ALCOHOL, DRUG & MENTAL HEALTH SERVICES
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WELLNESS • RECOVERY • RESILIENCE

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MHSA STAKEHOLDER GROUP

Friday June 24, 2016
2:00-4:00pm
2000 Embarcadero Cove, Oakland – Suite 400
Alvarado Niles Conference Room – 5th Floor

To participate by phone, dial-in to this number: (641) 715-3580
Participant access code: 346-748

MISSION	VALUE STATEMENT	FUNCTIONS
The MHSA Stakeholder Group advances the principles of the Mental Health Services Act and the use of effective practices to assure the transformation of the mental health system in Alameda County. The group reviews funded strategies and provides counsel on current and future funding priorities.	*We maintain a focus on the people served, while working together with openness and mutual respect.*	The MHSA Stakeholder Group: • *Reviews* the effectiveness of MHSA strategies • *Recommends* current and future funding priorities • *Consults* with BHCS and the community on promising approaches that have potential for transforming the mental health systems of care • *Communicates* with BHCS and relevant mental health constituencies

I. Staff Reports **[Carl Pascual]**

II. Committee/Program Updates
   A. African American Steering Committee on Health & Wellness
   B. Innovations In Re-entry (AB109) Program **[Sophia Lai]** www.innovationsinreentry.org

III. Whole Person Care Pilot **[Freddie Smith]**
   A. Target Population
   B. Use of MHSA Funds as match

IV. Follow-Up

MHSA Stakeholder Group
ROSTER (Non-Staff Only)

	First Name	Last Name	Agency/Affiliation	Gender/Orientation	Consumer?	Family Member?	Provider/Other?	MH Board?	Age Group serving? CY-TAY-A-OA	Area of County serving? N-C-S-E	Ethnicities serving?
1	Alane	Friedrich	Mental Health Board	Female				1	All	N	All
2	Elsa	Gutierrez	Pool of Consumer Champions	Female	1				A	C	Latino
3	Brian	Hill	Brian's Online Success Services	Male	1				A	C	AfAm
4	James	Scott	Reaching Across	Male	1				TAY, A, OA	C,S,E	All
5	Cecilia	Wynn	Pool of Consumer Champions	Female	1				A	C	AfAm
6	Margot	Dashiell	Alameda County Family Coalition	Female		1			A	N	AfAm
7	Sherri	Millick	Family Education & Resource Center	Female		1			TAY	S	Any
8	Yvonne	Rutherford	African American Family Support Group	Female		1			All	N	AfAm
9	Liz	Rebensdorf	NAMI	Female		1			All	N	All
10	Penny	Bernhisel	Telecare	Female			1		OA	N,C,S	AfAm, C
11	Karen	Grimsich	City of Fremont	Female			1		OA	S,C	All
12	Janet	King	Native American Health Center	Female			1		All	N	NA
13	Tracy	Murray	Area Agency on Aging	Female			1		A, OA	All	All
14	Pysay	Phinith	Asian Community Mental Health Services	Female			1		All	All	API
15	Gwen	Wilson	G.O.A.L.S. For Women	Female/Lesbian			1		A	N	AfAm
				TOTALS	**4**	**4**	**6**	**1**			

Overview:

Innovations In Reentry (IIR) is a pilot grant program designed to spur innovative, creative ideas for addressing the needs of the adult reentry population. The program awards grants to support community-based projects that contribute to reducing adult recidivism in Alameda County.

Round 2 Funding Categories:

- **Stakeholder Participation** (6 month grant period) – Effective and implementable models or practices to ensure the "voice of stakeholders" is included in significant decisions impacting the design and effectiveness of programs serving reentry or formerly incarcerated individuals in the community.
- **Re-entry Workforce Development for Peer Services** (18 month grant period) – Effective and adoptable plans for incorporating formerly incarcerated individuals into the workforce of agencies and programs providing services to the reentry population.
- **Medi-Cal Billing Readiness** (6 month grant period) – Development and field testing of a standardized and effective assessment of organizations' capacity and readiness to claim and retain funding through Short-Doyle claiming processes.

Key Dates:

- June 27, 2016 – Kickoff Meeting
- July 1, 2016 – December 31, 2017 / 2018 – Project Implementation
- February 2017 – Innovations In Reentry Learning Conference

Round 2 Grantees:

Grantee(s)	Category	Amount
Asian Prisoner Support Committee Building Opportunities for Self Sufficiency	Reentry Workforce Development	$200,000
California Institute for Behavioral Health Solutions Roots Community Health Center	Medi-Cal Billing Readiness	$150,000
E C Reems Community Services Conscious Voices	Reentry Workforce Development	$200,000
Genesis Worship Center Tricities Community Development	Reentry Workforce Development	$200,000
Roots Community Health Center Timelist Centerforce	Stakeholder Engagement	$154,497
The Reset Foundation	Stakeholder Engagement	$25,000
Oakland California Youth Outreach	Reentry Workforce Development	$100,000

Alameda County

BHCS
Whole Person Care Pilot

MHSA Stakeholders Meeting

June 24, 2016

Freddie Smith MPH

fsmith@acbhcs.org

Goal of WPCP Project

Improve the Coordination of health services, behavioral health, and social services with the goal of improving health outcomes and wellbeing of clients through more efficient and effective use of resources.

