Medi-Cal Health Homes Program

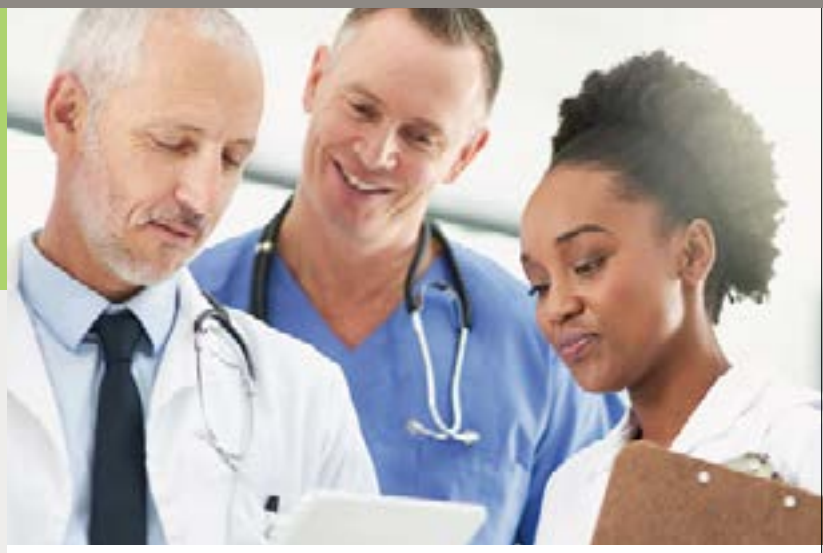
Provider Guide

This provider guide provides information on the California Medi-Cal Health Homes Program (HHP) for Community-Based Care Management Entities (CB-CMEs), providers, community-based organizations, and other stakeholders.

Health Homes Program

An Overview

The Medi-Cal Health Homes Program (HHP) provides new services for certain Medi-Cal members with chronic conditions.



Health Homes Program Basics

- HHP services are new services that are free for eligible individuals as part of their Medi-Cal benefits.
- Patients stay enrolled in their Medi-Cal Managed Care Plan and continue to see the same doctors, but they now have an added layer of support.
- Patients have a care coordinator and a care team to coordinate their health care services and link them to community services and housing as needed.

Who Is Eligible for the HHP?

Medi-Cal members who have certain complex medical needs and chronic conditions are eligible for the HHP. They must be enrolled in a Medi-Cal Managed Care Plan and meet the following two requirements:

1. Have certain chronic conditions
2. Meet at least one acuity/complexity criteria

See "Eligibility and Enrollment" for more information.

How Do Eligible Medi-Cal Members Join the HHP?

1. **Most eligible patients will be contacted about the program.** The Department of Health Care Services (DHCS) gives the Medi-Cal Managed Care Plans a list of most of their members who are eligible for the HHP. This list is based on patient data and claims histories. It is updated every 6 months. Other individuals may be eligible even if they are not on the list. Medi-Cal Managed Care Plans and/or Community-Based Care Management Entities (CB-CMEs) will be responsible for outreach.
2. **A provider submits a referral form for a patient.** If a patient is not on the HHP list but may be eligible, the provider can submit a referral form to the patient's Medi-Cal Managed Care Plan to see if they are eligible. This may be necessary if the individual is newly enrolled in Medi-Cal.
3. **A patient asks to join.** Individuals can contact their Medi-Cal Managed Care Plan and ask if they qualify for the Health Homes Program.

The HHP is for Medi-Cal Managed Care Plan Members

Only Medi-Cal Managed Care Plan members can receive HHP services. Individuals who receive care through the fee-for-service delivery system and qualify for the HHP must enroll in a Managed Care Plan to receive HHP services.

What Are CB-CMEs?

Community-Based Care Management Entities (CB-CMEs) are health care and community providers that contract with Medi-Cal Managed Care Plans to provide HHP care coordination and other services. CB-CMEs can be primary care providers, Federally Qualified Health Centers, community health centers, local health departments, and other service providers. Many patients will be able to receive HHP services where they are already receiving care.

