# Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

*Transmittal Number: CA-16-007 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2017 Approval Date: Attachment 3.1-H Page Number:*

## Submission Summary

**Transmittal Number:**
***Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.***

CA-16-007

**Supersedes Transmittal Number:**
***Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.***

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

**Name of Health Homes Program:**

CA Health Home Program (HHP)

**State Information**

| | |
|---|---|
| **State/Territory name:** | **California** |
| **Medicaid agency:** | Department of Health Care Services (DHCS) |

**Authorized Submitter and Key Contacts**

**The authorized submitter contact for this submission package.**

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**Proposed Effective Date**

01/01/2017 (mm/dd/yyyy)

**Executive Summary**

Summary description including goals and objectives:
California's first SPA in a series of HHP SPAs is for 11 counties and the population criterion of chronic conditions. More counties and additional population criteria of Serious Mental Illness or Serious Emotional Disturbance will be included in subsequent SPAs. The HHP will utilize the Medi-Cal Managed Care infrastructure. HHP services and care team providers will be added to the Medi-Cal managed care delivery system. HHP will be person-centered, primary care-based and case-managed by a multidisciplinary team.

Managed care plans (MCPs) will be responsible for the overall administration of the HHP. The HHP will be structured as a HHP network with members functioning as a team to provide care coordination. This network includes MCP, one or more Community Based Care Management Entities (CB-CMEs), and linkages to community and social support services. MCPs also have existing relationships with the Medi-Cal specialty mental health plans in each county to facilitate care coordination.

The multi-disciplinary care team of care manager, director, clinical consultant, community health worker, and housing navigator are employed by the CB-CME. When there are insufficient entities in the community to provide the full range of CB-CME duties, the MCP can perform needed CB-CME duties.

The goals for HHP are: improve care coordination; integrate palliative care into primary care delivery; strengthen community linkages; strengthen team-based care, including use of community health workers; improve the health outcomes of HHP members; and wrap increased care coordination around existing care as close to the member's

usual point of care delivery as possible in the community. DHCS Objectives include: ensure sufficient provider infrastructure and capacity to implement HHP as an entitlement benefit; ensure HHP providers appropriately serve members experiencing homelessness; and increase integration of physical and behavioral health services.

**Federal Budget Impact**

| | Federal Fiscal Year | Amount |
|---|---|---|
| **First Year** | 2017 | $ 2293434.00 |
| **Second Year** | 2018 | $ 4233762.00 |

**Federal Statute/Regulation Citation**

Section 2703 of the Patient Protection & Affordable Care Act

**Governor's Office Review**

- ○ **No comment.**
- ○ **Comments received.**
  Describe:
- ○ **No response within 45 days.**
- ◉ **Other.**
  Describe:
  Governor office does not want to review.

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## Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- ○ **Public notice was not required and comment was not solicited**
- ○ **Public notice was not required, but comment was solicited**
- ◉ **Public notice was required, and comment was solicited**

**Indicate how public notice was solicited:**

- [ ] **Newspaper Announcement**

- [x] **Publication in State's administrative record, in accordance with the administrative procedures requirements.**
  **Date of Publication:**
  05/29/2015 (mm/dd/yyyy)

- [ ] **Email to Electronic Mailing List or Similar Mechanism.**
  **Date of Email or other electronic notification:**
  (mm/dd/yyyy)
  Description:

- [ ] **Website Notice**
  Select the type of website:
  - [ ] Website of the State Medicaid Agency or Responsible Agency
    **Date of Posting:**
    (mm/dd/yyyy)
    Website URL:
  - [ ] Website for State Regulations
    **Date of Posting:**
    (mm/dd/yyyy)
    Website URL:
  - [ ] Other

- [ ] **Public Hearing or Meeting**

- [ ] **Other method**

**Indicate the key issues raised during the public notice period:(This information is optional)**

- [ ] **Access**
  **Summarize Comments**
  **Summarize Response**

☐ **Quality**

**Summarize Comments**

**Summarize Response**

☐ **Cost**

**Summarize Comments**

**Summarize Response**

☐ **Payment methodology**

**Summarize Comments**

**Summarize Response**

☐ **Eligibility**

**Summarize Comments**

**Summarize Response**

☐ **Benefits**

**Summarize Comments**

**Summarize Response**

☐ **Service Delivery**

**Summarize Comments**

**Summarize Response**

☐ **Other Issue**

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## Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