Alameda County
WPCP Target Population

1. Homeless-10,000 individuals

2. High Users of Multiple Systems of Care- 6500 individuals (Medical System, MH Services, SUD Services, and Incarceration)

3. Both Homeless and High Users

What are the WPCP Benefits to BHCS Stakeholders?

1. A Data Sharing System that providers can access patient information in real time (EDs, Clinics, Crisis Services, and homeless services).

2. Improved Care Coordination services for the 4,080 SMI consumers in all healthcare systems in Alameda County.

3. BHCS and HCSA Workforce with improved skills and training to support the delivery of services to clients with complex health conditions.

4. A funded housing development pool to expand supportive housing services beyond the WPCP grant period.

BHCS Whole Person Care (WPC) Match Proposal
Revised 6/13/16

Program		Amount	Funding Source	Staff
SUD-Sobering Center	$	802,258	Measure A	Tom Trabin
SUD-Drug Court Clinical Staff S&EB	$	520,000	2011 Realignment	Tom Trabin
SUD-Centerpoint	$	403,814	CGF	Tom Trabin
Housing Office FSP Staff	$	450,000	MHSA	Robert Ratner
Housing Office Staffing & Management Contracts	$	1,200,000	MHSA	Robert Ratner
IBHP-Psychiatric Consultation at FQHCs	$	2,000,000	MHSA	Freddie Smith/Aaron Chapman
IBHP-Care Coordinators at FQHCs	$	791,167	MHSA	Freddie Smith
IBHP-Medical Home Care Coordination	$	1,233,572	MHSA	Freddie Smith
Trust Clinic	$	1,149,000	MHSA	Robert Ratner
IBH-Training & Workforce Development	$	682,646	MHSA	Sanjida Mazid
TOTAL as of 6/20/2016	**$**	**9,232,457**		

Alameda County Whole Person Care Pilot Population

The WPCP **eligible population** is comprised of those who are **Medi-Cal eligible** and who fall into **at least one of the following target populations**. We anticipate significant overlap between the target populations.

Target Population #1: Homeless – Literally and at-risk-of

	HUD Definition	HRSA Definition (Broader)
Category 1	Individuals and families who lack a fixed, regular, and adequate nighttime residence, including a place not meant for human habitation	They are living on the streets; in an abandoned building or vehicle;
	Living in a shelter (Emergency shelter, hotel/motel paid by government or charitable organization)	Their primary nighttime residence is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations. They are staying in a mission.
	Exiting an institution (where they resided for 90 days or less AND were residing in emergency shelter or place not meant for human habitation immediately before entering institution)	They were previously homeless, are to be released from a prison or a hospital, and do not have a stable housing situation to which they can return
Category 2	Individuals/families who will lose their primary nighttime residence within 14 days, and who: - Have no subsequent residence identified AND - Lack the resources or support networks needed to obtain other permanent housing	
Category 3	Unaccompanied youth (under 25 years of age) or families with children/youth who: - Have not had lease, ownership interest, or occupancy agreement in permanent housing at any time during last 60 days - Have experienced two or more moves during last 60 days - Can be expected to continue in such status for an extended period of time because of: chronic disabilities, OR chronic physical health or mental health conditions, OR substance addiction, OR histories of domestic violence or childhood abuse (including neglect) OR presence of a child or youth with a disability, OR two or more barriers to employment	
Category 4	Individuals/families fleeing or attempting to flee domestic violence, dating violence, violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or family member and: - Has no identified residence, resources or support networks - Lacks the resources and support networks needed to obtain other permanent housing	

HUD Definition		HRSA Definition
		They are a resident in transitional housing
		They are staying in a single room occupancy facility,
		They are "doubled up," unable to maintain their housing situation and forced to stay with a series of friends and/or extended family members.
		They are staying in **any other unstable or non-permanent situation**.

DECISION: Which definition to use?

- *HUD Definition is narrower and more carefully accounted for in the HMIS database, providing an easier denominator for monitor outcomes*
  - *~10,000 people are in the HMIS data system for 12 months meeting narrower HUD definition*
  - *This could be used as the denominator for this target population.*
- *HRSA definition is broader, making it easier for clients to qualify for the WPCP target population but harder to determine the denominator up front*
  - ~10,000 people are served annually through HCSA's Health Care for the Homeless Program which uses the broader HRSA definition, but we assume many more qualify
  - Housing issues were named as a primary issue throughout key informant interviews. Does the HUD definition cover this need, or is the flexibility of the HRSA definition needed to capture those whose health outcomes are influences by housing instability?

