CSH

Aligning Services and Systems to Address Californians' Housing Needs

Ten Approaches to Connect Homeless Systems with CalAIM Community Supports

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Authors

Cheryl Winter, CSH
Alison Klurfeld, Klurfeld Consulting, LLC

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Contents

Key Takeaways 4

Background 4

- Why Align Continuums of Care and Community Supports? 5
- Overview of Methods 6

Notable Themes 9

- Both Time and Resources Are Needed 9
- Counties Play a Significant Role in Leading Community Supports Integration 9
- Aligning Community Supports with Housing Resources through Eligibility Criteria, Attestations, and Network 10
- Subcontractor vs. Direct Contract Model 12

Community Profiles 14

Appendix A: Methodology 26

Appendix B: Process Maps of Alignment & Coordination Activities 29

Appendix C: Best Practice Literature Review 32

Key Terms 35

Key Takeaways

Many counties in California are improving coordination efforts among Continuums of Care (CoCs), their Coordinated Entry Systems (CES), and Community Supports. This paper highlights the specific efforts of ten California communities working to ensure that people experiencing and at risk of homelessness are connected to California Advancing and Innovating Medi-Cal (CalAIM) Community Supports to help them exit homelessness, move home, and remain stably housed.

With new services and funding for housing Community Supports, each community tailored its approach to the local context. Communities used and improved existing data systems, usually their local Homeless Management Information System. Most also streamlined referral processes and made efforts to align provider networks between the CoC and Community Supports. All communities invested significant time and resources, especially from the Housing and Homelessness Incentive Program, to facilitate alignment. Nine out of ten communities had a county agency as the lead entity spearheading coordination. Some communities had a single agency that centralized contracting for all or some housing Community Supports and subcontracted down to an existing homeless services network, but others took a decentralized approach with direct contracting between the Medi-Cal Managed Care Plans (MCP) and homeless services providers.

Background

State, local, and federal partners are helping more people access housing and services than ever before. Nevertheless, local homeless responses systems face significant challenges across the state as more people are falling into homelessness than homeless response systems can house.[1] With gaps in both affordable housing[2] and services funding to support people experiencing homelessness, partners must work together to make existing resources more effective. MCPs are now offering some housing-related services through CalAIM Community Supports. These services can help communities fill some of the existing gaps in homeless services funding, especially when MCPs and homeless response systems align with existing CES (typically administered through federally designated and regional HUD CoC). This paper highlights partnerships that ten California communities have created to align housing and Community Supports-funded services offered through local homeless and housing response systems.

[1] More than 30% of the nation's homeless population is in California. Homelessness directly correlates to housing affordability in CA and across the U.S. Californians: Here's why your housing costs are so high in 2024

[2] There are only 24 affordable and available homes for every 100 extremely low-income renter households in California today. California | National Low Income Housing Coalition

Why Align Continuums of Care and Community Supports?

U.S. Department of Housing and Urban Development (HUD) CoC and the CES they manage receive federal and state housing and service resources to assess, prioritize, and serve people experiencing homelessness. But these federal resources, even combined with state and local funding, are insufficient to meet the needs of people experiencing homelessness.

HUD released guidance encouraging collaboration and coordination between CoC, their providers, and MCPs. This guidance urges CoC and their contracted provider agencies to develop partnerships with MCPs, share data, align eligibility for housing and service programs, make referrals for services in partnership with MCPs, support Medicaid enrollment, coordinate services, and become Medicaid providers. In California, the Department for Health Care Services (DHCS) has also formally encouraged MCPs to collaborate with CoCs and homeless services systems as a priority measure in the Housing and Homelessness Incentive Program (HHIP), as well as through other channels.

To scale services and coordination to meet local needs, California communities are finding that CoC Lead Agencies and/or county agencies must actively lead coordination efforts with MCPs. In some cases, CoC are acting as a Medi-Cal Community Care Hub[3] and administrative entity for Community Supports and Medi-Cal coordination so that the burden does not fall solely on already stretched CoC homeless and housing service providers.

Many other excellent publications[4] exist on the role of CoC, CES, the importance of health and housing collaborations, how MCPs can partner with housing and homeless service networks, how to share data between systems, and why it is important to coordinate funding and services from mainstream resources (like Medi-Cal) with other federal, state, and local responses to end homelessness. This paper seeks to offer more detail on what ten California communities have done to integrate CES and housing-related Community Supports.

[3] For more on Medi-Cal Community Care Hub models, see: https://www.chcf.org/publication/exploring-emerging-medi-cal-community-care-hubs/

[4] See Appendix C for a list of relevant publications on health and housing partnerships, data sharing, and partnership toolkits.

Overview of Methods

This paper draws from the efforts of the Housing Community Supports Implementation Advisory Committee, a group made up of MCPs, housing-related Community Supports providers, HUD CoC lead entities, CA Counties, Medi-Cal members, people with lived experience of homelessness (the majority of whom are Medi-Cal members), and others with an interest in improving the availability and efficacy of housing-related Community Supports. See Appendix A for more information.

Each Partner Benefits from Collaboration

When CoCs and MCPs coordinate to implement housing-related Community Supports, each partner benefits.

CoC Providers and Lead Agencies benefit from:

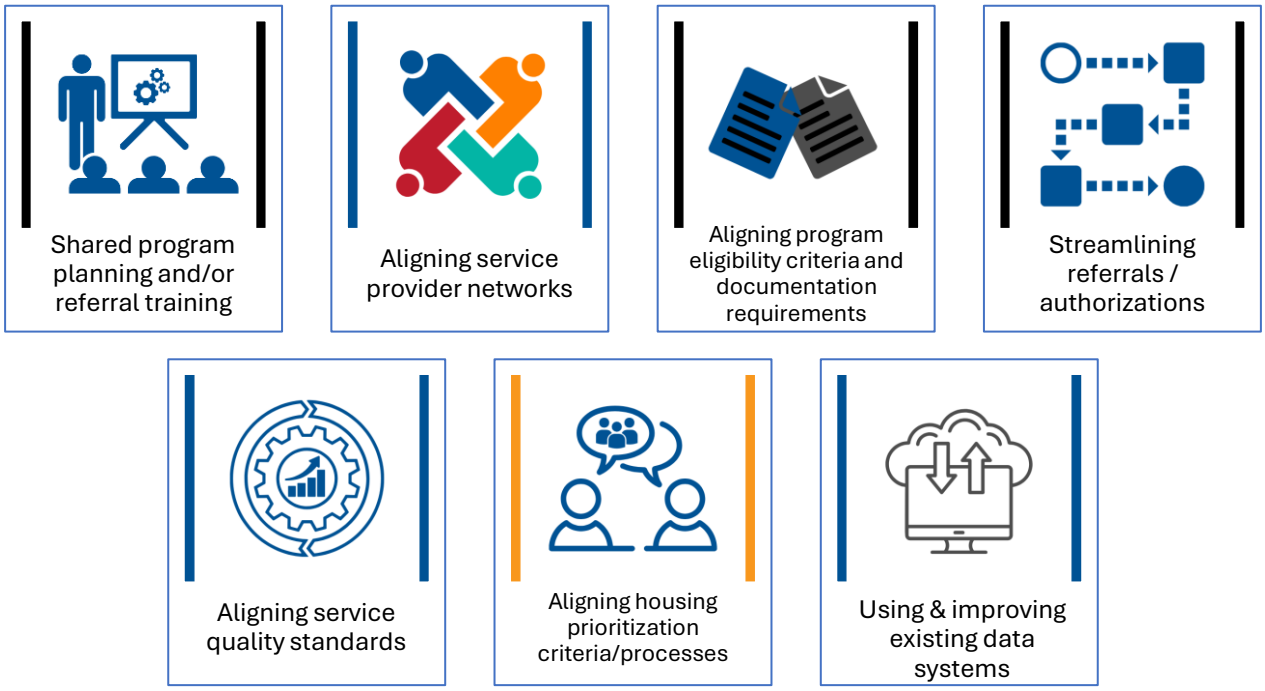
- Funding from MCPs to provide housing-related services can help fill gaps for underfunded services, such as housing navigation to help people experiencing homelessness locate safe and affordable housing and tenancy supportive services to help tenants remain stably housed.
- MCP grants from HHIP, Incentive Payment Program (IPP), and other discretionary funds can support CoC and CES operations, HMIS data system improvements, and underfunded administrative costs. These are often costs that CoCs cannot otherwise cover fully due to limited indirect cost allowances and unstable funding sources.
- Contracted Community Supports providers have access to MCP portals where they can track Medi-Cal enrollment status, CalAIM referrals and authorizations, and receive contact information on clients' Enhanced Care Management (ECM) providers and other care team members.

