Enhanced Care Management and Community Supports: Key Findings and Opportunities to Improve Implementation[1]

Overview of CalAIM's Housing Support Programs

Introduction to Enhanced Care Management and Community Supports

In 2022, California's Department of Health Care Services (DHCS) launched California Advancing and Innovating Medi-Cal (CalAIM), a sweeping initiative that aims to deliver coordinated, holistic care for Medi-Cal (California's Medicaid program) members with the most complex needs, including people experiencing or at risk of homelessness. Through CalAIM, the State is leveraging federal Medicaid flexibilities to pay for housing-related services.[2] Among the many components of CalAIM, two key programs introduced in 2022 have significant implications for people experiencing or at risk of homelessness: Enhanced Care Management (ECM) and Community Supports (referred to collectively herein as ECM/CS). Administered through Medi-Cal managed care plans (MCPs), ECM/CS were designed to enhance care coordination, address many of the social drivers of health, improve health outcomes, and reduce unnecessary health care spending for people with complex needs.

Enhanced Care Management (ECM)[3] delivers comprehensive care management to Medi-Cal members with the most complex needs. The program provides eligible members with a care team or staff who help that individual navigate physical, mental, behavioral, and social systems, and coordinate their clinical and non-clinical needs. Importantly, ECM providers can meet members where they are, whether that's in a shelter, encampment, at home, or otherwise. The State has prioritized several "Populations of Focus" to receive ECM, including individuals experiencing homelessness.[4] ECM is a statewide benefit that MCPs are required to offer individuals who meet eligibility criteria.

Community Supports[5] are 14[6] services that are intended to address members' health-related social needs and prevent costlier, more intensive health care interventions like hospitalization. Of the 14 services, five are specifically housing-related:

- **Housing transition navigation services** (HTNS) help members find, apply for, and secure housing.
- **Housing deposits** provide deposits to secure a unit, which includes support with things such as utilities.
- **Housing tenancy and sustaining services** (HTSS) are supportive services to help members maintain tenancy once they have been housed.
- **Recuperative care** (medical respite) provides members with a facility to continue to heal from an injury or illness, with a focus on monitoring and recovery from their condition.
- **Short-term post-hospitalization housing** provides housing up to six months following a discharge from a recuperative care facility or inpatient facility.

While Community Supports are optional services that MCPs can choose to provide on a county-by-county basis, all MCPs offer the core housing trio (HTNS, Housing Deposits, and HTSS).[7]

When taken together, ECM/CS create a unique opportunity to better serve people experiencing homelessness, leverage Medi-Cal dollars to provide – and potentially expand – housing services typically funded by the homeless response system, and integrate the homeless and health care systems as they serve shared clients.

[1] This paper is part of a larger report entitled Statewide Initiatives to Address Complex Needs of People Experiencing Homelessness: Key Takeaways from Implementation of the Department of Health Care Services' Systems Integration Efforts, developed by Homebase and funded by the California Health Care Foundation. The report offers a deep dive into the impact, challenges, and opportunities made possible by two critical and complementary state initiatives aimed at improving health and housing outcomes of Californians experiencing homelessness: CalAIM's housing-related services – Enhanced Care Management (ECM) and Community Supports (collectively referred to in these materials as ECM/CS) – and the Housing and Homelessness Incentive Program (HHIP).

[2] CalAIM 1115 Demonstration & 1915(b) Waiver, California Department of Health Care Services (DHCS).

[3] Medi-Cal Transformation: Enhanced Care Management, California Department of Health Care Services (DHCS).

[4] For the full list of Populations of Focus, see Enhanced Care Management Population of Focus Eligibility Criteria, Attachment 1, California Department of Health Care Services (DHCS). Note that individuals experiencing homelessness include adults, children, and youth.

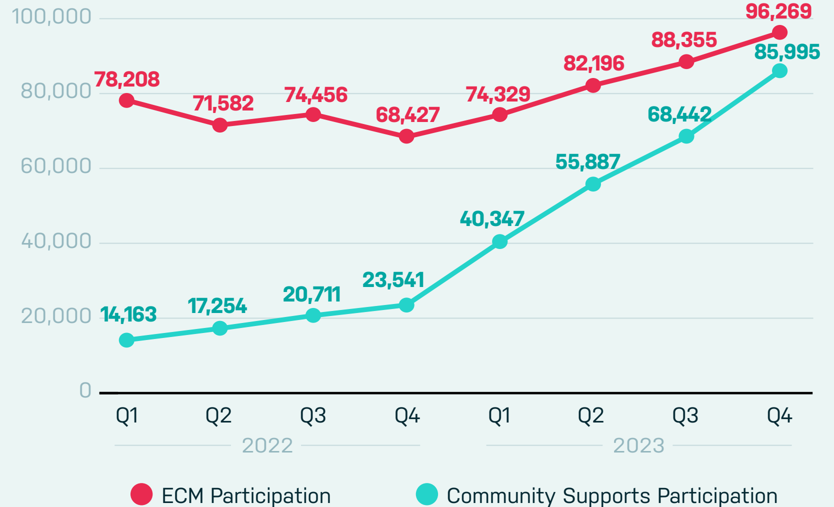
[5] Transformation of Medi-Cal: Community Supports, California Department of Health Care Services (DHCS).

