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Finding a Path to Support Aging in Place in California

Gaps in Financing Enhanced Services to Address Affordable Housing Resident Needs and Priorities

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The SCAN Foundation (TSF) envisions a society where all of us can age well with purpose. We pursue this vision by igniting bold and equitable changes in how older adults age in both home and community. Our grants and impact investments prioritize communities that have been historically marginalized with an emphasis on: older people of color, older adults with lower incomes, and older residents in rural communities. Learn more at https://www.thescanfoundation.org/.

This report was additionally made possible through the close collaboration of housing provider partners Retirement Housing Foundation (RHF), Menorah Housing Foundation, Mercy Housing of California and TELACU Residential Management. The views expressed in this report are those of the authors and do not necessarily reflect the views of the housing provider partners.

EXECUTIVE SUMMARY

Research consistently shows that more than 70 percent of Americans want to age in place, remaining in their own homes. Yet the country's shifting demographics, rising costs for long-term services and supports, and changing financing landscape make achieving this goal more challenging than ever, especially for low-income older adults. The aging services landscape continues to be highly siloed, leading to inefficient use of resources, services, and gaps with an inherent bias toward institutional services.

As Californians live longer but with greater levels of disease burden and functional limitation, an urgent need has emerged to maximize the value of home and community-based supports, Medicaid and Medicare benefits, and older adult services and housing infrastructure. In this way, we can reduce waste and redundancy of services and ensure that people who need support to age in place can access them. There is an opportunity to do more with less so that a person-first, place-based approach to seamless care coordination emerges and leverages trusted community relationships.

More than a quarter million older Californians live in affordable housing developments designed for older adults, ranging in size from a few dozen apartments to over a thousand units in large high-rises. Most of these residents are not only low-income and disproportionately burdened with chronic disease, but most are also dually eligible for Medicaid and Medicare—a group shown in countless studies to represent a considerable proportion of Medicare and Medicaid costs. Few residents appear to participate in aligned Medicare and Medicaid special needs plans (D-SNPs) or to access Medi-Cal waiver services.

This study answers fundamental questions about older adults living in supportive housing and the components of a housing-based model of care that could prevent avoidable health and human costs that arise when access to resources is so difficult and identify how this model could be financed. More specifically, this research:

- Identifies resident service gaps and priorities to understand how a place-based health and social care hub should be designed to meet the unique needs of California's linguistically and culturally diverse older adult populations
- Identifies financing options to meet these needs, as well as funding gaps in Medi-Cal (via California Advancing and Innovating Medi-Cal), Medicare Advantage (especially D-SNPs), Older Americans Act programs, Housing and Urban Development (HUD) funding, and other sources
- Provides recommendations for financing strategies and partnerships to implement, scale, and sustain a housing-centered health and social care access and coordination model

The most striking finding was that many residents are dually eligible for enrollment in one of a small number of health plans in Los Angeles County and are poor enough to qualify for many aging services programs, regardless of whether they use them. This situation suggests that a primary source of care navigation is critical and should be linked to the provision of long-term services and supports or home and community-based services provided by Medicaid managed care plans (MCPs) or by Medicare Dual Special Needs Plans. Most residents expressed concern about mobility limitations, cognitive decline, chronic pain, and awareness about resources for substance use disorders. It was striking that 59 percent of respondents rated their physical health as poor or fair, and 44 percent rated their mental and emotional health as poor or fair, indicators of rising risk in the resident population.

Although California has a laundry list of programs that could address resident concerns and risks, each source would require different partnerships, processes, and infrastructure. This schematic makes a braiding and blending plan daunting without fundamentally revisiting how older adults are demographically and financially screened for eligibility and then assessed for intensity of need. This program-centric, rather than person-centric, model underscores the need for comprehensive care navigation.

Because most residents are dually eligible for Medicaid and Medicare, an important opportunity to finance a place-based health and social care access and coordination model is California's Exclusively Aligned Enrollment D-SNPs, (EAE D-SNPs). Other opportunities that would fit the model partners envision for housing-centered care, include becoming Community Health Worker providers, and partnering or providing Enhanced Care Management and Community Supports services.

BACKGROUND

Across the United States, the population of older adults is growing rapidly and, with it, the number of older adults living in poverty or on the edge of it. As of 2023, more than 17 million adults older than age 60 live at or below 200 percent of the federal poverty level (FPL).[1] Research consistently shows that lower income older adults are more likely to experience chronic health conditions, face barriers to accessing care and support, and live in socially and economically disadvantaged environments that put them at higher risk for negative outcomes.[2]

As it relates to physical and cognitive health, rates of chronic conditions—including diabetes (37%) and hypertension (61%)—are significantly higher among the low-income aging population.[3] Cognitive decline and dementia are also more common among these individuals, often linked to trauma, educational disparities, and environmental stressors.[4,5]

The behavioral health needs of low-income older adults are also high. Nationally, 25 percent of older adults report symptoms of depression or anxiety with even higher rates among those with unmet medical or social

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[1] KFF (Kaiser Family Foundation). Poverty Rate by Age, 2023. Available at: https://www.kff.org/state-health-policy-data/state-indicator/poverty-rate-by-age/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[2] US Department of Health and Human Services. Social Determinants of Health and Older Adults. Office of Disease Prevention and Health Promotion. Updated March 17, 2025. Available at: https://odphp.health.gov/our-work/national-health-initiatives/healthy-aging/social-determinants-health-and-older-adults.

[3] National Center for Health Statistics. Health, United States: Chronic Conditions Data Tables. Centers for Disease Control and Prevention. Available at: https://search.cdc.gov/search/?query=Health%20United%20States%3A%20Chronic%20Conditions%20Data%20Table&siteLimit=NCHS&dpage=1.

[4] Alzheimer's Association. 2024 Alzheimer's Disease Facts and Figures. 2024. Available at: https://www.alz.org/facts

[5] I-WISH Study. *Improving Wellness in Senior Housing (I-WISH): Cognitive and Functional Health Findings.* 2024. Internal report.

needs.[6] The National Council on Aging also reports that access to behavioral health care is significantly limited among low-income and particularly for those with co-occurring cognitive issues, mobility limitations, or who live alone.[7]

Further exacerbating the physical and behavioral health needs of low-income adults are numerous non-medical drivers of health. For example, Feeding America reports that food insecurity affects 29 percent of older adults living in poverty.[8] Older adults also frequently lack reliable transportation, limiting their access to health and social services.[9]

The demographic profile of low-income older adults in the US is disproportionately people of color. Among adults aged 65 and older living below 200% of the FPL, over 40% are from racial and ethnic minority communities,[10] nearly two-thirds are women,[11] and a growing share are immigrants or non-English speakers, especially in states with large immigrant populations.

Needs Among Low-Income Older Adult Populations in California and Los Angeles

California, the nation's most populous state, has the largest population of low-income older adults in the United States. In 2023, more than 2.3 million adults older than age 60—approximately 6% of the state's total population—were living at or below 200 percent of the FPL.[12]

Los Angeles (LA) County, the most populous in the state, has the largest number of low-income older adults in California, with more than 700,000 aging Californians living in or near poverty.[13] According to the California Department of Aging (CDA), more than 80 percent of low-income older adults in the region identify as racial and ethnic minorities, including 45 percent of Latino/a, 15 percent of Black, and 12 percent of Asian populations. Among these groups, 40 percent are non-English speakers, and seven in 10 live alone.

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[6] Centers for Disease Control and Prevention. Mental Health Among Older Adults. DC Behavioral Risk Factor Surveillance System (BRFSS). 2022. Available at: https://www.cdc.gov/brfss.

[7] National Council on Aging. Mental Health in Aging: Policy and Practice Brief. 2023. Available at: https://www.ncoa.org.

[8] Feeding America. The State of Senior Hunger in America. 2023. Available at: https://www.feedingamerica.org.

[9] California Department of Health Care Services. Community Supports Community Needs Assessment Summary. California Advancing and Innovating Medi-Cal. 2022. Available at: https://www.dhcs.ca.gov.

[10] Federal Interagency Forum on Aging-Related Statistics. *Older Americans: Key Indicators of Well-Being.* 2023. Available at: https://agingstats.gov.

[11] Administration for Community Living (ACL). (2022). *2022 Profile of Older Americans.* U.S. Department of Health and Human Services. Retrieved from: https://acl.gov

[12] California Health Interview Survey (CHIS). (2023). *Older Adult Poverty and Health Indicators in California.* UCLA Center for Health Policy Research. Retrieved from: https://healthpolicy.ucla.edu/chis

[13] UCLA Center for Health Policy Research. California Poverty Measure (CPM) Report. October 2022 (using data from 2019-2021). AVAILABLE AT???

Low-income older adults in Los Angeles face complex and compounding health and social challenges. For instance, 75 percent of Medi-Cal enrolled older adults have three or more chronic conditions, 30 percent exhibit signs of cognitive impairment,[14] and 40 percent report depression or anxiety.[15]

Data from California Health and Human Services indicate that, as of May 2025, more than 455,000 Los Angeles residents older than age 65 were dually eligible for both Medicare and Medi-Cal,[16] which represents 32 percent of all such individuals living in the state and significant growth (58%) over the past 15 years.

Affordable Housing as a Hub for Health

A large segment of low-income older adults resides in affordable housing communities, where age-related health needs intersect with long-standing inequities in access to care. Nationally, 30 percent of older adult households are cost-burdened, meaning they spend 30 percent or more of their household income on housing, utilities, and other expenses.[17] The same report notes that, in 2021, "the number of renters age 62 and over eligible for rental assistance reached 5.9 million, an increase of almost 50 percent since 2011. However, housing assistance—including public housing, Housing Choice Vouchers, project-based Section 8 vouchers, and Section 202 Supportive Housing for the Elderly—is not an entitlement and does not fully meet demand. The available assistance was only sufficient to serve 36.5 percent of eligible households."[18] In California, about six in 10 older rental households were cost-burdened and four out of 10 were severely cost-burdened.[19]

As California advances integrated, community-based models through California Advancing and Innovating Medi-Cal (CalAIM) and other initiatives, the opportunity to reimagine care delivery in these settings is both urgent and actionable.