What Services Does the HHP Provide?

The HHP provides six main services to help manage and improve a member's health:

- Developing and updating a Health Action Plan to guide services and care
- Coordinating care across all of their providers
- Facilitating care transitions between the hospital, nursing homes, other treatment facilities, and home
- Supporting the self-management and decisionmaking efforts of patients and their family and/or support team
- Educating patients about and supporting them in healthy behaviors
- Connecting patients to community and social services, including housing, as needed

Can Patients Join the HHP and Other State Programs?

It depends on what the other program is. For details, see "Patients Enrolled in the HHP and Other California Programs."

Who Provides HHP Services?

The HHP gives each member a care team, including a care coordinator. The care coordinator is either from a CB-CME or from the member's Medi-Cal Managed Care Plan. The care coordinator works with all of the patient's providers—such as doctors, specialists, pharmacists, and others—to make sure everyone is on the same page about their health and care needs. The HHP care team also includes a HHP director, clinical consultant, and housing navigator. The team may also include a community health worker and other team members such as a pharmacist or nutritionist, as needed.

Health Homes Program

Eligibility and Enrollment

The Health Homes Program (HHP provides new services for certain Medi-Cal members with chronic conditions. Patients qualify for HHP services based on their health conditions.

Who Is Eligible for the HHP?

To be eligible for the HHP, patients must meet both of the following requirements:

1 **The individual has certain chronic condition(s)** that are determined by certain ICD 10 codes. The patient can check **at least one** box below:

- ☐ At least two of the following: chronic obstructive pulmonary disease (COPD), diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic kidney disease, dementia, or substance use disorders
- ☐ Hypertension (high blood pressure) and one of the following: COPD, diabetes, coronary artery disease, or chronic or congestive heart failure
- ☐ One of the following: major depression disorders, bipolar disorder, or psychotic disorders (including schizophrenia)
- ☐ Asthma

2 **The individual meets at least one acuity/complexity criteria.** The patient can check **at least one** box below:

- ☐ Has three or more of the HHP-eligible chronic conditions
- ☐ Had at least one inpatient hospital stay in the last year
- ☐ Had three or more emergency department visits in the last year
- ☐ Has chronic homelessness (see next page for definition)

Who Is NOT Eligible for the HHP?

- Individuals whose health is well-managed through self-management or another program, or the patient is otherwise determined to not fit the high-risk eligibility criteria
- Patients who do not want to cooperate or participate in the HHP
- Patients whose behavior or environment is unsafe for staff
- Patients who would be better served in another care management program

How to Determine Chronic Homelessness

The federal definition of chronic homelessness is used in HHP eligibility determinations. According to the definition, a person is homeless if he or she has been homeless for:

1. 12 consecutive months, or
2. A total of 12 months over the past 3 years with minimal breaks between periods of homelessness.

If a person met this definition of homelessness and then resided in an institution such as a jail, substance abuse facility, mental health facility, or hospital for fewer than 90 days, they are still considered chronically homeless.

A whole family can be counted as homelessif the head of household was homeless under this definition.

For more details, see the Department of Housing and Urban Development's definition at www.ecfr.gov.

How Do Patients Join the HHP?

1. **The Medi-Cal Managed Care Plan or community-based care management entities (CB-CMEs) will contact their eligible members to discuss the program.** The Department of Health Care Services (DHCS) gives each Medi-Cal Managed Care Plans a list with most of their members who are eligible for the HHP. The lists are based upon the Medi-Cal members' health conditions, eligibility, and medical service information. Other individuals may be eligible even if they are not on the list and can join the HHP in the following two ways.
2. **A health care provider submits a referral form for a patient.** If a patient is not on the HHP list but may be eligible, the provider can explore their eligibility by submitting a referral form to the patient's Medi-Cal Managed Care Plan. This may be necessary if the patient is newly enrolled in Medi-Cal and not yet on the HHP list.
3. **A patient asks to join.** Patients can contact their Medi-Cal Managed Care Plan and ask if they qualify for the HHP.

