September 21, 2020

A Roadmap for Phased Implementation of an Older Adult Housing Pilot in Los Angeles County

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September 21, 2020

To: Supervisor Kathryn Barger, Chair
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From: Fesia A. Davenport
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PILOTING A COMPREHENSIVE CRISIS RESPONSE TO ENSURE POST-COVID-19 HOUSING FOR HOMELESS OLDER ADULTS IN LOS ANGELES COUNTY (ITEM NO. 8, AGENDA OF APRIL 14, 2020)

On April 14, 2020, the Board of Supervisors (Board) directed the Chief Executive Office (CEO) Homeless Initiative, along with all appropriate County departments, and in coordination with the City of Los Angeles and State officials, to:

1. Report back in writing within 30 days with a strategy to provide long-term housing options to individuals experiencing homelessness who are age 65 years or older, and were provided emergency housing based on the COVID-19 emergency public health declaration; and

2. Report back in writing within 45 days with an interim report, followed by a multi-year implementation framework as part of Fiscal Year 2020-21 Supplemental Budget deliberations, with cost estimates for the pilot program targeting all individuals experiencing homelessness who are age 65 years or older.

The first report was submitted to the Board on May 15, 2020. to address Directive No. 1, and a follow-up report was submitted on June 23, 2020. in response to Directive No. 2. The attached report is a multi-year implementation framework for a pilot program that would target all homeless older adults (ages 65 and above) and is in response to Directive No. 2.

Housing for Homeless Older Adults Pilot

The attachment entitled, "A Roadmap for a Phased Implementation of an Older Adults Housing Pilot in Los Angeles County," contains a description of the overall population of people experiencing homelessness who are age 65 and above in Los Angeles County and includes the cost estimates of housing this population over five years. This research was conducted by the following research team: Dennis Culhane and Dan Treglia from the University of Pennsylvania; Randall Kuhn from the University of California, Los Angeles; and Andy Perry and Max Stevens from the Los Angeles County CEO/Chief Information Office, with funding support from the United way of Greater Los Angeles.

The report estimates that the Year-One cohort would consist of 4,796 older adults, and it is estimated that the gross costs would be $73.3 million over the first 12 months of the pilot. By the start of Year Five, attrition over the first four years of the pilot can be expected to reduce the Year-One cohort by roughly 30 percent, which means that 3,312 older adults would remain in the pilot by Year Five. There will also be additional homeless older adults that are expected to "age into" the pilot and older adults who will become homeless, so that the caseload would grow to a cumulative total of nearly 13,000 clients served over the course of the five-year pilot, inclusive of the Year -One cohort of clients. It is estimated that the Year-One cohort will incur a total of $395.8 million in inflation-adjusted costs over five pilot years. The inflation-adjusted annual costs for all 13,000 clients would be $757.1 million over the five-year pilot.

Funding for the Pilot

All individuals experiencing homelessness, ages 65 and older, are included in the target population for the Recovery Plan for People Experiencing Homelessness developed by Los Angeles Housing Services Authority at the Board's direction. County funding for that plan – Coronavirus Relief Funds, Emergency Solutions Grant, and Measure H – could potentially be utilized to launch this pilot in some, or all of the County; however, these funding sources are insufficient to sustain the pilot for five years for the Year-One, cohort or to expand the pilot beyond the Year-One cohort.

The COVID-19 pandemic has delayed the State's pursuit of the California Advancing and Innovating Medi-Cal (CalAIM) program, which was previously identified as a potential source of funding for case management costs and one-time costs, such as housing stabilization and move-in assistance. The State implementation of this new program is delayed until at least January 2022 and should be explored further.

Conclusion

The CEO will await further direction from the Board regarding the potential implementation pilot. Should you have any questions concerning this matter, please contact Phil Ansell, Director of the Homeless Initiative, at (213) 974-1752 or pansell@ceo.lacounty.gov.

FAD:JMN:TJM
PA:JR:RM:tv

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Health Services
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Los Angeles Homeless Services Authority

A ROADMAP FOR PHASED IMPLEMENTATION OF AN OLDER ADULT HOUSING PILOT IN LOS ANGELES COUNTY

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EXECUTIVE SUMMARY

A ROADMAP FOR PHASED IMPLEMENTATION OF AN OLDER ADULT HOUSING PILOT IN LOS ANGELES COUNTY

Responding to Board Action Addressing Homeless Older Adults

This report is responsive to a motion approved by the Los Angeles County Board of Supervisors on April 14, 2020, which directs the Chief Executive Office (CEO) to work with '*all appropriate County departments, and in coordination with City and State officials, to report back in writing within 45 days with an interim report, followed by a multi-year implementation framework as part of Fiscal Year 2020-21 Supplemental Budget deliberations, with cost estimates for a pilot program targeting all individuals experiencing homelessness who are age 65 or older*.'

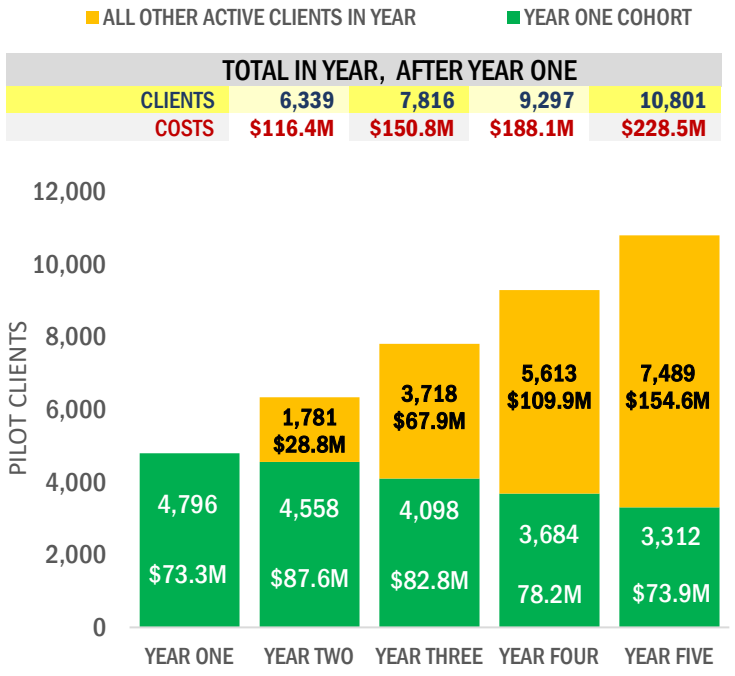
Adjusting to Limitations Imposed by COVID-19

An Increasingly Urgent Problem Collides with the Challenging Realities of a Pandemic. The implementation framework provided here builds on a March 24, 2020 report prepared by the CEO's Office of Homeless Initiative (HI), which provides the basic contours for an Older Adult Housing Pilot that would seek to permanently house all willing homeless adults who are at least 65 years of age. The HI's report, however, represents deliberations and the realities of Los Angeles County's homeless services system prior to the onset of the coronavirus public health emergency.

The implications of the pandemic have unfolded contemporaneously with the development of a pilot implementation approach and created some challenges for the pilot planning process during the past six months, particularly in terms of questions about pilot funding sources. While some details have gradually come into sharper focus over this period, a number of key issues remain unresolved at the present time, and the availability of some previously assumed funding sources has been deferred until Year Two of the pilot, at the earliest.

Within this fluid context, the plan we offer in this report - the projected population for which is shown in Figure 1, along with the costs associated with serving these clients - represents a necessary modification of our initial plan but also reflects the persistence of a basic tension:

FIGURE 1. CLIENTS AND COSTS IN ALL FIVE PILOT YEARS: YEAR-ONE COHORT AND OVERALL TARGET POPULATION



TOTAL IN YEAR, AFTER YEAR ONE				
CLIENTS	6,339	7,816	9,297	10,801
COSTS	$116.4M	$150.8M	$188.1M	$228.5M

YEAR-ONE COHORT % ATTRITION	-5.0	-14.6	-23.2	-30.9
	ESTIMATED FIVE-YEAR TOTAL PILOT COST			
YEAR-ONE COHORT	$395.8M			
ALL PILOT CLIENTS	$757.1M			

While COVID-19 temporarily, but indefinitely, places restrictions on the use of previously-available resources, older adult homelessness is a growing and increasingly expensive problem, one likely to worsen in the absence of a systematic and coordinated intervention. More immediately, the heightened risk of complications and fatality for older adults who become infected with the coronavirus adds to the urgency of moving homeless older adults from the streets to the safety of permanent housing.

A Phased and Temporarily Scaled Down Approach. Despite uncertainties surrounding funding sources for the pilot, resources available through the Coronavirus Aid, Relief, and Economic Security (CARES) Act, including the Emergency Solutions Grant-COVID 19 (ESG-CV), are known and sufficiently understood at the present time. This situation provides the basis for the temporarily scaled-down approach to implementation planning represented in this report; specifically, the plan provided in this report distinguishes a *first phase* of implementation, which encompasses only the Year-One Older Adult Housing Pilot cohort, from a *second phase* in which all older adults experiencing homelessness during the pilot's remaining four years would be housed.

Pilot Cost Estimates. In presenting this phased plan, we present the following *estimated costs associated with serving the Older Adult Housing Pilot's projected Year-One Cohort Target Population,* consisting of 4,796 clients (Figure 1):

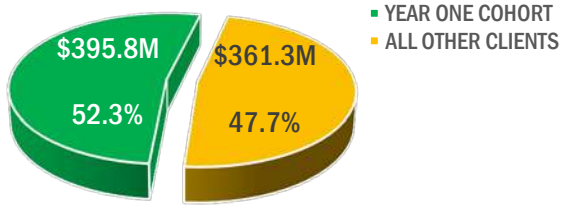
In Year-One of the Pilot: $73.3 million;
Over All Five Years of the Pilot: $395.8 million

- The five-year costs incurred in serving only the first-year cohort would comprise 52.3 percent of the projected five-year total pilot expenditure on all pilot participants: $757.1 million. (Figure 2)

- By the fifth year of the pilot, attrition is expected to have reduced the number of Year-One cohort clients still being served by close to one-third;

- At the same time, we project 10,801 clients to be served in Year Five of the pilot should the second phase be implemented.

Figure 2.
Projected Five-Year Total Expenditure on Older Adult Pilot
$757.1 MILLION*



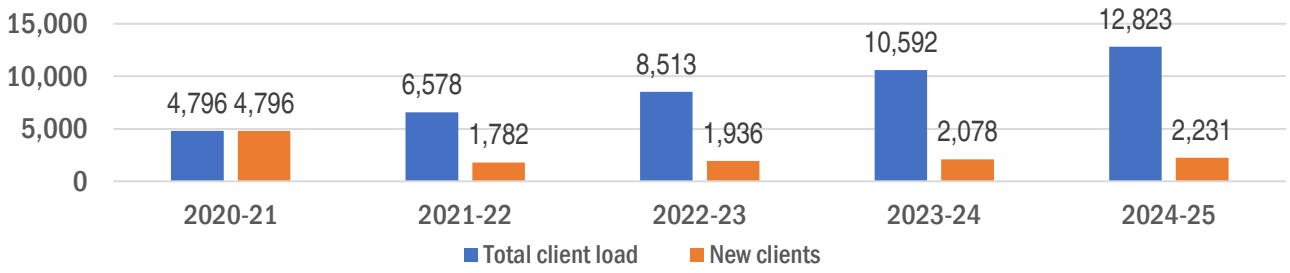
*12,823 older adults are projected to be served through the pilot over five years.

Underlying Homeless Older Adult Population Projections

The Population Basis for Annual Pilot Cost Estimates. As detailed in an interim report the HI submitted to the Board on June 23, 2020, an ongoing rise in homelessness among adults over age 65 results from a long-term pattern of disadvantage within the cohort of persons born between about 1954 and 1962. Even if the number of people over 55 experiencing homelessness were to remain the same over the next several years, the subset of those persons over 65 would increase significantly during the same period, as members of the cohort disproportionately experiencing homelessness grow older.

We project an initial caseload in the pilot's first year of just under 4,800 people, growing to a cumulative total client load of nearly 13,000 clients ever served by the end of the pilot's fifth year. This significant projected growth in aged homelessness is the primary motivating factor for this pilot, to avert a massive increase in elderly homelessness that would occur absent the pilot. The population projections presented here form the basis for our annual and overall pilot cost estimates (Figure 3).

Figure 3. Projected Cumulative Total Older Adults Requiring Housing Assistance Services Over Five Years



Basic Features of the Older Adult Housing Pilot

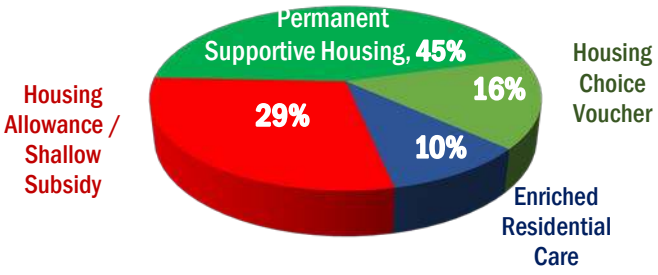
Housing Options and their Expected Distribution Across the Target Population. Program participants will be placed into one of four housing options based on their level of vulnerability. Table 1 shows the projected newly inflowing clients in all five years of the pilot and parses them by the four housing modalities into which these clients are most likely to be placed. Figure 4 shows the proportional distribution of these inflowing clients by modality, which we assume will remain uniform in all five years.

Table 1. Projected New Inflow Clients in All Five Pilot Years, by Housing Modality

	Year One	Year Two	Year Three	Year Four	Year Five
	2020-21	2021-22	2022-23	2023-24	2024-25
New inflow	4,558*	1,782	1,936	2,078	2,231
Enriched Residential Care	475	178	194	208	223
Permanent Supportive Housing	2,033	802	871	935	1,004
Housing allowance/shallow subsidy	1,337	517	561	603	647
Housing Choice Voucher or equivalent	713	285	310	332	357

*Year One new inflow estimates shown here subtract clients projected to exit the program before the end of the first year.

Figure 4.
Distribution of the Pilot's Annual New Client Inflow, by Housing Modality



The pilot will create, and provide to 29 percent of newly inflowing clients each year, a *Housing Allowance*, which is similar but not identical to a shallow subsidy and is therefore given a different name as a modality. The low-acuity segment within the target population, which is projected to comprise slightly more than one in six or 16 percent of inflowing clients in each pilot year, will gain facilitated access to *Housing Choice Vouchers* or an equivalent type of instrument. The most vulnerable decile will receive *Enriched Residential Care.*

Finally, we estimate that 45 percent of new clients in each year will have significant vulnerabilities that nevertheless do not necessitate the service intensity attendant to Enriched Residential Care. This segment of the pilot's overall target population will be offered Permanent Supportive Housing (PSH). The pilot will additionally cover move-in and security deposit costs, and Intensive Case Management Services (ICMS) at two levels of service intensity, depending on client needs and vulnerability levels.

Estimated Pilot Costs from Varied Perspectives

Pilot Costs by Housing Type. Within the pared-down parameters of pilot planning necessitated by COVID-19, the analyses informing the plan presented in this report focus primarily on the 4,796 clients projected to comprise the pilot's Year-One entry cohort. This entry cohort will account for roughly 37 percent of 12,823 clients we project would be served over a program period of five years, should the pilot move to phase two. As previously noted, the entry cohort is expected to account for more than half the estimated five-year pilot expenditures overall. Table 2 shows pilot costs from varied perspectives and parses estimated expenditures by the service modalities/instruments we anticipate will be used to place clients in permanent housing.