[6] The 14 Community Support services are: Housing Transition Navigation Services; Housing Deposits; Housing Tenancy and Sustaining Services; Short-Term Post-Hospitalization Housing; Recuperative Care (Medical Respite); Respite Services; Day Habilitation Programs; Nursing Facility Transition/Diversion to Assisted Living Facilities; Community Transition Services/Nursing Facility Transition to a Home; Personal Care and Homemaker Services; Environmental Accessibility Adaptations (Home Modifications); Medically-Tailored Meals/Medically-Supportive Food; Sobering Centers; Asthma Remediation. At the end of 2024, DHCS received approval to roll-out Transitional Rent, which will be an additional housing support, structured as a benefit (rather than an optional service).

[7] CalAIM Community Supports Elections – Managed Care Plan Elections, California Department of Health Care Services (DHCS).

Importance of ECM/CS to People Experiencing Homelessness

Medi-Cal coverage of housing-related services has come online at an urgent time in California's housing and homelessness crisis. A full 30% of America's unhoused population – and 50% of its unsheltered population – resides in California.[8] Amidst a severe housing shortage,[9] the number of people experiencing homelessness in California continues to grow.[10] Unlike Medicaid, which is an entitlement program jointly funded by states and the federal government that guarantees health care coverage for anyone who meets the eligibility criteria, there is no entitlement program for housing at the federal or state level. Moreover, the federal appropriation allocated for homelessness is insufficient to meet the growing need. This funding shortage leads to long waitlists, systems that prioritize people based on their severity of need, and far too many people left experiencing homelessness for far too long.



Leveraging Medi-Cal as a source of funding and services is a tremendous opportunity. Yet bringing health care – specifically MCPs – into the delivery of housing services is a sea change and demands that two systems with different perspectives, mandates, and operating models collaborate to deliver services in a coordinated way that works for people experiencing homelessness.

ECM/CS Implementation Progress to Date

As with any new program that requires systems change and integration, implementation of ECM/CS presents many challenges for both the individuals eligible for new resources and the systems intended to support them.

Aiming to address the physical ***and*** social needs of Medi-Cal members with complex needs requires a reimagining of how health care is delivered. In a system as large and complex as Medi-Cal – which insures nearly 15 million people[11] – it is a massive undertaking. Efforts like this require new policies, processes, and technology. Relationships between health and homeless response system partners require time to take hold.

Fortunately, CalAIM builds upon two precursor programs: Whole Person Care (WPC)[12] and the Health Homes Program (HHP),[13] both initiated after the expansion of Medi-Cal to childless adults and designed to address the physical, behavioral, and social needs of Medi-Cal members. In many of the places that participated in these programs, WPC and HHP infrastructure served as a foundation for CalAIM and helped kickstart partnerships between health care and homeless response systems. Since not all California counties participated in WPC or HHP, many places had to start CalAIM efforts from scratch. ECM/CS are also administratively different from the precursor programs, especially WPC, so even participating counties had to make significant changes.

As a result of the scale and complexity of CalAIM, ECM/CS has been slow to fully roll out. There are still hundreds of thousands of Medi-Cal members across the state likely eligible but not enrolled in either program. Significant progress has been made, however, fueled by DHCS's investments in technical assistance and capacity building through the CalAIM Incentive Payment Program (IPP),[14] the Providing Access and Transforming Health (PATH) initiative,[15] the Housing and Homelessness Incentive Program (HHIP), and DCHS' policy efforts to standardize and streamline access and participation for providers and members alike.[16] With time, enrollment in both programs has increased and is expected to grow.[17]

The above chart, tracking overall ECM/CS participation through the end of 2023, indicates that participation in both programs is steadily increasing. Despite the growth, only a fraction of

[8] Fact Sheet: Homelessness in California, California State Senate Housing Committee, January 2024. Based on The 2023 Annual Homeless Assessment Report to Congress.
[9] Walters, Dan, Eye-popping construction costs intensify California's chronic housing shortage, CalMatters, July 25, 2024.
[10] Kendall, Marissa, Exclusive: California's homeless population grew again this year, especially in these counties, CalMatters, September 10, 2024.
[11] Medi-Cal Monthly Eligible Fast Facts, California Department of Health Care Services (DHCS), September 2024.
[12] Whole Person Care Pilots, California Department of Health Care Services (DHCS).
[13] Health Homes Program, California Department of Health Care Services (DHCS).
[14] Incentive Payment Program, California Department of Health Care Services (DHCS).
[15] CalAIM Providing Access and Transforming Health Initiative, California Department of Health Care Services (DHCS).
[16] CalAIM Enhanced Care Management & Community Supports, 'Action Plan' to Refine & Improve the Services, California Department of Health Care Services (DHCS), March 2024.
[17] ECM Members Data, ECM and Community Supports Quarterly Implementation Report, California Department of Health Care Services (DHCS), August 2024.

those individuals who accessed ECM/CS in 2022 and 2023 were experiencing homelessness, even though they are a Population of Focus. (For a breakdown by county, please see individual CoC data sheets for each of the CoCs in California.) With over 300,000 individuals accessing California's homeless response systems in both 2022 and 2023,[18] data indicates that – depending on the county where they reside – between 1% and 25% of people experiencing homelessness who are likely eligible for ECM/CS are actually receiving Medi-Cal's housing-related services. While not all individuals experiencing homelessness are eligible for ECM or housing-related Community Supports, the limited participation of people experiencing homelessness invites an examination of what is going well in the roll-out of these programs, what can be enhanced and/or replicated, and where there is room for improvement.

Medi-Cal Member Feedback about ECM/CS

Through one-on-one interviews and focus groups in Alameda, Fresno/Madera, Los Angeles, and Santa Barbara Counties, Homebase asked Medi-Cal members with experiences of homelessness about the ECM/CS services they received and the benefits or impacts of those services.

