Medi-Cal Health Homes Program
Program Guide
06/28/18

I.   Introduction

The Medi-Cal Health Homes Program: Program Guide (Program Guide) is intended to be a resource for Medi-Cal Managed Care health plans (MCPs) in the development, implementation, and operation of the Health Homes Program (HHP). The Program Guide includes a brief synopsis of the HHP, identifies all of the HHP requirements, and identifies the documentation MCPs must submit to the Department of Health Care Services (DHCS) as part of the required HHP readiness review. The Program Guide refers to additional guidance documents, when applicable.

The Medicaid Health Home State Plan Option is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the provisions will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that 1) an evaluation of the program is completed; and 2) a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The Program Guide contains the Health Homes Program: Medi-Cal Managed Care Plan Readiness Checklist (Readiness Checklist) in Appendix D. The Readiness Checklist identifies the specific components that MCPs are required to provide to DHCS and identifies the process DHCS will use to determine when the specific components are due to DHCS. The Program Guide provides additional guidance and context regarding HHP readiness requirements.

II.   HHP Infrastructure

A. Organizational Model

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care (Managed Care) infrastructure as the foundational building block. HHP services will be provided through the Managed Care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Medi-Cal Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. The MCPs' existing communication and reporting capabilities will be utilized to perform health promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate HHP care coordination.

The HHP will be structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP network will be developed to meet the following goals:

- Ensure that sufficient HHP funds are available to support care management at the point of care in the community
- Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available as needed
- Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- Forge new relationships with community provider care management entities, where possible and appropriate
- Utilize community health workers in appropriate roles.

The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services,

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or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

1) Medi-Cal Managed Care Plan Responsibilities

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician, behavioral health providers, or other specialists, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Health Action Plan (HAP). These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal MediConnect and other programs.)

MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow-up care. MCP health care informatics analytics teams will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community-based organizations. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) are required to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

2) Duties

MCPs will be expected to perform the following duties/responsibilities to the extent their information systems allow or through other available methods:

- Attribute assigned HHP members to CB-CMEs;

- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;

- Notify the CB-CMEs of inpatient admissions and ED visits/discharges;

- Track and share data with CB-CMEs regarding each member's health history;

- Track CMS-required quality measures and state-specific measures (see *Reporting Template* and *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later *document*);

- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process (see *Reporting Template*)

- Provide member resources (e.g. customer service, member grievances) relating to HHP

- Add functionality to the MCP's customer service line and 24/7 nurse line or other available call line so that members' HHP needs are also addressed (e.g. equip nurse line with educational materials to train them about HHP, nurse line receives the updated list of HHP members and their assigned care coordinator, etc.)

- Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME

- Establish and maintain a data-sharing agreement with other providers, with whom MCP shares HHP member health information, that is compliant with all federal and state laws and regulations

- Ensure access to timely services for HHP members, including seeing HHP members after discharge from an acute care stay.

- Encourage participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

- Develop CB-CME training tools as needed or preferred, in addition to DHCS-provided training

- Develop CB-CME reporting capabilities

- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

3) Community Based Care Management Entity Responsibilities

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current MCP provider certification and will contract with selected entities. DHCS will not require MCP use of a standardized assessment tool. DHCS will provide general guidelines

and requirements, including examples of best practice tools that the MCP can use at their option to select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;

- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;

- Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate; and

- OPTIONAL - Utilizing community health workers in appropriate roles (for more information, see Multi-Disciplinary Care Team below).

CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four network goals noted above.

In most cases, the CB-CME will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four network goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

DHCS' readiness review will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the

extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

4) Community-Based Care Management Models

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which a member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not practical. Assessments of potential HHP providers, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

Model I

The first and ideal model embeds care coordinators on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete a provider assessment to determine 1) the extent to which the community provider will need to recruit and hire additional staff to meet the HHP care coordinator resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site. For this model, the care management would be handled by another community-based entity or a staff member within the existing MCP care management department, which will act as the CB-CME. This model will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care coordinators located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location, will become CB-CMEs who can be geographically close to rural members and/or those members who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

B. Staffing

1) Care Coordinator Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population. To develop the aggregate population care coordinator ratio requirement, DHCS assumed that after two years:

- Tier 1 – 20% of population; care coordinator ratio of 10:1
- Tier 2 – 30% of population; care coordinator ratio of 75:1
- Tier 3 – 50% of population; care coordinator ratio of 200:1

2) Multi-Disciplinary Care Team

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. DHCS requires the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The team will primarily be located at the CB-CME organization, except as noted above regarding model flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's physical and/or behavioral health service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. As an example, an MCP could use HHP care coordination funding to pay a member's specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

Table 1: Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	• Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma-informed care practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or MCP)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma-informed care practices • Monitor treatment adherence (including medication)
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

C. Health Information Technology/Data

Health Information Technology (HIT)/Health Information Exchange (HIE) are important components of information sharing in the HHP.

MCPs should consider the following potential uses of HIT/HIE (developed by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

1) Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management –standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement.
2) Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information.
   - Telehealth services including remote patient monitoring.
3) Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
4) Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.
5) Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence).
   - Ability to electronically refer patients to necessary services.

Organizations that are covered by the Meaningful Use requirements should utilize EHR/HIT/HIE to meet the applicable goals noted above, where possible. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP to support the achievement of applicable goals where possible. In some areas relatively few providers have EHRs; there is limited interoperability between the systems; and, where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the EHR/HIT/HIE activities noted above in some geographic areas, or with certain providers, the MCP will determine procedures to share information that is critical for HHP services through other methods.

III.   HHP Member Eligibility

A. Target Population

The HHP is intended to be an intensive set of services for a small subset of Medi-Cal members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of International Classification of Diseases (ICD)-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

B. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, DHCS will develop a Targeted Engagement List (TEL) of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The TEL will be refreshed every six months using the most recent available data. The MCP will actively attempt to engage the members on the TEL. (See Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must meet the following eligibility criteria. See Appendix B for *Targeted Engagement List data specification document* and specific ICD 10 codes that define these eligible conditions:

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in <u>at least one</u> of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

The TEL may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services.

People Excluded from Targeted Engagement List
The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community-Based Care Management Entity (CB-CME) (see *Reporting Template-Instructions* for additional information):
- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

IV.   Health Home Program Services

This section describes the six HHP services. HHP arranges for and coordinates interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP members.

All HHP engagement and services can be provided to members and family/support persons through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and, to the extent and whenever possible, in-person meetings where the member lives, seeks care, or is accessible. Communication and information must meet health literacy standards and trauma-informed care standards and be culturally appropriate.

A. Comprehensive Care Management

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, palliative care, trauma-informed care needs, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals. The HAP must be completed within 90 days of HHP enrollment.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers.

Comprehensive care management services include, but are not limited to:

- Engaging the member in HHP and in their own care

- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's physical, mental health, substance use, palliative, and social service needs
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals
- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

1) Care Management Assessment Tools

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination. MCPs have extensive experience administering Health Risk Assessments and developing care plans.

MCPs may use current Cal MediConnect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and completing the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in an existing tool and/or process must be added to the existing MCP assessment and planning tools. Such elements could include an assessment of social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all HHP members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the care coordinator will work with the HHP member and their family/support persons to develop a HAP.

2) Duties

MCPs in partnership with CB-CMES must be able to carry out the following comprehensive care management services:

Member Engagement and Support
   a. MCPs must ensure that CB-CMEs accomplish the following:
      1) Engage the member in the HHP and their own care

2) Assess the HHP member's readiness for self-management using standardized screenings and assessments with standardized tools
3) Track and promote the member's self-management skills to increase their ability to engage with health and service providers
4) Support the achievement of the member's self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines

Member Assessment
   a. MCPs/CB-CMEs must have a process for assessing and reassessing the member to identify their physical, mental health, substance use, palliative, trauma-informed care, and social service needs. The process should identify:
      1) How their tools align with current tools used for the defined population and avoid unnecessary duplication of assessment?
      2) How trauma-informed care best practices will be utilized?
      3) Whether the assessment process and HAP are standard across the CB-CMEs or whether variations exist.
   b. MCPs/CB-CMEs must have a process and tools for developing the member's HAP and revising, as appropriate
   c. MCPs/CB-CMEs must develop and use the HAP and screening and assessment tools, and develop processes for:
      1) How the HAP is shared with other providers and if it can be shared electronically; and
      2) How the HAP will track referrals and follow ups.

Coordination
   a. MCPs/CB-CMEs must have a process for integrating community social supports, long term support services, mental health, substance use disorder services, palliative care, and housing services into a member's HAP
   b. MCP must ensure that the CB-CMEs:
      1) Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and
      2) Clarify roles and responsibilities of the multi-disciplinary team, providers, HHP member, and family/support persons.
   c. MCPs must have policies and procedures to ensure that members are not receiving the same services from another state care management program (see non-duplication of care coordination services for more information).

B. Care Coordination

Care coordination includes services to implement the HHP member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete CB-CME/care coordinator training as discussed in Appendix C.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

1) Member Support
   - Working with the member to implement their HAP
   - Assisting the member in navigating health, behavioral health, and social services systems, including housing
   - Sharing options with the member for accessing care and providing information to the member regarding care planning
   - Identifying barriers to the member's treatment and medication management adherence
   - Monitoring and supporting treatment adherence (including medication management and reconciliation)
   - Assisting in attainment of the member's goals as described in the HAP
   - Encouraging the member's decision making and continued participation in HHP
   - Accompanying members to appointments as needed

2) Coordination
   - Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed
   - Sharing information with all involved parties to monitor the member's conditions, health status, care planning, medications usages and side effects
   - Creating and promoting linkages to other services and supports
   - Helping facilitate communication and understanding between HHP members and healthcare providers

MCPs in partnership with CB-CMEs must develop, and ensure the implementation of, policies and procedures to support CB-CME coordination efforts to:

a. Maintain frequent, in-person contact between the member and the care coordinator when delivering HHP services. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled members per quarter. DHCS used the following assumptions to develop the aggregate population visit requirement listed above:
   i. After two years, the population equals: 20% in tier 1, 30% in tier 2, 50% in tier 3
   ii. Tier 1 – two in-person visits per month
   iii. Tier 2 – 1 in-person visit per month
   iv. Tier 3 – 1 in-person visit per quarter
b. Ensure members see their PCP within 60 days of enrollment in HHP. This is a recommended best practice only – not service requirement.
c. Ensure availability of support staff to complement the work of the Care Coordinator.
d. Ensure availability of providers with experience working with people who are chronically homeless.
e. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.
f. Link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing.
g. Maintain an appointment reminder system for members. This is a recommended best practice only – not a service requirement.

h. Identify and take action to address member gaps in care through:
   i. Assessment of existing data sources for evidence of care appropriate to the member's age and underlying chronic conditions
   ii. Evaluation of member perception of gaps in care
   iii. Documentation of gaps in care in the member case file
   iv. Documentation of interventions in HAP and progress notes
   v. Findings from the member's response to interventions
   vi. Documentation of discussions of members care goals
   vii. Documentation of follow-up actions, and the person or organization responsible for follow-up

C. Health Promotion

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

D. Comprehensive Transitional Care

Comprehensive transitional care includes services to facilitate HHP members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners

- Collaborating, communicating, and coordinating with all involved parties
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member's transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member's HAP
- Providing transition support to permanent housing

E. Individual and Family Support Services

Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving the member's adherence to treatment and medication management
- Evaluating family/support persons' needs for services

F. Referral to Community and Social Supports

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members.

