



## CalAIM: Leveraging Medicaid Managed Care for Housing and Homelessness Supports

April 15, 2022 / Allie Atkeson

### Introduction

Driven by challenges facing individuals with complex care needs, states are increasingly working to address the physical, behavioral, and social needs of their Medicaid beneficiaries. For many with complex care needs, [research shows](#) supportive housing services are essential for exiting homelessness and staying successfully housed.

In January 2021, the Centers for Medicare and Medicaid Services (CMS) released a [roadmap](#) for states to address social determinants of health that includes several options for supportive housing services. California's most recent Medicaid transformation initiative, CalAIM, builds upon the state's previous work on whole person care to meet the care needs for complex care populations. This paper summarizes the different elements of California's initiative, which provides a model for other states seeking to expand housing services and whole person care through Medicaid.

### California Advancing and Innovating Medi-Cal

In late December 2021, CMS [approved Medicaid authorities](#) for the California Advancing and Innovating Medi-Cal program, or CalAIM. The program was launched through a five-year extension of the state's [1115 demonstration waiver](#) and [Medicaid managed care section 1915\(b\)](#)

#### Whole Person Care Pilots

California launched [Whole Person Care](#) (WPC) pilots in 2016 through the Medi-Cal 2020 1115 waiver. The pilots support local efforts to address physical health, behavioral health, and social needs through contracting between managed care and social service providers. The goal of the initiative is to increase coordination across agencies for the most vulnerable Medi-Cal members and reduce emergency department and inpatient health costs.

#### Health Home Program

The Home Health Program (HHP) is an optional state plan benefit that California began in 2018. Through the HHP, community-based care management entities coordinate with managed care plans to provide additional services to members with chronic or behavioral health needs. Services include care management, care coordination, health promotion, transitional care services, member and family support, and referral to community services.



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[waiver](#). CalAIM builds upon California’s previous Medi-Cal initiatives, including [Whole Person Care](#) (WPC) pilots and the [Health Homes Program](#) (HHP).

The CalAIM initiative is unique in that it relies on the state’s 1115 demonstration authority, [Medicaid managed care section 1915\(b\) waiver](#) and managed care contracting. In CalAIM, housing supports will be delivered through managed care plans under the 1915(b) authority, creating a sustainable funding source for these services. Shifting to enhanced care management (ECM) and community supports (also known as in lieu of services, or ILOS) under managed care “represents an opportunity for MCPs (managed care plans) to work with providers, counties, and community-based organizations (CBOs) to knit together a stronger set of supports for those who need it most, supported entirely within the managed care delivery system.”

CalAIM will provide Medi-Cal members experiencing homelessness and housing instability services through the ECM and ILOS programs. California’s Department of Health Care Services (DHCS) released the document “[CalAIM’s Commitment to Addressing California’s Homelessness Crisis](#),” which identifies the following goals:

- Move beyond regional pilots to statewide implementation of housing services
- Tailor community-based ECM services for members who are homeless
- Establish a long-term sustainable approach to covering housing-related services in Medi-Cal
- Support a broader array of housing services through community supports and targeted ECM to support access to and coordination of these services
- Offer major new funding and resources to support the launch of ECM and take-up of community supports throughout California

## Enhanced Care Management

ECM is intensive care coordination for Medi-Cal managed care plan (MCP) members with high needs and complex care conditions. ECM will be delivered through the managed care 1915(b) waiver and [contracting](#) with MCPs and is accounted for in capitation rates. The benefit will be rolled out in phases by county and populations of focus between January 2022 and July 2023 depending on where WPC and HHP programs currently exist.

### Services

ECM includes seven core services:

1. Outreach and engagement
2. Comprehensive assessment and care management plan
3. Enhanced coordination of care
4. Health promotion
5. Comprehensive transitional care
6. Member and family supports

7. Coordination of and referral to community and social support services

More information on these services can be found in Appendix B of the [ECM policy guide](#).