Target Population #2: Serious Persistent Mental Illness (SPMI) – 8,509 Alliance Medi-Cal Clients

a. Being on a service team (called Level 1: ~3,300 clients) or FSP (~780 clients) and/or
   i. Already with significant care coordination services including housing navigation
b. 3 or more episodes with an SPMI DX with the last service occurring in the last 3 years and/or
c. 10 or more SPMI DX episodes ever (data goes back as far as 1991)

Target Population #3: High Users of Multiple Systems – 6,509 Alliance Medi-Cal Clients

a. Touching any two of the following systems in a 12 month period
   i. Medical crisis/high acuity utilization in 2015
      1. 3 or more ED visits OR
      2. Inpatient stay (other than for pregnant women giving birth) OR
      3. Medical Sub-acute
   ii. Mental Health high acuity utilization in 2015/high need
      1. 2 or more PES/5150 OR
      2. Psych inpatient admission OR
      3. IMD
      4. SPMI as defined above (on a service team/FSP or multiple episodes with SPMI diagnoses)
   iii. Substance Abuse Treatment Services: at least one SUD service in 2015
   iv. Incarceration
      1. Discharge from Santa Rita in 2014
      2. AB109 Clients

3. Others with known Person File Number (PFN) in sheriff system

Target Population #4: High Users of Emergency Services (even within one system) in a 12 month period

a. 3 or more ED visits (13,713 Alliance Medi-Cal clients; 12,674 had no visit to PES)
b. 2 or more PES visits (1,045 Alliance Medi-Cal clients; 189 had no ED visit)

Overall, the Health Homes Program and Alameda Health System's Complex Case Management are intended to care for those who are very medically sick, with or without behavioral health issues. This group may often have multiple hospitalizations due to their conditions. The Whole Person Care Pilot on the other hand is intended to meet the needs of those who have significant unmet social needs, housing instability, and substance use issues that often lead to inappropriate seeking of emergency services across siloed systems with no cohesive consistent care coordination to assist the client in getting the care they need. There is certainly overlap, and the Whole Person Care Pilot will determine when an individual already has a care coordinator, if there are services that the client is already eligible for through other programs, and if there are gaps in services that Whole Person Care might cover.

Medi-Cal 2020 Waiver – Whole Person Care (WPC) Pilots
Frequently Asked Questions and Answers
Revision 4.0

This document is a compilation of frequently asked questions (FAQs) and responses regarding the Medi-Cal 2020 Whole Person Care (WPC) pilots. This document will continue to be updated over time.

A. Overview, Timeline, and Contact Information

1. What are the Whole Person Care (WPC) pilots?

Answer: The WPC pilots are a 5-year program authorized under California's Medi-Cal 2020 waiver to test locally-based initiatives that will coordinate physical health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple health care systems and continue to have poor outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC pilots will identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population health progress. Up to $1.5 billion in federal funds is available over five years to match local public funds for the WPC pilots.

2. What are the key deadlines for launching the WPC Pilots?

Answer: The anticipated timeline is as follows:

Deliverable/Activity	Date
1. DHCS releases draft WPC pilot Request for Applications (RFA) and selection criteria for public comment	April 11, 2016
2. Public comments on WPC pilot application and selection criteria due to DHCS	April 18, 2016
3. CMS approves the WPC pilot application	May 6, 2016
4. DHCS releases WPC pilot RFA, timeline, and selection criteria	May 16, 2016
5. DHCS conducts webinar for potential applicants/interested entities	May 19, 2016
6. WPC pilot applications due to DHCS	July 1, 2016
7. DHCS completes WPC application review; sends written questions to applicants	September 1, 2016
8. Applicants' written responses due to DHCS	September 8, 2016
9. DHCS notifies CMS of WPC pilot selection decisions	October 7, 2016
10. DHCS notifies applicants of WPC pilot selection final decisions	October 24, 2016
11. Lead entities provide formal acceptance to DHCS	November 3, 2016

Updated information about the timeline and WPC application will be posted on the WPC webpage at http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx and released through the Medi-Cal 2020 waiver and the WPC stakeholder listserv, which will be active soon. DHCS recommends checking the WPC website weekly for updates. To join the WPC listserv, send an e-mail to 1115wholepersoncare@dhcs.ca.gov. If you participate in the upcoming WPC FAQ webinar, you will automatically be added to the WPC listserv.

3. **Who decides which entities will participate in the WPC pilot?**

   Answer: Each lead entity will need to indicate who the participating entities will be for the WPC pilot. The first opportunity to provide preliminary information on this will be through the non-binding Letter of Intent. WPC pilot applicants must include letters of participation agreement from WPC participating entities as part of their application (STC 117(b)(xvi)).

