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Innovative Care Coordination Programs for California's Medi-Cal Beneficiaries: The Health Homes Program and the Whole Person Care Pilots

By Lilly Clements, MPH, Tanya Schwartz, MPP, MSW, and Hilary Haycock, MPP

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The State of California is operating two innovative programs that provide care management and care coordination services to Medi-Cal beneficiaries with high health care needs to improve their overall health and well-being – the **Health Homes Program (HHP)** and the **Whole Person Care Pilot Program (WPC)**.[1] Administered by the Department of Health Care Services (DHCS), these two programs represent similar, but structurally different, efforts to improve the coordination of care for Medi-Cal beneficiaries across the health care system and address their social determinants of health.

The HHP offers extra services to help manage and coordinate care and social services for the highest risk Medi-Cal managed care plan (MCP) enrollees. MCPs operate the program and contract with community providers to deliver HHP services. The HHP launched in July 2018 in San Francisco, January 2019 in Riverside and San Bernardino counties, and will be rolled out in 10 other participating counties in July 2019 – for a total of 13 counties. See Appendix A for a list of participating HHP counties.

The WPC pilot program tests county-based initiatives that coordinate health and social services for Medi-Cal beneficiaries who are high users of multiple health care systems and have poor health outcomes. The WPC pilots involve the collaboration of a series of local providers and partners. The WPC pilot is currently in its fourth year of the five-year Medi-Cal 2020 Section 1115 waiver program, with 25 pilots operating in 25 counties and one city.[2] See Appendix B for a list of WPC pilots.

The success of these two programs hinges on health plans, county health departments, health care providers, community-based organizations (CBOs), and other stakeholders understanding who qualifies for each program and the services that are available. Additionally, it is critical to coordinate between MCPs and WPC pilots, avoid duplication of services, and ensure that beneficiaries are enrolled in the program that best fits their needs. This paper summarizes the key objectives and features of HHP and WPC, highlights their similarities and differences, explains the requirements for Medi-Cal beneficiaries who qualify for both programs, and suggests some ways that MCPs and WPC pilots can coordinate to avoid duplication of services. Appendix C provides a high-level comparison of the two programs.

Health Homes Program Summary

The Affordable Care Act created the option for states to establish an HHP and California Assembly Bill (AB) 361 authorized DHCS to submit a Medicaid (Medi-Cal) State Plan Amendment to the federal government to establish the program. The objective of the HHP is to manage and coordinate care for the highest risk Medi-Cal managed care members.

The HHP is operated by MCPs, which choose whether to participate in the program. MCPs work with community health care providers – referred to as Community-Based Care Management Entities (CB-CMEs) – to engage beneficiaries and to provide care management and care coordination services. MCPs and CB-CMEs also connect members to community and social service resources, including housing.

CB-CME Examples
• Primary care providers • Federally Qualified Health Centers • Community health centers • County health departments

Eligibility

The HHP targets the highest risk Medi-Cal members. To qualify for the HHP, members must meet the following eligibility criteria:[3]

1. Be enrolled in a Medi-Cal managed care plan (MCP);
2. Have certain chronic health and/or mental health conditions; and
3. Have been in the hospital, had visits to the emergency room, or be experiencing chronic homelessness.[4]

Within these criteria, each MCP can choose to prioritize its outreach to populations with the most needs.

Medi-Cal operates multiple care coordination programs, some of which provide the same services that are available through the HHP. Therefore, there are requirements around whether members can receive both HHP services and services through other programs. See bit.ly/HealthHomes for detailed information.

