CalAIM Bright Spots

Four Communities' Successes Supporting People Experiencing Homelessness

Homebase with support of California Health Care Foundation - Feb 2025

Each of the communities Homebase engaged with to learn how Medi-Cal's new housing-related services have impacted people experiencing homelessness, health and homeless system providers, managed care plans (MCPs), Continuums of Care (CoCs), Counties, and others have their own unique stories about implementing these new Medi-Cal services. Below are profiles and highlights from Alameda County, Fresno/Madera counties (a two-county Continuum of Care), Los Angeles County, and Santa Barbara County.[1] Each case study includes a data profile; to learn more about the data sources and calculations used in that table, see the endnotes.

[1] While the case studies span from CalAIM's inception to the present (interviews were completed as late as October 2024), the data tables use data sources from 2023 to ensure consistency. The anecdotal information from MCPs and Medi-Cal providers is that many more people are receiving ECM and housing-related Community Supports in 2024.

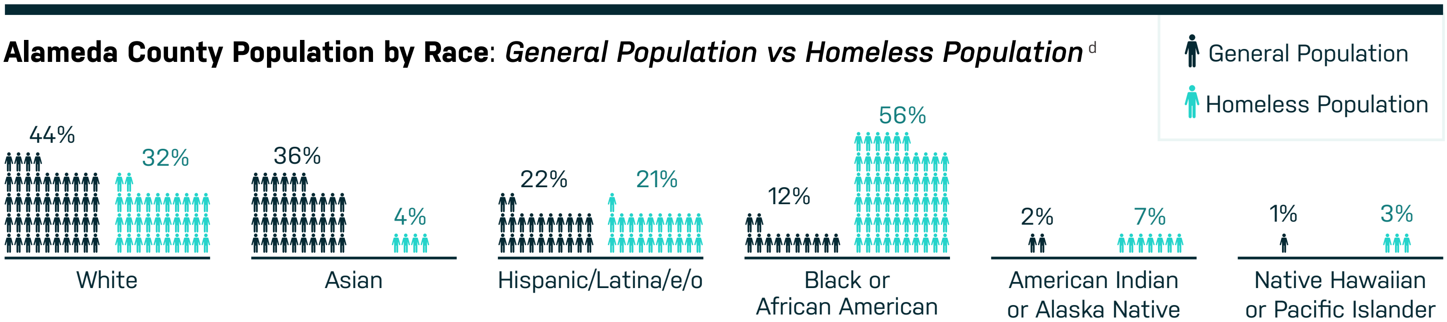
Alameda County

An Engaged County Builds on Whole Person Care to Advance Housing and Street Medicine

CalAIM Bright Spots

- **Two Managed Care Plans (2023):**[a]
  Alameda Health Alliance and Anthem Blue Cross
- **Total Managed Care Medi-Cal Enrollment (2023):**[b]
  440,994
- **Whole Person Care/Health Homes Participant:**[c]
  Yes

Alameda County Population by Race: *General Population vs Homeless Population*[d]



NEED

Calendar Year 2023

13,655

Estimate of People Experiencing Homelessness **in Alameda County** via HMIS/HDIS[e]

9,342

Estimate of People Experiencing Homelessness **with Disabling Conditions**[f]

7,936

Estimate of People Experiencing Homelessness **Who Accessed Care through the Emergency Department**[g]

ACCESS/SERVICES

Calendar Year 2023 Quarter 4 only

Enhanced Care Management (ECM)

2,567

Number of Members who are **Enrolled in Enhanced Care Management (ECM)**[h]

26%

665

Enrollment of Members **Experiencing Homelessness in ECM**[i]

Community Supports

2,496

Number of Members who **Utilized Community Supports**[j]

26%

657

Number of Members Receiving **Housing Transition Navigation Services**[k]

2%

47

Number of Members Receiving **Housing Deposits**[l]

38%

959

Number of Members Receiving **Housing Tenancy and Sustaining Services**[m]

A County's Unique Role in Streamlining Housing-Related Community Supports

Alameda County covers nearly 738 square miles in the San Francisco Bay Area and is home to more than 1.6 million people. EveryOne Home, a collective impact initiative, serves as the Oakland-Berkeley/Alameda County Continuum of Care (Alameda County CoC). Alameda County Health's (ACH) Housing and Homelessness Services (H&H) is the Collaborative Applicant, HMIS Lead, and Coordinated Entry Lead for the Alameda County CoC.

Alameda County has engaged in cross-sector work with its health and homeless systems of care for a long time. The County participated in both the State's Whole Person Care (WPC) 1115 Waiver and Health Homes (HH) pilot projects, programs that served as the foundation for the CalAIM initiative. Because of its participation in WPC and HH, Alameda County had a robust network of health and homeless service providers and had launched a Social Health Information Exchange (SHIE) and Community Health Record (CHR),[2] which allowed previously siloed systems to collaborate in a shared database on behalf of mutual clients.

> What was magical about how all of this was established in Alameda County was seen in the incredible dedication from all our partners being united with a shared purpose. Our collaborative efforts focused on connecting our most vulnerable community members with life-changing resources, while striving for high-quality service provision, equity, and accessibility. While we're still on this journey and continue to face new learnings, the progress we've made is a testament to what can be achieved when we combine our expertise and work towards a common goal. We're grateful for the ongoing commitment of all involved and look forward to continuing this important work together.
>
> *– Alameda Alliance Representative*

Because of their successful work with WPC, many local providers in Alameda County participate in Medi-Cal's Enhanced Care Management (ECM) and Community Supports (collectively known as ECM/CS). As WPC funding ended, providers were motivated to stay involved and provide similar services under the new Medi-Cal initiative, CalAIM. Today, several County agencies are deeply engaged in CalAIM, demonstrating how a county can play a pivotal role in rolling out ECM/CS to people experiencing homelessness.

Alameda County is one of few counties that has decided to serve as an administrative intermediary for the housing-related Community Supports. *(See the Los Angeles County case study for another example of a county that took a similar approach.)* The Alameda County Health team took on the role of intermediary for several reasons. Through their prior WPC experience providing housing navigation, housing deposits, and tenancy sustaining services, they had established trusting relationships with housing providers, which the local managed care plan (MCP), Alameda Alliance for Health (the Alliance), lacked at the time. Housing and Homelessness Services (H&H) saw that their existing contracts and provider relationships could be maintained and expanded, and that the infrastructure they had developed under WPC – including a payment structure and their robust data exchange framework – could be adapted to Medi-Cal's CalAIM initiative. By serving as an intermediary and braiding funds on the back end, the County could provide all individuals with the same level of service regardless of their Medi-Cal status, which aligned with their values. They also knew they could simplify processes so providers could continue providing services to clients seamlessly.