Research shows that integrated, on-site services connected to housing can significantly improve outcomes for older adults. For instance, a 2021 study found that after moving into affordable housing, that residents of older adults and people with disabilities (SPD) facilities used more primary care (+19 percent) and less emergency care (-18 percent) than in the year prior to moving in.[20] In a region like Los Angeles, where

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[14] I-WISH Study. *Improving Wellness in Senior Housing (I-WISH): Cognitive and Functional Health Findings.* 2024. Internal report.

[15] LA County Department of Public Health. (2024). *Behavioral Health Trends Among Older Adults.* Retrieved from: http://publichealth.lacounty.gov

[16] California Health and Human Services datasets: Dual Medi-Cal Enrollment and Medicare Advantage Enrollment in the Medicare Population in California Counties (May 2025). https://data.chhs.ca.gov/dataset/dual-medi-cal-and-medicare-advantage-enrollment-in-the-medicare-population-in-californian-counties

[17]. Joint Center for Housing Studies at Harvard University. Housing America's Older Adults 2023. (2023) https://www.jchs.harvard.edu/housing-americas-older-adults-2023

[18] Ibid

[19] Justice in Aging. "California's Older Low-Income Renters Continue to Be Squeezed by Housing Unaffordability and Face a Growing Threat of Aging into Homelessness (March 2024) https://justiceinaging.org/california-older-renters-unaffordability-homelessness/

[20] Enterprise and CORE. Health and Housing: Exploring the Intersection between Housing and Health Care (February 2026)

housing insecurity and care fragmentation are widespread, affordable housing communities represent a uniquely efficient and effective platform for delivering coordinated, preventive, and culturally tailored care.

California Integrated Care at Home Model Inspired by Vermont's Support and Services at Home

The California Integrated Care at Home Model (CICH) model draws inspiration from an affordable housing embedded enhanced service model developed in Vermont. In 2011, the Support and Services at Home (SASH®) model activated Vermont's affordable housing network as new nodes for prevention, primary care, long-term supports and services and community outreach. Housing providers became extenders to primary care providers, making health care less episodic, more person-centered, and more accountable.

SASH leverages housing-based service coordination and integrates **Community Health Workers (CHWs)**, **wellness coaches, nursing support**, and **community partnerships** to serve older adults where they live. It is intentionally designed to reach individuals at greatest risk for avoidable healthcare costs and least access to preventive care.[21] Staffing elements of the model include:

- **CHWs:** Conduct health and social assessments, coordinate services, and support culturally responsive engagement
- **Nursing Support:** Provide medication management, chronic disease screening, and health education
- **Wellness Coaches:** Address low-acuity behavioral health needs, with a focus on early intervention
- **Program Managers:** Oversee operations and partnerships

One evaluation of SASH showed that participants reported improvement in and better management of chronic conditions, healthier lifestyles, and fewer hospitalizations.[22] The same evaluation showed that the program resulted in Medicare savings of more than $1,450 per urban beneficiary per year and Medicaid savings of up to $400 per beneficiary per year.[23]

Adapting to the California Context and Related Needs

This report examines how the SASH model could be adapted to meet the needs of older adults living in California's affordable housing settings, including the diverse and densely populated urban environment of Los Angeles. It further explores possible financing pathways for CICH services provided by CHWs, nurses, and wellness coaches for mild to moderate behavioral health supports. The CICH model, as proposed, draws inspiration from the SASH model, but would be tailored to the unique demographic, linguistic, and

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[21] https://www.leadingageca.org/California-Integrated-Care-at-Home

[22] Support and Services at Home (SASH) Evaluation: Highlights from the Evaluation of Program Outcomes from 2010 to 2016," HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, July 2019. https://aspe.hhs.gov/system/files/pdf/262061/SASH5hl-rs.pdf.

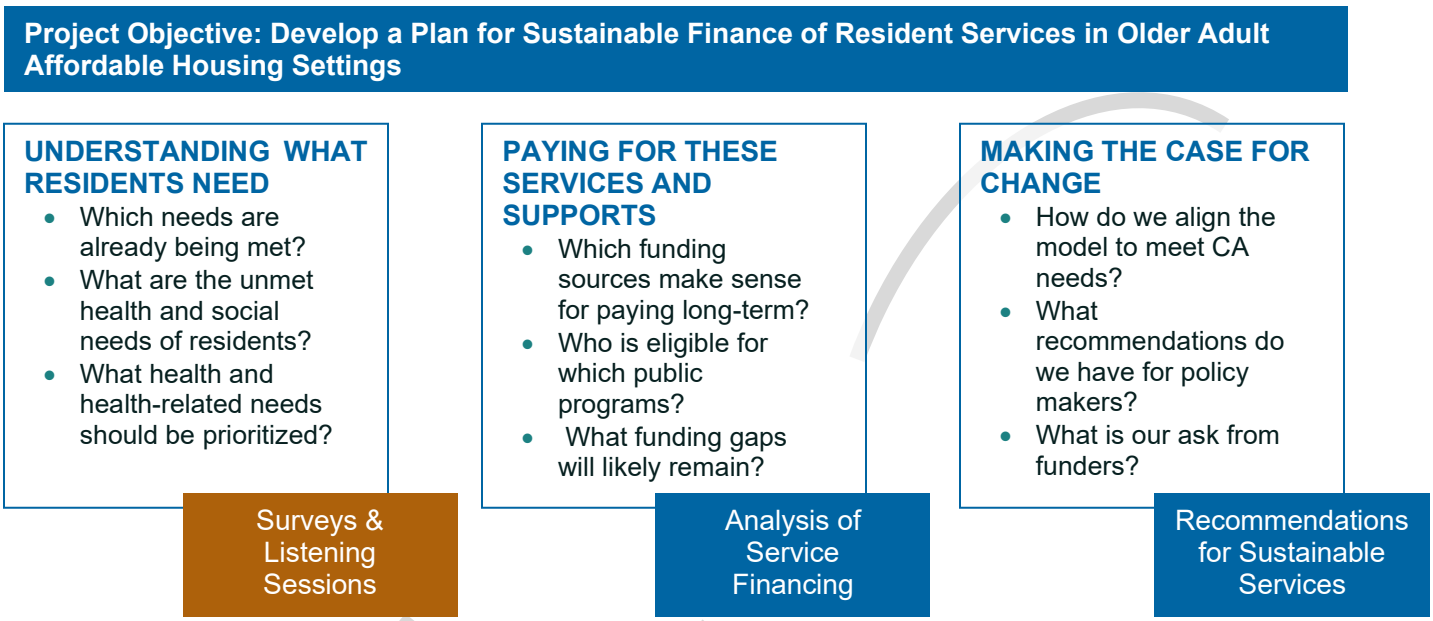
[23] Ibid.

structural realities of Los Angeles and California in alignment with state and regional programmatic and workforce needs and opportunities.

To explore the model's fit, Health Management Associates, Inc. (HMA), sought to understand the needs of older adults living in low-income housing in partnership with four affordable housing providers operating in Los Angeles—Mercy Housing of California (Mercy Housing), Retirement Housing Foundation (RHF), Menorah Housing (MHF), and The East Lost Angeles Community Union Residential Management (TELACU). Each housing partner selected sites that had service coordinators who had established relationships with the residents and who agreed to serve on the project advisory board to guide the research. Buildings where there was high turnover of service coordinators were not selected. This convenience sample is not representative of all affordable housing older adult residents in LA County. However, we analyzed results by race and ethnicity and found that responses were mostly similar across racial and ethnic groups.

The combined number of residents in the housing sites studied was **4,490 residents.** As Figure 1 indicates, HMA sought to understand what residents need via interviews, surveys, and focus groups, potential pathways to pay for these services, and recommendations to align the model with older adults' needs. To support this effort, HMA convened a group of resident advisors from each site to inform the survey development and data collection process.

Figure 1. Efforts to Understand Housing Needs for LA County Older Adults



As Tables 1 and 2 indicate, most residents in the 14 program sites (spanning the four different affordable housing providers) are older than 65 years of age and income-eligible for both Medi-Cal and Medicare.

Table 1. Occupancy and Demographic Data of Sites

Participating Site	Total # Residents	% 65+	% Younger than Age 65
Mercy Housing of California	283	81.63%	18.37%
Retirement Housing Foundation (RHF)	1,355	97.71%	2.07%
TELACU* (All Sites)	1,648	90.96%	9.04%
Menorah Housing Foundation (MHF)	1,204	99.17%	0.83%
Total (All Sites) Age Eligible	4,490	95%	5%

Table 2. Presumed Eligibility of Medi-Cal and Medicare Eligibility*

Participating Site	% Meeting Income Eligibility (Single Occupancy)	% Meeting Income Eligibility (Double Occupancy)	Total Calculated (Income-Eligible)
Mercy Housing of California	55%	16%	71.0%
RHF	60%	37%	96.5%
TELACU	64%	31%	94.8%
MHF	67%	21%	88.0%
Total (All Sites)	62.9%	29%	92.0%

Eligibility based on data reported by housing organizations in June 2025 of occupants based on single and double occupancy thresholds ($21,598 and $29,188).

Findings from Resident Survey

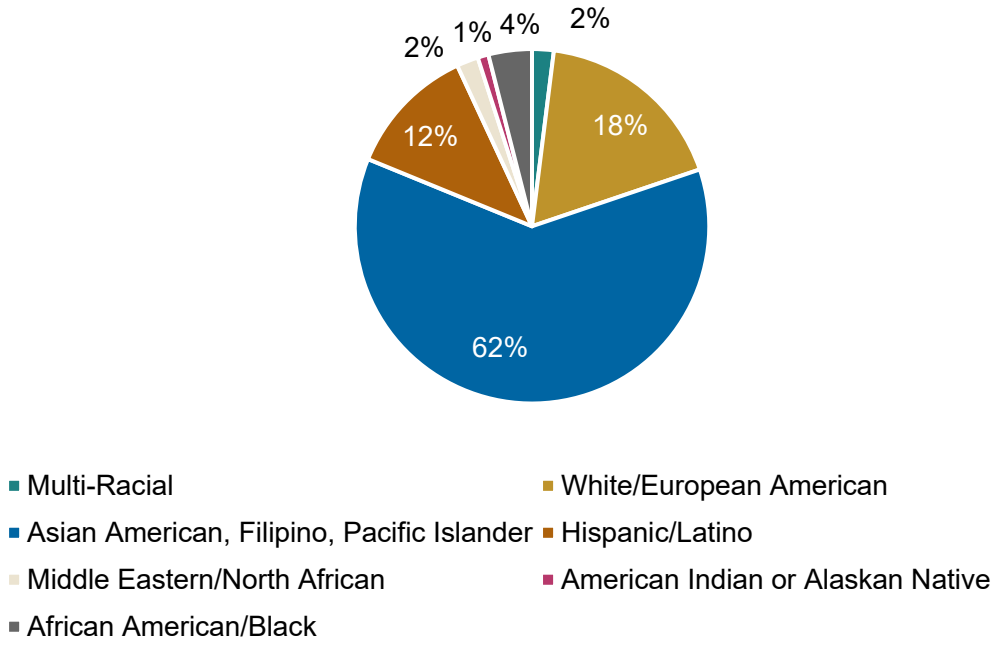
A total of 698 surveys were completed across four housing organizations—MHF, Mercy Housing California, RHF, and TELACU—providing valuable insights into the demographics, health experiences, and service needs of older adult residents.