Community and social support referral services may include, but are not limited to:

- Identifying the member's community and social support needs

- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Providing member with information on relevant resources, based on the member's needs and interests.
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Providing Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing
- Providing Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

V.   Health Homes Program Network

A. MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities:

a. Develop and implement criteria for network sufficiency determination, including county-wideness and number of projected members
b. Develop an adequate network of Community-Based Care Management Entities (CB-CMEs) in each of the MCP's implemented counties for HHP to serve enrolled members
c. Design and implement a process for determining the qualifications of organizations to meet CB-CME standards and for providing support for CB-CMEs, including:
    1. Identify organizations who meet the CB-CME standards
    2. Provide the infrastructure and tools necessary to support CB-CMEs in care coordination
    3. Gather and share HHP member-level information regarding health care utilization, gaps in care and medications
    4. Provide outcome tools and measurement protocols to assess CB-CME effectiveness
d. Integrate community entities focused on services to individuals experiencing homelessness into the care model and, if applicable, the multi-disciplinary care team; meet the State legislation requirement to ensure availability of providers with experience working with individuals who are chronically homeless.
e. Engage with community and social support services by building new, or enhance existing, relationships with programs, services, and support organizations to provide care to members, including but not limited to:
    1. County specialty mental health plans;
    2. Housing agencies and permanent housing providers; and

      3. Individual Housing and Tenancy Sustaining Services.

  f. Contract with CB-CMEs for the provision of HHP services, including outlining the MCP and CB-CME roles and responsibilities, and ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, including the network development goals.

  g. Have methods to ensure compliance with HHP requirements throughout the network, including portions of the network contracted through delegated entities.

  h. Ensure the development of a communication and feedback strategy for all members of the HHP care team, including the member and their family/support persons, to ensure information sharing occurs. Encourage all of the HHP member's providers who supply input to the HAP and coordinate with the CB-CME care coordinator to conduct case conferences, including with those whom may not be formally included on the CB-CME's multi-disciplinary care team.

      1. If the CB-CME is not the member's MCP-assigned PCP, the MCP must have policies and procedures for ensuring: the MCP/CB-CME maintains a strong and direct connection to the PCP and PCP's participate in HAP development and ongoing coordination.

  i. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

1) Administration

  a. Attribute assigned HHP members to CB-CMEs, providing for increased care coordination as close to the member's usual point of care delivery as possible in the community. HHP members must be notified of their CB-CME options.

  b. Receive payment from DHCS and disperse funds to CB-CMEs. Have policies and procedures regarding:

      1. The process for how an MCP determines that the appropriate level of services are provided and documented by CB-CMEs in accordance with the contract and service requirements; and

      2. The process/structure/tiering (if used) for payments to CB-CMEs.

2) Data Sharing and Reporting

  a. Develop reporting capabilities and methodologies

  b. Establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations, and when necessary, with other providers

  c. Notify CB-CMEs of inpatient admissions and emergency department (ED) visits/discharges

  d. Track and share data with CB-CMEs regarding each member's health history

  e. Establish procedures for hospitals participating under the Medicaid State Plan or a waiver of such plan for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated HHP providers. However, HHP primarily uses the TEL to identify and refer members to HHP.

3) Training and Education

  a. Develop and offer learning activities that will support CB-CMEs in effective delivery of HHP services

  b. Develop CB-CME training tools, as needed, to supplement DHCS-developed tools.

c. Ensure participation of the CB-CME and MCP staff delivering HHP Services in DHCS-required CB-CME and care coordinator training and learning collaboratives.

B. CB-CME Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP member, to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by the MCP, according to the CB-CME contract with the MCP;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care.

C. CB-CME Certification

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group
- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

D. CB-CME General Duties

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;
- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination;
- Ensure person-centered health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;
- Collaborate with and engage HHP members in developing a HAP and reinforcing/implementing/reassessing it in order to accomplish stated goals;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers;
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and to improve health;
- Provide evidence-based care;
- Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed;
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member; and
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

VI. General HHP Operations

A. Non-Duplication of Care Coordination Services

MCPs must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving HHP care coordination services. The process would likely include: 1) checking available MCP data; and 2) asking members as part of both the in-person member assessment during the eligibility/enrollment process and the assessment/care plan process.

The Targeted Engagement List (TEL) does not include members who are participating in the following programs:

- 1915(c) Home and Community Based (HCPS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), Pediatric Palliative Care (PPC);
- County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month; and
- Hospice.

Below is a summary of how HHP intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: 1) Members can receive services through both HHP and the other program; 2) Members must choose HHP or the other program; and 3) Members cannot receive HHP services.

1) Members Can Receive Services through BOTH HHP and the Other Program

- 1115 Waiver Whole Person Care Pilot Program
Members participating in a Whole Person Care (WPC) Pilot Program may also be eligible for the HHP. DHCS has released specific guidance related to the interaction between the Health Homes Program and the WPC Pilot Program which can be found in Appendix K of this Program Guide.

- California Children's Services
Children who are enrolled in the Children's Services program are eligible for the HHP.

- Specialty Mental Health and Drug Medi-Cal
DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHP's contracted provider acting as a designated CB-CME. To facilitate care coordination for HHP members through a MHP-designated CB-CME, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform CB-CME HHP responsibilities through a contract with the MCPs in the county at the discretion of the MCP. This type of entity would perform the CB-CME HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the

Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the CB-CME.

2) Members Must Choose HHP OR the Other Program

- Targeted Case Management
  County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and is duplicative of HHP. Members who are receiving TCM services have a choice of continuing TCM services or receiving HHP services.

  However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of HHP. The HHP provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

- 1915(c) Waiver Programs
  1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs that are duplicative of HHP services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving HHP services.
  The 1915(c) HCBS waiver 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).

- Cal MediConnect or Fee-for-Service Delivery Systems
  Members who are eligible for both Medi-Cal and Medicare are eligible for the HHP. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the HHP. However, HHP is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for-Service delivery systems to receive all their Medi-Cal services, including HHP services, through a regular Medi-Cal Managed Care Plan.

- Other Comprehensive Care Coordination Programs
  Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of HHP services, including programs that are operated or overseen by the MCP. Examples include, but are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

3) Members CANNOT Receive HHP Services

- Nursing Facility Residents and Hospice Recipients

Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the HHP.

B. HHP Outreach Requirements

MCPs will be responsible for engaging HHP-eligible members, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria. Engagement of eligible HHP members will be critical for the program success. MCPs will link HHP members to one of the MCP's contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider (PCP) is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions.

1) MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities or delegate to CB-CMEs and provide appropriate oversight.

   a. Capacity
      Have the capacity to engage and provide services to eligible members, including:
      1) Establish an engagement plan with appropriate modifications for members experiencing homelessness;
      2) Evaluate the TEL provided by DHCS;
      3) Attribute assigned HHP members to CB-CMEs;
      4) Ensure the engagement of members on the targeted engagement list;
      5) Secure and maintain record of the member's consent to participate in the program (which can be verbal); and
      6) Provide member resources (e.g. customer service, member grievance process) relating to HHP.

   b. Engagement Process
      1) Have policies and procedures for identifying, locating, and engaging HHP-eligible members.
      2) Use the following strategies for engagement as appropriate and to the extent possible: mail; email; social media; texts; telephone; community outreach; and in-person meetings where the member lives, seeks care, or is accessible.
      3) Show active, meaningful and progressive attempts at member engagement each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face-to-face, mail, electronic, telephone), follow-up if the member presents to another partner in the HHP network, or using claims data to contact providers the member is known to use. Examples of acceptable engagement include:
         a. Letter to member followed by phone call to member
         b. Phone call to member, outreach to care delivery partners and social service partners
         c. Street level outreach, including, but not limited to, where the member lives or is accessible

4) Establish a process for reviewing and excluding people from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization or be enrolled in another acceptable care management program – see Reporting Template-Instructions for definition);
5) Report Members determined not appropriate for the HHP, along with a reason code, to DHCS.
6) DHCS will evaluate the MCP enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the targeted engagement list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.
7) Include housing navigators in the engagement process, at the MCP's discretion
8) Document the member engagement process
9) Develop a methodology and criteria used by the MCP or the CB-CME to stratify high, medium and low need members
10) Develop educational materials or scripts that you intend to develop to engage the member.
11) Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma-informed care standards
12) Have policies and procedures for the following:
    a. Required number and modalities of attempts made to engage member
    b. MCP's protocol for follow-up attempts
    c. MCP's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate

c. Assignment
MCPs will link HHP members to one of their contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions. MCP's and/or CB-CME's notification will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. This notification will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. It will also explain the process for participation. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies.

C. Priority Engagement Group

After the MCP has screened people who are inappropriate for HHP from the TEL based on the HHP requirements, MCPs are required to create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The

criteria and size of the group for priority engagement status will be at the MCP's discretion (upon approval by DHCS).

D. Referral

HHP services must be made available to all full scope Medi-Cal members who meet the DHCS-developed eligibility criteria, including those members dually eligible for Medicaid and Medicare. Providers, health plan staff, or other, non-provider community entities/care providers may refer eligible members to the member's assigned MCP to confirm if the member meets the eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method for identifying and engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referral forms will indicate that the provider has verified that the member meets the HHP eligibility criteria. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and may receive HHP services from a CB-CME.

E. Consent

The member will be considered enrolled in the HHP once the member has given either verbal or written consent to participate in the program. The MCP or CB-CME will secure consents by the member to participate in HHP and authorize release of information to the extent required by law. Either the MCP or the CB-CME must maintain a record of these consents.

F. Disenrollment

If an eligible member has, or develops, an exclusionary criterion, cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be disenrolled from the HHP, and the MCP will discontinue CB-CME HHP funding for that member. Additionally, if the MCP determines that the member's eligible chronic conditions have become well-managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status – the HHP member will be disenrolled and the MCP will discontinue CB-CME HHP funding for that member.

A Notice of Action (NoA) Letter is required in all situations except for when an eligible member chooses not to participate. The eligible member may choose to participate in the HHP at any time.

G. Risk Grouping

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP members. Members in the higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness, as specified in AB 361.

H. Mental Health Services

MCPs will develop or amend existing Memoranda of Understanding with county Mental Health Plans (MHPs) to address HHP-specific information. DHCS will update All Plan Letter (APL) 13-018 to address the HHP-specific information that MCPs will include in new, or amended, MOUs. This requirement will be completed prior to the start of HHP implementation for the Serious Mental Illness or Serious Emotional Disturbance (SMI) population. The updated APL may include requirements to address the following information:

   a. The relationships with county MHPs, Drug Medi-Cal – Organized Delivery System demonstration participants, CB-CMEs and MCPs and the procedures for linkage, coordination and participation in the HHP;
   b. The communication flow between the MCP, the CB-CME, and the MHP; the County MHP role in care management; and a discussion of any technology used to improve communications;
   c. How specialty care and ancillary providers will give feedback to the care coordinators;
   d. Details about how the MCP/CB-CME will work with Primary and Specialty physicians who will provide care to the member, but are not part of the HHP, including gathering feedback for the HAP and sharing the document with these physicians; and
   e. The process for sharing beneficiary information (including medication list and service utilization information) and conducting care coordination.

