Special Meeting of the

Santa Clara County Health Authority
Governing Board

Thursday, May 20, 2021, 3:00 PM – 5:00 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference
(669) 900-6833
Meeting ID: 872 2175 5147
Passcode: SPBD052021
https://us06web.zoom.us/j/87221755147

AGENDA

1.	**Roll Call**	Mr. Brownstein	3:00	5 min
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Governing Board reserves the right to limit the duration of the public comment period to 30 minutes.	Mr. Brownstein	3:05	5 min
3.	**CalAIM Study Session** Review and discuss CalAIM.	Ms. Hennessy Mr. Haskell	3:10	80 min
4.	**Innovation Fund Expenditure** Consider funding for the Agrihood Senior Apartment Pilot. **Possible Action:** Approve expenditure from the Board Designated Innovation Fund for the Agrihood Senior Apartment Pilot, subject to noted contingencies.	Ms. Andersen	4:30	30 min
7.	**Adjournment**		5:00	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Governing Board on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Rita Zambrano 48 hours prior to the meeting at (408) 874-1842.
- To obtain a copy of any supporting document that is available, contact Rita Zambrano at (408) 874-1842. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com.

Santa Clara Family Health Plan™

CalAIM Study Session

Governing Board

May 20, 2021

What is CalAIM?

California Advancing and Innovating Medi-Cal

- Roughly two dozen Medi-Cal proposals designed to address Governor's top challenges:
  - Homelessness
  - Insufficient access to behavioral health care
  - Children with complex medical needs
  - Clinical needs of justice-involved populations
  - Aging population

Three Primary Goals

1. Identify and manage member risk and need through whole person care approaches and addressing the social determinants of health

2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility

3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform

Ok, so what does it propose?

Seven Core Initiatives

- Enhanced Care Management
- In Lieu of Services
- Mandatory managed care populations
- Population health management plan
- Ending Cal MediConnect and requiring DSNPs
- Regional rates
- NCQA accreditation for plans and delegates

Oh. Is that all?

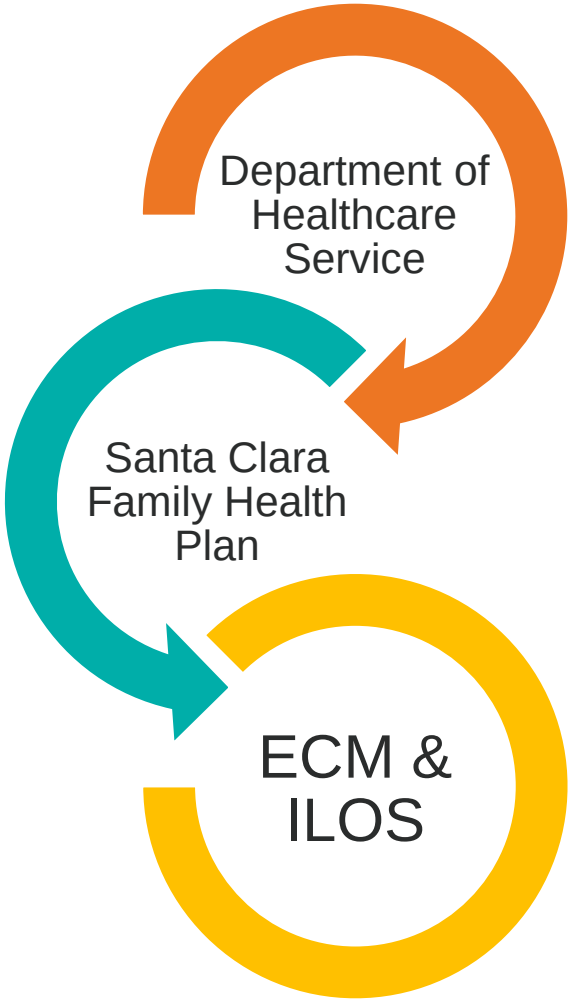
No, there's a bunch of other stuff

- Behavioral health changes
- Long-term plan for foster care
- Full integration plans/pilots
- County inmate pre-release application process
- Improving beneficiary contact and demographic info
- Institutions for Mental Disease waiver
- New dental benefits and PFP
- Waiver changes
- Carve outs and ins

Transitioning Whole Person Care and Health Homes Program

Purpose

- Build on the design and learning from Whole Person Care (WPC) pilot and the Health Homes Program (HHP)
  - **On January 1, 2022, Enhanced Care Management (ECM) with In Lieu of Services (or ILOS) replaces WPC and HHP**
- Transition WPC and HHP members into ECM and/or ILOS
  - Transition plans due to DHCS on July 2021
- Scales up the interventions to form a statewide care management approach
- Targets high-need, high-cost Medi-Cal managed care members



Enhanced Care Management (ECM)

Definition

- ECM is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals

- **Goals of ECM:**
  - Improve care coordination;
  - Integrate services;
  - Facilitate community resources;
  - Improve health outcomes; and
  - Decrease inappropriate utilization and duplication of services.