   DHCS will review and approve the WPC applications and confirm the selection of participating entities. We strongly encourage lead entities to engage in a collaborative process at the local level to identify participating entities based on the needs of the target population.

4. **Are lead entities required to submit letters of participation or letters of support as part of the WPC application?**

   Answer: The lead entity should submit a Letter of Participation for each Participating Entity participating in the WPC pilot. The lead entity should also submit letters of support for participating providers and other relevant stakeholders in the geographic area where the WPC pilot will operate. Letters must:
   - Confirm participation in (for letters of participation), or support of (for letters of support), the WPC pilot program
   - Not be form letters
   - Be on the appropriate letterhead
   - Not be more than two pages long
   - Be signed by an authorized representative of the participating entity, provider or stakeholder
   - Be addressed to Sarah Brooks, Deputy Director, Health Care Delivery Systems, Department of Health Care Services

5. **In a WPC pilot county, are all Medi-Cal managed care plans required to participate in the pilot?**

   Answer: While only one managed care plan is required to participate in each pilot county, DHCS encourages applicants to include multiple participating plans.

6. **In a county with managed care plans that directly contract with DHCS and then subcontract with other plans, will the subcontracted plans also be encouraged to participate in WPC?**

   Answer: WPC pilot proposals are required to include at least one Medi-Cal managed care plan and are encouraged to include additional plans. Plan participation must include the plan's entire network (i.e., where delegation of full risk has occurred to an entity in the plan's network). However, the participating plan(s) may determine whether or not to include specific full-risk delegated entities in pilot participation. Also, specific pilot-requested exclusions may be considered by DHCS on a case-by-case basis.

7. **Can an organization be a lead entity for more than one WPC pilot?**

   Answer: Nothing precludes organizations from being a lead entity on more than one WPC pilot, as long as the applicant meets all requirements for each pilot application. However, it is unlikely that DHCS would approve multiple pilots for the same geographic area. DHCS is more interested in applications with a higher degree of complexity from one entity than multiple applications from the same entity and asks that entities in the same geographic area work to submit a single application.

8. **Which entities are required to participate in the development of the WPC application?**

   Answer: The lead entity is responsible for submitting the WPC application, including obtaining letters of participation agreements from participating entities, and should collaborate with participating entities as part of this process.

C. Target Population

1. **How will the target population for the WPC pilot be defined and assigned?**

   Answer: The waiver Special Terms and Condition[1] (STC) 111 describes the target populations for the WPC. WPC pilots shall identify high-risk, high-utilizing Medi-Cal beneficiaries in the geographic area that they serve and assess their unmet need. WPC pilots must define their target populations and interventions to provide integrated services to high users of multiple systems. The target population shall be identified through a collaborative data approach to identify common patients who frequently access urgent and emergent services, often times across multiple systems. Section 2.3 of the Application Selection Criteria notes that applications will be scored on the "quality of methodology used to define target population(s)." The application should include a description of the collaborative data approach(s), and the aggregate data result and findings that the applicant used to select the target population(s). (The aggregate data results and findings required for the application are separate from "Target Population Baseline Data," which will be required for approved pilots as a subsequent deliverable relating to Year 1 funding.)

   Participants will opt into the program and may be enrolled on a rolling basis. Target populations may include, but are not limited to, individuals:

   A. With repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement;
   B. With two or more chronic conditions;
   C. With mental health and/or substance use disorders;
   D. Who are currently experiencing homelessness; and/or

[1] http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx

E. Individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (hospital, subacute care facility, skilled nursing facility, rehabilitation facility, Institution for Mental Disease (IMD), county jail, state prisons, or other).

Individuals who are not Medi-Cal beneficiaries may participate in approved WPC pilots, but funding in support of services provided to such individuals is not eligible for federal financial participation. These individuals shall only be included in the pilot at the discretion of the WPC pilot and as approved during the application process. The non-Federal funds expended providing services to individuals who are not Medi-Cal beneficiaries may exceed the funding limits described in STCs 125 and 126.

2. **Can individuals eligible for Medicaid and Medicare (dual eligibles) be included in the WPC Pilot target population?**

   Answer: WPC pilot target populations may include dually eligible beneficiaries. For counties where the Coordinated Care Initiative (CCI) is in place and a beneficiary is eligible for both programs, the WPC pilot would be expected to coordinate with the model already in place.

D. Services

1. **The STCs state that: *"Individuals who are not Medi-Cal beneficiaries may participate in approved WPC pilots, but funding in support of services provided to such individuals is not eligible for federal Financial Participation."* How will this requirement be applied in the context of WPC pilots?**

   Answer: WPC pilot payments for infrastructure and other non-service deliverables may benefit individuals who are not Medi-Cal beneficiaries. Generally, WPC pilot payments may support activities, such as 1) building infrastructure to integrate services among local entities that serve the target population; 2) providing services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population, such as housing components; and 3) implementing strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes. Thus, federal WPC payments are not available for items in category 2 for patients who are not Medi-Cal beneficiaries. The Pilot may provide WPC-funded services for limited scope Medi-Cal beneficiaries, but the Pilot may only provide services that would not be covered by Medi-Cal for a full-scope Medi-Cal beneficiary.