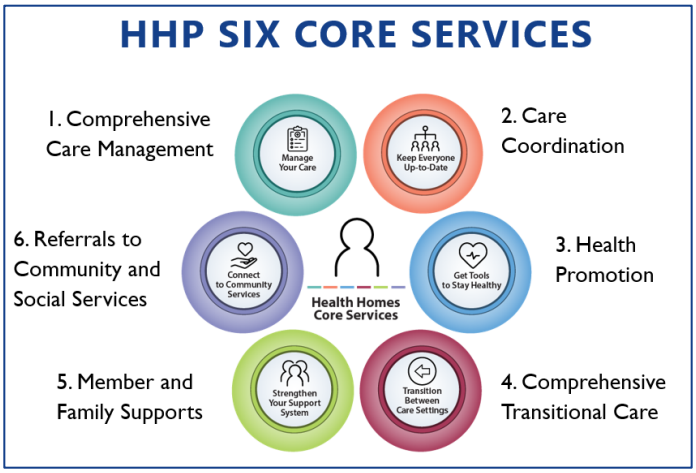
Services

In the HHP, each member is given their own care team – including a care coordinator – that works with all of their health and social service providers (including housing supports, if needed) to ensure the member gets the services they need. The HHP has specific requirements for health professionals that must be part of every HHP care team – a care coordinator, an HHP Director, and a Clinical Consultant. The HHP care team may also include additional people based on the member's needs and wishes – such as their primary care provider, specialists, pharmacists, nutritionists, community health workers, a housing navigator, CBO representatives, and family/friends. Even if these optional team members are not part of the

member's HHP care team, the team is still expected to coordinate with other professionals who serve the member.

The care team is required to develop a plan in consultation with the member to set goals; identify health and social service needs; and track referrals, progress, and outcomes. Services are provided in six core areas:

1. *Develop a Plan* (called a "Health Action Plan") to help manage and guide the member's care to meet their health goals;
2. *Connect and Update* the member's doctors and other providers about their health needs and wishes;
3. *Provide Information and Support* to help members manage their health and mental health issues;
4. *Move Members Safely Across Care Settings*, such as in and out of a hospital or nursing home and to where they live;
5. *Strengthen Members' Support Systems* to make sure they and others supporting them understand their health care needs; and
6. *Connect Members to Community and Social Services* such as food, housing, job training, child care, and disability-related services among others.



Funding and Payment

The Medicaid program is jointly funded by the federal government and states. The Federal Medical Assistance Percentage (FMAP) is used to determine the share of the cost of covered services that the federal government pays in each state. In California, the federal government typically pays 50% of the cost of services and the state pays the other 50%. Medi-Cal beneficiaries who became newly eligible under the 2014 Medicaid expansion for low-income adults currently qualify for a federal matching rate of 93 percent; in 2020 the federal match reduces to 90 percent indefinitely.

The HHP is an optional Medicaid State Plan benefit established by the Affordable Care Act. California added the HHP for qualified Medi-Cal beneficiaries enrolled in a Medi-Cal managed care plan. Federal funding is available for the HHP for as long as California maintains the HHP benefit in its Medicaid State Plan.

To support states in launching the HHP, federal funding is provided at an enhanced rate for the first two years of each phase of implementation. This means that 90 percent of the HHP is funded by federal Medicaid dollars for eight quarters, starting on the implementation date for

each of the two HHP phases. These phases are based on two state plan amendments (SPAs) – one for members with chronic conditions and substance use disorders and the other for members with serious mental illness. See Table 1 below for information on when the 90 percent federal funding is available for managed care plans by group. During this time period, the 10 percent non-federal share will be provided by The California Endowment.

After eight quarters, the federal portion will be the regular California Medicaid funding match for Medi-Cal beneficiaries (50% for most members and 90% for the Medicaid expansion adult group members) for as long as California chooses to maintain this HHP State Plan benefit. State General Funds will be used to pay for the non-federal share of the cost for providing HHP services.

California's legislation AB 361, which authorizes the implementation of the HHP, specifies that there should be no net cost to the state General Fund in operating the HHP.[5] California is permitted to finance the non-federal share to the extent that the HHP generates cost avoidance from reduced avoidable utilization, such as hospital visits. It is the state's expectation that the HHP will achieve state General Fund cost neutrality through cost avoidance, generated by improved health outcomes and reduced utilization, that is at least equal to the state General Fund cost of providing HHP services.

Table 1. Federal Enhanced HHP Funding Schedule

Group	Phase 1: Enhanced Federal Funding - Members with Chronic Conditions & Substance Use Disorders	Phase 2: Enhanced Federal Funding - Members with Serious Mental Illness
Group 1	July 1, 2018 – June 30, 2020	Jan. 1, 2019 – Dec. 31, 2020
Group 2	Jan. 1, 2019 – Dec. 31, 2020	July 1, 2019 – June 30, 2021
Group 3	July 1, 2019 – June 30, 2021	Jan. 1, 2020 – Dec. 31, 2021

DHCS distributes the HHP funding to MCPs based on a per-member per-month (PMPM) capitation rate. The MCP payments to CB-CMEs and other providers are based on negotiated contracts for HHP services with each provider.