TABLE 2. ESTIMATED PILOT COSTS IN YEAR ONE AND OVER FIVE YEARS

	YEAR ONE		YEAR-ONE COHORT OVER FIVE YEARS		ALL PILOT CLIENTS OVER FIVE YEARS	
	CLIENTS	ESTIMATED COSTS	CLIENTS	ESTIMATED COSTS	CLIENTS	ESTIMATED COSTS
All Clients	**4,796**	**$73,327,031**	**4,796**	**$395,816,967**	**12,823**	**$757,132,141**
Enriched Residential Care	499	$11,387,403	499	$79,503,036	1,302	$144,690,308
PSH	2,140	$34,465,503	2,140	$191,813,373	5,752	$363,391,929
Housing Allowance	1,406	$17,898,571	1,406	$77,143,395	3,734	$155,851,958
Housing Choice Voucher	751	$9,575,554	751	$47,356,620	2,035	$93,197,946
Homeless Returns			**1,563**	**$30,401,523**	2,623	$51,606,986
Enriched Residential Care			172	$4,623,876	280	$7,629,767
PSH			762	$15,306,773	1,259	$25,614,756
Housing Allowance			389	$6,870,772	674	$12,117,262
Housing Choice Voucher			240	$3,600,102	410	$6,245,201

Table 2 shows the distribution of the housing modalities attached to the following pilot costs:

- $73.3 million in estimated Year-One Pilot Costs;
- $395.8 million in projected expenditure on the Year-One entry cohort over a *phase one* five-year pilot;
- $757.1 million in expected expenditures on an overall total of 12,823 older adult clients over a *phase two* five-year pilot.

Figure 5.
Distribution of Estimated Five-Year Pilot Cost, by Housing Modality
$757.1M

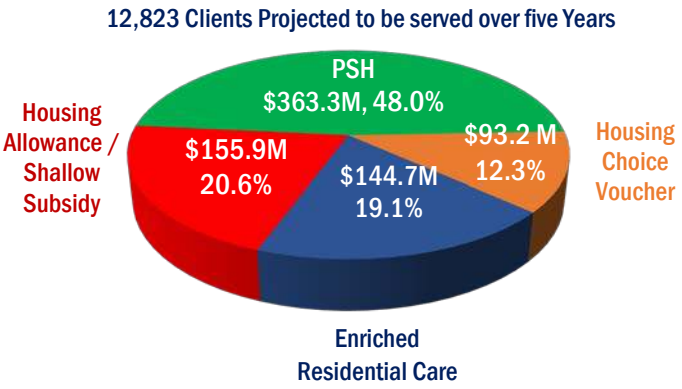


Figure 3 provides the distribution of the full estimated five-year pilot cost by housing modality/instrument. We anticipate close to half this overall cost will be spent on pilot clients placed in Permanent Supportive Housing. Slightly more than one-fifth of the estimated cost will be used to serve low-acuity clients receiving a Housing Allowance, and close to the same share will be used to serve a considerably smaller group of high-vulnerability clients provided with Enriched Residential Care. Finally, 12.3 percent of the full five-year cost is expected to be accounted for by pilot clients receiving a Housing Choice Voucher.

Clients Who Return to Homelessness After Permanent Housing Placements. The cost estimates provided as part of the implementation plan seek to anticipate costs associated with persons who are re-engaged by the pilot after they return to homelessness following an initial permanent housing placement, in which case a new placement will incur new move-in costs. As shown in Table 2, we project roughly one-third of the Year-One entry cohort - accounting for close to 8 percent of expected expenditure on Year-One clients ($30.4 million of $395.8 million) - will experience such returns over the course of a five-year program period. This reflects the implications of an evidence-based assumption that 10 percent of persons housed through the pilot in each year of the program will return to homelessness.

Pilot Funding Sources

Leveraging COVID-19-Related Resources. Initial funding to house the Year-One target population of the Older Adult Housing Pilot will rely on the fact that all members of this target population are also members of the broader client base to be served by the Los Angeles Homeless Services Authority's COVID-19 Recovery Re-Housing Plan. That plan identifies several State and Federal emergency and recovery funding streams that can be leveraged to rehouse adults over age 65 experiencing homelessness. These sources include resources created by the CARES Act (the Coronavirus Relief Fund [CRF], Emergency Solutions Grant-COVID-19 [ESG-CV], and Community Development Block Grant-COVID-19 [CDBG-CV]). There are multiple competing uses for these funds, and multiple jurisdictions involved in their allocation and expenditure.

- Our analysis suggests, however, that sufficient CARES Act resources exist to fund the pilot's net new costs for the Year-One cohort through September 30, 2022, the deadline for ESG-CV expenditures.

Funding Opportunities Beyond Year One. Medi-Cal and Medicare appear to represent the most promising potential sources of long-term pilot funding:

- Over the next few years, the California Advancing and Innovating Medi-Cal (CalAIM) initiative will, subject to federal approval, provide a vehicle for gradual expansion of Medi-Cal coverage for homeless services.

- CalAIM's implementation has been postponed, but, as of September, the State is moving forward with preparation for the next round of Medi-Cal RFPs on the assumption that it will be implemented and is planning to incorporate CalAIM language and instruments into future Medi-Cal Managed Care Plan contracts.

Next Steps

Alignment with the Coordinated Entry System. Any pilot implemented in Los Angeles County must be aligned with, and at least partly integrated into, the County's Coordinated Entry System (CES). The CES prioritizes persons experiencing homelessness for access to housing resources and matches each client to the appropriate resource. This is accomplished through a process consistent with the CES Prioritization Policy and the CES Matching Policy established by the CES Policy Council. An effort seeking to end homelessness for a specific subpopulation can either attempt to prioritize the subpopulation in question above others with similar needs or work to create specialized targeted resources to which the CES would then match appropriate clients. More precedent exists for the latter option, which would therefore likely present fewer legal and administrative hurdles.

Securing Immediate Funding. The proposed pilot was intended to contribute to the Los Angeles County response to Governor Newsom's Executive Order N-23-20 and his presentation of his proposed FY 2020-21 budget. The order directed the Department of Finance to create a State-administered Access to Housing and Services Fund, that would serve as a statewide analogue to the County's Flexible Housing Subsidy Pool but would be able to fund a wider range of interventions and services, including innovative pilots.

While the Governor initially envisioned a one-time $750 million appropriation to create seed money for the Fund, his plan proved not to be viable following the advent of the current economic crisis. However, the Governor's commitment to increasing the State's financial contribution to ending homelessness may bear fruit in later pilot years, assuming revenues recover from the current economic impacts of the COVID-19 pandemic. At the present time, our plan views CARES Act resources as a bridge that, in combination with existing resources, will support Year One and at least a portion of Year Two of the Older Adult Housing Pilot.

Ongoing Advocacy. Discussions with the State about possible State-sponsored funding streams for housing subsidies will be necessary and should begin as soon as possible. We recommend that the County work with LAHSA to convene a stakeholder group to coordinate advocacy efforts and develop strategy to guide negotiations with the State, as well as with MCOs.

Despite Changed Plans, Evidence of Outcomes and Savings Will Remain Essential. An earlier version of our implementation plan envisioned the pilot administered as a five-year Demonstration Project in which the State would authorize the use of Medi-Cal to fund specified components of the program. Under the terms of such an arrangement, client trajectories would be closely monitored and evaluated at regular intervals to determine the extent to which the use of Medi-Cal resources authorized by the State yields improved outcomes and healthcare cost savings. Given a number of economic uncertainties, the basis for such a Demonstration Project is not in place at the present time. The concept could potentially be revisited in the future but is not a feature of the plan presented in this report.

- Regardless of whether the mechanism is a formal, State-sanctioned Demonstration Project or a different process, however, systematic examination of outcomes and cost savings must necessarily be built into the pilot.

Upon expiration of CRF, ESG-CV and CDBG-CV funding, continuation of the pilot will hinge on whether other funding sources can be used to support it. Within this context, evidence of improved outcomes and/or promising healthcare cost curves among the pilot's initial clients will be indispensable in deliberations over how to infuse the pilot with needed *ongoing* funding. Where sources are identified, moreover, their use will likely require a commitment to evidence-based demonstrations of favorable outcomes and savings to be conducted on a routine basis.

Immediately Available Information Sources on Healthcare Costs Are Instructive but Insufficient. The twin ravages of old age and homelessness suggest that a substantial share of the pilot's target population will consist of persons with comparatively expensive healthcare needs. Seizing upon an opportunity to reduce these costs is a key component of the pilot's rationale. Were the pilot to commence immediately, however, the information sources available to Los Angeles County would not be sufficient to reliably evaluate the effects of the pilot on the target population's patterns of healthcare service use and, most importantly from the standpoint of MCOs, the expression of these patterns in longitudinal health costs and obligations.

- Closing the underlying healthcare information gaps in advance of the pilot's implementation will be a critical task, one we recommend the HI work on collaboratively with the County's Office of the Chief Information Officer (OCIO), as well as with LAHSA and other key stakeholders.

Restating the Need. The homeless population over age 65 will continue to grow through 2027, with substantial excess healthcare costs, and its members are highly vulnerable to significant complications should they be infected with COVID-19, as well as to the ill health effects of homelessness generally. The cost of foregoing any organized intervention would be substantial, in both human and economic terms. The phased Homeless Older Adult Housing Pilot implementation plan provided in this report reflects the best guidance we can offer given the uncertainty with respect to funding sources, and the competing demands on scarce housing resources by a variety of highly vulnerable populations.

A crucial next step will be the formation of a coalition of groups with expertise in housing, healthcare regulations, local public administration, State legislation and policy advocacy. The coalition should include and build upon existing collaboratives, including the Los Angeles Aging Advocacy Coalition (LAAAC), Funders Together to End Homelessness, the County's Homeless Older Adult Working Group, the participants in the October 2019 Los Angeles Homeless Health Summit, and others. It must also include leaders from LAHSA and the County who would assume leadership roles in implementing the pilot once funding is secured.

A ROADMAP FOR PHASED IMPLEMENTATION OF AN OLDER ADULT HOUSING PILOT IN LOS ANGELES COUNTY

September 2020

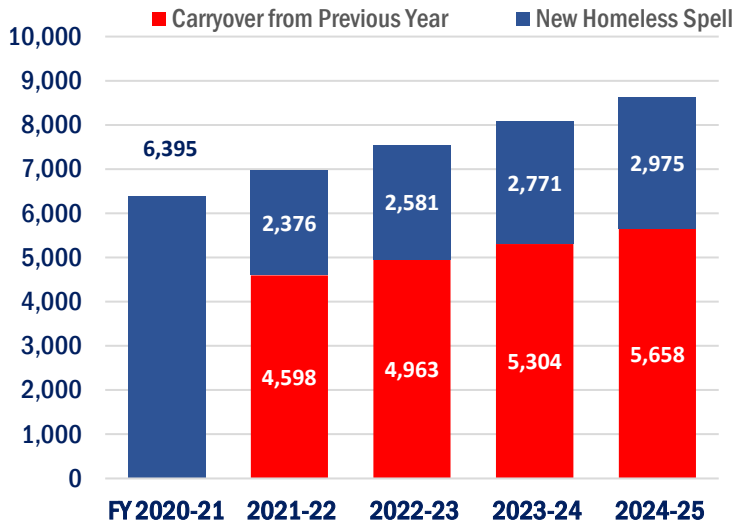
1. INTRODUCTION

1.1. Background and Context

1.1.1. A Response to Board Action Addressing an Aging Homeless Population. This report is responsive to a motion approved by the Los Angeles County Board of Supervisors on April 14, 2020, which directs the Chief Executive Office (CEO) to work with '*all appropriate County departments, and in coordination with City and State officials, to Report back in writing within 45 days with an interim report, followed by a multi-year implementation framework as part of Fiscal Year [2020-2021] Supplemental Budget deliberations, with cost estimates for a pilot program targeting all individuals experiencing homelessness who are [age] 65 or older.*'

1.1.2. The Vision Informing the Plan Presented in this Report. The implementation framework provided here builds on a March 24, 2020, report prepared by the CEO's Office of the Homeless Initiative (HI) in response to a January 21, 2020, Board motion, which requested a proposal for a pilot program that would seek to *'ensure shelter or housing for those ready to receive such services.'* Pointing to research showing the 'greying' of the County's homeless population, as illustrated in Figure 1A, the HI's report back to the Board proposed and described the basic contours for a program that would focus on permanently housing homeless adults aged 65 and over.

Figure 1A. Projected Number of Older Adults Who Would Experience Homelessness in Each of the Next Five Years, Absent New Interventions



	FY 2020-21	2021-22	2022-23	2023-24	2024-25
Total	6,395	6,974	7,544	8,075	8,633

1.1.3. Adjusting a Pre-COVID-19 Concept to the Conditions Imposed by the Pandemic. The HI's March 24, 2020, overview of the Older Adult Housing Pilot was released shortly after the onset of the COVID-19 pandemic and therefore reflects deliberations and the realities of Los Angeles County's homeless services system prior to the public health emergency. This disjunction introduces a challenging balancing act into the pilot planning process. On the one hand, COVID-19 temporarily but indefinitely places restrictions on the use of previously available resources due to public health considerations and the economic and fiscal impact of the pandemic. On the other hand, the heightened risk of complications and fatality among older adults increases the urgency of moving homeless older adults into permanent housing. Closely intertwined with this tension, the County's commitment to housing high-vulnerability homeless persons sheltered in connection with Project Roomkey adds further complexity that must be accounted for in implementing the pilot.

Section 2 of this report provides a more detailed discussion of the implications of COVID-19 for the pilot. As the Board notes in its April 14, 2020, motion, the goals of the pilot are well aligned with the County's overall COVID-19 response strategy, which seeks to use pandemic-specific strategies as a springboard to create long-term, sustainable solutions for COVID-19–vulnerable people experiencing homelessness. Despite this alignment, however, the resources available to serve Los Angeles's homeless population remain finite, and the economic uncertainty caused by the pandemic imposes difficulties on efforts to engage in long-term budgetary planning. Programs that could provide a framework for long-term funding, such as California Advancing and Innovating Medi-Cal (CalAIM), have been postponed, and the State leadership needed to support the proposed pilot is understandably preoccupied with coordinating the State's COVID-19 response.

Limitations imposed by the pandemic necessitate scaling down the scope of the implementation plan we initially intended to submit, which would not only have provided annual and overall cost estimates, itemized by service modalities and client vulnerability groupings within the pilot's target population, but would also have tied pilot costs to potential funding sources. Pursuit of the latter in particular – i.e., the assignment of projected expenditures to funding sources for all five years of the pilot – becomes an increasingly speculative task given the import of several critical questions for which definitive answers are not yet available. In consultation with the HI, therefore, we concluded that a more gradual implementation plan on a less aggressive timeline would be the wisest and most useful approach at this time, one that includes a discussion of a range of funding options that may be available to support the pilot but does not assign specific costs to sources that have yet to solidify.

1.2. The Purpose and Contents of this Report

1.2.1. The Reworked Implementation Plan: A More Gradual and Phased Approach. Despite uncertainties surrounding funding sources for the pilot, resources available through the Coronavirus Aid, Relief, and Economic Security (CARES) Act, including the Emergency Solutions Grant-COVID 19 (ESG-CV), are known and sufficiently understood at the present time. This situation provides the basis for the temporarily scaled down approach to implementation planning represented in this report. Specifically, we provide a plan for the *first phase* of implementation, which encompasses only the Year-One cohort of the Older Adult Housing Pilot. In doing so, we seize upon historic opportunities both to show the costs associated with serving the pilot's projected Year-One target population in all five years of the pilot *and* additionally to provide topline annual cost estimates for full pilot target populations in each of the pilot's five years, but we stop short of identifying the sources that will absorb these costs for all but the Year-One cohort (Table 1A).