What Can Patients Expect When They Join the HHP?

Someone from the patient's care team will contact them to talk about their health needs, goals, and current providers.

The patient will be assigned a care coordinator who will work with them to make a plan for getting the health care and community services they need.

Tips for Talking to Patients About the HHP

CB-CMEs, providers, and communitybased organizations play key roles in explaining the HHP to patients. When talking to patients, consider sharing the following messages:

- You receive extra support for free as part of your Medi-Cal benefits, including help with:
  - Finding doctors and getting appointments
  - Understanding your prescription drugs
  - Setting up transportation to your doctor visits
  - Getting follow-up services after you leave the hospital
  - Finding and applying for food benefits and housing
  - Connecting to other community programs and services
- You can keep your doctors, and you can get connected to other doctors you might need.
- You will have a care coordinator who supports you and your team. They make sure everyone is on the same page about your health and care needs.
- You must qualify for the HHP, based on needing extra help with your health.

Health Homes Program

Patients Enrolled in the HHP and Other State Programs

California has multiple programs designed to coordinate care. Counties, Medi-Cal Managed Care Plans, and providers work together to coordinate services across these programs and toavoid duplication.

Patients can receive services through both the HHP and the programs listed below:

- Whole Person Care Pilot Program
- California Children's Services Program
- Specialty Mental Health and Drug Medi-Cal

Patients must choose the HHP OR the program listed below:

- Cal MediConnect and Fee-for-Service Delivery Systems

  To receive HHP services, patients have to leave the Cal MediConnect or Fee-for-Service Delivery System and join a Medi-Cal Managed Care Plan.

- Targeted Case Management

  Patients with county-operated Targeted Case Management (TCM) have to choose TCM or the HHP. HHP members can receive TCM as part of the County Mental Health Plan Specialty Mental Health (MHP SMH) as long as their providers coordinate.

- 1915(c) Home and Community-Based Waiver Programs

  These programs include: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), and Pediatric Palliative Care (PPC).

Medi-Cal Managed Care Plans can determine if other programs are duplicative of the HHP.

Patients cannot receive HHP services if they are:

- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month
- Hospice services recipients

Health Homes Program

Six Core Services

The Health Homes Program (HHP) provides extra services for certain Medi-Cal members with chronic conditions. It provides additional care coordination services and connections to community supports.

How Can Patients Access HHP Services?

- These services can be provided in-person where the patient seeks care or lives, or at any location that is accessible to the patient.
- Services can also be provided by phone or other communication methods that work for the patient.

What Extra Services Does the HHP Provide?

1. Care Management
2. Care Coordination
3. Health Promotion
4. Transitional Care
5. Member and Family Supports
6. Referral to Community and Social Supports

HHP services must be culturally appropriate and meet trauma-informed care standards. All communications must meet health literacy standards.

1 Care Management: The patient, their care coordinator, and their HHP care team work together to develop a comprehensive, individualized Health Action Plan. This plan is based on the patient's health status, needs, preferences, and goals regarding:

- Physical health
- Mental health
- Substance use disorders
- Community-based long-term services and supports
- Palliative care
- Trauma-informed care needs
- Community and social supports
- Housing

Health Action Plan

This is a comprehensive plan developed with the patient that addresses their physical and mental health and community support needs and goals. The plan is used to guide and track their care. It is reviewed and revised over time based on their changing needs.

2 **Care Coordination:** Services are provided to help patients implement their Health Action Plan and navigate and connect to needed health and community services. The care coordinator is a key point of contact for patients and their providers. Care coordination services may include:

- Helping the patient navigate, connect to, and communicate with health, behavioral health, and social service systems, including housing.
- Sharing options for accessing care and providing information regarding care planning.
- Monitoring and supporting treatment adherence, including medication management and reconciliation.
- Monitoring referrals to needed services and supports, as well as coordination and follow-up.
- Facilitating transitions among treatment facilities, including admissions and discharges, and reducing avoidable hospital readmissions.
- Sharing information with all involved parties to monitor the patient's conditions, health status, medications, and any side effects.
- Accompanying patients to appointments.
- Holding case conferences for the care teamto discuss the patient's needs and services.