Throughout this Medi-Cal member engagement, most people shared positive feelings about their ECM and Community Supports providers. Medi-Cal members felt the staff supporting them were trustworthy and genuinely cared about them. While they spoke positively about their providers, most changes in services were invisible to Medi-Cal members (e.g., from homeless response service providers or Federally Qualified Health Centers (FQHCs)), except for the availability of housing deposits and medical respite care. People appreciated when service providers came to them at a shelter or on the streets. They also shared the ways in which being housed had positive impacts on their health, from enabling them to keep medical appointments to reducing stress to enabling recovery from medical conditions. "If I wasn't housed, I don't think I would be alive," shared one interviewee.

Close to 50% of the interviewees had some knowledge that Medi-Cal was now covering housing-related services. Some individuals were surprised to learn that Medi-Cal was paying for services like ECM/CS, yet thought it was appropriate and helpful. Most people were aware that Medi-Cal helps with housing deposits, which are not typically covered through the CoC. Most interviewees had not heard the terms "Enhanced Care Management," "ECM," or "Community Supports."

Interviewees shared concerns about high turn-over for their case managers and/or housing navigators, and how that inconsistency could result in services gaps. They also shared that there was varying quality in staffing. Interviewees felt that there needed to be better training of staff who provide housing navigation and some suggested the need for higher salaries to support more stable staffing.

Among those who received ECM, most people were unaware that an ECM care coordinator could connect them to other social benefits and housing-related services. Some individuals who were not enrolled in Community Supports mentioned that their ECM providers helped them with housing, connecting them to resources to help with rent or to help find a more suitable apartment. They noted that it was welcome to have both a case manager and a nurse checking their vital signs and asking them about their health.

I don't feel like a number here, I feel like they really truly care about my well-being.

– Focus Group Participant

[18] Homeless Data Integration System (HDIS), State of California Business, Consumer Services, and Housing Agency (BCSH).

Key Findings from ECM/CS Implementation

The sections below outline key findings about the successes and challenges of implementing ECM/CS and the programs' impact on people experiencing homelessness. Through interviews and focus groups with MCPs, health care providers, homeless response service providers, State agency staff, and people experiencing homelessness, Homebase surfaced insights that cut across communities and stakeholders.

ECM/CS Implementation Successes

People experiencing homelessness are receiving critical services through ECM/CS. Health and homeless response systems are building collaborative relationships and the infrastructure needed to implement care coordination and housing-related services effectively.

ECM/CS provide critical services to people experiencing homelessness.

- Individuals who received ECM or Community Supports highlighted the role that their ECM care managers and Community Supports providers were playing in their lives and their gratitude for the support they received.
- ECM/CS have enabled many people experiencing homelessness to **gain access to health system resources**. ECM providers described patients who are increasingly able to access both primary and specialty care. Providers offer medication adherence support, take members to doctors' appointments, help them access benefits and other social services – and generally provide them with the intensive, individualized support needed to address clinical and non-clinical needs. One street medicine program described their newfound ability to embed an additional care manager in their street team as critical to helping patients manage their care and recover from serious health incidents. Other providers felt that the State's ECM requirements caused them to strengthen their pre-existing case management services, often in ways that led to a deeper focus on health outcomes and patient priorities.

Some ECM providers – particularly hospital- or clinic- based providers – shared that early data indicate reductions in emergency department and inpatient utilization.

- Despite housing shortages, some Community Supports providers helped clients **access stable housing**, while others focused on their success in helping clients **maintain housing once obtained**. Providers also described educating their clients about the housing search process and helping them access resources and documents needed to qualify and apply for housing.

Medi-Cal is enhancing housing-related supportive services that homeless response systems typically fund with scarce resources.

- Some providers felt that leveraging Medi-Cal has allowed **communities and providers to start new services, expand the number of people served, or sustain programs**. While CoC resources are often focused on serving individuals prioritized by the Coordinated Entry System, the infusion of additional Medi-Cal funding has allowed some communities to **serve more individuals, especially those who would otherwise be unlikely to receive services**.
- The ability to bill Medi-Cal represents **financial sustainability to many local community providers**. Since Medicaid is an entitlement program, it feels more reliable than other competitive, unstable, and/or one-time federal, state, or local grants.

If I can help [my client] within [their] first three months of experiencing homelessness, because [they] work at Cracker Barrel and [they're] just having a hardship last month, and that's what got [them] to live in [their] van, and I can help [them] now before [they] ever become chronically homeless, it's great. I feel like there's nothing else in our system allowing for us to serve that population, because our Coordinated Entry referrals are always prioritizing the most vulnerable.[19]

MCPs are developing strong relationships with their ECM/CS providers and local homeless response systems to better serve members experiencing homelessness.

- MCPs and CoCs are communicating and collaborating more. There has been a marked increase in understanding each other's systems, limitations, strengths, needs, and cross-system opportunities.
- In many communities, MCPs have been engaged, flexible, and accessible partners in the roll-out and implementation of ECM/CS, offering a range of assistance, from in-depth trainings to support with reporting and claims processes to revised Models of Care that align with the needs of local housing and supportive services providers.
- Relationships between MCPs and CoCs have strengthened as MCPs, CoC leadership, and Counties encourage experienced homeless service providers to become Medi-Cal providers, ensuring contracted providers are using CoC systems and expanding overall program referrals and enrollment.
- Some MCPs encourage Community Supports providers who are new to serving unhoused individuals to use the CoC's Homeless Management Information System (HMIS) and the Coordinated Entry System (CES), which allows for better information sharing about the services people may be receiving and allows the system to track in real-time when someone has entered stable housing.