2. **How can WPC pilots support Medi-Cal beneficiaries' housing needs?**

   Answer: WPC pilots may target individuals who are experiencing, or are at risk of, homelessness who have a demonstrated a medical need for housing or supportive services. In the event that this population is included in the WPC pilot proposal, participating entities would include local housing

authorities, local Continuum of Care (CoC) programs, and community based organizations serving homeless individuals.

Federal Funding for Housing Supports

The types of housing services that may be offered as part of the pilot that are eligible for federal financial participation (FFP) may include the services described below, which are quoted from the June 26, 2015 CMCS Informational Bulletin, *"Coverage of Housing-Related Activities and Services for Individuals with Disabilities."*[1] Housing-related services described in the Informational Bulletin include:

a. Individual Housing Transition Services: Housing transition services are meant to assist beneficiaries with obtaining housing and include:
   i. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy.
   ii. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
   iii. Assisting with the housing application and/or search process, including identifying and securing available resources to assist with subsidizing rent (such as Section 8 or Section 202, etc.).
   iv. Identifying and securing resources to cover expenses, such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs, and other one-time expenses.
   v. Ensuring that the living environment is safe and ready for move-in.
   vi. Assisting in arranging for and supporting the details of the move.
   vii. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

b. Individual Housing & Tenancy Sustaining Services: This service is made available to support individuals in maintaining tenancy once housing is secured. The availability of ongoing housing-related services, in addition to other long-term services and supports, promotes housing success, fosters community integration and inclusion, and develops natural support networks. These tenancy support services are:
   i. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
   ii. Educating and training on the role, rights, and responsibilities of the tenant and landlord.

[1] CMCS Informational Bulletin. June 26, 2015. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

iii. Coaching on developing and maintaining key relationships with landlords/property managers, with a goal of fostering successful tenancy.
iv. Assisting in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
v. Advocating and linking individuals to community resources to prevent eviction when housing is or may potentially become jeopardized.
vi. Assisting with the housing recertification process.
vii. Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
viii. Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

c. Additional examples of transition services: The bulletin includes these additional examples of services that can be covered:
   i. Assessing the participant's housing needs and presenting options
   ii. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history)
   iii. Searching for housing
   iv. Communicating with landlords
   v. Coordinating the move
   vi. Establishing procedures and contacts to retain housing
   vii. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
   viii. Identifying, coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility.
   ix. Identifying, coordinating, securing, or funding services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access, first month coverage of utilities, including telephone, electricity, heating, and water; essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; first month's rent; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically necessary services, such as hospital beds, hoyer lifts, etc. to ensure access and reasonable accommodations.

These services may also include outreach to people experiencing homelessness where they live to form trusting relationships with service providers.

In addition, federal funding may be used for housing-related collaborative activities between public agencies and the private sector that assist WPC entities in identifying and securing housing for the target population.

It is important to note that federal Medicaid funds may **not** be used to cover the cost of room and board, monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. State or local government and community entity contributions are separate from federal matching funds, and may be allocated to fund support for long-term housing, including rental housing subsidies.

Financial Structures for Housing
The county-wide Flexible Housing Pool is one suggested way to structure funding to pay for housing services and supports.

WPC pilots may utilize a county-wide Flexible Housing Pool to structure funding to pay for housing services and supports. The Flexible Housing Pool may include WPC pilot payments for housing-related deliverables for which federal financial participation is available. In addition, the Flexible Housing Pool may include funds that will be used for long-term housing costs, including rental subsidies that are not eligible for federal matching funds through the WPC pilots. WPC pilot entities may provide or collect contributions to the Flexible Housing Pool from partner agencies or from community entities, subject to the applicable provisions of Section 1903(w) of the Social Security Act and 42 C.F.R. Part 433, subpart B.

WPC pilot entities should track funding through the Flexible Housing Pool to demonstrate that federal financial participation funds are not applied for services for which federal financial participation is prohibited. The Flexible Housing Pool may incorporate a financing component that makes funds available to the WPC pilot based on a portion of the reduced utilization of health care services associated with the operation of the WPC pilot housing-related services.

3. **What are some examples of specific services that stakeholders have asked about that can be included in a WPC pilot?**

Answer:

- Services currently provided by a local government entity: In addition to the exclusion for Medi-Cal funded services, WPC cannot be used to fund local responsibilities for health care or social services that are mandated by state or federal laws, or to fund services for which state or federal funding is already provided.

