Medi-Cal Health Homes Program

PROVIDER GUIDE

This Provider Guide covers key information about the California Medi-Cal Health Homes Program (HHP) for managed care plans, Community-Based Care Management Entities, providers, community-based organizations, and other stakeholders.

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The Health Homes Program
bit.ly/HealthHomes

Overview

The Medi-Cal Health Homes Program (HHP) helps manage and coordinate care for Medi-Cal managed care members with certain chronic health and/or mental health conditions who have high health care needs or experience chronic homelessness.

What is the Health Homes Program?

- The HHP gives qualified members **extra services**, including their own **care team** that works together to connect their health care services and doctors and link them to community and social services
- Members get these **extra services at no cost** as part of their Medi-Cal benefits
- Members can keep their doctors, but now they can access an **added layer of support**
- The HHP will **not take away or change** any of the member's current Medi-Cal benefits

The HHP is for Medi-Cal Health Plan Members

Only health plan members can access HHP services. Medi-Cal beneficiaries who receive care through the fee-for-service delivery system must enroll in a health plan to see if they qualify.

Who Can Access HHP Services?

Medi-Cal members with certain chronic conditions and high health care needs can access HHP services. Members must meet all 3 of the following requirements:

1. Be enrolled in a Medi-Cal managed care plan; and
2. Have certain chronic health and/or mental health conditions; and
3. Meet at least one acuity or complexity criteria.

If members qualify, getting HHP services is their choice.

See the Eligibility and Enrollment section for more information.

What Services Does the HHP Offer?

The HHP offers 6 types of services to help members manage and improve their health:

1. **Care Management:** Develop and implement a Health Action Plan to manage and guide their care
2. **Care Coordination:** Coordinate care and information across all their providers
3. **Health Promotion:** Teach them about how to monitor and manage their health
4. **Care Transitions:** Help them move safely and easily in and out of the hospital or other treatment facilities and where they live
5. **Member and Family Supports:** Educate them and their personal support system about their health issues to improve treatment adherence
6. **Referrals to Community/ Social Services:** Connect them to community and social services, including housing as needed

Who Provides HHP Services?

Each member is given a care team, including a care coordinator. The care coordinator works with all of their providers—such as doctors, specialists, pharmacists, social service providers and others—to make sure everyone is on the same page about the member's needs and care.

Their care team is led by someone from their Community-Based Care Management Entity (CB-CME) or health plan.

What Are CB-CMEs?

CB-CMEs are health care providers and community organizations that contract with health plans to provide HHP care management, care coordination, and other services.

CB-CMEs can be primary care providers, Federally Qualified Health Centers, community health centers, local health departments, and other providers. Many members will be able to receive HHP services where they already receive care.

How Do Qualified Medi-Cal Members Access HHP Services?

There are 3 ways to access HHP services:

1. Many members who may qualify will be contacted
2. A provider submits a referral form for a member
3. A member contacts their health plan for information and to see if they qualify

Can Members Access HHP Services and Other State Programs?

It depends on what the other program is. For details, see the Eligibility and Enrollment section.

Health Homes Program

Eligibility and Enrollment

The Health Homes Program (HHP) helps manage and coordinate care for Medi-Cal managed care members with certain chronic health and/or mental health conditions who have high health care needs or experience chronic homelessness.

Who Can Access HHP Services?

To access HHP services, members must meet all 3 requirements:

1. **Be enrolled in a Medi-Cal managed care plan** (health plan)

2. **Have certain chronic condition(s)** that are determined by certain ICD-10 codes. The member can check at least 1 box below:

   - ☐ At least 2 of the following:
     Chronic obstructive pulmonary disease (COPD), diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic kidney disease, dementia, or substance use disorders

   - ☐ Hypertension (high blood pressure) and 1 of the following:
     COPD, diabetes, coronary artery disease, or chronic or congestive heart failure

   - ☐ 1 of the following:
     Major depression disorders, bipolar disorder, or psychotic disorders (including schizophrenia)

   - ☐ Asthma

   See the HHP Program Guide at bit.ly/HealthHomes for the condition diagnosis ICD-10 codes.

3. **Meets at least one acuity or complexity criteria.** The member can check at least 1 box below:

   - ☐ Has 3 or more of the HHP-eligible chronic conditions
   - ☐ Had at least 1 inpatient hospital stay in the last year
   - ☐ Had 3 or more emergency department visits in the last year
   - ☐ Is experiencing chronic homelessness

Who is Considered Chronically Homeless?

