Understanding CalAIM Implementation Across California

Authors:
Carol Wilkins, Consultant with Abt Associates

Anika Kalra, Ashley Smith, Pam Olsen, Maria Barakat, Michelle Kim, Margot Kushel,
UCSF Benioff Homelessness and Housing Initiative

Carolina Reid, Terner Center for Housing Innovation

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TERNER CENTER FOR HOUSING INNOVATION UC BERKELEY

Abt ASSOCIATES

UCSF University of California San Francisco

Benioff Homelessness and Housing Initiative

Acknowledgements

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Introduction

In January 2022, California's Department of Health Care Services (DHCS) and its local partners began the implementation of California Advancing and Innovating Medi-Cal (CalAIM). DHCS describes CalAIM as "*a long-term commitment to transform Medi-Cal, making the program more equitable, coordinated, and person-centered to help people maximize their health and life trajectory*."[1] Using the authority and flexibility provided by two new Medicaid waivers approved by the federal government at the end of 2021, CalAIM seeks to address the upstream factors that contribute to health disparities.[2] This is an ambitious undertaking: Medi-Cal, the state's Medicaid program, provides health insurance for low-income people: in total, over 13 million Californians — one in three — rely on the program for health coverage.[3]

While CalAIM has broad goals related to improving Medi-Cal implementation, it is particularly important for efforts to address homelessness. Specifically, CalAIM expands the capacity of Medi-Cal managed care plans[4] (MCPs) to partner with community-based organizations and other entities and allows health care dollars to be spent on supportive services that are critical to enhancing the well-being of people experiencing or at risk of homelessness. For example, CalAIM enables MCPs to contract and share Medi-Cal data with an expanded network of community partners, including organizations that offer services such as street medicine, recuperative care (medical respite), housing navigation, and tenancy-sustaining services. In addition, CalAIM creates new opportunities for MCPs to pay existing partners for delivering services that had not been financed through Medi-Cal previously (e.g., health center staff working as members of a street medicine team providing care to people living in encampments).

CalAIM is a multi-year effort and is still in the midst of implementation. There are both state and local efforts to improve coordination between MCPs and organizations that provide housing and services to people experiencing homelessness. However, there also remain barriers to the implementation of CalAIM, particularly with regards to

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1 California Department of Healthcare Services (2022). "California Advancing and Innovating Medi-Cal (CalAIM): Our Journey to a Healthier California for All." California Department of Healthcare Services. Retrieved from: https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-Primer-042022.pdf.

2 The federal government grants states flexibility in administering their Medicaid programs (called Medi-Cal in California) through "waivers," such as those allowed under Section 1115 of the federal Social Security Act. When a state's waiver request is approved by the federal government, the state is permitted to waive certain federal requirements on the basis that the waiver serves to further the purpose of the state's Medicaid program.

3 Finocchio, L. et al. (2021). Medi-Cal Facts and Figures – 2021 Edition: Essential Source of Coverage for Millions. California Health Care Foundation. Retrieved from: https://www.chcf.org/publication/2021-edition-medi-cal-facts-figures/.

4 Nearly all California residents who are eligible for health coverage through Medi-Cal (California's Medicaid program) receive most of these benefits through enrollment into Medi-Cal MCPs. The MCPs establish contracts for health care services through established networks of providers in organized systems of care, which emphasize primary and preventive care. MCPs are intended to facilitate the cost-effective use of health care resources that improve health care access and ensure quality of care.

building connections between the health and housing sectors.[5] In this brief, we describe the challenges related to the implementation of CalAIM at the local level, as well as highlight the potential for CalAIM to improve service coordination and provide person-centered care for people experiencing homelessness. We draw on interviews with stakeholders from local government, health and housing-related service organizations, and health care entities working to address homelessness in California.[6] We also conducted 10 additional interviews with county staff, Continuums of Care (CoCs), MCPs, and service providers in 2023 to understand CalAIM further into its implementation.

Background

Tapping into health care dollars to help support people experiencing homelessness is not a new idea. Both San Francisco and Los Angeles have directed health care funding to housing-related services, recognizing that providing people experiencing homelessness with stable housing can improve their health and reduce health care costs.[7] For more than a decade, some providers of Medicaid-funded health and behavioral health services have partnered with housing organizations to deliver the "support" for tenants in permanent supportive housing.[8] These early efforts provided evidence for the importance of housing as part of efforts to improve health, which has led several states to explore ways to use Medicaid – the federal program that is implemented in partnership with states to provide health care benefits to lower-income people – to fund services to address health-related social needs.

