Implementation of the Housing & Homelessness Incentive Program (HHIP)

New HHIP Implementation Toolkit

April 18, 2023

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ADVANCING SOLUTIONS TO HOMELESSNESS

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Today's Webinar

- Introduction to HHIP Implementation Toolkit
- Understanding HHIP Performance Metrics
- Maximizing Enhanced Care Management (ECM) and Community Supports for People Experiencing Homelessness
- Next Step: Expenditure Planning
- Data Sharing Components of Toolkit
- Q&A

Reminder: Follow Up Office Hours on April 20 and 26

Introduction to HHIP Implementation Toolkit

August 2022: CalAIM & HHIP Basics

CalAIM Basics

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What is CalAIM?

California Advancing and Innovating Medi-Cal (C
a new Medi-Cal initiative that seeks to improve t
of Californians. It is a multi-year program that is
particularly on Californians with the most comple
The federal government granted a special waiv
state that allows California to adapt Medi-Cal
it more "equitable, coordinated, and person-cen

The first of CalAIM's reforms began in January 2
additional changes will be added through 2027. F
in depth information about CalAIM, see the C
Health Care Foundation's resource, CalAIM Exp
Five-Year Plan to Transform Medi-Cal.

The CalAIM Initiative aims to:

- Offer services that are standard and e
for all.
- Address the needs of the whole person
their "medical" needs, by integrating M
with other social service programs.
- Streamline and make it easier for mer
navigate through the Medi-Cal system
- Encourage greater collaboration and
nation with other social services secto
criminal legal system, child welfare
housing and homeless systems.)

CalAIM has many different components that
health coverage and use innovative strategies to
better health care to California residents. As pa
goal, the state takes a broad view of the types of
the state will pay for under CalAIM. (For more info
about the types of housing-related services cov
people experiencing homelessness, see our cor
fact sheet: *CalAIM Housing-Related Services*.)

Medi-Cal

California's name for the state Medicaid progra

Medicaid

A joint federal/state funded program that pro
health coverage to individuals and families with
incomes; children; pregnant people; older adults
people with disabilities.

CalAIM's Housing-Related Services

Among the many components of California's CalAIM initiative, three new programs
opportunities to improve care for people at risk of or experiencing homelessness:

Enhanced Care Management (ECM) | Community Supports (CS)

Enhanced care management services are the only one of the three new programs th
care plans (MCPs) are required to provide. The other two are optional.

Enhanced Care Management (ECM)

Enhanced care management is a statewide program for Medi-Cal members with complex care needs that impact their physical, mental, and/or social well-being. The State has identified several "populations of focus" who should be offered the opportunity to receive these services and to facilitate referrals to and engagement in enhanced care management programs that meet their needs. Typically, plans are contracting with other providers, such as Federally Qualified Health Centers, to be enhanced care management providers.

Enhanced care management (ECM) services

Enhanced care management is intended to address the clinical and non-clinical needs of Medi-Cal members by providing intensive care coordination and services across multiple systems of care. Enhanced care management providers are required to meet members where they are in their communities, instead of just at the doctor's office; that means they can care for members at a shelter, on the street, or at home. Enhanced care managers help Medi-Cal members set clear goals, make sure that they receive the full array of benefits they're eligible for to meet those goals, and coordinate across systems to help members achieve their goals.

**Members who can rec
management (ECM)**

Medi-Cal members who a
management can be refe
referred by community m
etc.) to receive enhanced
The populations eligible
management are:

- Individuals and famili
- Adults, youth, and ch
of avoidable emerge
short-term skilled nu
- Adults with serious m
disorders.
- Children and youth w
bances at clinical hig
encing a first episode
- Adults and youth wh
tioning to the commu
- Adults at risk of insti
long-term care.
- Adult nursing facility
community.
- Children and youth e
Services (CCS) with a
- Children and youth
system (including i
involvement with chil
the foster care systen

The Housing & Homelessness Incentive Program (HHIP)

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What is HHIP?

The Housing & Homelessness Incentive Program (HHIP) allows Medi-Cal managed care plans (MCPs) to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. It is a voluntary program and MCPs that choose to participate must work at the county-level with local community stakeholders (including Continuums of Care or CoCs) to improve both health outcomes and access to health and housing services by addressing housing insecurity and instability.