[19] All quotations in this document are from ECM/CS providers unless otherwise noted.

I never talked to any managed care plan until two years ago, and now I talk to them weekly. The whole world in terms of homeless services has completely changed in terms of the role of managed care in all aspects of what we do in a way that is fundamentally different.

As millions of Medi-Cal dollars flow through MCPs into the homeless response system, MCPs are building expertise and capacity internally and within their provider networks.

Some MCPs offer trainings on CoC systems and pay for providers' HMIS licensing fees.

- Several MCPs hired staff with direct experience in the housing and homelessness sector to lead or oversee their ECM/CS efforts. This helps build relationships, enables translation across sectors, and ensures that program design and implementation map to the needs of the homeless sector and people experiencing homelessness.
- Many MCPs launched ECM/CS using their traditional Medi-Cal contracted entities – often larger health care providers with limited expertise serving people who are unhoused – but over time they have recognized the importance of working with local organizations with expertise in serving those facing homelessness and housing instability. MCPs dedicate significant time to supporting organizations that have expertise in serving the unhoused population but may not have experience with Medi-Cal billing.
- Some MCPs are engaging ECM/CS providers to serve people experiencing homelessness or housing instability who are unlikely to receive housing resources through their local CoC's Coordinated Entry System due to scarcity of CoC resources.

Counties are supporting implementation and expansion of ECM/CS through administrative and contracting approaches.

- Counties such as Alameda and Los Angeles serve as administrative hubs, contracting directly with their MCPs on behalf of housing and supportive service organizations so the organizations don't need to contract directly with the MCPs. Administrative hubs help take the burden off of providers – especially those smaller organizations that lack the infrastructure, funding, staffing, or expertise needed to contract with MCPs – and enable more organizations to serve a larger and more diverse range of Medi-Cal members.
- Counties are braiding CalAIM funding with other funding streams, so that all residents can receive services regardless of their Medi-Cal status.

★ **BRIGHT SPOTS**

Four Communities' Successes Supporting People Experiencing Homelessness Through ECM/CS

As part of developing this report, Homebase engaged deeply with four communities to learn how Medi-Cal's new housing-related services have impacted people experiencing homelessness. Health and homeless system providers, MCPs, CoCs, Counties, and others have their own unique stories about implementing these new Medi-Cal services. Profiles and highlights from Alameda County, Fresno/Madera counties (a two-county CoC), Los Angeles County, and Santa Barbara County can be found here. Each case study includes a data profile; to learn more about the data sources and calculations used in that table, see here.

[The County] has historically had a belief that everybody should get the same level of service, not based on your Medi-Cal enrollment status. The benefits of being an intermediary were that we could maintain that commitment to everybody getting the same level of service and that there were existing contracts in place and relationships in place. [We wanted] to make things as easy as possible for the providers to be able to continue services seamlessly.

– County Representative

ECM/CS Implementation Challenges

ECM and Community Supports provide tangible benefits for people experiencing homelessness. However, communities have encountered significant operational barriers, particularly around developing and maintaining provider networks and ensuring information sharing takes place at the level needed to manage referrals and service delivery. Better coordination across sectors is needed to maximize resources, minimize administrative complexities, and significantly increase program enrollment for some of the most vulnerable people in the health care system.

I think the opportunities are on scaling the program and reaching the people who need it. I see every day how much of a difference this program could make, and then I look out there in the world and see that we're serving a fraction of the people who are eligible for it [...] The frustration I feel is I want to get this to more people faster.

Operational Barriers and Administrative Challenges

CalAIM administrative requirements create operational hurdles for ECM/CS providers, especially homeless response organizations that are new to the world of Medi-Cal.

- Homeless response service providers consistently experience challenges as ECM and/or Community Supports providers, such as lengthy contracting processes; claims denied or delayed for unknown reasons; and heavy administrative efforts needed to check enrollees' Medi-Cal status, approve re-authorizations, and submit required reports. The lack of standardization further complicates matters: each MCP interprets the State's policy guides differently, resulting in varied application and credentialing requirements and processes, referral forms, and enrollment processes.

Even after 12-18 months of operation, and despite initial training, many providers still struggle with claims submission. Technical specifications prove particularly challenging, with providers struggling to interpret and implement billing requirements. Many providers required continuous 1:1 technical support from MCPs.

- Providers unaccustomed to the world of health care must contract with MCPs, consider investing in Electronic Health Record systems, and document and bill for services in entirely new ways. Smaller organizations lack the infrastructure for electronic billing, and some organizations lack case management data systems needed for the requisite documentation. Some providers must resort to manual claim entry, creating additional burdens.
- Billing reconciliation issues contribute to the administrative and financial burden of providing ECM/CS, as providers spend significant time resolving payment issues and confirming eligibility in MCP portals, only to face denied claims due to lapsed coverage.
- Communication from MCPs is often unclear or inconsistent. Multiple ECM providers expressed a disconnect between initial contract expectations and audits. Some providers shared that MCPs make program changes without provider input and often don't communicate them effectively.

We've needed to rehire a dedicated biller who's familiar with electronic billing using a clearinghouse. We've had to reconfigure our electronic health record system multiple times...The health plans have changed some of the billing rules and I don't know that it's been published or communicated effectively. We've received denials for reasons within the last three months for things that we never got denials for 18 months ago...And then when claims are paid, we've had certain services where, because of software updates for the health plans, our claims have been paid the incorrect amount, about half of what our contract specifies. The changing of billing rules has really just thrown a huge loop into an organization who is really trying to settle ourselves.

Knowledge and Capacity Challenges

Enrollment in and overall awareness of ECM/CS is still extremely low.

