coordination.

Sharon Rapport, Corporation for Supportive Housing: We see opportunities in Health Homes to provide the housing based case management services although there are many unknowns.

Shirley Sanematsu, Western Center on Law and Poverty: I am so gratified to hear DHCS pushing forward on Health Homes in spite of no CalSIM. The eligibility criteria for Health Homes 2703 should remain targeted to most vulnerable who have not been helped through other avenues.

Identifying Potential Challenges To Meeting Goals
Facilitated by Bobbie Wunsch
Presentation slides available at: at http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Housing.aspx

Sharon Rapport listed a number of challenges for input from the workgroup:

- Ensuring meaningful use of recuperative care
- Working with housing programs
- Integrating more flexibility and simplicity for health care professionals

Lisa Bates, California Housing Finance Agency: One mitigating factor on sustaining health homes after the two years is the risk pool shared savings? Is that the same risk pool we are discussing in the waiver?

Sharon Rapport, Corporation for Supportive Housing: It is very similar in concept about how to capture savings. The federal guidance allows any savings during the 2-year period to be used as state share going forward. Given that legislation prohibits state general fund, a savings pool from Health Homes may be created to pay for state portion going forward. This is a way to maximize partner funding and leverage all resources. It gets to the same goal as the proposal discussed today.

Lisa Bates, California Housing Finance Agency: As it begins to gel, it would be important to know how much of the waiver pool is available for continuing waiver services vs. Health Homes.

Cindy Cavanaugh, California Housing and Community Development: We need to worry about performance metrics and really making sure we're learning from the project, not just whether we're maintaining budget neutrality.

Dave Folsom, St. Vincent de Paul Village Family Health Center: Would the shared saving pools from both programs be mixed together? Now, for Medi-Cal expansion population, federal government pays 100% going down to 90%. What is the savings that the state actually gets to use?

Sharon Rapport, Corporation for Supportive Housing: For seniors and persons with disabilities, the match is 50% after two years; the federal government will fund health home services at 100% for the Medi-Cal expansion population. Eventually, the state match for this population will be 10%. The state has an interest in making sure the cost of these individuals is as low as possible before there is state responsibility.

Shen, DHCS: During this period of enhanced federal participation, the question is how can we work with new partners and bring the cost down to a point that the state can afford to continue when the responsibility is 50-50?

Ann Warren, Community Health Group: On the complications of current systems, under Cal MediConnect there are withholds and HEDIS measures and the requirements go up each year. It feels like it is the same pool of money. Having Health Home as a benefit, if funding goes away but it is still a benefit from the plan, how do we finance it? How do ensure long term sustainability?

Carol Wilkins, ABT Associates: It does seem the notion of a savings pool as a way to fund the nonfederal share is way too complex. However, if we do have a way to capture the savings and evaluate cost neutrality to the state general fund, that would accomplish what we need without the complexity. I would argue for an evaluation and a strong program as the way to demonstrate lower costs of incarceration and other costs to the state. In order to develop a feasible way to develop a shared savings mechanism, it would need to be at the local level in order to achieve county willingness to participate. I think it will be a county-specific mechanism to be feasible.

Sharon Rapport, Corporation for Supportive Housing: Just to clarify, the legislation states that no general fund dollars can be used unless there is some demonstration of cost savings. So, you don't need to change the statute in order to do what you're talking about. I had a question about the counties. Could several small counties participate? Is that feasible?

Carol Wilkins, ABT Associates: Yes, they have experience with JPAs and other mechanisms where they come together to do things jointly. In particular, there are health plans that serve multiple counties.

Kelly Brooks Lindsey, California State Association of Counties: A state pool is very difficult for counties. I think a regional savings pool is much more attractive. There are many examples of JPA's and other ways of participating together. For example, San Bernardino and Riverside already do a lot together with Inland Empire Health Plan. In order to gain participation at the county level, there needs to be local control.