Managed Care Partners benefit from alignment with CoCs in the following ways:

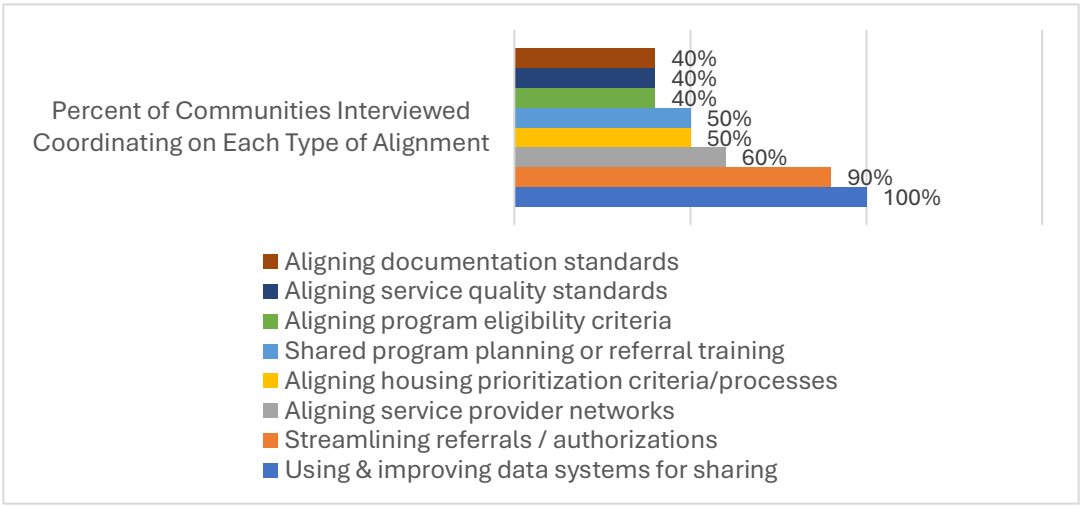
- By aligning Community Supports services with individuals who are prioritized for permanent supportive housing (PSH) resources through CES, MCPs can ensure that members receiving housing navigation can quickly move into permanent housing and avoid hospitalization and other institutional stays.
- CoCs and their providers can increase referrals to and thus the number of members receiving Community Supports housing services and ECM services.
- CoCs can share data on members experiencing homelessness, as well as nearly housed or newly housed members, to signal eligibility for the Community Supports Housing Trio (Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy Sustaining Services).
- CoCs offer connections to a network of trained providers with experience and community trust, who practice models that DHCS identified as evidence-based or best practices, such as Housing First, Trauma-Informed Care, Harm Reduction and Motivational Interviewing.
- MCPs gain entree to CoC resources, such as locally- and state-funded outreach programs, interim housing, or provider training programs.
- Access to HMIS data to support ECM and Community Supports providers serving members experiencing homelessness.
- Access to housing placement and retention data (via HMIS or data exchanges) to track effectiveness of Community Supports services.

Key Opportunities for Collaboration

Recommendations, guidance, and technical assistance offerings about collaboration between health and housing partners commonly cite these categories of collaboration as key opportunities. Partners can advance the availability and coordination of housing and supportive services for people experiencing homelessness through these opportunities:



Using and improving data systems was a key area of collaboration for all ten communities interviewed, followed closely by efforts to improve and streamline referral processes. Other areas varied more by community. (See breakdown below.)



Notable Themes

Both Time and Resources Are Needed

Most partnerships began after the launch of CalAIM in January 2022, with some beginning in 2023 after receiving the Providing Access and Transforming Health Capacity and Infrastructure Transition, Expansion and Development (PATH CITED) or HHIP grant funding to cover the costs related to data system improvements. Several larger counties already had partnerships in place because of previous Medi-Cal waivers or pilot programs, including Whole Person Care. Many interviewees noted that it takes at least one to two years to start to build effective partnerships, and that the changes are meaningful but not quick. All interviewees noted that HHIP[5] funding was instrumental in covering costs associated with partnership coordination on the new Community Supports referral and authorization processes, legal agreements, data system improvements, provider capacity building and billing structures. Multiple partners also shared about the value that PATH CITED grants had for CoC Providers who needed the start-up funding to manage costs associated with becoming Community Supports providers. A few partners noted that Community Supports service funding maintained available resources in their community (rather than expanding them) because they had already incorporated similar Medi-Cal funding under the Whole Person Care 1115 waiver.

Counties Play a Significant Role in Leading Community Supports Integration

Among the ten communities uplifted and interviewed, nine had a county agency engaged as a lead CalAIM coordination partner or as the CoC Lead Agency tackling Community Supports integration. In California, counties administer Medi-Cal enrollment, creating natural opportunities for data sharing to identify Medi-Cal enrollees experiencing homelessness. When paired with information on MCP assignment, this information allows CoC Lead Agencies to make batch referrals (referring multiple people to Community Supports at once).

County agencies can also offer administrative resources for implementation and bring in other county partners such as Behavioral Health departments.

LEAD AGENCY ROLE:

Coordinates the community's efforts to end homelessness.

Manages the HMIS.

Designs and operates a CES.

Submits the annual funding application to HUD.

Not all CA CoCs have county agencies as the Lead Agency. Without county support or Medi-Cal data, coordination between CoCs and MCPs to access Medi-Cal data and make batch referrals of clients in CES becomes more difficult. See Appendix B and Tools Library for more information on data sharing, workflows, and community examples.[6]

[5] HHIP: The Housing & Homelessness Incentive Program enabled Medi-Cal MCPs to earn one-time funds for partnering with homeless systems of care, using federal American Rescue Plan Act dollars. Housing and Homelessness Incentive Program - California Health Care Foundation

[6] Please reach out to Advisory Committee facilitators Cheryl Winter (cheryl.winter@csh.org) and Alison Klurfeld (alison@klurfeldconsulting.com) to request access to the Tools Library.

Aligning Community Supports with Housing Resources through Eligibility Criteria, Attestations, and Network

One of the eligibility criteria for Housing Transition Navigation Services (HTNS), Housing Deposits, and Housing Tenancy Sustaining Services (HTSS) is currently "Individuals who are prioritized for a PSH unit or rental subsidy resource through the local homeless CES or similar system…".[7] This criterion makes it possible for CoCs and MCPs to have automatically agreed-upon, shared eligibility criteria, and led to several partnerships focusing on batch referrals for CalAIM housing-related Community Supports from CoCs or County Leads to MCPs. These batch referrals led to thousands of people who had already been assessed by the Coordinated Entry System and met eligibility criteria being referred quickly to HNTS and HTSS.

Efforts to align eligibility criteria are also critical because many members who qualify for HTNS and HTSS will not be able to get housing vouchers due to the overall inadequacy of federal, state, and local subsidy funding. While many communities focused on aligning MCP criteria and processes to match the CES, some also did the reverse and adjusted their CES housing prioritization criteria to give increased priority to people with severe health needs, or incorporating Community Supports referral processes into each stage of the CES process.

MCPs also have the option to accept attestations of housing need, which reduced documentation barriers because the CES already assesses housing need and stores that documentation in HMIS. Attestations enable CoC Lead Agencies or County Leads making referrals to simply declare that an assessment was completed and the member met eligibility requirements, instead of having to share document copies. In addition, many MCPs and CoCs made a conscious effort to align provider networks, both by recruiting CoC providers to contract with the MCP as Community Supports providers, and by encouraging other Community Supports providers to formally join the CoC.

[7] See the Community Supports Policy Guide from July 2023, pgs. 12, 17, and 21: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

HMIS Access and Adaptations

All ten communities surveyed leveraged HMIS to support collaboration and alignment. In the same way that each healthcare provider may choose a different electronic health record for its data system, each CoC contracts with a vendor to build out its HMIS. However, not all HMIS systems have the capacity to meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security standards or to collect data related to Community Supports. Most communities surveyed used the same HMIS vendor (BitFocus' Clarity software, which is the most popular in California) to integrate Community Supports in some way. HMIS alignment activities common to the surveyed communities included:

- Authorizing MCP partners to have reading, writing, and/or report pulling access;
- Granting read or write access to MCPs and/or to ECM and Community Supports providers serving people experiencing homelessness;
- Adding new programs or program types in HMIS for housing-related Community Supports;
- Adding new data elements in HMIS for tracking Medi-Cal enrollment, MCP assignment, Medi-Cal client identification number (CIN), and/or enrollment in ECM and /or Community Supports programs;
- Creating new HMIS forms for service providers to collect housing assessments, crisis plans, and/or Individual Housing Support Plans for Community Supports; and
- Creating new client contact forms for service providers to collect data necessary for invoices and claims for reimbursement for Community Supports.