Respondent Characteristics

Survey respondents represented a diverse cross section of the community. Most participants (62%) self-identified as Asian, Filipino, or Pacific Islander,[24] followed by White (18%), Hispanic/Latino/a (12%), and African American (4%). Smaller percentages identified as Middle Eastern/North African (2%), multiracial (2%), and American Indian/Alaskan Native (1%) (see Figure 2).

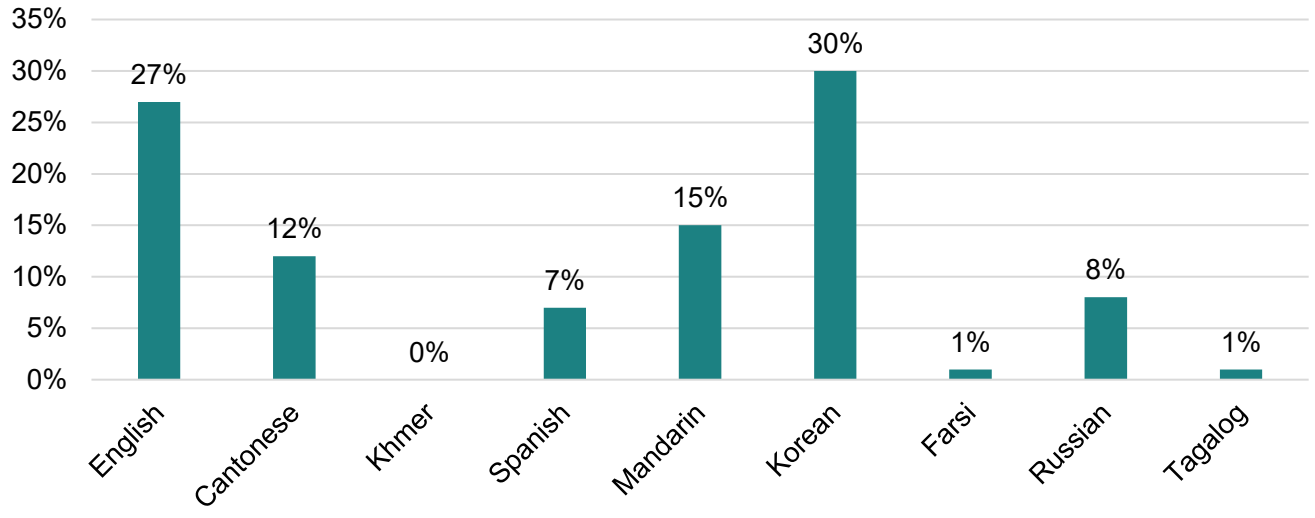
[24] Given the higher than expected proportion of Asian, Filipino, and Pacific Islander respondents, HMA analyzed survey responses to identify statistically significant differences (if any) between Asian and non-Asian respondents.

Figure 2. Ethnic and Racial Identities of Respondents



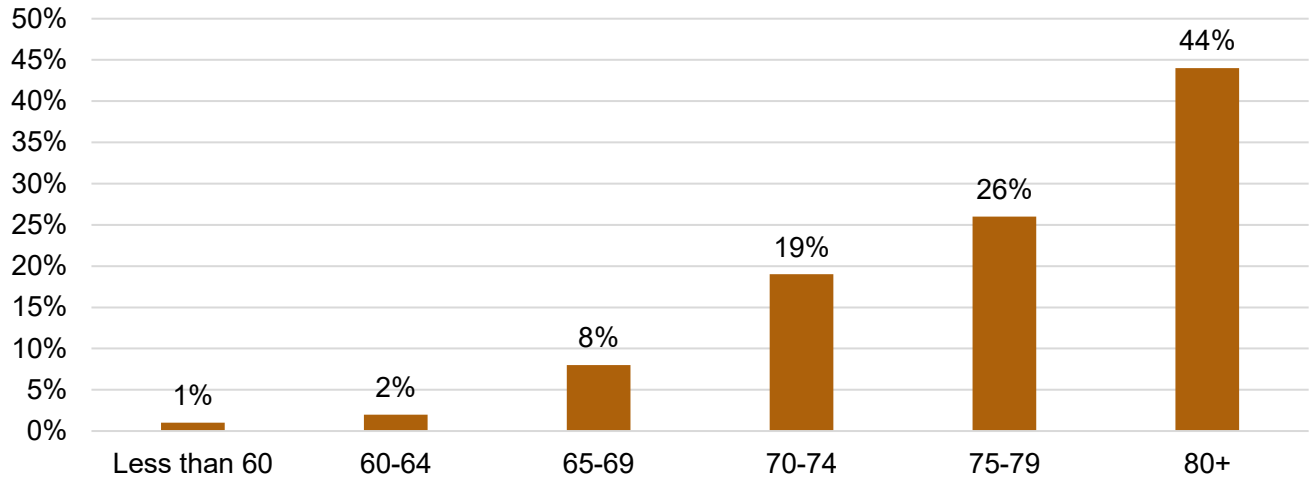
The survey was conducted in multiple languages, with the highest response rates in Korean (30%) and English (27%), followed by Mandarin (15%), Cantonese (12%), and Spanish (7%). Other languages, including Khmer, Farsi, and Tagalog, accounted for 1 percent or less each (see Figure 3).

Figure 3. Preferred Languages of Survey Participants



Respondents tended to be older, with the largest group composed of people age 80 and older (44%), followed by those ages 75–79 (26%), 70–74 (19%), and 65–69 (8%). Women were more highly represented (64%) than (35%) (see Figure 4).[25]

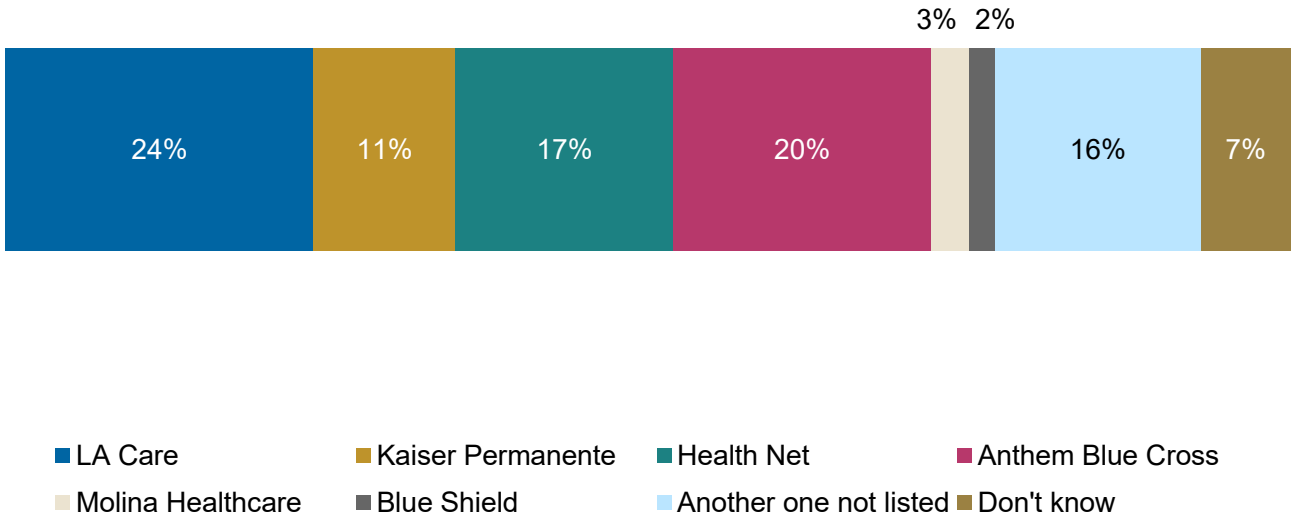
Figure 4. Age Distribution of Respondents



[25] Differences based on gender, where significant, are reported.

LGBTQIA+ and US military veterans' representation was limited: 1 percent and 6 percent, respectively. Most respondents had insurance coverage, with 96 percent enrolled in Medicare and 86 percent in Medi-Cal. Many respondents were dually enrolled, with the most common managed care organizations being LA Care (24%), Anthem Blue Cross (20%), Health Net (17%), other plans (16%), and Kaiser (11%) (see Figure 5).

