CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
1115 WAIVER RENEWAL
HOUSING/SHELTER EXPERT STAKEHOLDER WORKGROUP

Tuesday, December 16, 2014
10:00am – 3:00pm
USC State Capitol Center
MEETING SUMMARY

Members present: Kelly Brooks Lindsey, California State Association of Counties; Cindy Cavanaugh, California Housing and Community Development; Clayton Chau, L.A. Care Health Plan; Vitka Eisen, HealthRight 360; Dave Folsom, St. Vincent de Paul Village Family Health Center; Dena Fuentes, County of San Bernardino; Jonathan Istrin, Libertana Home Health; Marty Lynch, Lifelong Medical Care; Ed Ortiz, Health Plan of San Mateo; Shirley Sanematsu, Western Center on Law and Poverty; Rusty Selix, Mental Health Association of California; Cathy Senderling, County Welfare Directors Association; Doug Shoemaker, Mercy Housing California; Ann Warren, Community Health Group; Carol Wilkins, ABT Associates; Lynn Warren, California Housing Finance Agency.

Members on the phone: Peter Lynn, Los Angeles Homeless Services; LaCheryl Porter, Skid Row Housing Trust; Neal Richman, Westside Center for Independent Living; Courtney Gray, San Francisco Health Plan; Marc Trotz, Los Angeles Department of Health Services.

Members Not Attending: Ann McLeod, California Hospital Association; Ben Schwartz, California Tax Credit Association.

Others Attending: Hannah Katch, DHCS; John Shen, DHCS; Rebecca Schupp, DHCS; Efrat Eilat, DHCS; Urshella Starr, DHCS; Wendy Soe, DHCS; Kiyomi Burchill, CHHS; Rachel McLean, CDPH Bobbie Wunsch, Pacific Health Consulting Group; Sharon Rapport, Corporation for Supportive Housing (CSH); Kathy Moses, CHCS.

16 Members of the public attended the meeting.

Announcement from Sharon Rapport, CSH: There are two stakeholder meetings planned by Corporation for Supportive Housing to get more ideas from community stakeholders. Jan 6th at TCE Oakland 10-1 and Jan 9th at the A Chamber of Commerce. RSVP to Sharon Rapport

DHCS Goals for Housing Workgroup and Waiver Component on Housing
John Shen, Department of Health Care Services
Presentation slides available at: at http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Housing.aspx

John Shen offered background on the workgroup, reviewing the context for including housing as a topic in the 1115 waiver. The waiver allows the state to: 1) experiment with new systems and service delivery that are not statewide; 2) waive choice under Medicaid; 3) change the federal funding participation. Knowing the homeless population and nursing home population have significant cost, the basis of this conversation is to develop ideas to lower the health care costs for this population through housing. How do we stretch health care dollars to cover services not usually covered? What is the support service needed? What are the services that cannot be provided unless the person has stable housing?

Member Comments and Questions:
Dave Folsom, St. Vincent de Paul Village Family Health Center: Are there parts of the 1115 waiver that are impossible to get approved and we should spend less time on?
Shen, DHCS: It is impossible for DHCS to become a housing provider. There are many housing programs funded by HUD, like section 8. The question is what is the gap? There are creative ways to use savings from health plans to offer some subsidies. This is challenging for housing developers given their 30 year time horizon.

Clayton Chau, LA Care Health Plan: Is it possible to ask the housing experts for a presentation of how it works on the housing side and who the population is; and how we could determine the medical necessity to create a smooth transition to housing.
Cindy Cavanaugh, California Housing and Community Development: We will touch on this in the panel later today. It is a diffuse system of financing for operations, capital, vouchers, etc.

Lynn Warren, California Housing Finance Agency: We are looking at what is the housing model built for frequent users? Subsidies are a difficult subject with CMS although we want to fully explore that. If not for long term housing, but for the shorter term transitional period.

Neal Richman, Westside Center for Independent Living: Is Illinois requesting a waiver for supportive housing? Also, the NY waiver? Are we coordinating with them?

Carol Wilkins, ABT Associates: Illinois did submit an 1115 waiver that includes an incentive to managed care health plans for stable housing as an outcome. At the state Medicaid directors' national meeting, there was discussion and interest about ways to create subsidies and investments in housing. We can provide a link to the Illinois waiver.