**Target Population**

The following are the rollout phases, populations of focus and definitions:

**Table 1: Populations of Focus and Definitions for CalAIM’s Enhanced Care Management Benefit**

Rollout Phase <sup>1</sup>	Population of Focus	Definition
Phase 1	Individuals and Families Experiencing Homelessness	(1) are experiencing homelessness (as defined below) and (2) have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.
	High-Utilizer Adults	Adults with (1) five or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence; and/or (2) three or more unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.
	Adults with severe mental illness or substance use disorder (SMI/SUD)	Adults who (1) meet the eligibility criteria for participation in or obtaining services through: <ul style="list-style-type: none"> <li>• The county Specialty Mental Health (SMH) System</li> <li>• The Drug Medi-Cal Organization Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) program</li> </ul> and (2) are actively experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, history of adverse childhood experiences (ACEs), former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms or associated behaviors); and (3) meet one or more of the following criteria: <ul style="list-style-type: none"> <li>• Are at high risk for institutionalization, overdose, and/or suicide</li> <li>• Use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care</li> </ul>

<sup>1</sup> ECM will be rolled out by counties and populations of focus depending on where whole person care pilots and health home programs currently exist.

Rollout Phase <sup>1</sup>	Population of Focus	Definition
		<ul style="list-style-type: none"> <li>Experienced two or more emergency room visits or two or more hospitalizations due to SMI or SUD in the past 12 months; or</li> <li>Are pregnant or postpartum women (12 months from delivery)</li> </ul>
Phase 2	Individuals Transitioning from Incarceration	<p>Individuals who:</p> <p>(1) are transitioning from incarceration or transitioned from incarceration within the past 12 months</p> <p>and (2) have at least one of the following conditions:</p> <ul style="list-style-type: none"> <li>Chronic mental illness</li> <li>Substance use disorder</li> <li>Chronic disease (e.g., hepatitis C, diabetes)</li> <li>Intellectual or developmental disability</li> <li>Traumatic brain injury</li> <li>HIV</li> <li>Pregnancy</li> </ul>
	Members Eligible for Long-Term Care and at risk of Institutionalization	Individuals at risk for institutionalization who are eligible for long-term care services who, in the absence of services and supports, would otherwise require care for 90 consecutive days or more in an inpatient nursing facility. Individuals must be able to live safely in the community with wraparound supports.
	Nursing Home Residents Transitioning to the Community	Nursing facility residents who are strong candidates for successful transition back to the community and have a desire to do so.
Phase 3	Children and Youth	<ol style="list-style-type: none"> <li>Children (up to age 21) experiencing homelessness</li> <li>High utilizers</li> <li>Those with serious emotional disturbance or identified to be at clinical high risk for psychosis or experiencing a first episode of psychosis</li> <li>Those enrolled in California Children’s Services (CCS)/CCS Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition</li> <li>Those involved in, or with a history of involvement in, child welfare (Including foster care up to age 26)</li> <li>Those transitioning from incarceration</li> </ol>

### Provider Network

ECM builds on the provider networks designed through the WPC and HHP models. Managed care plans contract with WPC lead entities or HHP community-based care management entities as ECM providers. New [provider standards](#) were developed based on WPC and HHP. Managed care plans are also expected to work and contract with county behavioral health systems.



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## Community Supports (formerly “In Lieu of Services”)

California is able to provide community supports, or “in lieu of services” (ILOS), as cost-effective substitutes to medical services covered under the state plan under the federal regulation 42 C.F.R . § 438.3(e), as approved by CMS. The goal of community supports is to support managed care plans with alternative proven options to better be able to address social determinants of health concerns with their members. Managed care plans are not required to provide community supports but are strongly encouraged to do so by DHCS. Managed care plans may add community supports every six months and remove them annually with prior notice to DHCS.

### Services

Community supports includes 14 broad categories:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Short-term post-hospitalization housing
5. Recuperative care (medical respite)
6. Respite services
7. Day habilitation programs
8. Nursing facility transition/diversion to assisted living facilities, such as residential care facilities for the elderly and adult residential facilities
9. Community transition services/nursing facility transition to a home
10. Personal care and homemaker services
11. Environmental accessibility adaptations (home modifications)
12. Medically tailored meals/medically supportive food
13. Sobering centers
14. Asthma remediation

The recuperative care and short-term post-hospitalization housing services are provided through California’s 1115 waiver while the other 12 community supports are provided under the state’s 1915(b) waiver and incorporated into managed care plan contracts. Managed care plans that elect to offer any of California’s preapproved community supports may choose which counties to offer them in and do not need to offer the services or settings statewide or in all counties in which the Medi-Cal managed care plan operate.