While the majority of people experiencing homelessness are eligible or already enrolled in Medi-Cal managed care, MCPs have historically not been engaged in efforts to address homelessness. HHIP offers incentive funds to build relationships and partnerships between MCPs and homeless systems. Through CalAIM, some MCPs are funding certain homeless services for their members (e.g., housing navigation, deposits, tenancy supports, recuperative care), yet are often not connected to or fully educated about the larger homeless system of care. HHIP is an opportunity for MCPs to better understand the homeless system of care, just as it is an opportunity for homeless system partners to understand the role of MCPs and how Medi-Cal programs can support community efforts to address homelessness.

August 10, 2022

Goals of HHIP

Opportunities for Homeless Systems of Care under the Housing & Homelessness Incentive Program (HHIP)

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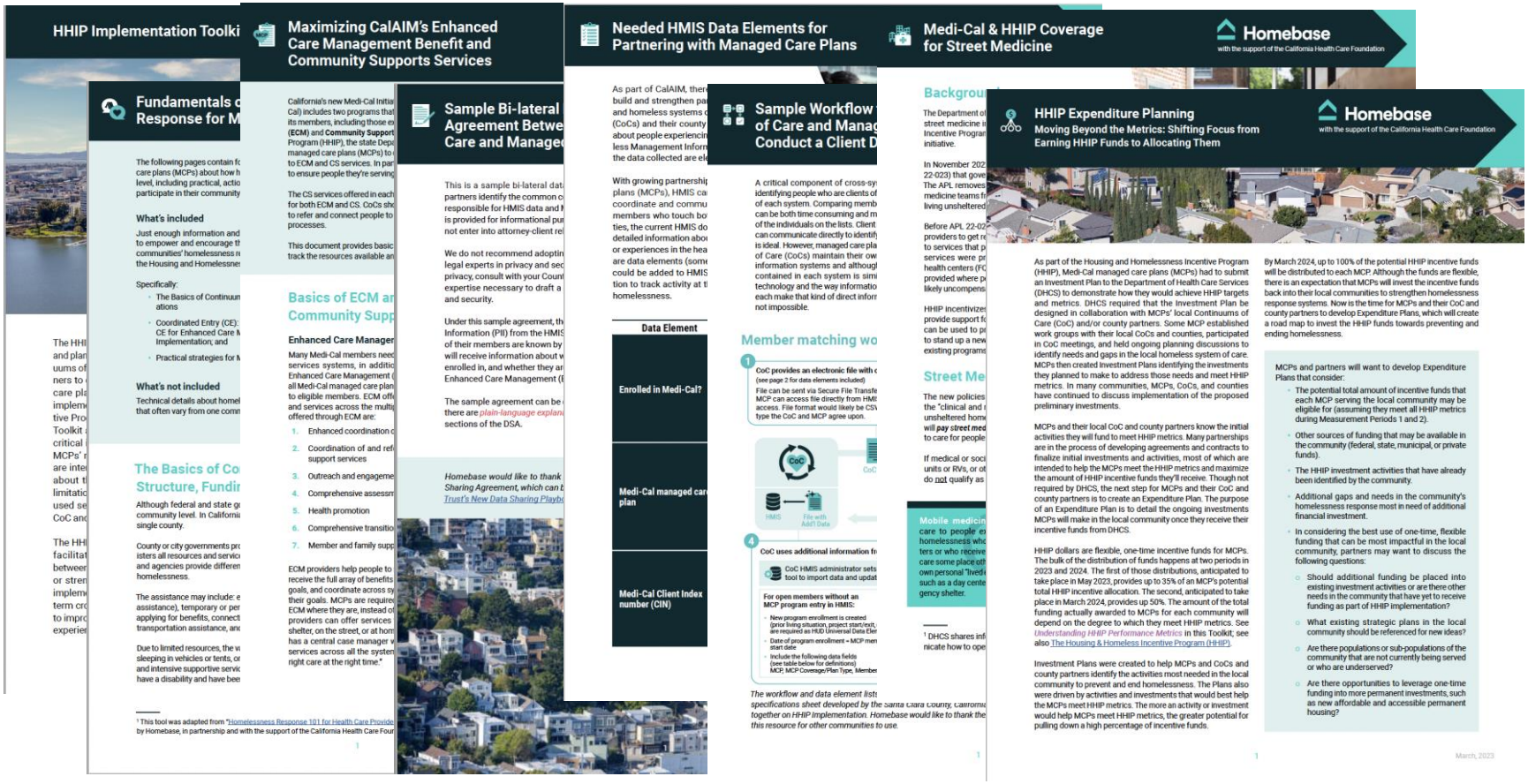
Under the new Housing & Homelessness Incentive Program (HHIP), the California Department of Health Care Services (DHCS) offers incentive funds to Medi-Cal managed care plans (MCPs) who choose to participate in the program and are able to meet certain metrics demonstrating that they have increased their capacity, engaged in partnerships with local homeless systems of care, and used their resources to reduce and prevent homelessness. While on its face, HHIP is a program to incentivize MCPs, it has the potential to result in significant additional investment (of funding and other resources) in local community efforts to prevent and end homelessness. Most, if not all, of the MCPs in California have chosen to participate in HHIP and are moving forward to partner with local homeless systems to undertake activities that will help them meet the state metrics. (For more information on HHIP and the state metrics, see our companion fact sheet: The Housing & Homelessness Incentive Program (HHIP).)