Whole Person Care Pilot Program Summary

The WPC pilots were established as part of the five-year Medi-Cal 2020 Section 1115 waiver.[6] WPC is a federally/locally funded pilot program to test county-based initiatives that coordinate health, behavioral health, and social services for Medi-Cal beneficiaries who are high users of multiple health care systems and have poor health outcomes. Each WPC pilot designs their own program within federal and state requirements, but they all seek to improve coordination and communication across the health and social service systems, including by developing the

technology and information-sharing infrastructure to provide client-centered care. The WPC pilots also provide other services that are not available through Medi-Cal.

DHCS approved 25 WPC pilots across the state – led by 25 counties (two counties – Mariposa and San Benito are partnering) and the City of Sacramento. The WPC pilots involve the collaboration of a series of partners – including county and city health departments, health plans, hospitals, providers, and social service organizations. This collaboration takes various forms depending on the pilot, including joint participation in multidisciplinary care teams, sharing data for commonly-served beneficiaries, increasing access to services and providing warm-hand-off referrals to health, behavioral health, and social services.

Target Population(s)

Each WPC pilot identified target Medi-Cal population(s) based on their county's or city's needs and developed eligibility criteria for each population. WPC pilots chose to target Medi-Cal beneficiaries who are considered high-risk and are high utilizers of emergency departments and hospital services, beneficiaries who are experiencing or are at-risk for homelessness, and individuals recently released from institutions (e.g. hospitals, jails, and Institutions for Mental Diseases).

Services

Each WPC pilot determines the services that are appropriate for their target population(s). All of the WPC pilots are using innovative approaches to coordinate primary and behavioral health care and social services, and many of them are focused on homelessness and housing support systems. Some pilots also provide services that are not otherwise covered by Medi-Cal, including: medical respite, recuperative care, sobering center services, and mobile/street-based services.

WPC pilots were also permitted to use some funding to develop program infrastructure, collaborate with community partners, and improve data sharing between entities. These efforts have facilitated improved care coordination and information sharing among the local governing entities, health plans, and community partners.

Funding and Payment

The WPC is now in its fourth year of the five-year program. There is up to $1.5 billion in federal funds available over the five years, matched by $1.5 billion in local funds from the WPC pilots. As part of applying to participate in the WPC pilot program, entities requested an annual dollar amount that specified payments for each element of their pilot. Pilots transfer local matching funds to DHCS, which transfers them to the federal government where they are matched through Medicaid – and then the combined gross amount is paid back to the WPC pilot through an intergovernmental transfer.

WPC pilots receive a mix of fee-for-service (FFS), PMPM capitation, and incentives based on enrollment, services provided, and the milestones achieved. Each WPC pilot developed their own payment structure to match the services and goals of their individual pilot. For example, pilots may receive PMPM payments for providing "bundles" of care coordination or supportive housing services, FFS payments for individuals receiving care at respite centers, funding to build data sharing infrastructure, and incentive payments for achieving pilot-specific outcomes or milestones.

Similarities Between WPC and HHP

Both WPC and HHP focus on coordinating physical and mental health care and social services for vulnerable Medi-Cal beneficiaries. The programs share the following elements:

- **General Target Population:** Both programs are for Medi-Cal beneficiaries who have complex health issues and are high utilizers of the health care system. However, HHP has standard eligibility criteria to target beneficiaries with the highest health care needs and each WPC pilot designed their eligibility criteria to meet a specific set of local needs.

- **Voluntary Enrollment:** In both programs, Medi-Cal beneficiaries must consent to participate. Participation in these programs is not required.

- **Single Point of Contact:** In both programs, beneficiaries have a single point of contact that coordinates their health and social services and facilitates communication with their care team – referred to across the programs as a "community health worker," "navigator," or "care coordinator."

- **Care Coordination:** Both programs provide care coordination to support members. As noted in the HHP summary above, care coordination is a core HHP service. Additionally, each member must be given their own care team composed of certain health professionals – additional providers may also be included depending on the member's needs. Members can also choose to include people from their personal support system. The care team is required to develop a "Health Action Plan" with each member to guide their care.