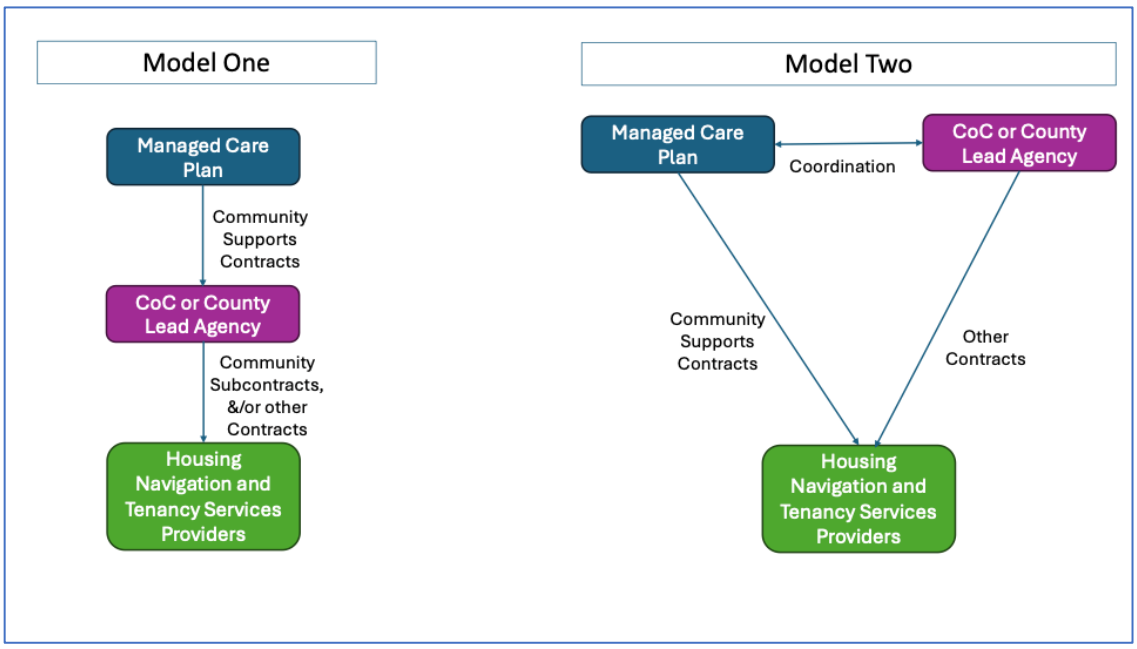
In some communities, HMIS data was already being pulled into larger county health information exchanges (e.g. in Alameda, Humboldt). In other communities, data sharing agreements had to be completed by all MCP and/or ECM/Community Supports provider partners before HMIS access could be granted or aggregate data could be shared. Several interviewees noted that data sharing agreements were one of the most challenging and time-consuming barriers to alignment, especially because of the different privacy standards for homeless and housing services and health care systems.

Subcontractor vs. Direct Contract Model

For regions across the size spectrum, there were two main models for MCP coordination:

1. Model One: The CoC or County Lead Agency takes on a role as an intermediary contracting directly with the MCP(s) for Community Supports and subcontracts to an existing network of homeless and housing services providers participating in CES. This can be understood as a version of the "Medi-Cal Community Care Hubs" model[8]; or
2. Model Two: The MCP contracts directly with one or more homeless and housing services providers who also participate in the CoC, and the CoC or County Lead Agency acts as a collaborative planner and facilitation partner. The CoC or County Lead may also assist providers with Community Supports documentation via HMIS changes.

Each model was found in both large and small areas. Regions often chose model one where there was already infrastructure from Whole Person Care pilots that they hoped to continue funding via CalAIM, and/or where there was local housing services funding to braid with Community Supports. Model one requires more non-Community Supports funding and higher risk tolerance, since lead agencies will be responsible to ensure compliance for their subcontractors as well as full payment regardless of reimbursement received from MCPs. However, having the CoC take the lead in Model one also makes it much easier to align processes and networks with Community Supports.



[8] For more on the model, see: https://www.chcf.org/publication/exploring-emerging-medi-cal-community-care-hubs

Regional Variation: CoC Size and Resources, Number of MCPs, and Coordinating Agency Type

Large urban areas and smaller rural or suburban areas took different approaches. Larger, urban areas typically had a larger county agency with staff that could take on an administrative and/or contracting role for Community Supports. In contrast, several smaller CoCs incorporated case conferencing for all Community Supports and CoC provider agencies. With fewer staff to participate and fewer people experiencing homelessness (PEH) to discuss, it was easier to get everyone in the same room to connect clients to both CoC and Community Supports resources (instead of pursuing technology and contract changes). Outside MCP funding was important to all Lead Coordinating Agencies, but much more critical to small CoCs .

Counties can have one, two, or multiple local MCPs offering Community Supports, depending on the local Managed Care model. Places with two or more MCPs found more value from a stronger CoC or county coordinating agency role. In regions with multiple MCPs and model one, the county or CoC lead agency was able to take on the role of navigating MCP differences so that subcontractors were insulated from those challenges.

If the coordinating agency was a part of county government, some changes to integrate Community Supports required additional approvals and signoff. For example, many data sharing agreements required input from county counsels, and both data sharing and funding agreements often required approval from the County Board of Supervisors. This added time and complexity that nonprofit lead agencies did not experience.

Community Profiles

Below are details of the alignment and coordination processes adopted within each of the ten communities. Included in each community profile is the HUD CoC Category[9] (Largely Rural, Largely Suburban, Major City CoC, and Other Largely Urban CoC), most recent Point-In-Time count of people experiencing homelessness, and names of local MCPs. Each example includes the current alignment efforts that leaders shared were happening, as well as a brief narrative of alignment activities highlighted in interviews. Process maps of alignment processes for some counties are in Appendix B, along with links to sample documents and templates shared by community leaders.

ALAMEDA COUNTY

Major City CoC
Coordination Lead Agency: Alameda County Health, Housing & Homelessness Services (Administrative Entity for state & local programs and support for HMIS document changes, in partnership with the local CoC, Everyone Home)
MCPs: Alameda Alliance for Health, Kaiser Permanente
2024 PIT count = 9,450

Current Alignment Efforts

- Aligning service provider networks
- Aligning program eligibility criteria and / or documentation requirements
- Streamlining referrals / authorizations to / from CES and Community Supports
- Aligning housing prioritization criteria/processes in CES with Community Supports criteria / processes
- Using and improving existing data systems

Alameda County Health contracts directly with MCPs for housing-related Community Supports and serves as the administrative hub for its network of housing service providers who then receive referrals from the county after the county determines eligibility and prioritization using CES. County staff manage:

1) Identifying eligible people being served in the Coordinated Entry System who are prioritized for PSH and pulling this report from HMIS;
2) Assigning members to contracted housing service providers in the CoC network;
3) Adding in Medi-Cal CINs and identifying the MCP assignment by pulling data from its county Social Health Information Exchange**;** county staff work to create a spreadsheet containing the information necessary to make an authorization request for each Medi-Cal member experiencing homelessness or housing instability;
4) Sending hundreds of authorization requests in batches via spreadsheet to MCPs;
5) Tracking the authorization status of each referral (12-month authorizations, 6-month authorization extensions);

[9] For details on HUD CoC Categories and Point-In-Time count data, visit: PIT and HIC Data Since 2007 - HUD Exchange

ALAMEDA COUNTY (CONTINUED)

6) Tracking when authorization extensions and updated assessments are due, notifying providers two months in advance, and tracking receipt of necessary documentation from providers;
7) Submitting documentation for authorization extensions (every 6 months) to MCPs;
8) Billing the MCPs by sending claims and receiving reimbursement;
9) Braiding in local funding to cover service costs and clients not covered through MCP contracts;
10) Resubmitting documentation to MCPs for denied authorizations or claims, including pulling assessments and service plans from HMIS when requested;
11) Negotiating contracts with MCPs; and
12) Managing compliance with all Community Supports standards of care, contract obligations and Medi-Cal requirements.

As a part of CalAIM Community Supports, the county has updated its housing supports service assessment and individualized service plan template, in coordination with MCPs, to meet Community Supports requirements. The county also uses HMIS as the data entry platform for all service assessments and plans so that providers do not have to duplicate documentation.