The purpose of this handout is to help counties, CoCs, and local homeless response system partners better understand what MCPs are likely to invest in and prioritize to meet as many HHIP metrics as possible over the coming months and years. The Investment Plans will highlight some of the key partnership and collaboration opportunities that will help MCPs access and fully leverage the HHIP incentive funds that are available. While each MCP was provided a specific allocation amount for each county, they will only receive 100% of that amount if they can meet all of the HHIP metrics. This handout helps answer the question: How can CoCs and their partners help MCPs meet their HHIP metrics to maximize the amount of HHIP incentive funds they receive, while also filling critical gaps in local homeless response efforts?

Many counties and local homeless systems of care (Continuums of Care or CoCs) were approached by their local MCPs in late Spring and early Summer 2022 to provide needed data and Homeless Housing, Assistance and Prevention (HHAP) Grant Round 3 application information to support their local MCPs' HHIP applications (also referred to as Local Homeless Plans). As of this writing, MCPs are waiting for the Department of Health Care Services' approval of their Local Homeless Plans. In the meantime, the Department asked MCPs to develop more detailed Investment Plans that indicate how they will leverage resources in their local communities to meet the HHIP metrics required to receive their incentive funds. MCPs are required to submit their Investment Plans to the Department by September 30, 2022. They will likely look to CoCs and local homeless system partners to help them develop and implement their Investment Plans. If the MCP efforts are done meaningfully, the future holds great opportunity to build or strengthen cross-system partnerships and fill many of the gaps communities have previously identified in their homeless response systems.

www.homebaseccc.org/healthcare

NEW: HHIP Implementation Toolkit



Overview: HHIP Implementation Toolkit

1. Fundamentals of Homelessness Response for MCPs
2. Understanding HHIP Performance Metrics
3. Maximizing CalAIM ECM and Community Supports
4. Sample Bi-lateral Data Sharing Agreement
5. Needed HMIS Data Elements for Cross-Sector Work
6. Sample Workflow for Data Matching
7. Medi-Cal and HHIP Coverage of Street Medicine
8. HHIP Expenditure Planning

Understanding HHIP Performance Metrics

Overview: HHIP Implementation Toolkit

Red = priority

1.1 Engagement with the local CoC, including, but not limited to:

1.2 Connection and integration with the local Coordinated Entry System (CES).

1.3 Identifying and addressing barriers to housing-related CS

1.4 Partnerships with counties, CoCs, and/or organizations with which the MCP has a data sharing agreement for member matching.

1.5 Data sharing agreement with county mental health plans

1.6 Partnerships and strategies to address disparities and equity in service delivery,

1.7 Lessons learned from development and implementation of the Investment Plan.

2.1 Connection with street medicine

2.2 MCP connection with HMIS

2.3 Tracking & managing referrals for CS

3.1 Percent of MCP members screened for homelessness/

3.2 The # of MCP members who were discharged who were screened for homelessness

3.3 The # of MCP members experiencing homelessness who were successfully engaged with ECM.

3.4 The # of members receiving at least 1 CS

3.5 The # of members who were successfully housed.

3.6 The # of members who remained successfully housed.

Metric 1.2: Connection and integration with the local Coordinated Entry System

Information Required	A narrative description of updates made to the CE process as a result of the MCPs involvement, including how health factors and risks have been incorporated into the CE assessment and prioritization process, and the MCP's progress toward becoming a CE access point.
To meet the performance measurement	**Pay for Reporting Metric**: MCPs are awarded for the narrative description on progress, rather than for meeting a specific performance measure.
How CoCs can assist	Work with their local MCPs to explain how CE works locally and discuss the possibility and desirability of them becoming access points to ensure their members experiencing homelessness are referred to access points. Together with the MCPs they should discuss health-related factors that can be incorporated into CE prioritization and assessment process to improve the overall equity and operation of CE.