These services are integrated with current Medi-Cal Managed Care Plan coordination activities, but the HHP provides a more intensive level of support.

3 **Health Promotion:** Patients are coached on how to monitor and manage their health, and identify and access helpful resources. These services may include:

- Supporting health education for patients and their family and/or support team.
- Coaching about chronic conditions and ways to manage them.
- Using evidence-based practices to help patients manage their care.

4 **Transitional Care:** Patients receive services to facilitate their transitions between treatment facilities, including admissions and discharges, and to reduce avoidable hospital admissions and readmissions. This includes transitions between the emergency department, hospital inpatient facility, residential/treatment facility, mental health facility, skilled nursing facility, incarceration facility, or other treatment center, and their own home. These services may include:

- Collaborating, communicating, and coordinating with all involved parties.
- Planning timely follow-up appointments with outpatient and/or community providers and arranging transportation as needed.
- Educating patients on self-management, rehabilitation, and medication management.
- Planning appropriate care and social services post-discharge, including a place to stay.
- Developing and facilitating the transition plan, evaluating the need to revise the Health Action Plan, and preventing and tracking avoidable admissions or readmission.
- Providing transition support to permanent housing.

5 **Member and Family Supports:** Patients and their family and/or support team are educated about their conditions to improve treatment adherence and medication management. These services may include:

- Assessing strengths and needs of patients and the family and/or support team and promoting engagement in self-management and decision-making.
- Linking patients to self-care programs and peer supports to help them understand their condition and care plan.
- Determining when patients are ready to receive and/or act upon information provided and assist them with making informed choices.
- Helping patients identify and obtain needed resources to support their health goals.
- Accompanying patients to appointments when necessary.
- Evaluating the family and/or support team's need for services.

6 **Referral to Community and Social Supports:** Patients receive referrals to community and social support services and follow-up to help ensure they get connected to the services they need. This may include:

- Identifying community and social support needs and community resources.
- Identifying resources and eligibility criteria for programs, including housing, food security and nutrition programs, employment counseling, child care, and disability services.
- Actively engaging with appropriate referral agencies and other community and social supports.
- Providing housing transition services and tenancy sustaining services.
- Routinely following up to ensure needed services 5 are obtained.

What Transportation Services Are Provided?

The HHP arranges for transportation to be provided, but it does not provide actual transportation to services.

However, under Medi-Cal, Managed Care Plans are responsible for providing non-emergency transportation to medical services.

What Housing Services Are Provided?

The HHP provides services to help patients obtain and maintain housing. It does not provide actual housing for patients.

For HHP patients experiencing homelessness, the housing navigator that is part of the care team partners with housing agencies to help patients find and maintain permanent independent housing, including supportive housing.

Health Homes Program

Care Management and the Health Action Plan

The Health Homes Program (HHP) provides extra services for certain Medi-Cal members with chronic conditions. HHP care coordination is centered around the Health Action Plan.

The Health Action Plan

Each patient has a Health Action Plan to guide their services and care. It is developed by the patient and their HHP care team.

The plan is based on the patient's health status, needs, preferences, and goals regarding:

- Physical and mental health
- Substance use disorders
- Community-based long-term services and supports, and palliative care
- Trauma-informed care needs
- Community supports, including housing

Who's Involved

One of the main members of the care team is the care coordinator. Either the Medi-Cal Managed Care Plan or the Community-Based Care Management Entity (CB-CME) assigns a care coordinator for each member. This person works with the patient to create the Health Action Plan, coordinates their care, and makes sure they receive all needed services. Other care team members also participate in developing and implementing the Health Action Plan, as necessary.

If the patient's primary care provider is affiliated with a CB-CME, the patient will be assigned to that CB-CME, unless they choose a different one. If the patient's primary care provider is not part of the CB-CME, the CB-CME must coordinate with the primary care provider.