- Services for people in jail or an Institution for Mental Disease (IMD): In addition to the exclusion for Medi-Cal funded services, WPC cannot be used to fund local responsibilities for health care or

social services that are mandated by state or federal laws, or to fund services for which state or federal funding is already provided. In addition, the WPC pilots are intended to serve people living in the community, or to prepare, support and facilitate a transition into the community of an institutionalized beneficiary. WPC services may not be provided for individuals who are both 1) residing in institutions, and 2) who are reasonably expected to spend more than 90 consecutive days in the institution before transitioning into the community.

- Recuperative care/medical respite: Medical respite care, also referred to as recuperative care, is acute and post-acute medical care for individuals, primarily those who are homeless or those with unstable living situations, who are too ill or frail to recover from a physical illness or injury in their usual living environment but are not ill enough to be in a hospital. Unlike "respite" for caregivers, "medical respite" is short-term residential care that allows individuals with unstable living situations the opportunity to rest in a safe environment while accessing medical care and other supportive services. In addition to providing post-acute care and clinical oversight, medical respite programs seek to improve transitional care for this population and end the cycle of homelessness by supporting patients in accessing benefits and housing while also gaining stability with case management relationships and programs. Recuperative care/medical respite is an allowable WPC service if it is 1) necessary to achieve or maintain medical stability, which may require behavioral health interventions, 2) directly linked to the overarching strategies and goals for the target population, 3) not more than 90 days in continuous duration, 4) does not include funding for building modification or building rehabilitation, and 5) not covered by Medi-Cal.

- Sobering centers: Sobering centers provide a safe, supportive, environment for individuals found to be publicly intoxicated, primarily those who are homeless or those with unstable living situations, to become sober. A sobering center is an allowable WPC service if it is 1) necessary to achieve or maintain medical stability, which may require behavioral health interventions, 2) directly linked to the overarching strategies and goals for the target population, 3) not more than 24 hours in continuous duration, 4) does not include funding for building modification or building rehabilitation, and 5) not covered by Medi-Cal. For alcohol or other drug-dependent persons, primarily those who are homeless or those with unstable living situations, the goals of a sobering center are to:
    - Provide better care and improve health outcomes
    - Decrease the number of inappropriate ambulance trips to the emergency department (ED)
    - Decrease the number of inappropriate ED visits

- Transportation: Transportation is an allowable WPC service if it is 1) necessary to achieve or maintain medical and/or behavioral health stability, 2) directly linked to the overarching strategies and goals for the target population, and 3) not covered by Medi-Cal.

- Field-based care (examples include, but are not limited to, nurses, case managers, therapists delivering services on the street or in the home): Field-based care is an allowable WPC service if it is

1) necessary to achieve or maintain medical and/or behavioral health stability, 2) directly linked to the overarching strategies and goals for the target population, and 3) not covered by Medi-Cal.

- Information Technology (IT) Infrastructure: The WPC pilot may fund new IT infrastructure development, or existing infrastructure operations, that are: 1) necessary to achieve or maintain medical and/or behavioral health stability, 2) directly linked to the overarching strategies and goals for the target population, 3) not otherwise covered by Medi-Cal, and 4) not a local responsibility for health care or social services that is mandated by state or federal laws, or already funded with state or federal funds. The WPC pilot IT infrastructure project funding must be adjusted proportionally to: reflect a target population cap approved in the WPC pilot application as a percent of the total possible target population, and/or adjust for utilization of the IT infrastructure project to serve individuals outside of the target population; across the lead and participating entities.

E. Funding

1. **How much funding can one WPC pilot receive? If the total proposed funding in all WPC applications exceeds the total allocated program funding, how will DHCS decide what to approve/fund?**

   Answer: DHCS is developing application selection criteria, which will be released for public comment and later shared with CMS for approval. The selection criteria will be released along with the formal WPC application in May 2016.

   A single WPC pilot may not receive more than 30 percent of the total statewide funding available in a given year, unless additional funds are available after all initial awards are made and the WPC pilot receives approval through an application process. In the event that an approved WPC pilot application is approved for less than 90 percent of its requested funding, DHCS will allow the lead entity to withdraw its application.

2. **How will the WPC pilot funding flow?**

   Answer: As part of the WPC application submission, Lead Entities will need to include a total requested annual dollar amount that specifies budgeted payments for each element for which funding is proposed including: infrastructure, data collection, interventions, and outcomes, such that a specific dollar amount is linked in each year to specific deliverables, e.g., performance of specific activities, interventions, supports and services, and/or outcomes. Lead entities will also be required to outline how they plan to distribute funds among the participating entities.

   For each payment that will be made from DHCS to the Lead Entity over the duration of the five-year pilots, once DHCS has determined a payment amount for what has been earned by the pilot, DHCS will notify the lead entity of the IGT amount and the Lead Entity, or participating entity, will transfer the required IGT funding amount to DHCS. (The Application should indicate which entities will be

transferring the IGT funding to DHCS.) The IGT funds are then matched by the federal government and the combined gross amount is paid to the Lead Entity. The Lead Entity is responsible for disbursing those funds in accordance with the terms of the approved pilot.