Today, the County's network providing Medi-Cal's housing-related services to people experiencing homelessness is comprised of 24 local organizations of differing sizes. While some have the infrastructure and capacity to contract directly with the Alliance, many of the smaller organizations working with people experiencing homelessness do not have the staffing or resources to do so. The County contracts with the Alliance directly so that smaller organizations can serve as sub-contractors to the County and avoid administrative complications.

[2] To learn more about the SHIE and CHR, see: Social Health Information Exchange, Alameda County Health Care Services Agency, August 2022.

> If the agencies were contracting directly with the managed care plans, there would be a lot of administrative burden put on the billing and claiming aspect of it. Instead, they're able to really support what they do best, which is the supportive services to individuals.
>
> *– H&H Representative*

As the intermediary, the County navigates referrals, requests for authorization and re-authorization, billing, reporting, and other administrative responsibilities. As a result, Alameda County homeless system response providers do not have to worry whether their clients are enrolled in Medi-Cal or not. They simply provide Housing Transition Navigation Services, Housing Deposits, and/or Housing Tenancy and Sustaining Services, and in the background, the County determines how to fund those services. If the client is on Medi-Cal, they bill the Alliance; if the client is not enrolled in Medi-Cal, they use other funding sources, such as California's Homeless Housing, Assistance, and Prevention (HHAP) grant. This allows those individuals who need housing services to receive them, regardless of their Medi-Cal status.

H&H leverages existing homeless system infrastructure to administer housing-related Community Supports. The County uses the CoC's Coordinated Entry System to provide Medi-Cal funded navigation and tenancy services to people at the top of the Coordinated Entry priority list. The CoC's Homeless Management Information System (HMIS) is the primary data source for the provision of services, as all H&H providers are required to use HMIS to capture interactions and service provisions, including administering housing deposit financial assistance. From there, the County's data exchange unit conducts significant work to extract the data from HMIS, match it with MCP and CHR data, and send the information to the Alliance. The County sends bulk authorization requests to the Alliance for new enrollments via a data upload and a data integration process; once those authorizations are approved and services begin, the County bills the Alliance for the applicable Community Supports services.

Since January 2022, the County has used an estimated $23 million in managed care funding for the three housing Community Supports. Alameda County providers have served over 4,000 individuals, 80% of whom were already eligible and enrolled in Medi-Cal. Through this approach, Alameda providers have been able to serve more people experiencing homelessness, more providers have joined the network, and H&H's model has integrated more providers and clients into the homeless system of care. Systems created through WPC have enabled the County's successful work on CalAIM: the County and providers use the SHIE and CHR to locate members for services and the Medi-Cal billing infrastructure is built on a WPC requirement for providers to use HMIS.

Despite the successes, everyone recognizes the tremendous administrative burden and financial risk the County has undertaken to implement Medi-Cal's housing-related services. The County's network of Community Supports providers grew from 11 to 24 within three years. While this growth has led to more individuals getting services from a diverse range of providers, the County's infrastructure needed to quickly adapt to accommodate double the number of providers. While most of the County's housing supports providers have experience with CoC funding and/or other homelessness-related funding, this larger network now includes a variety of organizations that typically work with different populations: transition age youth, older adults, people with disabilities, people with serious mental illness or substance use disorder. These populations are not always prioritized through the CoC's Coordinated Entry system, which can make it challenging for them to receive services unless the provider contracts separately with the Alliance. There are also concerns about the ability to continue identifying sources of funding to cover individuals whose services aren't reimbursable through Medicaid.

> Teams are literally saving lives. They are finding people who have not been found, they are engaging people who are isolated.
>
> *– Homeless Services Provider*

Enhancing Street Medicine and ECM in Alameda County

The systems and relationships developed during WPC also kickstarted some of the services, relationships, and coordination needed for local providers to become Medi-Cal ECM providers. While the County does not act as an intermediary between ECM providers and the Alliance, it is deeply engaged in ECM implementation.

Alameda County established its Street Health Program in 2015, which today provides services to over 3,500 unsheltered residents. Starting in 2022, the California Department of Health Care Services offered specific guidance to MCPs about options for engaging with Street Medicine teams as Medicaid providers and incentive funding for health plans that contract with Street Medicine providers – in addition to launching ECM.

Alameda County Health convened MCPs, experts, and Alameda County Health Care for the Homeless leadership to begin planning for a sustainable model.

> There are other providers that we're collaborating with more consistently. We have more formalized centralized spaces to be able to better network and reach more folks through that collaboration.
>
> *– Homeless Services Provider*

This collaboration resulted in the establishment of a County/Health Plan joint governance model and implementation of ECM services across Alameda County's four Street Medicine providers. This has allowed the partners to fully leverage these new funding sources and guidance from the State.

The County's Behavioral Health Department (BHD) is also involved in ECM, as it became a provider in 2022. The Department was eager to get involved with CalAIM, recognizing the importance of the initiative and the fact that many of their clients experiencing serious mental illness or substance use disorder would benefit from ECM. Housing instability is a common issue for their clients, although not all face literal homelessness.

Building a community

Providers are seeing some of the early benefits of Alameda County's ECM/CS infrastructure. They have noted that there is more consistent collaboration across organizations and with the County, which ultimately allows them to connect with more unhoused individuals. Providers are seeing managed care engaged in homelessness in new and unprecedented ways, and appreciating the level of partnership across government, providers, and the Alliance. Others felt that CalAIM programs established a pathway for patients to have a relationship with physicians and care teams that goes beyond a hospital's four walls. Providers are able to not just address medical situations with individuals, but also housing, food resources, family reunification, and criminal legal system involvement. Most importantly, providers noted that clients are happy to get connected and have a supportive person, someone they can call on and say, "What do I do?"