 See additional information at Health Home Program Services.

I. Housing Services

MCPs will work with community resources to ensure seamless access to the delivery of housing support services. MCPs or contracted CB-CMEs must provide housing navigation services, not just referrals to housing. A Housing Navigator is required to be part of the HHP care team for members experiencing homelessness. HHP members must receive the following services:

1) Individual Housing Transition Services

Housing transition services assist beneficiaries with obtaining housing, such as individual outreach and assessments. These services include:
   • Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
   • Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
   • Assisting with the housing application process. Assisting with the housing search process;
   • Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;

- Ensuring that the living environment is safe and ready for move-in;
- Assisting in arranging for and supporting the details of the move; and
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2) Individual Housing and Tenancy Sustaining Services

Housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
- Education and training on the roles, rights and responsibilities of the tenant and landlord;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

J. Training

MCPs are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the administration of the HHP.   See Appendix C for training requirements.

K. Service Directory

MCPs or CB-CMEs must ensure a directory of community services and supports is developed, maintained, and is made available to all care coordinators to inform referring members to social services. The community services directory may be sourced from existing directories so long as it is available as a resource for CB-CMEs and care coordinators. This type of directory may be maintained by either the MCP or the CB-CME; however, the contracted MCP will ensure its availability.

L. Quality of Care

MCPs must incorporate HHP into existing quality management processes.

MCPs must have the capacity to collect and track information used to manage and evaluate the program, including tracking quality measures, and collecting, analyzing, and reporting financial measures, health status and other measures and outcome data to be reported for the State's evaluation process. The MCP will report core service metrics and the recommended core set of health care quality measures established by CMS, as well as the three utilization measures identified by CMS to assist with the overall federal health home evaluation. MCPs must report on the measures listed in the *Reporting Template, and provide* encounters for all HHP services*.*

M. Cultural Competency, Educational and Health Literacy

MCPs must incorporate HHP into existing policies and procedures related to ensuring that services, communication, and information provided to members are culturally appropriate, and meet health literacy, reading and trauma-informed care standards.

N. Member Communication

MCPs must incorporate HHP into existing policies and procedures regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers) into account in communicating with enrollee. DHCS and DMHC will review member materials from Knox-Keene plans through the usual process and criteria. DHCS will use a parallel process for non-Knox-Keene plans.

All notices to be sent by the MCP to Medi-Cal beneficiaries regarding the provision of HHP services will be submitted to DHCS for review.

Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. MCPs may use the DHCS HHP Member Handbook as an optional resource for examples of "best practice" member messaging (though the Handbook messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

MCPs must maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.

O. Members Experiencing Homelessness

MCPs must incorporate HHP-specific information into the appropriate policies and procedures for homeless members, including special provider and service requirements criteria (to achieve homeless experience requirements and other requirements per AB 361), and engagement processes.

MCP has a signed a Housing Services Memorandum of Understanding and Business Associate

Agreements for sharing information between the MCP and housing organizations, to ensure seamless access and delivery of housing support services.

P. Reporting

MCP must have the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP encounters for services provided by the MCP and the CB-CMEs. See Appendix G (*Reporting Template);* and the *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later, for details.

CMS has established a core set of seven required health care quality measures and three utilization measures (see *Reporting Template* and *document* for details). Additional details can be found in the CMS technical specifications and resource manual. These measures were identified by CMS to assist with the overall federal health home evaluation.

MCPs will utilize the Supplemental Payment process to report members enrolled in HHP and to initiate capitation payments. See Appendix J - HHP Supplemental Payment File. *[Placeholder]*

VII. Appendix

A. Appendix A – Example of an Acceptable Model Outreach Protocol

This Model Outreach Protocol is only offered as one example of a protocol that would be acceptable. It is meant to give the MCP ideas about how they might want to design their outreach protocols with the CB-CMEs. The details of this protocol are at the discretion of the MCP, as long as their protocol broadly meets DHCS' intent as stated in the body of the Program Guide and the Readiness Checklist.

SAMPLE PROTOCOL

The Medi-Cal managed care plan (MCP) will send an initial "Welcome Packet" to HHP-eligible members in accordance with their engagement process. After the initial packet is sent, the CB-CMEs will follow up with their HHP-eligible members through phone calls, in-person visits, and other modalities. Each CB-CME or the MCP will attempt to contact the member **five times** within 90 days after the initial packet is sent using various modes of communication (letters, calls, in-person meetings, etc.).

If the CB-CME does not have the capacity to conduct outreach to eligible members, MCP care coordination staff, including community health workers, will conduct the outreach to these members and note the outreach attempts in the members' record.

After five attempts, the CB-CME and the MCP will note the challenges with the active outreach and remind the PCP to discuss the HHP with the member at the next PCP visit. If the member declines HHP enrollment at the PCP visit, this will be noted in the EHR and the MCP will be notified.

If the CB-CME or the MCP learns that the contact information is out of date, efforts will be made to update that information using recent provider utilization data and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations. The CB-CME will also review members' housing history and work with the MCP Housing Program Manager to determine if that member can be reached at an alternative housing site or through a community-based organization.

CB-CMEs will track all outreach attempts within a three month intensive outreach period after the initial welcome letter is sent. The MCP will require that each outreach attempt and the outcome of each attempt be documented in the member's record in the HHP care management system and reported back to the MCP and DHCS. All outreach and engagement attempts will be evaluated by the care coordination team every 30 days within this three month period. The MCP will create policies and procedures for tracking and evaluating outreach and engagement efforts.

If a member declines participation in the HHP, or if their PCP determines that the member is not a good candidate for the HHP (using categories determined and provided by DHCS), this will be noted in the record in the HHP care management system to avoid repeated outreach

attempts. Members who do not enroll in the HHP will be noted, tracked in the MCP's data system and reported to DHCS. Members who graduate from the program will be disenrolled, which will be noted in the record, tracked in the data system, and reported to DHCS.

The MCP will create a mechanism for CB-CMEs and PCPs to identify potential HHP members who are not on the targeted engagement list and who meet the diagnostic and acuity criteria but not the utilization criteria. These individuals may be excellent candidates for the program to help prevent future avoidable health care utilization. In general, MCP will require CB-CMEs to justify the inclusion of the referred member into the program or onto the targeted engagement list. This would be reviewed by a medical director and/or nurse manager with experience in intensive case management to see if the member qualifies for the HHP or if they might be better served by another case management program, and if the rationale provided by the CB-CME or PCP justifies engagement and enrollment in the program.

Staff and Providers

The MCP will train MCP and CB-CME staff who may interact with HHP members, including customer service staff, 24-hour nurse line staff, and provider representatives, to ensure all member- and provider-facing staff are knowledgeable about the HHP, can answer questions and refer participating or eligible members or providers to the appropriate staff. MCP staff, CB-CME staff, providers and community providers are required to participate in webinars and trainings required by DHCS.

The MCP will work to educate all contracted providers, including providers at contracted CB-CMEs and providers from smaller clinics whose patients will receive HHP services through MCP care coordinators.

There will be on-the-ground community health workers who work in the local community and will visit members at their homes or community-based organizations where the members receive services. The MCP has made significant investments in developing this team of community health workers and they will be a key part of success in engaging and educating members on HHP.

Materials

The MCP will work with DHCS to educate providers, beneficiaries and key stakeholders to ensure strong member engagement and participation. The MCP will use outreach and education materials (flyers, brochures, sample email content, sample scripts, etc.) that are approved by DHCS. If the MCP is licensed by DMHC, these materials should additionally be filed with DMHC for review, as applicable. The MCP will also use existing communication channels to promote outreach and education opportunities for providers and members, such as informational webinars, trainings and tele-town halls.

At a minimum, the MCP will develop the following materials:

- Call scripts for Customer Service and 24-hour Nurse Advise Line;
- Member "Welcome Packet," including outreach letters and brochures;

- Appointment reminder letters for both medical and care coordination appointments;
- Content for both the member and provider sections of the MCP website; and
- Training guides for the MCP and CB-CME staff who interface with providers and members.

All member-facing materials for HHP will meet DHCS requirements for cultural competency and health literacy standards.

B. Appendix B – Targeted Engagement List Process

The Targeted Engagement List (TEL) Process identifies the Medi-Cal members that are the most appropriate candidates for the enhanced care coordination services in the Health Home Program (HHP). The TEL is sent to each participating Managed Care Plan (MCP) so that they can initiate engagement activities. This document provides additional details for the criteria and steps used in the TEL Process.

The data source for the TEL Process is DHCS's Data Warehouse. The Data Warehouse contains service level detail for most Medi-Cal programs, including managed care encounters, Fee-For-Service claims, Short-Doyle Mental Health services, Drug-Medi-Cal services, and others. MEDS eligibility information available in the Data Warehouse is also used in the TEL Process.

TEL Process – There are four main steps in the TEL Process, as follows:

1. SPA Eligibility Requirements for Chronic Condition Disease Identification – During the 24 months prior to the running of the TEL, if a member has at least two separate services on different dates for any of the following conditions it will be considered a chronic condition for the TEL. HHP chronic conditions include Asthma, Bipolar Disorder, Chronic Kidney Disease (CKD), Chronic Liver Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic or Congestive Heart Failure, Coronary Artery Disease, Dementia, Diabetes, Hypertension, Major Depression Disorders, Psychotic Disorders (including Schizophrenia), Substance Use Disorder, and Traumatic Brain Injury. The specific ICD-10 diagnosis codes for each chronic condition are listed below. The TEL process uses the primary and secondary diagnosis during the disease identification process.

2. SPA Eligibility Requirements for Chronic Condition Criteria. A member meets the chronic condition criteria if they have:
   2.1. Chronic Condition Criteria #1: At least two of the following: Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder.
   2.2. Chronic Condition Criteria #2: Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure.
   2.3. Chronic Condition Criteria #3: One of the following: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders (including Schizophrenia).
   2.4. Chronic Condition Criteria #4: Asthma

3. SPA Eligibility Requirements – Acuity – These parameters ensure that potential HHP members are high utilizers of health services. A member must meet one of these acuity factors:

3.1. A high chronic condition predictive risk level (operationalized as three or more of the HHP eligible chronic conditions) or

3.2. At least one inpatient stay (not required to be related any particular condition*) in the 16-month period prior to the running of the TEL. (The inpatient stay algorithm is aligned with industry standards and the HEDIS inpatient algorithm) or

3.3. Three or more Emergency Department (ED) visits (not required to be related to any particular condition*) in a 16-month period prior to the running of the TEL. (The ED algorithm is aligned with industry standards and the HEDIS ED algorithm) or

3.4. Chronic Homelessness (there are no data parameters for this criteria. Members who only meet eligibility through this criteria will be identified solely through provider referral and MCP prior authorization)

   * MCPs have the option to adjust this requirement.