In 2015, the federal Centers for Medicare & Medicaid Services (CMS) indicated that states can use Home and Community-Based Services (HCBS) and demonstration programs authorized by waivers to support Medicaid recipients obtain and maintain stable housing. California first initiated this type of effort through its Whole Person Care (WPC) program, which it piloted in 25 counties.[9] Participating counties implemented

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5 Goodwin Simon Strategic Research (2023). "CalAIM Experiences: Implementer Views after 18 Months of Reforms," California Health Care Foundation. Retrieved online from: https://www.chcf.org/publication/calaim-experiences-implementer-views-18-months-reforms/#:~:text=When%20asked%20about%20how%20CalAIM,or%20that%20they%20are%20unsure.

6 For more information on the study's qualitative data collection and analysis, see: Finnigan, R., Economy, C., & Reid, C. (2024). "Addressing Homelessness in California: Qualitative Data and Methodology. Terner Center for Housing Innovation." Retrieved from: https://ternercenter.berkeley.edu/addressing-homelessness-california-research-series/.

7 Hunter, S. (2018). "Housing for Health: Los Angeles County's Department of Health Tackles Homelessness with an Innovative Housing Program That Saves Money, RAND. Retrieved from https://www.rand.org/blog/2018/01/housing-for-health-los-angeles-countys-department-of.html.

8 Burt, M., Wilkins, C. & Locke, G. (2014). "Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices From the Field," U.S. Department of Health and Human Services. Retrieved from: https://aspe.hhs.gov/reports/medicaid-permanent-supportive-housing-chronically-homeless-individuals-emerging-practices-field-0.

9 California's Whole Person Care (WPC) initiative was authorized as a component of a Medicaid waiver and implemented by participating jurisdictions (primarily counties). The purpose of the WPC pilots was the coordination of health, behavioral health, and social services in a patient-centered manner for particularly vulnerable groups of Medi-Cal beneficiaries, with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. California's Medicaid waiver

WPC between 2017 and 2021.[10] In some of these counties, WPC pilots provided opportunities to strengthen connections among the homeless service system, CoCs, MCPs, and providers of Medi-Cal services in health and behavioral health systems.[11] Overall, the evaluation of WPC found improvements in data sharing and coordination, as well as reductions in health care costs in participating counties.[12] WPC also demonstrated the value of focusing on the links between health and homelessness. Half of WPC enrollees (50.2 percent) were identified as experiencing homelessness, and the majority of WPC pilots reported that they used housing navigators and/or specialists to improve care coordination for these people.

CalAIM builds on the experiences of the WPC pilots, creating a statewide approach that seeks to reduce health disparities and inequities, as well as to address the complex challenges facing people experiencing homelessness. CalAIM encourages coordination among local health departments, Medi-Cal MCPs, and networks of service providers to transition to expand and sustain services that address the social determinants of health. However, unlike WPC, which was administered by county governments, most of the programs and services authorized by CalAIM are administered through MCPs. MCPs historically have not provided funding for programs that deliver services for people experiencing homelessness, and the state uses several managed care models. Some counties have a single nonprofit MCP (also called a County Organized Health System); most other counties use a "two-plan model," which allows beneficiaries a choice between two MCPs. In a few counties three or more MCPs enroll Medi-Cal beneficiaries. The number and diversity of MCPs at the local level complicates CalAIM implementation, since MCPs are responsible for establishing contracts with networks of health care providers to deliver Medi-Cal benefits for their members.

The most significant components of CalAIM for people experiencing homelessness, as well as the housing and service providers that participate in the homeless assistance system, are Enhanced Care Management (ECM) and Community Support Services

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allowed these WPC pilots to receive federal matching funding and other support to share data between system, and to integrate care through collaborative leadership and systematic coordination among public and private entities – all to provide comprehensive coordinated care for the beneficiary resulting in better health outcomes. For more information, see https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx and https://www.dhcs.ca.gov/provgovpart/Documents/WPCProgramOverview.pdf.

10 The WPC program was implemented under "Medi-Cal 2020," a Section 1115 Medicaid waiver from January 1, 2016, to December 31, 2021. It was focused on high-risk, high-utilizing enrollees with multiple service needs.