A person is chronically homeless if they have a condition limiting his or her activities of daily living and have been homeless for:

- 12 consecutive months or more; or
- 4 or more periods of time in the last 3 years

A person who lives in traditional housing, or has been residing in permanent supportive housing, for less than 2 years is considered chronically homeless if they were chronically homeless prior to residence.

Source: AB 361 / W&UI Code Section 14127(e)

Who Cannot Access HHP Services?

Members who:

- Based on further assessment are determined to be sufficiently well-managed through self-management or through another program, or members otherwise determined to not fit the HHP eligibility criteria
- Have a condition that cannot be improved because the member is uncooperative
- Have behavior, or are in an environment, that is unsafe for staff
- Would be better served by, or are already enrolled in, another care management program (see the HHP and Other State Programs section)

How Do Members Access HHP Services?

There are 3 ways members can access HHP services:

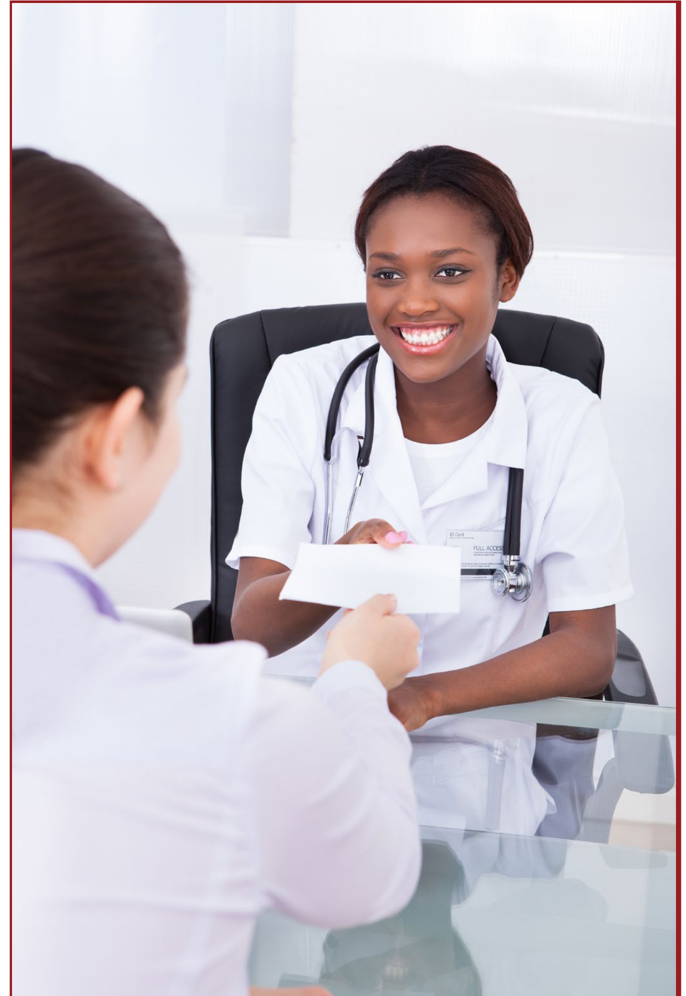
1. Many members who may qualify will be contacted
The Department of Health Care Services (DHCS) gives each health plan a list of their members who may qualify for the HHP. The list is based on the Medi-Cal members' health conditions and medical service information from their health care claims history. The list is updated every 6 months. Health plans also use their own data to see which members may qualify.

The health plan and/or a CB-CME will contact many members who may qualify to discuss the HHP.

Other members may qualify even if they are not on the DHCS list. They can join the HHP in the following two ways.

2. Health care providers can submit a referral form for members
If a member has not joined the HHP but may qualify, their provider can explore their eligibility by submitting a referral form to their health plan.

3. Members ask for HHP information
Members can contact their health plan for information and to see if they qualify.



What Happens After Members Join the HHP?

Someone from the member's care team will contact them to discuss their current providers and their health and social service needs and goals.

The member will be assigned a care coordinator who will work with them to develop a plan – called a Health Action Plan – for getting the services they need.