In this context, IGT refers to an intergovernmental transfer of public funds from a governmental entity (e.g. county, city, Indian Tribe) to the State Medicaid agency (DHCS). The transferring governmental entity must certify that the transferred funds are public funds that qualify for federal financial participation under relevant federal Medicaid law, including that the funds are not derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as state match, impermissible taxes, and non-bona fide provider donations. For transferring governmental entities that are also providers, the above exclusions will not preclude use of patient care revenue received as payment for services by the transferring entity under programs such as Medicaid, Medicare, or Designated State Health Programs, or PRIME payments.

For more information on WPC financing, review STCs 126 and 188. The application will also include additional details.

3. **Are per-member-per-month/bundled pilot payments permissible?**

Answer: WPC pilots may include in their budget request one or more per-member-per-month (PMPM)/bundled payments. These PMPM/bundled payments, if approved by DHCS in the WPC pilot application/agreement, may be used solely or in conjunction with non-PMPM/bundled payment funding structures to complete the total proposed budget request for the pilot. Any PMPM/bundled payment must be based on an identified set of services that will be made available for a specific target population; supporting documentation must be included as a part of the WPC pilot application. Should the pilot or a participating entity experience savings for a PMPM/bundled payment due to administrative implementation efficiencies, the pilot may utilize these savings to pay for services under in its WPC pilot flexible housing pool (Pool). The WPC pilot lead entity and each WPC pilot participating entity may individually determine if their savings under this construct would be utilized in the Pool, as approved in the WPC pilot application/agreement. Savings may also be utilized under the pilot for other purposes, as approved by DHCS. The use of funds in this manner is not permissible if the budget is not in a PMPM or bundled payment amount.

4. **What are the timing and deliverables requirements for Program Year 1 funding?**

Answer: Funding for the WPC pilot in Program Year 1 (2016) will be based on the submission of the WPC application and target population baseline data. The allocation will be 75% for the submission of the application and 25% for the submission of baseline data. Applicants must submit both an approved application and timely baseline data to be eligible for payment. The baseline data will be considered

the Annual Report (as required in Attachment GG) for Program Year 1. The baseline data will be due to DHCS within 60 days from the end of Program Year 1. DHCS will release additional guidance and a template in the second half of 2016 regarding the specific baseline data pilot reporting requirements. Once the pilot has submitted baseline data in 2017 which is complete and timely, and DHCS has reviewed and approved the deliverable, a request for the pilot IGT amount will be made. The pilot may then submit the appropriate IGT funding for the non-federal share of the total approved amount of Program Year 1 funding (according to the timelines and process specified in Attachment GG). DHCS will then make the earned payment to the lead entity in accordance with the required timeline.

5. **Can WPC collaboratives estimate funding used by undocumented individuals in the program on the back end / after spending or does it have to be tracked up front on the individual level based on the services that specific person receives?**

   Answer: The WPC budget and WPC funding apply to MC beneficiaries only. DHCS will only provide Pilot funding to Pilots for completed deliverables that are for Medi-Cal beneficiaries. There would be no computation in the budget request by the pilot or the payment made by DHCS regarding non Medi-Cal individuals. Individuals who are not Medi-Cal beneficiaries may participate in approved WPC pilots, but funding in support of services provided to such individuals is not eligible for federal financial participation. These individuals shall only be included in the pilot at the discretion of the WPC pilot and as approved during the application process. The non-Federal funds expended providing services to individuals who are not Medi-Cal beneficiaries may exceed the funding limits described in STCs 125 and 126.

6. **Is a year-by-year funding plan required in the application?**

   Answer: Yes. Please see WPC Pilot Application for addition information. The application is available on the Whole Person Care Pilot webpage at www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.

F. Other

1. **Is there an opportunity to submit comments on the STCs, or have they already been finalized and approved?**

   Answer: The Medi-Cal 2020 waiver has been approved by the Centers for Medicare & Medicaid Services, and the STCs are final. The selection criteria and Request for Applications (RFA) will be released for public comment prior to finalization.

2. **What data and information sharing requirements should the WPC lead entity follow?**

   Answer: Applicable state and federal laws regarding data sharing apply, but may vary depending on the target population.

3. **How do Distinct Part Skilled Nursing Facilities (DP-SNFs) fit into the 2020 demonstration waiver program?**

   Answer: A DP-SNF may serve as a participating entity in a WPC pilot. To the extent DP-SNF services are already covered under Medi-Cal, they are not eligible for support through the WPC pilot. In general, pilots should work to include all providers of care to a beneficiary in the beneficiary's care team and care planning.