Soe, DHCS: From very preliminary discussion, CMS is interested in this proposal. Some hard lines are that they will not pay for housing subsidies. But CMS is interested in this issue and they are looking for states to come up with proposals. In terms of other states, we have not yet but could definitely reach out to Illinois and NY.

Shen, DHCS: We have a grant from HUD to pay for housing subsidies to transition people from nursing homes to housing. We agree there will be more and more states coming to this issue but right now we need creativity from the group to move the issue along.

Bobbie Wunsch, Pacific Health Consulting Group: This is the beginning of a long conversation that DHCS is entering and there will be more opportunities to engage in the issue.

Target Populations for Housing & Housing-Based Services in Waiver
Sharon Rapport, Corporation for Supportive Housing and John Shen, DHCS
Presentation slides available at: at http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Housing.aspx

Sharon Rapport, CSH presented information on CMS recommendations related to Home and Community Based Services … including what types of housing the group might consider and what evidence tells us about supportive services to keep individuals stably housed. Core components of fair housing (Housing First) and services in supportive housing were discussed. The need for stable housing and gaps in funding for services were presented. The mental health system is the major funder of services for homeless but only to those with a diagnosis of seriously mentally ill. Factors to consider for eligibility under the waiver:

- Need for housing stability to improve health
- Health conditions that warrant housing and services
- High costs

She offered information about operating and capital housing costs as well as service costs and the offsets from other systems, such as health care and criminal justice. Ms. Rapport presented potential services for consideration, the number of chronic homeless and the cost savings that would be realized. A financial model was offered for discussion.

Member Comments and Questions
Marty Lynch, Lifelong Medical Care: On the ratio of 1:20 for case management. Targeting is important because some people need a higher ratio; others less depending on need.
Sharon Rapport, CSH: Yes, that ratio takes into consideration that some need a ratio of 1:15, others need 1:30 or 1:40 as people get stable or don't have high acuity.

Marty Lynch, Lifelong Medical Care: Trust is an issue. If a person has not engaged in the health or mental health system previously, building trust is considered an outreach function that is not reimbursed in an FQHC.
Sharon Rapport, CSH: This is often not included or is funded by philanthropy.

Clayton Chau, LA Care Health Plan: I am concerned by the language on core components that says "housing not contingent on participation" If we include this in the waiver and they do not participate in health care, will CMS consider that a housing cost?
Sharon Rapport, CSH: This is an area for discussion. Housing First does mean that there is no requirement for participation in services prior to housing. We see high levels of participation once the trust is built.

Clayton Chau, LA Care Health Plan: I see it differently. They are engaged but they engage in ER or inpatient. On the MH side, there are people not engaged anywhere. You see them when someone calls 911 because they are so ill. They are a separate group from those that engage

inappropriately because they don't have housing. Otherwise, we run a risk of rejection similar to NY because it will appear we are funding housing, not care related to housing.
Sharon Rapport, CSH: We are talking about housing and services as health care. Part of the engagement is to motivate someone to take care of themselves in appropriate care – not through acute care.
Shen, DHCS: From health care side, we talk about placement. From housing side, we talk about choice. We have to find a balance between consumer choice and placement.

Kelly Brooks Lindsey, California State Association of Counties: Among existing supportive housing, to what extent have we been able to access Medicaid to pay for services? What types of services do you envision pursuing through the waiver?
Sharon Rapport, CSH: All of them. The package of services won't be needed or accessed by all but this is the list that should be available. Mental Health Medicaid funding is used to provide some of the services through the rehab option for those with SMI. Outreach is difficult to fund.
Shen, DHCS: In a general sense, Medi-Cal, there is nothing called Case Management, however, it is available through managed care plans and is included in many waiver programs.

Dena Fuentes, County of San Bernardino: I know we aren't trying to solve the spectrum of homelessness. I am not yet seeing a definition of chronic homeless and that is crucial to plug into the underwriting equation. Ultimately, the definition may limit the people you can help.
Sharon Rapport, CSH: We are assuming a HUD definition. Homeless for one year or 4 episodes over 3 years and has a disability limiting their function. There are a number of homeless people who don't meet the definition and they have barriers to maintaining stable housing. They may be captured in other categories presented. We need to get at who are the people who can't access housing without services and who needs services to keep them in permanent housing.
Dena Fuentes, County of San Bernardino: As you have a tight definition, it becomes challenging to use those funds into developer framework.