Metric 1.4: Partnerships with counties/CoCs, and others with which the MCP has a data sharing agreement that allows for exchange of info and member matching

Information Required	The total # of providers the MCP has contracted with to deliver housing-related services and the # of those who are actively sharing MCP member housing status information. If the data sharing agreement is through an intermediary, the MCP must have access to the members' information related to their housing status.
To meet the performance measurement	**Pay for Performance Metric**: At least 75% of the providers the MCP has contracted with to deliver housing-related services must be actively sharing MCP member housing status information.
How CoCs can assist	Work to develop a data-sharing agreement that facilitates information exchange and member matching between HMIS and MCP client records. Identify the process required to engage in data exchange and provide sufficient time to engage in that process. Seek bi-lateral data exchange so information about clients is coming back to the CoC, which can facilitate housing stability.

Metric 2.1: Connection with street medicine team providing health care for individuals who are homeless

Information Required	The % of MCP members experiencing homelessness during the measurement period who received care from the MCP's street medicine partner (or the alternative services provided directly by the MCP in rural communities where no street medicine program exists).
To meet the performance measurement	**Pay for Performance Metri**c: MCPs must report a 10% increase as compared to Measurement Period 1 submission.
How CoCs can assist	Identify current street medicine programs, if any. Make connections with health care providers who have street medicine programs or would be open to participate with associated funding. Share best practices about how the CoC does street outreach, which can be applied to street medicine programs. Connect street outreach to street medicine programs, if any. Strategize with MCPs on what is needed to begin or expand street medicine so that additional people are able to access these services.

Metric 2.2: MCP connection with the local HMIS

Information Required	Whether the MCP has the ability to: 1) Receive timely alerts from their local HMIS when an MCP's member experiences a change in housing status; and 2) Match their member information with HMIS client information. MCPs must also describe their process to translate the timely alerts into supporting referrals for CS from CoCs and other housing providers.
To meet the performance measurement	The first two elements are **Pay for Performance**. The MCP must answer yes to both. The element of translating timely alerts into CS referrals is a **Pay for Reporting Metric**, which means MCPs are awarded for reporting on their process, rather than for meeting a specific performance measure.
How CoCs can assist	Work with their MCPs to provide direct access to HMIS that is more than read-only or enter into DSAs to facilitate both member matching and alerts of housing status changes for MCP members.

Metric 3.4: MCP Members experiencing homelessness receiving at least one housing-related Community Support

Information Required	The % of MCP members experiencing homelessness who received at least one of the MCP's offered housing-related CS services
To meet the performance measurement	**Pay for Performance Metric**: MCPs must report a 5% increase from their Measurement Period 1 submission or their LHP (whichever of the two reported a higher percentage).
How CoCs can assist	Educate providers about the specific CS services offered by their local MCPs. Collaborate with MCPs to provide information to homeless service providers that describe the process for making CS referrals and can encourage their housing service providers to apply to become CS providers.

Metric 3.5: MCP Members who were successfully housed

Information Required	The % of MCP members who experienced homelessness during the 10-month measurement period 2 (Jan.-Oct. 2023) who were successfully housed during that time.
To meet the performance measurement	**Pay for Performance Metric**: MCPs must report a 25% improvement from Submission 1 for full points; partial points awarded for signficant improvement that is less than 25%.
How CoCs can assist	Help ensure that as many MCP members experiencing homelessness as possible are connected to the community CE, as well as referred to/ connected to ECM, housing-related CS, and other resources and services that help people find and access stable housing. Share with the MCPs the lack of affordable housing in the area and discuss ways to leverage MCP funding to increase housing availability.

Metric 3.6: MCP Members who remain successfully housed

Information Required	The % of MCP members experiencing homelessness who were successfully housed during the first four months of 2022 who remained housed through Oct. 31, 2023; the % of members experiencing homelessness who were successfully housed from May 1-Dec.31, 2022 who remained housed through Oct. 31, 2023.
To meet the performance measurement	**Pay for Performance Metric**: MCPs must report at least 85% for full points; partial points will be awarded for significant achievement that is less than 85%.
How CoCs can assist	Provide insight to MCPs on the strategies and supports most likely to help recently homeless individuals and families sustain their housing. Provide MCPs information on prevention resources and discuss ways to leverage MCP funding to increase housing availability.

Questions?