Figure 5. Common Managed Care Plans Among Respondents

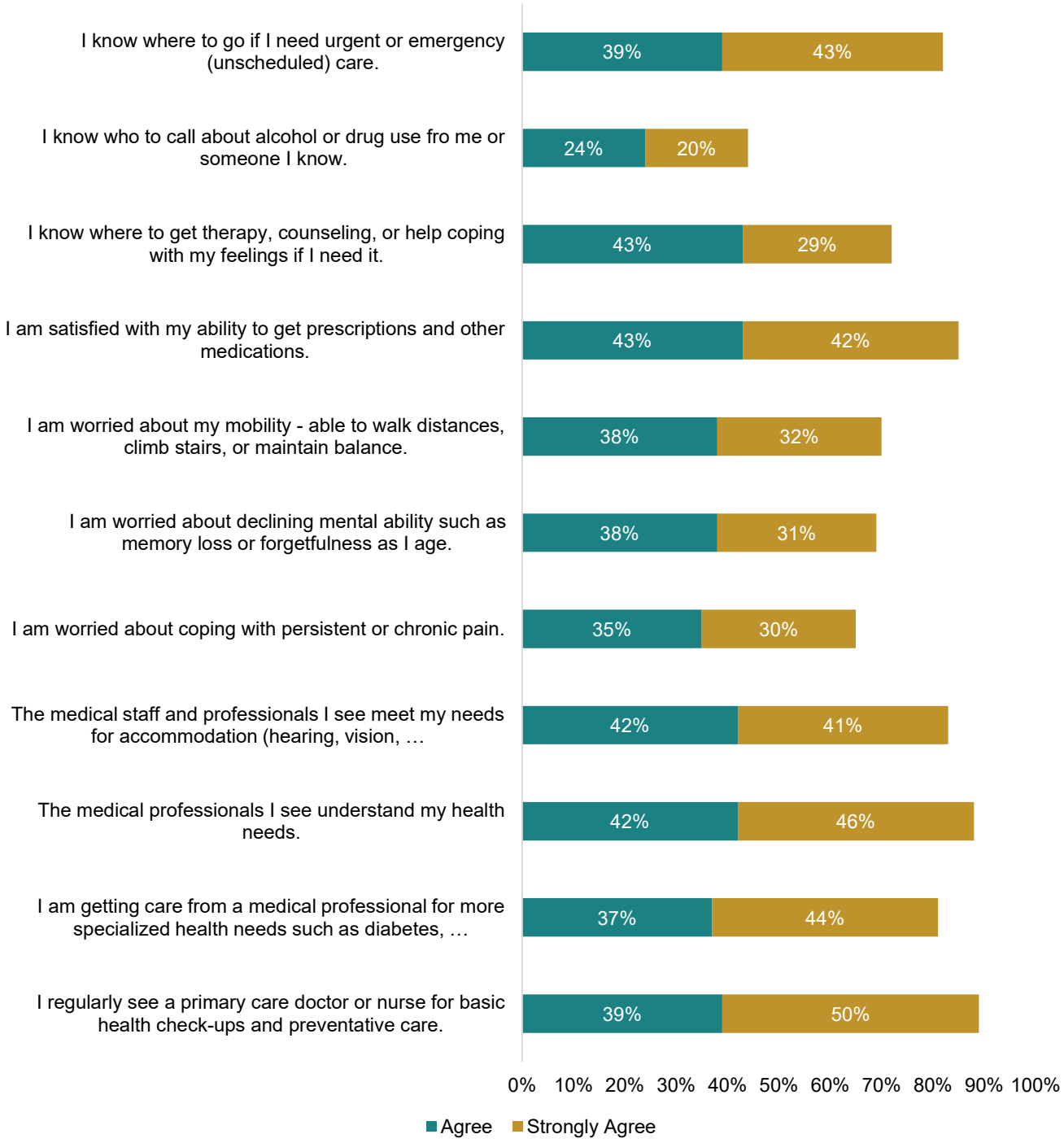


Highest Areas of Health Satisfaction

Residents reported high satisfaction in the following areas of access to care (see Figure 6).

- **Primary care providers are accessible.** 89 percent agreed (50% strongly agreed, 39% agreed).
    - A statistically significant difference emerged between Asian American and other ethnic groups, with Asian Americans more likely to "agree" rather than "strongly agree." In other word, non-Asians were more positive about access to primary care.
- **Medical professionals who understand health needs are accessible.** 88% agreed (46% strongly agreed, 42% agree).
- **Prescriptions and medications are accessible.** 85 percent agreed (42% strongly agreed, 43% agreed).
- **Specialized care is accessible:** 81% agreed (44% strongly agreed, 37% agreed).

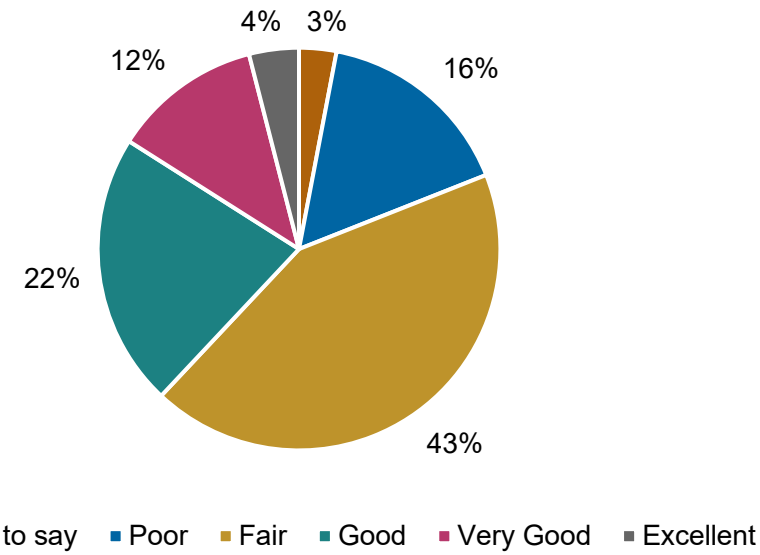
Figure 6. Respondent Experiences with Access to Care



Top Health Priorities

As shown in Figure 7, 38 percent of respondents rated their physical health as excellent, very good, or good and a sizable portion reported their health as fair (43%) or poor (16%).

Figure 7. Current Physical Health of Respondents



Some of the key health concerns shared by respondents included:

- **Mobility limitations:** 70 percent of respondents expressed concern (32% strongly agree, 38% agree), with 27 percent reporting they use a cane or walker and 6 percent needing a wheelchair or scooter.
    - Asian American respondents tended to express moderate concern ("agree"), indicating more concern about mobility.
- **Cognitive decline:** 69 percent were concerned about memory loss or forgetfulness as they aged.
    - Asian respondents were more likely to express concern, with higher rates of both "strongly agree" and "agree" than among other groups. Put another way, Asian respondents expressed greater concern about cognitive decline than to other respondents.
- **Chronic pain:** 65 percent expressed concern about chronic pain.
    - Asian American respondents were less likely to "strongly agree" that they had concerns about chronic pain and more likely to report neutral or milder concern. In other words, other respondents were more likely to express concern about chronic pain
- **Substance use awareness:** Only 44 percent reported they knew who to call about alcohol or drug use, with more than one-third selecting "don't know" or "N/A."

Top Health-Related Services and Supports
Respondents identified several priority support needs:

- Interpretation services for health information in languages other than English (25%)
- Help using technology to schedule appointments or connect with providers (19%)
- Assistance coordinating medical and healthcare appointments (19%)
- Guidance understanding health insurance coverage and benefits (18%)
- Access to healthy food or participation in healthy meals (18%)

We found no statistically significant differences based on race/ethnicity or gender in terms of priorities for health-related services and support.

Mental Health and Social Connectivity
Mental and social well-being emerged as important considerations. As shown in Figure 8, Eight percent rated their mental/emotional health as poor. Fourteen percent often lacked companionship, and 19% reported "hardly ever" interacting in person with other residents. Additionally, as shown in Figure 9, 20% said they "hardly ever" left the facility to visit friends, family, or attend outside activities — with men slightly more likely than women to report rarely leaving (13% vs. 8%). This was the one statistically significant survey response based on gender.

