HEALI Coalition Meeting
June 21, 2023

Waiver Updates:
- Expecting waiver approval this summer and rollout of RFP in the fall and funds to flow in the beginning of 2024.
- Social Care Network (SCN – previously referred to as the Social Determinant of Health Network (SDHN)) will play major function in the waiver to ensure dollars are going into CBOs for social care related needs and integrate health and social care
  - Screening, referral, light care management
  - Nutrition, housing, and transportation services

State Plan Amendment (SPA) Updates:
- State submitted SPA at the end of March requesting reimbursement for CHWs providing services for pregnant and postpartum individuals as well as certified dietitians and nutritionist.
- We are expecting a second SPA to be submitted that expands services and populations to support children and adults with health-related social needs.
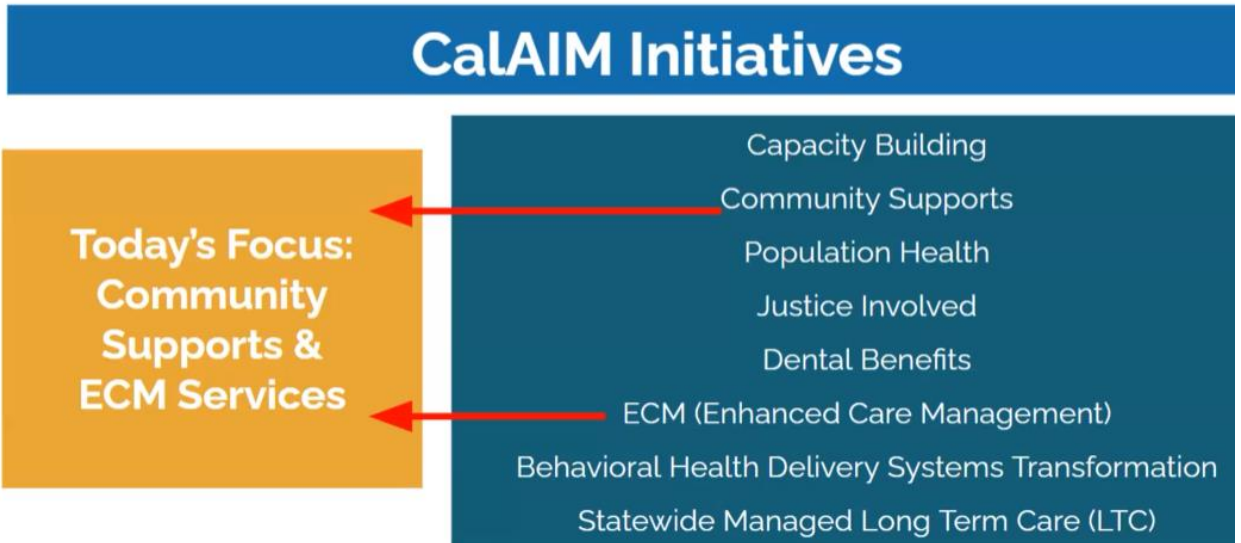
Denise DiNoto, Intrepid Ascent
Agenda:
- CalAIM Overview
- Community Supports Housing
- Challenges | Opportunities
- Synergies with NY State 1115 Waiver

- CalAIM Overview
  - Vision is to meet people where they are and in particular to address social drivers of health and break down walls of health care. Thinking about a different approach of healthcare delivery with social intersection.
  - Similarities with NY: recognition of need to support citizens in different way and breaking barriers

Snapshot: CalAIM Initiatives

CalAIM Initiatives

Today's Focus: Community Supports & ECM Services

- Capacity Building
- Community Supports
- Population Health
- Justice Involved
- Dental Benefits
- ECM (Enhanced Care Management)
- Behavioral Health Delivery Systems Transformation
- Statewide Managed Long Term Care (LTC)

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  - Community Supports & ECM (Enhanced Care Management) work together
- Community Supports – 14 categories
  - Currently not available in all regions but it is changing to require that all Managed Care Plans provide 14 services
  - These services are cost effective alternative services
- Housing Support Services
  - Support to Reach Long-Term Housing:
    - Housing Transition navigation
    - Housing Deposits
    - Housing tenancy & Sustaining
  - Recovery-Focused Housing:
    - Short-term Port-Hospitalization
    - Recuperative Care (Medical Respite)
- Housing Transition Navigation:
  - Similar to New York State and looks at helping individuals navigate finding housing. Individuals are usually in critical life event, but not in a crisis situation, and also those who experience chronic homelessness
  - Funding: Reimbursed to those providing services who are not HIPAA-covered organizations and that do not typically bill for reimbursement. Those orgs are billing today.
- Housing Deposit: receive $5,000 one-time to those establishing a household
- Example: Titanium Healthcare – provide primary care and wrap-around support
- Housing Tenancy & Sustaining
  - Focused on after initial placement and sustaining housing once its been secured
  - Billing and reimbursement of this doesn't always funnel through managed care
- Short-term Post-hospitalization Housing (STPHH)

- o Housing for individuals who don't have a residence and who have high medical, behavioral health needs. Allows continuation of recovery immediately after discharge w/ goal of gaining (or regaining) ability to perform daily living activities
  - o Rules around timeframe and dollars
    - ▪ Not to exceed duration of 6 months for an individual's lifetime
    - ▪ May not address the reality of homelessness but it is a start in covering services under Medicaid Managed Care
- Recuperative Care (Medical Respite)
  - o Short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment
  - o Service providers work together to provide wrap-around services to provide those 14 services supports
  - o CalAIM is lacking a statewide referral network outside the bounds of health system
- Short Term Housing | Recuperative Care
  - o Example: PATH – connected more than 9,000 people into homes
- Challenges & Opportunities
  - o Variability by MCP (Eligibility, Referral, Authorization, Billing)
    - ▪ Start to look at ways to synergize and make these aspects similar → need for standardization
  - o Reimbursement Sustainability
    - ▪ Capacity to stand up and then to maintain
  - o PATH CPI Collaboration
    - ▪ PATH = Providing Access and Transforming Health Initiative
    - ▪ CPI = Collaborative Planning and Implementation
  - o Navigating Different State/Federal Initiatives – State Regs and Certification
  - o Data Sharing, Standardization, Reporting Requirements

Discussion

Q: For all Medicaid requirements and SNAP benefit requirements, applicants have to fill out their needs. Why is there no federal policy that connects housing needs and other needs to it?

A: That level of data sharing is going to be critical in New York State to integrate health and human services.