11 Continuums of Care (CoC) are HUD-mandated groups that promote, implement, and advocate for programs for ending homelessness. California is divided into 44 CoCs, with representatives from educational institutions, faith-based organizations, nonprofits, civic organizations, health and mental health providers, government leaders, and private entities. https://homelessstrategy.com/california-continuums-of-care/.

12 Pourat, N. et al. (2022). "Final Evaluation of California Whole Person Care Program," UCLA Center for Health Policy Research. Retrieved from: https://www.dhcs.ca.gov/CalAIM/Documents/Final-Evaluation-of-California-Whole-Person-Care-WPC-Program-05042023.pdf.

(CSS).[13] ECM focuses on the coordination of care and services to address clinical and non-clinical needs of enrollees, with a focus on high-need populations including individuals and families experiencing homelessness. A single Lead Care Manager is expected to coordinate care and services among the physical, behavioral, dental, developmental, and social services delivery systems and to meet beneficiaries wherever they are – on the street, in a shelter, in a health care setting, or at home.

CalAIM allows and encourages all MCPs to offer Community Support services to address social drivers of health for plan members, including recuperative care (medical respite) and housing-related supports such as housing navigation, housing deposits, and tenancy sustaining services. It requires MCPs to establish or expand their provider networks, but they are not required to offer all these services. In addition, while Community Support services can provide some forms of housing aid, they cannot be used to pay for rent or new housing development.

Challenges in Implementation

Interviews across the state highlighted the importance of implementing CalAIM effectively, noting that it holds significant promise to direct health care funding for much needed services. However, housing, social service providers, and health system stakeholders identified challenges that would need to be overcome for implementation. Both health care and homelessness system stakeholders expressed the need to "*learn how to speak a new language*" and as with any new program, a need to scale up the capacity for implementation:

> *CalAIM is so new, we can't even find consultants to help us understand it, because they don't.*[14]

Although knowledge of CalAIM has increased over time, a recent survey found that even among people who serve a large share of Medi-Cal patients, a quarter said that they were "not familiar at all" with the program.[15] In addition, many interviewees emphasized that although they were aware of the potential for CalAIM, understanding what it actually entailed and how it intersected with their own work was challenging. Stakeholder interviews raised three interrelated barriers to implementation: system fragmentation, reliable funding, and insufficient capacity.

System Fragmentation

The health care and homelessness response systems are complex. Funding, policymaking, delivery of health care, housing assistance, and supportive services

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[13] For more information, see this DHCS fact sheet on CalAIM and homelessness and housing instability: https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-HHI-a11y.pdf.

[14] Stakeholder interview, Bay Area, July 5, 2022.

[15] Goodwin Simon Strategic Research (2023). "CalAIM Experiences: Implementer Views after 18 Months of Reforms," California Health Care Foundation. Retrieved online from: https://www.chcf.org/publication/calaim-experiences-implementer-views-18-months-reforms/#:~:text=When%20asked%20about%20how%20CalAIM,or%20that%20they%20are%20unsure.

engage multiple public agencies, MCPs and other homeless service providers. Interviewees said some MCPs had limited experience contracting with nonprofit service providers that were connected to local homelessness response systems and housing assistance programs.

> *CalAIM is now involving managed care plans. Managed care plans are where the money is coming to. So the managed care plan itself has no idea how the [county] homeless [service] runs. So there's a lot of cross training, completely learning how to speak a new language, understanding we're not going to just be able to take it…create an entire new billing system and a new invoicing system and a new data system for CalAIM.*[16]

In addition, fragmentation means that organizations working with the health care system may lack familiarity with core components of the homelessness system, including Housing First practices and coordinated entry systems. For example, MCP contracts might not require service providers to enter data into a Homelessness Management Information System (HMIS) but doing so (and assessing clients for coordinated entry) are critical for homeless service prioritization and tracking of outcomes. One stakeholder involved in CalAIM implementation described the importance of this type of training for new service providers:

> *We want them to understand that using HMIS can help their members get connected to services and housing assistance. This work is helping to increase [their] understanding about what services are available in our counties.* [17]

Some counties that had implemented WPC found it easier to adopt CalAIM (e.g., Community Supports and ECM), as they had established funding streams and service contracts through WPC. In one instance, a large county health department worked closely with and financed training for local housing organizations to ensure that investments made in WPC were sustainable as part of CalAIM:

> *The training of health folks and housing folks together, that is continuing right now. Our local health initiative…is using some of their [Incentive Payment Program] dollars. IPP is one of the incentive programs for CalAIM to help providers in those areas become knowledgeable and be able to do this work ongoing. And so our local health initiative is investing in the same training program that we had, during Whole Person Care.*[18]

However, other counties with WPC pilots expressed concern that the transition to CalAIM required substantial operational changes, in part because it shifted investments

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16 Stakeholder interview, Bay Area, July 5, 2022

17 Stakeholder interview, North Bay Region, July 11, 2022

18 Stakeholder interview, Bay Area, July 22, 2022.

from counties (which had led WPC efforts) to MCPs. This shift was particularly challenging for housing organizations, which have more familiarity working with county governments. Many housing providers had little or no experience with working or receiving referrals from Medi-Cal MCPs prior to implementation of CalAIM, and very few housing organizations had used Medi-Cal as a source of funding for services. Similarly, few of the MCPs had provided funding for services in supportive housing or for recuperative care.[19] A city housing department official explained:

> *We've been able to take advantage of Whole Person Care funding, cash funding. You know, I wish we could figure out CalAIM, I don't know why they shifted there, it's so hard. And we have, we just, I know we need it, I don't know how to make it work.*[20]

Another stakeholder from a housing department described the transition as *"creating chaos"* and *"starting all over"* as they made substantial changes to operational practices to fund comparable services through MCPs. Coordination is particularly challenging in counties with two or more MCPs:

> *CalAIM, for me, has been a little bit more of this wild animal that I'm trying to understand…we've got five managed care plans, and they're all doing things a little bit differently. We've talked them into some common referral forms, which was a win for us.* [21]

In some counties, there has been different levels of engagement by MCPs in offering Community Supports or coordinating with other plans. This can be challenging as each MCP can decide which of these services to offer and establish its own eligibility criteria and referral and authorization procedures (including how long clients are authorized to receive a covered service).[22]

> *CalAIM has been a giant disappointment [in our county]. I'm sure you're hearing that from other people. Although I do hear in some counties it's working better than ours…. We have some good MCOs,*

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19 Recuperative care refers to interim shelter (congregate or non-congregate) with health and social support to provide a place for people experiencing homelessness who do not meet criteria for hospitalization but are too frail for other homeless environments. Recuperative care is typically for people exiting hospitals, although it can be used to prevent hospitalization.

20 Stakeholder interview, Central Coast, April 28, 2022.

21 Stakeholder interview, Southern California, May 17, 2022.

22 In 2023 DHCS acknowledged that variability in these MCP decisions and procedures were contributing to challenges in implementation, for both community-based service providers and plan members, including people experiencing homelessness. In July 2023 DHCS published updated Policy Guides for ECM and Community Supports that are intended to facilitate greater uptake and delivery of services to eligible members while reducing administrative burden and duplication. These updates cover key areas including eligibility, referrals and authorizations, provider networks, payment, market awareness, and data exchange.

DHCS also released a "Cheat Sheet" to help providers and other stakeholders navigate the ECM and Community Supports policy updates. It summarizes the key policies as well as the distinction between state-standardized policies and where there is flexibility for MCPs to define their own policies and procedures.

> *but one local managed care plan is not playing ball. And we've actually had to say that we won't match their members to [housing-related intensive case management] services because they refuse to work with us and provide any resources. Like, that's horrific to say, "If you're homeless and on this plan, we can't help you. Because your plan won't work with us." There's a lot of different MCOs in our county. And it's really hard to get them to all play ball.* [23]

Compounding the challenge of a complex MCP landscape is the diversity of social service and housing providers across the state. Housing assistance, for example, is provided by both private and public sector entities, which also vary in their size and capacity. One of the main challenges for CalAIM will be to continue to incentivize and create the conditions that will bridge the relevant actors and systems in each county and build the partnerships needed for successful implementation.

Unreliable Funding

The second concern that emerged related to CalAIM implementation is the sufficiency and reliability of funding over time.