Figure 8. Current Mental and Emotional Health of Respondents

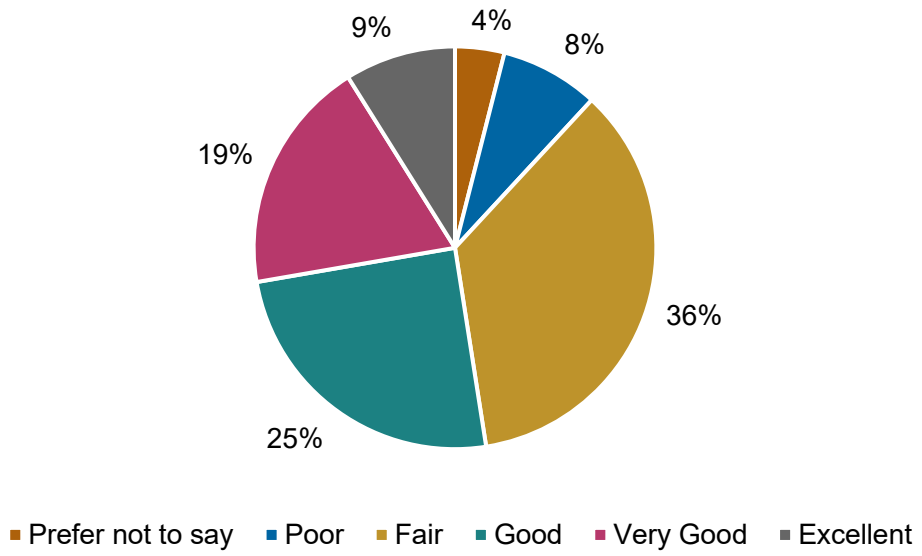
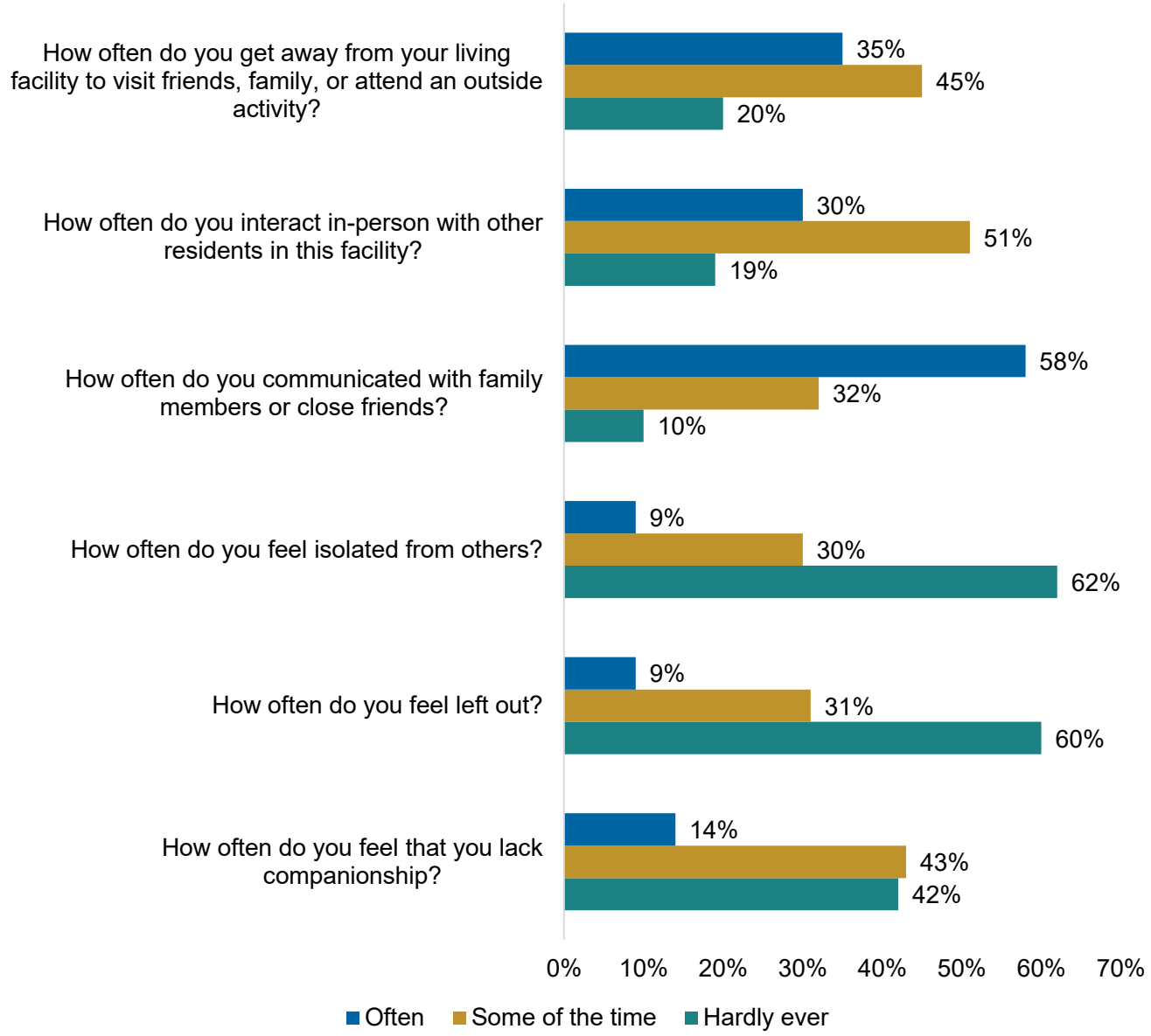
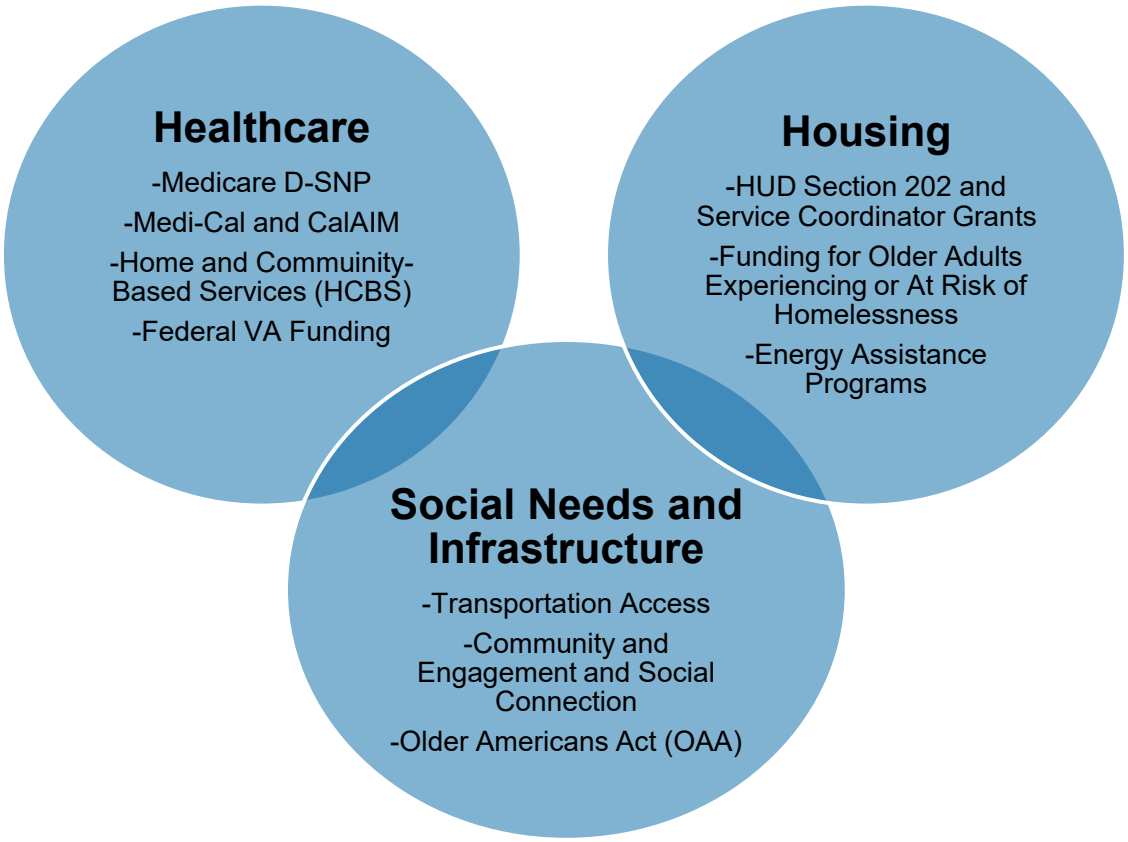


Figure 9. Feelings of Loneliness and Isolation Among Residents



PUBLIC FUNDING SOURCES OF INTEGRATED CARE FOR LOW-INCOME OLDER ADULTS

Several federal, state, and local programs fund for services that address the health and social needs of low-income older adults. These funding streams vary in their target populations, benefit structures, and delivery systems. Herein, we have divided the programs into three overlapping categories: health care, housing, social needs and infrastructure. Some programs are described in a single category but may span several domains. Key programs that were explored in the analysis are described below.



Healthcare

A. Medicare and Dual-Eligible Special Needs Plans

Medicare is the federal health insurance program for adults over 65, and dual-eligible special needs plans (D-SNPs) are Medicare Advantage plans specifically for people who qualify for both Medicare and Medi-Cal. D-SNPs offer enhanced care coordination and may include benefits beyond traditional Medicare, such as:

- Behavioral health services
- Prescription drug coverage
- Telehealth
- Vision, hearing, and dental
- Case management and chronic disease support

D-SNPs contract with states and managed care plans to integrate Medicare and Medicaid benefits, improving coordination for dually eligible members.

B. Medi-Cal and CalAIM: Foundational Support for Integrated Care

CalAIM is a statewide initiative launched in 2022 to reform Medi-Cal delivery and payment models, especially for individuals with complex care needs. CalAIM introduces new benefits and care models that address the social drivers of health for high-need populations. Key components of CalAIM relevant to this analysis include:

1. **Enhanced Care Management**

Enhanced Care Management (ECM) is a core benefit under CalAIM that provides comprehensive, person-centered care coordination for Medi-Cal enrollees with high needs. ECM is delivered by certified providers, including community-based organizations, clinics, and behavioral health agencies. It is funded on a per member, per month (PMPM) basis, with rates from $325 to $580, depending on the member's risk tier and geography.

ECM focuses on people with multiple chronic conditions, cognitive impairment, serious mental illness, or who are experiencing homelessness, among others. Table 3 includes ECM populations of focus relevant to older adults.

Table 3. ECM Populations and Eligibility Criteria

ECM Population of Focus	Eligibility Criteria (Summary)
Adult Individuals Experiencing or at Risk of Homelessness	Must be homeless or at risk of homelessness AND have at least one complex physical, behavioral, or developmental health need
Adult Individuals at Risk of Avoidable Hospital Usage	≥5 avoidable emergency department (ED) visits or ≥3 unplanned hospital/skilled nursing facility (SNF) stays in 6 months
Adult Individuals Living in the Community and at Risk of Long-Term Institutionalization	Meet SNF level of care or need skilled nursing AND have complex social/environmental factors AND can remain in the community with support
Adult Nursing Facility Residents Transitioning to the Community	Transitioning from a nursing facility to community living
Adults with Serious Mental Health or Substance Use Disorder Needs	Must qualify for specialty mental health or SUD services AND have complex social factors AND meet high-risk criteria (e.g., ED use, overdose risk, pregnancy)
Adult Individuals Transitioning from Incarceration	Recently released from incarceration

2. CalAIM Community Supports

Community Supports (CS) are flexible, non-clinical services offered in lieu of traditional Medi-Cal benefits to address social determinants of health. MCPs may offer these services to eligible enrollees based on assessed needs. A total of 14 CS are available, but eligibility is more complex and is an optional benefit. CS services eligibility is often based not only on a member's characteristics (for example, an individual at risk of or experiencing homelessness), but on the specific medical and social service needs of the member. Like ECM enrollment, members must agree to receive the benefit and participate in the program to access the services. Table 4 summarizes each community support available to adults and corresponding eligibility criteria.