Rachel McLean CDPH: Was there any information about the etiology of liver disease – was it alcohol related?
Sharon Rapport, CSH: Yes.
Rachel McLean CDPH: What is the relationship between this group and the 2703 Health Home effort? It seems we need to package this together to CMS.
Sharon Rapport, CSH: There is overlap and we need to discuss that and how they address different needs and interrelate. A number of people are involved in both groups.
Rachel McLean CDPH: Generally, there are policy barriers to getting housing, such as criminal record. Is there a parallel process to remove those barriers?
Sharon Rapport, CSH: Yes, there is a huge overlap and important to consider. The highest cost individuals have jail or other criminal justice in their background.

Dave Folsom, St. Vincent de Paul Village Family Health Center: On the narrow HUD definition, the points made are good ones. However, the narrow definition will focus us on the hardest to reach and serve. On engagement, one lesson we learned is that upfront rules will exclude a large number of people and likely those who are hardest to reach and serve. Not requiring

people to jump through case management hoops is the best way to get people into programs. San Diego VA vouchers are an example of what not to do – only target the easiest to serve and have lots of rules.

Doug Shoemaker, Mercy Housing California: We have experience with frequent utilizers. Whether we have good data or not, providing safe housing will likely reduce costs 50-75%. Even if we can only fund services through Medicaid, we will reap savings.

Cathy Senderling, County Welfare Directors Association: Thinking of how to do this as whole person care, what seems missing is intensive case management and available services on social service and justice side. We need to add coordination with probation and parole so we help people to not re-offend.

Carol Wilkins, ABT Associates: Can we add conditions for older homeless adults? We have talked about nursing home and chronic homelessness as separate but we are seeing large increases in nursing home as the alternative to homelessness based on cognitive impairments, incontinence at younger ages (50's).

Neal Richman, Westside Center for Independent Living: Can we add housing counseling to boost rates of people getting housing on their own?
Sharon Rapport, CSH: good point.

Sharon Rapport, CSH: One clarification on Clayton's point, shelter plus care does not require every individual receive services but that they are available.

Dave Folsom, St. Vincent de Paul Village Family Health Center: CA has low rates for Medi-Cal and I am wondering how important that will be in the calculation of the ROI?
Sharon Rapport, CSH: We did look at studies in CA and they were pretty consistent.

Marty Lynch, Lifelong Medical Care: What is included in the top 20-30% of individuals?
Sharon Rapport, CSH: I made some guesses based on studies, such as Economic Roundtable, to create the slide on the combination of factors that drive the highest 10% costs.
Marty Lynch, Lifelong Medical Care: Could we try to predict those homeless people who are ending up in nursing homes?
Sharon Rapport, CSH: Great point.

Rusty Selix, Mental Health Association of California: is there a duration for the length of housing?
Sharon Rapport, CSH: That is a critical question we have not discussed. The waiver is only for 5 years.
Shen, DHCS: For chronically ill, we expect health care costs to be consistent and increasing. Should we think of the housing intervention as a medical intervention back filled by section 8?

Rusty Selix, Mental Health Association of California: if it is short term, what is the transition plan and how do we develop a continuum of care model? How long can an individual get the benefit? There has to be a success model for individuals who no longer need this.
Sharon Rapport, CSH: I think the evidence is clear that the health care costs would continue to increase without housing and services.

Ann Warren, Community Health Group: Going to the common risk factor question, I would add inappropriate ER. We have a continuum of care with Project 25 and I think there is a way to transition.

Doug Shoemaker, Mercy Housing California: I want to be realistic. It is not as if the schizophrenia disappears just because you have housing. We are talking about people who likely have long term health problems so the "graduation" would be very low, like 10%. This is all based on existing housing which has its rules. One of our core concepts is that we will take advantage of existing housing constructs and that won't allow us to take people out of the system at some point. We have to assume they will require high cost for a long time.

Ann Warren, Community Health Group: Yes, I agree, but people can transition from high touch to low touch. The housing cost would remain.

Dena Fuentes, County of San Bernardino: The 5 year time horizon doesn't provide the financing vehicle.

Clayton Chau, LA Care Health Plan: I agree with Doug. As a health plan, this is about medical care. In the waiver, we need to leverage HUD housing. Can this group get priority on the HUD side? There has to be clear guideline for the health plan. We also have to remember that the MH system is a different financing system.