Maximizing Enhanced Care Management (ECM) and Community Supports (CS)

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Enhanced Care Management (ECM)

- For Medi-Cal members with **complex care** needs
- Intensive care coordination and services across multiple systems to help address both clinical and non-clinical needs of Medi-Cal members
  - Required to meet members where they are in their communities, not just at the Dr.’s office (e.g., at shelters, on the street, or at home)
  - Care managers help Medi-Cal members set clear goals, ensure they receive the full array of benefits they are eligible for, and coordinate across systems
  - Anyone can refer Medi-Cal members for ECM, including self-referrals

Community Supports (CS)

- For Medi-Cal members with **complex health needs** and **unmet social needs**
- MCPs can provide as many of the 14 pre-identified services as possible:
  - Housing Transition Navigation Services
  - Housing Tenancy and Sustaining Services
  - Recuperative Care (Medical Respite)
  - Caregiver Respite Services
  - Community Transition Services/Nursing Facility Transition to a Home
  - Environmental Accessibility Adaptations (Home Modifications)
  - Sobering Centers
  - Housing Deposits
  - Short-Term Post-Hospitalization Housing
  - Day Habilitation Programs
  - Personal Care and Homemaker Services
  - Nursing Facility Transition/Diversion to Assisted Living Facilities
  - Medically Supportive Food/Meals/Medically Tailored Meals
  - Asthma Remediation

For more details about each Community Support, see DHCS Community Supports Policy Guide

CoCs and MCPs are critical partners

- CoCs can:
  - Identify eligible members;
  - Make referrals to ECM and CS services; and
  - Support people not yet enrolled in Medi-Cal to enroll and select their MCP.
  - Support CoC agencies to become contracted Community Support providers
- MCPs can:
  - Leverage Medi-Cal funding to pay for CS housing-related services (e.g., housing navigation, housing deposits); and
  - Preserve precious CoC funding for other needed services

Tips for Maximizing ECM and CS for People Experiencing Homelessness

- Know the forms your local MCPs use and the processes they require for referrals.
- If more than one MCP in the county, ask them to coordinate and agree to one central form for ECM and CS referrals.
- Use the template included in the HHIP Implementation toolkit to collect referral information and share with local providers.
- Understand which CS services the local MCPs offer (the HHIP Implementation toolkit includes a template CoCs can use to track which CS services are being offered by each of their local MCPs).

Topics to discuss with MCP partners

- **Streamlining referral forms;**
- **Required documentation;**
- **Process for referrals;**
- **Steps and time frames; and**
- **Referral follow-up protocols from MCP partners**
  - Update the CoC on referral status
  - Connect with CoC for missing documentation
  - Confirm enrollment and approval
  - Provide name and contact information of ECM or CS provider.

Topics to discuss with MCPs (cont.)

- **Ensure success by:**
  - Matching Medi-Cal members with providers who have experience working with people experiencing homelessness;
  - Minimizing the number of providers each person is connected to (especially if multiple CS services are involved);
  - Helping CoC providers to become contracted CS providers;
  - Identifying the most needed CS services among people experiencing homelessness; and
  - Training CoC providers to facilitate successful referrals.

Questions?

Expenditure Planning

Looking ahead…

- Long-term, ongoing investments and partnerships with MCPs
- Not all MCPs will continue to provide services in your county (DHCS limited the # of MCPs in many counties).
- Opportunity to leverage incentive funds toward needed:
  - HOUSING
  - Filling gaps where state and federal funding is limited or non-existent

Investment Plans → Expenditure Plans

- MCPs and partners will want to develop Expenditure Plans that consider:
  - The potential **total amount of incentive funds** each MCP s may be eligible for (assuming they meet all metrics).
  - Other sources of funding that may be available in the community (federal, state, municipal, or private funders).
  - The HHIP investment activities that have already been identified by the community.
  - Additional gaps and needs in the community's homelessness response most in need of additional financial investment.

Key Considerations

- CoCs may want to discuss the following with MCP partners:
  - Should additional funds be invested in existing activities or in other needs that have yet to receive HHIP funding?
  - What existing strategic plans in the local community should be referenced for new ideas?
  - Are there populations or sub-populations of the community that are not currently being served or who are underserved?
  - Are there opportunities to leverage one-time funding into more permanent investments, such as new affordable and accessible permanent housing? (E.g., Can MCPs invest in rehabilitation or renovation of a building that a homeless service provider could then operate as PSH moving forward?)