BUTTE COUNTY

Largely Rural CoC
CoC Lead Agency: Butte County Department of Employment and Social Services
MCPs: Partnership Health Plan of California
2023 PIT count = 1,237

Current Alignment Efforts

- Aligning program eligibility criteria and/or documentation requirements
- Streamlining referrals / authorizations to/from CES and Community Supports
- Aligning housing prioritization criteria / processes in CES with Community Supports criteria / processes
- Using and improving existing data systems
- Aligning service quality standards between CES and Community Supports

Other innovations: Deep coordination across providers, with agreements in place, to support alignment & referrals

The Butte Countywide Homeless CoC, in collaboration with the HMIS Lead Agency (Butte County Department of Employment and Social Services), has worked closely with a range of stakeholders—including the CoC's HMIS/CES subcommittee, 211, True North Housing, Oroville Rescue Mission, Community Action Agency, Safe Space, and external consultants—to establish a streamlined process for referring households to CalAIM Community Supports and ECM services. This system ensures individuals or households are connected to Coordinated Entry (CE) and enrolled with ease through the same network of service providers.

BUTTE COUNTY (CONTINUED)

With the support of HHIP funding, outreach providers, shelters, and 211 have now become contracted CalAIM providers, helping to facilitate housing transition and navigation services.
When individuals experiencing homelessness engage with any of these entry points, they are promptly supported in enrolling in ECM, accessing Community Supports, and undergoing Coordinated Entry enrollment and assessments. In addition, they are connected to services designed to address basic needs. Using Community Supports service funding, providers assist clients throughout the CES process. This includes collecting the necessary documentation for housing, as well as providing move-in assistance and tenancy-sustaining services once the client/household is matched with a housing opportunity.

Effective coordination and client data security requires Community Supports providers to enter into agreements to share client information and data to enhance care delivery. This necessitated updates to the HMIS to allow multiple organizations to be part of the same "project type" for CalAIM Community Supports services. HMIS stores client data, which can be accessed by ECM and Community Supports providers, ensuring continuity of care when a client transitions between service providers or begins new services. As part of this effort, additional users were integrated into HMIS, which involved additional costs, but remains critical to ensuring seamless coordination. Initially, HHIP funding was available to support additional costs of new users in HMIS, however as this one-time funding ends it will be necessary for partners to find an alternative source of funding to cover user costs and any additional system improvements needed.

A key piece of advice shared by Butte County leaders for others undertaking similar efforts is to recognize that building shared language between health and housing providers can be challenging. Achieving this requires clear and consistent communication, a commitment to collaboration, and a willingness to ask questions and navigate any language barriers as new processes are developed. As a guiding principle: "Stay persistent in your communication. Keep pushing forward, embrace change, and maintain patience and flexibility."

CONTRA COSTA COUNTY

Largely Suburban CoC
CoC Lead Agency: Contra Costa County Health Services
MCPs: Contra Costa Health Plan, Kaiser Permanente
2024 PIT count = 2,843

Current Alignment Efforts

- Shared program planning and/or referral training between CES and MCPs implementing Community Supports
- Aligning service provider networks between CES and MCPs for Community Supports and/or ECM
- Streamlining referrals / authorizations to/from CES and Community Supports
- Using and improving existing data systems

Since the end of 2023, Contra Costa County Health Services has made both formal and ad hoc changes to align CalAIM programs with homeless services infrastructure. They integrated "in-house" CalAIM programs for Housing Tenancy Sustaining Services, Recuperative Care, and Short-term Post Hospitalization Housing (STPHH) into their HMIS system. Clients entering Recuperative Care and STPHH are also enrolled into Coordinated Entry and assessed for housing needs at program entry. The County Health Services division also works closely with another division (Public Health) to connect with the ECM Community Connect Team.

The CoC's HMIS data sits within the same systems as the Contra Costa Health's data, enabling the county to make queries and report on ECM, Community Supports, and CES enrolled populations together, identifying individuals who are eligible for both CES and CalAIM services who are connected to only one program. The CoC is also exploring a potential data sharing partnership with a local health system that is also a CalAIM provider.

In order to connect individuals receiving services through the CoC to available CalAIM services, Contra Costa Health trained select CES staff in the Community Supports referral process. They are also in the process of updating their CES assessment tool and prioritization process to include more medical providers and programs.

HUMBOLDT COUNTY

Largely Rural CoC
CoC Lead Agency: Humboldt County Department of Health and Human Services
MCPs: Partnership Health Plan of California
2023 PIT count = 1,656

Current Alignment Efforts

- Streamlining referrals / authorizations to/from CES and Community Supports
- Using and improving existing data systems

Humboldt County acts as the lead agency for the local Continuum of Care and recently contracted with the local MCP (Partnership Health Plan) to provide housing-related Community Supports as a direct service provider. Over the past two years, they have been planning changes to their HMIS system to allow both the county and other Community Supports providers in the CoC to document their CalAIM services in HMIS. The new system went live in late 2024, and offers free HMIS licenses for CoC providers, an API for referrals, and documentation for assessments, individual housing support plans, and claims generation. To facilitate this, the county secured a new HMIS vendor, made updates to their HMIS privacy policy, and created new data sharing agreements which required Board of Supervisors approvals. Having additional funding through Community Supports will allow both the county and other CoC providers who contract with MCPs to serve additional individuals, as there are not currently enough community resources available to provide housing navigation and tenancy supportive services to all clients who need it through the CoC's funding alone.

TULARE COUNTY

Largely Suburban CoC
CoC Lead Agency: Kings Tulare Homeless Alliance
MCPs: Both: Anthem Blue Cross, Kaiser Permanente; Tulare: Health Net Community Solutions
2024 PIT count = 1,672 (*combined PIT count for Kings & Tulare counties)

Current Alignment Efforts

- Shared program planning and/or referral training between CES and MCPs implementing Community Supports
- Aligning service provider networks between CES and MCPs for Community Supports and/or ECM
- Streamlining referrals / authorizations to / from CES and Community Supports
- Using and improving existing data systems

Kings and Tulare's non-profit CoC collaborated closely with one of their local MCPs, Anthem Blue Cross, to integrate Community Supports into their local CES. They came together initially as they talked through two funding opportunities (HHIP and the CHCF-funded Partnerships for Action grant) and then the MCP invested in a self-assessment of the CoC's processes, assets, and gaps so that they could plan collaboratively to address those gaps through CalAIM.

TULARE COUNTY (CONTINUED)

The MCP also funded a CalAIM coordinator position at the CoC to lead case conferencing and client-level work to help with access to Community Supports, as well as multiple other CoC investments, including upgrades to HMIS. Kings United Way worked with MCPs to set up CalAIM services in HMIS, which allows services to be tracked by provider and type of service. The HMIS also includes a CalAIM dashboard, and the CoC and MCP exchange data regularly on shared clients / members. The CoC also implemented case conferencing to review client-level access to both Community Supports and housing services through the CoC on a biweekly basis, with all CalAIM and CoC providers participating and reviewing their cases via HMIS. Positive results include increased referrals to Community Supports as compared with other regions where the MCP operates. On the provider network side, the CoC and MCP emphasized the value of contracting with local homeless service providers that were already a part of the local homeless response system to deliver ECM and Community Supports services to Medi-Cal members.

LOS ANGELES COUNTY

Major City CoC
Lead CalAIM Coordinating Agency: L.A. County Dept. of Health Services
MCPs: L.A. Care Health Plan, Health Net Community Solutions, Kaiser Permanente
2024 PIT count = 75,312

Current Alignment Efforts

- Aligning service provider networks between CES and MCPs for Community Supports and/or ECM
- Aligning program eligibility criteria and/or documentation requirements between CES and Community Supports
- Aligning housing prioritization criteria/processes in CES with Community Supports criteria / processes
- Using and improving existing data systems
- Aligning service quality standards between CES and Community Supports

Los Angeles County's Department of Health Services, Housing for Health Division (HFH) holds contracts with the three local primary MCPs and their three subcontracted plan partners to provide housing-related Community Supports. HFH subcontracts with its existing network of 75+ experienced homeless and housing services providers countywide to deliver housing-related Community Supports. To serve people experiencing homelessness who are prioritized for PSH through LA County's CES, and for permanently housed people who were previously homeless, HFH subcontractors implement the PSH Intensive Case Management Services (PSH ICMS) Statement of Work, which is equivalent to providing HTNS and HTSS through CalAIM. HFH's subcontractor network additionally includes local Recuperative Care and Short-Term Post-Hospitalization Housing providers, and Brilliant Corners, which operates LA County's Flexible Housing Subsidy Pool and provides Housing Deposits.

LOS ANGELES COUNTY (CONTINUED)

While HFH is an integral part of LA County's CES, HFH is not the CoC Lead Agency, which is the Los Angeles Homeless Services Authority (LAHSA). HFH operates its own documentation system (CHAMP) that is separate from the local HMIS operated by LAHSA, although data from CHAMP and HMIS is shared regularly between HFH and LAHSA.