Table 4. Community Supports and Eligibility Criteria

Community Support	Eligibility Criteria (Summary)
Environmental Accessibility Adaptations (Home Modifications)	- At risk for institutionalization in a nursing facility
Medically Tailored Meals/Medically Supportive Food	- Members with chronic conditions (e.g., diabetes, cardiovascular disorders, HIV, cancer, etc.) - Members being discharged from the hospital or at high risk of hospitalization or nursing facility placement
Personal Care & Homemaker Services	- Members at risk for hospitalization or institutionalization in a nursing facility - Members with functional deficits and no other adequate support system - Members approved for in-home supportive services (IHSS)
Asthma Remediation	- Individuals with poorly controlled asthma (e.g., ED visits or hospitalizations in the past 12 months). - Licensed healthcare provider documents that remediation will likely avoid asthma-related hospitalizations or ED visits
Recuperative Care (Medical Respite)	- Members at risk of hospitalization or post-hospitalization - Members who face housing insecurity or have housing that jeopardizes health and safety - Members who meet HUD definition of homelessness or are at risk of homelessness
Short-Term Post-Hospitalization Housing	- Members exiting recuperative care or inpatient stays (hospital, substance use treatment, correctional facility, etc.) - Members who meet HUD's definition of homelessness or at risk of homelessness
Respite Services	- Members dependent on a caregiver for activities of daily living (ADLs) - Children previously covered under Pediatrics Palliative Care Waiver, foster care, or with complex care needs
Sobering Centers	- Members ages 18+ who are intoxicated but conscious, cooperative, and nonviolent, and would otherwise be transported to the ED or jail

Community Support	Eligibility Criteria (Summary)
Day Habilitation	- Members experiencing homelessness - Members who exited homelessness and entered housing in the past 24 months - Members at risk of homelessness or institutionalization
Nursing Facility Transition/Diversion to Assisted Living Facilities	- For transition: Resided 60+ days in a nursing facility, willing to live in assisted living, and able to reside safely with supports - For diversion: Interested in remaining in the community, willing to reside in assisted living, and meets nursing facility level of care criteria
Community Transition Services/Nursing Facility Transition to a Home	- Receiving nursing facility level of care services - Lived 60+ days in a nursing home or medical respite setting - Interested in returning to the community and able to reside safely with supports
Housing Deposits	- Received or is receiving housing transition/navigation services - Prioritized for permanent supportive housing or rental subsidy through the local homeless Coordinated Entry System - Meets HUD definition of homelessness or is at risk of homelessness
Housing Tenancy and Sustaining Services	- Member received Housing Transition/Navigation Services - Member prioritized for permanent supportive housing or rental subsidy through the local homeless Coordinated Entry System - Meets HUD definition of homeless or at risk of homelessness
Housing Transition Navigation Services	- Prioritized for permanent supportive housing or rental subsidy through the local homeless Coordinated Entry System - Meets HUD definition of homelessness or at risk of homelessness

3. Community Health Worker Reimbursement Under Medi-Cal

As part of CalAIM, the California Department of Health Care Services (DHCS) issued All Plan Letter (APL) 24-006, which requires Medi-Cal MCPs to reimburse for services provided by CHWs. CHWs may provide health education, care coordination, outreach, and system navigation, particularly for enrollees with chronic conditions or social risk factors. CHW services are billed by the hour, with reimbursement rates of $45–$65.

C. Home and Community-Based Services

Medi-Cal offers a range of HCBS through various waivers and programs, including:

- Multipurpose Senior Services Program (MSSP)
- Community-Based Adult Services (CBAS)
- In Home Supportive Services (IHSS)

These programs provide services such as adult day health care, personal care assistance, respite, case management, and support for ADLs. HCBS programs help older adults remain safely in the community and delay or avoid institutionalization.

D. Federal VA Funding

Through the Veterans Health Administration (VHA), veterans can receive a broad package of medical benefits that include primary care, behavioral health, pharmacy, and specialty services. Veterans who cannot easily access VA facilities due to geographic or logistic barriers may qualify for the Community Care Program, which pays non-VA providers—such as local hospitals, home health agencies, or SNFs—to deliver needed services. For homebound or medically fragile veterans, the Home-Based Primary Care program brings VA care teams into the home, while the Homemaker/Home Health Aide (H/HHA) benefit funds community-based agencies to provide personal care, ADL support, and respite.

Housing Assistance and Housing Instability

A. HUD Section 202 and Service Coordinator Grants

The US Department of Housing and Urban Development (HUD) offers housing subsidies and supportive service funding for older adults through programs such as:

- Section 202 Supportive Housing for the Elderly, which funds construction, rehabilitation, and rental assistance for low-income older adults
- HUD Service Coordinator Grants, which support staff positions within affordable housing settings to help residents access health and social services

Although HUD programs do not fund direct healthcare or clinical services, they provide a foundation for housing stability and resident engagement.

Older adults in Los Angeles who are either experiencing homelessness or are at risk of losing housing can access different resources that are supported at the state, county, and city levels. These programs include:

B. Funding for Older Adults Experiencing or at Risk of Homelessness

1. State Programs

California has prioritized programs that integrate housing stability with social and health services. The Home Safe Program, administered by the California Department of Social Services, is specifically designed for older adults involved with Adult Protective Services (APS), offering supports such as rent arrears, home modifications, and housing navigation. As previously noted, for Medi-Cal eligible individuals, including many older adults, CalAIM CS offer flexible services such as housing transition navigation and tenancy support—critical for frail or medically complex individuals who require stable housing to manage their health.

Other programs like the Housing and Disability Advocacy Program (HDAP) focus on individuals who are likely eligible for disability benefits. It provides housing assistance along with help applying for Social Security Income (SSI), which can be a critical lifeline for older adults with unaddressed disabilities or chronic conditions.

California also supports broader housing stability efforts through flexible funding pools, including DHCS Flexible Housing Pools and capital-focused programs like Veterans Housing and Homeless Prevention (VHHP) and Homekey, which help develop or sustain Permanent Supportive Housing (PSH) for high-need populations, including veterans and older adults. Meanwhile, programs like the Encampment Resolution Fund (ERF) and the Behavioral Health Bridge Housing Program (BHBH) serve unhoused older adults in crisis, providing bridge housing and behavioral health care.

2. City and County Programs

Los Angeles County has an established system of care for unhoused individuals, largely funded by Measure H, a dedicated sales tax. Measure H supports a continuum of services including outreach, shelter, rapid rehousing, and PSH, many of which include aging-specific adaptations. For example, the Older Adult Housing Stability Pilot directly supports adults ages 55 and older with housing navigation and stabilization. The Los Angeles County Department of Health Services (DHS) operates the Care Transitions Program, which helps hospitalized older adults transition to housing. DHS also administers the Flexible Housing Subsidy Pool, often braided with other programs to support permanent placements for aging individuals. APS, part of the new Aging & Disabilities Department, provides frontline eviction prevention services, intervening with landlords, providing referrals, and leveraging additional support through Home Safe and IHSS programs.

The City's Department of Aging provides light-touch housing navigation, application assistance, and referrals to rental relief and legal services. Through the Los Angeles Housing Department (LAHD), the city offers eviction prevention, emergency rental assistance, and legal aid—all vital for low-income older adults with fixed incomes who may be at risk because of rising rents or eviction actions.

3. Homeless Prevention Programs for Veterans

For veterans at risk of homelessness or struggling to remain stably housed, the VA offers Housing and Urban Development – Veterans Affairs Supportive Housing (HUD-VASH), which combines long-term housing vouchers from HUD with intensive case management from the VA, providing a critical bridge to permanent housing for chronically homeless veterans. For shorter-term needs, the Supportive Services for Veteran Families (SSVF) program funds nonprofits to deliver rapid rehousing, homelessness prevention, and flexible financial assistance—such as help with rent, utilities, or security deposits. In California, veterans can also benefit from the VHHP, a state bond-funded initiative that supports capital and operating costs for PSH tailored to veterans' needs. These state investments are often braided with federal sources like SSVF and HUD-VASH to provide wraparound services.

C. Energy Assistance Programs

California offers multiple programs that assist older adults in managing their energy costs and staying connected to vital services:

- LIHEAP (Low-Income Home Energy Assistance Program): Federally funded, this program provides one-time utility payment support, emergency assistance, and home weatherization.
- Weatherization Assistance (via LIHEAP): Local providers install energy-efficient improvements for eligible older adults.
- California Alternate Rates for Energy (CARE) and Family Electric Rate Assistance (FERA): State-run discount programs that reduce monthly energy bills for low-income residents.
- Energy Savings Assistance (ESA) Program: Offers free home upgrades like weather stripping, insulation, and appliance replacements to qualifying households.
- Medical Baseline Program: Provides additional energy allotments at the lowest billing rate for customers with medical needs requiring high energy use.
- LADWP Senior Citizen Lifeline Rate: A local discount on utility bills for older adults in Los Angeles served by the Department of Water and Power.

Social Needs and Infrastructure

A range of programs—spanning the federal, state, and local levels—help older adults stay connected to their communities, engage in services, and reduce isolation as follows.

A. Transportation Access

- Federal Section 5310 (Enhanced Mobility of Seniors & Individuals with Disabilities): Administered by Caltrans, this program provides grants to nonprofit organizations and public agencies to fund transportation services and vehicle purchases tailored to older adults and people with disabilities.

- Low Carbon Transit Operations Program (LCTOP): Supports fare subsidies for low-income older adults who use public transit, funded by California's Cap-and-Trade program.
- Transportation Development Act (TDA): Allows local jurisdictions to fund older adults transportation options, including dial-a-ride and paratransit services.
- Access Paratransit: Provides door-to-door, Americans with Disabilities Act (ADA)-compliant transit for people with qualifying disabilities.
- CityRide Program: Offers subsidized ride credits (e.g., taxi vouchers) for adults ages 65+ and people with disabilities in the City of Los Angeles.
- Dial-a-Ride and Community Shuttle Services: Operated by local cities and agencies, these help older adults travel to medical appointments, older adult centers, and shopping.
- Metro Reduced Fare Transit Access Pass (TAP) Card: Available for riders age 62 and older, offering discounted transit fare across Metro-operated systems.

B. Community Engagement and Social Connection

- MSSP: Combines health and social services case management for Medi-Cal-eligible older adults at risk of institutionalization.
- Aging and Disability Resource Connection (ADRC) and CBAS: Provide person-centered counseling, access to adult day programs, and connection to long-term services and supports.
- Los Angeles County Department of Aging and Disabilities: Offers caregiver support, health promotion, legal assistance, nutrition services, and digital inclusion programs.
- 211 LA: A centralized navigation hub that helps older adults find services from transportation and food to health care and housing.
- Community and Wellness Centers: Operated at the city and county levels, these centers provide access to exercise classes, arts, meals, educational programming, and intergenerational opportunities.
- Digital Literacy and Device Programs: State-funded efforts, including those aligned with California's Digital Equity Plan, help older adults acquire devices and skills for internet use, thereby improving social connection and service access.
- Volunteer and Civic Engagement Programs: Opportunities like LA Works, RSVP (Retired Senior Volunteer Program), and Experience Corps offer pathways for older adults to stay engaged in their communities.

C. Older Americans Act

The Older Americans Act (OAA) is a federal law that provides funding for community-based services to support the health and well-being of adults ages 60 and older. OAA programs are administered locally by

Area Agencies on Aging (AAAs) and often delivered by community-based organizations (CBOs). Services funded by OAA include:

- Congregate and home-delivered meals
- Evidence-based health promotion programs
- Chronic disease and falls prevention workshops
- Transportation
- Caregiver support and respite

Funding is generally provided in the form of grants to local providers and is intended to promote independence and prevent or delay institutional care.