**Table 2: Housing-Related Services Covered under Community Supports**

Service	Service Description	Duration of Service	Eligibility	Providers	Service Rate (estimated, based on non-binding pricing guidance)
Housing Transition Navigation Services	Services to assist members obtain housing. <ul style="list-style-type: none"> <li>• Housing assessment</li> <li>• Housing support plan</li> <li>• Housing search</li> <li>• Application assistance</li> <li>• Landlord education</li> <li>• Member advocacy</li> <li>• Care coordination</li> </ul>	Service duration is as long as necessary in the individual’s individualized housing support plan.	Individuals prioritized for permanent supportive housing (PSH) through the homeless coordinated entry system.  Individuals who meet the U.S. Department of Housing and Urban Development (HUD) definition of homelessness who are receiving ECM; or have a chronic condition, SMI, or SUD; or are at risk of institutionalization <sup>2</sup> .  Individuals who meet the HUD definition of at risk of homelessness.	<ul style="list-style-type: none"> <li>• Vocational services agencies</li> <li>• Providers of services for individuals experiencing homelessness</li> <li>• Life skills training and education providers</li> <li>• County agencies</li> <li>• Public hospital systems</li> <li>• Mental health or SUD treatment providers, including county behavioral health agencies</li> </ul>	<ul style="list-style-type: none"> <li>• \$324–449 per member per month (PMPM)<sup>3</sup></li> </ul>

<sup>2</sup> Qualifying institutions include hospitals, correctional facilities, mental health residential treatment facilities, substance use disorder residential treatment facilities, recovery residences, institution for mental disease, and state hospitals.

<sup>3</sup> The pricing considers a housing care manager with a college degree providing services face-to-face in an office as well as in the community and via phone/other technology to a midpoint caseload of 1:35 individuals concurrently.



Service	Service Description	Duration of Service	Eligibility	Providers	Service Rate (estimated, based on non-binding pricing guidance)
				<ul style="list-style-type: none"> <li>Affordable housing providers</li> <li>Supportive housing providers</li> <li>Federally qualified health centers and rural health clinics</li> </ul>	
Housing Deposits	<p>Services to assist with identifying, coordinating, securing, or funding one-time services and modifications to allow a person to establish a basic household. Does not include room and board.</p> <ul style="list-style-type: none"> <li>Security deposit</li> <li>Set-up fees/utility deposits</li> <li>First month coverage of utilities (telephone, gas, electricity, heating, water)</li> <li>First and last's month's rent</li> <li>Pest eradication, one-time cleaning</li> </ul>	<p>Available once in an individual's lifetime. Services must be identified as reasonable and necessary in the individual's housing support plan.</p> <p>Services can be approved one additional time with documentation as to what conditions have changed to demonstrate why it would be more successful on the second attempt.</p>	<p>Members receiving housing transition/navigation services.</p> <p>Individuals prioritized for PSH by the coordinated entry system.</p> <p>Individuals who meet the HUD definition of homelessness who are receiving ECM; or have a chronic condition, SMI, or SUD; or are at risk of institutionalization.</p>	<p>Coordinating entities for housing transition navigation services or Medi-Cal care plan case manager, care coordinator, or housing navigator. Plans may subcontract services.</p>	<ul style="list-style-type: none"> <li>Two times the Fair Market Rent (FMR) value as established under HUD, which would represent first and last month's rent plus \$1,000 for discrete moving costs/initial utilities.</li> </ul>