Carol Wilkins, ABT Associates: I want to respond to what happens when people need a lower level of care as people recover? What happens for those who have a lifelong condition that gets worse and better? Services could be designed with care continuity as people recover so that people can receive intensive services when they are sick, and continue relationships with a provider they trust as they recover, even if we are titrating down the level of service they receive.

Lynn Warren, California Housing Finance Agency: Financing for bridge/transition housing will be difficult. There may be a percentage that work well in that but I am cautious that is an alternative.
Sharon Rapport, CSH: We are not necessarily building new bridge housing but we are trying to find a way there is a place for people to go until they can get into supportive housing.

Kelly Brooks Lindsey, California State Association of Counties: We are working on whole person care concept that overlaps with this discussion as high utilizers of multiple systems where we see inappropriate use of EMS. There is doubt in health care community about whether there

will be another waiver after this one. Finally, how do we marry priorities at state level to local decisions so we get to the results we want.

Cindy Cavanaugh, California Housing and Community Development: I have questions about the financial model slide: what is the translation of the financial information to investment? Are you suggesting the waiver would request both capital and services along this model?
Sharon Rapport, CSH: I started with a goal of getting people into permanent housing. I don't know what the right strategy is to make those investments. Yes, I was trying to think about Medicaid investments in housing and services.

Ed Ortiz, San Mateo Health Plan: As we narrow the target populations, we should broaden the ideas of housing options. We seem to be talking more about a certain supportive housing and development. We should think about a range of housing and service providers. We have had a successful relationship with our local housing authority to get developer partnerships and set asides.

Shen, DHCS: One comment about the waiver resources, we are looking at primarily existing resources rather than thinking of new money from the state or CMS.

Rebecca Shupp, DHCS presented data and population characteristics about Medi-Cal beneficiaries in skilled nursing facilities (SNF). Screening and criteria for nursing facility residents returning to community were discussed. She described California Community Transitions that works to help nursing home residents' move to community settings. She presented data about California's experience and cost in CCT between skilled nursing and community. Information about the potential size of the population that could be transitioned out of nursing facilities. A number of questions were posed for discussion:

Member Comments and Questions
Shirley Sanematsu, Western Center on Law and Poverty: Can you clarify the costs outside nursing facility but while they are a resident?
Schupp, DHCS: Some medical services occur outside the facility such as some primary care, pharmacy, etc.
Shen, DHCS: This may be a stable, select group that could be a target to transition to community housing. This is for only 1200 people, a very small number compared to size of nursing home census statewide.

Rachel McLean, CDPH: Has there been monitoring of health status for those who transitioned out of nursing homes. Thinking about SROs in the Tenderloin, they are low cost because they are not getting services they need.
Schupp, DHCS: We do a quality of life survey that shows higher levels post-transition. They are using IHSS, HCBS and other services.

Cathy Senderling, County Welfare Directors Association: Do the characteristics of the 1200 who transitioned look different than those targeted here?

Schupp, DHCS: Yes, this population are ages 18-64, not as many chronic conditions and a limited number of conditions.

Ed Ortiz, San Mateo Health Plan: The average cost of nursing facility in San Mateo are $150 higher/month than reflected here so the costs can be even greater.

LaCheryl Porter, Skid Row Housing Trust: On slide 5, what is the definition of independent housing - is supportive housing included as community setting? Also, can you clarify whether the savings include only medical costs or others as well?
Schupp, DHCS: Independent is an unlicensed apartment. On the savings question, yes rent is included with additional savings beyond that. Medical cost savings are slide 6.

Neal Richman, Westside Center for Independent Living: How do we get to scale? It is not just the existence of affordable housing or vouchers because individuals need lots of hand holding, coordinating doctors, first/last rent, furnishings, etc. How do we streamline and fund all of these services? There are many challenges to transition from nursing home to community.
Schupp, DHCS: Yes, we agree. There are options like putting money into health plans that they can contract out.

Kelly Brooks Lindsey, California State Association of Counties: Are any of the 10—15,000 individuals targeted included in Cal MediConnect? How are plans thinking about this now that they have responsibility for all costs?
Schupp, DHCS: Our numbers are statewide and we didn't drill down to Cal MediConnect counties.
Ed Ortiz, San Mateo Health Plan: We are a Cal MediConnect demonstration county and we are doing some of this work to connect people to housing. We are experiencing the issues being discussed here – it is hard to identify housing and connect medical and social needs. We have a goal of reaching 1,000 people in five years. The challenges are that it may not be sustainable if we don't get the funding mechanisms worked out. Our rates erode over time if medical cost is reduced so sustainability requires a long term solution. On other thing is that the scope of our program is broader – it includes people in SNF transitioning out and those at risk of SNF who we can keep in their home. We should broaden the conversation to think about housing as a tool.