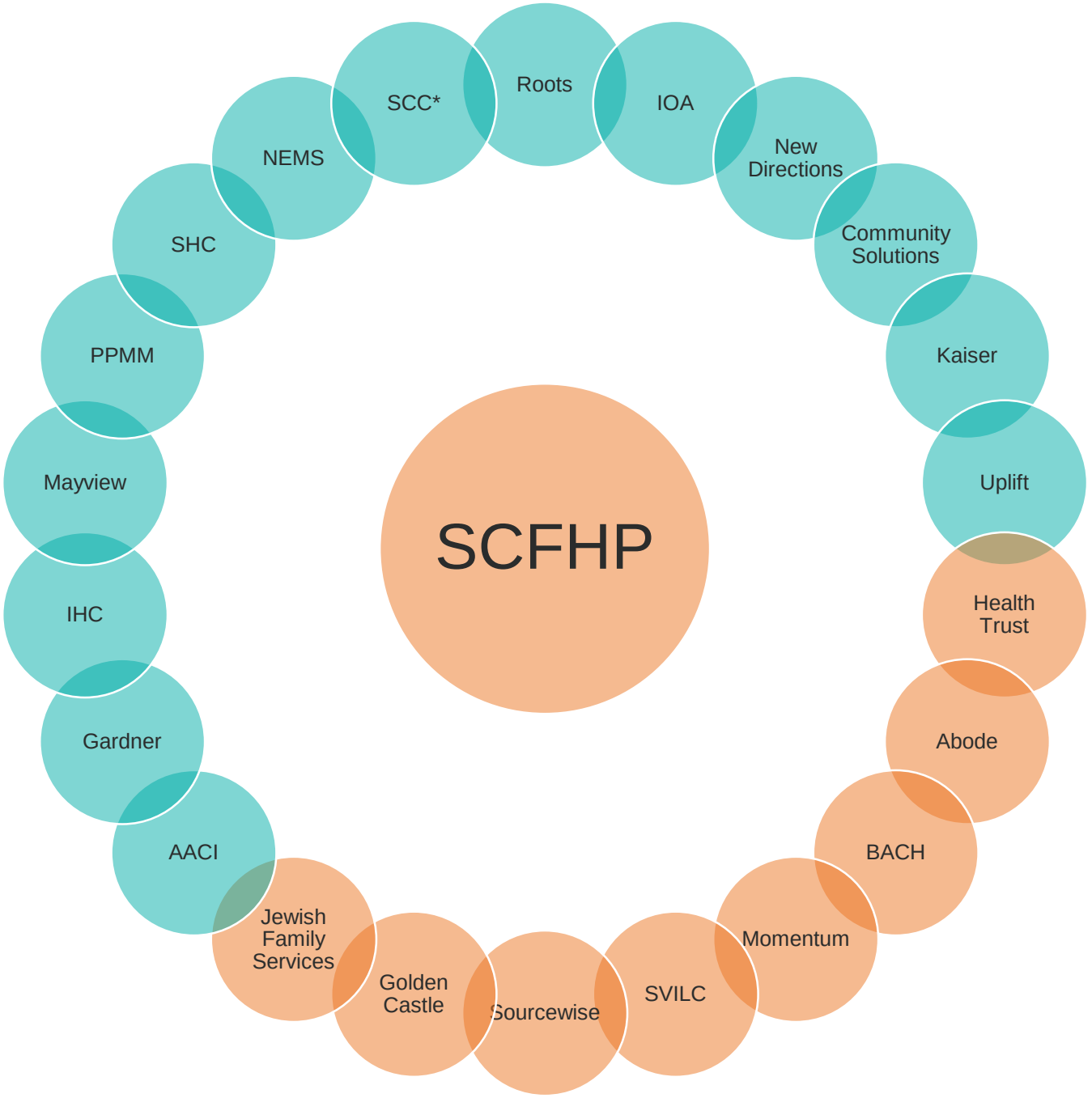
ECM Population of Focus

Homeless Individuals	• As defined by HUD and have at least 1 complex physical, behavioral, or developmental health need
High Utilizers	• 6+ avoidable ED visits or 2+ avoidable unplanned hospital and/or short-term SNF stays in a 12 month period
SMI/SUD	• Meet the eligibility criteria for participation in County Specialty Mental Health Plans and/or
Long Term Care	
Nursing Facility Residents	
Justice Involved	
Children with Complex Health Needs	