Service	Service Description	Duration of Service	Eligibility	Providers	Service Rate (estimated, based on non-binding pricing guidance)
	<ul style="list-style-type: none"> <li>Medically necessary adaptive aids and services</li> </ul>				
Housing Tenancy and Sustaining Services	<p>Service provides tenancy and sustaining services.</p> <ul style="list-style-type: none"> <li>Landlord community</li> <li>Dispute resolution</li> <li>Eviction prevention</li> <li>Assistance with housing recertification</li> <li>Lease compliance</li> <li>Independent living and life skills</li> </ul>	Available from the initiation of services until they are no longer needed, as determined by the individual's housing support plan.	<p>Individuals who received housing transition/navigation services.</p> <p>Individuals prioritized for PSH by the coordinated entry system.</p> <p>Individuals who meet the HUD definition of homelessness who are receiving ECM; or have a chronic condition, SMI, or SUD; or are at risk of institutionalization.</p> <p>Individuals who meet the HUD definition of at risk of homelessness.</p>	<ul style="list-style-type: none"> <li>Vocational services agencies</li> <li>Providers of services for individuals experiencing homelessness</li> <li>Life skills training and education providers</li> <li>County agencies</li> <li>Public hospital systems</li> <li>Mental health or substance use disorder treatment providers, including county behavioral health agencies</li> <li>Supportive housing providers</li> <li>Federally qualified health centers and rural health clinics</li> </ul>	<ul style="list-style-type: none"> <li>\$413–475 (PMPM)<sup>4</sup></li> </ul>

<sup>4</sup> The pricing considers a housing care manager with a college degree providing services face-to-face in an office as well as in the community and via phone/other technology to a total caseload of 25 individuals concurrently



Service	Service Description	Duration of Service	Eligibility	Providers	Service Rate (estimated, based on non-binding pricing guidance)
Short-Term Post Hospitalization Housing	Housing for members who do not have a residence and are unable to meet such an expense.	<p>Available once in an individual's lifetime and cannot exceed a duration of six months.</p> <p>Members must be offered housing transition navigation supports during the period.</p>	<p>Individuals exiting recuperative care.</p> <p>Individuals exiting an inpatient hospital, residential SUD treatment of recovery facility, residential mental health treatment facility, correctional facility, or nursing facility who meet any of the following criteria:</p> <p>Individuals who meet HUD's definition of homeless and who are receiving ECM; or have a chronic condition, SMI, or SUD; or are at risk of institutionalization.</p> <p>Individuals who meet the HUD definition of at risk of homelessness.<sup>5</sup></p>	<ul style="list-style-type: none"> <li>• Interim housing facilities with additional on-site support</li> <li>• Shelter beds with additional on-site support</li> <li>• Converted homes with additional on-site support</li> <li>• County directly operated or contracted recuperative care facilities</li> <li>• Supportive housing providers</li> <li>• County agencies</li> <li>• Public hospital systems</li> <li>• Social service agencies</li> <li>• Providers of services for individuals experiencing homelessness</li> </ul>	<ul style="list-style-type: none"> <li>• \$97–119 per diem.<sup>6</sup></li> </ul>

<sup>5</sup> In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, rehospitalization, or institutional re-admission.

<sup>6</sup> Pricing considers a direct care worker available 24 hours a day who provides monitoring/support to a facility of 15 to 30 beds.



Service	Service Description	Duration of Service	Eligibility	Providers	Service Rate (estimated, based on non-binding pricing guidance)
Recuperative Care (Medical Respite) <sup>7</sup>	<p>Interim housing and meals in a recovery care setting for individuals who no longer require hospitalization.</p> <p>Services may include:</p> <ul style="list-style-type: none"> <li>• Assistance with instrumental activities of daily living</li> <li>• Transportation coordination</li> <li>• Connection to other ongoing services (e.g., mental health or SUD services)</li> <li>• Support accessing benefits and housing</li> <li>• Stability with case management</li> </ul>	No more than 90 days in continuous duration	<p>Individuals who are at risk of hospitalization or are post-hospitalization and Individuals who live alone with no formal supports.</p> <p>Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.</p> <p>Individuals who meet the HUD definition of at risk of homelessness.</p>	<ul style="list-style-type: none"> <li>• Interim housing facilities with additional on-site support</li> <li>• Shelter beds with additional on-site support</li> <li>• Converted homes with additional on-site support</li> <li>• County directly operated or contracted recuperative care facilities</li> </ul>	<ul style="list-style-type: none"> <li>• \$181–226 per diem.<sup>8</sup></li> </ul>

<sup>7</sup> Allowable under community supports if it is necessary to achieve or maintain medical stability and prevent hospital admission or re-admission. Cannot include funding for building modification or rehabilitation.

<sup>8</sup> The pricing considers medically trained direct care workers providing 24 hours a day of monitoring/support to a facility of 10 to 20 beds.