  WPC pilots, on the other hand, have flexibility for how care coordination services are provided. Although care teams are not required, most WPC pilots have a care manager and/or case manager that provides these services. Many WPC pilots focus on building multidisciplinary care teams across county health and social services and others regularly hold "case conference" meetings with key partners.

- **Addresses Housing Instability and Homelessness:** Both programs address housing instability and homelessness, which are significant social determinants of health for vulnerable populations. The HHP and most WPC pilots help beneficiaries prepare for, and transition into, housing and provide services to help them sustain housing, such as education about tenant rights, paying bills, and developing positive relationships with landlords. See the HHP/WPC Services Crosswalk for more information on housing services.[7] However, neither program is permitted to use the funding to provide rental subsidies or housing development.

- **Payment for Community-Based Organizations:** The MCPs participating in HHP may contract directly with CBOs to provide HHP services. CBOs can serve as CB-CMEs, delivering the full range of HHP services, or they may provide a targeted set of HHP services. For example, some CBOs specialize in providing supportive housing services. The MCP or the CB-CME may contract with a housing CBO. At the MCP's discretion, a portion of the HHP per-member per-month capitation rate could be divided between these partners.

  WPC pilots may also contract with CBOs to provide services, including outreach, care coordination, supportive housing services, respite services, or sobering center care. Some WPC pilots use incentive payments to reimburse CBOs for participating in data sharing or care management platforms.

- **Quality Measurement:** Both programs are required to track and report metrics on program participation and outcomes to DHCS and CMS. In HHP, all health plans report on a standard set of measures related to enrollment, services provided, and clinical outcomes (from the CMS HHP core set measures).

  In WPC, there are some metrics that are reported by all WPC pilots and other measures that are pilot-specific. The UCLA Health Center for Health Policy will use the data to conduct separate evaluations for both the WPC pilot and the HHP.

Differences between HHP and WPC

The overall structure, target populations, covered services, payment, funding, and timeline for WPC and HHP differ in the following key ways:

- **Program Structure:** The structures of the WPC pilots and the HHP are very different. For HHP, MCPs serve as the lead entities. CB-CMEs provide most HHP services through contracts with MCPs, but in many cases where CB-CME provider gaps exist, MCPs fill the

role of CB-CMEs to provide HHP services. MCPs and CB-CMEs are also required to coordinate with county substance use disorder and specialty mental health providers as appropriate. The HHP expects the participation of CBOs, but they are not required to be formally involved.

For WPC, county or city health, behavioral health, human services, or hospital systems lead program implementation. WPC pilots are required to partner with health plans, hospitals, providers, and CBOs – these partnerships had to be outlined in their applications to DHCS. Though partnerships are required, not all partners are directly engaged in delivering WPC services. Pilots were able to seek WPC funding to support data sharing infrastructure across partners to facilitate care coordination services delivered by the pilot lead entity.

- **Target Populations:** For HHP, DHCS set the following program-wide eligibility criteria: Members must be enrolled in an MCP, have specified medical conditions, and a certain level of condition acuity based on hospital and emergency room utilization (or experience chronic homelessness).[8] However, MCPs can choose to prioritize their outreach to the populations most in need, as long as they meet this criteria.

  WPC pilots, on the other hand, customized their target populations based on their county's or city's needs. While most WPC pilots target high utilizers of services, using varying definitions based on acuity, utilization, or specific medical conditions, some pilots further refined their efforts to target individuals at risk of, or experiencing, homelessness or justice-involved individuals upon release. Further, WPC pilots may offer services more broadly available to Medi-Cal beneficiaries, such as sobering centers and respite care.

- **Covered Services:** HHP provides a standard set of enhanced care coordination services to all members enrolled in the program. All members in HHP receive a Health Action Plan, which is developed by the member and their care team. The Health Action Plan defines the members' health goals and the menu of covered services that are most appropriate for them. Members are eligible to receive all HHP services determined necessary through the Health Action Plan.

  Since WPC is authorized under Medi-Cal 2020, WPC pilots may provide services that are not traditionally covered under Medi-Cal, enabling them to utilize innovative strategies to address complex issues and meet individual service needs. The services offered under WPC are specific to each pilot, but may include care coordination, supportive housing services, respite care, sobering centers, reentry support, and others.