4. HHP Enrollment Targeting and Exclusions – This step starts with the Medi-Cal members that meet the SPA chronic conditions and acuity eligibility requirements and determines if the members meet any of the specific program enrollment targeting and exclusionary criteria.:

   a) Members that meet the eligibility requirements are excluded from the TEL, and are excluded from participation in HHP unless their status changes, if the members are identified as:

   - Nursing Facility Residents
   - Hospice Recipients
   - Members with TCM
   - Members in 1915 (c) programs
   - Members in Fee-For-Service
   - Members in PACE, SCAN, or AHF
   - Members in Cal MediConnect

   b) Members that meet the eligibility requirements are not included on the TEL (but could be enrolled through referral) if the members are identified as:

   - Dually eligible members
   - Members in CCS or GHPP
   - Members with ESRD

TEL and TEL Supplement Reporting

The members that meet the eligibility requirements for chronic conditions and acuity will be reported to the managed care plans (MCPs) in either the TEL or the TEL Supplement. The TEL will contain all of the members that meet the SPA eligibility criteria through step 3 above and do not meet any of the specific program enrollment targeting and exclusionary criteria listed in step 4. The MCPs will use the TEL, their TEL verification process, and their internal priority

engagement rules to focus their enrollment activities and enroll the most appropriate members into HHP. The TEL Supplement will contain members that meet the SPA eligibility requirements for chronic condition criteria but are not included on the TEL. The TEL and the TEL Supplement will be provided within the same physical data set with the appropriate indicators.

TEL and TEL Supplement List Management

DHCS' expectations are that most of the HHP eligible members will be identified on the first TEL/TEL Supplement for an MCP in a region (first for chronic conditions, and six months later, for SMI) and most subsequent TEL/TEL Supplement files, at six month intervals, will have a smaller number of new members. To manage the members that appear on the TEL and the TEL Supplement, DHCS is considering the following parameters:

- Members may not appear on subsequent TEL/TEL Supplement files for an MCP because:
  - The member is no longer Medi-Cal eligible in MEDS
  - The member has changed MCPs
  - The member may not meet the disease identification or SPA eligibility requirements for chronic condition criteria
- Members may move from the TEL to the TEL Supplement and from the TEL Supplement to the TEL

TEL and SPA Assignment

DHCS is required to provide separate reporting to CMS for the HHP SMI SPA and the HHP Physical Health\SUD SPA. This requirement is reflected in the HHP implementation schedule. The TEL/TEL Supplement process includes all SPA-defined chronic conditions in the initial steps. In order to support the implementation schedule and MCP requests for additional TEL-related information, the initial TEL/TEL Supplement in each geographic implementation group will include both Physical health/SUD and SMI conditions.

However, members with only SMI conditions are not eligible for the first implementation in each County. The SMI-only members on the TEL/TEL Supplement are identified when Chronic Condition Criteria #3 equals '1' and Chronic Conditions Criteria #1, #2, and #4 are all equal to '0'. MCPs will be required to separately identify HHP members between physical health\SUD and SMI on the Supplemental Payment file sent to DHCS for payment purposes (See Appendix J - HHP Supplemental Payment File). *[Placeholder]*

HHP TEL/TEL Supplement – Fixed-width Record Layout v1.2

Field Id	Field Name	Description	Length	Start	End	Data Type
1	TEL Report Date	Date of generation of the TEL and TEL Supplement (CCYYMMDD)	8	1	8	A

Field Id	Field Name	Description	Length	Start	End	Data Type
2	CIN	Client Identification Number is the unique Member ID assigned by MEDS.	9	9	17	A
3	Birth Date	Member's Birth date (CCYYMMDD format).	8	18	25	A
4	Age	Member's Age	3	26	28	A
5	Member's Last Name	Member's Last Name	20	29	48	A
6	Member's First Name	Member's First Name.	20	49	68	A
7	Member's Middle Initial	Member's Middle Initial	1	69	69	A
8	Member's Gender Code	Member's Gender Code	1	70	70	A
9	Member's County Code	Member's County Code	2	71	72	A
10	Member's County Code Description	Member's County Code Description	15	73	87	A
11	Member's Primary Aid Code	Member's Primary Aid Code	2	88	89	A
12	Medicare Part A Status	Medicare Part A Status	1	90	90	A
13	Medicare Part B Status	Medicare Part B Status	1	91	91	A
14	Medicare Part D Status	Medicare Part D Status	1	92	92	A
15	Plan Code for Member	Plan Code for Member	3	93	95	A
16	Asthma Chronic Condition	Member met the HHP criteria for Asthma ('1' for yes, '0' for no).	1	96	96	A
17	Bipolar Chronic Condition	Member met the HHP criteria for Bipolar ('1' for yes, '0' for no).	1	97	97	A
18	Chronic Congestive Heart Failure (DHF) Chronic Condition	Member met the HHP criteria for Chronic Congestive Heart Failure ('1' for yes, '0' for no).	1	98	98	A
19	Chronic Kidney Disease Chronic Condition	Member met the HHP criteria for Chronic Kidney Disease ('1' for yes, '0' for no).	1	99	99	A
20	Chronic Liver Disease Chronic Condition	Member met the HHP criteria for Chronic Liver Disease ('1' for yes, '0' for no).	1	100	100	A

Field Id	Field Name	Description	Length	Start	End	Data Type
21	Coronary Artery Disease Chronic Condition	Member met the HHP criteria for Coronary Artery Disease ('1' for yes, '0' for no).	1	101	101	A
22	Chronic Obstructive Pulmonary Disease Chronic Condition	Member met the HHP criteria for Chronic Obstructive Pulmonary Disease ('1' for yes, '0' for no).	1	102	102	A
23	Dementia Chronic Condition	Member met the HHP criteria for Dementia ('1' for yes, '0' for no).	1	103	103	A
24	Diabetes Chronic Condition	Member met the HHP criteria for Diabetes ('1' for yes, '0' for no).	1	104	104	A
25	Hypertension Chronic Condition	Member met the HHP criteria for Hypertension ('1' for yes, '0' for no).	1	105	105	A
26	Major Depression Disorders Disease Category	Member met the HHP criteria for Major Depression Disorders ('1' for yes, '0' for no).	1	106	106	A
27	Psychotic Disorders Chronic Condition	Member met the HHP criteria for Psychotic Disorders ('1' for yes, '0' for no).	1	107	107	A
28	Substance Use Disorder Chronic Condition	Member met the HHP criteria for Substance Use Disorder ('1' for yes, '0' for no).	1	108	108	A
29	Traumatic Brain Injury Chronic Condition	Member met the HHP criteria for Traumatic Brain Injury ('1' for yes, '0' for no).	1	109	109	A
30	Count of Chronic Conditions	A count of the number of chronic condition.	2	110	111	A
31	Chronic Condition Criteria #1	Member met the HHP Chronic Condition Criteria #1 (At least two of the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Traumatic Brain Injury, Chronic Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, and Substance Use Disorder) ('1' for yes, '0' for no).	1	112	112	A

Field Id	Field Name	Description	Length	Start	End	Data Type
32	Chronic Condition Criteria #2	Member met the Chronic Condition Criteria #2 (Hypertension from above and at least one of the following conditions, Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, or Chronic Congestive Heart Failure) ('1' for yes, '0' for no).	1	113	113	A
33	Chronic Condition Criteria #3	Member met Chronic Condition Criteria #3 (Any one of the following conditions, Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders) ('1' for yes, '0' for no).	1	114	114	A
34	Chronic Condition Criteria #4	Member met Chronic Condition Criteria #4 (Asthma) ('1' for yes, '0' for no).	1	115	115	A
35	Count of Chronic Condition Criteria	A count of the number of Chronic Conditions Criteria the member met.	1	116	116	A
36	Acuity Factor #1	Member met acuity factor #1: three or more of the HHP eligible chronic conditions ('1' for yes, '0' for no).	1	117	117	A
37	Acuity Factor #2	Member met acuity factor #2: one or more inpatient stay ('1' for yes, '0' for no).	1	118	118	A
38	Acuity Factor #3	Member met acuity factor #3: three or more ED visits ('1' for yes, '0' for no).	1	119	119	A
39	Count of ED visits	The number of Emergency Department visits during the study period.	3	120	122	A
40	Latest ED visit DOS	The date of service for the most recent Emergency Department visit.	8	123	130	A
41	Count of Inpatient Admissions	The number of Inpatient Admissions during the study period.	3	131	133	A
42	Latest Inpatient Admission DOS	The date of service for the most recent Inpatient Admission.	8	134	141	A
43	Exclusion - Duals	The member is Dual Eligible ('1' for yes, '0' for no).	1	142	142	A
44	Exclusion - Hospice	The member had at least one service with one of the following procedure codes in the time period, Z7100, Z7102, Z7104, Z7106, Z7108 ('1' for yes, '0' for no).	1	143	143	A

Field Id	Field Name	Description	Length	Start	End	Data Type
45	Exclusion - ESRD	The member had at least one service with one of the following procedure codes in the time period, Z6000, Z6002, Z6004, Z6006, Z6008, Z6010, Z6012, Z6014, Z6016, Z6018, Z6020, Z6022, Z6036, Z6038, Z6040, Z6042, Z6030, Z6032, Z6034, 90967, 90968, 90969, 90970, 90989, 90993, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90935, 90937, 90945, 90947 ('1' for yes, '0' for no).	1	144	144	A
46	Exclusion - CCS	The member had at least one CCS End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	145	145	A
47	Exclusion - GHPP	The member had at least one GHPP End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	146	146	A
48	Exclusion - TCM	The member had at least one Targeted Case Management service in the time period (services where the Vendor Code was "92" or "93" ('1' for yes, '0' for no).	1	147	147	A
49	Exclusion - 1915c	The member met at least one of the following 1915c exclusions defined below, HIVAExcl, ALWExcl, DDExcl, IHOExcl, MSSPExcl, or PPC_Exclu ('1' for yes, '0' for no).	1	148	148	A
50	Exclusion - HIV/AIDS Waiver	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver exclusion. The member had at least one service in the time period where the Provider type was "073" and Procedure Code in (90837, 90846, 90847, 90847, G0156, G0299, G0300, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029) ('1' for yes, '0' for no).	1	149	149	A
51	Exclusion - Assisted Living Waiver	Assisted Living Waiver (ALW) Exclusion. The member had at least one service in the time period where the Vendor Code In ("44" or "84"), and (Provider Type was "092", "093", or "014"), and (the Category of Service was 118 or 119) ('1' for yes, '0' for no).	1	150	150	A