Preview: Expenditure Planning Tools

Initial stages planning tool:

Priority Area	Potential Programs or Strategies	Gap or Need Addressed	Additional Information Needed or Next Steps to Refine Ideas	Discussion Participants

Expenditure Plan template:

Program or Strategy	**Description of Activities** (2-3 sentences per activity)	**Funding to be Allocated** ($ amount or percentage of total HHIP award)	**Intended Funding Recipient(s)** [or whether an RFP or similar process should be used to identify recipient(s)]	**Goals, Performance Metrics, and Timeline**

Questions?

Data Sharing Components

Data Sharing Sample Agreement

Sample Bi-lateral Data Sharing Agreement Between a Continuum of Care and Managed Care Plan

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This is a sample bi-lateral data sharing agreement (DSA) that is meant to help cross-sector partners identify the common components of a DSA between Continuum of Care (CoC) agencies responsible for HMIS data and Medi-Cal managed care plans (MCPs). The content in this sample is provided for informational purposes only and does not constitute legal advice. Homebase does not enter into attorney-client relationships nor dispense legal advice.

We do not recommend adopting this sample wholesale. To enter into a DSA requires review by legal experts in privacy and security. If you do not have the resources to hire legal specialists in privacy, consult with your County Counsel. Note, however, that County Counsel may not have the expertise necessary to draft a cross-sector DSA without the advice of experts in data privacy and security.

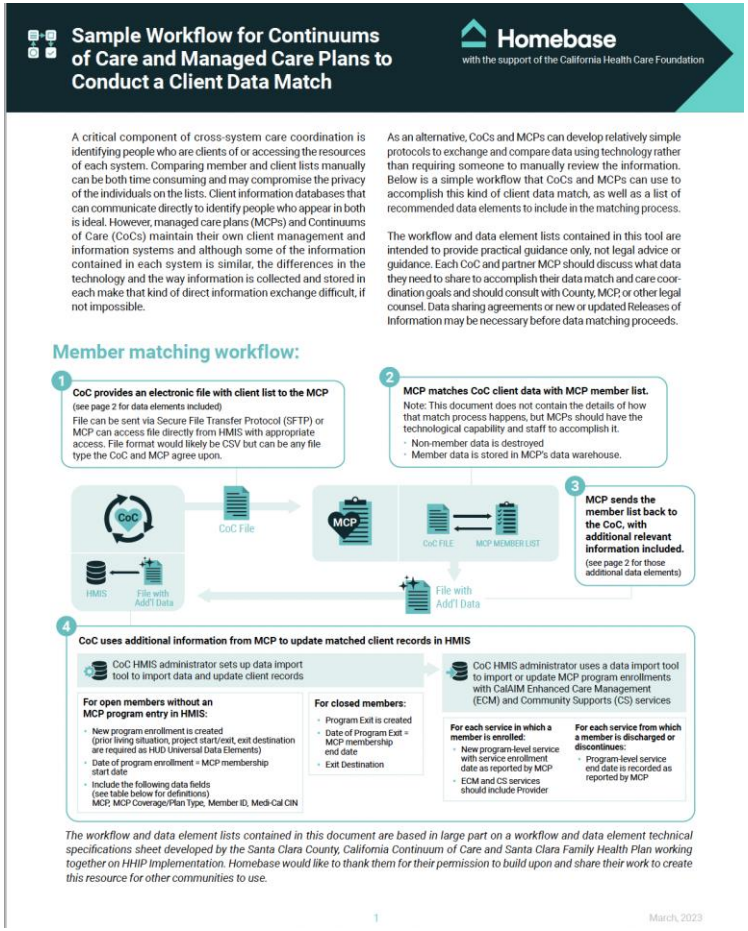
Under this sample agreement, the intention is to have Medi-Cal MCPs receive Personally Identifiable Information (PII) from the HMIS Lead. The data from HMIS will allow the MCPs to identify which of their members are known by the CoC to be experiencing homelessness. In exchange, the CoC will receive information about which individuals in HMIS are MCP members, what plans they are enrolled in, and whether they are receiving housing-related services through the MCP, especially Enhanced Care Management (ECM) or Community Supports (CS).

The sample agreement can be customized to a specific community. Throughout the document, there are *plain-language explanations and directions in italicized red text* to guide you through the sections of the DSA.

Homebase would like to thank Benefits Data Trust (BDT) for allowing us to use their shell Data Sharing Agreement, which can be found in "Bolstering Benefits Access: Introducing Benefits Data Trust's New Data Sharing Playbook," as a model for this sample CoC-MCP agreement.

- Thanks to partners at Benefits Data Trust
- Identifies key considerations for a bi-lateral data sharing agreement with MCPs.
- Not legal advice, but a template to work with legal advisors.