Two key assumptions are worth noting here: (1) A plan or series of plans for subsequent phases of implementation can be prepared once outstanding questions about funding sources are resolved; and (2) the core objective articulated in the March 24, 2020, Board report – i.e., to permanently house all willing older adults – may necessarily be pursued through a more graduated approach than was initially envisioned but will not be abandoned as the pilot's overarching goal.

1.2.2. Orientation Towards Previous Reports. The HI has provided two previous responses to the Board's April 14, 2020, motion. The first set forth a strategy for housing older adults served through Project Roomkey, and the second provided a cost estimate for Year-One of the older adult pilot. Producing this cost estimate necessitated projecting the size and makeup of the homeless older adult population in

FY 2020-21.[1] The implementation plan presented here builds on these two reports (released on May 19, 2020, and June 23, 2020, respectively) and applies adjustments to compensate for limitations imposed by the pandemic at various levels. Funding source assumptions applied, and scenarios entertained, in the June 23, 2020, report in particular are not operative in this report for the reasons described above.

Table 1A: CLIENTS AND COSTS IN ALL FIVE PILOT YEARS: YEAR- ONE COHORT AND OVERALL TARGET POPULATION

PILOT YEAR	Year One	Year Two	Year Three	Year Four	Year Five
FISCAL YEAR	2020-21	2021-22	2022-23	2023-24	2024-25
YEAR-ONE TARGET POPULATION	4,796	4,558	4,098	3,684	3,312
Costs	$73,327,030	$87,561,982	$82,804,602	$78,242,194	$73,881,098,
Costs Per Person: Year One Cohort	$15,289	$19,211	$20,226	$21,238	$ 23,307
All ACTIVE CLIENTS		6,339	7,816	9,297	10,801
Costs		$116,395,833	$150,807,733	$188,063,441	$228,538,103
Costs Per Person: Full Client Population		$18,362	$19,295	$20,228	$21,159
YEAR-ONE COHORT COSTS AS % OF ALL ACTIVE		75.2	54.9	41.6	32.3
				FIVE YEAR TOTAL COST	
YEAR-ONE COHORT				$395,816,966	
ALL PILOT CLIENTS				$757,132,141	

*Annual costs are prospectively adjusted for expected inflation

1.2.3. Specifying the Main Features of the Pilot. As described in the previous reports prepared in response to the April 14, 2020, Board motion, the pilot will create a *Housing Allowance*, a term we deploy to distinguish the instrument from different but related instruments categorized as *shallow subsidies.* Additionally, the low-acuity segment within the target population will gain facilitated access to Housing Choice Vouchers.

The most vulnerable decile within the target population will receive *Enriched Residential Care*, while those in the target population with significant vulnerabilities that nevertheless do not necessitate the service intensity attendant to Enriched Residential Care will be offered Permanent Supportive Housing (PSH). The annual pilot cost estimates include one-time move-in costs, as well as higher- or lower-intensity case management services depending on vulnerabilities and acuity levels.

1.2.4. Estimated Annual Pilot Costs and Year-One Funding Sources. As shown in Table 1A, we estimate pilot costs associated with the Year-One cohort in the amount of $395.8 million over the five pilot years. We project, moreover, that five-year pilot spending on the Year-One cohort will comprise 52.3 percent of an estimated $757.1 million in five-year pilot expenditures overall.

The Year-One cohort consists of 4,796 older adults and we estimate 12-month, Year-One pilot gross costs of $73.3 million[2]. By the start of Year Five (FY 2024-25), attrition over the first four years of the pilot can

[1] Culhane, Dennis *et al. Older Adults Sheltered Under Project Roomkey*: A 30-Day Report Back on a Motion Approved by the Los Angeles County Board of Supervisors on April 14, 2020. May 15, 2020, and *What It Will Cost to House Homeless Older Adults:* A 45-Day Report Back on a Motion Approved by the Los Angeles County Board of Supervisors on April 14, 2020. June 23, 2020.

[2] In the June 23 interim report, we estimated this Year-One cost to be $100.5 million. The estimate is less now for two reasons: First, the interim report posited a hyper-intensive effort to house all clients immediately, resulting in clients being housed for almost all of FY 2020-21. The current estimate assumes that clients will be moving into housing throughout the fiscal year, so housing costs are reduced. Second, as explained in Section 3, we now incorporate a greater variety (and therefore a greater number) of program exits into our projections, rather than treating death as the only exit pathway.

be expected to reduce the Year-One cohort by roughly 30 percent to 3,312 older adult clients, and inflation-adjusted expenditures on the remaining Year-One cohort are projected to total $73.8 million in that year. By comparison with 4,796 active clients in Year One, the pilot is projected to serve a population that is 125 percent larger in Year Five, 10,801 active clients overall, inclusive of the remaining Year-One cohort, and we estimate $228.5 million in FY 2024-25 pilot expenditure on these older adults.

1.2.5. Avoiding Net New Costs and Demonstrating Cost Savings. The COVID-19 economy significantly restricts the County's capacity to assume new costs for the purpose of launching the Older Adult Housing Pilot. An earlier version of a pilot implementation plan proposed minimizing new County expenditures in implementing the pilot through a State-sanctioned Demonstration Project that would authorize the use of Medi-Cal to cover the target population's one-time move-in costs in order to gauge the degree to which this arrangement yields medical cost savings associated with the placement of otherwise homeless older adults into permanent housing. Within the parameters of the same arrangement, the plan suggested that the target population's case management needs should be included in medical case management entitlements attached to Medi-Cal and Medicare, and suggested the County work with the State in testing this assertion.

While a collaborative effort of this kind would be consistent with the State's openness to forming strategic partnerships with counties for the purpose of attacking California's homelessness crisis, it has since become clear that the State's emergency response to the pandemic effectively closes off the initiation of a Medi-Cal and Medicare cost savings Demonstration Project, at least until sometime during Year Two of the Pilot. The present, scaled-down version of our plan assumes that pilot implementation in Year One will be funded by a combination of ESG-CV and other CARES Act funds, as well as existing County resources.

The delay in the start of a Demonstration Project is to the County's advantage. The use of Medi-Cal and Medicare for the pilot is by no means guaranteed, and the added time will enable the County to examine these possibilities, explore alternative funding sources, strengthen necessary relationships with Managed Care Organizations (MCOs) and community clinics, and determine whether a formal California Demonstration Project in fact represents the most appropriate mechanism for systematically measuring medical cost savings associated with the pilot. Obtaining clarity on these issues and answers to the questions they raise is a precondition for any partnership the County might propose to the State in connection with the pilot.

1.2.6. A More General Discussion of Funding Sources. Long-term funding for the Older Adult Housing Pilot must negotiate two facts of the existing system. First, the funds currently available through Medi-Cal to pay for homeless services, by design, have stringent eligibility requirements attached to them. They target only the most expensive homeless beneficiaries in order to ensure compliance with cost neutrality provisions of State and Federal law. Second, as the Whole Person Care pilot sunsets, its temporary creation of a pathway for Medi-Cal funds to reach homeless services providers through County governmental agencies will also sunset. Moving forward, the County's MCOs will be the primary, if not the only, conduit for Medi-Cal funds to reach providers. Thus, plans for future Medi-Cal funding must involve working closely with Los Angeles' two MCOs to plan and advocate for specific funding mechanisms, as well as exploring avenues for expanding the pool of beneficiaries who are eligible for Medi-Cal-funded case management and housing navigation services.

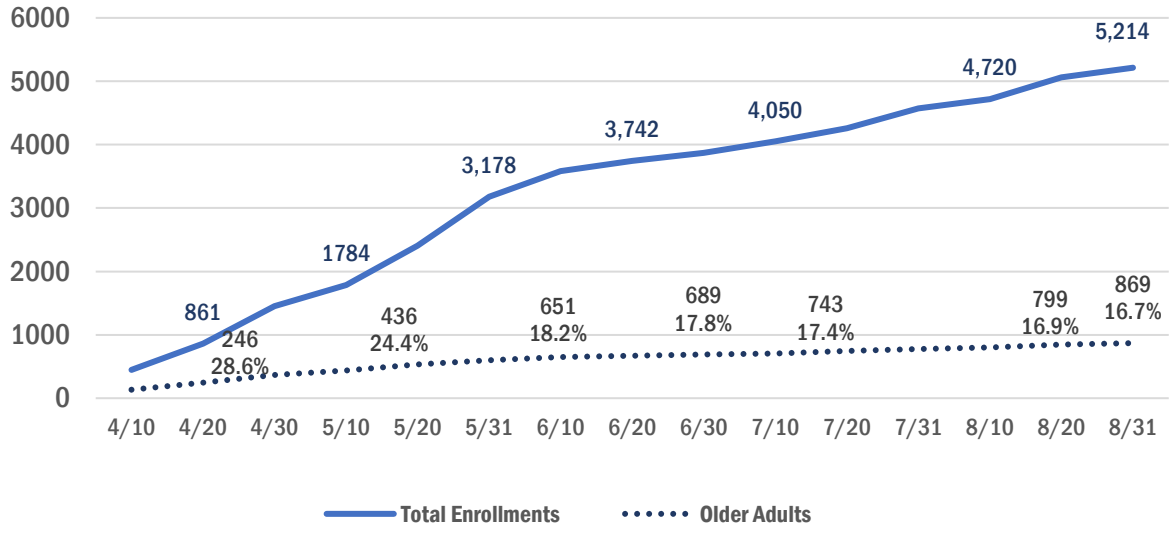
At the same time, the State is already moving in the direction of innovating Medi-Cal's use to pay for homeless case management and other services that address the social determinants of health. CalAIM, when implemented, will include multiple programs that could provide platforms for expanded homeless services for older adults, including In Lieu of Services, Managed Long-Term Services and Supports, and Dual Eligible Special Needs Plans. These programs will create a baseline structure and framework within which MCOs will be able to expand coverage for homeless services, to the extent they deem feasible. The programs thus form a promising jumping-off point to discuss funding for the pilot, not only after CalAIM is implemented, but even sooner as a way to test out assumptions about how to conduct its implementation.

2. THE IMPLICATIONS OF COVID-19 FOR PILOT IMPLEMENTATION AND PLANNING

2.1. Public-Health-Related Challenges and Considerations

2.1.1. Project Roomkey. With the onset of the Coronavirus Pandemic, Los Angeles County's homeless crisis presents new policy challenges. The unsheltered homeless population faces outsized risk of infection, and those contracting the virus have the potential to become broad transmitters of the disease. While all those in the unsheltered segment of the homeless population contracting COVID-19 are in danger of serious health consequences, the most vulnerable among the unsheltered—persons with underlying health issues, as well as older homeless adults in general—face a comparatively high risk of complications. At the same time, those staying in congregate shelters, where providers frequently seek to maximize bed counts, are at risk of contracting and transmitting the coronavirus.

Figure 2A. Cumulative Project Roomkey Enrollments
March to August 2020
Percentages are Relative to Total Enrollments



In March 2020, Los Angeles County worked in collaboration with LAHSA and the State to launch Project Roomkey, which to date has moved nearly 5,000 people experiencing homelessness off the streets and out of congregate shelters into private hotel and motel rooms where they can shelter safely. Project Roomkey is committed to moving its clients to long-term housing solutions and not returning any client who wishes to remain sheltered to unsheltered homelessness. Temporary modifications have been made

to the Los Angeles Coordinated Entry System Prioritization Policy to ensure that COVID-19–vulnerable persons, including Project Roomkey clients, are prioritized appropriately for housing resources.

As of August 31, 2020, 805 (18 percent) of the 4,586 persons ever enrolled in Project Roomkey were older adults. These clients represent what would be roughly 17 percent of the Older Adult Housing Pilot's projected Year-One enrollment had implementation of the pilot commenced in the first quarter of FY 2020-21. More importantly, Project Roomkey has, of necessity, innovated new service models and housing pathways in order to serve a large group of clients under emergency circumstances. The program can therefore function not only as a platform to serve a portion of the pilot's target population, but also as an exemplar of service coordination and delivery for this population, and a crucial source of information to help pilot staff anticipate their clients' likely needs.

2.1.2. The Shift to a Singular Focus on Permanent Housing Placements. One necessary but atypical aspect of Project Roomkey is its provision of emergency shelter on a one-client- or one-couple-per-room basis. Social distancing requirements imposed during COVID-19 have compelled interim housing providers to significantly decompress occupancy levels. Capacity at the Union Rescue Mission shelter, for example, has been reduced by 40-45 percent since the onset of the pandemic due to decompression guidelines.[3] Most importantly from the standpoint of pilot planning, health and safety regulations imposed in response to the pandemic place restrictions on older adult stays at congregate facilities, decompression notwithstanding, due to the heightened risk of complications should they become infected with the coronavirus.

2.1.3. Demand and Supply. The lack of sufficient permanent housing supply to meet demand has been an ongoing challenge facing the County's coordinated approach to the homeless crisis since the electorate's approval of Measure H in 2017. New PSH facilities developed with Proposition HHH resources are scheduled to begin coming online in the City of Los Angeles in FY 2020-21 and beyond, while supply will be available through the County's Affordable Housing Trust and the "No Place Like Home" program, though COVID-19 could complicate the various timetables. Housing vouchers remain in finite supply as well. As of September 2020, the Housing Authority of the City of Los Angeles (the largest source of vouchers in Los Angeles County) reports housing almost 19,000 homeless households with a supply of 20,283 total vouchers available to such households, indicating that just over one thousand are available or in the process of leasing up. Assuming the reduced capacity at which interim housing providers are required to operate compels a subset of persons who would otherwise be interim housing clients to alternatively seek permanent housing, then reduced shelter capacity will be among the factors that test whether new facilities appreciably improve the system's capacity to meet permanent housing demand.

We revised an earlier version of our implementation plan with the assumption that demand for permanent housing will continue to outstrip supply indefinitely. We project placement of new pilot inflow into housing will be evenly distributed over a 12-month year, i.e., that one-twelfth of the total inflow in each pilot year will be placed with each new month. This projection is most impactful in Year One insofar as Year One's client load consists entirely of new inflow. Given a Year-One target population of 4,796 older adults, our projection implies 400 pilot placements per month, as compared to Year Two, when the new inflow decreases to 1,782, where the assumption of monthly placements parsed into twelfths

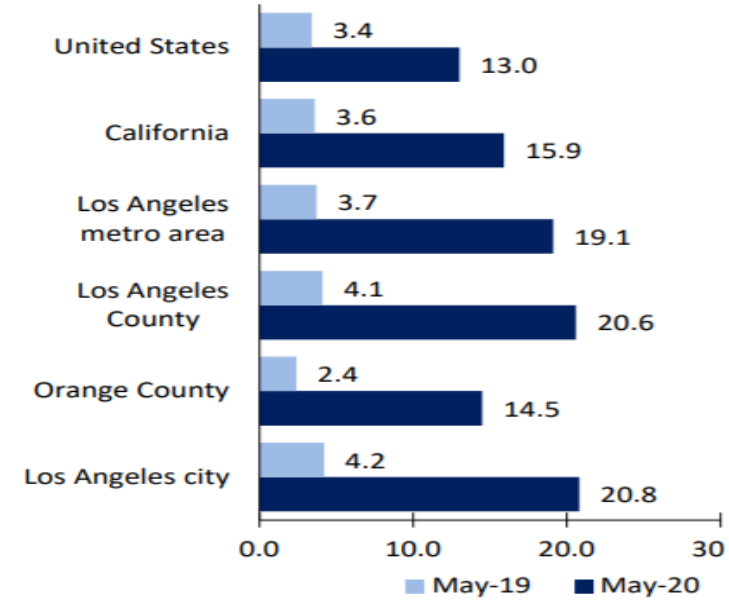
[3] *'Biggest challenge we've faced in 128-year history': Union Rescue Mission reopens under new restrictions since shelter's COVID-19 outbreak*. ABC7 Eyewitness News interview with CEO Rev. Andy Bales. Available at: https://abc7.com/homeless-community-covid-19-los-angeles-union-rescue-mission-urm-reopen/6196593/.

translates to roughly 150 placements per month over the year, not including a moderate number of additional placements due to homeless returns during the year.