Within the homelessness response system, service providers often braid together different funding sources to fund their work, such as U.S. Department of Housing and Urban Development (HUD) CoC grants, state programs such as Homeless Housing and Assistance Program (HHAP), local revenues dedicated to homeless programs, and Mental Health Services Act funding administered through the county, as well as private philanthropic funding. Although these funds should not be affected by CalAIM, some stakeholders expressed fears that existing funding streams would disappear due to expectations that providers would be able to access CalAIM funding instead:

> *If I'm X Hospital and I'm funding Y Nonprofit for a recuperative care program, my question is: Why should I be funding the nonprofit to the tune of $189,000 a year when they could be going through CalAIM to get reimbursed for recuperative care? Why would I fund them for housing, transition to navigation, housing tenancy, or Enhanced Care Management when they could be going through CalAIM to get reimbursed?* [24]

In addition, many interviewees expressed concerns that MCPs would not set sufficient payment rates for Community Supports or other services, would not authorize services for all who need them, and/or that the organizations would not be able to negotiate with MCPs for rates that would allow them to cover the full costs of their programs.[25] Stakeholders noted that MCPs often prioritize reducing costs for Medi-Cal when establishing contracts with nonprofit service providers, meaning that they would be less

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23 Stakeholder interview, Sacramento, May 12, 2022.

24 Stakeholder interview, North Bay Region, April 29, 2022.

25 See also Goodwin Simon Strategic Research (2023). "CalAIM Experiences: Implementer Views after 18 Months of Reforms," California Health Care Foundation.

likely to fund programs at levels needed to support adequate staffing and provider capacity. Stakeholders shared that they have seen funding drop under CalAIM:

> *It's pretty underfunded…the per client per month reimbursement for that same client when we transitioned from Whole Person Care to CalAIM dropped almost in half.* [26]

Others expressed concerns about delays in payments from MCPs through CalAIM:

> *There's going to be a lot of oversight, internal controls, compliance with HIPAA, all the required forms, maybe claim adjudication at some point. We're not going to get paid on time. So we know that we're going to have to be, you know, funding the cash flow, because there's going to be a really slow payment process.* [27]

Though stakeholders often spoke of "reimbursement," payments to service providers are not based on actual program costs, so this is different from the program funding many housing and homelessness services organizations have relied on.[28] Instead, the agreements between MCPs and service providers establish rates that can be paid for services that are authorized by the MCPs and delivered to eligible members. MCPs authorize these services for eligible members for a maximum number of days or months, and providers must request reauthorization if they want to continue to get paid for delivering services beyond this time period. The uncertainty that comes with this payment structure raised concerns among many housing and service providers, and made them more hesitant to take on the work that would be needed to partner with a local MCP.

Insufficient Capacity

Housing and homelessness providers are concerned about their ability to build capacity for CalAIM implementation, including concerns about their ability to meet administrative requirements related to billing Medi-Cal. Some entities reported looking externally for support with Medi-Cal billing and procedures:

> *We keep on hearing how complicated it is. We're going to be applying for a grant for administrative support through CalAIM and [our local Medi-Cal MCP] to bring in what we're calling a CalAIM "czar," somebody with a lot of Medi-Cal billing experience to help lead and oversee this entire process. We…have to have the systems and*

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26 Stakeholder interview, Orange County, May 31, 2022.

27 Stakeholder interview, North Bay Region, April 29, 2022.

28 Rapport, S. (2023). "Building on CalAIM's Housing Supports" Strengthening Medi-Cal for People Experiencing Homelessness," California Health Care Foundation. Retrieved from: https://www.chcf.org/publication/building-calaims-housing-supports-strengthening-medi-cal-people-experiencing-homelessness/.

> *processes in place to make it work for us. It's going to take a long time, but anything is possible.* [29]

Others expressed concern about navigating the complexity of new contracts:

> *Every contract is so different. And so if my CFO had some technical support to model out a successful ECM or Community Supports contract, that would be amazing…. But I do see tremendous potential to scale up the support and meet some of the state goals through CalAIM, but only if providers have the capacity to do it well, right? No provider is going to take it on and lose a bunch of money.* [30]

Both MCPs and homelessness system leaders expressed concerns about having adequate provider capacity to implement CalAIM programs, especially if MCPs expect them to accept a significant number of new client referrals in addition to the people they are already serving.