ECM Populations of Focus Go Live Changes

Go Live Date	WPC	HHP
1/1/2022	• Transition all WPC and HHP enrollees into ECM regardless of population of focus	
	• Go live with Homeless adults/youth, High Utilizer adults, SMI/SUD adults, adults transitioning from incarceration (if transitioned from WPC) for newly eligible	• Go live with Homeless adults/youth, High Utilizer adults, and SMI/SUD adults
1/1/2023	• Go live with justice-involved adults/children/youth, at risk LTC eligible, and SNF transitioning to community for newly eligible	
7/1/2023	• Go live with all other populations serving children and youth	

Potential ECM Providers



***SCC (Santa Clara County) includes:**
- VHC Bascom
- VHC Downtown
- VHC East Valley
- VHC Gilroy
- VHC Milpitas
- VHC Moorpark
- VHC Sunnyvale
- VHC Tully
- Valley Specialty
- Valley Homeless
- Office of Supportive Housing
- Behavioral Health Services Dept.

Current WPC and HHP providers

In Lieu of Services

Timeline

- Transition plans due July 2021
- Statewide implementation January 2022

Details

- NOT a benefit
- Will include the social support elements of WPC and HHP
- Plans can offer additional services at their discretion
- Services are to be medically-appropriate, cost-effective alternatives to approved state plan services
- DHCS expects ILOS offerings to become part of MLTSS benefit package offered in 2024
- If an ILOS is not offered initially countywide, plans must develop a plan for how and when it will be expanded throughout the county.

In Lieu of Services - Menu

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Recuperative care (medical respite)
5. Short-term post-hospitalization housing
6. Respite
7. Day habilitation programs
8. Nursing facility transition/diversion to assisted living facilities, such as residential care facilities or elderly & adult and adult residential facilities
9. Nursing facility transition to a home
10. Personal care (beyond IHSS) and homemaker services
11. Environmental accessibility adaptations (home modifications)
12. Meals/medically tailored meals
13. Sobering centers
14. Asthma Remediation

In Lieu of Services - Network Development for Phase 1

- Town Hall meeting with interested providers
- Crosswalk WPC and HHP services with ILOS
- Individual meetings with potential providers
- ILOS Readiness Assessment distributed to providers

Next Steps

- Review and score submitted readiness assessments
- Determine provider capacity and experience for ILOS options
- Prioritize ILOS to offer in Phase 1 – January, 2022
- Estimate plan & timeline for subsequent phases of ILOS network development
- Determine cost savings & effectiveness, estimated eligible members and ILOS pricing