- Individuals can be referred for ECM/CS by organizations, health providers, family, friends, and/or themselves – but that requires widespread knowledge about the program and referral pathways. Three years into CalAIM, program awareness and referrals are still very low. Across the communities highlighted in the case studies, less than 1% of their total Medi-Cal MCP enrollment was receiving ECM or Community Supports by the end of 2023.
- Medi-Cal members with lived experience of homelessness are unfamiliar with ECM/CS – even if they are receiving the services under one or both programs. It is hard for providers to convince someone to enroll in a program they have never heard of and nearly impossible for individuals to self-refer if they are unaware of the programs.
- Homeless response system providers and hospitals – entities that interact daily with unhoused individuals who are likely eligible for ECM/CS – are not systematically referring their clients for services.
- Many providers, and even some MCPs, remain confused about ECM/CS, sometimes conflating the two programs or unclear about which services are covered by which program.

This negatively impacts MCP expectations of providers, providers' understanding of reimbursable services, and care coordination for people receiving services from multiple providers.

- Some ECM providers limit the scope of their services to patients who regularly come to their brick-and-mortar sites, but Medi-Cal members living on the street are often unable to go on site for services. ECM providers whose care managers don't go where people are located are not aligning with the intentions of the ECM program and thereby limiting access to critical services.

It's surprising to me that we're this far in, and you still find hospitals that don't even know about [CalAIM] or that haven't done anything towards implementing it.

Providers struggle to build and maintain the capacity needed to provide ECM/CS services.

- Many organizations overestimated their service capacity and are serving fewer clients than they expected. Providers struggle to maintain the higher caseloads needed for financial sustainability while ensuring service quality. Minimal requirements set by MCPs can be particularly difficult to meet when clients stop engaging or can't be found but remain on caseloads, especially since attempted contacts are often not billable.
- Providers struggle to hire and retain qualified staff to provide ECM/CS services. Competition with other employers that can offer comparable or higher pay, including fast food establishments, affects hiring. High turnover rates compromise the ability of organizations to maintain institutional knowledge and create a continuous need for retraining on complex systems, billing processes, and data entry.

Loss of trained billing staff particularly impacts smaller organizations. Rural areas face particular difficulties with provider capacity.

- Many homeless service providers were unaware of or had not accessed the State's Providing Access and Transforming Health (PATH) initiative funds, which were allocated to support organizations with the costs of becoming ECM/CS providers and invest in the systems and staffing needed to manage the administrative workload.

Financial Pressures and Reimbursement Challenges

CalAIM creates challenging financial pressures for ECM/CS providers serving people experiencing homelessness.

- Reimbursement rates – especially for ECM – are insufficient to cover the costs of serving people experiencing homelessness and may make the work unsustainable. Many critical services for people who are unsheltered are unbillable or unaccounted for in reimbursement rates, including attempts to contact members, extensive travel time, and repeated visits to build trust. Per member per month (PMPM) rates don't increase based on the efforts required to address complex health and social needs. While MCPs are largely aware of the reimbursement rate challenges, they have not yet received higher PMPM rates from the State to account for the additional costs of Community Supports; the cost savings that Community Supports are intended to yield have yet to be realized.

Providers described traveling long distances to identify and connect with their transient clients and spending significant amounts of time to establish trust and effectively coordinate their health and housing needs.

- Variation in payment rates and structures across MCPs creates budgeting complexity. MCPs offer different rates for the same services and have different expectations around service provision, all of which impacts caseload sizes.
- Providers face significant payment delays, which are exacerbated when authorizations or invoices and claims are denied. Multiple providers described payment delays of up to several months, especially during the initial period of being a contracted provider. These delays create substantial financial strain, especially on small nonprofit organizations, and require significant cash reserves to maintain operations.
- Many homeless response service providers have taken on significant costs – from new staff to new technology systems – to manage the administrative requirements of Medi-Cal. Some worry that other funders will cut grants and contracts, assuming that Medi-Cal reimbursements will make up the difference; in at least a few communities, County and City funders have failed to renew grants, expecting that providers can instead receive reimbursements through ECM/CS.

For many providers, billing Medi-Cal is a far more expensive way of getting funding than drawing down grants from their typical funding sources – and for many, it hasn't translated to additional revenue with which to expand or deepen services.

Medi-Cal funding limitations are resulting in confusion and competition.

- Both state and federal regulations require that providers use Medi-Cal services and funds to complement and supplement, but not supplant, existing programs and funding streams.[20,21] For some providers, this has led to concerns and confusion about how to braid funds and create wraparound services in a way that does not run afoul of state and federal rules.
- The shift to Medi-Cal billing is creating competition amongst ECM/CS providers in a field where clients historically engage with multiple providers at the same time. Providers describe a sense of urgency around enrolling clients into their program to capture the associated revenue, instead of jointly serving the client depending on the needs of the individual.

System Integration and Coordination Challenges

Disconnected and varying referral systems create barriers to facilitating appropriate referrals and ensuring care coordination.

- Referral pathways are typically built on individual relationships between providers and their clients and/or providers and MCPs, as opposed to consistent, institutionalized, referral systems.
- MCPs have different pathways to refer people for ECM/CS and different documentation requirements, which has led to significant provider confusion. Some MCP staff have inconsistent knowledge about eligibility and referral processes, as well.
- Many ECM/CS providers from outside the homeless response system lack knowledge about how to refer members to local Coordinated Entry Systems and housing resources.
- Homeless response service providers consistently expressed frustration that Community Supports providers try to house individuals without using Coordinated Entry – the CoC infrastructure designed to match people to scarce housing resources and coordinate services for people experiencing homelessness.