Field Id	Field Name	Description	Length	Start	End	Data Type
52	Exclusion - Developmental Disabilities Waiver	HCBS Waiver for Californians with Developmental Disabilities (DD) exclusion. The member had at least one service in the time period where the Vendor Code was "76" and the Procedure Code in (Z9002, Z9003, Z9004, Z9005, Z9012, Z9014, Z9015, Z9016, Z9020, Z9021, Z9022, Z9023, Z9025, Z9025, Z9026, Z9026, Z9027, Z9028, Z9029, Z9030, Z9031, Z9032, Z9034, Z9038, Z9039, Z9043, Z9046, Z9047, Z9048, Z9050, Z9056, Z9058, Z9059, Z9060, Z9061, Z9062, Z9063, Z9064, Z9065, Z9066, Z9067, Z9069, Z9072, Z9073, Z9074, Z9075, Z9076, Z9077, Z9078, Z9079, Z9101, Z9102, Z9103, Z9104, Z9105, Z9106, Z9110, Z9111, Z9112, Z9113, Z9121, Z9122, Z9123, Z9124, Z9125, Z9126, Z9200, Z9202, Z9203, Z9204, Z9205, Z9206, Z9207, Z9208, Z9302, Z9303, Z9304, Z9305, Z9306, Z9307, Z9308, Z9310, Z9311, Z9312, Z9313, Z9314 ,Z9315, Z9400, Z9401, Z9402, Z9403, Z9404, Z9405, Z9406, Z9406, Z9407, Z9408, Z9999) ('1' for yes, '0' for no).	1	151	151	A
53	Exclusion - IHO/HCBA Waivers	In-Home Operations Waiver (IHO) / Home and Community-Based Alternatives (HCBA) exclusion. The member had at least one service in the time period where the Vendor Code was "71" and Provider type is "014, 059, 066, 067, 069, 078, 095") or where the Vendor Code was "89" and the Special Program Code (SPECIAL_PGM_TYPE_CD was "3" (IHO Personal Care Services (WPCS)) ('1' for yes, '0' for no).	1	152	152	A

Field Id	Field Name	Description	Length	Start	End	Data Type
54	Exclusion - MSSP Waiver	Multipurpose Senior Services Program Waiver (MSSP) exclusion. The member had at least one service in the time period where the Vendor Code was "81", the Provider Type is '074', and the Procedure Code in (Z8550, Z8551, Z8552, Z8553, Z8554, Z8555, Z8556, Z8557, Z8558, Z8559, Z8560, Z8561, Z8562, Z8563, Z8564, Z8565, Z8566, Z8567, Z8568, Z8569, Z8570, Z8571, Z8572, Z8573, Z8574, Z8575, Z8576, Z8580, Z8581, Z8582, Z8583, Z8584, Z8585, Z8586, Z8587, Z8588, Z8589, Z8590, Z8591, Z8592, Z8593, Z8594, Z8595, Z8596, Z8597, Z8598, Z8599, Z8600, Z8601, Z8602, Z8603) ('1' for yes, '0' for no).	1	153	153	A
55	Exclusion - PPC Waiver	Pediatric Palliative Care (PPC) Waiver exclusion. During the observation period, the member in one of the following counties: Fresno, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, Sonoma, or Ventura, the Provider Type is '014 or '039, the Category of Service is '120, and the Procedure Code is 'G9012' ('1' for yes, '0' for no).	1	154	154	A
56	Exclusion - PACE, SCAN, AHF	PACE, SCAN, and AHF exclusion. As of the last month, the member had one of the following Plan Codes: 050-065, 200-207, 601, or 915. ('1' for yes, '0' for no).	1	155	155	A
57	Exclusion - LTC Resident	Long Term Nursing Facility residents exclusion. As of the end of the study period the member had one of the following Long Term Care (Nursing Facility) Aid Codes: "13", "23", "53", or "63" ('1' for yes, '0' for no).	1	156	156	A
58	Exclusion - FFS	Fee-For-Service exclusion. As of the end of the study period the member was in Fee For Service (Plan Code 000) ('1' for yes, '0' for no).	1	157	157	A
59	Count of Exclusions	A count of the number of Exclusions for which the member met the requirements.	2	158	159	A
60	TEL Indicator	A value of "1" indicates a TEL record; a value of "0" indicates a TEL Supplement record	1	160	160	A

This section outlines training that MCP and CB-CME staff who will be delivering HHP services are required to receive prior to participating in the administration of the HHP. It also includes recommendations for training CB-CME staff on several core competencies.

Required HHP Trainings for Prior to HHP Implementation
MCP and CB-CME staff who will be delivering HHP services are required to receive HHP-specific training prior to HHP implementation. The required training topics described below cover basic program components. DHCS will provide webinar based training that will fulfill these requirements. However, it is also acceptable for an MCP to use a non-DHCS developed training modules to satisfy one, or more, of the requirements. DHCS developed training webinars will be saved on the portal and available on demand.

MCPs must be prepared to follow the required high-level trainings with more specific HHP operational training for their staff and CB-CME staff that provide HHP services. This should include MCP-specific information on operations, workflows, how HHP intersects with MCP care coordination initiatives, data reporting, and other implementation issues. The DHCS-sponsored trainings will be provided prior to the implementation start date for each phase. DHCS will work with each MCP to discuss their needs and the best approach for providing the required trainings.

The required HHP training topics are:

1. **Health Homes Program Overview**
All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on the program. Required training modules shall describe the goals and scope of the HHP, team member roles and how they should work together, the services that should be provided, and how HHP intersects with other California state care coordination programs. The training shall introduce topics related to caring for the populations served under HHP, including those with chronic conditions and homeless individuals, and the impact of social determinants of health on patients.

2. **Health Action Plan, Care Coordination, and Care Transitions within the Health Homes Program**
All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan, conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.

3. **Community Resources and Referrals** (required for care coordinators and housing navigators)

This training shall provide information about available community resources, how to develop relationships with community partners, and best practices for connecting members to community services. This training is required for MCP and CB-CME care coordinators and housing navigators.

MCPs are encouraged to provide additional training and/or guidance about specific local and community organizations and resources available to the CB-CME staff.

Recommended but Optional Training for CB-CME Staff on Core Competencies

DHCS recommends that relevant MCP and CB-CME staff receive training on the following core competencies in order to successfully implement HHP. DHCS plans to provide trainings and/or resources on these topics, which will be saved on the portal and available on-demand.

1) Special Populations (homelessness, domestic violence, SMI, etc.)

Team members should have access to training and resources specific to the patient populations they serve.

2) Social Determinants of Health

Trainings and resources related to social determinants of health should be made available for team members. Social determinants of health include gender, age, education, income and employment, social/cultural networks, housing and physical environments and other factors that impact health outcomes and access to care.

3) Motivational Interviewing

Motivational interviewing is a communication technique that seeks to elicit an individual's internal motivation to make set and accomplish positive goals. The technique uses a non-confrontational, collaborative approach to help the patient find his or her own motivation and initiate change. The patient is empowered to make personal choices, resulting in increased likelihood of compliance with care plans.

4) Trauma-informed Care

Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma. Trauma-informed care emphasizes safety (physical, psychological and emotional) for patients and providers and seeks to empower patients with self-care tools.

5) Health Literacy Assessment

Health literacy refers to a patient's capacity to find and understand health information and services in order to make informed health decisions. Assessment of patient health literacy is essential to the creation of a patient-centered care plan.

Readiness Requirements and Checklist

This checklist is not intended to be all-inclusive. Additional information as needed may be requested by the Department.

General Instructions

Thank you for your interest in participating in the Health Homes Program (HHP). To ensure that Medi-Cal managed care health plans (MCPs) are ready to implement the Health Homes Program, MCPs must submit the documentation listed below and attest that other program requirements have been completed. **There are three deadlines for submissions for each implementing MCP group. Please see Appendix I for the HHP Implementation Schedule by group. Submission deadlines for each group are as follows:**

1. **Group 1 – March 1, 2018; May 1, 2018; and November 1, 2018.**
2. **Group 2 – September 1, 2018; November 1, 2018; and May 1, 2019.**
3. **Group 3.1 – January 1, 2019; April 1, 2019; and October 1, 2019.**
4. **Group 3.2 – March 1, 2019; May 1, 2019; and November 1, 2019.**

List of Deliverables:

Policies and Procedures (P&Ps) and Attestations: Section I – HHP Infrastructure (Deliverables #1 – 3), Section II – HHP Services (Deliverables #4 – 5), Section IV – General HHP Operations (Deliverables #7 – 10 and 12), and the Attestations (Deliverable #13)

Network: Section III – Network (Deliverable #6.1, 6.3, 6.4, 6.5)

SMI Deliverables: Section IV – General HHP Operations, MHP-MOU (Deliverable #11) and Section III – Network (Deliverable #6.2)

Group	Counties		Deliverable Due Dates		Deliverable Approval Dates
Group 1	San Francisco		**P&Ps**:	3/1/18	5/1/18
			Network:	5/1/18	6/1/18
			SMI Deliverables:	11/1/18	12/1/18
Group 2	Riverside San Bernardino		**P&Ps**:	9/1/18	11/1/18
			Network:	11/1/18	12/1/18
			SMI Deliverables:	5/1/19	6/1/19
Group 3.1	Del Norte Humboldt Imperial Lake Lassen Marin Mendocino Merced Monterey Napa	Orange San Mateo Santa Clara Santa Cruz Shasta Siskiyou Solano Sonoma Yolo	**P&Ps**:	1/1/19	5/1/19
			Network:	4/1/19	6/1/19
			SMI Deliverables:	10/1/19	12/1/19
Group 3.2	Alameda Fresno Kern Los Angeles Sacramento San Diego Tulare		**P&Ps**:	3/1/19	5/1/19
			Network:	5/1/19	6/1/19
			SMI Deliverables:	11/1/19	12/1/19

DHCS expects the deliverables to be submitted in the form of MCP policies and procedures except for the organizational chart, assessment tool, health action plan template, network adequacy tables, and CB-CME subcontract. MCPs may develop standalone policies and procedures for the HHP and/or may incorporate HHP into existing policies and procedures. **When submitting existing policies & procedures with HHP-related revisions, please use the "track changes" function in Word, or strike-thru/underline equivalent in other applications, to show deletions and additions. Other forms of documentation are also permitted to supplement MCP policies and procedures. If single documents are used to demonstrate compliance with multiple requirements/deliverables, please provide a crosswalk with the specific location for each deliverable.**

Please see the *"Medi-Cal Health Homes Program: Program Guide"* (Program *Guide)* for Health Home Program requirements that correspond to this Readiness Checklist.

MCPs should follow the regular process for submitting required deliverables to their current Contract manager(s). Please submit HHP-related deliverables to 2PlanDeliverables@dhcs.ca.gov and copy the HHP mailbox at hhp@dhcs.ca.gov.

For each submission, please provide the Plan's Name and the primary Contact Person's name and telephone number.

In addition, when submitting, please use the following email subject line and file naming conventions:

- In the subject line of the email, please note that these are HHP Deliverables by using the following subject line convention:
  "HHP Deliverable 1"; "HHP Deliverables 2 and 3"; etc.

- Please use the following file naming convention:
  [plan name and deliverable number]

The Contact Person is responsible for ensuring that all documentation and attestations are accurate. Questions may be directed to hhp@dhcs.ca.gov. DHCS will provide additional information as it becomes available, and may request additional information at a later date.