Implementing the Health Action Plan

Once the Health Action Plan is complete, the HHP offers comprehensive care management activities to help patients achieve their goals. Care management services are supported by the care coordinator and care team, and may be provided in person or by phone, email, text, or other communication methods that work for the patient. The Health Action Plan is reviewed and revised over time, based on the patient's progress and changes in their needs.

Care Management Best Practices

Materials have been developed to assist CB-CMEs and providers engaged in care management activities. These evidence-based practices have been found to be effective for treating complex patients such as those in the HHP. See best practices in care management on the DHCS Health Homes Program website or contact the Medi-Cal Managed Care Plan for resources and training opportunities.

Health Homes Program

Team Roles and Responsibilities

The Health Homes Program (HHP) provides extra services for certain Medi-Cal members with chronic conditions.

Members stay enrolled in their Medi-Cal Managed Care Plan and continue to see the same doctors. However, they now have a care coordinator and an HHP care team that coordinates their health care services and links them to community services and housing, as needed.

HHP Team At a Glance

Three main entities work together to deliver HHP services:

- Medi-Cal Managed Care Plans
- Community-Based Care Management Entities (CB-CMEs)
- Community-Based Organizations

Together, they form a care team around the patient. This care team could include:

- Care coordinator
- HHP director
- Clinical consultant
- Community health worker
- Housing navigator
- Current providers
- Family/friends
- Case manager from a community organization

Medi-Cal Managed Care Plans

Medi-Cal Managed Care Plans oversee the administration of the HHP. They must be certified to participate in the HHP by meeting certain criteria and passing a readiness review. They receive payments from the Department of Health Care Services (DHCS) and disburse payments to the CB-CMEs and other contracted providers of HHP services.

Medi-Cal Managed Care Plan responsibilities include:

- Contracting with qualified CB-CMEs to provide and oversee HHP services
- Assigning eligible patients to CB-CMEs to coordinate their care
- Notifying CB-CMEs of inpatient admission and emergency department visits/discharges
- Tracking and sharing data with CB-CMEs regarding each patient's health history
- Developing training tools and reporting capabilities for CB-CMEs
- Providing HHP customer service and member grievance resources
- Conducting regular auditing and monitoring to ensure that HHP requirements are completed
- Collecting, analyzing, and reporting health status, financial and other measures, and outcome data to DHCS.

Community-Based Care Management Entity

Each patient has a Community-Based Care Management Entity (CB-CME) that serves as their provider of HHP services. The patient's Medi-Cal Managed Care Plan assigns them to a CB-CME, but they may choose another one if they prefer.

In most cases, the CB-CME will be a community primary care provider that serves a high number of HHP-eligible patients. If the CB-CME is not the patient's assigned primary care provider, the CB-CME must maintain a strong connection to the primary care provider to ensure their participation in the development and implementation of the Health Action Plan.

CB-CME responsibilities include:

- Overseeing care team staffing and the delivery of HHP services
- Working with patients and care teams to develop and update the Health Action Plan
- Ensuring that patients have access to their care team and care coordination services, including case conferences to ensure coordination among providers
- Managing referrals, coordination, and follow-up to needed services and supports
- Supporting patients and their families during discharge from the hospital and treatment facilities
- Providing services in person and accompanying patients to appointments when needed

CB-CMEs must meet HHP certification and qualification requirements.

If your organization is interested in becoming a CB-CME, please contact the Medi-Cal Managed Care Plans in your county.

CB-CMEs may be, but are not limited to:

- Primary care or specialist physician or physician group
- Federally Qualified Health Center
- Community health center
- Hospital or hospitalbased physician group or clinic
- Rural health center
- Indian health center or clinic
- Local health department
- Behavioral health entity
- Community mental health center
- Substance use disorder treatment provider
- Providers serving individuals experiencing homelessness

Community-Based Organizations

As part of providing comprehensive care coordination, the HHP care team tries to identify a patient's community and social support needs and link them to social services and housing, as needed. Since many community-based organizations (CBOs) have established trusting relationships with patients, they can be an important source of information and support to help patients meet their health goals. The HHP care coordinator, community health workers, and housing navigators work with CBOs to make connections to needed services.