WPC funds are being used to invest in data infrastructure building and data sharing to break down silos between physical health, behavioral health, and social service systems, including corrections departments. All WPC pilots provide care coordination services that may be similar to the coordination services provided by HHP. But WPC pilots provide additional services beyond care coordination, and certain types or methods of WPC coordination may be different than in the HHP.

- **Housing Services:** There is overlap in the housing services that HHP and WPC pilots may provide, as summarized in the HHP-WPC Services Crosswalk. These include housing navigation and tenancy sustaining case management services. However, WPC Pilots can choose to provide additional housing services that are not covered under HHP, such as covering some initial move-in costs, first/last months' rent, and utilities. Additionally, WPC encourages local governments to use non-Medi-Cal funds to establish flexible housing pools to improve access to subsidized housing.

- **Payment:** The MCPs participating in HHP receive a per-member-per-month capitated rate for each plan member enrolled in the program. This payment rate, which was developed by actuaries, covers all of the services provided to members. The payment rate is higher at the beginning of the program to account for outreach and engagement to members. The overall payment rate is lower for dual eligibles because the HHP is designed to primarily coordinate members' Medi-Cal doctors and services, and Medicare funds some care coordination services.

  As noted in the WPC summary above, WPC pilots receive a mix of FFS, PMPM capitation payments, and incentives based on enrollment, services provided, and the milestones achieved.

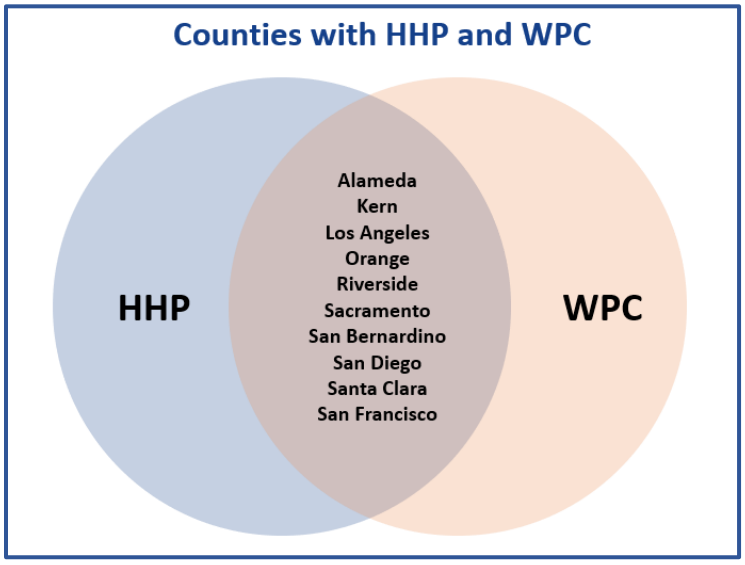
- **Program Funding:** For the HHP, the federal government provides a 90 percent match for services provided to each enrollee for the first eight quarters of the program. After this period, the federal share is reduced to the standard federal matching rate for the population served. Since the HHP is a Medi-Cal benefit, federal funding will continue as long as the HHP State Plan benefit remains in place.

  For WPC, up to $1.5 billion in federal funding is available for the five-year program. County WPC pilots provide up to $1.5 billion in order to receive the federal matching funds.

- **Timeline:** HHP is authorized under a state plan amendment, making it an ongoing benefit in the Medi-Cal program. The WPC is authorized under the five-year Medi-Cal 2020 waiver, which is set to expire in December 2020.