Leveraging CalAIM to Expand Recuperative Care

Cardea Health was founded to address the complex medical needs of people experiencing homelessness, born out of the founders' experiences serving as the medical directors of Alameda County's Project Roomkey program[3] during COVID. When CalAIM came online, they were quick to contract with Alameda Alliance to begin providing recuperative care services – including end of life care – for individuals experiencing homelessness. Two of Cardea's standalone recuperative care sites are now funded through CalAIM's Community Supports program, and the number of recuperative care beds in Alameda County has doubled in the past year. Cardea attributes that growth to CalAIM, and the fact that clinical and supportive services for this highly vulnerable population can be covered by Medi-Cal, rather than through one-time grants. "We have brought [...] a couple dozen people from respite into the permanent supportive housing program that will support them through the end of their lives, which would have been much more difficult before CalAIM expanded access to respite care...That has made a really big change individual by individual." Cardea hopes to provide Short-Term Post-Hospitalization Housing in 2025 if the MCP elects to offer it as a Community Support.

[3] Project Roomkey, Alameda County Health Housing and Homelessness Services, December 2022.

Fresno/Madera Counties

Investing in the Strength of Local Homeless Service Providers

- **Two Managed Care Plans (2023):** [a]
  Anthem Blue Cross and CalViva Health
- **Total Medi-Cal Managed Care Plan enrollment (2023):** [b]
  584,607
- **Whole Person Care/Health Homes Participant:** [c]
  No

Fresno & Madera Counties Population by Race: ***General Population vs Homeless Population*** [d]

Race	General Population	Homeless Population
White	66%	62%
Asian	11%	3%
Hispanic/Latina/e/o	55%	47%
Black or African American	6%	20%
American Indian or Alaska Native	3%	6%
Native Hawaiian or Pacific Islander	<1%	1%

NEED

Calendar Year 2023

11,120
Estimate of People Experiencing Homelessness
in Fresno/Madera Counties via HMIS/HDIS [e]

5,303
Estimate of People Experiencing Homelessness **with Disabling Conditions** [f]

5,708
Estimate of People Experiencing Homelessness
Who Accessed Care through the Emergency Department [g]

ACCESS/SERVICES

Calendar Year 2023 Quarter 4 only

Enhanced Care Management (ECM)

1,433
Number of Members who are
Enrolled in Enhanced Care Management (ECM) [h]

43%

618
Enrollment of Members **Experiencing Homelessness in ECM** [i]

Community Supports

1,121
Number of Members who
Utilized Community Supports [j]

66%
738
Number of Members Receiving
Housing Transition Navigation Services [k]

1%
12
Number of Members Receiving
Housing Deposits [l]

9%
107
Number of Members Receiving
Housing Tenancy and Sustaining Services [m]

Leveraging HHIP for CalAIM Goals

Although very different in nature – Fresno County includes the fifth largest city in California[4] while Madera is a small, rural community – Fresno and Madera Counties are part of a two-county Continuum of Care (CoC) based in the Central Valley. They share a CoC as well as the same Medi-Cal managed care plans (MCPs). The CoC is anchored by the Fresno County Housing Authority as the CoC Collaborative Applicant and HMIS Lead, is Chaired by the Division Chief from Fresno County's Department of Social Services, and a local non-profit Poverello House serves as the Coordinated Entry System lead. The two primary MCPs, Anthem and CalViva, have a history of working with the CoC, so when California initiated CalAIM's Housing and Homelessness Incentive Program (HHIP), Enhanced Care Management (ECM) and Community Supports (collectively known as ECM/CS) in 2022, there were pre-existing relationships across the health care and homelessness systems.

The cross-sector successes in Fresno and Madera accelerated with HHIP. The MCPs embraced the vision of HHIP – to deepen and strengthen the relationships between MCPs and the homeless system of care and invest in the homeless system – and supported the local community. Early in 2022, the MCPs worked closely with the CoC leaders to identify gaps in the homeless system and leveraged their incentive funds to fill those gaps. They became more involved in the CoC, attending meetings, pledging matching funds for federal grants, and convening regular check-ins to develop ongoing opportunities for collaboration. Prompted by HHIP's data sharing goals, the MCPs gained HMIS access to support care coordination efforts and conducted the first HMIS and Medi-Cal data match, which allowed them to better understand the extent of homelessness among their Medi-Cal membership and opened the door to exploring bi-directional data sharing.

The MCPs were strategic about their HHIP dollars. One of the key gaps identified by local CoC partners was the lack of street-based navigation services. The CoC, County partners, and City of Fresno helped identify housing organizations that were already providing these services through public funding, although on a limited scale. MCPs used their funding to expand the scale of these services – particularly street outreach – that could eventually be funded through the housing-related Community Supports. They used HHIP as a bridge to support longer-term work in the community, with the expectation that HHIP recipients would eventually become CalAIM providers and continue providing services funded by Medi-Cal reimbursements. The MCPs also invested in street medicine services, which did not exist in the region prior to HHIP; helped the CoC explore and start providing shared housing services; and expanded a landlord engagement program.

[4] California Cities by Population, Cubit, June 2024.

Recognizing the Expertise of Local Homeless Providers

At the onset of ECM/CS implementation, the MCPs contracted with larger providers, such as local hospitals and national providers who were already networked with the MCPs and had the capacity to immediately serve members. Few local community-based organizations were positioned to support the work on day one of CalAIM: "They needed more education, more training, they needed a lot more advocacy, and they needed a lot more funding to build capacity." Many were unaware of CalAIM or unclear how to become contracted providers. The MCPs joined CoC leadership calls with providers, presented on CalAIM at various CoC board meetings and working groups, and presented at and attended the CoC's Built for Zero bootcamps to get the word out.

Over time, the MCPs have prioritized relationships with local homeless providers who have expertise in the system. The MCPs have worked hard to help them become Medi-Cal providers, engaging with CoC providers one-on-one, offering trainings about CalAIM and support once they join the Medi-Cal system. Using both HHIP and Incentive Payment Program (IPP) funds, they have invested in the organizations to help them develop the infrastructure needed to become contracted providers and get their internal systems in sync with the requirements of Medi-Cal. They have worked hand in hand with RH Community Builders, which provides the largest number of ECM/CS services in the two counties, just as they invest time and energy in getting new providers on board. As one MCP representative shared, "We've seen [through] data reports that [local homeless providers] are the ones having the most success because they have that rich history and experience in delivering these services."