4. **As a program to assist with establishing infrastructure, to what extent can a WPC pilot be used to fund the implementation of Coordinated Entry for Local Continuums of Care (CoC)? We anticipate staffing, technology, and infrastructure costs, tying together multiple community providers, medical providers, and county departments as well as trying to identify solutions to share data between health exchange and Homeless Management Information Systems. Building out a sophisticated system that allow for maximum coordination of care is the goal. How can WPC be utilized toward this end?**

   Answer: While WPC pilots are not specifically designed to provide supporting infrastructure of implementation of the CoC, several provisions of the STCs allow pilot entities to perform these activities. Pilot entities may apply for WPC funds to coordinate existing resources available to provide housing and services to people in the WPC pilot target population experiencing homelessness, and to enhance data sharing between partner agencies. Additionally, housing-related activities available through WPC pilots may include assessing the housing needs of the target population. These services and activities may be included in WPC pilots to the extent they do not duplicate services and activities for which federal funding is available through other sources.

   For example, to the extent that WPC funds are not duplicating any federal funding for the creation, strengthening, or implementation of coordinated entry and assessment or data matching systems, pilot entities may use WPC funds to fund many of the specific activities of a coordinated assessment and entry system in support of the WPC pilot target population. In addition, WPC pilot activities may include matching Homeless Management Information Systems with health plan data to identify a health plan's homeless members to coordinate housing, CoC, and health partners and partner resources, and to assess the housing needs of the target population.

   If proposals are put forward to leverage dollars on building coordinated entry infrastructures, the coordinated entry systems must have one consolidated assessment tool that measures housing and health care, behavioral health and LTSS needs across the entities included in the pilot. In addition, the coordinated entry must weigh the member's vulnerability, ensuring members with the highest

utilization, who obtain high-cost services from multiple systems with the highest care needs, are having their services coordinated and accessing available housing first.

5. **How are the WPC pilots and the Affordable Care Act Section 2703 Health Homes Program (HHP) similar and different?**

   Answer: Please see the comparison table in the Appendix for a detailed description of the similarities and differences between the two programs. Note that the HHP program has not yet received federal approval and is subject to change.

   Both programs will serve beneficiaries with complex, chronic conditions who are frequent users of health services, but specific eligibility requirements for each program may differ. The WPC pilots will have the flexibility to establish their own eligibility criteria within the guidelines of the waiver STCs, whereas DHCS has defined the beneficiary eligibility criteria[4] for HHP across the state. Thus, a beneficiary enrolled in a WPC pilot may also be in a HHP, or a beneficiary might be eligible for one program and not the other. Nothing prohibits a beneficiary from being in both programs. Finally, the HHP is an entitlement, such that any beneficiary who meets the eligibility criteria must be offered services, while WPC pilot eligibility is at the discretion of the county.

   In general, the WPC pilots are focused on infrastructure development and cross-system coordination, whereas the HHP is a new Medi-Cal benefit that will pay for specific care coordination services for beneficiaries. WPC pilots cannot be used to fund services that are otherwise payable by Medi-Cal. However, if a HHP is not operating in a county, or serving specific WPC-eligible members who are not eligible for HHP, the WPC pilot could provide Health Home-like services.

   For example, for HHP members experiencing homelessness, a "Housing Navigator" is a required member of the HHP care team. Their role is to:

   - Form and foster relationships with and communication between team members, housing providers, and member advocates
   - Connect and assist the HHP member to get recuperative care or bridge housing gaps
   - Connect and assist the HHP member to identify available permanent housing
   - Coordinate with HHP members in the most easily accessible setting, within MCP guidelines (e.g., could be a mobile unit that engages members on the street).

   WPC pilots have the option to provide housing interventions and supports beyond what is required in the HHP. See FAQ Section "Services."

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4 http://www.dhcs.ca.gov/services/Documents/Health%20Homes%20for%20Patients%20with%20Complex%20Needs%20California%20Concept%20Paper%20Version%203.0%20(Draft-Final)%2012-14-15.pdf

6. **How should a WPC application address the relationship between the WPC pilot and a concurrent Affordable Care Act (ACA) Section 2703 Health Homes Program that is operating in the county?**

   Answer: If a Health Homes Program is scheduled to operate in a county that is also applying for the WPC pilot, the WPC application should describe the interaction of the Health Home and WPC pilot programs, demonstrating at a minimum how the programs complement each other and are not duplicative.

7. **What assistance can DHCS provide with Information and Data Sharing?**

   Answer: To assist with the WPC goals of care integration and coordination across systems through the sharing of beneficiary assessment and treatment information, DHCS will provide information in the latter half of 2016 regarding State and federal law on information and data sharing. This document will compile currently available information into one document pertaining to the types of data that can be shared between entities. However, DHCS expects WPC pilot entities to comply with State and federal law and, as part of the application, describe methods to address information and data sharing issues through the pilot interventions.

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