Ed Ortiz, Health Plan of San Mateo: It is concerning to have yet another savings pool. I think we should designate a local coordinating entity for the waiver – the county, the health plan? Finally, as we design this 1115 waiver, how will this work with other waivers, other large programs like the Duals Demonstration so these are aligned?

Kelly Brooks Lindsey, California State Association of Counties: The difficult thing about designating the lead agency is that it will be different in different places.

Leveraging State, County and Local Resources for More Housing Units
A Panel of Workgroup Members

Lisa Bates let the group know how important the discussion has been already to stimulate creativity at the state level. There are five housing entities at the state that are coordinating efforts through ongoing discussions about how we can do things differently. We will take this discussion into that effort. The savings pool concept, flexible and local, could be a public-private opportunity for state participation. The Kresge Foundation is supporting our efforts and would support additional development of the concepts we are discussing here about how we use resources. It has been important for us to be at the state-level health table to coordinate across sectors. The other thing we've been working on is the 811 program. Although the federal 811 program has a lot of requirements, the concept has merit based on our discussions here today.

Cindy Cavanaugh, California Housing and Community Development: The housing system is complex. In some places it is county, city or even the state that is the primary leader in housing. The state's primary role has been financing. The new role is creating access through coordinated entry programs. The 811 program is a pilot that uses the pipeline of state-financed affordable housing to develop an operating subsidy for a specific population. The idea is to have a resource that is project-based and targeted to specific populations. It may be a model.

Shen, DHCS: The underlying foundation is that 811 is a CMS-HUD effort. We need to push on our respective partners at the federal level to continue discussion at their level.

Ben Schwartz, California Tax Credit Association: Appreciate the discussion and the ability to stay connected. One issue I see going forward is that a new funding source has to be fully committed. I am not sure how the waiver financing will look but for our purpose, it has to be committed resources. We have talked about adjusting the definition of homelessness and we want to expand to the populations who are included here. This discussion is different in that the funding goes through the individual, not through project financing. We don't have a chronic homelessness set-aside and every group wants to have a priority. If we were to create a set-aside for skilled nursing facility, for example, it will take tax credits from another pool. It would be easier to do that within a pool. We would be able to give an incentive to developers to create more housing for this population.

Doug Shoemaker, Mercy Housing California: There are broadly defined priorities at the state level, like senior housing. In the case of tax credits, we need state funding agencies to include a definition of SNF target under an existing definition. To the extent the program changes at the state level, it needs to offer flexibility for how we operate. We don't want to have a narrow program that does not allow us to maneuver.

Cindy Cavanaugh, California Housing and Community Development: The housing programs have increasingly added targets in reaction to the ACA. Perhaps we should strip that away and just create housing and have mechanisms to buy access and ensure access to populations that are going to change over time.

Doug Shoemaker, Mercy Housing California: There are things you can do to make the application process simpler. For example, anyone who comes to the table with an 811 waiver should get a preference in scoring.

Katch, DHCS: Are you saying it creates a new incentive?

Ben Schwartz, California Tax Credit Association: Yes, redevelopment went away and local entities lost a source of funding. If there is a way to come forward with more public funds, it gives them an advantage.

Katch, DHCS: Would it be sufficient if funding is attached to only a portion of the residents?

Doug Shoemaker, Mercy Housing California: We need a technical session and we can structure this in a way that will work. If we partner with a housing authority and you have agreement they will serve a certain population, it may create the flexibility if the funding disappears.

Katch, DHCS: So theoretically in a world where we have these shared savings incentives to fund rental subsidies, and those subsidies are only going to Medi-CaL beneficiaries that meet these criteria that would do what you're suggesting?

Doug Shoemaker, Mercy Housing California: By virtue of applying for these funds, I am committed to serve this population. We need a circuit breaker element of this. We don't want to be tied too closely to the definitions that may need to change over the course of the waiver.

Carol Wilkins, ABT Associates: This is a sticky issue called targeted relief. Capital funders require 30-50 year commitment to offer capital financing. When the funding disappears to successfully house that target population, is the housing provider on the hook to serve them?