Intersection of WPC and HHP Services and Beneficiaries

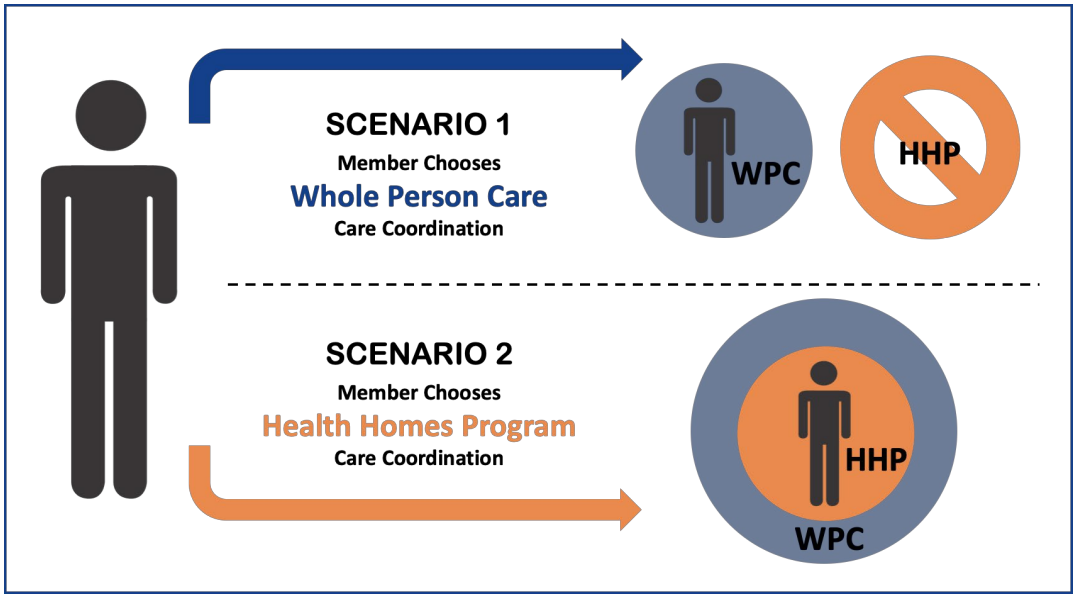
Eleven counties will be operating both HHP and WPC pilots once HHP is fully implemented (see visual). Since HHP and WPC services may overlap and the programs may have similar general target populations, some Medi-Cal beneficiaries may qualify for both programs. DHCS established guidance for how to handle these situations to ensure that beneficiaries do not receive duplicative services and to clarify how payments will work (see the DHCS HHP Program Guide – Appendix K at bit.ly/HealthHomes).



Beneficiaries

Members can only receive care coordination services from one program – either HHP or WPC. If a member qualifies for both programs, they may choose which program's care coordination services they want to receive.

- If members choose to receive care coordination services from WPC, they cannot receive HHP services.
- Members who choose to receive care coordination services from HHP can still be enrolled in WPC to receive other services (such as sobering center services).



Services

In many cases, WPC care coordination services are duplicative of HHP. When a member is in both programs and has chosen to receive care coordination services through HHP, the WPC pilot is responsible for ensuring it does not provide care coordination services. WPC pilots may not claim reimbursement for any duplicative care coordination services provided to a member if they are also enrolled in HHP in that month.

Harbage Consulting worked with DHCS to create an HHP-WPC Crosswalk Tool that provides a template for WPC pilot lead entities to use to compare the services that will be provided to Medi-Cal beneficiaries under the HHP and the services that can be provided by the WPC pilot. DHCS has recommended that WPC pilots review all of the services they provide to determine if they are duplicative of HHP services and discuss them with DHCS if needed. This requires HHP MCPs and WPC pilots to coordinate and share information on program enrollees.

HHP and WPC: Looking Ahead

As the HHP starts to roll out in participating counties across the state, the WPC program is entering its final two years, and WPC pilots are starting to think about how to ensure sustainability of their services. It is important to leverage the lessons learned and best practices gleaned from WPC and apply them to HHP implementation.

Given the overlap between WPC and HHP in the services provided and the beneficiaries served, some counties are looking to HHP as a potential sustainability vehicle once the WPC waiver period ends. Regardless of the future, both programs represent important efforts to improve care coordination and provide person-centered care in the Medi-Cal program and offer important lessons for policy makers and Medi-Cal stakeholders.