The assumption that housing placements—and, by extension, inflow—will be spread evenly over each year of the pilot is intended both to account for and to soften difficulties encountered in the face of a likely permanent housing supply shortfall, but pilot planning should build in an expectation that tight supply will be a constant challenge for which those working to place the target population must be prepared. Evidence does suggest that the current economy has made some landlords more amenable to accepting rental subsidies and, in this respect, has expanded supply, so those working to place the target population should be ready to seize upon opportunities for facilitated permanent housing placements to capitalize on this willingness.

2.1.4. Project Roomkey and Housing Placement Prioritization. The County's commitment to prioritize persons served through Project Roomkey due to their health risks, acuity and vulnerability presents an additional demand pressure and a challenge for the pilot planning process. Since, as current evidence indicates, roughly 18 percent of the Project Roomkey client population overlaps with the pilot's target population, these prospective pilot participants will be put on an expedited path to permanent housing placement. At the same time, however, the remaining 82 percent of the Project Roomkey client population will not be on the same expedited path, and this is likely to put pressure on the permanent housing supply available for non-Roomkey homeless older adults.

Figure 2B. Unemployment Rates, May 2019 vs. May 2020



Source: U.S. BLS, Local Area Unemployment Statistics.

2.2. Economic and Fiscal Challenges

2.2.1. From Public Health Emergency to Fiscal Crisis. The economic impact of COVID-19 can be characterized as a massive national dislocation and, as the comparative unemployment rates shown in Figure 2B attest, its effects are felt especially within Los Angeles County's economy and the regional economies of the Greater Los Angeles Metro Area. The implementation process must recognize the challenges these realities will impose in the near and intermediate terms, and the pilot must be sufficiently resourceful to make progress despite such constraints.

2.2.2. Los Angeles County's FY 2020-21 Budget. Despite the substantial reduction in sales, property, and income tax revenues resulting from the cessation of commercial activity across broad sectors of the economy, Los Angeles County delivered a balanced FY 2020-21 budget in June 2020. This was accomplished through the imposition of significant curtailments across all departments and programs, but these curtailments were applied with an expectation that relief would be forthcoming and permit a portion of the cuts to be reinstated in the supplemental budget process in September 2020. While this

expectation was borne out in July 2020 with the Board's approval of a $1.2 Billion spending plan in connection with CARES Act relief funds, the County's operations will nevertheless occur within a considerably more restrictive fiscal environment into the foreseeable future.

2.2.3. Homeless Services, Measure H and the Older Adult Housing Pilot. The economic and fiscal impacts of the pandemic on the homeless services system, Measure H revenues, and the implementation of the Older Adult pilot are not completely unknown, though many questions cannot be answered at the present time since the duration of the pandemic itself and the depth of its aftereffects can only be speculated. Homeless services typically included in the budgets of the Departments of Health Services (DHS), Mental Health (DMH), and Public Social Services (DPSS) are funded with varied combinations of Net County Cost (NCC) dollars from the County's General Fund and revenues received from non-County sources. Where such services were affected by initial budgetary curtailments, they will be buoyed to varying degrees by Federal and State COVID-19 relief funds. These funds are time-limited, however, and fiscal conditions beyond their expirations cannot be fully projected at the present time.

Measure H revenues, which fund services connected to select HI strategies, are driven by a quarter-cent sales tax and, as such, are especially vulnerable to the ravages of the COVID economy. It is projected that the FY 2020-21 Measure H revenue shortfall will be $67 million. Projecting the Measure H resources that will be available in FY 2020-21, both in general and specifically for services targeted to older adults, is particularly speculative given the economic uncertainties that lie ahead, but all service providers and program managers with a stake in these resources recognize that COVID-19 relief funding will be an invaluable source of assistance but is not an alternative to Measure H resources sufficient to retain present levels of service provision indefinitely.

This report seeks to find an optimal balance in recognizing, at once, the public health challenges and fiscal limitations presented by the pandemic, and the urgency of removing homeless older adults from exposure to potentially deadly infection and the heighted health dangers living on the streets presents for them more generally. To achieve such an acceptable balance, we scale back a previously contemplated plan that was more aggressive in projections of the time the target population would spend in permanent housing during Year One, while nevertheless retaining the goal of housing the full Year-One target population in the course of the initial 12 months of the pilot.

As noted previously, moreover, we assume that all costs not absorbed by existing County resources during the first year of the pilot will be underwritten by State and Federal COVID-19 funding. Given the uncertainties surrounding funding sources and the economic and fiscal environment beyond Year One of the pilot, we provide gross cost estimates for Years Two through Five of the pilot, but we do not attach the components of these costs to funding sources, opting instead for a separate and more exploratory section on funding sources that does not directly assign them to annual pilot budget line items.

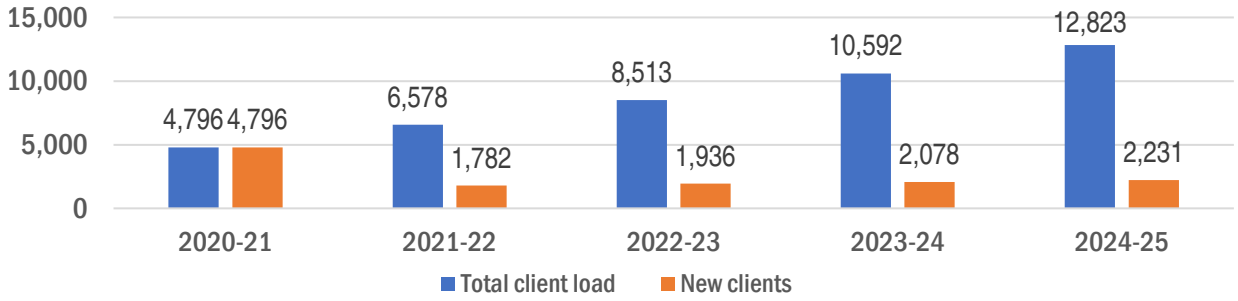
3. PROJECTING THE HOMELESS OLDER ADULT POPULATION IN EACH OF THE FIVE PILOT YEARS

3.1. Projecting the Full Five-Year Target Population

3.1.1. A Sustained, 30-year Cohort Effect Drives the Increase in Older Adult Homelessness. As detailed in the HI's June 23, 2020, interim report, the ongoing rise in homelessness among adults over 65 results from a long-term pattern of disadvantage within the cohort of persons born between about 1954 and 1962. Even if the number of people over 55 experiencing homelessness were to remain the same over the next several years, the subset of those persons over age 65 would increase significantly during the same period

as members of the cohort disproportionately experiencing homelessness grow older. Thus, the interim report projected an initial caseload in the pilot's Year One of about 4,800 people, growing over the first five years to a cumulative total of nearly 13,000 clients ever served (see Figure 3A) .[4] (This significant projected growth in aged homelessness is the primary motivating factor for this pilot, to avert a massive increase in elderly homelessness that would occur absent the pilot.)

Figure 3A. Projected Cumulative Total Older Adults Requiring Homeless Services Over Five Years



3.2. Projecting the Active Caseload in Each Year of the Program

3.2.1. Following the Year-One Cohort. As indicated in Section 1.2.1, the economic and institutional landscape engendered by the Coronavirus Pandemic requires us to distinguish between a *phase one* plan to house only members of the Year-One cohort over five years and a *phase two* plan to meet the needs of other pilot year cohorts should funding be identified. In Section 3.2.3, we project the total potential caseload of a fully funded five-year pilot. In Section 3.2.2, we project the annual caseload of only those clients projected to enter the program in its first year.

3.2.2. Annual Attrition and Program Transfers. The Year-One cohort of the Older Adult Housing Pilot is projected to comprise 4,796 people. This cohort will shrink in each subsequent year as clients exit the program. Some will pass away, while others will find permanent housing placements outside of the program, transfer to skilled nursing facilities or other higher levels of care, or exit to institutions including jails and long-term hospital stays. By the end of Year Five, only an estimated 2,975 clients (62 percent of the cohort) will remain active in the program. Figure 3B shows the anticipated caseload, over five years, of the cohort expected to enter the program in Year One.

3.2.3. Projecting the Full Potential Caseload. Figure 3A provides an estimate of the total number of clients who would be served under a fully funded five-year pilot. As is the case with the Year-One cohort, however, attrition and program transfers must be factored into our year-by-year estimates to determine the pilot's potential annual caseload. For the full pilot, expected inflow of new clients and those clients' subsequent trajectories must also be quantified.

In each year after the first, then, should it be fully funded, the Older Adult Housing Pilot's clients will fall into one of four categories: 1) housed in previous years and housed continuously during the current year; 2) newly homeless and/or newly 65 years old; 3) housed in the previous pilot year but returned to

[4] See Section IV of the interim report for further details. As discussed in that section, the figure of 12,823 older adults projected to require homeless services over the five years of the pilot does not include an additional 4,274 individuals who are projected to experience brief spells of homelessness and to find housing on their own without interacting with the homeless services system.

homelessness during the current year; or 4) permanently exited, including those exited due to death and those exited to unsubsidized housing or institutional settings.[5]

Figure 3B: Projected Year One Pilot Cohort Annual Caseload

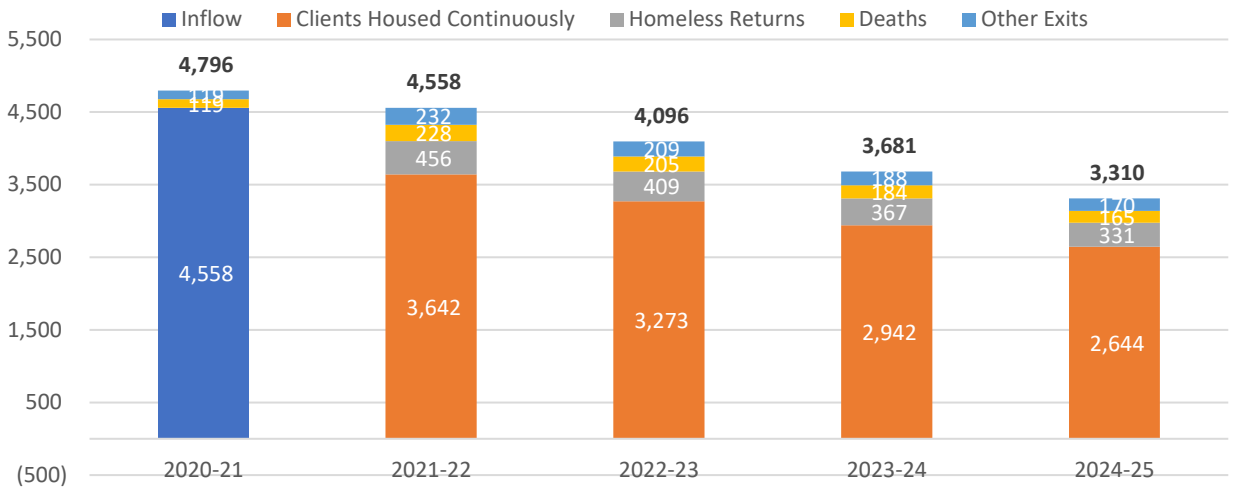
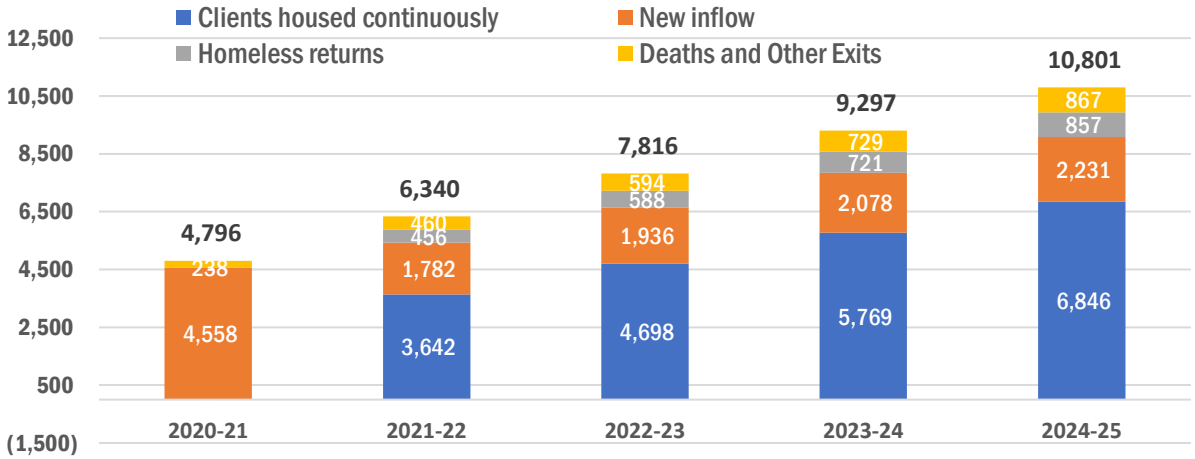


Figure 3C shows the projected distribution of program clients among these four categories in each of the first five years of the program. Housed clients will require case management and housing retention services, as well as full or partial housing subsidies, for all 12 months of the year. Unhoused clients will require housing navigation and housing stabilization case management services for part of the year (including move-in fees), as well as tenancy support services and housing subsidies once they move into housing. Clients who exit the program during the year will require services and subsidies for the portion of the year during which they are enrolled.

Figure 3C: Projected Older Adult Pilot Annual Caseload



[5] For resource-planning purposes, we assume that all clients who enter or return to homelessness in a given fiscal year will be (re)housed during the same fiscal year. We similarly assume that requisite program transfers take place between fiscal years. Thus, all clients who do not exit the program in a given year are assumed to be housed at the beginning of the following year in the resource best suited to meet their needs during that year. In practice, there will be much greater variation in client trajectories.

4. PROGRAMMTIC COMPONENTS OF THE OLDER ADULT HOUSING PILOT

4.1. Innovative Features

4.1.1. A Supplement to the Existing System. Los Angeles County has forged an effective and well-aligned homelessness assistance system, founded upon the comprehensive set of strategies funded by Measure H, including the Coordinated Entry System (CES). As a result, the County has successfully housed thousands of people experiencing homelessness in the past few years. However, a long-term housing affordability crisis in California has caused an even greater inflow of newly homeless individuals to offset the gains the County has made in connecting clients with stable, permanent housing.

The current pandemic and economic crisis have already exacerbated this imbalance, and their effects will continue to be felt in the coming years. Moreover, in the specific context of older adult homelessness, the cohort effect discussed in Section 3 will also cause a significant increase in the homeless subpopulation of interest, even beyond the increases observed in the population as a whole. For all these reasons, a supplement to the existing system is both timely and necessary, and the Older Adult Housing Pilot will complement existing programs rather than simply replace or improve them.