Clayton Chau, LA Care Health Plan: CCI is new to health plans and with our size it has been a large task. We are talking locally to supportive housing and are funding a pilot to understand more. There are different groups – CCI is not Medi-Cal only. How many of the potential candidates include the Medi-Cal expansion population? They are sicker than traditional or older Medi-Cal.
Schupp, DHCS: This data based on the Long Term Care aid codes in Medi-Cal – not claims of all in SNF. There are many other Medi-Cal aid codes.

Ann Warren, Community Health Group: To Ed's point, there is a continuum and we need to have a high touch to understand their needs. Are they really SNF candidates? If they can go to community, how do we help them transition and keep them stable in the community? It is

challenging but we are working to see that everyone who can be transitioned to community are helped.

Carol Wilkins, ABT Associates: My questions are about criteria to define population. How impaired are they to be eligible but not so impaired they can live in community? What is continuous monitoring?
Schupp, DHCS: We have recognized 3 basic arrangements. 1) informal support; no IHSS; 2) have limitations; have IHSS but no other home-based services; 3) SNF certified; have functional/cognitive disabilities; care supports at home mitigate frequent ER or rehab stays.
Carol Wilkins, ABT Associates: For those in #1, are they a target for this discussion?
Schupp, DHCS: They are eligible; they are SNF residents and long stay.

Ann Warren, Community Health Group: As a health plan, we assess risk and build a care program around the needs. Some in home need additional services that we are adding through CCI – wrapping around their needs. We assess their home environment, have 24 hour nurse advice, physicians on call, and provide meals so they can stay in their home. It certainly would not work just to provide an apartment for them.

Marty Lynch, Lifelong Medical Care: The 3rd category are candidates for ADHC and CBAS – if there is capacity. To Ed's comment, we need to figure out how all of these services impact rates. If we can include language in the waiver so this does not erode rates, it would be helpful.

Dena Fuentes, County of San Bernardino: If someone is in SNF, can we use Shelter Plus Care or VASH vouchers or are they no longer considered chronic homeless because they were housed for 90 days?
Sharon Rapport, CSH: You are not considered chronic homeless If you are in an institutional setting for 90 days. We are proposing to add those living in institutions through the waiver.
Peter Lynn Los Angeles Homeless Services Authority: They would not be eligible for Shelter Plus Care but still eligible for VASH.

Carol Wilkins, ABT Associates: Many local housing authority set policy about defining homelessness and setting priority for local programs.

Jonathan Istrin, Libertana Home Health: The set-asides are great but LA County had only 20 set asides and they were used quickly. The housing authority doesn't want to do reasonable accommodation because they are afraid of being sued by tenant's rights groups.

Using Waiver Funds to Stimulate the Creation of New Housing Opportunities
A Panel of Workgroup Members including Carol Wilkins, Peter Lynn, Los Angeles Homeless Services Authority, LaCheryl Porter, Skid Row Housing, Doug Shoemaker, Mercy Housing, Cindy Cavanaugh, CA Department of Housing and Community Development, Marc Trotz, Los Angeles County, Sharon Rapport, CSH, Facilitated by Bobbie Wunsch

Carol Wilkins, ABT Associates: We need to consider all of the options to stimulate more housing. That means, work with nonprofit developers to stimulate new housing, partner with housing authorities to access vouchers, leverage other rent subsidy programs. We need to include more than one strategy in the waiver. An optimal outcome for the workgroup would be a policy reach "ask" for the waiver that might advance the dialog between state and CMS plus a more modest, perhaps indirect way to expand housing by providing more flexible, less disability-specific, less siloed funding for services people need to live in community when they have obstacles. A strategy from the Illinois waiver is to incentivize health plans to identify and improve housing status for members experiencing homelessness. An example of a big ask might be a DSRIP as a way of paying for things that are not covered to individuals. What if we asked for housing navigators attached to the health plans to help search for housing, qualify and use vouchers. Hennepin Health is doing this from their capitation payment.