Sample Data Matching Workflow



Sample Workflow for Continuums of Care and Managed Care Plans to Conduct a Client Data Match

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A critical component of cross-system care coordination is identifying people who are clients of or accessing the resources of each system. Comparing member and client lists manually can be both time consuming and may compromise the privacy of the individuals on the lists. Client information databases that can communicate directly to identify people who appear in both is ideal. However, managed care plans (MCPs) and Continuums of Care (CoCs) maintain their own client management and information systems and although some of the information contained in each system is similar, the differences in the technology and the way information is collected and stored in each make that kind of direct information exchange difficult, if not impossible.

As an alternative, CoCs and MCPs can develop relatively simple protocols to exchange and compare data using technology rather than requiring someone to manually review the information. Below is a simple workflow that CoCs and MCPs can use to accomplish this kind of client data match, as well as a list of recommended data elements to include in the matching process.

The workflow and data element lists contained in this tool are intended to provide practical guidance only, not legal advice or guidance. Each CoC and partner MCP should discuss what data they need to share to accomplish their data match and care coordination goals and should consult with County, MCP, or other legal counsel. Data sharing agreements or new or updated Releases of Information may be necessary before data matching proceeds.

Member matching workflow:

1 **CoC provides an electronic file with client list to the MCP**
(see page 2 for data elements included)
File can be sent via Secure File Transfer Protocol (SFTP) or MCP can access file directly from HMIS with appropriate access. File format would likely be CSV but can be any file type the CoC and MCP agree upon.

2 **MCP matches CoC client data with MCP member list.**
Note: This document does not contain the details of how that match process happens, but MCPs should have the technological capability and staff to accomplish it.
- Non-member data is destroyed
- Member data is stored in MCP's data warehouse.

CoC
CoC File
MCP
CoC FILE
MCP MEMBER LIST
HMIS
File with Add'l Data
File with Add'l Data

3 **MCP sends the member list back to the CoC, with additional relevant information included.**
(see page 2 for those additional data elements)

4 **CoC uses additional information from MCP to update matched client records in HMIS**

CoC HMIS administrator sets up data import tool to import data and update client records

For open members without an MCP program entry in HMIS:
- New program enrollment is created (prior living situation, project start/exit, exit destination are required as HUD Universal Data Elements)
- Date of program enrollment = MCP membership start date
- Include the following data fields (see table below for definitions) MCP, MCP Coverage/Plan Type, Member ID, Medi-Cal CIN

For closed members:
- Program Exit is created
- Date of Program Exit = MCP membership end date
- Exit Destination

CoC HMIS administrator uses a data import tool to import or update MCP program enrollments with CalAIM Enhanced Care Management (ECM) and Community Supports (CS) services

For each service in which a member is enrolled:
- New program-level service with service enrollment date as reported by MCP
- ECM and CS services should include Provider

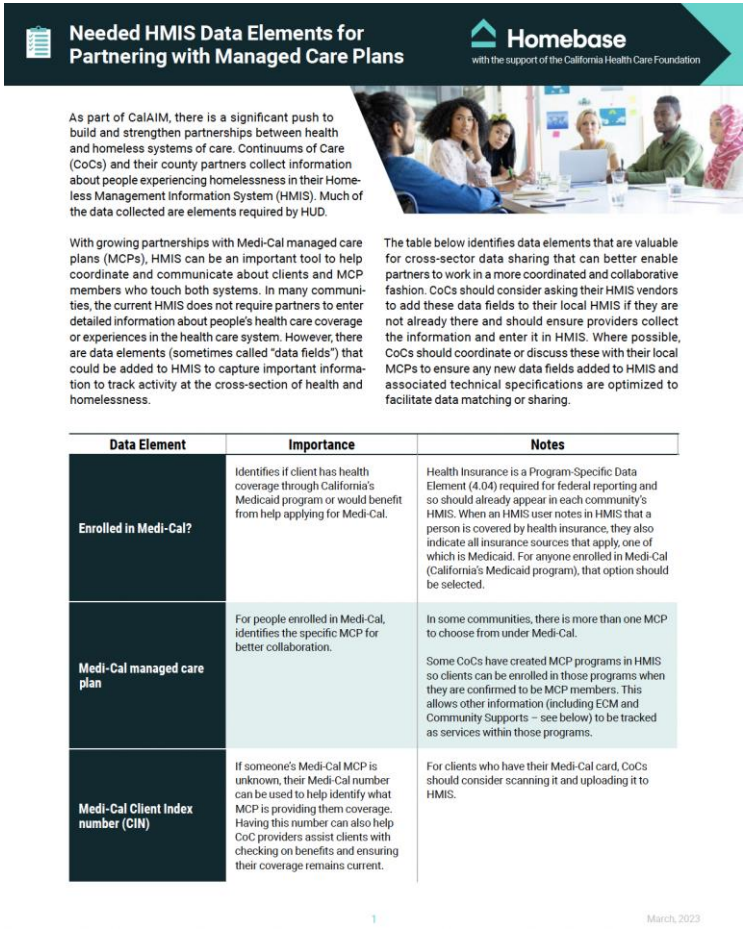
For each service from which a member is discharged or discontinues:
- Program-level service end date is recorded as reported by MCP