HFH uses complementary local funds to pay subcontractors for services delivered to program participants regardless of whether the county receives any Community Supports reimbursement from the MCPs for these services. However, MCP funds increase the overall availability of services in the region. In order to seek MCP coverage for services, HFH does ask all program participants at intake to consent to the county pursuing housing-related Community Supports authorization(s) and reimbursement from their MCP, when applicable, to help cover the costs of eligible housing-related services provided by HFH.

For Community Supports operations, HFH contracts with a third-party entity to generate a report at the beginning of each month that helps identify the MCP each program participant is currently enrolled in. The adoption of this process was vital due to HFH's large scale (over 20,000 participants), and how prohibitive it would be to continue the manual re-screening of eligibility in the Medi-Cal provider portal from month to month. Despite the mass re-screening that was adopted, most MCPs in LA County still require HFH to seek authorizations via individual client submissions, which is challenging to do at HFH's scale; however, some MCPs are now experimenting with the acceptance of batch referral submissions. After the MCP has authorized Community Supports, HFH's subcontracted providers deliver services and complete documentation in CHAMP for assessments, individual housing support planning, and participant encounters. HFH provides subcontractor oversight and quality assurance, regularly extracts data from CHAMP to bill MCPs for Community Supports via claims and reconciles payments from MCPs with services rendered. HFH also regularly processes all MCP Authorization Status Files, submits Return Transmission Files to MCPs, and requests reauthorizations for cases, as needed. Documentation requirements for Community Supports are more extensive as compared with Whole Person Care (WPC); however**,** the bulk of the changes in HFH's programming under the shift from WPC to Community Supports have occurred at the administrative level, with fewer changes at the direct service (subcontractor) level.

SAN FRANCISCO CITY / COUNTY

Major City CoC
CoC Lead Agency: San Francisco City & County
MCPs: San Francisco Health Plan, Anthem Blue Cross, Kaiser Permanente
2024 PIT count = 8,323

Current Alignment Efforts

- Streamlining referrals / authorizations to / from CES and Community Supports
- Using and improving existing data systems
- Aligning service quality standards between CES and Community Supports

San Francisco's Department of Homelessness and Supportive Housing (HSH) is the CoC Lead Entity and holds contracts with the two local MCPs to provide housing-related Community Supports (HTNS and HTSS, and adding Housing Deposits) via the city and county's Department of Public Health. HSH subcontracts these services to its existing network of homeless services providers through the CoC, with a current focus on serving people prioritized for housing or experiencing homelessness and health risks who are in CES. They intend to branch out to prevention and diversion programs for at risk clients in the future. HSH focuses on serving clients who are already a part of CES and they only do bottom-up referrals to MCPs (i.e. they do not accept referrals from the MCP for any new clients outside of CES for Community Supports).

For its Community Supports operational workflow, HSH begins from its pool of clients already prioritized to receive services akin to HTNS, HD, and/or HTSS through contracted providers in CES. HSH identifies clients in HMIS who are or will be receiving those services on a monthly basis and pulls information into a separate data warehouse to identify net new clients. HSH then sends the new client list to the Dept. of Public Health, which pulls in Medi-Cal enrollment and MCP information and provides the list back. HSH then makes batch referrals to their MCPs for those new clients via a spreadsheet. The MCPs provide a response spreadsheet, which is like a simplified Authorization Status File (ASF), as well as including those clients on the next full ASF, and HSH provides a Return Transmission File.

HSH used its existing Housing Navigation, Housing Deposits / Move-In Assistance, and Tenancy Support Services contracts with subcontractors to deliver Community Supports, as the scopes of work were already aligned (and their Tenancy Services scope was broader). The subcontractors deliver services and document them in HMIS. HSH made several configuration changes to accommodate this, including adjusting service options, creating new templates, and creating new formats for individual housing support plans. HSH recently began to use this data for MCP billing via a spreadsheet invoice process, in which they pull HMIS data from their data warehouse using SQL reports and then populate the relevant information into the MCP's excel invoice template. Using complementary funding from the City and County of San Francisco, HSH pays its subcontractors for services regardless of whether the county gets paid by the MCPs for an individual client. This occurs because some clients may not be eligible for Community Supports, while others may have had a lapse in Medi-Cal enrollment or are not yet enrolled. The MCP payments add valuable new funding to expand overall service capacity, but do not cover the full cost of services at the per client level.

SANTA BARBARA COUNTY

Largely Suburban CoC
CoC Lead Agency: County of Santa Barbara Community Services Department/Housing and Community Development Division (CSD/HCD)
MCPs: CenCal Health
2024 PIT count = 2,119

Current Alignment Efforts

- Shared program planning and/or referral training between CES and MCPs implementing Community Supports
- Aligning service provider networks between CES and MCPs for Community Supports and/or ECM
- Streamlining referrals / authorizations to / from CES and Community Supports
- Using and improving existing data systems

Santa Barbara County works closely with its local MCP (CenCal). CenCal contracted with the county as CoC lead to support the efforts to meet HHIP metrics. Through HHIP, CenCal funded a full-time Healthcare Liaison position within the county for two years, in order to coordinate and facilitate access to ECM and Community Supports for clients in CES. HHIP funding also helped support the 2023 and 2024 Point-in-Time counts and several other initiatives, including:

- **CES Access Points support:** Santa Barbara County emphasized service delivery and client connection for all participants, including CenCal members, and worked to educate Providers about MediCal enrollment and promote the MediCal redetermination process.
- **In-person "Santa Barbara County Homeless Education Conference":** Occurred in fall 2024 and breakout session topics included ECM/Community Supports Best Practices for Providers, and Community Resources
- **Referral tracking consistency via oversight of Access Points:** The county works closely with Access Point Providers to improve outreach and referral for CenCal members and monitors Access Points, including the Diversion Hot line, to address any barriers to service for CenCal members
- **Addressing access to services for all communities:** Ongoing efforts include discussion of client barriers at case conferencing; the Healthcare Liaison also attends a monthly CoC-established work group to ensure all community members experiencing homelessness can access services.
- **Incorporating language services:** The county contracted with LanguageLine to deliver on demand language services for CES Access Points starting in summer 2023 and trained all Access Point providers.

While the HHIP funding recently ended, Santa Barbara County plans to continue collaboration with the MCP, to provide the services listed above, and to expand and improve opportunities for service delivery and connection for ECM and Community Supports Providers.

SANTA BARBARA COUNTY (CONTINUED)

The county also works closely with the MCP to exchange data on shared clients / members. The county and the MCP exchange excel spreadsheets on a regular basis to identify all clients in CES who have been referred into CalAIM services, as well as their ECM/Community Supports enrollment status, enrollment date, and assigned provider. The Healthcare Liaison reviews the list and follows up to ensure that connections have been made at the individual client level, as well as monitoring trends globally to identify where there may be provider or systems gaps (e.g. identifying providers having difficulty engaging members who may need to be trained to use HMIS to see their history). The liaison also meets weekly with MCP staff to identify and resolve individual and systemic issues, and with MCP-contracted ECM and Community Supports providers who are not yet connected to the local CES. The county also provides a weekly housing status change report that tracks member movement through the system of care from unhoused, to interim, and permanent housing as well as reporting and referral tracking for HHIP measures.

HMIS has been a key part of the collaboration as well. Santa Barbara has added additional HMIS End User licenses for new and existing ECM, Community Supports, and HHIP providers, and is available for assistance with HMIS program setup and training on accurate data entry and system use. Santa Barbara also procured a new HMIS vendor (Clarity/Bit Focus) to expand and improve their system. Data migration began in late 2024 and will hopefully streamline data exchange between the CoC and the MCP, as well as allow for a more automated process for identifying member status and enrollments.

SANTA CLARA COUNTY / SAN JOSE CITY

Major City CoC
CoC Lead Agency: County of Santa Clara, Office of Supportive Housing
MCPs: Santa Clara Family Health Plan, Anthem Blue Cross, Kaiser Permanente
2023 PIT count = 9,903

Current Alignment Efforts

- Shared program planning and/or referral training between CES and MCPs implementing Community Supports
- Aligning service provider networks between CES and MCPs for Community Supports and/or ECM
- Streamlining referrals / authorizations to / from CES and Community Supports
- Aligning housing prioritization criteria / processes in CES with Community Supports criteria / processes
- Using and improving existing data systems

The Santa Clara County Office of Supportive Housing (OSH) acts as the lead agency for the Santa Clara CoC, managing its contracts with CoC providers and braiding in local county resources, in addition to federal HUD dollars.