The City of Fresno and Fresno County's Department of Social Services are also trying to encourage additional CoC providers to become CalAIM providers, believing that CalAIM is a path to financial sustainability. With that in mind, the County recently added requirements in their contracts – particularly the State's Homeless Housing, Assistance and Prevention (HHAP) grant agreements – that providers must either become ECM and/or CS providers or have a strong referral plan in place (reviewed by the County) to ensure their clients have access to all the services they are eligible for. While the County recognizes some of the challenges associated with becoming a CalAIM provider, it is eager to help providers access a more diverse mix of funding streams.

> "
>
> We continue to work with the Fresno Madera CoC and all of the partners at the table to ensure that those who have the experience doing this work are in conversation with us about CalAIM…It took a little while for folks to understand exactly what the CalAIM initiative was all about and how they fit into that work, and also take a leap of faith into the program and be a part of the program, knowing that it would be different than what they're used to in terms of how they operate and how they implement their programs…We are patient and ready to engage with all of those folks, and are excited to see many of them come to the table ready to take a step into all of this work.
>
> – *Managed Care Plan Representative*

A More Integrated System

The MCPs' and Fresno County's efforts are paying off, as is the hard work of the homeless providers who have taken on CalAIM. Some of the organizations in the Fresno/Madera CoC have been providing both ECM/CS for over 12 months, while others are just getting their Medi-Cal systems up and running. For example, Poverello House – one of the largest housing and homeless services organizations in Fresno and the CoC's CES lead entity – has recently become a CalAIM provider.

This means that more Medi-Cal members will be able to receive ECM/CS from their trusted, homeless services providers, and allows CalAIM to be more integrated into CoC systems like CES. Providers can use HMIS to access background information about their clients. They know if clients are staying in a shelter, living on the streets in an encampment, or have transitional housing. This information helps providers more quickly and effectively locate and engage clients in ECM/CS services and develop a housing plan. Because the anchor organizations in the CoC are also now CalAIM providers, many of their regular clients have the chance to receive the full panoply of Medi-Cal housing-related services for which they are eligible. It is also increasing the number of members receiving ECM/CS services, with new housing providers using a "bottom up referral" model instead of relying on MCPs to send referrals.

And both MCPs want their non-CoC providers to get more engaged with the homeless system of care. They encourage them to attend CoC meetings, access HMIS, and engage with Coordinated Entry. They provide training and support for newcomers to learn HMIS and funding for licensing fees to help them get up and running.

As one of the MCPs shared, "We are always looking for additional community-based organizations to enter the network, but we're kind of a little bit more picky now because we understand what is going to lead to the best outcomes. And that's really [providers who] are integrated into those systems, [who] are part of those conversations, [who] are at the table where those conversations are happening and understand the needs of the community."

Braiding Funding to Provide Comprehensive Care

RH Community Builders is an anchor of the Fresno Madera CoC, and one of the largest ECM/CS providers in the two counties. They were one of the earliest CoC providers to start offering both ECM/CS in the region. They have grown increasingly adept at braiding funds to expand their services. They partner directly with County Behavioral Health Services to operate Behavioral Health Bridge Housing (BHBH) for people with behavioral health and substance use issues, braiding CalAIM with BHBH operational funds and Specialty Mental Health Services to offer high intensity services in low-barrier shelters. The more robust care teams allow RH Community Builders to meet the high-level needs of individuals who previously could not be supported in a traditional, low-barrier shelter. They have also braided CalAIM with CalWORKs Homeless Assistance[5] funds, providing additional housing navigation services to anyone staying in the County's temporary housing motel, while the County accesses additional funding streams to extend families' stay beyond the 16 nights provided by CalWORKs.

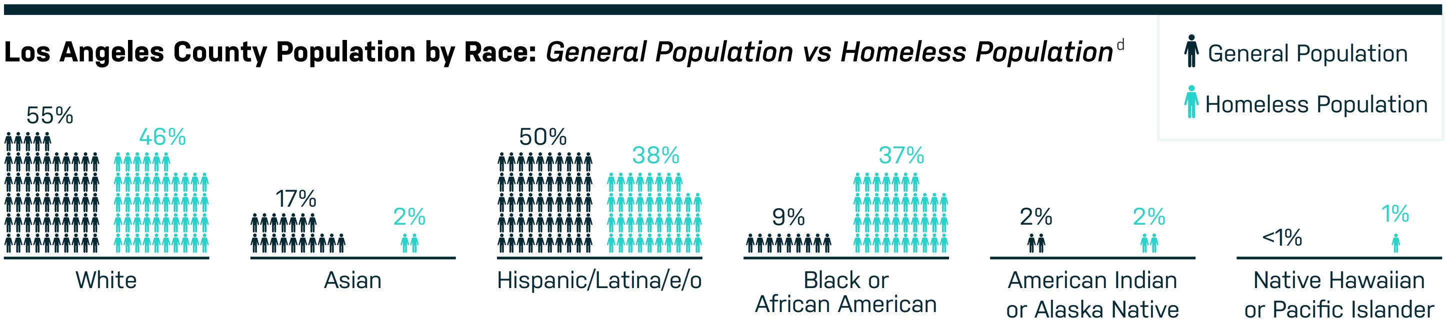
[5] CalWORKs Homeless Assistance, California Department of Social Services.

Los Angeles

Leveraging the Hub Model to Support Local Participation in CalAIM

- **Four Managed Care Plans (2023):** [a]
  AIDS Healthcare Foundation, Health Net Community Solutions Inc., L.A. Care Health Plan, SCAN Health Plan
- **Total Medi-Cal Managed Care Plan enrollment (2023):** [b]
  3,807,455
- **Whole Person Care/Health Homes Participant:** [c]
  Yes

Los Angeles County Population by Race: ***General Population vs Homeless Population*** [d]



NEED
Calendar Year 2023

108,442
Estimate of People Experiencing Homelessness
in Los Angeles County via HMIS/HDIS [e]

43,893
Estimate of People Experiencing Homelessness **with Disabling Conditions** [f]

43,875
Estimate of People Experiencing Homelessness
Who Accessed Care through the Emergency Department [g]

ACCESS/SERVICES
Calendar Year 2023 Quarter 4 only

Enhanced Care Management (ECM)

23,113
Number of Members who are
Enrolled in Enhanced Care Management (ECM) [h]

42%

9,622
Enrollment of Members
Experiencing Homelessness in ECM [i]