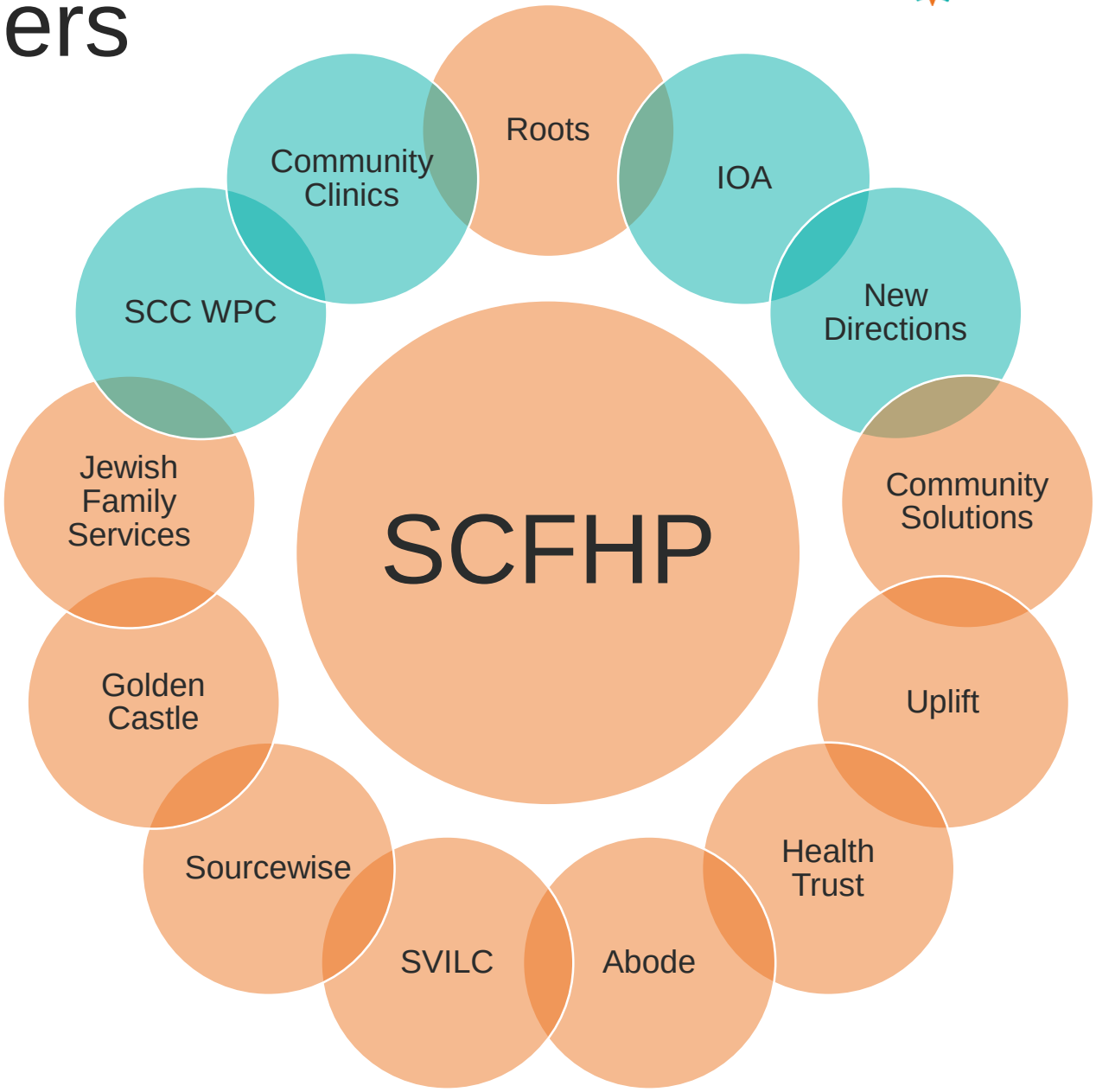
Potential ILOS Providers

HHP/WPC ILOS include:

- Housing Navigation
- Recuperative Care
- Sobering Center

Other Potential ILOS:

- Medically Tailored Meals
- Nursing Facility Transitions (2 ILOS)
- Housing (3 ILOS)
- Home Modifications
- Asthma Remediation
- Short Term Post Hospitalization
- Respite
- Personal Care
- Day Habilitation



Current WPC and HHP providers

Santa Clara County
Whole Person Care (WPC) Collaboration

- Developed a WPC Transition Workgroup involving SCFHP, Anthem, WPC, and VHP representatives
- Completed a crosswalk of the current WPC services to align with ECM requirements and ILOS options
- Next Steps with the WPC Transition Workgroup
  - Conduct deeper dives with county agencies into ILOS-like services provided under WPC to align with ILOS requirements
  - Receive completed ECM and ILOS readiness assessments to determine expanded capacity and infrastructure needs
  - Develop a transition plan for WPC enrollees into ECM and offered ILOS

ECM and ILOS Incentive Funding

- Incentive funding to assist with building infrastructure for ECM and ILOS for FY 2021-2022
- Funds can support infrastructure and/or capacity building needs for the plan or providers
- Anticipated release of guidance and allocations in June 2021
- SCFHP will assess for start up incentives for ECM/ILOS providers

Mandatory Managed Care Populations

Timeline

- Most new populations: January 2022
- Duals aid code groups except Share of Cost and Restricted Scope (for non-CCI counties): January 2023

Details

- Mandatory managed care enrollment for many currently voluntary or excluded populations
- Mandatory fee for service enrollment for certain beneficiaries now in managed care
- DHCS will implement blended SPD/LTC rate for SCFHP in 2023

Mandatory Managed Care Populations

New Mandatory Populations, by Aid Code (SCFHP count estimates in parenthesis)

- Trafficking and Crime Victims Assistance Program (138)
- Accelerated Enrollment (474)
- Pregnancy Related Aid Codes—Title XIX (PRS/ES) 138-213% (880)
- American Indian (360)
- Rural zip codes (13)
- Beneficiaries with Other Healthcare Coverage (20,860)