SANTA CLARA COUNTY / SAN JOSE CITY (CONTINUED)

OSH has contracted with Santa Clara Family Health Plan and Anthem Blue Cross for one of the housing-related Community Supports: Housing Transition Navigation Services to support outreach, engagement and transition services for all individuals prioritized for PSH through the Coordinated Entry System, VI-SPDAT assessment tool. OSH employs county staff who provide the outreach and housing navigation services to support people as they exit homelessness and move into PSH.

OSH works with another county agency, the Office of System Integration and Transformation (OSIT) to verify Medi-Cal enrollment and MCP assignment so that OSH can make batch referrals to MCPs. PSH system housing navigation staff meet to review batch referrals, as needed. MCPs have agreed to retroactively authorize services from the date a client is prioritized for PSH and outreach begins. These partnerships and batch referrals ensure that many members can access services quickly and move into permanent housing.

OSH uses HMIS for its documentation of services and for pulling data to create invoices to submit for reimbursement. Through HHIP and HMIS data sharing agreements, MCPs have access to the CoC's HMIS system and are able to pull custom reports to track members' housing status.

Additionally, MCPs and OSH have coordinated program planning for using HHIP funding and have brought in partners to provide cross training (Fundamentals of Medi-Cal for CoC providers and Fundamentals of Homeless Services for MCP staff). Partners from both the county and MCP meet every other week to increase partnership and coordination efforts funded through HHIP.

SANTA CRUZ COUNTY

Largely Suburban
CoC Lead Agency: County of Santa Cruz, Housing for Health Partnership
MCPs: Central California Alliance for Health, Kaiser Permanente
2024 PIT count = 1,850

Current Alignment Efforts

- Shared program planning and/or referral training between CES and MCPs implementing Community Supports
- Aligning service provider networks between CES and MCPs for Community Supports and/or ECM
- Aligning program eligibility criteria and / or documentation requirements between CES and Community Supports
- Streamlining referrals / authorizations to / from CES and Community Supports
- Aligning service quality standards between CES and Community Supports
- Aligning housing prioritization criteria / processes in CES with Community Supports criteria / processes
- Using and improving existing data systems

SANTA CRUZ COUNTY (CONTINUED)

Santa Cruz County's local approach involves training "Connectors", individuals within CoC agencies that have specific roles within the county. Connectors are trained to support people experiencing homelessness in accessing a variety of services and supports, including ECM and Community Supports.

The county is also formalizing data sharing agreements with the local Medi-Cal Managed Care Plans to explore the overlap between CES participants and ECM/Community Supports enrolled individuals. MCPs have representation on the CoC Board and have regular check-in meetings with CoC/county staff. Through HHIP and collaborative work, partners have supported CoC providers in contracting with MCPs and these newly contracted providers are getting capacity building support to grow knowledge and the infrastructure needed to support new processes, claims procedures, and contractual obligations.

Through HHIP, MCPs have also helped to fund lived expertise leadership engagement and development. The CoC and county also already prioritized hiring people in key leadership positions who also have lived experience of homelessness.

The county has conducted an analysis of the data elements and program changes that will be needed in HMIS to better share data, track enrollments, and ease administrative burden of documentation in multiple systems.

Appendix A: Methodology

Process

This paper draws on the efforts of Workgroup 4 from the Housing Community Supports Implementation Advisory Committee. This project is co-convened by the Corporation for Supportive Housing and Klurfeld Consulting, LLC, and was generously funded by the California Health Care Foundation.

The CES and Community Supports-focused Workgroup met in summer 2024 to map out coordination efforts undertaken across California. The workgroup created a list of potential interviewees, made up of MCP, CoC, and county staff across the state who were involved in coordination efforts to align homeless service systems with housing-related Community Supports. The workgroup also surveyed all Advisory Committee members to learn if there were other communities to be considered. In addition, workgroup members connected with CoCs participating in a learning community hosted by HomeBase, and with CoCs presenting in a webinar series hosted by Clarity Bitfocus, an HMIS vendor.

Ten different Counties were uplifted as having unique efforts in aligning CalAIM housing-related Community Supports implementation with homeless CoC priorities and practices. Managed Care Plans, CoC, and county leaders were emailed and invited to participate in Zoom video calls for interviews. They were also offered the opportunity to complete the interviews using a survey tool online, if time did not allow for a Zoom meeting. Ten counties were included in the interview/survey process. In most cases, just one of the partners shared on behalf of all parties within the community working to align coordinated entry and CoC practices with CalAIM Community Supports services.

Community Partners Interviewed or Surveyed

Interviewee Name(s)	Organization Name & Organization Type	County Represented
1. Josh Levine	Alameda County Health, Housing & Homelessness Services, County Agency	Alameda
2. Elisa Rawlinson	Butte County Department of Employment and Social Services, County Agency	Butte
3. Kimberly Thai, Mary Juarez-Fitzgerald	Contra Costa Health, County Agency	Contra Costa
4. Aaron Zell, Robert Ward	Humboldt County Department of Health & Human Services, County Agency	Humboldt
5. Leepi Shimkhada, Kiara Payne, Oisin O'Shaughnessy	L.A. County Department of Health Services, Housing for Health, County Agency	Los Angeles
6. Jessie Shimmin, Nisha Anand	San Francisco County Department of Homelessness and Supportive Housing, County Agency & CoC Lead Agency	San Francisco
7. Sarah Brasel	County of Santa Barbara Housing & Community Development	Santa Barbara

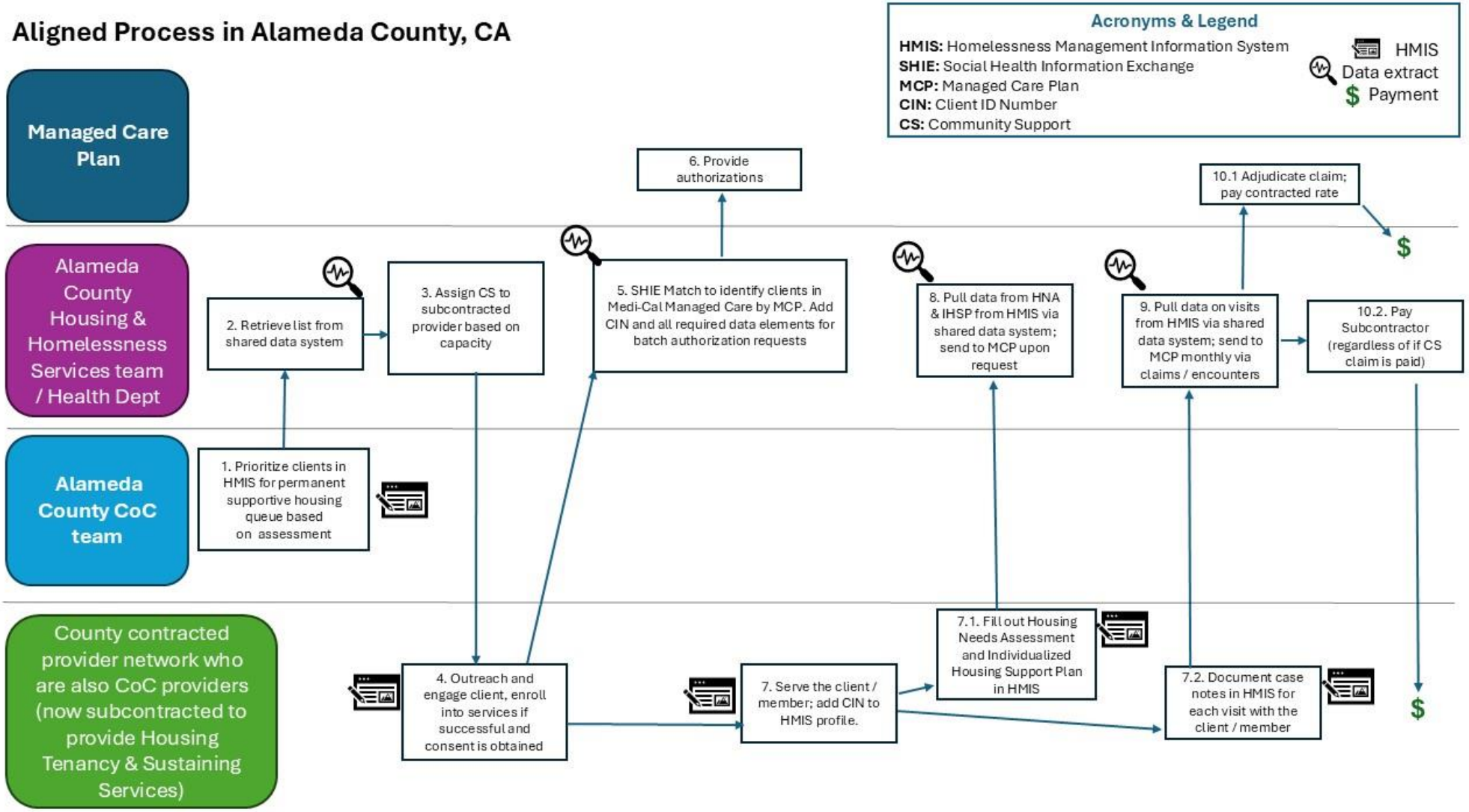
8. Andrew Somera	Santa Clara Family Health Plan, Managed Care Plan	Santa Clara
9. Robert Ratner	County of Santa Cruz Human Services Department, Housing for Health, County Agency and CoC Lead Agency	Santa Cruz
10. Miguel Perez Lopez	Anthem Blue Cross, Managed Care Plan	Tulare