Community Supports

18,720
Number of Members who
Utilized Community Supports [j]

26%

5,340
Number of Members Receiving
Housing Transition Navigation Services [k]

<1%

37
Number of Members Receiving
Housing Deposits [l]

68%

12,707
Number of Members Receiving
Housing Tenancy and Sustaining Services [m]

Leveraging the Hub Model to Streamline Housing Services

Los Angeles County is a large region that covers over 4,000 square miles and is home to more than 9.5 million people. The county is split into four separate Continuums of Care (CoCs), each working to prevent and end homelessness within a specific geographic portion of the county: the City of Glendale CoC, the Los Angeles Homeless Services Authority (LAHSA), the City of Long Beach CoC, and the City of Pasadena CoC. LAHSA is the largest CoC, serving the majority of Los Angeles County and encompassing the City of Los Angeles proper.[6]

Because of its size, the county is separated into eight Service Planning Areas (SPAs). Data shared in the table above reflect the entire region, but the focus of Homebase's interviews and community engagement was on SPA 6, the service area for South Los Angeles (South LA). Volunteers conducting the 2024 Point-in-Time Count identified more than 13,750 individuals experiencing homelessness in South LA.[7] South LA is located in one of the SPAs with the largest population of people experiencing homelessness, second only to Metro Los Angeles (SPA 4).[8]

The CoC has a close relationship with the County of Los Angeles. The Housing for Health Division (HFH) at the Los Angeles County Department of Health Services is the primary provider of housing-related Community Supports. LAHSA and HFH worked with Los Angeles County's Medi-Cal managed care plans (MCPs) to streamline the administration of Community Supports through the County. *(See the Alameda County case study for another example of a county that took a similar approach.)* HFH contracts directly with the MCPs and then subcontracts out to its existing provider network,[9] meaning that the providers do not have to contract directly with the MCPs unless they choose to.[10] The MCPs reimburse HFH for CalAIM-eligible services administered by providers, and then HFH directly pays the providers. As an administrative hub, HFH oversees contracts with MCPs and its providers; manages the MCP and provider relationships; tracks the services provided; and oversees all referral and authorization requests and billing for reimbursement.

The administrative hub model has benefitted the region in several ways. People in need of housing-related services get them, whether or not they are enrolled in Medi-Cal, as HFH braids Medi-Cal reimbursements with 40 different funding streams.[11] HFH has been able to work with the MCPs to streamline different administrative processes – like referral forms and submissions – which likely would not have happened without the County acting as an intermediary. Lastly, the hub model opens the door for more providers – who may lack the experience and capacity to manage CalAIM's administrative requirements – to sustainably provide the housing-related services they have expertise in.

The hub model has enabled strong providers to serve people experiencing homelessness across LA, and within specific communities, like SPA 6.

[6] The Homeless Data Integration System (HDIS) data featured in the data above only includes data from the LAHSA CoC, and therefore represents a smaller number of individuals than all of Los Angeles County. Data from the City of Glendale CoC, the City of Long Beach CoC, and the City of Pasadena CoC are not included in the overall Los Angeles County HDIS data.

[7] Homeless Count 2024 Data Summaries, Los Angeles Homeless Services Authority (LAHSA), October 2024.

[8] Ibid

[9] HFH works with its network that provides Interim Housing and Intensive Case Management Services and then braids funding on the back end. For more information, see: Housing for Health Programs, Los Angeles County Health Services.

[10] Some providers do not participate in the hub model but instead contract directly with the MCPs, while some contract with both the County and MCPs. The organizations that contract directly often have experience with Electronic Health Records or billing medical/Medi-Cal services, allowing them to navigate the complexities of administering ECM and Community Supports without the support of HFH.

[11] One of the sources of funding that HFH is able to access is from Measure H, the County's special housing and homeless tax fund. For more information, see: Homeless and Housing Measure H Special Revenue Fund, Auditor-Controller, Los Angeles County.

Community Anchors in SPA 6

SPA 6 – described by one provider as "a very underserved community that faces a lot of daily challenges just to survive" – has the second highest population of homeless individuals in LA County.[12] While housing is being built in SPA 6 – unlike most areas in LA – providers share concerns that the new units are unaffordable and not accessible to local residents or those receiving services from local homeless providers. Significantly, 92% of SPA 6's unhoused population identifies as African American and/or Latinx, which is the highest of any SPA.[13] This makes the area's serious housing affordability challenges all the more concerning, since people of color are being shut out of housing options in their own community.

SPA 6 is fortunate to have strong community anchors that consider the unique needs of its population, including the safety-net hospital, Martin Luther King Community Healthcare (MLKCH) and the primary local homeless services provider, Homeless Outreach Program Integrated Care System (HOPICS), who have been able to deliver more comprehensive care to local residents through CalAIM.

> I definitely would encourage every and any hospital that is thinking about bringing in ECM or Community Supports on board to just do it... Unfortunately, a lot of our community members...don't know how to access the resources. So I think that's where as hospitals or even ambulatory sites, it's our responsibility to give that to our communities.
>
> *– MLKCH Representative*

> There was no other program within MLKCH that provided close to the things that...we're able to provide now.
>
> *– MLKCH Representative*

Martin Luther King Community Healthcare (MLKCH) provides Enhanced Care Management (ECM) services and Community Supports (collectively known as ECM/CS) as well as maternity, critical, and inpatient care at its 131-bed hospital and primary and specialty care in its outpatient doctors' offices throughout South LA. Before the State introduced CalAIM, MLKCH had a large population of unhoused individuals getting services at the hospital, but no staff capacity to provide the level of care that the two new programs allow them to offer. Before CalAIM, MLKCH staff referred patients to the CoC and the Coordinated Entry System for housing and supportive services but weren't guaranteed to have further contact with their patients.

Today, CalAIM allows MLKCH to focus on individuals who frequently come to the hospital and provide them with the case management support they need. While the hospital gets referrals for ECM/CS patients from their partner MCPs, most of their patients have been in MLKCH's Emergency Department or admitted to the hospital and have been identified through careful review of hospital data. Both teams integrate with MLK's local street medicine providers who serve South LA residents living in encampments or other places not meant for human habitation.