I. HHP Infrastructure

1. Organizational Model:

1.1   Submit MCP's policies and procedures describing the HHP infrastructure, the roles and division of labor between the MCP and Community-Based Care Management Entities (CB-CMEs), and whether the MCP delegates any responsibilities to other entities.

1.2   Organizational chart illustrating the HHP infrastructure.

2. Staffing:

2.1   Submit MCP's policies and procedures describing the staffing plan for MCP and CB-CMEs, including care coordinators, community health workers, and housing navigator(s). The care coordinator ratio requirements are included in the Program Guide; however, if an MCP is interested in using a staffing model that de-emphasizes the care coordinator and instead emphasizes the roles of other team members, please describe the model here and DHCS will consider how to handle the care coordinator ratio.

The participation of community health workers in appropriate roles is recommended but not required.

2.2 Job descriptions for care coordination staff, including MCP and CB-CME staff, as appropriate.

3. Health Information Technology/Data and Information Sharing:

3.1 Submit MCP's policies and procedures describing how information is shared among the entire care team (including the member, CB-CME, and MCP), including whether EHR/HIT/HIE, or other methods, are used regarding the following activities:

  a. Comprehensive Care Management
   • Identify cohort and integrate risk stratification information.
   • Shared care plan management – standard format.
   • Clinical decision support tools to ensure appropriate care is delivered.
   • Electronic capture of clinical quality measures to support quality improvement. Include other methods if electronic means of collection are not used.
  b. Care Coordination and Health Promotion
   • Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
   • Tools to support shared decision-making approaches with patients.
   • Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.
   • Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   • Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.
   • Telehealth services including remote patient monitoring.
  c. Comprehensive Transitional Care
   • Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER. Include other methods if an electronic process is not used.
   • Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR. Include other methods if electronic sharing is not used.
   • Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
  d. Individual and Family Support Services
   • Patient specific education resources tailored to specific conditions and needs.
  e. Referral to Community and Social Support Services
   • Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.

- Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used.

II. HHP Services

4. Care Management:

4.1   Submit the assessment template or tool reflective of HHP-required elements such as housing instability, palliative care, and trauma-informed care.

4.2   Submit the Health Action Plan (HAP) template.

4.3   Submit MCP's policies and procedures for conducting care management, including how the MCP, in conjunction with contracted CB-CME, will:
- Develop and implement an HHP member assessment and HAP requirements and process, with enrollee and caregiver participation;
- Design the multi-disciplinary care team composition and process;
- Manage the communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; and
- Maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.
- Maintain a process for referring to other agencies, such as long term services and supports (LTSS) or behavioral health agencies, as appropriate.
- Disenroll members from HHP who no longer qualify for or require HHP services.

5. Care Transitions:

5.1   Submit MCP's policies and procedures for conducting care transitions, including discharge-planning workflows.

III. HHP Network

6. MCP Duties/Responsibilities - Health Homes Program Network

6.1 Physical Conditions and SUD implementation

a.   Provide a list of CB-CMEs expected to be contracted and the projected capacity as of the program launch date. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP and the projected capacity if the MCP is also expected to serve in the CB-CME role. This deliverable is due as a part of the Network Deliverables submission.

Please provide expected network capacity information as of the launch date using the following table format;

CB-CME Network Information – Phase 1 (Physical Conditions and SUD)			
CB-CME Name	CB-CME NPI #	Projected Capacity for each Contracted CB-CME	Expected Contract Effective Date

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

b. Provide a timeline for expanding capacity over time that corresponds with timeline for enrollment expansion. This deliverable is due as a part of the Network Deliverables submission.

Please provide information using the following table format;

CB-CME Network Capacity – Physical Conditions and SUD			
Year 1	Estimated HHP Enrollment	Total Number of CB-CMEs Projected to be Contracted	Total Capacity to Serve HHP Members Using Contracted CB-CMEs
Launch Date			
Last Day of Q1			
Last Day of Q2			
Last Day of Q3			
Last Day of Q4			

Note: A separate DMHC review specific to HHP will not be conducted; however, MHC will continue to conduct regular Knox-Keene Act required network reviews through DMHC established processes.

6.2 SMI Implementation

    a. Provide a list of CB-CMEs expected to be contracted and the projected HHP enrollment capacity for these CB-CMEs as of the program launch date for the SMI implementation. This deliverable update is due as a part of the SMI Deliverables submission.

Please provide the expected network information using the following table format;

CB-CME Network Information – Phase 2 (SMI)			
CB-CME Name	**CB-CME NPI #**	**Projected Capacity for each Contracted CB-CME**	**Expected Contract Effective Date**

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

    b. Provide a timeline for expanding capacity over time that correspond with timelines for enrollment expansion. This deliverable is due as a part of the SMI Deliverables submission.

Please provide information using the following table format;

CB-CME Network Capacity – SMI			
Year 1	**Estimated HHP Enrollment**	**Total Number of CB-CMEs Projected to be Contracted**	**Total Capacity to Serve HHP Members Using Contracted CB-CMEs**
Launch Date (SMI)			
Last Day of Q1 (SMI)			
Last Day of Q2 (SMI)			
Last Day of Q3 (SMI)			
Last Day of Q4 (SMI)			

c. Provide a description of how behavioral health providers are incorporated into the HHP service delivery model. This deliverable is due as a part of the SMI Deliverables submission.

6.3 Provide any MCP-specific CB-CME qualifications (beyond the DHCS requirements listed in the Program Guide) that the MCP requires for the CB-CME to contract for HHP Services. This deliverable is due as a part of the Network Deliverables submission.

6.4 Submit CB-CME oversight policies and procedures, including monitoring, corrective action, progressive consequences for continued non-compliance, auditing care coordination conducted by CB-CMEs. This deliverable is due as part of the Network Deliverables Submission.

6.5 Submit CB-CME subcontract boilerplate that complies with the DHCS MCP contract requirements and includes: 1) Business Associate Agreement that allows for information and data sharing between MCP and CB-CME, 2) CB-CME to provide services in accordance with requirements in this Program Guide, and 3) CB-CME to complete DHCS/MCP required training. **If submitting prior DHCS approved subcontract boilerplate with HHP-related revisions, please use the "track changes" function in Word, or the "strike-through/underline" equivalent in other applications, to show deletions and additions.** This deliverables is due as part of the Network Deliverables Submission.

Note: MCP must have DHCS-approved subcontracts or subcontract amendments with a sufficient number of CB-CMEs to serve its HHP enrollees.

IV. General HHP Operations

7. Non-Duplication of Care Coordination Services:

7.1 Submit MCP's policies and procedures for ensuring that members are not enrolled in another Medi-Cal care coordination program that would disqualify them from receiving HHP services (see Program Guide for requirements).

8/9. HHP Outreach Requirements

8.1 Member Engagement:

Submit MCP's policies and procedures that include the following:
- Protocols for a progressive outreach campaign (see Program Guide Appendix A for model outreach campaign protocols)
- Process for assisting members who require additional prompting or guidance to participate;
- Process for conducting outreach to homeless individuals;

- Process for reviewing and excluding names from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization **or** enrollment in another acceptable care management program – see Reporting Template-Instructions for definition);
- After people have been excluded from the TEL based on the process above, the process and criteria for identifying a "priority engagement group" or ranking process within the remaining TEL members. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for 'priority engagement' status will be at the MCP's discretion (upon approval by DHCS) with the goal of engaging and serving TEL members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization; and

9.1   Member Notices:

- All beneficiary notices to be sent by the MCP regarding the HHP should be filed for DHCS review. If the MCP is licensed by DMHC, these notices should additionally be filed with DMHC for review. DHCS is aligning with DMHC requirements regarding notice review, and DMHC requires MCPs to file all advertisements for review. All outreach materials and scripts that will be distributed should be filed prior to use by the MCP. Submission through this readiness checklist process will begin the DHCS notice review/approval process. MCPs may provide notices for DHCS review at any time prior to the member notices deliverable due date.

Note: Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. DHCS' HHP Beneficiary Toolkit is an optional resource for the MCPs for examples of 'best practice' member messaging (though the HHP Member Toolkit messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

10. Risk Grouping:

10.1   Submit MCP's policies and procedures for ensuring that HHP members receive the appropriate services at the appropriate intensity level, including tiering of services based on risk grouping and the associated payment structure (but not amounts).

11. Mental Health Services:

11.1   Signed local Mental Health Plan (MHP) Health Memorandum of Understanding (MHP-MOU) to ensure seamless access and delivery of mental health services The MHP-MOU must be in place as of the date of implementation of HHP for members with SMI

conditions. MCPs will develop or amend existing MOUs with county MHPs to address HHP-specific information. DHCS will update All Plan Letter (APL) 13-018 to address the HHP-specific information that MCPs will include in new, or amended, MOUs. MCP must submit the new or amended MHP-MOU by November 1, 2018 for Group 1 MCPs; May 1, 2019, for Group 2 MCPs; October 1, 2019 for Group 3.1 MCPs; and November 1, 2019 for Group 3.2 MCPs.

11.2   The MHP-MOU must include the process for sharing beneficiary information (including medication list and service utilization information) and conducting care coordination.

12. Housing Services:

12.1   Submit MCP's policies and procedures for providing the required housing services, including how the MCP will identify and work with community resources to ensure seamless access to delivery of housing support services. MCPs must provide housing navigation services, not just referrals to housing. (See Program Guide for requirements.)

13. Health Homes Program Readiness – Attestations

The operational process attestations below reflect the MCP's commitment to being fully prepared as of the HHP implementation date (July 1, 2018, for Group 1; January 1, 2019, for Group 2; and July 1, 2019, for Group 3). Please check the boxes and sign below to indicate MCP's compliance with the following readiness requirements for the Health Homes Program.

☐ **F. Training**: Attest (check the box) that the MCP and CB-CMEs will complete all DHCS-required HHP training prior to participating in the administration of the HHP, as outlined in the *Program Guide*.

☐ **G. Service Directory**: Attest (check the box) that the MCP or the CB-CME(s) has completed and will maintain a directory of community services and supports that is available to all CB-CMEs and care coordinators.

☐ **H. Quality of Care**: Attest (check the box) that the MCP has incorporated HHP into existing quality management processes.

☐ **I. Cultural Competency, Educational and Health Literacy**: Attest (check the box) that the MCP has incorporated HHP into existing Policies & Procedures on these topics.

☐ **J. Member Communication**: Attest (check the box) that the MCP has incorporated HHP into existing policies regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers), into account in communicating with enrollee.

☐ **K. Members Experiencing Homelessness**: Attest (check the box) that the MCP has incorporated HHP-specific information into the appropriate Policies & Procedures for homeless members, including special service requirements, provider criteria (to comply with homeless experience requirements per AB 361), and engagement processes.

☐ **L. Reporting**: Attest (check the box) that the MCP has the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP service encounters for services provided by the MCP and the CB-CMEs (see *Program Guide* and *reporting template* for reporting requirements).

☐ **M. Service Requirements**: Attest (check the box) that the MCP will comply with all the with all service requirements, including for the six core services and the additional service requirements listed in the Program Guide.