> *I think from a capacity perspective, [MCPs] talk about the same providers as us. So it's interesting, because they're like, "Well, we're going to tap into the homeless service provider system." I'm like, but they're already at capacity…. And now there's this whole other level of demand coming in. And I don't know how our system is going to work with that.* [31]

Despite efforts to build capacity for CalAIM implementation, stakeholders noted that health plans and some providers of health-related services still struggle to offer services they do not have experience with, including developing connections with housing and homelessness programs.

> *Some of the service providers that [MCPs have] chosen to contract with under Community Supports are organizations I've never heard of… it's such a variety of contracts…. And I think they're having a hard time understanding. I think they're trying, but I think there's going to be a big learning curve still with them understanding Community Supports and housing. And I've really tried to sort of help some of those educational efforts. But I think that we've just given them a whole plate of services that they've never done before and don't understand, really.* [32]

Addressing capacity issues is central to CalAIM implementation. Early evidence suggests that MCPs are turning to larger nonprofits to fulfill their Community Supports contracts.[33] However, smaller community-based organizations are often the best-suited

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29 Stakeholder interview, North Bay Region, April 29, 2022.

30 Stakeholder interview, Coastal Region, June 10, 2022.

31 Stakeholder interview, Orange County, June 7, 2022.

32 Stakeholder interview, Sacramento, May 12, 2022.

33 Wong, V. et al. (2023). "CBO-Health Plan Contracting Under CalAIM and The Competitive Social Care Market." *Health Affairs Forefront*. https://doi.org/10.1377/forefront.20230817.806978.

to providing culturally appropriate care and are critical to ensuring place-based health equity and health outcomes. CalAIM's potential for addressing the needs of people experiencing homelessness hinges on the ability of these community-based organizations to build the capacity and infrastructure to allow them to collaborate with MCPs.

Advances in CalAIM Implementation

Recognizing the complexity of CalAIM, the state has invested in technical assistance and capacity-building among local providers. For example, DHCS's Providing Access and Transforming Health (PATH) is a five-year, $1.85 billion initiative to build up the capacity and infrastructure of implementation partners, including community-based organizations, public hospitals, county agencies, and Tribal entities to participate in the Medi-Cal delivery system.[34]

The state's Housing and Homeless Incentive Program (HHIP), which launched during 2022, provides up to $1.3 billion in incentive payments to MCPs to encourage them to develop and strengthen partnerships with counties, CoCs, and local providers of housing and services for people experiencing homelessness. Structured as an incentive payment program, DHCS has established HHIP performance metrics to incentivize MCPs to expand access to housing services and street medicine and to increase the number of people who move into housing and do not return to homelessness.[35] To receive HHIP payments, MCPs must collaborate with CoCs and counties to develop plans based on a shared understanding of local needs and gaps. Many of them are using HHIP funding to expand staff capacity and IT systems to support data sharing and to track progress toward the performance measures. Still others are using it to offer start-up funding to help community partners expand housing-related services for people experiencing homelessness, with hopes that these services can be sustained through MCP contracts for Community Supports. Some MCPs have also used HHIP to make investments in capital costs of expanding permanent or interim housing for people experiencing homelessness, leveraging additional funding from other sources such as federal housing subsidies.

Between January 2022 and June 2023, more than 50,900 people received at least one housing support service, including housing transition/navigation services, housing tenancy and sustaining services, and/or housing deposits.[36] In addition, by June 2023,

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34 For more information, see https://www.ca-path.com/.

35 This incentive payment program is being implemented with one-time funding over a two-year period that ends in March 2024. For more information regarding the HHIP performance metrics, see https://www.dhcs.ca.gov/services/Pages/Housing-and-Homelessness-Incentive-Program.aspx.

36 California Department of Health Care Services (2023). "Enhanced Care Management and Community Support Implementation Update: Data Through Q2 2023." Retrieved from: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-and-Community-Supports-Q2-2023-Implementation-Update.pdf.

every MCP serving Medi-Cal beneficiaries in the state was providing housing-related Community Supports for some members or preparing to do so within a few months.[37]

Local Models

Interviewees also pointed to local innovations and models. In one county, a CoC leader described conversations about a promising partnership to engage the local MCP and public hospital to add recuperative care (medical respite) services in a navigation center for people experiencing homelessness. Funding from the MCP was expected to pay for the ongoing costs of the program, which will be operated by staff from the county's health system, as well as for additional supportive services for people who would be linked to housing assistance available through the public housing authority. The MCP and county health system were engaged with homelessness system leaders in developing coordinated plans for investments of funding to strengthen program infrastructure, including HMIS and capacity to support cross-system data linkages:

> *So I think that partnership really has changed. It's really startling to even hear people are having these conversations, when they really just weren't talking for so long. And I think it just speaks to the level of frustration people have with the different revenue streams, and an effort, real effort, to try to take care of the patients as best as they can with the resources that they have.* [38]

The interviewee expressed hope that this would help to build their capacity to use some additional housing resources coming from state and federal programs effectively, including housing vouchers and funding for homelessness prevention, as they were struggling to respond to significant increases in requests for housing assistance.

There is also evidence that MCPs are adopting internal strategies related to housing and homelessness. For example, some MCPs have created dedicated teams to engage in local housing and homelessness efforts, support HHIP activities, and move internal strategy forward. Several MCPs hired senior staff who brought experience with housing and services delivery, including former CoC leaders or non-profit executive directors. Others established presumptive eligibility criteria for some services and streamlined processes for authorizing the delivery of housing-related Community Supports to members who are experiencing homelessness, including those who have been prioritized for housing through the local coordinated entry system.[39] In counties

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[37] California Department of Health Care Services. "Community Supports Elections by MCP and County," Retrieved from: https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf.

[38] Stakeholder interview, Los Angeles, June 21, 2022.

[39] Presumptive eligibility permits a provider to determine that an individual meets eligibility criteria for a service under certain circumstances (for example, the person has been awarded a housing subsidy set aside for persons experiencing homelessness) and to expedite enrollment and billing for those services, without waiting to obtain prior authorization from the MCP. In most cases, verification of eligibility can be completed later or if the provider requests reauthorization to continue services beyond the initial period of presumptive eligibility.

where multiple MCPs contract with the same service provider organizations, some of the plans took steps to align their business practices – for example, by adopting consistent forms and procedures for accepting referrals and authorizing the delivery of some Community Supports to their members who are experiencing homelessness.

CalAIM's Potential

Despite concerns over payment rates, interviews also pointed to the hope that CalAIM could eventually improve funding for homeless services. In some interviews, nonprofit organizations said that the Community Supports payment model provided more flexibility in meeting their clients' needs than did the prior model of managing funding streams from multiple government programs, each with its own restrictions on eligible participants or allowable uses:

> *We have state, federal, city, county. And we're actually probably too government-contract reliant. Which comes with so many compliance things. That's why we like CalAIM because CalAIM has a fee-for-service model. And that gives us more flexibility.* [40]

Additionally, some stakeholders shared that MCP contracts have the potential to provide more certainty in funding, particularly in counties where local governments have provided little funding for homeless services, leaving organizations reliant on grants or private fundraising:

> *CalAIM having the Enhanced Care Management and Community Support be something they're really targeting towards people experiencing homelessness…that's a secure funding stream that we can access to support our services at the shelter and for our resource center and our peer support counselors that we haven't had before.* [41]

Others pointed to the potential for broader systems change. Health system stakeholders thought CalAIM, by supporting services that address both medical and non-medical drivers of health, also had the potential for spurring system transformation, especially in connection to the need for more housing:

> *To me, the Holy Grail, particularly with the chronically homeless. has always been using Medicaid funds to support housing. And since housing is health care, we can use CalAIM to do some housing, navigation through [in lieu of services], some security deposits, and things like that. But the number one thing from the health care perspective was being able to use Medicaid dollars to pay for people's rent, or partial rent at least, to support people in their housing. That will*

40 Stakeholder interview, North Bay Region, April 19, 2022.

41 Stakeholder interview, North Bay Region, July 11, 2022.

> *increase their health outcomes and reduce health care costs more than anything, amongst the chronically homeless anyway.* [42]

Conclusion

Stakeholders in the health care and homelessness systems recognize the importance of CalAIM. Interviewees conveyed optimism that CalAIM could provide reliable and flexible funding for services that are critical components of local homelessness rehousing efforts, and spur much-needed systems reform:

> *It has yet to be fully realized that the concept of CalAIM is pretty revolutionary. It's beyond reform, it really has the potential to dramatically shift and break down the high, thick walls of silos that exist between medical care, more traditional concepts of medical care, and some of these other social determinants. To me, things like payment reform, certainly, and things like the fact that you can start to pay for a community health worker. Those kinds of positions, historically, have been under appreciated and therefore unfunded.* [43]

However, interviews also pointed to areas where continued technical assistance and resources are needed to support that implementation. Stakeholders highlighted important challenges and concerns, including administrative burdens, system fragmentation, insufficient payment rates, and needs for technical assistance and investments to build data systems and service delivery capacity. Capacity for implementation is also uneven across the state.