MLKCH's ECM team is comprised of Community Health Workers (CHWs) and Care Coordinators. Staff appreciate that ECM allows them to build long-term, trusting relationships with their patients. It also allows for continuity of care post-discharge, since the care team can help patients connect to services, maintain their health, and avoid hospital readmissions or admissions. They currently provide ECM on an outpatient basis, but staff are hoping they can do inpatient ECM so they can connect with more clients while they're in the hospital, making it even more likely that they can sustain the relationships post-discharge.

[12] Homeless Count 2024 Data Summaries, Los Angeles Homeless Services Authority (LAHSA), October 2024.

[13] SPA 6 HC2024 Data Summary, Los Angeles Homeless Services Authority (LAHSA), May 2024.

MLKCH's Community Supports team includes six housing navigators. The team provides housing navigation services to people in both an outpatient and inpatient setting. One staff person shared, "The [Community Supports] program allows the housing navigators to build this next level relationship that you can't build when a patient is admitted to the hospital… So now having [Community Supports] builds that relationship and makes them aware that MLKCH really does care about you and wants the best for you. And we want to make sure that you do get housing eventually. Because it is a long road to get housing."

While still early in the process, these programs are making a difference at MLKCH. "The main goal for our hospital at least is to make sure that we're following the patients that come into the hospital the most. […] So those patients coming into the Emergency Department, work with a social worker and that social worker can easily email [the] team and say, 'Hey, I think this patient would be great for Community Supports. Can you please see them at bedside?'"

The **Homeless Outreach Program Integrated Care System (HOPICS)** has been an essential homeless services provider in South LA since 1988. They are an integral part of LAHSA's CoC, serving as the Coordinated Entry System lead for SPA 6, and are deeply embedded in the community. They are also one of the many homeless service providers who offer Community Supports under the County's HFH program. Through the County's Intensive Case Management Services (ICMS) program, HOPICS provides Community Supports to South LA residents. HOPICS applies on behalf of its ICMS clients needing Community Supports or gets a referral directly from HFH through its online provider portal.

HOPICS is not new to providing housing navigation or housing tenancy and sustaining services. While the organization has been providing ICMS services since 2015, they shared that Community Supports has relieved some financial burdens, as they have a new funding resource for staff to tap into. The homeless system of care gets limited funding, which leads to individuals and households being placed on a waiting list for housing and services. But Medi-Cal is an entitlement program, so Community Supports are available to anyone who qualifies for Medi-Cal and meets the Community Supports eligibility criteria. The additional infusion of Medi-Cal funding has provided more resources to serve HOPICS' clients.

> "It relieves some financial burden off of us because we can tap into those Community Supports. It's providing additional financial support to try to help get those folks housed or maintain housing stability, because we're not tapping into other unrestricted funding that we would normally go to try to get a housing deposit or utility assistance. We're not tapping into those funds. We have another resource that we can utilize.
>
> *– HOPICS Representative*

> "[We] have a nurse, a therapist, a substance use counselor, who meets clients where they're at. The client doesn't ever need to touch our office. They could be out wherever – under the freeway, a tent on the side of the road, anywhere – we go meet them there. They don't need to ever step inside one of our doors. We also offer services that are not your regular sit down 1:1 therapy, like art and music. Having that uniqueness helps provide services.
>
> *– HOPICS Representative*

HOPICS is also exploring ways to provide Community Supports to individuals who are not receiving HFH's ICMS services by contracting directly with local MCPs: "Any client needing Community Supports could be enrolled in any of our HOPICS programs. They could be receiving mental health, just regular housing, substance use treatment, etc. If we identify there's a need for Community Supports – we would be contracted for Housing Deposits, Housing Navigation, and/or Housing Tenancy and Sustaining Services." To prepare for these contracts, HOPICS applied for and received an Incentive Payment Program (IPP) grant to help set up an Electronic Health Records (EHR) system, and received technical assistance on developing billing processes, and a protocols and procedures manual for the organization.

One of the biggest challenges for both MLKCH and HOPICS is the dearth of affordable housing in South L.A. Even as new housing goes up, providers struggle to place their clients – those individuals from SPA6 – in these units. HOPICS staff shared, "It's unrealistic what they're charging and they're expecting our clients to pay this [...]. They need to meet their immediate needs of their children, themselves, the food, the water, the clothing, it's expensive. It's really expensive in L.A."

Enhancing Street Medicine through ECM

USC Street Medicine team, run through the Keck School of Medicine, provides on the ground clinical services to people living unsheltered throughout Los Angeles. ECM has allowed them to add a layer of coordination and support to their street medicine teams – and they are seeing the benefits. They provide full scope primary care on the street, then focus on connecting patients to specialty care and diagnostic studies while managing challenging post-hospitalization episodes, helping patients access housing, and more. The team is careful to stress that these new ECM team members are part of the street medicine team, also seeing patients on the street, so patients don't feel as if they're losing their relationship with their clinical providers who have always served them. As a result, patients are eager to enroll in ECM and go on to have productive long-term relationships with their ECM providers. While logistics and rates have been challenging, ECM allows USC Street Medicine to focus on the big picture and care coordination needs of a patient. "Before ECM it meant that essentially our team had to choose, do we provide medical care to somebody or do we help a different patient follow through on these tasks that are equally important to contribute to their medical care? And so, you were always pulled. And now ECM can make sure those other tasks are completed so that they can really get the full benefit of full scope care."

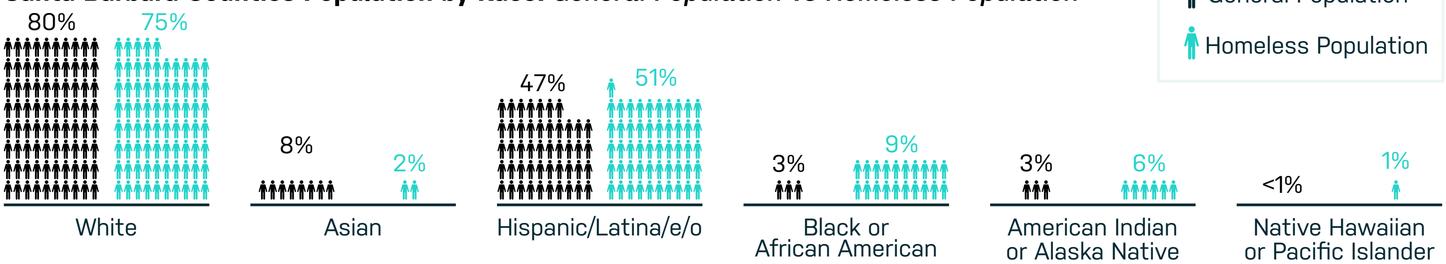
Santa Barbara

A Local Managed Care Plan Forges Partnerships to Bring CalAIM to Life

- **One Managed Care Plan (2023):** [a]
  CenCal Health
- **Total Medi-Cal Managed Care Plan Enrollment (2023):** [b]
  163,155
- **Whole Person Care/Health Homes Participant:** [c]
  No