Tips for Talking to Members About the HHP

Health plans, CB-CMEs, providers, and community-based organizations play key roles in explaining the HHP to members. When talking to members, consider sharing the following messages:

- You will have a **care team** – including a care coordinator – that works together to help you get the care you need
- You receive **extra services at no cost** as part of your Medi-Cal benefits, including help with:
    - Finding doctors and making appointments
    - Understanding your prescription drugs
    - Setting up transportation to your doctor visits
    - Getting follow-up services after you leave the hospital
    - Connecting to and applying for community programs and services, including food benefits and housing
- You can **keep your doctors**, but you can get an **added layer of support**
- To get HHP services, you must have certain health and/or mental health issues and need extra help with your health care or experience homelessness

HHP and Other State Programs

California has multiple programs designed to coordinate care for people with Medi-Cal. Counties, health plans, and providers work together to coordinate services across these programs and to avoid duplication.

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

- Whole Person Care Pilot Program
- California Children's Services Program
- Specialty Mental Health (including Targeted Case Management) and Drug Medi-Cal
- Long-term services and supports benefits, such as Community-Based Adult Services and In-Home Supportive Services
- Medicare
    - Members who have both Medi-Cal and Medicare may qualify for HHP services, but there may be other health care choices available that will work better for them

Members cannot receive HHP services if they are:

- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month (i.e., members are only eligible within the first 2 months of admission to the SNF)
- Hospice services recipients

Members must choose the HHP OR the program listed below:

- **Cal MediConnect and Fee-for-Service Delivery Systems**
  To receive HHP services, members must leave the Cal MediConnect plan or the fee-for-service delivery system and join a health plan

- **County-Operated Targeted Case Management (excluding Specialty Mental Health Services)**
  Members with county-operated Targeted Case Management (TCM) must choose TCM or the HHP. HHP members can choose to receive TCM as part of the County Mental Health Plan Specialty Mental Health (MHP SMH) services program. If members choose this option, their HHP providers must coordinate with their SMH TCM providers to avoid duplication of services.

- **1915(c) Home and Community-Based Waiver Programs**
  These programs include: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), and Pediatric Palliative Care (PPC)

Health plans have discretion to determine and designate other comprehensive care coordination programs as duplicative of HHP services.

Health Homes Program

Six Core Services

The Health Homes Program (HHP) offers extra services for qualified Medi-Cal members. These services help members manage and coordinate their care and connect to community and social services.

What Services Does the HHP Offer?

The HHP offers 6 core services:

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

Below are descriptions of these services.

1. **Care Management:** The member, their care coordinator, and their HHP care team work together to develop a comprehensive, individualized Health Action Plan.

This plan is based on the member's health status, needs, preferences, and goals regarding their:

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

Health Action Plan

A comprehensive plan developed with the member that addresses their health, mental health, and social service needs and goals. It is used to guide and track their care. It is reviewed and revised over time based on their changing needs.

2 Care Coordination: Services are provided to help members implement their Health Action Plan and navigate and connect to needed health and community services. The care coordinator is a key point of contact.

Services may include:

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

These services are integrated with current Medi-Cal managed care plan (health plan) coordination activities, but the HHP provides a more intensive level of support.

3 Health Promotion: Members are coached on how to monitor and manage their health and identify and access helpful resources. Services may include:

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

4 **Transitional Care:** Members receive services to help them transition between treatment facilities, including admissions and discharges, and to reduce avoidable hospital admissions and readmissions.

This includes transitions between the emergency department, hospital inpatient facility, residential/treatment facility, mental health facility, skilled nursing facility, incarceration facility, or other treatment center, and to where they stay or live.

Services may include:

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

5 **Member and Family Supports:** Members, their families, and their personal support system are educated about the member's condition(s) and are connected to support to improve treatment adherence and medication management. Services may include:

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

6 Referral to Community and Social Supports: Members receive referrals to community and social services and follow-up to help ensure they get the services they need. Services may include:

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

Where do Members Access HHP Services?

HHP services can be provided:

- In-person where members seek care or live, or at any location they prefer;
- By phone; and/or
- Through other communication methods that work for members.

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

What Transportation Services Are Offered?

The HHP, through the care team, arranges for and helps coordinate transportation, but it does not provide actual transportation to services.

However, under Medi-Cal, health plans are responsible for providing non-emergency transportation to medically necessary services.

What Housing Services Are Offered?

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

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

Health Homes Program

Care Management and the Health Action Plan

The Health Homes Program (HHP) offers extra services for Medi-Cal members with certain chronic conditions. The Health Action Plan is used to guide care management and care coordination.