Appendix A. Health Homes Program County Implementation Schedule

Group	Counties	Phase 1 Implementation date for members with eligible chronic physical conditions and substance use disorders	Phase 2 Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Imperial • Kern • Los Angeles • Orange • Sacramento • San Diego • Santa Clara • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

Appendix B. Whole Person Care Pilots[9]

Lead Entity
Alameda County Health Services Agency
City of Sacramento
Contra Costa Health Services
County of Marin, Department of Health & Human Services
County of Orange, Health Care Agency
County of San Diego, Health & Human Services Agency
County of Santa Cruz, Health Services Agency
County of Sonoma, Department of Health Services Behavioral Health Division
Kern Medical Center
Kings County Human Services Agency
Los Angeles County Department of Health Services
Mendocino County Health & Human Services Agency
Monterey County Health Department
Napa County
Placer County Health & Human Services Department
Riverside University Health System – Behavioral Health
San Bernardino County – Arrowhead Regional Medical Center
San Francisco Department of Public Health
San Joaquin County Health Care Services Agency
San Mateo County Health System
Santa Clara Valley Health & Hospital System
Small County Whole Person Care Collaborative
Shasta County Health & Human Services Agency
Solana County Health & Social Services
Ventura County Health Care Agency

Appendix C. Comparison of the Health Homes Program and the Whole Person Care Pilots

Key Program Elements	Health Homes Program	Whole Person Care Pilot
Program Objective	Ongoing Medi-Cal benefit to develop a network of providers to coordinate health, behavioral health, and social services for the highest risk Medi-Cal beneficiaries	Five-year pilot program to test county-based initiatives that coordinate health, behavioral health, & social services for Medi-Cal beneficiaries who are high health care system utilizers
Administrative Lead	Medi-Cal Managed Care Plans in 13 counties	25 counties and 1 city*
Partners	• Community-Based Care Management Entities (CB-CMEs) • Contracted and non-contracted community-based organizations	• Hospitals, health plans, providers, county agencies, community-based organizations
General Target Population	• Medi-Cal Managed Care Plan enrollees at the highest health care risk and utilization	• Medi-Cal beneficiaries who are high-risk and high-utilizers of hospitals/ emergency systems & have poor health outcomes • Varies by pilot based on community needs
Eligibility Criteria	• Enrolled in a Medi-Cal Managed Care Plan • Have chronic physical conditions and/or mental health conditions • Visited the hospital or emergency department, or experience chronic homelessness	• Enrolled in Medi-Cal or Medi-Cal-eligible • Varies by pilot
Covered Services	• Standardized comprehensive care planning and management, care coordination, care transition support, health promotion, health education, and connections to social service providers.	• Flexibility to develop innovative strategies for each target population • Infrastructure and data sharing • Varies by pilot
Payment	• Per-member per-month capitation rate	• Mix of fee-for-service, per-member per-month capitation rate, and incentives
Program Funding	• 90% federal funding for the first 2 years for each phase; 50% after that (90% for Medicaid expansion group members in 2020 and beyond)	• Up to $1.5 billion in federal funds matched by $1.5 billion in local funds from pilots
Timeline	July 1, 2018 – Ongoing; phased in by county	5 years January 1, 2016 – December 31, 2020
Authority	State Plan Medi-Cal Benefit	Medi-Cal 2020 Section 1115 Waiver

*Note: Health/hospital authorities and consortiums of entities are also eligible to serve as the pilot administrative lead.

[1] More HHP information is available at: bit.ly/HealthHomes. More WPC information is available at: https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.
[2] One WPC pilot is a partnership between Mariposa and San Benito counties.
[3] To qualify for the HHP, members must meet all 3 of the following requirements:

1. Be enrolled in a Medi-Cal managed care health plan
2. **The member has 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 one of the following: COPD, diabetes, coronary artery disease, or chronic or congestive heart failure
    - 1 of the following: major depression disorder, dementia, bipolar disorder, or psychotic disorder (including schizophrenia)
    - Asthma
3. **The member meets at least one acuity/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

[4] 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) available at: https://california.public.law/codes/ca_welf_and_inst_code_section_14127.
[5] California AB 361. Available at: https://california.public.law/codes/ca_welf_and_inst_code_section_14127.
[6] Medi-Cal 2020 information is available at: https://www.dhcs.ca.gov/provgovpart/pages/medi-cal-2020-waiver.aspx.
[7] HHP-WPC Services Crosswalk Template. Available at: https://www.dhcs.ca.gov/services/Documents/MCQMD/HHP_WPC_Services_Crosswalk.pdf.
[8] See first footnote above for eligibility criteria.
[9] DHCS Whole Person Care Pilot website. Available at: https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.