The Care Team

Certain team members are part of every HHP care team. Additional professionals, such as pharmacists and nutritionists, may be included in the care team if needed. There may also be other providers (such as specialists) who are not part of the care team but who provide services to patients, participate in case conferences, and share information to support the Health Action Plan. Patients can also include family and other people from their support system on their care team.

Team Member	Qualifications	Key Role
Care Coordinator (CB-CME, MCP, or by contract)	Paraprofessional with appropriate training, or licensed care coordinator, social worker, or nurse	• Engage eligible patients • Oversee services and Health Action Plan implementation • Connect patients to medical and social services • Advocate on behalf of patients • Monitor treatment adherence and help with medication management • Accompany patients to office visits as needed and permitted • Arrange transportation
HHP Director (CB-CME)	Ability to manage multidisciplinary care teams	• Oversee management and operations of the team • Oversee reporting for the team, including quality measures • Oversee quality measures and reporting
Clinical Consultant (CB-CME or MCP)	A health care professional such as a primary care physician, specialist, psychiatrist, nurse, nutritionist, social worker, or behavioral health care professional	• Review and advise on Health Action Plan • Act as clinical resource for care coordinator • Facilitate access to primary care and behavioral health providers as needed
Community Health Workers (CB-CME or by contract)* * Recommended but not required	Paraprofessional or peer advocate	• Engage eligible patients • Accompany patients to office visits, as needed and permitted • Support health promotion and self-management training • Arrange transportation • Assist with linkage to social supports
Housing Navigator (CB-CME or by contract)** ** Only required for members experiencing homelessness	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Develop and maintain relationships with housing agencies and permanent housing providers • Connect members to permanent housing options, including supportive housing • Coordinate with members in the most easily accessible setting as permitted (e.g., mobile unit)

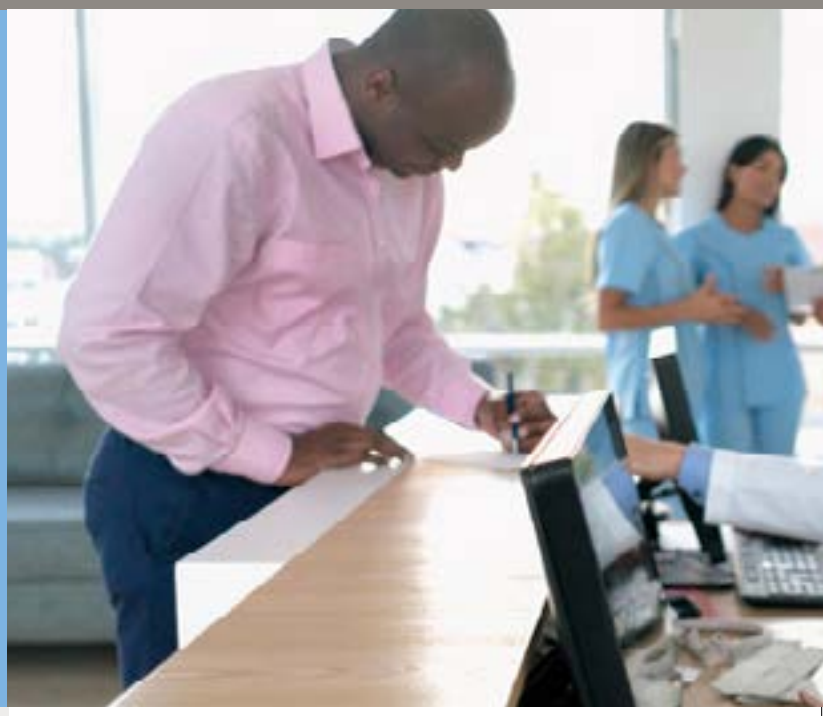
Health Homes Program

Information Sharing, Reporting, and Payment

The Health Homes Program (HHP) provides new services for certain Medi-Cal members with chronic conditions.

The HHP care team must share information about the services they provide to the patient.