Santa Barbara Counties Population by Race: ***General Population vs Homeless Population*** [d]

General Population
Homeless Population



NEED

Calendar Year 2023

4,444

Estimate of People Experiencing Homelessness
in Santa Barbara County via HMIS/HDIS [e]

2,392

Estimate of People Experiencing Homelessness **with Disabling Conditions** [f]

3,011

Estimate of People Experiencing Homelessness
Who Accessed Care through the Emergency Department [g]

ACCESS/SERVICES

Calendar Year 2023 Quarter 4 only

Enhanced Care Management (ECM)

1,000

Number of Members who are
Enrolled in Enhanced Care Management (ECM) [h]

51%

506

Enrollment of Members
Experiencing Homelessness in ECM [i]

Community Supports

579

Number of Members who
Utilized Community Supports [j]

32%

186

Number of Members Receiving
Housing Transition Navigation Services [k]

7%

42

Number of Members Receiving
Housing Deposits [l]

28%

163

Number of Members Receiving
Housing Tenancy and Sustaining Services [m]

A Supportive Anchor for CalAIM Implementation

Santa Barbara County spans a large portion of the Southern California coast, covering almost 3,000 square miles and home to nearly half a million people. The County has just one Medi-Cal managed care plan (MCP), CenCal Health, a nonprofit local health plan that has served primarily Santa Barbara and San Luis Obispo counties for forty years. The Continuum of Care (CoC) is anchored by the County of Santa Barbara through the Department of Housing and Community Development.

During the early stages of CalAIM implementation, the supportive services available through Enhanced Care Management (ECM) and Community Supports (collectively known as ECM/CS) were not widely known within Santa Barbara County. Recognizing the need to increase awareness and build a stronger local provider network, CenCal Health collaborated with community-based organizations to understand and address the barriers to becoming contracted CalAIM providers. Through these partnerships, CenCal Health refined its approach, which has not only increased the utilization of services but also earned widespread recognition from providers. CenCal Health's flexibility, support, and commitment to local partnerships have transformed the landscape of housing-related services in the county.

There are unique circumstances in Santa Barbara County that enabled deeper coordination between CenCal Health and the CoC, which has helped people experiencing homelessness access ECM/CS. Having just one County-based Health Plan – unlike many mid-size communities in California – made it simpler for all partners to collaborate. The providers only need to learn how to navigate one MCP system. The MCP does not need to compete for Medi-Cal members and can instead focus on providing coverage effectively to its members.

Early into the launch of CalAIM, it became clear that while local providers understand the health and housing needs of people experiencing homelessness, they had limited knowledge of Medi-Cal billing and/or claims. CenCal Health focused on finding the organizations already working with the targeted populations and then introducing them to the new reimbursement model. Many local providers faced challenges due to insufficient administrative infrastructure to work with the MCP. Many required assistance setting up their National Provider Identifier (NPI) and had subsequent questions about billing processes and proper medical documentation.

To support these providers, CenCal Health utilized Housing and Homeless Incentive Program (HHIP) and Incentive Payment Program (IPP) funding to offer financial grants and encouraged them to apply for the State's Providing Access and Transforming Health (PATH) funding, which is designed to build CalAIM provider capacity and infrastructure. CenCal Health also established a comprehensive training program for new providers, known as the CalAIM "boot camp," which includes dedicated sessions on billing. Providers receive reference guides for each program, complete with step-by-step instructions for submitting claims. Recognizing that most ECM/CS providers do not use Electronic Health Records (EHRs) which allow them to bill claims via a clearinghouse, CenCal Health offers all providers access to a secure provider portal which enables electronic claims submission. The MCP offers one-on-one support to providers when they're submitting their first claims.

To engage community partners, CenCal Health has convened a CalAIM Community Steering Committee in Santa Barbara and in San Luis Obispo County with members from different County departments, health care providers, and community-based organizations. This committee plays a pivotal role in fostering collaboration and making connections with local providers. CenCal Health actively seeks new providers to address service gaps within its ECM/CS portfolio, ensuring comprehensive and equitable access to care.

> "CenCal Health values the whole person care approach that ECM and Community Supports offers our members. We see our members coming full circle: beginning with Recuperative Care, Housing Navigation, and Housing Tenancy and Sustaining Services. We feel grateful to have such strong local partners who are delivering these services to our members, ensuring that members are not just receiving services, but instead have long term success.
>
> *– CenCal Health Representative*

CenCal Health also brought flexibility into its approach. When CalAIM was first introduced, Santa Barbara already had a robust set of recuperative care providers. Before CenCal Health added more services, they met with the existing recuperative care providers and reviewed the MCP's model of care requirements line-by-line. The providers responded, "We are never going to be able to do that." CenCal Health realized that they needed to be responsive to what the providers in the community were doing and how they were doing it.

Providers feel supported by CenCal Health, and described how they partnered with the MCP to make improvements to ECM/CS. One provider who has served people experiencing homelessness for decades said of CenCal Health:

> *[We have a] good partnership with CenCal Health...Early on we were figuring it out at the same time as the MCP. We were working with [them] and saying, 'this form doesn't work. What you're asking doesn't make sense. We would like to suggest this.' And so, we really helped them fine tune what was needed. We're really thankful for that and thankful that we only have one MCP. I think is such a gift from what I hear from my peers [in other counties]. For the most part our work with CenCal Health is very seamless. If something doesn't make sense, we know we can call someone.*

Another provider shared,

> *I have talked with other agencies locally and they all have the same feeling about CenCal Health, that they're very approachable and they're very much wanting to make sure that everyone has their questions answered and that they feel comfortable in what they're doing. And if there are errors or mistakes that are made, CenCal Health has people that are there to try to help you figure out what went wrong and how to do it better.*

Partnering with Health Care

Marian Regional Medical Center, owned by Dignity Health, has had a partnership with CenCal Health for many years, based on a shared commitment to improved access to care, timely and coordinated care, and financial responsibility.