The ECM and Community Supports programs are not tightly coordinated

- ECM providers are not consistently referring clients for Community Supports – and vice versa – even when there's a clear need for the other program's services. If a Medi-Cal member is enrolled in both programs, their providers aren't necessarily collaborating to coordinate care.
- ECM providers frequently mentioned supporting their clients with housing needs as part of their overall case management approach – even though the housing-related Community Supports are designed to address housing navigation, raising questions about fragmentation and duplication of services.

[ECM and CS providers] are siloed. We don't know who each other are. We don't have a way to communicate. We find that, especially the housing Community Supports, there's very high turnover, and so even if we do build a relationship with a navigator, that might change over time. So a lot of resources are going into these entities doing parallel play.

MCPs and homeless response systems have different perspectives and interpretations on the length and scope of necessary housing-related supportive services.

- Authorization periods vary by MCP, which creates complications for providers and homeless response systems seeking to build system flows and manage care coordination.
- Re-authorization requirements for housing-related Community Supports are overly burdensome, especially when it is known that a Medi-Cal member has a long-term need for services, e.g., those in permanent supportive housing who likely need Housing Tenancy and Sustaining Services year after year.
- The homeless response system provides supportive services – like those now available through Medi-Cal's Housing Tenancy and Sustaining Services – to individuals who may need those services for their whole lives to avoid falling back into homelessness. In contrast, managed care often views services like ECM/CS as up-front investments designed to stabilize an individual so that their condition improves and reduces the need for ongoing, intensive (and expensive) services. CalAIM guidelines do not limit the length of time a Medi-Cal member may receive Housing Tenancy and Sustaining Services,[22] but in practice, many MCPs cap the length of time they authorize services.

I'm nervous of how long they'll continue to have reauthorizations. There'll be a point where we have to discontinue services. And especially in my programs where we're building a long-term support service model for people who've moved into Housing First type opportunities, chronically homeless… These people need long-term subsidies.

[20] 2 CFR Part 200 Appendix XI: Compliance Supplement, U.S. Office of Management and Budget (OMB), April 2022.

[21] Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide, California Department of Health Care Services (DHCS), July 2023.

[22] The Community Supports Policy Guide states "These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed." For more, see: Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide, California Department of Health Care Services (DHCS), July 2023.

Information Sharing and Data System Challenges

Separate information systems compromise effectiveness of referrals and care coordination.

- Homeless response service providers cannot see into Medi-Cal systems, making it challenging for them to learn if someone has already been referred to ECM or a specific Community Support. ECM/CS providers who don't use HMIS cannot access information about members' existing case workers who could help those providers find and connect with their assigned members. Without that assistance, many ECM/CS providers cannot locate or contact members experiencing homelessness to enroll them in services. As a result, many Medi-Cal members are approved for ECM/CS but not ultimately enrolled.
- It is hard, if not impossible, to track someone's receipt of CalAIM services. Referring providers are not informed of and have difficulty accessing referral status or needed documentation. ECM/CS services and outcomes (e.g., if a person is housed) are not accessible to homeless response system partners.

The inconsistent use of HMIS limits true integration between health care and homeless response systems.

- The landscape of HMIS usage and interaction for housing-related Community Supports is varied and complicated. CalAIM does not require that ECM/CS providers – even those providing housing-related services – use HMIS, which can lead to duplication of efforts. Clients may be successfully housed through an ECM/CS program, but the homeless response system has no way of knowing it.
- Some ECM/CS providers are eager to use HMIS, but find it difficult to gain access to the system from HMIS administrators. HMIS users must pay licensing fees and while some MCPs pay those costs for their providers, that is not happening universally. Other providers have access to HMIS but don't know how to navigate the system or correctly enter data, leading to data quality concerns.

> “You can do Housing Transition Navigation Services and you don't have to even be an HMIS provider. That's really confusing to me. How can someone be doing housing navigation, but they have never even touched HMIS?

Housing scarcity is the ultimate challenge.

Providers are challenged trying to address their clients' true needs: stable and affordable housing. At the end of the day, an individual's primary need is for housing – and navigation and coordination can only be so successful without this critical resource.

> “The number one thing that would help this population is additional [housing] units, and that's the piece that we don't have control over.
>
> *– MCP Representative*

Looking Forward: Opportunities to Improve ECM/CS Implementation

Three years into implementation, CalAIM's ECM/CS programs have provided critical services to people experiencing homelessness, infused Medicaid dollars into the homeless system of care, turned MCPs into engaged participants in homeless response systems, and resulted in deeper collaboration across the health and homeless/housing sectors. More changes are afoot, as DHCS streamlines implementation challenges through its Action Plan,[23] adds Transitional Rent,[24] and plans to leverage California's new investment in behavioral health to address homelessness.[25]

There are many opportunities to improve the implementation of ECM/CS in California. State agencies, managed care plans (MCPs), counties, Continuums of Care (CoCs), health care providers, homeless response providers, people experiencing homelessness, and others have shared the successes and challenges experienced during the first three years of the programs' roll-out. Lessons learned from those experiences inform the following opportunities:

- Make ECM/CS Simpler and More Accessible;
- Enhance Provider Support;
- Enable Providers' Financial Sustainability;
- Adopt System Integration; and
- Promote Better Data Systems & Information Sharing

Fulfilling these opportunities requires significant upfront investment but is critical for long-term success. Communities that have made these investments report improved coordination, more efficient service delivery, and better outcomes for clients. Key to success is recognition that infrastructure development is an ongoing process requiring sustained commitment and resources from all partners.