Ed Ortiz, Health Plan of San Mateo: We have contracts with two developers for set asides for the Duals population. The conversation is very confusing.

Sharon Rapport, Corporation for Supportive Housing: The opportunity is to figure out how to get the funding sources work together so we can leverage the capital funding to create more housing.

Shen, DHCS: The housing provider becomes a service provider committed for 30 years. All of a sudden the housing financing piece is relying on Med-Cal services.

Ben Schwartz, California Tax Credit Association: This is different than the existing situation where a rental subsidy falls out and we allow you to raise the rent. This is funding services instead, so what happens when that funding goes away?

Maria Funk, LA County Mental Health: LA County is a service provider and we are investing in capital, housing subsidies and vouchers. All the resources are leveraged together. Any service currently we can't use Medi-Cal for, we use local general funds. Every conversation includes discussion of needing more services; most providers are not Medi-Cal providers. Any opportunity to bring these providers into the Medi-Cal program will allow us to expand our services. In LA, local county departments can apply for Shelter Plus Care vouchers. Through MHSA we know that every client is provided services because we certify they are our clients. There is a lot of work in LA to coordinate together to end chronic homelessness.

Kelly Brooks Lindsey, California State Association of Counties: Some of the keys to the local conversation is leadership across multiple county departments to make this a priority and develop workable solutions. Many innovations in HHS, started at county levels. The coordination across plans, cities and county health departments will be key. We got $20M of

CalWORKs homeless funding and counties of all sizes applied with innovative solutions – even small counties – with solutions on the housing side. There is a more natural fit for the chronic homeless, the SNF is a harder fit.

Dena Fuentes, County of San Bernardino: I agree with Kelly. We are not only looking for service dollars, we also need construction dollars for housing units. In our region, tie breaker points make the difference. We only approved four projects per year across the region. Because we lost redevelopment and have one-time veterans funding, the majority of cities won't be able to compete with cap and trade money. We try to tie into those providing services in innovative ways. Our objective is to revitalize and spur economic development – not just housing. For example, we have commercial lease – how do we turn that into housing? How do we still accomplish revitalization with no redevelopment money? This source of funds will be useful if there is flexibility in the requirement.

Carol Wilkins, ABT Associates: HUD issued guidance to those providing permanent supportive housing to prioritize those with highest need. As long as it is not a single-focus target population, housing providers can prioritize people based on vulnerability. There is also a set of criteria that aligns with Medicaid eligibility so that gives them explicit authority to target the populations we are identifying here.

Next Steps
John Shen, DHCS and Bobbie Wunsch, Pacific Health Consulting Group
Bobbie Wunsch summed up next steps. On this topic, there is a need for three follow up conversations:

- How does Health Homes Initiative intersect and complement the waiver?
- Bring the health plans together to discuss rate setting and the savings pool.
- Continue the state department dialog across health and housing to collaborate.

Overall in the waiver process, next steps include DHCS integrating ideas and create a story from all workgroups to create the application to CMS. This is the end of phase one and there is much more to get to the final approval by October 31st. A presentation at the Stakeholder Advisory Committee on February 11 of the overview of the waiver. The workgroup depended on support from the foundations, the work of Sharon Rapport and DHCS staff as well as all of you.

Katch, DHCS: The only thing I would add is that I think the very next phase is looking across the working groups and seeing where there is overlap to simplify and reduce the complexity. Part of that will involve reaching back out to you to get feedback on any changes.

Public Comment
Kym Flores, Senate Office of Research: How will the locations for this effort be chosen? Will they apply? Thinking back to the Coverage Initiative, that preceded the LIHP. What is the idea here in light of the Health Homes?

Katch, DHCS: There are different ways to go forward and we are still developing concepts and assessing the feasibility. For some services, we are talking about making it available across all counties. For Health Homes, we are talking about starting in the CCI counties. We are also talking about expanding that, so it is not determined.