4.1.2. Broader Options for Lower Acuity. The HI's March 24, 2020, report back to the Board specifies that under the proposed pilot, '*Each older adult would receive the following assistance, as needed: (1) one-time move-in costs; (2) case management or intensive case management services (ICMS); and (3) either a standard rental subsidy, shallow subsidy, or an enriched residential care subsidy.*' In other words, there would be assistance for everyone that matched their particular needs. This expansion of available resources to cover all homeless older adults, including those lower-acuity individuals who do not usually receive permanent supports in the existing system, represents the primary innovation of the pilot.

This innovation is necessary to ensure that older adult homelessness can be eliminated and not merely reduced. In particular, the pilot proposed in the June 23, 2020, interim report and modified here includes the Housing Allowance subsidy, an indefinite partial subsidy meant to secure stable, permanent housing for low-to-mid-acuity consumers unlikely to qualify for or fit well with permanent supportive housing or to obtain a comparatively scarce Housing Choice Voucher. Similarly, the pilot will provide flexible case management services to all homeless older adults who need them at the intensity most appropriate for each individual's needs.

The pilot's ability to adequately address the needs of clients at all acuity levels is dependent upon another component described in the March 24, 2020, report back: leveraging of mainstream systems. In particular, because nearly all older adults experiencing homelessness will be eligible for Social Security or Supplemental Security Income (SSI), they will have a guaranteed income that can serve as a foundation for housing stability that the Housing Allowance subsidy can augment.[6] Leveraging SSI for all eligible participants is thus a necessary component of the program, and all case managers will need to be trained benefits navigators and advocates. Because of an exemption for State and local government supplements under an SSI regulatory provision called "assistance based on need," clients' SSI eligibility and payment levels should not be affected by the new Housing Allowance, so long as it is paid directly to landlords and not to beneficiaries.

[6] Supplemental Security Income, while administered by the Social Security Administration, is funded by general tax revenues, not by Social Security taxes, and is thus available to all eligible recipients. Designed to help aged, blind, and disabled persons who have little or no income, the program provides cash assistance to meet basic needs for food, clothing and shelter.

4.2. Coordination

4.2.1. A Coordinated Housing Intervention. As stated in the March 24, 2020, and June 23, 2020, Board reports, the pilot will require a coordinated approach in the domains of prevention, outreach, assessment, benefits connection, care coordination, housing navigation, Recovery Re-Housing, permanent housing with services, and housing placement retention, as well as coordinating across the homeless services and aging services systems.[7]

To realize the March 24, 2020, report's vision of a fully coordinated intervention, direct pathways from homelessness to housing navigation would need to be forged, such that engaged target population clients would be routed directly into housing stabilization case management as smoothly as possible and could be connected with stable housing as quickly as possible. Given the proposed use of Medi-Cal funding for housing stabilization case management, behavioral health and aging services providers with Medi-Cal licensure and billing capacity will need to be enlisted to support staffing for the effort, including through contractual relationships with homeless service providers.

4.3. Pilot Interventions

4.3.1. The Pilot's Core Interventions. As discussed in Section 4.1.2, all older adults who present themselves to or become known to the housing pilot will receive resources. The resources clients are most likely to require are tentatively projected based on estimates of the distribution of the pilot's clients among four acuity groups and seven sub-tiers within those groups. Flexibility must be built into the pilot, allowing each client to be matched to the resources most appropriate to their needs.

Table 4A. Projected Acuity Groupings and Tiers of New Inflow, by Program Year

	5-YR TOTAL		By Year	YR 1	YR 2	YR 3	YR 4	YR 5
TARGET	17,098		TARGET	6,395	2,376	2,581	2,771	2,975
Self-Resolvers	4,275		Self-Resolvers	1,599	594	645	693	744
	#	% *N*		CLIENTS, GROUPS AND TIERS				
Net Target *N*=	12,823	100	Net Target	4,796	1,782	1,936	2,078	2,231
Group 1	3,197	25.0	INTERVENTION	1,191	445	484	520	557
Tier 1	512	4.0	ERC	192	71	77	83	89
Tier 2	2,685	21.0	PSH	999	374	407	437	468
Group 2	5,144	40.0		1,933	713	774	831	893
Tier 1	790	6.0	ERC	307	107	117	125	134
Tier 2	3,067	24.0	PSH	1,141	428	464	498	536
Tier 3	1,287	10.0	Allowance	485	178	193	208	223
Group 3	3,719	29.0		1,390	517	562	603	647
Tier 1	2,447	19.0	Allowance	921	339	368	395	424
Tier 2	1,272	10.0	Voucher	469	178	194	208	223
Group 4	763	6.0	Voucher	282	107	116	124	134

[7] Project Roomkey offers a useful model to consider in this context. The program's clients have benefited from coordinated on-site services provided by DPSS benefits eligibility workers, community clinics and other medical professionals providing on-site healthcare through the philanthropy-sponsored Health Pathways Expansion initiative, and DMH behavioral health providers, among other services.

On average, those in the top acuity group will receive high-acuity ICMS services and either an enriched residential care (ERC) subsidy or a PSH subsidy. Those in the second acuity group will largely receive the same resources as the top group, although roughly 25 percent will receive a Housing Allowance subsidy. Members of the third group will receive low-acuity ICMS services and either a Housing Allowance or a Housing Choice Voucher or equivalent instrument. The lowest-acuity group will receive low-acuity case management and vouchers. The program will also pay move-in expenses for all clients as necessary. Table 4A shows the anticipated initial distribution of new inflow clients across acuity groups, tiers, and interventions in each year of the program.

5. OLDER ADULT HOUSING PILOT COSTS FROM TWO POINTS OF VIEW

5.1. Revisiting and Expanding Previous Pilot Cost Estimates

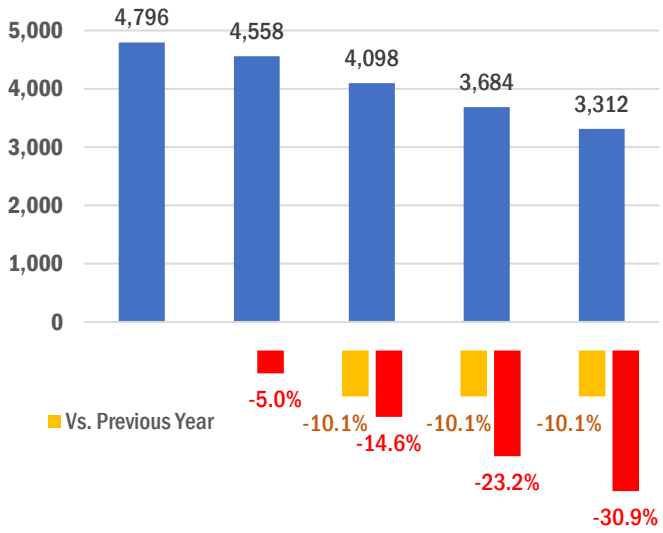
5.1.1. An Adjusted Year-One Cost Estimate with More Depth and Refinement. In this section, we use the population projections presented in Section 3 and the acuity groupings presented in Section 4 to estimate Older Adult Housing Pilot costs at two levels. Analysis submitted with the HI's June 23, 2020, Board report estimated that gross costs for Year One of a five-year housing pilot would total to $100.5 million. Our first-level estimates here focus on the Year-One cohort and assume the same number of pilot clients in the first year, 4,796 older adults, but our analysis adjusts the projected Year One costs downwards by approximately 27 percent to $73.3 million.

This adjustment is applied in response to a number of the pandemic-related challenges described in Section 2 of this report, which had not been fully understood and accounted for in the previous analysis. Given the heightened demand for permanent housing, for example, our adjusted Year-One estimate assumes fewer months in housing for the first cohort than was previously the case, as well as lengthier average durations from the point at which target population clients are engaged by the pilot to placement in housing.

5.1.2. Ramp Up, Attrition and the Costs Associated with Serving the Year-One Cohort. In addition to the adjustment described above, we add depth to the analysis submitted with the HI's June 23, 2020, Board report by estimating expenditures on the Year-One cohort over five years of the pilot.

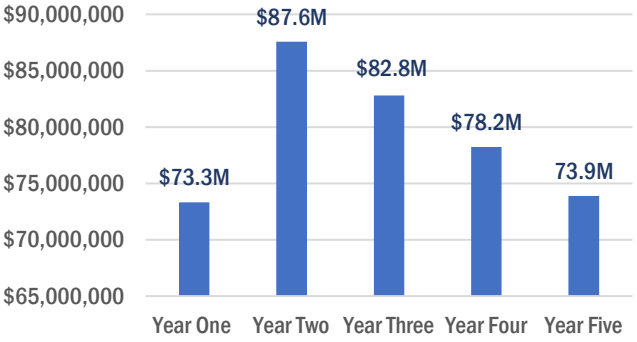
The outreach and engagement processes in Year One, as well as an expected initial ramp-up period, explain why projected costs associated with the Year-One cohort increase by roughly one-fifth between Year One and Year Two.

Figure 5A. Year-One Cohort Clients Served Over Five Pilot Years



At the same time, we expect attrition resulting from deaths and other pilot exits starting in Year Two to steadily reduce the costs of serving the Year-One cohort from Year Three through Year Five (Figures 5A and 5B).

Figure 5B.
Year-One Cohort Costs Over A Five-Year Pilot*



ESTIMATED FIVE-YEAR TOTAL PILOT COSTS FOR SERVING THE YEAR-ONE COHORT: $395.8 MILLION

*Annual estimates are prospectively adjusted for inflation

By comparison with the first year of the pilot, as shown in Figure 5A, the Year-One cohort is expected to be reduced by roughly 31 percent by the pilot's fifth year. Despite the attrition, however, expenditures on those remaining in the pilot from the Year-One cohort in the pilot's fifth year are projected to be slightly higher than the costs associated with serving the full cohort in Year One. This is largely a function of the necessary ramp up and outreach/engagement processes in Year One, which means that costs for the first year represent less than one year of utilization cost for clients in the Year-One cohort. Additionally, inflation adjustments we apply to our annual cost estimates affect the comparison.

5.1.3. Year-One Cohort Costs Over Five Years, by Housing Modalities and Instruments. We estimate that the Year-One cohort will incur a total of $395.8 million in inflation-adjusted pilot cost over five pilot years.

Figure 5C. Projected Pilot Clients Served Annually Over Five Years

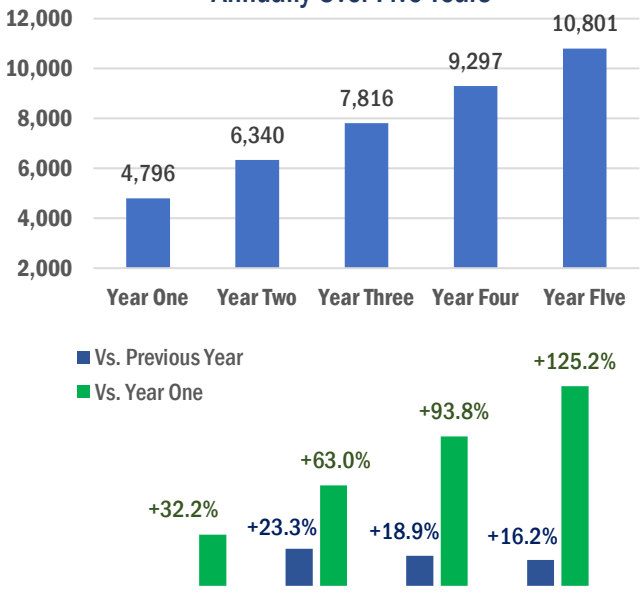


Table 5A, on the following page, parses these costs by the housing service modalities and instruments detailed in Section 4 of this report and the groupings of clients expected to use the various housing options. The assumptions built into the cost estimates are provided in the table notes.

Attrition affects the fully inclusive, second-level estimates but is more than offset by the demographic dynamics expected to increase inflowing clients in each of the five pilot years. As distinct from the first-level estimates, the population at the basis of the second-level estimates therefore increases each year. By comparison with the number of clients served in Year One of the pilot, Year Five's caseload is expected to be approximately 125 percent larger (Figure 5C).

TABLE 5A. ESTIMATED ANNUAL YEAR- ONE COHORT COSTS OVER FIVE PILOT YEARS*

+Services by Client Category	FY 2020-21^		FY 2021-22		FY 2022-23		FY 2023-24		FY 2024-25	
	YEAR-ONE COHORT	ESTIMATED COSTS	REMAINING COHORT++	ESTIMATED COSTS	REMAINING COHORT	ESTIMATED COSTS	REMAINING COHORT	ESTIMATED COSTS	REMAINING COHORT	ESTIMATED COSTS
**Housed Continuously	4,558	$71,124,155	3,642	$74,495,352	3,274	$70,506,600	2,944	$66,672,221	2,646	$62,962,235
Enriched Residential Care	475	$11,109,063	396	$15,552,583	370	$15,098,181	346	$14,669,474	323	$14,228,415
PSH	2,033	$33,412,355	1,627	$33,775,251	1,568	$33,819,925	1,491	$33,413,331	1,403	$32,667,458
Housing Allowance	1,337	$17,335,876	1,056	$16,161,520	824	$13,261,721	659	$10,887,666	521	$8,943,400
Housing Choice Voucher	713	$ 9,266,861	563	$9,005,998	501	$8,326,773	446	$7,701,750	397	$7,122,962
Homeless Returns			456	$8,345,166	410	$7,818,261	368	$7,330,339	331	$6,907,757
Enriched Residential Care			48	$1,221,365	44	$1,163,249	41	$1,126,210	39	$1,113,052
PSH			203	$3,855,563	196	$3,867,794	187	$3,834,109	176	$3,749,307
Housing Allowance → PSH			134	$2,257,898	106	$1,855,756	83	$1,509,763	66	$1,247,355
Housing Choice Voucher			71	$1,010,340	63	$931,463	56	$860,257	50	$798,042
Deaths and Other Exits	238	$2,202,876	461	$4,721,463	414	$4,479,801	372	$4,239,635	335	$4,011,107
Enriched Residential Care	24	$278,340	52	$1,021,129	49	$999,744	46	$975,138	43	$947,093
PSH	107	$1,053,148	203	$2,107,061	196	$2,113,745	187	$2,095,336	176	$2,048,992
Housing Allowance	69	$562,695	134	$1,025,399	106	$842,771	83	$685,642	65	$566,473
Housing Choice Voucher	38	$308,693	71	$567,874	63	$523,540	56	$483,518	50	$448,549
Totals	**4,796**	**$73,327,030**	**4,558**	**$87,561,982**	**4,098**	**$82,804,662**	**3,684**	**$78,242,194**	**3,312**	**$73,881,098**

*Cost estimates shown here are prospectively adjusted for inflation and assume an annual homeless return rate of 10 percent, a 5 percent mortality rate, and a 5 percent rate of other program exits. In addition, we project that 1 percent of the clients in each intervention pool will require a transfer to a higher-level intervention, from Housing Allowance and vouchers to PSH, from PSH to ERC, and from ERC out of the pilot to skilled nursing or similar placements. In addition, any client receiving a Housing Allowance who returns to homelessness is considered a candidate for PSH in the subsequent year.

+One-time move-in and Intensive Case Management Services (ICMS) costs are built into the rates applied to the housing modalities shown here. In including these costs, the varied costs associated with ICMS, which are based on client acuity and vulnerability, are factored into our method and calculations.