The workflow and data element lists contained in this document are based in large part on a workflow and data element technical specifications sheet developed by the Santa Clara County, California Continuum of Care and Santa Clara Family Health Plan working together on HHIP Implementation. Homebase would like to thank them for their permission to build upon and share their work to create this resource for other communities to use.

1 March, 2023

- Text and visualization
- Sample to implement data matching

Needed Data Elements



Needed HMIS Data Elements for Partnering with Managed Care Plans

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As part of CalAIM, there is a significant push to build and strengthen partnerships between health and homeless systems of care. Continuums of Care (CoCs) and their county partners collect information about people experiencing homelessness in their Homeless Management Information System (HMIS). Much of the data collected are elements required by HUD.

With growing partnerships with Medi-Cal managed care plans (MCPs), HMIS can be an important tool to help coordinate and communicate about clients and MCP members who touch both systems. In many communities, the current HMIS does not require partners to enter detailed information about people's health care coverage or experiences in the health care system. However, there are data elements (sometimes called "data fields") that could be added to HMIS to capture important information to track activity at the cross-section of health and homelessness.

The table below identifies data elements that are valuable for cross-sector data sharing that can better enable partners to work in a more coordinated and collaborative fashion. CoCs should consider asking their HMIS vendors to add these data fields to their local HMIS if they are not already there and should ensure providers collect the information and enter it in HMIS. Where possible, CoCs should coordinate or discuss these with their local MCPs to ensure any new data fields added to HMIS and associated technical specifications are optimized to facilitate data matching or sharing.

Data Element	Importance	Notes
Enrolled in Medi-Cal?	Identifies if client has health coverage through California's Medicaid program or would benefit from help applying for Medi-Cal.	Health Insurance is a Program-Specific Data Element (4.04) required for federal reporting and so should already appear in each community's HMIS. When an HMIS user notes in HMIS that a person is covered by health insurance, they also indicate all insurance sources that apply, one of which is Medicaid. For anyone enrolled in Medi-Cal (California's Medicaid program), that option should be selected.
Medi-Cal managed care plan	For people enrolled in Medi-Cal, identifies the specific MCP for better collaboration.	In some communities, there is more than one MCP to choose from under Medi-Cal. Some CoCs have created MCP programs in HMIS so clients can be enrolled in those programs when they are confirmed to be MCP members. This allows other information (including ECM and Community Supports – see below) to be tracked as services within those programs.
Medi-Cal Client Index number (CIN)	If someone's Medi-Cal MCP is unknown, their Medi-Cal number can be used to help identify what MCP is providing them coverage. Having this number can also help CoC providers assist clients with checking on benefits and ensuring their coverage remains current.	For clients who have their Medi-Cal card, CoCs should consider scanning it and uploading it to HMIS.

1 March, 2023

- In anticipation of data sharing
- List of potential new data fields/data elements for HMIS to track newly shared health care data.

Questions?

Join us for Virtual Office Hours!

* Thursday, April 20th, 11:00 am – 12:00 pm

* Wednesday, April 26th, 11:00 am – 12:00 pm

Register to get the Zoom link!

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Additional Resources

- Homebase website: Resources for Building Health Care-Homeless Response System Partnerships, which will include Toolkit and already hosts a packet of Materials on Understanding and Leveraging CalAIM:
  - CalAIM Basics
  - CalAIM's Housing-Related Services
  - The Housing & Homelessness Incentive Program (HHIP)
  - Opportunities for Homeless Systems of Care under HHIP
- Homebase webinars on Health Care-Homeless Response System Collaboration (this webinar recording and slides will be available here)
- DHCS Housing and Homelessness Incentive Program site: resources, informational webinar, submission materials (templates and metrics)
- Medi-Cal Managed Care Health Plan Directory