## Providing Access and Transforming Health (PATH) Funding<sup>9</sup>

As ECM and community supports build on whole person care, coordination between managed care plans, counties, hospitals, and community-based organizations will be necessary to support patient-centered care coordination and evaluation. To do so, California is approved to deploy up to \$1.44 billion in Providing Access and Transforming Health (PATH) funding through the 1115 waiver to support local and cross-agency coordination over the five-year renewal period (January 2022 to December 2026). Importantly, this funding is not for reimbursable services but will be provided to qualified applicants to support capacity building, infrastructure, and systems for local networks to deliver care. This includes [PATH supports](#) to fund the following:

**Support for transition to managed care.** WPC pilot lead entities will receive funding to continue services offered to members under WPC pilots until they can be transitioned to managed care. This includes funding to lead entities providing justice-involved services.

### **Technical assistance marketplace.**

Funding for qualified applicants that work with managed care plans to provide ECM or ILOS. Allowable expenditures include:

- Workforce training
- Assistance with data mining to identify members eligible for ECM and/or community supports services
- Guidance on data-sharing practices to connect members to housing community support services
- Creating and implementing regional learning collaboratives
- Training on connecting justice-involved individuals to housing services

**Qualified applicants:** entities approved by the state to receive PATH payments.

Criteria for qualified applicants depends on the PATH initiative but are generally cities; counties; other government agencies; county and community-based providers including but not limited to public hospitals, CBOs, and Medi-Cal Tribal and the Designees of Indian Health Programs contracted with or that intend to contract with MCPs as ECM or community supports providers; and other entities as approved by DHCS. Qualified applicants for the justice-involved planning and implementation program include jails, county behavioral health agencies, youth correctional facilities, probation offices, sheriff's offices, state prisons, and other

**Collaborative planning.** Funding for third-party vendors to convene localities, government agencies, community-based providers, public hospitals, Indian Health programs, and other stakeholders that plan to contract with managed care plans. Regular meetings over the five-

<sup>9</sup> [Approved 1115 waiver, STC 31, Page 32](#)



year period will include development of implementation plans and service gap analysis, service delivery challenges, and quality improvement processes.

**Support for expanding access to services.** Funding for workforce, closed loop referral systems, billing systems, and up-front funding to providers and community-based organizations to deliver ECM and ILOS. Counties, county hospitals, community-based providers, and Indian Health programs are eligible to receive funding.

**PATH justice-involved planning and implementation program.** Investments to support collaboration and planning between DHCS, state prisons, county jails, youth correctional facilities, probation officers, peer support specialists, health plans, sheriff's offices, and enrollment offices. Allowable expenditures include:

- Electronic health record for Medi-Cal applications pre-release and coordination of pre- and post-release services
- Hiring of staff and training by qualified applicants to assist with care coordination for pre- and post-release services
- Billing systems
- Conferences and meetings to support collaboration
- Planning and process development for identification of uninsured, application assistance and submission, and ongoing oversight and monitoring

## Conclusion

In 2022, 95,000 Medi-Cal members will be eligible for ECM, and an estimated 40,000 members will transition into community supports from existing WPC and HHP. CalAIM builds upon California's success in addressing the physical, behavioral, and social needs of Medi-Cal members. Whole Person Care pilots have already shown the effectiveness of [ECM](#) and [community supports](#). For example, Los Angeles County saw a 71 percent reduction in hospital readmissions and 24 percent reduction in emergency department visits from the use of a psychiatric recuperative care service. Additionally, emergency department and inpatient utilization rates decreased, and positive indicators for preventive care and engagement increased. CalAIM moves beyond the state option for innovation in 1115 demonstration waivers by creating sustainable funding for services through the managed care delivery system. As states consider how to address the health and social needs of their Medicaid members, CalAIM provides a model for leveraging Medicaid managed care for housing services.

## Additional Resources:

- [Contract Template Provisions for ECM and Community Supports \(ILOS\)](#)
- [ECM and Community Supports Provider Standard Terms and Conditions](#)

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- [CalAIM Enhanced Care Management and Community Supports Repository of Data Sharing Authorization Forms and Agreements](#)
  - [CalAIM Data Guidance: Billing and Invoicing between ECM/Community Supports Providers and MCPs](#)
  - [Community Supports \(In Lieu of Services\) Fact Sheet](#)

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