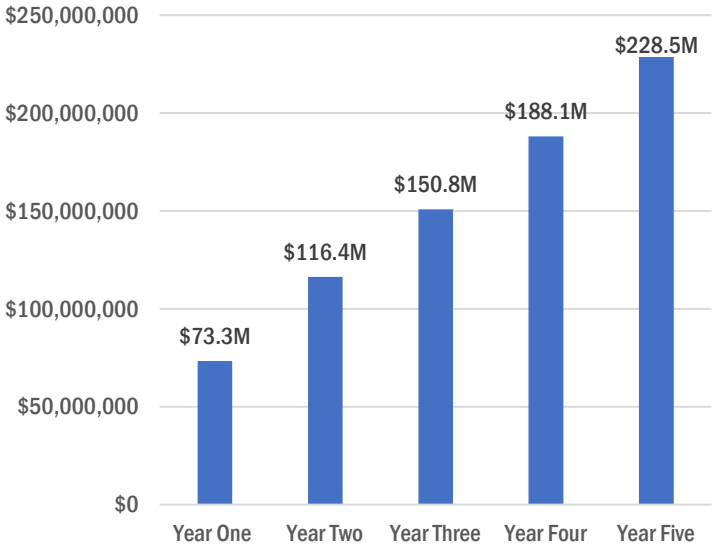
^If the pilot is implemented after the beginning of FY 2020-21, it would be necessary to adjust estimated FY 2020-21 costs downwards.

**In projecting the Year-One Cohort's costs in Year One of the pilot, *Housed Continuously* is operationalized as housed continuously from the point of move-in to the end of the year. In subsequent years (Year Two through Year Five), *Housed Continuously* refers to persons who remain housed for all 12 months of the year.

++For Years Two through Five of the Pilot, *Remaining Cohort* refers to clients who carry over from the previous year – i.e., those who did not pass away in the previous year and did not otherwise exit the pilot.

Using Year One as a comparative baseline for pilot costs, where the estimated expenditures in serving 4,796 pilot clients total to $73.3 million, pilot expenditures on 10,801 active pilot clients in Year Five are projected to be more than three times (211.7 percent) higher, totaling to $228.5 million (Figure 5D).[8]

Figure 5D. Estimated Annual Pilot Expenditures: All Active Clients

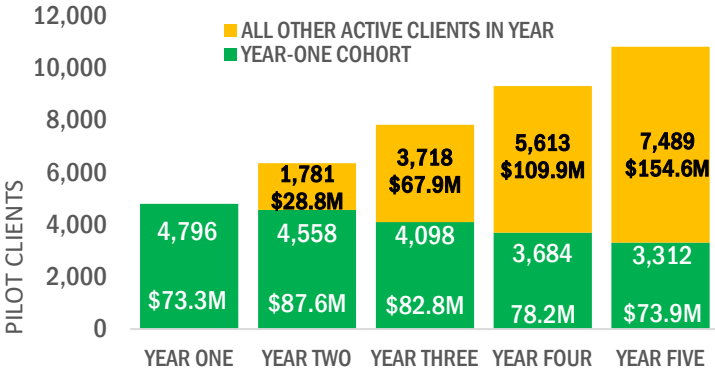


ESTIMATED FIVE-YEAR TOTAL EXPENDITURES
$757.1M

5.1.4. Projected Total Pilot Cost. The inflation-adjusted annual costs shown in Figure 5D sum to a five-year total of $757.1 million, which represents our estimate for the total cost of the five-year pilot. Table 5B on the following page parses the costs by client type and housing modality.

5.1.5. Convergence of the First- and Second-Level Estimates. Figure 5E illustrates the relationship between the first- and second-level estimates presented here, while Figure 5F shows that the $395.8 million the pilot is projected to spend in serving the Year-One cohort over five years constitutes 52.3 percent of the $757.1 million in total pilot expenditure over this period.

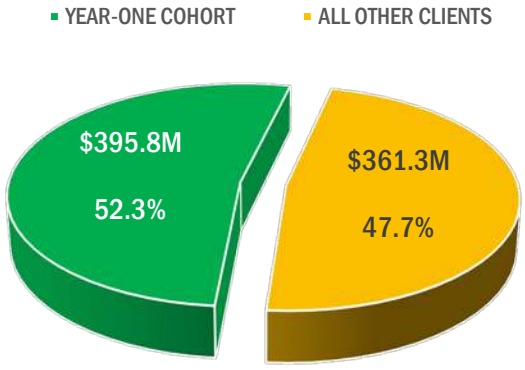
Figure 5E. Clients and Costs in All Five Pilot Years: Year-One Cohort and Overall Target Population



	TOTAL IN YEAR AFTER YEAR ONE			
CLIENTS	6,339	7,816	9,297	10,801
COSTS	$116.4M	$150.8M	$188.1M	$228.5M

Figure 5F. Projected Five-Year Total Expenditure on Older Adult Housing Pilot

$757.1 MILLION



[8] Inflation adjustments partially explain why cost increases over the five-year pilot period outstrip population growth by such a significant margin. Given the ramp up process built into our Year-One estimate, however, a comparison between Year Two and Year Five is more meaningful. By comparison with Year Two, the number of active clients projected in Year Five is 70.4 percent larger and the annual pilot costs are 96.3 percent higher. Controlling for inflation, the projected pilot costs are 75.1 percent higher from Year Two to Year Five in real dollars; the difference not explained by inflation is a result of some clients requiring more intensive interventions as they age.

TABLE 5B. ESTIMATED ANNUAL PILOT COSTS FOR ALL PROJECTED CLIENTS OVER FIVE YEARS

	YEAR ONE: FY 2020-21*		YEAR TWO: FY 2021-22		YEAR THREE: FY 2022-23		YEAR FOUR: FY 2023-24		YEAR FIVE: FY 2024-25		FIVE-YEAR ROW TOTALS	
	CLIENTS	ESTIMATED COSTS	CLIENTS	ESTIMATED COSTS	CLIENTS	ESTIMATED COSTS	CLIENTS	ESTIMATED COSTS	CLIENTS	ESTIMATED COSTS	Clients*	Estimated Costs
New Inflow	4,796	$73,327,031	1,782	$28,833,852	1,936	$32,553,168	2,078	$36,301,282	2,231	$40,490,923	12,823	$211,506,244
Enriched Residential Care	499	$11,387,403	178	$4,325,331	194	$4,897,976	208	$5,456,244	223	$6,077,862	1,302	$32,144,815
PSH	2,140	$34,465,503	802	$13,694,924	871	$15,453,219	935	$17,235,662	1,004	$19,229,395	5,752	$100,078,702
Housing Allowance	1,406	$17,898,571	517	$6,964,990	561	$7,852,507	603	$8,769,571	647	$9,776,443	3,734	$51,262,082
Housing Choice Voucher	751	$9,575,554	285	$3,848,607	310	$4,349,466	332	$4,839,805	357	$5,407,214	2,035	$28,020,645
Housed Continuously	4,558	$71,124,155	3,642	$74,495,352	4,698	$100,652,899	5,769	$129,242,931	6,846	$160,137,146		$464,528,329
Enriched Residential Care	475	$11,109,063	396	$15,552,583	518	$21,137,453	647	$27,431,068	779	$34,315,588		$98,436,693
PSH	2,033	$33,412,355	1,627	$33,775,251	2,210	$47,667,113	2,806	$62,882,499	3,409	$79,375,171	N/A	$223,700,035
Housing Allowance	1,337	$17,335,876	1,056	$16,161,520	1,243	$19,765,371	1.425	$23.543.133	1,602	$27,499,668		$86,969,692
Housing Choice Voucher	713	$9,266,861	563	$9,005,998	727	$12,082,962	891	$15,386,231	1,056	$18,946,719		$55,421,910
Homeless Returns			456	$8,345,166	588	$11,214,193	721	$14,321,780	857	$17,725,848	2,623	$51,606,987
Enriched Residential Care			48	$1,221,365	62	$1,639,123	77	$2,115,077	93	$2,654,202	280	$7,629,767
PSH			203	$3,855,563	277	$5,466,219	351	$7,196,643	427	$9,096,331	1,259	$25,614,756
Housing Allowance			134	$2,257,898	157	$2,748,620	180	$3,274,184	203	$3,836,561	674	$12,117,262
Housing Choice Voucher			71	$1,010,340	92	$1,360.231	113	$1,735,877	134	$2,138,754	410	$6,245,201
Deaths and Other Exits	238	$2,202,876	460	$4,721,463	594	$6,387,473	729	$8.197.448	867	$10,184,196	2,650	$29,490,581
Enriched Residential Care	24	$278,340	52	$1,021,129	68	$1,387,400	85	$1,801,886	103	$2,268,617	308	$6,479,033
PSH	107	$1,053,148	203	$2,107.061	277	$2,987,283	351	$3,932,957	427	$4,971,135	1,259	$13,998,436
Housing Allowance	69	$562,695	134	$1,025,399	157	$2,748,620	180	$1,486,935	203	$1,742,332	674	$5,502,922
Housing Choice Voucher	38	$ 308,693	71	$567,874	92	$1,360.231	113	$975,670	134	$1,202,112	410	$3,510,190
Totals	**4,796**	**73,327,031**	**6,340**	**$116,395,833**	**7,816**	**$150,807,733**	**9,297**	**$188,063,441**	**10,801**	**$228,538,103**	**12,823**	**$757,132,141**

*Year One New Inflow line items duplicate (i.e., represent the sum of) the Housed Continuously and Death and Other Exits line items. In all other years, New Inflow represents unique, non-duplicative clients and services. The five-year total columns include Year One in the New Inflow total rows only.

6. PILOT FUNDING SOURCES

6.1. Funding Year One

6.1.1. Leveraging COVID-19–Related Resources. Initial funding to house the Year-One target population of the Older Adult Housing Pilot will rely on the fact that all members of this target population are also members of the broader client base to be served by LAHSA's COVID-19 Recovery Re-Housing Plan. That plan identifies several State and Federal emergency and recovery funding streams that can be leveraged to rehouse adults over age 65 experiencing homelessness. These sources include resources created by the CARES Act (the Coronavirus Relief Fund [CRF], Emergency Solutions Grant-COVID-19 [ESG-CV], and Community Development Block Grant-COVID-19 [CDBG-CV]). There are multiple competing uses for these funds, and multiple jurisdictions are involved in their allocation and expenditure. However, we believe that sufficient CARES Act resources exist to fund the pilot's net new costs for the Year-One cohort through September 30, 2022, the deadline for ESG-CV expenditures.

Some pilot members will also qualify for and receive services through the Whole Person Care pilot, the Health Homes Program, and Measure H–funded Strategies including E6, E7, C4, B7, and D7.[9] In addition, as discussed in Section 6.2, early engagement with Los Angeles County's MCOs to explore avenues for expanding Medi-Cal reimbursement for homeless services will be necessary to the ultimate success of the pilot. Existing funds and CARES Act funds should be conceived as bridge funding to facilitate a transition of as much of the program's funding as possible to a Medi-Cal– and Medicare-based model.

6.2. Funding Opportunities Beyond Year One

6.2.1. The Funding Landscape for Housing Navigation and Case Management. At present, homeless ICMS services and (indirectly) move-in costs are reimbursed only for some specific clients by specific Medi-Cal and Medicare-funded programs:

- The Whole Person Care pilot and the Health Homes Program are innovative Medi-Cal programs designed to serve the most expensive, highest-need beneficiaries. These programs pay for ICMS services.[10]

- Cal MediConnect, a Coordinated Care Initiative program that unifies Medi-Cal and Medicare care coordination for dually eligible beneficiaries, can fund case management (including homeless case management) for dually eligible Medi-Cal/Medicare beneficiaries. This

[9] More Specifically, These HI strategies are as follows:

HI Strategy	
B7	Interim/Bridge Housing for those Existing Institutions
C4	Countywide SSI Advocacy Program for People Experiencing Homelessness or at Risk of Homelessness
D7	Provide Services and Subsidies for Permanent Supportive Housing
E6	Countywide Outreach System
E7	Strengthen the Coordinated Entry System

[10] Whole Person Care is a time-limited Medi-Cal 1115 waiver program; the State is currently seeking a one-year extension of this waiver from December 31, 2020 to December 31, 2021. The Health Homes Program is authorized by the State legislature under a provision of the Patient Protection and Affordable Care Act, so it has no inherent sunset (and is not scheduled to complete its implementation phase until December 31, 2021), but the functionality of Health Homes will likely be folded into the larger CalAIM initiative if and when it is implemented.

funding is at the discretion of the MCOs administering the plans and comes out of the savings they realize by combining administration of the two entitlements within a single program.

- Relatedly, pilot programs with the Health Plan of San Mateo and the Inland Empire Health Plan allow those plans to pay the costs of moving or diverting beneficiaries from institutional settings into stable, service-rich placements in the community. These transitions to community are funded as "in lieu of services," meaning that the plans pay these costs in lieu of the greater costs they would expect to realize were their beneficiaries to enter or remain in skilled nursing facilities or other institutions.[11]

Medi-Cal and Medicare resources, therefore, can currently be used to pay for case management for the most expensive homeless patients and/or through specific one-off agreements with individual health plans. Individual clients experiencing homelessness may or may not fall into the buckets that define eligibility for a given program, and funding is distributed inefficiently among such buckets. In the HI's June 23, 2020, interim report, we envisioned a more comprehensive Medi-Cal benefit, structured initially as a Demonstration Project, that would be available to the broader population of older adults experiencing homelessness.

We continue to believe that Medi-Cal and Medicare represent the most promising potential sources of long-term or even indefinite funding, especially because the State is beginning to move in that direction. However, it is unlikely that full coverage of homeless case management services for all clients needing such services will be instituted in a single step, or within the five-year window of the proposed pilot. It is more likely that, over the course of the pilot, coverage of the target population could begin to expand as new funding streams begin to develop and are explored by Los Angeles County's MCOs.

6.2.2. CalAIM and Potential Ways Forward. In the immediate term, the Coronavirus Pandemic has caused California to postpone its plans for Medi-Cal and Medicare innovation and has made it difficult to identify avenues to expand those programs' use to fund homeless case management services in the way that we envision. Over the next few years, however, the California Advancing and Innovating Medi-Cal (CalAIM) initiative will provide a vehicle for such expansion. CalAIM's implementation has been postponed, but, as of September 2020, the State is moving forward with preparation for the next round of Medi-Cal requests for proposals (RFPs) on the assumption that it will be implemented and is planning to incorporate CalAIM language and instruments into future Medi-Cal Managed Care Plan contracts.

Due to the way its "in lieu of services" are structured, the extent to which CalAIM ends up paying for housing stabilization case management services in Los Angeles County will largely be up to the County's MCOs. For that reason, the County should engage early with the MCOs to advocate for them to cover such services and to work with them to figure out the most expansive feasible benefit that can be designed for older adults—and all persons experiencing homelessness—within the bounds of the CalAIM initiative.[12]

[11] A key feature of the pilots' in lieu of services model is that clients who have exited or avoided SNFs are still covered by the State at the SNF per capita rate. Absent this feature, when institutional transitions cause clients who require a high level of care to be covered at a lower rate, health plans can lose money through such transitions rather than realizing net cost benefits.