Make ECM/CS Simpler and More Accessible

- **Minimize eligibility requirements:** Take advantage of systems already in place to very eligibility to help lessen the burden on providers and Medi-Cal members. Efforts might include:
  - offering presumptive eligibility for ECM and relevant Community Supports to people with certain conditions or life circumstances;
  - relaxing requirements for documentation/verification for eligibility criteria; and
  - simplifying or expediting diagnoses and/or prescriptions, where required.
- **Reduce documentation burden:** Require only information that is strictly necessary when requesting member-related documentation from ECM and Community Supports providers. Allow use of documentation already available from other sources, rather than duplicating requests that create heavy burdens on providers and take time from providing services to Medi-Cal members. Efforts might include:
  - developing clear and standardized guidance and templates for documentation requirements;
  - creating efficient mechanisms for collecting required information;
  - eliminating duplicative documentation requirements; and
  - supporting technology solutions for documentation management
- **Streamline authorizations:** Create a service authorization process that is uniform and fair across all MCPs so that all Medi-Cal members have equitable access to ECM/CS, regardless of where they live. Efforts might include:
  - standardizing authorization requirements across all MCPs;
  - extending authorization periods to reduce administrative burdens;
  - creating simplified processes for common service needs; and
  - ensuring consistent utilization of mechanisms for expedited authorizations when needed.
- **Simplify billing process:** Reduce the burden on providers, especially those not accustomed to working within Medi-Cal, so that providers can focus on services and clients/patients. Efforts might include:
  - creating simplified, uniform billing processes for common services;
  - developing clear guidance on allowable services;
  - reducing the complexity of billing specifications;
  - standardizing documentation requirements across programs and MCPs; and
  - extending billing submission timelines to accommodate provider capacity.

[23] CalAIM Enhanced Care Management and Community Supports: 'Action Plan' to Refine & Improve the Services, California Department of Health Care Services (DHCS), March 2024.

[24] "California Secures Unprecedented Federal Funding for Critical Behavioral Health Supports", DHCS, December 16, 2024.

[25] Behavioral Health Transformation, California Department of Health Care Services (DHCS); Behavioral Health Bridge Housing, California Department of Health Care Services (DHCS); and "California Secures Unprecedented Federal Funding for Critical Behavioral Health Supports", DHCS, December 16, 2024.

Enhance Provider Support

If you're becoming an ECM provider, if there could be a Housing 101 training – if you're having housing insecurity, living in your car, need a deposits or help moving in, what's next? Unless you are really in the field, you won't wrap your head around all of them. If there was a workshop for becoming an ECM provider, that would be amazing.

- **Increase provider capacity:** Build provider capacity and leverage additional resources to serve people experiencing homelessness.[26] Efforts might include:
  - providing ongoing technical support to providers beyond the initial implementation period, including resources for technology infrastructure development;
  - providing funding to support expanded staffing, infrastructure, and emerging challenges;
  - creating longer ramp-up periods for new providers to develop the infrastructure to participate in Medi-Cal;
  - developing statewide training programs for providers that address both health care and housing expertise;
  - offering specialized support for billing and documentation requirements, including development of administrative and billing capabilities for new providers;
  - strengthening and consistently leveraging regional or statewide resources, rather than having support be contingent on individual MCPs; and
  - providing financial and other support for providers to hire people with lived experience of homelessness.

The thing that saved our program was hiring people with lived experience that could build our program based on what they know is needed and would move the needle on people's lives.

- **Set-up administrative/billing hub models:** Coordinate across Counties, MCPs, and other systems to develop administrative and/or billing hub models to reduce the burden on direct service providers. Efforts might include:
  - facilitating Counties or other agencies to act as centralized administrative hubs to support smaller providers;
  - creating other alternative economies of scale for regional or statewide billing and reporting; and
  - providing sustainable infrastructure for smaller organizations.

It's all about the roll-out and support at the beginning. Better education and more time spent upfront has been critical in launching and sustaining a growing program.

- **Establish mentorship and peer learning opportunities:** Build off the knowledge and expertise of seasoned ECM/CS providers and MCPs. Efforts might include:
  - leveraging expertise of successful providers to guide new entrants (e.g., establishing formal mentorship programs between experienced and new ECM/CS providers);
  - creating learning communities to share challenges and best practices for CoCs, providers, and MCPs;
  - supporting peer-to-peer learning on billing and documentation requirements;
  - building networks of providers for ongoing support and problem-solving;
  - offering regular MCP "Office Hours" to discuss challenges and ask questions; and
  - identifying points of contacts/liaisons at each MCP who can provide easy access to information for contracted providers and those providers interested in becoming contracted providers.

[26] Some of the efforts described in this section could be accomplished, at least in part, through the State's existing PATH Technical Assistance Marketplace or PATH CITED (Capacity and Infrastructure Transition, Expansion and Development) initiative. But to fully address the issues explored in this report, there needs to be an increased effort to increase uptake of those resources, including by making the process to obtain technical assistance from the Marketplace less burdensome for providers.

Enable Providers' Financial Sustainability

> We learned that we really need upfront funding to make the program work.

- **Make braiding of funding easier:** Leverage state resources and relationships to support local community efforts to braid and maximize funding streams. Efforts might include:
  - creating guidance, processes, and tools on braiding multiple funding sources and sharing costs across systems;
  - supporting flexible funding approaches that allow systems to better meet the unique needs of individual clients; and
  - creating or providing guidance on sustainable funding models for ongoing operations.
- **Increase provider negotiating power:** Bring together providers from all over the state to learn together to negotiate sustainable rates and billing structures. Efforts might include:
  - facilitating communications and peer learning among providers; and
  - increasing transparency of rates and billing structures across communities and MCPs.