I am authorized to make this attestation on behalf of:

Managed Care Plan	Signature of Authorized Representative
Date	Name of Authorized Representative
	Title of Authorized Representative

E. Appendix E – Service Codes for the Health Homes Program

DHCS continues to plan for implementation of the ACA 2703 Health Home Program (HHP). One of the remaining activities is the finalization of HHP service codes for use on encounters and for other purposes. This revised coding scheme incorporates comments received on the initial proposed coding scheme released in October 2016. The HHP is required to utilize HIPAA-compliant coding standards. The HHP team and the DHCS Office of HIPAA Compliance identified CPT and HCPCS codes for HHP. In addition, the HHP team investigated other potential codes and reviewed codes used by a few other states.

DHCS selected HCPCS code G0506 for HHP. The definition of G0506 is as follows: Comprehensive assessment of and care planning for patients requiring chronic care management services. G0506 along with seven different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This proposed coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The proposed HHP coding scheme is as follows:

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 UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G0506	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G0506	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Additional documentation regarding service codes usage for HHP will be provided in the future.

Description:

<Plan Name> covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for Members with chronic conditions.

<Plan Name> will contact you if you qualify for the program. You can also call <Plan Name>, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call <Plan Name> to find out the conditions that qualify; and
- You meet one of the following:
  o You have three or more of the HHP eligible chronic conditions
  o You stayed in the hospital in the last year
  o You visited the emergency department three or more times in the last year; or
  o You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP Services:

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. <Plan Name> provides HHP services, which include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Cost to Member:

There is no cost to the Member for HHP services.

G. Appendix G – Reporting Template Excerpt

The below is an excerpt from the complete Reporting Template that MCPs will use to submit specific required data. For descriptions of data elements, please see Reporting Template.

Note: CPB = Controlling High Blood Pressure; CDF = Screening for Clinical Depression and Follow-up Plan; SMI = Serious Mental Illness/Serious Emotional Disturbance.

Health Home Program (HHP) Reporting Instructions

These instructions outline the requirements, references, and headings/categories for the following reporting template: Health Home Program Reporting Template. Reporting is required per the managed care contract.

• Data must be submitted in Excel (.xlsx). Do not submit data in .pdf, .xls, .csv, .txt, or any other format than .xlsx.

• The three months of data must be combined into one figure to represent the quarter.

• Each MCP must submit only one file per reporting period. All subcontractors must be rolled up into the main MCP's data.

Reports should be submitted to "DHCS-MCQMD-Monitoring" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov) and the file name needs to include the MCP's name, "HHP" and the calendar-year quarter and year. For example: MCPName.HHP.Q3.2018.xlsx

Reports are due 60 days after the end of the quarter. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date. For reference, the calendar-year quarters are listed below:

• Q1 – January, February, and March - due May 31

• Q2 – April, May, and June - due August 31

• Q3 – July, August, and September - due November 30

• Q4 – October, November, and December - due February 28

Definitions:

CB-CME: Community Based Care Management Entity

HAP: Health Action Plan

Unless otherwise noted, all "days" are calendar days.

Homeless: see
https://www.govregs.com/regulations/expand/title24_part91_subpartA_section91.5

Housing Services: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf - see Housing Transition Services and Housing & Tenancy Sustaining Services on pages 2, and 3-4.

For the purposes of this document, the following definitions will apply:

- HHP Member: a Medi-Cal beneficiary currently enrolled in a Medi-Cal Managed Care Plan and a Health Homes Program.

- Member: a Medi-Cal Managed Care Plan member not currently enrolled in a Health Homes Program.

- Individual: Medi-Cal beneficiary or other eligible person who may not be currently enrolled in a Medi-Cal Managed Care Plan or a Health Homes Program. E.g., FFS beneficiary. May also apply to person not currently enrolled in Medi-Cal.

Definitions of Reasons for Disenrollment and Non-Enrollment: The following are the allowable reasons, with definitions, for which a Medi-Cal member may be disenrolled from, or not enrolled into, a local Health Homes Program (HHP). These definitions will be used by DHCS and its HHP partners.

I. *Unsafe Environment*: for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ED: After reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment or deliver HHP services, such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff.

Individual: Member engagement/enrollment efforts, or delivery of HHP services, cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

II. *Declined participation*: After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate, or to continue to participate, in HHP. This may occur prior to or after enrollment into HHP.

III. *Unsuccessful engagement*: HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self-available, or is un-cooperative. Accurate contact information is not available for the member. This occurs before enrollment.

IV. *Well-managed*: An assessment, which may include a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible. For Disenrollment, the HHP member must be

deemed well enough managed to the extent that the HHP member or the MCP determines the program is no longer medically necessary and the HHP member is no longer appropriate for the program, even for the maintenance level of services.

V. *Participation in duplicative programs or programs excluded for HHP participation due to DHCS policy*. DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:

1. Duplicative Programs

   a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), Pediatric Palliative Care (PPC)

   b. Targeted Case Management (TCM) – County, not Mental Health TCM

   c. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)

2. Programs excluded by DHCS Policy

   a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.

   b. Hospice

   c. Fee-For-Service

Reporting Template Excerpt
1. Health Home Program Enrollment Reporting
Plan Code - Plan Name - County (Column A)
Reporting Period (Column B)
Number MCP excluded because not eligible - well-managed (Column C)
Number MCP excluded because declined to participate (Column D)
Number MCP excluded because of unsuccessful engagement (Column E)
Number MCP excluded because duplicative program (Column F)
Number MCP excluded because unsafe behavior or environment (Column G)
Number MCP excluded because not enrolled in Medi-Cal at MCP (Column H)
Number referred & enrolled (Column I)
Number referred but excluded (Column J)
Average number care manager (Column K)

Reporting Template Excerpt
2. Health Home Program Member Activity Reporting
Plan Code - Plan Name - County (Column A)
Reporting Period (Column B)
Received Housing Services (Column C)
Eligible population for Received Housing Services (Column D)
Homeless receiving supportive housing (Column E)
Eligible population for supportive housing (Column F)
Number initial HAP completed within 90 day (Column G)
Number initial HAP completed (Column H)
3. Health Home Program Network Reporting
Plan Code - Plan Name - County (Column A)
Reporting Period (Column B)
CB-CME NPI # (Column C)
Projected capacity for each CB-CME (Column D)
4. Health Home Program Semi-Annual Engagement Reporting
Note: This tab is to be submitted semi-annually with the previous January data included in the Q3 report of every year and the previous July data included in Q1 of every year.
Plan Code - Plan Name - County (Column A)
Reporting Period (Column B)
Percent engagements began within 6 months (Column C)
5. Health Home Program Annual CMS Core Measures Reporting
Note: This tab is to be submitted annually in the Q2 report of every year and include data on the previous calendar year of January through December.
Plan Code - Plan Name - County (Column A)
Reporting Period (Column B)
Controlling high blood pressure (CBP) (Med) age 18-59 w/HTN, BP < 140/90 - numerator (Column C)
CBP (Med) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column D)
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column E)
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column F)
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column G)
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column H)
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column I)

Reporting Template Excerpt
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column J)
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column K)
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column L)
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - numerator (Column M)
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column N)
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column O)
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column P)
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column Q)
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column R)
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column S)
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column T)
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column U)
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column V)
CDF (MED) - Age 12-17 - numerator (Column W)
CDF (MED) - Age 12-17 - denominator (Column X)
CDF (MED) - Age 18-64 - numerator (Column Y)
CDF (MED) - Age 18-64 - denominator (Column Z)
CDF (MED) - Age 65+ - numerator (Column AA)
CDF (MED) - Age 65+ - denominator (Column AB)
CDF (SMI) - Age 12-17 - numerator (Column AC)
CDF (SMI) - Age 12-17 - denominator (Column AD)
CDF (SMI) - Age 18-64 - numerator (Column AE)
CDF (SMI) - Age 18-64 - denominator (Column AF)
CDF (SMI) - Age 65+ - numerator (Column AG)
CDF (SMI) - Age 65+ - denominator (Column AH)
6. Health Home Program Reporting Comments
Comments (Column A)

H. Appendix H – HHP Eligible Condition Diagnosis Codes

HHP Eligible Condition Diagnosis Codes

Asthma
J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998
CAD
I20.0, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.710, I25.720, I25.730, I25.750, I25.751, I25.758, I25.759, I25.760, I25.790, I25.811, I25.82, I25.83, I25.84, I25.89, I25.9, Z95.1, Z95.5, Z98.61
CHF
I09.81, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
COPD
J41.0, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9
Dementia
F01.50, F01.51, F02.80, F0281, F03.90, F03.91, F04, F05, F06.0 , F06.8, F07.0 , F07.81 , F07.89, F09 , F48.2, G30.9 , G31.01, G31.09 , G31.1 , G31.83 , R41.81
Diabetes
E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E08.9, E09.9, E10.9, E11.9, E13.9, R81, Z46.81, Z96.41, R82.4

HBP

I10, I67.4, I11.9, I11.0, I12.9, I12.0, I13.10, I13.0, I13.11, I13.2, I15.0, I15.8, I15.1, N26.2, I15.2, I15.9

Liver Disease

K72.00, K74.0, K74.60, K74.69, K74.3, K74.4, K74.5, K75.81, K76.0, K76.89, K74.1, K74.2, K76.9, K75.0, K75.1, K70.41, K71.11, K72.01, K72.90, K72.91, K76.6, K76.7, K72.10, K72.11, K76.1, K76.3, K76.81, K76.5, K77, R17, R18.8, Z48.23, Z94.4