Cindy Cavanaugh, California Housing and Community Development: I will speak to housing funding streams, particularly state funding streams and new housing. A chart was prepared for a child welfare convening that is illustrative of state financing options that target special needs. Any funding, whether capital, operations or services, needs to be coordinated. Local agencies have vouchers, the state is primarily capital financing. There is an inherent challenge with site-based financing and individually-based services and we need to grapple with this. MHSA has combined funding of all parts of the continuum to successfully house and serve as a model. It does require a coordinating entity to work out all the issues.

Marc Trotz, Los Angeles County: I come back to the idea of making this easy to use to get to the scale we are looking at. I would like to see a simplified, bundled rate for services. Our experience in LA is that we are not using Medi-Cal funding for support services. We are using county health care dollars and we are able to house lots of people very quickly. If we could have a rate that is vastly less than nursing homes, we could get to scale across the state. We can shoot for Medicaid paying for rent subsidies, but I would hate to come out of this process without an easy to access, day-rate for services. In LA, we are spending county health dollars to pay both for rent subsidy and intensive case management services. We are housing a broad range of people with a range of problems in community housing.

LaCheryl Porter, Skid Row Housing: We are participating in the county intensive case management health services. We need to think about getting them into housing but also maintaining housing through the intensive case management services. Many of the intensive services needed are not covered by Medi-Cal. From the capital side, the formulas only include a low case management ratio. On the issue of choice, once we move someone into housing, they experience a big change and accommodating that change takes time. They do not immediately stop using the ER but with support services they do change over time. If we have too many requirements that mean they lose their housing immediately, we may fail. Also, reporting burdens and tracking services need to be low. Positive outcomes should replace tracking services down to the minute to ensure good service and lower administrative burdens. This might be lower use of ER, fewer police involvements.

Peter Lynn Los Angeles Homeless Services Authority: There are lots of housing navigation services needed for both getting the homeless into housing and for successful transition out of SNF. We need a "whatever it takes; as long as it takes" funding source that is per person, per day rate. There are many agencies to provide the services may not be Medi-Cal. There is varied need over time as discussed earlier. We do have successful models of moving people from intensive services to less intensive services if there is continued ability to offer case management in the permanent supportive housing. This does free-up housing units in the more intensive setting.

Doug Shoemaker, Mercy Housing California: I agree with what has been said. If we go down the road of a bundled payment, we need to be agnostic about the delivery mechanism. It might be different in apartment setting vs. single family. There is room for tenant-based and housing-based options. Tenant-based support is less likely to create new scaled housing opportunity. What will produce new housing? It may be acquisition of a currently non-affordable setting or new construction – much more expensive. It is difficult to think through all the strategies without knowing the cost saving parameters. We can save money on services that goes to financing capital. A general rule of thumb is that for every $100/month/100 units diverted from operating creates $1M of capital. Some service money won't add to housing capital but we need to get outside thinking like a traditional housing provider. New service money can get us part of the way to acquisition and getting closer will make it feasible for other partners to participate as collaborators. Also, there has to be an expectation that the commitment goes beyond 5 years, more like 15-20 years. We need to have that in mind even if it isn't in the waiver.

Peter Lynn Los Angeles Homeless Services Authority: I don't think we can solve the homeless and nursing home issue with new development. Putting out a product that can be used in multiple ways, including acquisition, is more useful. Trying to fashion it so that it is finance-able may be at odds with the idea of putting it out in a way that can be used by many different people.

Doug Shoemaker, Mercy Housing California: I agree, but we need also new asset relationships that will require longer term thinking. No one idea will get us all the way to success. Each of the strategies requires slightly different thinking.

Marty Lynch, Lifelong Medical Care: I have been assuming we are not going to pay for housing directly in the waiver, but financing the services that go with the housing. Some mention a daily bundled rate. Are you translating that to a PMPM?

Peter Lynn Los Angeles Homeless Services Authority: Yes, it would be a PMPM. We use $450/month/tenant ($15/da) which is a vast difference to the $300/da in a medical setting.

Dave Folsom, St. Vincent de Paul Village Family Health Center: As we stimulate housing opportunities, is there a way to ensure they go to the target population of chronic homeless and not into the general affordable housing for low income? Homeless individuals lose out in that scenario because they have difficulty getting paperwork done, etc.

Peter Lynn, Los Angeles Homeless Services Authority: One aspect is to set up a system where everyone is assessed for need for permanent supportive housing. This is a change from a system where individuals navigate to a coordinated entry system. This is putting pressure on housing providers because they are seeing higher need individuals.