Remaining Exclusions

- Limited/Restricted Scope Eligible
- Foster Children (voluntary)
- Presumptive Eligibility
- State Medical Parole/County Compassionate Release/Incarcerated Individuals

New Exclusion

- Share of Cost (865)

Mandatory Managed Care Populations

Rationale

- Continues trend of increasing Medi-Cal managed care enrollment, reduces State risk
- Increases share of Medi-Cal enrollees able to receive coordination and integrated care

Key Takeaways

- Significant confusion about treatment of members with other health coverage complicates this transition
- Awaiting information from DHCS about the transition of Share of Cost members to fee-for-service
- Blended SPD/LTC rate presents some new risk

NCQA Accreditation

Timeline

- Mandatory accreditation for all plans and health plan delegates by 1/1/2026

Details

- DHCS will review and consider elements of NCQA findings to deem certain requirements met/unmet in place of annual medical audits in the future with more stakeholder vetting
- DHCS will require all Medi-Cal managed care plans and their health plan subcontractors to be NCQA accredited by 2026.
- DHCS will also require Medi-Cal managed care plan NCQA accreditation to include the LTSS Distinction Survey subsequent to all health plans operating a D-SNP by 2027

NCQA Accreditation

Rationale

- Advances goal of reducing variation and complexity across delivery systems
- Simplifies DHCS monitoring and oversight of managed care plans

Key Takeaways

- DHCS will require all Medi-Cal managed care plans and their health plan subcontractors (Kaiser, VHP) to be NCQA accredited by 2026

Population Health Management Program

Timeline

- Plans must operate a Population Health Management (PHM) program for Medi-Cal beginning January 2023

Details

- Complete integration of PHM into functionalities of health plan for coordination of services across the spectrum
- PHM program must meet NCQA and DHCS requirements (not necessarily accreditation)
- Plans must use robust data analytics to stratify members into risk categories and define programs to address needs for each category

PHM Category in Health Plan Accreditation

PHM 1: PHM Strategy	1A: strategy description 1B: informing members
PHM 2: Population Identification	2A: data integration 2B: population assessment 2C: activities and resources 2D: segmentation
PHM 3: Delivery System Supports	3A: practitioner or provider support 3B: value-based payment arrangements
PHM 4: Wellness and Prevention	4A: frequency of health appraisal completion 4B: topics of self-management tools
PHM 5: Complex Case Management	5A: access to case management 5B: case management systems 5C: case management process 5D: initial assessment 5E: case management—ongoing management
PHM 6: PHM Impact	6A: measuring effectiveness 6B: improvement and action
PHM 7: Delegation of PHM	

Population Health Management Program

Rationale

- Ensures there is a plan to identify and manage member risk and needs across the continuum of care
- Provides for the incorporation of other CalAIM elements—NCQA accreditation, enhanced care management and in lieu of services

Key Takeaways

- Will require initial data collection and population assessment, risk stratification, and individual risk assessment tool
- Case management services are intended for members who are medium- or high-risk or may have rising risks that would benefit from case management services

Cal MediConnect Transition to D-SNP

Timeline

- Cal MediConnect (CMC) to conclude at the end of 2022
- Coordinated Care Initiative (CCI) plans required to operate Dual Eligible Special Needs Plan (D-SNP) to enroll duals starting in 2023, non-CCI plans in 2025

Details

- Cal MediConnect members will be transitioned to D-SNP
- Enrollment of dual eligibles in Medi-Cal managed care will be mandatory beginning in 2023 (already mandatory in CCI counties), while enrollment in D-SNP will remain optional (like CMC)
- DHCS will consider allowing default enrollment of a plan's Medi-Cal members who are newly eligible for Medicare (aging in or eligibility due to disability)
- No passive enrollment (of current Medicare enrollees) will be allowed

Cal MediConnect Transition to D-SNP

DHCS Integration Standards

- Develop and use integrated member materials
- Include consumers in existing advisory boards
- Quarterly joint contract management team meetings with CMS
- Include dementia specialists in care coordination efforts
- DHCS/CMS will avoid duplicating audits at the same time
- Coordinate carved-out LTSS benefits (IHSS, MSSP, other waiver programs)

Cal MediConnect Transition to D-SNP

Rationale

- Apply lessons learned from CMC and expand integrated care for dual eligibles statewide
- Provide more flexibility and lower regulatory burden versus what is possible with CMC
- Reduce administrative costs and burden on DHCS

Key Takeaways

- Resource burdens on plans will vary widely, especially between those with and without CMC
- While SCFHP is relatively well-positioned to transition from CMC to a D-SNP, we will face significant challenges