Interview Questions

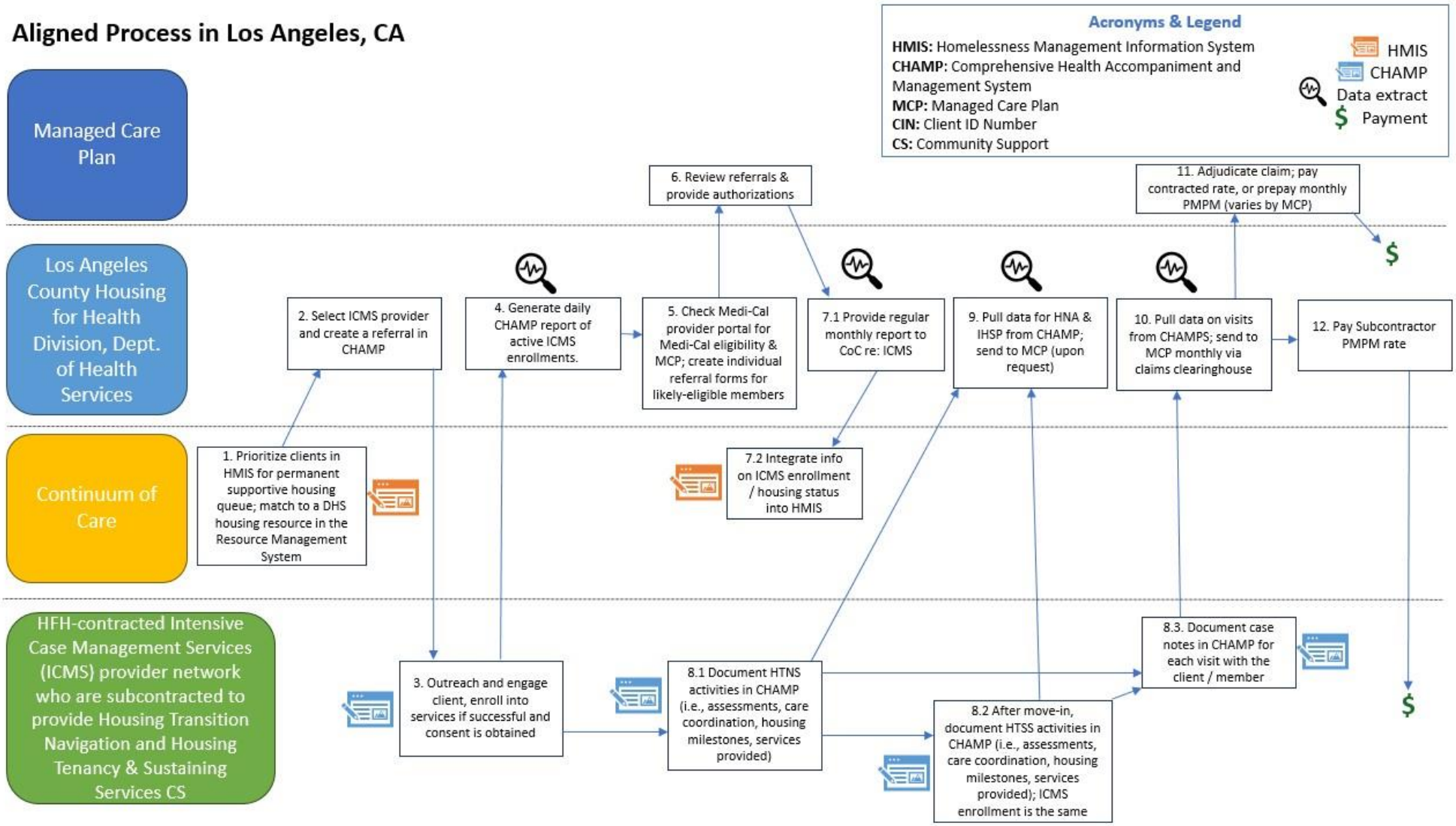
1. First and Last Name of person being interviewed (Interviewee):
2. Interviewee Role:
3. Interviewee Organization:
4. Email and phone number so we can follow up and/or share draft to check for accuracy
5. What are you doing to align Community Supports with CES resources or vice versa? Please briefly describe:
6. What types of alignment are currently active or planned:
    a. Shared program planning and / or referral training between CES and MCPs implementing housing-related Community Supports
    b. Aligning service provider networks between CES and MCPs for Community Supports and/or ECM
    c. Aligning program eligibility criteria and / or documentation requirements between CES and Community Supports
    d. Streamlining referrals / authorizations to / from CES and Community Supports
    e. Aligning service quality standards between CES and Community Supports
    f. Aligning housing prioritization criteria / processes in CES with Community Supports criteria / processes
    g. Using & improving existing data systems (for example: Tracking / including Community Supports program enrollment information from MCPs in HMIS; Collecting / tracking data for Community Supports providers in HMIS; Sharing housing status or other data between CES / HMIS and MCPs for CES / Community Supports coordination; Investments to improve the current HMIS data system(s); Updating HMIS policies, processes, and/or technology to become HIPAA-compliant; Integrating HMIS information with local Health Information Exchange(s); etc.)
    h. Other
7. Which partners (Names/Orgs.) are involved in planning and implementing this alignment activity? *Note both planners and implementers
8. When did this start / how long has this been going on?
9. Can you please describe your process, step by step?
10. What successes have you had with this alignment activity?
11. What challenges have you had?
12. What advice do you have for others trying to do similar work?
13. Were people with lived experience involved in the process? If so, how?
14. Were CoC service providers involved in the decision-making or partnership development process? If so, how?

15. Did you come up against any regulatory or policy/procedural challenges that required updating legal or procedural documents? Did any of this work need approval from your County Board, legal counsels, or other oversight entities to make it happen?
16. What shared goals, shared values or common workstyles did you see partners having that helped make this successful- any wisdom to share that we should include in the Spotlight?
17. We often hear about the role of "Champions" or leaders that were committed to making things work- looking to get to YES for coordination, instead of finding the No's or barriers to coordination. Who were the champions in your work that helped get you to success?
18. Anything else that you think it's important for someone else trying to work on aligning Coordinated Entry and Community Supports to know?
19. Anyone else that we should talk to? (Please share their names and emails if you can)