[12] The two Los Angeles County MCOs, as well as the Community Clinic Association of Los Angeles County and the Hospital Association of Southern California, convened a group of safety net health leaders in October, 2019, to

Of particular interest for our pilot, CalAIM will also largely supplant the function of California's Coordinated Care Initiative, which seeks to better serve low-income older adults and persons with disabilities who are dually eligible for Medi-Cal and Medicare. CalAIM will include a Managed Long-Term Services and Supports program, as well as a Dual Eligible Special Needs Plan (D-SNP). These programs, too, could be deployed—at each MCO's discretion—to better serve their clients experiencing homelessness, and they provide avenues to explore for funding the latter years of the Older Adult Housing Pilot.

6.2.3. Housing Allowance Funding. Long-term funding for the Housing Allowance subsidy is complicated by the fact that Medi-Cal cannot pay rental subsidies. This limitation of Medi-Cal was a primary influence on the decision to frame the pilot as a potential State Demonstration Project, bringing together 1115 waiver resources with other State funds beyond those available through the Federal Medicaid program. This avenue remains worth pursuing, as do other options for leveraging State funds to support the Housing Allowance subsidy.

7. DEMONSTRATING HEALTHCARE COST SAVINGS

7.1. A Planned Partnership with the State

7.1.1. An Initially Planned Demonstration Project Administered in Partnership with the State. An earlier version of this implementation plan envisioned that the pilot would be administered in partnership with the State. Specifically, a key component of our plan entailed establishing the pilot as a five-year Demonstration Project in which the State would authorize the use of Medi-Cal to fund specified components of the pilot. Client trajectories within the pilot would then be closely monitored and evaluated at regular intervals to determine if the use of Medi-Cal resources authorized by the State yields improved client outcomes and healthcare cost savings.

7.1.2. Despite Changed Plans, Evidence of Outcomes and Savings Will Remain Essential. With the postponement of CalAIM and other COVID-19-related developments, several of which are discussed in Section 2 above, the basis for a Demonstration Project is not in place at the present time. The concept could potentially be revisited at some time in the future but is not a feature of the plan presented in this report. Regardless of whether the mechanism is a formal, State-sanctioned Demonstration Project or a different process, an examination of outcomes and cost savings must necessarily be built into the pilot.

Upon expiration of CRF, ESG-CV and CDBG-CV funding, continuation of the pilot will hinge on the extent to which other funding sources can be used for pilot programs. Within this context, evidence of improved outcomes and/or promising healthcare cost curves among the pilot's initial clients will be indispensable. Where funding sources are identified, moreover, their use will likely require a commitment to ongoing, evidence-based demonstrations of favorable outcomes and savings.

identify the most important policy priorities to advance in order better to serve their patients experiencing homelessness. Beyond demonstrating an existing interest in this project, the resulting document includes several specific recommendations to improve Medi-Cal service delivery and leverage Medi-Cal as a funding source for homeless services. See *Report: Los Angeles Homeless Health Summit 2019.* Available at: https://www.lacare.org/sites/default/files/la2131_la_homeless_health_report_2019.pdf.

7.2. Information Gaps and the Pilot's Rationale

7.2.1. Immediately Available Information Sources on Healthcare Costs Are Instructive but Insufficient. Due to the twin ravages of old age and homelessness, a substantial share of the pilot's target population will likely consist of persons with comparatively expensive healthcare needs. Seizing upon an opportunity to reduce these costs is a key component of the pilot's rationale. Were the pilot to commence immediately, however, the information sources available to Los Angeles County would not be sufficient to reliably evaluate the effects of the pilot on the target population's patterns of healthcare service use and, most importantly from the standpoint of MCOs, the expression of these patterns in longitudinal healthcare cost curves. Closing the underlying healthcare information gaps in advance of the pilot's implementation will be a critical task, one we recommend the HI work on collaboratively with the County's Office of the Chief Information Officer (OCIO), as well as with LAHSA and other key stakeholders.

The healthcare utilization data currently available via the County's integrated data capacities, represented in Table 7A, are invaluable and provide highly compelling information that hints at what is likely to be observed given more inclusive and exhaustive sources. It is difficult to avoid the temptation to simply extrapolate and perform imputations from incomplete information. While these types of analytical practices are legitimate in certain contexts, they are not an adequate alternative approach to measurement given a pilot program with the potential to shape policymaking decisions that will have significant long-term fiscal impacts. There is no substitute for direct access to the full complement of necessary information under such circumstances.

7.2.2. Specifying the Gap. The primary limitation of the healthcare information immediately available to the County is that utilization data is available only from Los Angeles County healthcare providers. That is, it includes only services and treatment provided through DHS and DMH, as well as the Substance Abuse Prevention and Control (SAPC) program administered by the Department of Public Health (DPH). Client-level data available for analysis through DPH/SAPC and DMH includes residential services and treatment provided through contracted providers of substance use disorder (SUD) and outpatient mental health services. The information available through DHS and DMH is comprehensive, clinical utilization data capturing outpatient, inpatient and emergency encounters and episodes.

With respect to homeless older adults, the DPH/SAPC and DMH data do not represent significant blind spots. Previous analysis conducted by OCIO linking de-identified single adults with enrollments recorded in LAHSA's Homeless Management Information System (HMIS) to records of DMH and DPH/SAPC services suggest that older adults are not, in a comparative sense, high-volume or high-intensity users of behavioral health treatment services. With respect specifically to DMH, moreover, the department provides specialty mental health services for all Medi-Cal beneficiaries in the County and, since most if not all homeless older adults are presumably Medi-Cal beneficiaries, the limitation of utilization data to County service providers does not leave a sizable mental health information gap.

The lack of availability of outpatient, inpatient and emergency utilization data capturing non-County-administered physical health services constitutes a much more serious gap. While DHS is critically important in terms of health services provided to older adults, the implications for analysis of this population as a whole, which is the pilot's target population, is incomplete without access to service records from private hospitals and MCOs beyond DHS.

7.2.3. Examining What Can be Gleaned from Partial and Extrapolated Information. Table 7A provides partial information on health care costs among single adults served by LAHSA in FY 2018-19 (*n*=72,895). The LAHSA client population is parsed by older adults and persons under the age of 65. Of the 4,975 older adults in the LAHSA single adult population, a total of 1,624 used DHS and/or DMH services during standardized observation periods of one year prior to their first LAHSA enrollment in FY 2018-19.

Older adult representation among these healthcare users is roughly proportional, i.e., DHS and DMH service users comprise 35 percent of the LAHSA single adult population overall and the older adults among them comparably comprise roughly 33 percent of the older adult LAHSA client population observed; older adults, moreover, comprise 6.8 percent of all LAHSA single adults observed and comparably comprise 6.4 percent of the DHS and DMH clients in the overall LAHSA population (1,624 of 25,551). An additional standardized observation of three years prior to the earliest LAHSA enrollment in FY 2018-19 yields similar proportionality.

Table 7A: One- and Three-Year Healthcare Costs Associated with Single Adults Served by LAHSA in FY 2018-19

Single Adults Enrolled with LAHSA, FY 2018-19, *N*=72,895				<65, *n*=67,920					65+, *n*=4,975				
				Medical Users			Expenditures		Medical Users			Expenditures	
					%					%			
12 Months	**#**	**% *N***	**Total Cost**	**#**	**Age Grp *n***	**Row**	**$**	**Row %**	**#**	**Age Grp *n***	**Row**	**$**	**Row %**
All Users	25,551	35.1	$413.3M	23,927	35.2	93.6	$362.2M	87.6	1,624	32.6	6.4	$51.2M	12.4
DHS	14,109	19.4	$247.0M	13,277	19.5	94.1	$218.5M	88.5	832	16.7	5.9	$28.5M	11.5
DMH	15,623	21.4	$130.6M	14,956	22.0	95.7	$125.4M	96.0	667	13.4	4.3	$5.3M	4.0
*Assist Liv	1,725	2.4	$35.7M	946	1.4	54.8	$18.3M	51.3	779	15.7	45.2	$17.4M	48.7
3 Years	**#**	**% *N***	**Total Cost**	**#**	**Age Grp *n***	**Row**	**$**	**Row %**	**#**	**Age Grp *n***	**Row**		
+All Users	34,482	47.3	$752.1M	32,118	47.3	93.1	$673.5M	89.5	2,364	47.5	6.9	$78.6M	10.5
DHS	21,152	29.0	$443.4M	19,833	29.2	93.8	$394.2M	88.9	1,319	26.5	6.3	$49.2M	12.5
DMH	23,216	31.8	$273.0M	21,886	32.2	94.2	$260.9M	95.6	1,330	26.7	5.7	$12.1M	4.4

*The Assisted Living costs shown are estimates extrapolated from other research on homeless older adults. This is explained in further detail below.
+These costs include the same Assisted Living Expenditures shown for the one-year observation period.

In addition to matching LAHSA clients against records of DHS and DMH service use, we produced an estimate of Assisted Living clients within the LAHSA single adult population. Unlike the real data used to show the DHS and DMH utilization in Table 7A, the Assisted Living utilization shown represents an extrapolated estimate.[13] Based on this extrapolation, and assuming Assisted Living is categorized as a healthcare service, we project 48 percent of older adults receiving any kind of County-administered health care (779 of 1,624) to be Assisted Living clients, and they will comprise 45 percent of the 1,725 LAHSA single adults receiving such service over the 12 months after their LAHSA enrollment dates. Given the importance of these services to older adults in particular, obtaining actual Assisted Living utilization data prior to the initiation of pilot implementation should be afforded the same level of priority as obtaining utilization data from non-County health providers. While the information represented in Table 7A is partial, the distribution of cost is consistent with what would be expected given more exhaustive information. A total of $413.3 million in DHS, DMH and imputed Assisted Living costs is associated with

[13]Our Assisted Living cost estimates are extrapolated from nursing home costs associated with older adults enrolled in LAHSA-administered homeless services between 2005 and 2019, as reported in: Culhane, Metraux and Kuhn. 2019. *A Data-Based Re-Design of Housing Supports and Services for Aging Adults Who Experience Homelessness in Los Angeles.*

the LAHSA single adult population over the year prior to their FY 2018-19 enrollments. Within the expanded three-year window, the total expenditure climbs to $752.1 million. The proportion accounted for by older adults exceeds their share of the population by almost two times within the one-year observation window and by more than half within the three-year observation window.[14]

7.2.4. Costs Per Person. The disproportionate distribution of healthcare expenditures observed within the older adult segment of the FY 2018-19 LAHSA single adult population is suggestive of the comparative costliness of the target population and therefore speaks to the pilot's rationale. The one-year costs and clients together imply a total healthcare cost per service user of $31,553 for older adults in the LAHSA population, which is 123 percent higher than the $14,172 cost per user among those in the same population who are under the age of 65. When the same costs are distributed across the entire LAHSA population shown in Table 7A, which will be consistent with a required step in preparing cost per person targets for the pilot, the implied cost per person is $10,300 for the older adults, which is roughly 93 percent higher than the cost per person for those under 65 years of age ($5,331).

While the differences observed in these comparative costs per person are impressive, evidence compiled by the California Health Care Foundation (CHCF) suggests that the differences significantly understate what the comparison would show if data from private providers and MCOs were included with the County data represented in Table 7A. During California's FY 2017-18, for example, CHCF reports that the average Medi-Cal expenditure on Medi-Cal beneficiaries, inclusive of those who received healthcare treatment and those who did not, was $14,108 on those who were at least 65 years of age, three times higher (a difference of roughly 200 percent) than the $4,688 average for all adults regardless of age.[15] The gap would be even wider if the latter group of beneficiaries did not include the former, which re-emphasizes the information gap left by the County's current inability to access information from non-County health care providers and, by extension, the critical importance of addressing this gap prior to the implementation of the Older Adult Housing Pilot.

8. PROGRAM MONITORING AND EVALUATION

8.1. Data-Driven Pilot Implementation

8.1.1. Requirements for Monitoring and Evaluation. Given that the proposed intervention is framed as a pilot, program stakeholders should have access to actionable data that provide insight into the effectiveness of the suggested approaches for ending homelessness among older adults.

We suggest two different tracks: ongoing performance monitoring, to facilitate continuous assessment and potential revisions to the program model or implementation, and a robust program evaluation that provides semiannual feedback to funders as to whether the program is meeting its stated objectives related to service utilization, client well-being and cost savings. Both tracks should be conducted by

[14] Older adults comprise 6.4 percent of the healthcare services users represented in the one-year observation window presented in Table 7A (1,624 of 25,551), while the $51.2 million spent on these older adults exceeds their representation among all healthcare services users captured in the table by almost 94 percent, comprising 12.4 percent of the $413.3 million in overall one-year expenditures. Within the three-year window presented in Table 7A, older adults comprise 6.9 percent of the healthcare service users recorded (2,364 of 34,482), while $78.6 million in estimated three-year expenditure on the older adult subset accounts for 10.5 percent of the $752.1 million in total cost, thereby exceeding their representation among all healthcare services users shown in the table by approximately 52 percent.

[15] https://www.chcf.org/publication/2019-medi-cal-facts-figures-crucial-coverage/

and/or provided to stakeholders in a timely manner that allows for the assessment of the program's efficacy and for judgments on the continuation or expansion of the program.

Among the earliest concerns to be addressed in planning the monitoring and evaluation components of the pilot would be deciding which agency or agencies would conduct or oversee them. LAHSA should have resources sufficient to conduct program monitoring in cooperation with other stakeholders such as DHS, and the implementation and outcome evaluations described below could be conducted on a contract basis with data supplied by OCIO and LAHSA.

8.2. Monitoring

8.2.1. Monitoring and Program Management. Timely performance monitoring and management is critical to ensuring that the program meets the benchmarks outlined by HI and in this report. Such monitoring will require modifications to LAHSA's HMIS with any data elements required to track the metrics developed for this program. Data captured should include client use of housing services, the date of each service interaction, the person and organization with whom each service interaction occurs, and information related to their program-specific housing. Key benchmarks could focus on program engagement, application, enrollment, and retention, with an emphasis on the average time required to transition between each step and the rate at which clients exit the program during each such transition. Other collected information pertaining to client and provider characteristics should be used to identify successful providers, best practices, and program areas in need of remediation.

Beyond the administrative data collected as part of program operations, HI and LAHSA may consider routine surveying of clients. This would allow for more qualitative information to be collected regarding barriers to housing retention, as well as progress and challenges related to clients' health and well-being. This information could prove critical to any required mid-course corrections. Surveys could be administered through text messaging, perhaps through phones provided by the pilot for this purpose and/or with incentives for survey completion. This approach to client surveys is becoming increasingly common for homeless and other vulnerable populations in Los Angeles County and more broadly.

8.3. Evaluation

8.3.1. Measuring Outcomes. While a performance measurement system provides timely intelligence that allows managers to make programmatic changes, it does not provide meaningful insight into overall program effectiveness. We suggest that HI and LAHSA pursue two evaluation tracks: an implementation evaluation and an outcome evaluation.

The implementation evaluation should be an assessment of program development, roll-out, changes in the program model, and fidelity. It should include quantitative assessments of enrollment and placement milestones, descriptions of programmatic changes, and input—via interviews or focus groups—from stakeholders, including HI leadership, front-line staff and management of participating nonprofit providers, and enrolled clients.

8.3.2. Forward-Looking Evaluation Metrics. The outcome evaluation will be tasked with providing stakeholders with the data and analysis required to determine whether and how to continue or expand the program. We anticipate that program continuation and expansion would hinge on the pilot meeting at least one of the following conditions:

- cost savings with client outcomes either improved or unchanged

- cost neutrality combined with improved client outcomes
- net positive costs combined with improved client outcomes.