Regional Rates

Timeline

- Targeted plans: January 2022
- Statewide: January 2024

Details

- Rates will be used across multiple counties instead of single counties
- Phase I will include plans covering multiple counties
- Phase II will include the rest of the plans

Regional Rates

Rationale

- Reduce number of different rates developed and paid by using same rates across multiple plans in a given region
- Plans will be incentivized to compete on efficiency with plans in the same region

Key Takeaways

- SCFHP will likely be grouped with other single-county plans in the area
- Large cost variations, even within small regions, will create winners and losers

CalAIM Timeline

2021
- Submit transition plan for Whole Person Care and Health Homes Program to ECM/ILOS (July)

2022
- Implement ECM and ILOS
- Mandatory enrollment of all nondual populations in managed care
- Cal MediConnect ends December 31

2023
- Implement population health management plan
- D-SNP coverage begins for duals
- Blended SPD/LTC rate

2024
- Implement regional rates

2025

2026
- NCQA accreditation for plans

2027
- Full implementation of integrated, managed long-term services and supports program

Santa Clara County Health Authority
Board Designated Innovation Fund Request Summary

Organization Name:	Santa Clara County Office of Supportive Housing
Project Name:	**Agrihood Senior Apartments**
Contact Name and Title:	Lori Andersen, Director LTSS
Requested Amount:	$2,420,000
Time Period for Project Expenditures:	April 2024 – June 2028
Proposal Submitted to:	Governing Board
Date Proposal Submitted for Review:	May 20, 2021

Summary of Proposal:

Five (5) year partnership between Santa Clara Family Health Plan (SCFHP), Anthem Blue Cross, and the County Office of Supportive Housing (OSH) for a pilot program at Agrihood Senior Apartments. This project will provide permanent housing with services and supports for SCFHP members transitioning from long term care (LTC). An estimated 44 housing units will be set aside for SCFHP members identified as appropriate for transition but who lack housing. Funding will pay for the supportive services to residents and is contingent upon the following:

- SCFHP MOU with OSH that confirms set-aside units and resident selection process to include referrals of LTC members and process for identifying and selecting residents.
- Commitment from Anthem Blue Cross for shared funding of contracted services, with funding and allocation of designated units proportional to Medi-Cal market share.
- Language included in MOUs and agreements with Anthem, OSH and Core Companies that each plan takes responsibility for paying the supportive services cost for their members.

Summary of Projected Outcome/Impact:

Permanent supportive housing for an estimated 44 SCFHP members transitioning from LTC in nursing facilities but lacking housing, with supplemental services to support their aging in place, prevent institutionalization, and reduce other high cost utilization.

Proposal for Set-Aside Permanent Supportive Housing (PSH) Units for Long-Term Care (LTC) Transitions - Agrihood Senior Apartments

Proposal Summary
To commit $ 2,117,044 over 5 years estimated to begin in April, 2024 for contracted services (or equivalent cost if provided in-house) provided to an estimated 44 Santa Clara Family Health Plan members who transition from long term care (LTC) in a nursing facility to reside at Agrihood Senior Apartments. This project is a partnership between the County Office of Supportive Housing (OSH), Santa Clara Family Health Plan (SCFHP), Anthem Blue Cross and Core Companies, the housing developer. It will enable the transition out of long-term care (LTC) in a nursing home for an estimated 44 SCHFP members who are homeless, with these members provided designated set-aside units of permanent housing and supplemental services and supports. The objective of this program is to provide housing for transitioning LTC members, to enable them to age in place with dignity and a higher quality of life than if they remained in LTC.

Purpose
Decreasing Medicare and Medi-Cal expenditures by redirecting care away from institutional settings and toward more home and community-based services (HCBS) has been a priority for CMS and DHCS for decades. This was reflected in the Coordinated Care Initiative (CCI) and is also a primary focus of the current CalAIM initiative. Two of the In Lieu of Services (ILOS) services proposed under CalAIM specifically address the need for housing for members transitioning from the nursing facility setting.

SCFHP has long believed that many members will have a substantially better quality of life if transitioned from LTC facilities. Under the CCI, SCFHP developed internal capacity within the Long-Term Services and Supports (LTSS) case management team to support these transitions, and worked in partnership with the nursing facilities and other programs (Whole Person Care and California Community Care Transitions Program) to successfully transition to lower levels of care members who may not have otherwise been able to leave the institution. An estimated 10% of the LTC population chooses to, and is able to, transition back to the community if provided LTSS benefits and other supportive services. A major barrier for many, however, is the lack of housing, either because they were homeless when admitted to the facility, lost their housing while institutionalized, and/or do not have adequate income to pay for housing. SCFHP estimates that between 150 and 200 LTC members could be transitioned if housing was available.