Based on our interviews, we propose the following recommendations for improving CalAIM implementation:

- The State should extend funding for the HHIP program beyond March 2024. Incentivizing MCPs to sustain their partnerships and investments in local housing and homelessness systems is critical for building momentum towards collaboration.
- The State should evaluate and offer updated guidance to encourage MCPs to calibrate provider rates to ensure they cover the costs of evidence-based programs. This will ensure that homelessness providers receive reliable and sufficient funds for successful program implementation.
- DCHS should explore opportunities to reduce administrative barriers and foster shared infrastructure to simplify billing to increase participation among homeless service and housing providers who have significant expertise in serving people experiencing homelessness but who may not have the capacity to bill Medi-Cal directly.

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42 Stakeholder interview, North Bay Region, April 15, 2022.

43 Stakeholder interview, Los Angeles Region, June 21, 2022.

- MCPs should continue to strengthen their efforts to identify and offer ECM and Community Supports and to improve housing outcomes for their members experiencing homelessness. A significant share of social service organizations (36 percent) reported not knowing how to participate in ECM or Community Supports, suggesting that there continues to be a need for capacity-building throughout the system.
- CoCs and other local organizations (e.g., foundations) could support opportunities for translation and coordination among health and homelessness stakeholders. The fragmentation and specialized knowledge within each system creates barriers to coordination. Creating opportunities for building shared principles and partnerships and resources that share emergent best practices can strengthen the ability of stakeholders to partner on CalAIM implementation. It is important to support smaller, community-based organizations that serve Black, Indigenous, and People of Color and other under-served populations.
- The State should provide resources and invest in service providers' ability to enter data into HMIS. These data are critical for monitoring how programs are working to resolve homelessness, and for tracking racial/ethnic disparities in access or outcomes. The California Interagency Council on Homelessness and DHCS could also advance linkages between the Homeless Data Integration System and the state's Medi-Cal data to help policy makers direct funding and assess program outcomes.

Investing in efforts to improve collaboration and strengthen CalAIM implementation will build a stronger foundation for ongoing efforts to address health-related social needs through Medicaid. At the federal level, CMS has provided additional guidance encouraging broader implementation of services such as housing transition navigation services, pre-tenancy and tenancy-sustaining services, and one-time transition and moving costs including housing deposits.[44] Based on this guidance, California is seeking federal approval to expand the housing interventions that can be offered to people experiencing homelessness through CalAIM.[45] At the state level, Proposition 1, if it is passed by voters in March of 2024, will lead to significant changes in California's mental health system, and will further strengthen the ties between health and homelessness. There is also the opportunity for California to apply for federal approval for a uniform

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[44] The CMS guidance encourages states to use Medicaid waivers to provide rent or temporary housing for up to six months for individuals transitioning out of institutional care or congregate settings; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter; and/or for youth transitioning out of the child welfare system. Centers for Medicare & Medicaid Services (2022). "Addressing Health-Related Social Needs in Section 1115 Demonstrations," U.S. Department of Health & Human Services. Retrieved from https://www.medicaid.gov/medicaid/downloads/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf. Centers for Medicare & Medicaid Services (2023). SMD #: 23-001 RE: Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care," U.S. Department of Health & Human Services. Retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf/.

[45] For more information, see www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Demo-Rent-Amendment-Public-Notice.pdf.

housing support services benefit.[46] These and other efforts will require even stronger partnerships between MCPs and local homelessness housing and service providers. Investing in CalAIM and addressing some of its ongoing barriers to implementation will advance these efforts, as well as achieve its goals of addressing some of the underlying causes of health disparities.

[46] Rapport, S. (2023). "Building on CalAIM's Housing Supports" Strengthening Medi-Cal for People Experiencing Homelessness," California Health Care Foundation. Retrieved from: https://www.chcf.org/publication/building-calaims-housing-supports-strengthening-medi-cal-people-experiencing-homelessness/.