TBI

S01.90XA, S01.90XD, S04.011S, S04.012S, S04.019S, S04.02XS, S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S, S04.10XS, S04.11XS, S04.12XS, S04.20XS, S04.21XS, S04.22XS, S04.30XS, S04.31XS, S04.32XS, S04.40XS, S04.41XS, S04.42XS, S04.50XS, S04.51XS, S04.52XS, S04.60XS, S04.61XS, S04.62XS, S04.70XS, S04.71XS, S04.72XS, S04.811S, S04.812S, S04.819S, S04.891S, S04.892S, S04.899S, S06.0X0A, S06.0X0D, S06.0X0S, S06.0X1A, S06.0X1D, S06.0X1S, S06.0X2A, S06.0X2D, S06.0X2S, S06.0X3A, S06.0X3D, S06.0X3S, S06.0X4A, S06.0X4D, S06.0X4S, S06.0X5A, S06.0X5D, S06.0X5S, S06.0X6A, S06.0X6D, S06.0X6S, S06.0X7A, S06.0X7D, S06.0X7S, S06.0X8A, S06.0X8D, S06.0X8S, S06.0X9A, S06.0X9D, S06.0X9S, S06.1X0A, S06.1X0D, S06.1X0S, S06.1X1A, S06.1X1D, S06.1X1S, S06.1X2A, S06.1X2D, S06.1X2S, S06.1X3A, S06.1X3D, S06.1X3S, S06.1X4A, S06.1X4D, S06.1X4S, S06.1X5A, S06.1X5D, S06.1X5S, S06.1X6A, S06.1X6D, S06.1X6S, S06.1X7A, S06.1X7D, S06.1X7S, S06.1X8A, S06.1X8D, S06.1X8S, S06.1X9A, S06.1X9D, S06.1X9S, S06.2X0A, S06.2X0D, S06.2X0S, S06.2X1A, S06.2X1D, S06.2X1S, S06.2X2A, S06.2X2D, S06.2X2S, S06.2X3A, S06.2X3D, S06.2X3S, S06.2X4A, S06.2X4D, S06.2X4S, S06.2X5A, S06.2X5D, S06.2X5S, S06.2X6A, S06.2X6D, S06.2X6S, S06.2X7A, S06.2X7D, S06.2X7S, S06.2X8A, S06.2X8D, S06.2X8S, S06.2X9A, S06.2X9D, S06.2X9S, S06.300A, S06.300D, S06.300S, S06.301A, S06.301D, S06.301S, S06.302A, S06.302D, S06.302S, S06.303A, S06.303D, S06.303S, S06.304A, S06.304D, S06.304S, S06.305A, S06.305D, S06.305S, S06.306A, S06.306D, S06.306S, S06.307A, S06.307D, S06.307S, S06.308A, S06.308D, S06.308S, S06.309A, S06.309D, S06.309S, S06.310A, S06.310D, S06.310S, S06.311A, S06.311D, S06.311S, S06.312A, S06.312D, S06.312S, S06.313A, S06.313D, S06.313S, S06.314A, S06.314D, S06.314S, S06.315A, S06.315D, S06.315S, S06.316A, S06.316D, S06.316S, S06.317A, S06.317D, S06.317S, S06.318A, S06.318D, S06.318S, S06.319A, S06.319D, S06.319S, S06.320A, S06.320D, S06.320S, S06.321A, S06.321D, S06.321S, S06.322A, S06.322D, S06.322S, S06.323A, S06.323D, S06.323S, S06.324A, S06.324D, S06.324S, S06.325A, S06.325D, S06.325S, S06.326A, S06.326D, S06.326S, S06.327A, S06.327D, S06.327S, S06.328A, S06.328D, S06.328S, S06.329A, S06.329D, S06.329S, S06.330A, S06.330D, S06.330S, S06.331A, S06.331D, S06.331S, S06.332A, S06.332D, S06.332S, S06.333A, S06.333D, S06.333S, S06.334A, S06.334D, S06.334S, S06.335A, S06.335D, S06.335S, S06.336A, S06.336D, S06.336S, S06.337A, S06.337D, S06.337S, S06.338A, S06.338D, S06.338S, S06.339A, S06.339D, S06.339S, S06.340A, S06.340D, S06.340S, S06.341A, S06.341D, S06.341S, S06.342A, S06.342D, S06.342S, S06.343A, S06.343D, S06.343S, S06.344A, S06.344D, S06.344S, S06.345A, S06.345D, S06.345S, S06.346A, S06.346D,

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S06.4X7D, S06.4X7S, S06.4X8A, S06.4X8D, S06.4X8S, S06.4X9A, S06.4X9D, S06.4X9S,
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S06.9X8S, S06.9X9A, S06.9X9D, S06.9X9S, S14.0XXS, S14.101S, S14.102S, S14.103S, S14.104S,
S14.105S, S14.106S, S14.107S, S14.108S, S14.109S, S14.111S, S14.112S, S14.113S, S14.114S,

S14.115S, S14.116S, S14.117S, S14.118S, S14.119S, S14.121S, S14.122S, S14.123S, S14.124S, S14.125S, S14.126S, S14.127S, S14.128S, S14.129S, S14.131S, S14.132S, S14.133S, S14.134S, S14.135S, S14.136S, S14.137S, S14.138S, S14.139S, S14.141S, S14.142S, S14.143S, S14.144S, S14.145S, S14.147S, S14.148S, S14.149S, S14.151S, S14.152S, S14.153S, S14.154S, S14.155S, S14.156S, S14.157S, S14.158S, S14.159S, S14.2XXS, S14.3XXS, S14.4XXS, S14.5XXS, S14.8XXS, S14.9XXS, S24.0XXS, S24.101S, S24.102S, S24.103S, S24.104S, S24.109S, S24.111S, S24.112S, S24.113S, S24.114S, S24.119S, S24.131S, S24.132S, S24.133S, S24.134S, S24.139S, S24.141S, S24.142S, S24.144S, S24.149S, S24.151S, S24.152S, S24.153S, S24.154S, S24.159S, S24.2XXS, S24.3XXS, S24.4XXS, S24.8XXS, S24.9XXS, S34.01XS, S34.02XS, S34.101S, S34.102S, S34.103S, S34.104S, S34.105S, S34.109S, S34.111S, S34.112S, S34.113S, S34.114S, S34.115S, S34.119S, S34.121S, S34.122S, S34.123S, S34.124S, S34.125S, S34.129S, S34.131S, S34.132S, S34.139S, S34.21XS, S34.22XS, S34.3XXS, S34.4XXS, S34.5XXS, S34.6XXS, S34.8XXS, S34.9XXS, S44.00XS, S44.01XS, S44.02XS, S44.10XS, S44.12XS, S44.20XS, S44.21XS, S44.22XS, S44.30XS, S44.31XS, S44.32XS, S44.40XS, S44.41XS, S44.42XS, S44.50XS, S44.51XS, S44.52XS, S44.8X1S, S44.8X2S, S44.8X9S, S44.90XS, S44.91XS, S44.92XS, S54.00XS, S54.01XS, S54.02XS, S54.10XS, S54.11XS, S54.12XS, S54.20XS, S54.21XS, S54.22XS, S54.30XS, S54.31XS, S54.32XS, S54.8X1S, S54.8X2S, S54.8X9S, S54.90XS, S54.91XS, S54.92XS, S64.00XS, S64.01XS, S64.02XS, S64.21XS, S64.22XS, S64.30XS, S64.31XS, S64.32XS, S64.40XS, S64.490S, S64.491S, S64.492S, S64.493S, S64.494S, S64.495S, S64.496S, S64.497S, S64.498S, S64.8X1S, S64.8X2S, S64.8X9S, S64.90XS, S64.91XS, S64.92XS, S74.00XS, S74.01XS, S74.02XS, S74.10XS, S74.11XS, S74.12XS, S74.20XS, S74.21XS, S74.22XS, S74.8X1S, S74.8X2, S74.8X9S, S74.90XS, S74.91XS, S74.92XS, S84.00XS, S84.01XS, S84.02XS, S84.10XS, S84.11XS, S84.12XS, S84.20XS, S84.21XS, S84.22XS, S84.801S, S84.802S, S84.809S, S84.90XS, S84.91XS, S84.92XS, S94.00XS, S94.01XS, S94.02XS, S94.10XS, S94.11XS, S94.12XS, S94.20XS, S94.21XS, S94.22XS, S94.30XS, S94.31XS, S94.32XS, S94.8X1S, S94.8X2S, S94.8X9S, S94.90XS, S94.91XS, S94.92XS

Bipolar Disorder

F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9

Major Depressive Disorder

F06.30, F06.31, F06.32, F06.33, F06.34, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39

Psychotic Disorders

F06.0, F06.2, F20.0, F20.1, F20.2, F20.3 , F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F28, F32.3, F44.89

Alcohol Related

F10.121, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250,

F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.921, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, G62.1, I42.6, K29.20, K29.21, K70.0, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.9

Substance Related

F11.121, F11.122, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.920, F12.921, F12.922, F12.929, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.26, F13.27, F13.27, F13.280, F13.281, F13.282, F13.288, F13.288, F13.29, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.920, F14.921, F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.20, F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.121, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.21, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.920, F19.921, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, O35.5XX0, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, T40.0X1A, T40.0X1D, T40.0X2A, T40.0X2D, T40.0X3A, T40.0X3D, T40.0X4A, T40.0X4D, T40.1X1A, T40.1X1D, T40.1X2A, T40.1X2D, T40.1X3A, T40.1X3D, T40.1X4A, T40.1X4D, T40.2X1A, T40.2X1D, T40.2X2A, T40.2X2D, T40.2X3A, T40.2X3D, T40.2X4A, T40.2X4D, T40.3X1A, T40.3X1D, T40.3X2A, T40.3X2D,

T40.3X3A, T40.3X3D, T40.3X4A, T40.3X4D, T40.4X1A, T40.4X1D, T40.4X2A, T40.4X2D, T40.4X3A, T40.4X3D, T40.4X4A, T40.4X4D, T40.601A, T40.601D, T40.602A, T40.602D, T40.603A, T40.603D, T40.604A, T40.604D, T40.691A, T40.691D, T40.692A, T40.692D, T40.693A, T40.693D, T40.694A, T40.694D
Kidney Disease
N18.1, N18.2, N18.3 , N18.4 , N18.5, N18.6, N18.9, Z48.22, Z49.01 , Z49.02, Z49.31 , Z49.32, Z91.15 , Z94.0

I.   Appendix I – HHP Implementation Schedule

HHP Implementation Schedule

The California Department of Health Care Services (DHCS) announces that the implementation of the state's Health Homes Program (HHP) will begin July 1, 2018. The counties included in each group and the revised phased implementation schedule are outlined in the table below:

County Implementation Schedule

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and SUD	(Phase 2) Implementation date for members with SMI
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Fresno • Kern • Los Angeles • Sacramento • San Diego • Tulare • Del Norte • Humboldt • Imperial • Lake • Lassen • Marin • Mendocino • Merced • Monterey • Napa • Orange • San Mateo • Santa Clara • Santa Cruz • Shasta • Siskiyou • Solano • Sonoma • Yolo	July 1, 2019	January 1, 2020

J. Appendix J – HHP Supplemental Payment File *(Placeholder)*

Joint Medi-Cal Managed Care Health Plan and Whole Person Care Pilot Guidance:

Eligibility and Provision of Services in the Health Homes Program and

Whole Person Care Pilots

This notification provides DHCS policy guidance regarding the eligibility, enrollment and the provision of services for Medi-Cal beneficiaries concurrently eligible for both the Health Homes Program (HHP) and a Whole Person Care (WPC) Pilot.

Medi-Cal managed care health plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE). WPC eligibility is established by each Pilot.

DHCS' guidance is that Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice.

In most cases WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services that want to receive. The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

If the beneficiary chooses to receive care coordination services through WPC and is also interested in participating in the HHP, the beneficiary will not be able to receive any HHP services due to HHP, by default, being a program that consists of a set of 6 care-coordination services that are offered as the core benefit of the program.

In most cases WPC pilots also provide other services that are not duplicative, or similar to, HHP care coordination services. A sobering center service is one example of a WPC service that is likely to not be duplicative of HHP services. If a member is eligible for both WPC and HHP, and the member chooses to receive care coordination services through the HHP, the member may still receive other WPC services (that are not duplicative of HHP services) through the WPC. The WPC pilot may claim reimbursement for these other services regardless of whether the beneficiary chooses to receive care coordination services through the WPC or the HHP.

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.

- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.

- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.

- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.

- As always, DHCS reserves the right to perform an audit of LE data and MCP data.