Project Background
Through participation on the County's LTSS Integration Committee, discussions were initiated in 2018 between OSH and SCFHP representatives about a potential pilot program to set aside units at a planned senior housing site (Leigh Avenue), for the LTC transition population. These discussions resulted in a proposal, approved by the SCFHP Governing Board, to pay for a package of supportive services in exchange for twenty units designated for SCFHP members. Unfortunately, changes made by OSH and their funding for this project prevented the agreement from being implemented. However, these discussions led to subsequent advocacy with the County Board of Supervisors (BOS) and a formal request from the BOS that OSH prioritize the LTC transition population for permanent supportive

housing. Subsequently SCFHP and Anthem Blue Cross worked together with OSH on the Agrihood Senior Apartments proposal.

Agrihood Senior Apartments
The Agrihood Senior Apartments is an affordable housing development consisting of 165 units on a 1.6 acre site and is being developed by the Core Companies. The construction timeline is to break ground in June, 2021, with an opening date of October 2024. Core is requesting 54 Section 8 Project-Based Vouchers (PBVs) from the Santa Clara County Housing Authority, with a PBV covering the cost of rent for the resident. Per the contract between the County and the federal Department of Housing and Urban Development (HUD), onsite supportive services must be provided to the residents of these units.

These 54 units have been offered to SCFHP and Anthem for placement of LTC members, with the requirement that the health plans cover the costs of the supportive services, estimated at $11,000 per year per unit. With allocation of units between SCFHP and Anthem based on Santa Clara County Medi-Cal managed care market share, SCFHP is estimated to have an average of 44 of the 54 units and Anthem the remaining 10 units. Absent an agreement in place demonstrating that the health plans will pay for services, LTC residents hoping to transition into housing would almost certainly be ineligible to move to Agrihood or any other PSH project.

Supportive Services for Permanent Supportive Housing (PSH)
The health plans have the option of providing the supportive services directly or via contracts with experienced PSH providers. OSH currently contracts with five agencies that provide these services and, SCFHP can select which of the County's service providers best meet our needs. OSH plans to expand this network through a request for proposal (RFP) process in early 2022 and has invited the health plans to help shape the RFP to make sure listed providers have the necessary capacities.

The proposed mechanism for funding and purchasing services is to contract for a fixed amount ($11,000 per unit per year) for a package of services available to all SCFHP PSH residents. A description of the services is outlined below. In addition to this, the total year 1 cost includes the purchase of a van for non-medical transportation (Honda Pilot with wheelchair conversion: $60,000). The contracted provider would build transportation costs such as insurance and gas into the ongoing operating costs covered in the per-unit, per- year fixed fee.

Contracted Services provided in conjunction with Permanent Supportive Housing
Goals • Successful transition to lower level of care • Increase & maintain stability, functional capacity and independence, including housing retention • Connection to primary care • Single point of contact for providers and property manager • Prevent Emergency Department (ED) visits, readmissions or hospitalization
Supportive Services • Case management – minimum of 1 contact per month; voluntary (potential ECM services under CalAIM) • Tenancy support services (Potential In Lieu of Services (ILOS) under CalAIM) • Linkage to other benefits such as Supplemental Security Income (SSI), behavioral health and primary care

- Linkage to nonclinical resources: food, personal care, pest control, transportation
- Exploring clinical space on site for visiting physicians and RNs to use
- Purchase and use of a van for resident transportation

Eligibility and Placement

OSH oversees the selection of residents for unit placement and is required to base selection on an applicant's score from the VI-SPDAT assessment tool. A key limitation of the VI-SPDAT is how well it measures functional impairments and/or activities of daily living, two key measures for older adults with LTSS needs. These individuals typically do not score above 6, while a score of 13-16 is typically what is needed for placement in permanent supportive housing. The proposed agreement with OSH enables health plan members who meet criteria for placement to take priority over others scoring with a comparable score on the VI-SPDAT. The housing is estimated to open in October, 2024, with services starting six months prior, in April, 2024.

Project Cost and Financing

While the timeframe proposed for this project is five years, the intent is to continue the project beyond the initial period, to enable SCFHP members to age with dignity and in a community setting instead of in an LTC facility. During the five year period, we will track and evaluate the outcomes of the project, and determine how it aligns with future changes to Medi-Cal benefits. The project would only terminate due to substantial programmatic or fiscal reasons.