Cindy Cavanaugh, California Housing and Community Development: We have interpreted fair housing to mean first come, first serve. Those most able to get in will get housing. Coordinated entry will play out differently in different places and there is a role for the state to play here.

Carol Wilkins, ABT Associates: This is an example of partnership for state agencies to share goals. First, if a person doesn't have to have a specific disability, but need housing with a range of disabling conditions. Then the state could say, here is funding for operating housing where some units are set aside for target populations. If DHCS and Housing are jointly reviewing applications, you could get to a point of shared priorities, programs and accountability.

Doug Shoemaker, Mercy Housing California: There are two barriers: navigating entry and ongoing rent. To get someone into tax subsidy housing, you need operating subsidies because even if you get them through the system, they can't pay the ongoing rent.

Sharon Rapport, CSH: Marc, when you are talking about $450/month or $15/day, you are talking about services-only. Can you speak to the range of subsidies needed?

Peter Lynn, Los Angeles Homeless Services Authority: You can't house a very low income person without subsidy and there is not enough section 8 to cover this. We are using a pool of subsidies that is part of a housing intermediary. They can subsidize any type of housing (tax subsidy or others). So, with the case management plus the rent subsidy, it allows the two populations we are discussing to have ongoing housing.

Clayton Chau, LA Care Health Plan: In the waiver, we are talking about old money used in a new way. We are not really talking about 5 years, we are talking about long term solutions from using old money in a different way. However, if we set a certain priority, we have to consider social justice parameters – there may be others we have not identified at risk of homelessness. As a health plan, we must give the same to everybody. Second, regardless of the model, we must address the leveraging of other resources. Medicaid dollars are not enough for all of this.

Dena Fuentes, County of San Bernardino: Thinking from my experience in local housing and how to get people into the pipeline. It can take a lot of work to get 10 units in a 70 unit development and cities want to see case management and experienced agencies. You will have more cities involved if we use affordable housing as an economic revitalization tool. We need a longer term scenario because it takes 3 years to get new housing open. It's got to be site-based for shorter term timing. Finally, is there a way to quantify the savings from existing affordable housing that is already working to reduce medial costs vs new construction or units?

Doug Shoemaker, Mercy Housing California: We need lots of different strategies. Presumably there is a role for scattered site housing and other affordable housing. From an acquisition perspective, we can bring something into the fold in 9-12 months. New construction also has

different elements we can consider such as master leasing and negotiating pipeline proposals to include units. You may get some to start a new proposal that is a longer (3 year) horizon but large (150 units). Many of us in San Francisco or Los Angeles are getting going. Lower resourced counties need more help. Mercy Housing knows San Francisco, we have done 35 projects there. In Galt, there would be more skepticism that something could fall through. The state role is to take the risk out of the system and perhaps offer technical assistance.

Lynn Warren, California Housing Finance Agency: Doug is right on. There is a role for the state here. As you enter an uncertain, risk world, the state has a credit enhancement role. We need a more solid continuum of care system. That allows the state to say, in exchange for a credit enhancement, you will have a solid continuum of care and work directly with a health plan. On the "dividend", this is actually an annuity. How can we go to CMS and say we have a systematic solution for the long term.

Bobbie Wunsch, Pacific Health Consulting Group: How will this impact the chronic substance user?

Vitka Eisen, HealthRight 360: I have a comment first about bridge housing. It is a necessary and effective aspect for those transitioning from residential, inpatient substance use treatment. We currently have a network of sober living that is not regulated and there is a need for a funding stream. For chronic, advanced alcohol users, they need high level of care and may benefit from wet housing. One issue with VA housing is that veterans often lose housing due to alcohol use. We have large numbers of folks coming out of prison and jails and they typically don't meet the HUD definition, therefore are not able to access section 8 vouchers due to criminal history.

Dave Folsom, St. Vincent de Paul Village Family Health Center: We run a program in San Diego called Project 25, the top 25% of high need, cost individuals. There are 36 people involved and 32 have severe alcohol problems and health conditions. They have been homeless for years but didn't try shelter because they couldn't meet the sobriety requirements. We pushed for harm reduction and it has worked well. There are political implications in that the general community does not see the benefit of harm reduction approaches. It is a challenge to get buy-in. We see dramatic cost reductions with this approach.