Medi-Cal Managed Care Plans must report data to evaluate the enrollment, utilization, costs, and quality of care provided.



Information Sharing Across Entities

For care management activities to be successful, the entire HHP care team must share and access information about a patient's services and care. This helps all of a patient's providers stay on the same page about their care.

For example, Medi-Cal Managed Care Plans can provide electronic patient-level data about hospital and emergency department utilization to providers and care coordinators. Timely information about hospital discharge will support seamless care transitions.

Medi-Cal Managed Care Plans are responsible for developing standardized data-sharing agreements with HHP partners. These agreements will ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all other relevant federal and state regulations.

Program partners are encouraged to use technology to ensure timely, accurate, and secure sharing of information. Ideally, partners should use electronic health record (EHR), health information technology (HIT), and health information exchange (HIE) systems for tracking, charting, and information sharing. In cases where EHR/HIT/HIE technology is not widely used or available, Medi-Cal Managed Care Plans and program partners will work together to develop information sharing processes that are timely, accurate, and secure.

Reporting Requirements

Medi-Cal Managed Care Plans must report program data to the Department of Health Care Services (DHCS). Some of this data may be provided by community-based care management entities (CB-CMEs) and providers to Medi-Cal Managed Care Plans.

Data must be reported in three areas:

1 Program Eligibility and Enrollment

Medi Cal Managed Care Plans track and report the number of patients:

- Eligible for the HHP
- The MCP or the CB-CMEs are actively seeking to engage
- Participating in the HHP Reports must reflect any changes from the prior month and the reason for the changes (e.g., switching from engaging the patient to providing services).

2 Costs and Utilization

Medi-Cal Managed Care Plans report the number of:

- Services, visits, or units for each type of HHP service
- Associated costs

In some cases, these reports may require additional data submission from CB-CMEs and providers.

3 Quality of Care

Program partners must submit reports on HHP program measures:

- Core services measures
- Operational measures
- CMS core set measures
- CMS utilization measures

Payments

- HHP payments are made directly from DHCS to the Medi-Cal Managed Care Plans through capitation rates.
- Medi-Cal Managed Care Plans negotiate individual contracts and payment terms with CB-CMEs and other contracted providers to ensure the delivery of HHP services.
- Services may be provided directly by the MCP or CB-CME, or certain activities may be subcontracted to other entities.

HHP Program Measures

Core Service Measures*

- Number of members excluded from the targeted engagement list, by reason
- Number of members referred to HHP who were enrolled or excluded
- Average number of care coordinators
- Number of members with initial HAP completed within 90 days
- Number of members referred to, and receiving, housing and supportive housing services

CMS Core Set Measures

- Adult Body Mass Index (BMI) Assessment
- Screening for Clinical Depression and Follow-Up Plan*
- Follow-Up After Hospitalization for Mental Illness
- Controlling High Blood Pressure*
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Prevention Quality Indicator 92: Chronic Conditions Composite

Operational Measures*

- Number of members who received services
- Number of each HHP service received, by member
- Number of each HHP service unit provided
- Aggregate care coordinator ratio

CMS Utilization Measures

- Ambulatory Care — Emergency Department Visits
- Inpatient Utilization
- Nursing Facility Utilization

* MCPs must report these measures directly to DHCS. DHCS will calculate all other measures based on MCP-provided encounters. These reporting requirements are subject to change.

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Clinical Staff	G0506	U1	15 minutes equals 1 UOS; multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G0506	U2	15 minutes equals 1 UOS; multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G0506	U3	15 minutes equals 1 UOS; multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G0506	U4	15 minutes equals 1 UOS; multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G0506	U5	15 minutes equals 1 UOS; multiple UOSallowed
Other Health Home Services: Provided by Non-Clinical Staff	G0506	U6	15 minutes equals 1 UOS; multiple UOSallowed
HHP Engagement Services	G0506	U7	15 minutes equals 1 UOS; multiple UOSallowed

Use in conjunction with guidance from the Medi-Cal Managed Care Plans.