Prior to CalAIM, the organizations contracted for recuperative care services for people experiencing homelessness, where Marian coordinated referrals and case management and the local provider Good Samaritan managed the day-to-day needs of the patients. This was an early attempt to prepare for ECM/CS. Today, Marian has 1,800 ECM-assigned patients who live in the Orcutt-Paso region. Additionally, while Dignity Health develops a Health Information Exchange (HIE) with CenCal, the local hospital team has provided EHR access for the CenCal clinical teams to better manage their members with real-time data.

The partnership has generated creative solutions that have produced outcomes that include reduced length of stay, reduced hospital readmissions, and increased coordinated care after an emergency department or hospital visit. "All of this encourages and supports better access to the right level of care at the right time," say Dignity staff.

Building Bridges with the CoC

One of the unique aspects of cross-sector work in Santa Barbara County is that, in early 2022, CenCal Health leveraged significant HHIP resources to fund a dedicated position with the CoC/Santa Barbara County's Department of Housing and Community Development. The County's Healthcare Liaison leads partnership efforts with CenCal Health, working on behalf of the CoC to maximize HHIP dollars, serve as the key contact with the MCP, and ensure people experiencing homelessness are benefiting from ECM/CS. The Healthcare Liaison has helped the CoC leverage funding through CalAIM, and, importantly, created a bridge between the CoC and CenCal Health that has enabled significant progress in implementing ECM and Community Supports.

Data sharing has been front and center in the collaboration between the CoC and CenCal Health. In many communities, CoCs and MCPs share data unilaterally: the CoC provides a list of their clients to the MCP, and the MCP checks that list against their membership to learn who is experiencing homelessness. In those scenarios, the MCP does not share data with the CoC, preventing the CoC from determining if their clients are enrolled in Medi-Cal. In Santa Barbara, however, CenCal Health shares data with the CoC.

The CoC provides a weekly housing status change report to CenCal Health so they know who is housed, entering the system for the first time, and moving back into homelessness. The CoC gets a monthly match list from CenCal Health, which shows who is an identified CenCal Health member and if their membership has changed. Notably, the MCP shares which members have been referred to ECM/CS, which provider they have been referred to, and whether the provider has connected with the client and enrolled the person in services. The level of information shared is unprecedented, paving the way for the CoC to ensure their clients are receiving all the housing-related Medi-Cal services that they are eligible for.

This time-intensive, manual process happens through the secure exchange of Excel spreadsheets, since the CoC's Homeless Management Information System (HMIS) was unable to effectively adapt to the new opportunities and data needs CalAIM brought. In addition to the weekly housing status change report, the Healthcare Liaison spends significant time and resources using the monthly match list to manually update ECM/CS enrollment data in a free text field HMIS.

The CoC is launching a new, more sophisticated and higher functioning HMIS that will hopefully streamline data sharing between the two systems. The switch to a new system – which was funded through CenCal Health's HHIP dollars – will help improve ECM/CS implementation, while serving as a tangible reminder of what deep collaboration between managed care and CoCs can look like.

Using Community Supports to Expand Community Services

Good Samaritan is one of the largest homeless providers in Santa Barbara and saw CalAIM as an opportunity to address funding needs. The organization has been adept at braiding CalAIM funding into its existing services, which has allowed the program to add services for its clients. Since CalAIM, the organization has been able to better address the health needs of its clients, while also adding new recuperative care beds and sobering centers to serve the community. CalAIM has allowed Good Samaritan to provide housing supports for unhoused individuals who are employed and receiving income and are therefore lower down on the Coordinated Entry prioritization list. While these individuals are unlikely to receive services funded by the homeless system of care, this CalAIM-funded support helps resolve their homelessness quickly.

Endnotes for the Data Sources

a. ECM and Community Supports Quarterly Implementation Report, as of December 31, 2023. California Department of Health Care Services, August 2024. *Note: Homebase did not include Specialty Health Plans. Additionally, California Department of Health Care Services re-aligned Managed Care Plan (MCP) contracts on January 1, 2024. As a result, plans that were serving counties in 2023 may have shifted in 2024. To see which MCPs are currently serving which counties, see* Medi-Cal Managed Care Plans by County (as of 2023 and 2024).

b. Chart 1.7.1 ECM Penetration Rates by MCP and County in the Last 12 Months of the Reporting Period, 2023 Q4, California Department of Health Care Services, August 2024.

c. Ibid.

d. Homeless Data Integration System (HDIS) 2023 compared to American Community Survey 2023.

e. Homeless Data Integration System (HDIS), Calendar Year 2023, State of California Business, Consumer Services and Housing Agency. *Note: HDIS is a state database that de-duplicates data and displays information in aggregate from all 44 California Continuums of Care.*

f. Ibid.

g. 2023 Hospital Emergency Report, Calendar Year 2023, Department of Health Care Access and Information (HCAI), California Health and Human Services. *Note: To impute the number of individuals experiencing homelessness who access care through the emergency department, Homebase divided the total emergency department visits for people experiencing homelessness by 2.6. This was based on an analysis of 2019 HCAI discharge data conducted by the Public Policy Institute of California. See* How Hospital Discharge Data Can Inform State Homelessness Policy

h. Chart 1.7.2, Total Members Who Received ECM by MCP and County in Each Quarter of the Reporting Period., California Department of Health Care Services, Updated December 2024.

i. Chart 1.7.3 Total Number of Members Who Received ECM by MCP and County by Population of Focus by Quarter, 2023 Q4, California Department of Health Care Services, December 2024. *Note: CalAIM has pre-identified Populations of Focus (POF), which includes both adults and children experiencing homelessness. When MCPs report the data, they select a single POF for the Medi-Cal member. Given the intersectionality that leads some of the POFs to overlap, there may be additional people experiencing homelessness receiving ECM who are categorized under other POFs.*

j. Chart 3.9.2, Total Members who Received Community Supports by MCP and County in Each Quarter of the Reporting Period, California Department of Health Care Services, Updated December 2024.

k. Chart 3.9.3 Total Number of Members Who Utilized Community Supports by MCP and County by Service by Quarter, 2023 Q4, California Department of Health Care Services, December 2024.

l. Ibid.

m. Ibid.