Vitka Eisen, HealthRight 360: There are studies that they drink less, have fewer hospitalizations, less brain damage. If we put aside our opinions and treat it as a health condition, it saves costs.

Clayton Chau, LA Care Health Plan: We do tend to avoid that group. The cases that drive health plan case management crazy are the primary substance use disorders. My interest is to have this as a priority target population.

Rachel McLean, CDPH: In working with homeless youth, I know that this also includes use of serious drugs. We need to expand access to medication assisted treatment, like methadone, and we can reduce overdose risk. I would like to hear from housing providers, how do you deal with drugs that are both stigmatized and also illegal?

Dave Folsom, St. Vincent de Paul Village Family Health Center: It is true alcohol is easier because it is legal. Other drug use complicates medical treatment but we acknowledge that they are probably going to use and our goal is to reduce the harm and move them to sobriety if we can.

LaCheryl Porter, Skid Row Housing Trust: We are a harm reduction program but we don't sanction illegal drugs. We don't monitor people's homes and we offer services that provide other options to self-medication. Some choose detox, reduce use. We are subsidized with Shelter Plus Care and there is no recognition of medical marijuana. We provide education on substance use and hope they make better choices.

Marc Trotz, Los Angeles County: We work with groups, like Skid Row Housing Trust, who have been successful. We need to figure out how to work with these populations, not just kick them out. We need the waiver to include this approach of harm reduction.

Sharon Rapport, CSH: There has been discussion of using all available opportunities to create access to housing. Is there room in this waiver to incentivize local programs to use their dollars for this population – both housing dollars and general fund dollars?

LaCheryl Porter, Skid Row Housing Trust: Looking at LA, it is working well with health services. There are many contributing factors, beyond medical care to a person's health.

Marc Trotz, Los Angeles County: We are looking at money in all directions. If some portion is covered by the state, we will plow that into rent subsidies. I think other communities will do that as well.

Cindy Cavanaugh, California Housing and Community Development: What about the communities that don't do this regardless – how do we incentivize others?

Marc Trotz, Los Angeles County: There has to be a community discussion to allow recognition that serving this population is part of being a community. If we can remove the reason of no money from the table, it helps.

Kelly Brooks Lindsey, California State Association of Counties: There are potential hooks, to the extent there are Medicaid dollars to access new services not available now. For example, the LIHP used county dollars in exchange for match dollars. IF we are spending county dollars that could be matched and change outcomes – reduce recidivism or other big picture policy issues – there is a conversation to have. We need to build relationships and offer a framework like "whole person care" to think about things in a new way.

Cathy Senderling, County Welfare Directors Association: One of the things to focus on is the idea that we don't have to get the whole way with one idea. What is the gap that needs to be filled and what is available? That is the calculus for local government.

Carol Wilkins, ABT Associates: There are some counties doing this now and if we can, through the waiver get FFP to match and double the power of those investments that would incentivize others. If we can't do that through Medicaid, there is a realignment mechanism that takes into account how much counties residual costs are spending for medical services not covered by

Medi-Cal and they could calculate the money spent to house people to keep them out of the hospital.

Doug Shoemaker, Mercy Housing California: There are questions about whether Medicaid can directly pay for housing. One powerful way to encourage local entities and the private sector. If we say, annually we will share savings to be used to indirectly fund housing. Can we create a revenue stream local entities can count on, then I can calculate the risk and the rest is math. The power of that is important. Local government may have land and there may be something at the state level they want.

Dave Folsom, St. Vincent de Paul Village Family Health Center: We need to figure out how to do this in counties where it is more difficult politically.

Public Comment

Rojilio Lopez, Health Net: One thing I heard today is that there is a disconnect between the public and private sides. In our case, needing to understand how the health plans operate. It is a river where members move from plan to plan. It is important to think about the fact that one health plan might invest and the member may move to another plan within a few months. That is the environment we are in.

Next Steps
John Shen, DHCS and Bobbie Wunsch
At the next meeting, we would like to have straw proposals for how to structure this section of the waiver for the group to provide feedback to the department.

Thanks to CHCF, BSCF and TCE for supporting the stakeholder process for the waiver.

Housing Expert Stakeholder Workgroup Meeting Dates:

- Meeting #3: January 14, 2015: USC State Capitol Center, Room E, 1800 I Street, Sacramento
- Meeting #4: January 28, 2015: USC State Capitol Center, Room E, 1800 I Street, Sacramento