What is the Health Action Plan?

Each member is given a Health Action Plan to guide their services and care. It is developed by the member and their care team.

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

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

Who Provides Services?

Each member is given a care team that includes their health care providers and community and family or personal supports if they wish. Either their health plan or the Community-Based Care Management Entity (CB-CME) assigns a care coordinator for each member.

The care coordinator works with the member to create the Health Action Plan, coordinates their care, and makes sure they receive all needed services. Other care team members also help develop and implement the Health Action Plan.

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

How is the Health Action Plan Used?

The care coordinator and the care team work with the member to implement their Health Action Plan. The Health Action Plan guides the care they receive to help them improve their health outcomes and achieve their health goals.

Services may be provided in person, by phone, or through other communication methods that work for members.

The Health Action Plan is reviewed and revised over time, based on the member's progress and changes in their needs.

Care Management Best Practices

Materials have been developed to assist CB-CMEs and providers engaged in care management activities. These evidence-based practices have been found to be effective for treating members with complex needs, such as those in the HHP. See best practices in care management at bit.ly/HealthHomes or contact the health plans for resources and training opportunities.

Health Homes Program

Team Roles and Responsibilities

The Health Homes Program (HHP) offers extra services for Medi-Cal members with certain chronic conditions. Members are given a care team that works with all of their providers to manage and coordinate their care.

HHP Team at a Glance

Three types of entities work together to deliver HHP services:

- Medi-Cal managed care plans (health plans)
- Community-Based Care Management Entities (CB-CMEs)
- Community-Based Organizations (CBOs)

Together, they form an HHP care team around the member. The care team always includes a care coordinator, an HHP director, a clinical consultant, and a Housing Navigator for members experiencing homelessness.

It can also include the member's current health and social service providers, a community health worker, and people from their personal support system if they wish.

Medi-Cal Managed Care Plans

Health plans oversee the administration of the HHP. They must be certified to participate in the HHP by meeting certain criteria and passing a readiness review. Health plans negotiate contracts to furnish HHP services with each provider.

Health plan responsibilities include:

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

Community-Based Care Management Entities

Each member has a CB-CME that serves as their provider of HHP services. The member's health plan assigns them to a CB-CME, but they may choose another one if they prefer.

In most cases, the CB-CME will be a community primary care provider that serves a high number of HHP-eligible members. Where CB-CME provider gaps exist, health plans fill the role of CB-CMEs to provide HHP services.

If the CB-CME is not the member's assigned primary care provider, the CB-CME must maintain a strong connection to their primary care provider to ensure their participation in the development and implementation of the Health Action Plan.

CB-CME responsibilities include:

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

Health plans and CB-CMEs must also coordinate with county substance use disorder and specialty mental health providers as appropriate.

CB-CMEs must meet HHP certification and qualification requirements to serve HHP enrollees.

If your organization is interested in becoming a CB-CME, please contact the health plans in your county. For contact information go to: bit.ly/plandirectory.

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

Community-Based Organizations

As part of providing comprehensive care coordination, the care team works with members to identify their community and social service needs and links them to these services. To accomplish this work, the care team works with community health workers, housing navigators, and CBOs.

Since many CBOs and social service agencies have established trusting relationships with members, they are an important source of information and support in helping members meet their health goals.

The Care Team

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

Members can also include family, friends, CBO staff, and other people from their support system if they wish.

The table below lists the required and optional care team members, their qualifications, and their key role.

HHP Care Team		
Team Member	**Qualifications**	**Key Role**
Care Coordinator (CB-CME, health plan, or by contract)	Paraprofessional with appropriate training, or licensed care coordinator, social worker, or nurse	• Engage eligible members • Oversee services and Health Action Plan implementation • Connect members to medical and social services • Advocate on behalf of members • Monitor treatment adherence and help with medication management • Accompany members to appointments as needed and permitted • Arrange transportation
HHP Director (CB-CME or health plan)	Ability to manage multidisciplinary care teams	• Oversee management and operations of the team • Oversee reporting for the team, including quality measures • Oversee quality measures and reporting