A quantitatively driven assessment of program efficacy could rely on administrative and primary data through a quasi-experimental design. The staggered nature of program enrollment should allow for a natural experiment, comparing service-use changes for those who enroll early to changes for those who enroll later in a difference-in-difference study. Should the timeline and logistics of program enrollment not allow for robust difference-in-difference comparisons between individuals, evaluators could compare average service use before enrollment to that following enrollment for each individual in a pre-post study. However, given the aging of this population and potential increases in service use due to aging, this is not an optimal approach.

8.3.3. Required Evaluation Data. The OCIO Information Hub will be an important source of data on pilot participants' service utilization. To gain a full picture, however, it will be necessary to close the information gap discussed in Section 7.2.2 by expanding an in-process data match between LAHSA's HMIS records and the State's Medi-Cal service records.[16] Administrative data sources should be used to assess:

- emergency shelter and transitional housing use,
- hospital use, measured in number of emergency room visits and number and duration of inpatient hospitalization, and
- skilled nursing facility placements and length of time spent in nursing homes.

Primary data, collected through either the HMIS or a survey, can supplement the service-use data by providing insight into other measures of stability and well-being.

Political, policy, and fiscal conditions that determine acceptable conditions for establishing a permanent program will no doubt change between this moment and the time the pilot ends. That said, the specific outcome metrics that HI/CIO and LAHSA would use to make those determinations should be decided upon and integrated into the program's design before an evaluator is hired.

9. NEXT STEPS

9.1. System Alignment and Immediate Funding

9.1.1. Aligning the Pilot with the System as It Is. Any pilot implemented in Los Angeles County must be aligned with, and at least partly integrated into, the County's Coordinated Entry System. The CES prioritizes people experiencing homelessness for access to housing resources, and it matches each client to the appropriate resource, following the CES Prioritization Policy and the CES Matching Policy established by the CES Policy Council. Within this context, two avenues exist for an effort seeking to end homelessness for a specific subpopulation: 1) that subpopulation could be prioritized above others with similar needs; 2) resources could be created that are targeted specifically to that subpopulation, and the

[16] This match was being conducted under the terms of an agreement executed by DPH. The work has been held up by technical requirements in LAHSA's standard operating procedure for such data matches, and by the COVID-19 emergency, which has reduced the capacity of DPH and LAHSA to follow through with the state. However, it should be feasible to re-engage the process and complete the records match, and this should be pursued with an eye towards modifying the agreement in whatever way is necessary to enable HMIS-Medi-Cal matches to be conducted on a routine and ongoing basis.

CES would then match clients to those resources.[17] Option 2 has more precedent and would present fewer legal and administrative hurdles to overcome. Thus, in order to match all older adults experiencing homelessness to appropriate permanent housing resources, those specific, targeted resources must exist in sufficient quantity and must be aligned with the homeless services system as a whole.

Both in Section 6 and below, we suggest promising avenues to pursue the funding necessary to create the resources that would be needed to implement the Older Adult Housing Pilot. It is incumbent upon those managing implementation of the pilot to clarify the feasibility and timing of these potential funding sources and to secure initial funding commitments for at least Year One as the first step in moving the project forward. It should be reemphasized, however, that one feature of the current landscape that the pilot seeks to overcome is precisely the fragmented nature of funding streams to serve this population and the difficulty of securing comprehensive funding that works for all clients and all interventions. The path forward is unlikely to involve moving in a single step from fragmentation to unity. Program managers contemplating funding for the pilot's first years should expect to continue needing to patch together various sources with various eligibility requirements in the short term, even as they move the needle towards more comprehensive solutions.

9.1.2. Securing Immediate Funding. The COVID-19 pandemic has disrupted several aspects of funding and implementation that might otherwise have been anticipated for this report. Specifically, the proposed pilot was intended to contribute to the Los Angeles County response to Governor Newsom's Executive Order N-23-20 and his presentation of his proposed FY 2020-21 budget. The order directed the Department of Finance to create a state-administered Access to Housing and Services Fund that would serve as a statewide analogue to the County's Flexible Housing Subsidy Pool but would be able to fund a wider range of interventions and services, including innovative pilots. While the Governor initially envisioned a one-time $750 million appropriation to create seed money for the Fund, his plan proved not to be viable following the advent of the current economic crisis. However, the Governor's commitment to increasing the State's financial contribution to ending homelessness may bear fruit in later pilot years, should revenues recover from the economic impacts of the pandemic. In the intervening years, CARES Act funding could provide a bridge, as considered below. CARES Act funding for homeless programs, however, is a finite resource for which competition within Los Angeles is fierce.

The pandemic has also delayed, until at least January 2022, the State's implementation of CalAIM, which was thought to be a potential source of funding for the case management costs of the pilot, including the one-time costs for housing stabilization and move-in. Alternatives will have to be considered in light of this gap of at least one year; moreover, the ultimate provisions of CalAIM and its specific implementation by Los Angeles County's MCOs are as yet uncertain. However, this uncertainty could provide an opportunity for the County to work with the MCOs on the Older Adult Housing Pilot, were it to be framed as piloting the types of funding streams that the MCOs may seek to provide under CalAIM.

As discussed in Section 6.2.2, the proposed Housing Allowance is not fundable by CalAIM or any other Medi-Cal program. Discussions with the State about possible State-sponsored funding streams for this innovative subsidy program will be necessary and should begin as soon as possible.

[17] For example, veterans may be matched through the CES to veteran-specific resources, such as Veteran Affairs Supportive Housing (VASH) units, thereby increasing the number of veterans housed by the system without explicitly prioritizing veterans above other people experiencing homelessness as a matter of policy.

Some discussions with the State, with MCOs, and with Continuum of Care stakeholders will necessarily take place individually. However, as discussed in Section 9.4, we believe that convening a table of stakeholders that includes representatives from these entities, County leadership, LAHSA, local housing authorities, medical providers, and aging and homeless advocates is an equally necessary step.

9.2. Specific Interventions and Funding Needs

9.2.1. PSH and Housing Choice Vouchers. Members of the Year-One Pilot cohort are projected to require approximately 2,100 PSH units. Clients of the fully funded pilot will require roughly 800 to 1,000 PSH placements in each year thereafter. With the supply of PSH quite limited, relative to demand from across a variety of homeless populations, including Project Roomkey clients who are also being prioritized, identifying available units will be a challenge. Sources of available units are likely to be limited to the turnover of existing slots, typically about 10 percent per year, and to new units that will start to come online this year through Proposition HHH, No Place Like Home, and the County's Affordable Housing Trust Fund. Older adults will not be the only people vying for these units, and some units are dedicated to other populations, such as youth, people with severe mental disabilities, and veterans.

Given these constraints, it is highly unlikely that all 2,100 Year-One clients will access PSH during the pilot's inaugural year. LAHSA's Recovery Re-Housing program will therefore represent an invaluable bridge to permanent subsidies until more units become available. The County could also explore seeking additional HCVs or Section 202 vouchers from local housing authorities to allocate to the Year-One cohort.

One potential advantage of targeting these scarce units to older adults is that they will turn over faster than typical vouchers, as the population ages, exits to higher levels of care and/or dies. For example, we estimate that 40 percent of the Year-One population will have exited the program by the end of Year Five, which means that approximately 800 of these slots will be vacated, or about 200 per year. Thus, a portion of the annual demand for PSH among older adults could be met from turnover. Such an arrangement could involve instituting an administrative method of designating a unit, once occupied by a pilot client, as set aside for pilot clients for the duration of the pilot. The youngest members of the cohort driving the surge in older adult homelessness will reach age 65 in 2027. Once this peak is reached and the homeless population over age 65 starts to decline, the units reserved to the pilot could revert to general availability. Should the County and LAHSA decide to go this route, program leaders and County Counsel will need to determine the permissibility and implementation details of the set-aside as soon as possible.

9.2.2. Housing Allowance. A key component of the Older Adult Housing Pilot's ability to serve lower-acuity clients is the creation of the proposed Housing Allowance as a supplement to SSI. An allowance is suggested of $600 per month for people in shared living arrangements, and $750 per month for people living alone. This subsidy was initially anticipated to be funded through the Governor's proposed Access to Housing and Services Fund. Alternatively, it could be funded from CARES Act funding, in particular ESG-CV, which could pay for rental assistance through September 2022. We estimate about 1,400 people would be targeted for housing allowances in Year One, and 500-650 in subsequent years. The two-year costs to ESG-CV for the Year-One population to receive Housing Allowances would be approximately $16 million. Again, however, this cohort is not the only target population for ESG-CV funds. All people eligible for Project Roomkey, including all people experiencing homelessness who have underlying conditions that increase their vulnerability to COVID-19, are also targeted. Moreover, the County's ESG-CV funds are not intended for clients within the City of Los Angeles or any of the other five cities that receive their own ESG-CV allotment.

Los Angeles County, the City of Los Angeles, LAHSA, and other stakeholders will have to weigh how many ESG-CV–funded resources could go to older adults. One advantage of targeting older homeless adults with ESG-CV resources is that the proposed Housing Allowance builds on the Federal entitlement of SSI, and the subsidies could be sustained for the remainder of the pilot by shifting funding responsibilities to the State in FY 2022-23, should the County's discussions with the State bear fruit.

9.2.3. Enriched Residential Care and the Highest-Acuity Interventions. A projected 499 members of the Year-One Cohort will require a greater level of care than is typically available in PSH, and those clients are assigned in our projections to ERC slots. This intervention, however, should be explored in detail by MCOs and medical and homeless providers. Because high-acuity interventions are the most expensive, they are already the locus of the greatest intensity of innovation. The recommended stakeholder group should explore ways to serve high-acuity homeless older adults that would achieve both better outcomes and greater cost savings. Possible modalities include, but are not limited to: the Program of All-Encompassing Care for the Elderly (PACE), the State's nascent Medi-Cal Long-Term Care at Home benefit, In Lieu of Services programs (either as a part of, or as a pilot separate from, CalAIM), and the Home and Community-Based Services Waivers (which include the Home and Community-Based Alternatives Waiver and the Assisted Living Waiver, among others).

Almost all of the programs listed require clients to secure their own housing, or must be formally paired with housing as a separate component. For that reason, in many cases, the limited availability of PSH slots also limits the availability of slots in innovative programs seeking to divert clients from skilled nursing and other high-cost institutional settings. It would be worthwhile to explore whether Medi-Cal dollars could be used to leverage PSH subsidies in hybrid programs that would bundle community-based care services together with subsidized housing.

9.2.4. Case Management. The intended source of funding for the case management costs of the proposed pilot was CalAIM, which has now been delayed by at least one year. Thus, case management costs for Year One and possibly Year Two must be sought elsewhere. The pilot's highest-acuity clients are likely to be eligible for existing Medi-Cal–funded homeless case management services through the Health Homes Program and (should the State's application for a one-year extension be approved) the Whole Person Care pilot. The existing Cal MediConnect program for dual-eligibles is also a current vehicle for MCOs to reimburse case management services for some older adults experiencing homelessness, although it is not designed to reimburse specifically homeless case management services. In addition, as mentioned above, the County's MCOs could also explore an in lieu of services pilot in anticipation of CalAIM that would test out assumptions about appropriate eligibility criteria and funding levels for the CalAIM version of in lieu of services.

The potential "dual eligibility" of people who are age 65 and older, and the combining of Medi-Cal and Medicare funding vehicles, create other opportunities to address the service needs of older adults experiencing homelessness. Cal MediConnect provides an example of a program that already makes it possible for MCOs to pay for case management out of the savings realized by combining Medi-Cal and Medicare administration in a single program. However, Cal MediConnect has not experienced the level of client uptake that might have been expected, and it is likely to be supplanted by CalAIM over the next few years. Members of the proposed stakeholders table may consider potential proposals to the State to better align programs serving dually eligible clients with homeless services and supports.

9.3. Staffing, Training, and Other Administrative Needs

9.3.1. Staff Recruitment. Launching a new initiative of the scale of the proposed Older Adults Housing Pilot is a "heavy lift" under even conventional circumstances. With the Coronavirus Pandemic and its accompanying economic and fiscal crises ongoing, launching such an initiative is even more daunting. We cannot overstate the importance of the following proposition: in order for the pilot to house several thousand homeless older adults who would not otherwise have been housed, the County's homeless services providers will need to hire more staff to do more work.

9.3.2. Building Capacity to Bill Medi-Cal. Even considering the funding uncertainties for housing and case management, staffing and training for new staff will be a major challenge. If indeed MCOs are able to fund case management services, those services would have to be provided by agencies that have the licensure and billing infrastructure necessary to bill for Medi-Cal reimbursement. Most of the homeless service provider network is not currently accustomed to these requirements. So, in addition to having to identify and hire new workers who could coordinate housing placements and supports, consideration will have to be given to how many of these would be on-boarded at existing Medi-Cal–funded aging and behavioral healthcare providers, as well as how partnerships would be struck with homeless service providers, who may need to establish contractual relationships with these Medi-Cal–funded agencies to tap into their administrative infrastructure. Moreover, while many case managers have direct experience addressing clients' housing needs and conducting benefits enrollment as part of their work, a targeted housing stabilization case management service will require new skills and knowledge about how to navigate housing programs, negotiate benefits enrollments, and support tenancies. Acquiring these skills will require significant investment of time, resources and expertise, and stakeholders will have to consider these as part of the overall implementation process.

9.3.3. Enabling Data-Driven Program Management and Evaluation. In order to track progress, monitor program performance, and assess the achievement of goals, including cost offsets to justify in lieu of services funding by MCOs, new data will have to be captured by existing administrative data systems. Stakeholders must set metrics by which to evaluate the pilot for performance management purposes while it is implemented, as well as to perform outcome evaluations later. Program design and implementation must incorporate these metrics from the beginning and ensure that data can be captured. This will entail both providing technical resources to make data capture possible and building sufficient staff capacity to enter data and ensure data quality, hygiene, and security are maintained. LAHSA's HMIS and DHS's CHAMP system are the most likely to be modified to enable the capture of the necessary data, and implementing these modifications and training staff on their use will be essential next steps.

9.4. Relationship Building and Planning

9.4.1. Restating the Need. This report has made the case for addressing the permanent housing needs of homeless older adults in Los Angeles County. The homeless population over age 65 will continue to grow through 2027, with substantial excess healthcare costs, and its members are highly vulnerable to COVID-19 as well as to the ill health effects of homelessness generally. The cost of foregoing any organized intervention would be substantial, in both human and economic terms. The purpose of this report was to outline the scale of the problem, the opportunity costs, the potential approaches for an organized set of interventions, and some considerations for funding and cost efficiencies. But these are not ordinary times. The uncertainty regarding various funding sources, and the competing demands on scarce housing resources by a variety of highly vulnerable populations, create a challenging context in which to develop a set of implementation plans.

9.4.2. Collaboration and Trust. For all these reasons, and now more than ever, success in addressing the permanent housing needs of homeless older adults will require strong partnerships among various stakeholders who can leverage their expertise, funding and administrative infrastructures. The path forward is not clear, even if the goal is. A crucial next step will be the formation of a coalition of groups with expertise in housing, healthcare regulations, local public administration, state legislation and policy advocacy. The coalition should include and build upon existing collaboratives, including the Los Angeles Aging Advocacy Coalition (LAAAC), Funders Together to End Homelessness, Los Angeles County's Homeless Older Adult Working Group, the participants in the October 2019 Los Angeles Homeless Health Summit, and others. It must also include leaders from LAHSA and the County who would be in charge of implementing the pilot once funding is secured. We hope that this report can provide some guidance to such a coalition, but our strategy ultimately defers to them, and to the future landscape of funding, as to what will be possible to achieve.