> The way the MCPs set up the rates don't allow us to customize our services to meet people's needs. Some people need more than the required number of touch points, some need or ask for less.

- **Consider rate reform:** Ensure guidance, requirements, and incentives align with the need for MCPs to pay fair and equitable rates so that provider participation is sustainable and Medi-Cal members have access to providers with expertise, regardless of where they live in the state. Efforts might include:
  - establishing consistent rates across plans for the same services, adjusted for regional variation in rural and high cost areas;
  - incorporating flexibility that enables providers to meet the needs of individual clients in a person-centered way and/or that reflects the difference in costs in initial implementation; and
  - ensuring that mechanisms for regular rate review and adjustment incorporate input from providers working with people experiencing homelessness across the state, account for non-billable but essential activities, and reflect the true cost of service delivery including administrative infrastructure.

Integrate Health and Homeless Response Systems

> When it comes to the housing component, when an ECM referral comes in, we need to understand what their current situation is before they are engaged by outreach or housing navigators. That will help their housing journey a lot better, it would make initial intake better if we had some way to know: what is their current housing need?

- **Standardize referral flows:** Require MCPs to develop and standardize processes around referrals for individuals who are likely eligible for ECM/CS. This includes leveraging systems that have long served people experiencing or at risk of homelessness. Efforts might include:
  - defining roles and responsibilities and developing standard workflows for different types of referrals;
  - leveraging CoC Coordinated Entry intake points/hubs to facilitate referrals;
  - designating points of contacts at MCPs for referrals from CoCs/homeless response service providers;
  - assigning members experiencing homelessness to ECM and CS providers with experience serving unhoused individuals; and
  - streamlining referral protocol for street outreach/street medicine teams.
- **Enhance access to Medi-Cal/MCP enrollment:** Support campaigns to increase the number of people experiencing homelessness enrolled in Medi-Cal and streamline eligibility decisions in partnership with homeless response systems and providers. Efforts might include:
  - providing real-time access to enrollment information;
  - enabling immediate verification of eligibility;
  - supporting providers in maintaining client coverage;
  - creating alerts for coverage lapses or changes; and
  - streamlining enrollment and renewal processes.
- **Integrate ECM/CS into CoC systems:** Incorporate information about ECM/CS participation into long-standing CoC infrastructure. Efforts might include:
  - integrating referral processes into Coordinated Entry Systems;
  - developing common data fields in HMIS to collect ECM/CS eligibility, enrollment, and service information;
  - developing joint assessment and prioritization tools; and
  - creating bi-directional data sharing between systems (more details on the following page).

Promote Better Data Systems and Information Sharing

In my dream world, there would be an HMIS system that connects to the MCP's [data system] so it would ping us and flag us if there was a change [in Medi-Cal enrollment].

- **Enable information sharing that tracks client referrals, service receipt, and outcomes:** Ensure that MCPs and homeless response systems are sharing information about Medi-Cal members in common so that services and successful housing placements are reflected in both systems. Efforts might include:
    - establishing protocols and mechanisms for all stakeholders to track client progress and outcomes from referral and initial contact through service engagement;
    - developing alerts for providers when action is needed;
    - creating accountability measures for referral follow-up;
    - documenting housing placement in both health care and homeless response systems; and
    - supporting care coordination between multiple providers serving the same client, including across systems.
- **Institute real-time data sharing:** Support infrastructure, security, and privacy standards to increase communication, avoid duplication of services, and increase cross-sector collaboration. Efforts might include:
    - establishing infrastructure for immediate information exchange, including mechanisms for sharing protected health information appropriately;
    - enabling providers to access current Medi-Cal member enrollment status;
    - developing systems to alert providers of client status changes; and
    - sharing location data so that Medi-Cal members can successfully enroll in ECM/CS and receive services.
- **Standardize data sharing agreements:** Develop guidance and tools that can be used to support cross-sector data sharing efforts across the state. Efforts might include:
    - developing state-level templates for data sharing agreements between MCPs and CoCs;[27]
    - creating clear guidance on permissible data sharing under privacy regulations;
    - establishing standard protocols for protecting client privacy while enabling care coordination;
    - defining minimum necessary data elements for cross-system coordination; and
    - including provisions for bi-directional data sharing to support both systems.
- **Support HMIS integration:** Recognize that HMIS is a federally required system, albeit with limitations, and leverage it to the maximum effort. Efforts might include:
    - accepting that HMIS is primarily an inventory system rather than one for tracking outcomes;
    - funding expansion of HMIS to serve ECM/CS needs as current systems are already at capacity with existing federal data requirements;
    - developing standardized approaches for incorporating health care data into HMIS;
    - creating mechanisms to track ECM/CS service delivery within HMIS;
    - supporting costs of HMIS licenses for health care partners, including ECM/CS providers; and
    - addressing challenges of manual data matching and cleanup.

Conclusion

CalAIM represents the opportunity to turn the vision of "housing is health" into a reality. ECM/CS have already provided vital and – in many cases – lifesaving services to unhoused people with complex care needs. There is more work to do to ensure that all those who are eligible for these benefits and services receive them, and that the homeless and health care systems are integrated in a way that maximizes the strengths and resources of each party. As more states pursue a similar path with their Medicaid programs, all eyes are on California.

[27] Some efforts are already underway, e.g., DHCS' Data Sharing Authorization Guidance "Medi-Cal Housing Support Services" and "Reentry Initiative" Toolkits.