HHP Care Team		
Team Member	**Qualifications**	**Key Role**
Clinical Consultant (CB-CME or health plan)	A health care professional such as a primary care physician, specialist, psychiatrist, nurse, nutritionist, social worker, or behavioral health care professional	• Review and advise on Health Action Plan • Act as clinical resource for care coordinator • Facilitate access to primary care and behavioral health providers as needed
Housing Navigator (CB-CME or by contract) — *Required for members experiencing homelessness*	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Develop and maintain relationships with housing agencies and permanent housing providers • Connect members to permanent housing options, including supportive housing • Coordinate with members in the most easily accessible setting as permitted (e.g., mobile unit)
Community Health Workers (CB-CME or by contract) — *Recommended but not required*	Paraprofessional or peer advocate	• Engage eligible members • Accompany members to appointments, as needed and permitted • Support health promotion and self-management training • Arrange transportation • Assist with linkages to social supports

Health Homes Program

Information Sharing, Reporting, and Payment

The Health Homes Program (HHP) offers extra services for Medi-Cal members with certain chronic conditions. The care team shares information with each other about the services they each provide to members.

Medi-Cal managed care plans (health plans) must report data to the Department of Health Care Services (DHCS) to evaluate enrollment, utilization, and the quality of care provided.

Is Member Information Shared Across Entities?

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

For example, health plans can provide electronic member-level data about hospital and emergency department utilization to providers and care coordinators. Timely information about hospital discharge supports seamless care transitions.

Are Data Sharing Agreements Required?

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

Program partners are encouraged to use technology to ensure timely, accurate, and secure sharing of information. Ideally, partners should use electronic health records, health information technology, and health information exchange systems for tracking, charting, and information sharing.

In cases where this technology is not widely used or available, health plans and program partners will work together to develop information sharing processes that are timely, accurate, and secure.

What are the Reporting Requirements?

Health plans must track and report data on enrollment, utilization, and the quality of care provided across the care team to help DHCS and the Centers for Medicare & Medicaid Services (CMS) evaluate the HHP.

Most data are reported quarterly or semi-annually to DHCS. Data on the CMS measures are reported annually. DHCS calculates some measures based on health plan-provided encounter data.

Data must be reported in 3 areas:

1 Enrollment & Capacity

This includes the number of members:

- Participating in the HHP
- Excluded from HHP services, by reason
- With a completed Health Action Plan (HAP)

2 Service Utilization

This includes the number of:

- Members who received HHP services
- HHP services received, by member
- Members referred to, and receiving, housing and supportive housing services

3 Quality of Care & General Utilization

This includes:

- CMS quality measures
- CMS utilization measures

What are the HHP Performance Measures?

See the DHCS HHP Program Guide at bit.ly/HealthHomes for comprehensive and up-to-date information on the performance measures. The following performance measures are subject to change.

1. Enrollment & Capacity Measures

- # of members excluded from the targeted engagement list, by reason
- # of members referred to HHP who were enrolled or excluded
- # of members with initial HAP completed within 90 days
- # of members with HAP completed in the quarter
- # of members experiencing homelessness or requiring tenancy sustaining services & # no longer experiencing homelessness
- # of CB-CMEs and capacity
- Average # of care coordinators
- Aggregate care coordinator ratio

2. Service Utilization Measures

- # of members who received services
- # of each HHP service received, by member
- # of each HHP service unit provided
- # of members experiencing homelessness or requiring tenancy sustaining services who received HHP housing services

3. Quality of Care & General Utilization Measures

CMS Quality Measures

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

CMS Utilization Measures

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

What are the HHP Service Codes?

Health plans provide guidance to providers on the following service codes. For the most up-to-date information, see the DHCS HHP Program Guide at bit.ly/HealthHomes.

HHP Service	HCPCS Code*	Modifier
In-Person: Provided by Clinical Staff	G9008	U1
Phone/Telehealth: Provided by Clinical Staff	G9008	U2
Other Health Home Services: Provided by Clinical Staff	G9008	U3
In-Person: Provided by Non-Clinical Staff	G9008	U4
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6
HHP Engagement Services	G9008	U7

*Healthcare Common Procedure Coding System
Note: For each HHP service, 15 minutes equals 1 unit of service (UOS); multiple UOS are allowed.

How do HHP Payments Work?

- HHP payments are made directly from DHCS to the health plans through per-member per-month capitation rates.
- Health plans negotiate individual contracts and payment terms with CB-CMEs and other contracted providers to deliver HHP services.
- Services may be provided directly by the health plan or CB-CME, or certain activities may be subcontracted to other entities.