ANALYSIS OF SERVICE NEEDS AND AVAILABLE FUNDING

The CICH model is being designed to respond to the multifaceted health and social needs of low-income older adults living in affordable housing in California. To support and scale this model, HMA assessed the degree to which funding streams and programs—particularly through **Medi-Cal (CalAIM), Medicare Advantage**, the **OAA**, and **HUD service programs**—align with the core services CICH offers. Each funding stream comes with its own administrative requirements, benefit scope, and limitations.

CalAIM: A Foundational Strategy for Integration

Most residents included in the research sites qualify for Medi-Cal, and most are dually eligible for Medi-Cal and Medicare. CalAIM seeks to provide whole-person care to high-need populations through three primary vehicles relevant to CICH: **ECM**, **CS**, and **the formal inclusion of CHWs** as reimbursable providers.

ECM aligns with CICH's multidisciplinary, person-centered approach. ECM funding is structured as PMPM payment, ranging from $325 to $580, and is available for individuals with complex health and social needs. Some older adult residents surveyed identified as having needs related to cognitive impairment, multiple chronic conditions, or significant mobility limitations, and may be eligible. ECM is not available to enrollees in D-SNP plans, as these plans have their own care management requirements.

ECM promotes collaboration between MCPs and housing organizations, Federally Qualified Health Centers (FQHCs), and community-based providers, all of which are central to the CICH ecosystem. Accessing ECM funding would require that CICH sites/providers either become ECM providers or partners with entities that already are operating, such as local FQHCs, AAAs, or CBOs. ECM services would only be available to individuals who qualify based on the complexity of their health and social needs and may exclude many residents needing more preventive services and supports. In addition, opportunities to become an ECM provider have narrowed considerably over the past 12 months in highly saturated markets. In Los Angeles, for instance, MCPs are, for the most part, not entering into new contracts. Moreover, funding for technical assistance (through Providing Access and Transforming Health [PATH] and the TA marketplace) to support providers in becoming ECM providers and or developing related infrastructure has also narrowed or closed.

CS under CalAIM provide another potential funding pathway. This in lieu of services program allows Medi-Cal MCPs to cover non-clinical interventions that address health-related social needs. Relevant services for

the CICH population include home modifications, medically tailored meals, respite care, personal care, asthma remediation and housing transition services. CICH's model is structured to deliver or coordinate many of these services already, but eligibility is limited to high-risk Medi-Cal members, and each service must be authorized through the managed care plan. CICH would need to develop systematic referral and documentation processes, ideally in partnership with MCPs such as L.A. Care or Health Net, to deliver these benefits to residents. Here again, like with ECM, many of these opportunities to collaborate with MCPs with support from the state have narrowed or closed except for Transitional Rent.

CHW services are now reimbursable under Medi-Cal, thanks to APL 24-006. CHWs in the CICH model provide health and social assessments, health education, system navigation, cultural mediation, and some behavioral health support—all within the scope defined in the APL. However, housing providers cannot bill Medi-Cal directly for CHW services. Instead, CICH must contract with Medi-Cal MCPs or subcontract through an ECM provider to secure payment for CHW activities. Here again, in markets like Los Angeles, many of these pathways have narrowed or closed but could reopen or be established by building formal partnerships with local plans.

Medicare and D-SNPs: Unlocking Additional Supports for Duals

Although Medi-Cal is the primary payer for long-term services and supports, **Medicare Advantage (MA) plans**, particularly **D-SNPs**, offer financing potential. D-SNPs are tailored to individuals enrolled in both Medicare and Medi-Cal and often include enhanced care coordination, telehealth, behavioral health integration, and supplemental benefits, such as nutrition services or personal care services.

At most of the sites, residents are prima facie eligible for both Medi-Cal and Medicare, making them ideal targets for D-SNP engagement. These plans may be able to support core CICH services, such as **nursing, medication management**, and **preventive screenings**, through shared savings models or subcontracting arrangements. D-SNPs also have incentives to invest in social services that may reduce hospitalizations and improve quality metrics. Here again, alignment depends on individual plan design, and contracting would require negotiation with plans (e.g., Molina, SCAN, and Anthem) to integrate CICH activities into their networks.

It is worth noting that dually eligible individuals enrolled in a D-SNP are not eligible for ECM services funded through Medi-Cal. D-SNPS are already required to provide robust care management and coordination. Because of this, ECM services would be duplicative with what the D-SNP is supposed to deliver.

California established specific standards for integrated care coordination for certain vulnerable populations enrolled in D-SNPs called California Integrated Care Management (CICM). CICM builds on federal requirements by adding California-specific expectations. Beginning in 2026, CICM will replace the "ECM-like care management" requirements that applied to D-SNPs in 2024 and 2025.

Older Americans Act: Community-Based Supports Through AAAs

CICH also aligns with key components of the **OAA**, which funds nutrition programs, evidence-based health workshops, and wellness services administered through **AAAs**. These services are often underutilized in housing settings despite their relevance and availability. By co-locating OAA-funded services at CICH sites—and using CHWs to drive resident engagement—CICH can strengthen program uptake while offsetting operational costs. For example, on-site delivery of chronic disease self-management programs

and meal supports could complement CICH's wellness coaching and behavioral health offerings; however, CICH cannot bill OAA funds directly and must work through AAA partnerships. Moreover, Los Angeles AAAs receive only $7 million annually in OAA funds, which is a small amount compared with the number of older adults they serve.

HUD and Service Coordinators: Leveraging Site-Based Resources

Some sites may already benefit from **HUD Service Coordinator** grants or be eligible for **Section 202 supportive housing funding**, which can cover resident service coordination, transportation links, and assistance with benefits enrollment. Although these programs do not cover clinical services or CHW wages, they can provide a partial infrastructure for the CICH model—especially with regard to resident engagement, housing stability, and care navigation. However, HUD funding varies widely by site and is not universally available across all sites.

Table 5. Alignment and Action by Funding Source

Funding Source/Program	Alignment with CICH	Key Gaps	Action Required
CalAIM – ECM	High	Requires certification or subcontracting	Formalized partnerships with MCP or ECM providers
CalAIM – CS	High	Limited to qualified residents, plan approval required	Formalized partnerships with MCP or ECM providers
CHWs (APL 24-006)	High	Reimbursement only via MCP contracts	Contract with managed care organizations (MCOs), align roles with billing scope
HCBS (IHSS, CBAS, MSSP)	Moderate	Access limitations and challenges	Assist with enrollment, partner with existing providers
D-SNPs/MA	High	Plan-by-plan variation; requires outreach	Initiate partnerships, align services with plan priorities
OAA (via AAA)	Moderate	Must partner with AAAs; limited funding	MOU development, co-location of services
HUD Grants	Moderate	Unavailable to some sites; non-health focus	Leverage where possible; integrate data systems

Key Insights

- Dual-eligible older adults have the broadest access to funding streams and care coordination models, particularly through D-SNPs and CalAIM.
- Medi-Cal only older adults may access most CalAIM benefits, CHW services, and HCBS programs but lack Medicare's outpatient care coverage unless otherwise arranged.
- Older adults enrolled in D-SNP plans are not eligible for ECM. D-SNP plans are responsible for delivering comparable care management services, and state policy avoids duplication between Medicare and Medi-Cal programs.
- Medicare only older adults have access to traditional health care services but miss out on social supports and care coordination unless enrolled in a robust MA plan.
- Uninsured older adults are largely excluded from both Medi-Cal and Medicare-based services but may qualify for county programs (e.g., My Health LA) and limited OAA-funded resources.

Table 6. Funding Sources and Access by Coverage Type for Low-Income Older Adults

Funding Source/Program	Medi-Cal Only	Medicare Only	Dual-Eligible (Medi-Cal + Medicare)	Uninsured/ Underinsured
CalAIM ECM	Eligible if high need exists (e.g., chronic illness, SDOH risks)	Not available	Full access via Medi-Cal MCO; often higher PMPM rate; not available in D-SNP	Not covered
CalAIM CS	Access to home modifications, food support, respite, etc.	Not available	Full access; services tied to housing needs and health risks	Not covered
CHW Services (under APL 24-006)	Reimbursed via Medi-Cal MCPs	Not reimbursed under Medicare	Covered under Medi-Cal portion; can be integrated with D-SNPs	Not reimbursed
HCBS Programs (e.g., IHSS, CBAS, MSSP)	Eligible if medically or functionally qualifying	Not eligible	Eligible via Medi-Cal; subject to participant caps and geographic availability	Not eligible; no access
Medicare Part B (Primary & Preventive Care)	Not applicable	Covers primary care, outpatient, mental health, preventive services	Covered via Medicare; gaps filled by Medi-Cal (e.g., copays, long-term care)	Not eligible unless enrolled in limited benefit programs
Medicare Advantage/D-SNPs	Not eligible	Can enroll in MA plan (benefits vary by plan)	D-SNPs offer coordinated care and case management, which will expand in 2026 with CICM, meds, behavioral health, care management	Not eligible

Funding Source/Program	Medi-Cal Only	Medicare Only	Dual-Eligible (Medi-Cal + Medicare)	Uninsured/ Underinsured
OAA Services via AAAs	Eligible for services like nutrition, workshops, transportation	Eligible	Eligible	Eligible (citizens and eligible residents only)
HUD Section 202 & Service Coordinator Grants	Access based on housing site's funding and services	Access if in funded site	Same as others	Same, but services may be limited if not integrated with safety net programs
My Health LA (LA County)	Not needed (Medi-Cal enrolled)	Not eligible	No need	Available for low-income, undocumented, or uninsured residents via County
MHSA / County Behavioral Health Funding	Access to some behavioral health and wellness services	Limited; may qualify for outpatient services via Medicare	Covered via Medi-Cal and county safety net	May access county-funded mental health clinics or wellness programs

CRITICAL FUNDING GAPS

Although funding streams (Medi-Cal, Medicare, and OAA resources) exist, none is a perfect fit to the CICH model given the population it serves, reflecting not only shortfalls in funding, but also structural and administrative barriers that prevent many residents from accessing the services for which they are eligible. Without targeted solutions to close these gaps, the model risks leaving behind some of the most vulnerable residents and underdelivering on its promise of integrated, equitable care.