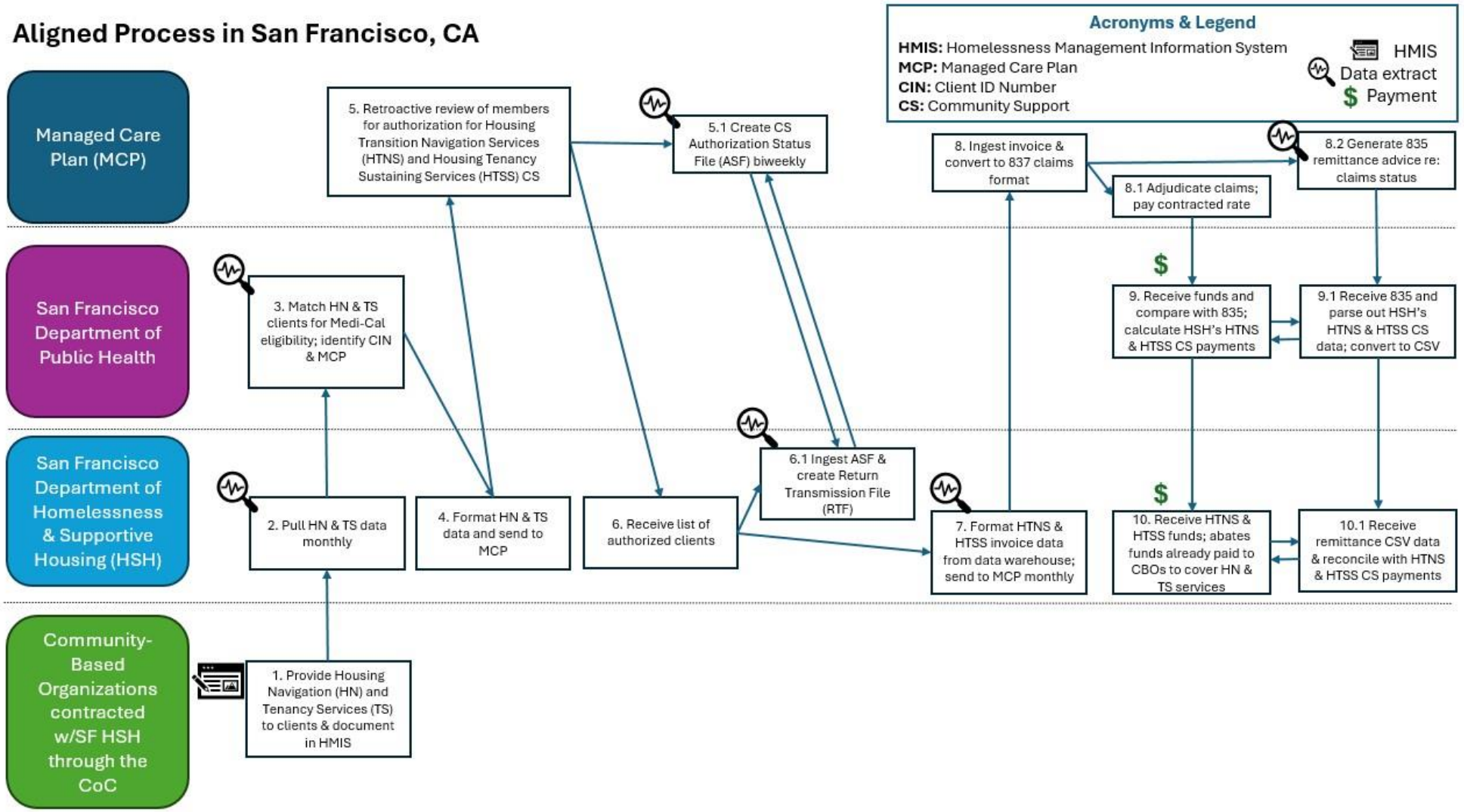
Appendix B: Process Maps of Alignment & Coordination Activities



Aligned Process in Los Angeles, CA



Aligned Process in San Francisco, CA



Appendix C: Best Practice Literature Review

Existing resources that include recommendations or spotlights for best practices in coordinating CES with housing-related Community Supports/Medicaid:

- Medicaid-Funded Housing Services: Opportunities for Alignment and Coordination with Housing Resources within Homeless Coordinated Entry Systems, U.S. Department of Housing & Urban Development, HUD Exchange, 2024
- Leveraging Managed Care to Expand Housing Resources and Formalize Partnerships, National Academy for State Health Policy, 2024
    - Includes recommendations for:
        - Participating in joint community planning
        - Investing profits back into housing
        - Incentivizing partnerships with housing providers
- Recommendations to Improve Implementation of ECM & Community Supports for People Experiencing Homelessness, HomeBase, 2023
    - Includes recommendations for:
        - Streamlining referrals and coordination
        - Enhancing education, awareness, and training
        - Improving data, metrics, and evaluation
- Building on CalAIM's Housing Supports: Strengthening Medi-Cal for People Experiencing Homelessness, CSH, 2023
    - Includes recommendations on:
        - How MCPs can align with Coordinated Entry Systems for referrals and authorizations- at the system level with presumptive eligibility
        - How MCPs can support CoCs HMIS systems to add new partners to complete CES assessments (hospitals and other health providers) to enter information into HMIS and ensure anyone experiencing homelessness becomes connected to CES
        - Need for investment in training for outreach and services staff funded through CoC grants on how to make referrals for CS and ECM
- Using Medicaid's Housing Related Services to Create New Supportive Housing, CSH, 2023
    - Highlights integrating Medicaid services and housing systems (Washington, DC)
    - Aligning eligibility criteria between housing and services (WA and MN)
    - Including people with lived experience meaningfully in systems integration
    - Reduce complexities for Medicaid reimbursement (WA)
    - Building Medicaid capacity for housing and homeless service agencies (CA, PATH-CITED and MD)
    - Aligning quality standards across sectors
- Creating Systems that Work, National Alliance to End Homelessness, 2023
- Guidance for Enhanced Care Management and Community Supports providers on the use of the Homeless Management Information System, Anthem, 2023
- Addressing Health-Related Social Needs in Section 1115 Demonstrations, Centers for Medicare and Medicaid (CMS) presentation, December 6, 2022.

- Homeless Response 101 for Health Care Providers and Stakeholders, Homebase, 2021
    - Includes overview of Coordinated Entry and CoCs
        - Key Components
        - HUD mandates and requirements
        - Opportunities for Health Care Provider participation
            - HMIS Basics
            - Examples of partnerships CES with both MCPs and healthcare providers (LA Care noted, Alameda and Santa Clara counties noted)
            - Key contacts
- Breaking Down Silos: How to Share Data to Improve the Health of People Experiencing Homelessness, Homebase, 2021
    - Includes information on strategies for sharing data to better coordinate and support mutual clients
- Using Health Information Exchanges to coordinate care
    - Humboldt County
    - San Diego
    - Alameda County
- Why and How Communities Are Sharing Data to Improve Outcomes for People Experiencing Homelessness, US Department of Housing and Urban Development, 2019
- Enhancing Coordinated Entry through Partnerships with Mainstream Resources and Programs, USICH, 2017
    - Coordinate referrals
    - Align resources and investments to expand capacity to prevent and end homelessness
    - Co-locate services and promote unified case planning
    - Prioritize access to services for people experiencing homelessness
- Patient Linkage to Coordinated Entry via Medicaid Managed Care Organization chart, CSH, 2017
    - MCO-Coordinated-Entry-Integration.pdf (csh.org)
- Administrative Models for Medicaid funding Services (in supportive housing), CSH, 2019
- Using Medicaid to Pay for Services in Permanent Supportive Housing: Steps for CoC Leads to Get Started, CSH, NAEH and TAC, 2016
    - Relevant sections include:
        - Making the case with data
        - Gathering Allies
- Managed Care and Homeless Populations: Linking the HCH Community and MCP Partners, National Health Care for the Homeless Council and United Healthcare, 2016
    - Relevant sections
        - Common Goals and Key Factors chart outlines opportunities for collaboration that could extend to collaboration with CES, CoC providers not contracted for Community Supports, and expectations between ECM, Community Supports providers and MCPs.

Other related documents:

- Reducing Homelessness for People with Behavioral Health Needs Leaving Prisons and Jails (csgjusticecenter.org)
    - Potential role for MCPs in connecting people leaving incarceration to the homeless assistance system through JII, ECM and Community Supports in partnership with CES. See tables on pages 16 and 17 to assess where MCPs should play a role.
- Microsoft Word - CalAIM Housing_FINAL.docx (nashp.org)
- COVID-19 HMIS Setup and Data Sharing Practices (hudexchange.info)
- Equity-Centered Strategies to Improve Care for People Experiencing Homelessness: Lessons from Kings and Tulare Counties
- CE-Written-Standards_9.2023_Clean.pdf (sfgov.org)
- Alameda County Coordinated Entry Policies 02.22.pdf (acgov.org)
- A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing (hhs.gov)
- Supportive Housing for Chronically Homeless Medicaid Enrollees: State Strategies - Center for Health Care Strategies (chcs.org)
- Health Home Connect Improves the Health of Aging Homeless Individuals through the Coordinated Entry System and the Affordable Care Act | Public Policy & Aging Report | Oxford Academic (oup.com)
- PowerPoint Presentation (itup.org)
- How Medicaid and States Could Better Meet Health Needs of Persons Experiencing Homelessness | Journal of Ethics | American Medical Association (ama-assn.org)
- Homelessness in California: Causes and Policy Considerations | Stanford Institute for Economic Policy Research (SIEPR)

Key Terms

- California Advancing and Innovating Medi-Cal (CalAIM)
- Client ID Numbers (CIN)
- Community Supports (CS)
- Continuums of Care (CoCs)
- Coordinated Entry System (CES)
- Enhanced Care Management (ECM)
- Homeless Management Information System (HMIS)
- Housing and Homelessness Incentive Program (HHIP)
- Permanent Supportive Housing (PSH)
- Medi-Cal Managed Care Plans (MCP)
- US Department of Housing and Urban Development (HUD)