Timeframe: FY	Cost	Assumptions
2024 - Year 1	$ 181,044	3 months of services @ $917 per unit X 44 units plus $60K van cost. Support services begin 6 months prior to opening to facilitate resident selection and placement
2025 - Year 2	$ 484,000	$11,000 per year X 44 units
2026 - Year 3	$ 484,000	$11,000 per year X 44 units
2027 - Year 4	$ 484,000	$11,000 per year X 44 units
2028 - Year 5	$ 484,000	$11,000 per year X 44 units
Total Request $ 2,117,044		

Impact of CalAIM: Enhanced Care Management Benefit (ECM) & In Lieu of Services (ILOS)

Nursing facility residents who want to transition to the community are one of the designated populations of focus for the CalAIM ECM benefit that will launch in January, 2022. As such, there is an assumption that many of the SCFHP LTC members identified for placement in Agrihood will be eligible for ECM, with the plan receiving payment for this benefit. In addition, two ILOS services target this population and DHCS has suggested that by 2024, these ILOS services will likely be added as Medi-Cal benefits. While rates are unknown at this time, this is a potential source of payment for the LTC population referred for this project.

Shared Savings Risk

The transition of these members from the nursing facility to Agrihood will result in both a decrease in nursing facility costs and an associated decrease in revenue for the plan. To strengthen financial incentives for plans to divert or transition beneficiaries from long-term institutional care to appropriate home and community based alternatives, supported by the availability of In Lieu of Services and

Enhanced Care Management, CalAIM includes a prospective model of shared savings/risk via the capitation rate development. Although the terms of this shared savings/risk have not been defined, we anticipate that it would address the current disincentive of revenue reduction associated with transitioning members from nursing facility to community settings such as Agrihood.

SCFHP Commitment Contingencies
If approved by the SCFHP Governing Board, SCFHP will commit funds contingent upon:

- Completion of MOU with Office of Supportive Housing that confirms set-aside of units and a resident selection process that includes referrals of LTC members and a process for identifying and selecting residents.
- Commitment from Anthem Blue Cross for shared funding of contracted services, with funding and allocation of designated units proportional to Medi-Cal market share.
- Language included in MOUs and agreements with Anthem, OSH and Core Companies that each plan takes responsibility for paying the supportive services cost for their members.

Next Steps

1. Review with Anthem Blue Cross the terms of commitment that will form the MOU with OSH.
2. Provide Letter of Intent to OSH by end of June 2021 specifying that SCFHP and Anthem will provide funding for 54 PSH units that OSH has agreed to set aside for LTC transitions.
3. Develop and finalize MOU with OSH, for presentation to the Board of Supervisors in Fall, 2021. Will include detailed description of services provided. Does not require BOS approval and not a contractual document.
4. Develop MOU with Core Companies, the developer. This will be included in the BOS packet.
5. Finalize an MOU with Anthem Blue Cross, to include terms that address how services will be provided when a member changes plans.

Project Summary
The Agrihood Senior Apartments is an affordable housing development consisting of 165 units on a 1.6 acre site and is being developed by the Core Companies. The project is located near major transit lines along Winchester Boulevard and Stevens Creek Boulevard and is minutes from the Santa Clara Senior Center, Central Park and the Valley Fair and Santana Row commercial hubs. The proposed affordable units will consist of 70 studios, 83 one-bedrooms and 10 two-bedrooms plus two manager's units. A portion of the units will be leased to qualifying senior veterans. Fifty-four (54) of the units will be set aside as permanent supportive housing (PSH) for homeless households. All of the units will be located in one 4- and 5-story building with an at-grade parking structure. Amenities will include but are not limited to on-site bicycle storage, offices for property management, laundry facilities, and a large community room with a kitchen for staff and residential use. This innovative residential development also will create an intergenerational community which combines affordable and market rate housing with a first of its kind 1.5 acre urban agricultural open space that will provide easier access to fresh produce.

Core is requesting a reservation of 54 Section 8 Project-Based Vouchers (PBVs) from the Santa Clara County Housing Authority. In addition to the County-provided services for the PSH households, Core has selected Lifesteps as the lead on-site service provider to deliver varied levels of services to all 165 senior households. John Stewart Company will be the on-site property management company. This housing development will also be a part of a unique services-enriched collaborative called The Mindful Aging Project (MAP) that aims to bring immigrant elders from diverse communities together for socialization, personal well-being, greater serenity and health through community produce and meditation gardening so that they can connect with peers and put down roots.