A. Behavioral Health: Underfunded and Fragmented

Behavioral health needs are common but poorly addressed within affordable housing communities for older adults. Among residents in the sites that participated in the needs assessment, few reported receiving behavioral health services through Medi-Cal or other sources. This shortfall is the result of multiple factors, including:

- **Limited reimbursement** for lower-acuity behavioral health services, such as those provided by wellness coaches, CHWs, or peer specialists
- **Strict credentialing requirements** for billable providers, excluding much of the non-clinical workforce involved in the CICH model
- **Lack of integration** between primary care and mental health providers, especially for Medicare-only or uninsured residents

Although some behavioral health services can be integrated through ECM or D-SNP care coordination, these approaches are insufficient to meet current demand. Dedicated funding for behavioral health—including low-intensity, preventive, and culturally tailored services—remains a critical gap.

B. Nursing and Medication Management: Inconsistent Coverage

The CICH model includes on-site nursing support (0.5 FTE per site) for medication reconciliation, chronic disease management, and preventive screenings; however, reimbursement pathways for these services are misaligned with the housing-based delivery model.

- **Medi-Cal** provides inconsistent reimbursement for preventive nursing services delivered outside of licensed clinic settings.
- **Medicare** fee-for-service reimbursement is limited to specific visit types, and D-SNP partnerships require negotiated arrangements that take time and capacity to establish.

Though nursing support is essential to reducing avoidable hospitalizations and maintaining functional independence, it remains a **critically underfunded component** of the CICH model. Alternative shared funding models should be considered in partnership with other CBOs (e.g., mobile medical clinics, etc.)

C. Underutilization of Home and Community-Based Services

Medi-Cal's HCBS waivers and programs such as MSSP, CBAS, and IHSS offer valuable support for personal care, adult day health, and in-home assistance. Nonetheless, key barriers remain, including:

- **Complex and lengthy enrollment processes**, often requiring multiple assessments and approvals

- **Limited outreach and navigation support**, particularly for non-English speakers and residents with cognitive or functional impairments
- **Service deserts**, where providers are unavailable or accept no new clients, particularly in certain parts of Los Angeles

Without proactive enrollment assistance and navigation—functions that could be provided by CHWs or care coordinators—many residents miss out on services that would allow them to remain independent and avoid costly institutional care.

POLICY RECOMMENDATIONS

California is a national leader among states attempting to improve their approach to aging services through implementation of a Master Plan for Aging. A major challenge recognized by state leaders and aging advocates is the fragmented nature of funding, eligibility, and service delivery. The meta-argument for "blending and braiding" of services is a common call to action, but the strategies and tactics have remained elusive. The results from this survey reaffirm both the challenges and slow progress. As California seeks to strengthen its capacity to support aging in place for low-income older adults, particularly those living in affordable housing settings, the following policy considerations emerge:

A. Establish a Single Lead Care Coordinator of the Older Adults' Choice to Coordinate Across All Programs

Care navigation is spread across a range of potential organizations and programs for older adults, including MCPs and their ECM providers, IHSS, Adult Day Services, and Program of All-Inclusive Care for the Elderly (PACE) programs. The reality is all these programs largely coordinate within their program or service footprint leaving older adults and their families the difficult challenge of coordinating *across* these programs. Care navigation is often provider-centric rather than person-centric.

To simplify the number of choices for comprehensive care navigation, **allow older adults to identify one provider to serve as their comprehensive navigator** and pay that provider a monthly care coordination fee. Providers would need to meet minimum standards for staffing, service provision, and data collection.

Pilot this policy as follows.

1. Develop a Targeted ECM Model for Older Adults Living in HUD Assisted Housing

Findings from the report highlight that most residents in affordable older adult housing settings who participated in the study were Medi-Cal eligible, and most are dually eligible for Medicare and Medi-Cal. These individuals often have multiple chronic conditions, cognitive decline, and behavioral health needs, yet they experience fragmented care and underuse existing benefits. Though CalAIM's ECM benefit is designed for high-need populations, eligibility and contracting structures and lower levels of engagement leave many older adults underserved—particularly those who are at rising risk but not yet in crisis.

Hence, **California should consider designing an ECM model tailored to older adults or explicitly focused on older adults as a population of focus**. This model could draw lessons from successful initiatives in other states, such as Massachusetts' Senior Care Options program that integrates care for older

adults dually eligible for Medicaid and Medicare,[26] while adapting to California's demographic diversity and housing landscape.

A specialized ECM model for older adults would:

- Address the complex health and social need (including mobility limitations, including cognitive decline, and behavioral health challenges) of rising risk populations before they require institutional care, reducing costly hospitalizations and SNF placements.
- Leverage housing as a care hub, aligning with evidence from Vermont's SASH® model and California's own goals for integrated, community-based care.
- Align with D-SNP California Integrated Care Management (CICM) requirements beginning in 2026, creating a unified platform for Medicare and Medi-Cal benefits and reducing administrative complexity.

This recommendation would require state policy and regulatory action, including possible assessment of current rates and possible adjustments to ECM rate setting to reflect housing-based delivery costs. DHCS would need to issue updated APLs or amend the ECM Policy Guide to define the new population and clarify housing-based ECM delivery standards. It would also require Centers for Medicare & Medicaid Services (CMS) approval if changes affected the 1115 waiver or rate structure, which may be challenging given the current environment.

2. Foster Partnerships Between Health Plans and Affordable Housing Providers

California is experiencing a major transformation in how care is delivered to dual-eligible individuals. While currently only available in 12 counties, DHCS is planning an expansion of Exclusively Aligned Enrollment (EAE) D-SNPs to at least 41 of California's 58 counties beginning in 2026. These plans will integrate Medicare and Medi-Cal benefits into a single product, creating a powerful platform for whole-person care. The D-SNPS are accountable for both medical and social outcomes and cover non-medical expenses (like nutrition, transportation, home modifications) that align with the CICH model.

Given the high percentage of dual eligibles in affordable housing settings and the trusted relationships between housing providers and residents, this shift creates an opportunity for housing providers to become potential hubs for D-SNP engagement and enrollment. Findings from this report suggest that residents are generally satisfied with access to primary care but struggle with care coordination, technology use, and social connectivity**. Embedding care teams in housing settings can close these gaps and address non-medical drivers of health, such as food insecurity and isolation**.

No specific policy or regulatory authority would be needed to operationalize this recommendation; however, DHCS might need to issue guidance or share information about how housing-based services can be integrated into D-SNP care coordination and quality improvement strategies. More than anything, it would require the willingness of health plans and affordable housers to partner together to design and implement

[26] Senior Care Options (SCO) | Mass.gov

such a program, including all the associated MOUs, workflows and data and financial assurances that might be necessary to advance such a partnership.

One potential action for funders to consider would be supporting a pilot project between housers and a D-SNP carrier (e.g., LA Care, Health Net, SCAN). The pilot might support elements of the CICH model in affordable housing communities and explore shared savings arrangements with D-SNPs and Medi-Cal MCPs to finance preventive services. The result would be data showing the impact and potential financial savings of such a model, alongside the development of a standardized model MOU and data-sharing agreements to streamline contracting between housing providers and D-SNPs.

3. Simplify the Pathway for Housing Providers to Become CHW Providers

CHWs are central to culturally responsive, housing-based care and have increasingly become essential tools in a strong, diverse, and vibrant health care workforce. They bridge language and cultural gaps, assist with navigation, and provide preventive support. Nevertheless, as the report notes, housing providers cannot bill Medi-Cal directly for CHW services, and certification requirements create barriers to participation.

Benefits of streamlining CHW integration include:

- Enable housing providers to deliver reimbursable services, reducing reliance on unstable grant funding
- Expand the workforce to meet the needs of linguistically diverse older adults, particularly in Los Angeles where 40 percent of residents are non-English speakers
- Align with APL 24-006, which formalized CHW reimbursement under Medi-Cal, ensuring sustainability for housing-based health navigation

Because housing providers are not recognized as eligible supervising entities, regulatory changes would be required. It would also require infrastructure investments to support the development of robust systems for documenting, billing and compliance with HIPAA that are required for Medi-Cal reimbursement under managed care plan requirements.

Even so, **thinking creatively about how to leverage CHWs or make contracting for CHWs in affordable housing setting simpler could unlock a critical resource** for aging in place and reduce fragmentation in care delivery.

B. Develop a Single, Simple Eligibility and Initial Service Need/Intensity Intake Assessment Tool

Most aging service programs in California remain highly siloed. Each has its own eligibility requirements that are like those of other programs but differ enough to stand alone. Most of these programs have more potential clients than service space leading to waitlists and capped programs. As noted previously, most of these programs do not coordinate with one another, leading to inefficient use of resources, services gaps, and missed opportunities, shifting the navigation burden to older adults or their families. To address this challenge, consider the following.

1. Eligibility Screening for Older Adults

Developing a single demographic and financial eligibility screen for the set of services and programs that vulnerable older adults most commonly use (i.e., the 90% of services that meet 90% of needs).

- Blend state-funded or managed programs by standardizing (unifying) eligibility across these programs (i.e., if a vulnerable older adult that met a certain set of requirements the individual is likely eligible for this list of programs). This approach would create an initial “presumptive eligibility” standard, which does not now exist in aging but is common in state health policy elsewhere such as pregnancy and obstetrical services.
- Braid unified state aging services platform with more siloed federal health programs—Medicaid and Medicare. Require health plans to support the care coordination platform as part of their state licensing and/or Medicaid contracts. This approach may require 1915 waivers, Medicaid state plan amendments and/or Centers for Medicare & Medicaid Services demonstration projects.

2. Intake Assessment Tool

Develop a secondary intensity of need criteria for specific programs to determine at what point an eligible older adult would meet the need intensity threshold. Need intensity thresholds could vary over time based on state fiscal realities. Service offering should be based on intensity of need. Waiting lists should be eliminated in favor of clear guidance about when services will be available based on intensity of need.

Taken together, these recommendations offer a road map for California to build a scalable, sustainable model that integrates health and housing, reduces fragmentation, and honors the preference of older adults to age in place. By acting now, the state can leverage existing policy levers—CalAIM, D-SNP alignment, and CHW reimbursement—to create a system that is both person-centered and fiscally responsible.