***Complete the following information regarding any tribal consultation conducted with respect to this submission:***

**Tribal consultation was conducted in the following manner:**

☐ **Indian Tribes**

☑ **Indian Health Programs**

| Indian Health Programs | |
|---|---|
| Name of Indian Health Programs: | |

| Indian Health Programs | |
|---|---|
| All IHPs<br>Date of consultation:<br>05/29/0015 (mm/dd/yyyy)<br>Method/Location of consultation:<br>On 5/26/15 the tribal notice was sent to Indian health programs and Urban Indian Organizations. On 5/29/15 a tribal webinar was held with Indian health programs and Urban Indian Organizations on the SPA. | |

☑ **Urban Indian Organization**

| Urban Indian Organizations | |
|---|---|
| Name of Urban Indian Organization:<br>All UIOs<br>Date of consultation:<br>05/29/0015 (mm/dd/yyyy)<br>Method/Location of consultation:<br>On 5/26/15 the tribal notice was sent to Indian health programs and Urban Indian Organizations. On 5/29/15 a tribal webinar was held with Indian health programs and Urban Indian Organizations on the SPA. | |

**Indicate the key issues raised in Indian consultative activities:**

☐ **Access**

**Summarize Comments**

**Summarize Response**

☐ **Quality**

**Summarize Comments**

**Summarize Response**

☐ **Cost**

**Summarize Comments**

**Summarize Response**

☑ **Payment methodology**

**Summarize Comments**

The HHP tiered payment structure should include metrics that account for the social determinants of health. The payment methodology should support and strengthen services provided by Federally Qualified Health Centers/Urban Indian Health Organizations while ensuring that duplicative payment does not occur and that FQHCs/UIHs can participate in the HHP network.

**Summarize Response**

Homelessness and other social determinants of health will be considered in how DHCS calculates the funding for HHP services. Duplication of services or payment is not allowed under HHP. DHCS anticipates that the additional funding allocated for HHP services will support and strengthen care coordination activities in all HHP participating organizations and providers including FQHCs/UIH organizations.

☐ **Eligibility**

**Summarize Comments**

**Summarize Response**

☐ **Benefits**

**Summarize Comments**

**Summarize Response**

☐ **Service delivery**

**Summarize Comments**

**Summarize Response**

☑ **Other Issue**

| Issues | |
|---|---|
| Issue Name: Definition<br>**Summarize Comments**<br>Definitional language needs to be added to include “Natural Helpers” and “Traditional Healers” to the multi-disciplinary HHP team.<br>**Summarize Response**<br>We will take this recommendation under consideration. | |

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## Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

| Date of Consultation | |
|---|---|
| Date of consultation: 12/21/2015 (mm/dd/yyyy) | |
| Date of consultation: (mm/dd/yyyy) | |
| Date of consultation: (mm/dd/yyyy) | |

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## Health Homes Population Criteria and Enrollment

**Population Criteria**

The State elects to offer Health Homes services to individuals with:

☑ **Two or more chronic conditions**

**Specify the conditions included:**

☐ **Mental Health Condition**
☑ **Substance Abuse Disorder**
☑ **Asthma**
☑ **Diabetes**
☑ **Heart Disease**
☐ **BMI over 25**

| Other Chronic Conditions | |
|---|---|
| chronic liver diease | |
| chronic obstructive pulmonary disease (COPD) | |
| chronic or congestive heart failure | |
| dementia | |
| traumatic brain injury | |

☑ **One chronic condition and the risk of developing another**

**Specify the conditions included:**

☐ **Mental Health Condition**
☐ **Substance Abuse Disorder**
☑ **Asthma**
☐ **Diabetes**
☐ **Heart Disease**
☐ **BMI over 25**

| Other Chronic Conditions | |
|---|---|
| asthma with diabetes or SUD or depression or BMI over 25 | |
| hypertension with COPD or diabetes or heart disease | |

Specify the criteria for at risk of developing another chronic condition:
To be eligible for HHP, a member must meet the following eligibility criteria: A) two or more chronic conditions specified above, or one chronic condition and the risk of developing another defined as 1) one chronic condition of asthma and the risk of developing at least one of the following: diabetes, SUD, depression, BMI over 25; or 2) one chronic condition of hypertension and the risk of developing at least one of the following: COPD, diabetes, coronary artery disease, chronic or congestive heart failure; and B) at least one of the following acuity/complexity criteria: chronic homelessness or a chronic condition predictive level above three based on a method to be determined by DHCS, or at least one inpatient stay in the last year, or three or more Emergency Department (ED) visits in the last year.

☐ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:

**Geographic Limitations**

☐ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

**If no, specify the geographic limitations:**

◉ **By county**

Specify which counties:
Counties of Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, Shasta, Solano, Sonoma, and Yolo

○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

**Enrollment of Participants**

**Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:**

(●) **Opt-In to Health Homes provider**

Describe the process used:
The eligibility criteria will be run on a monthly or quarterly basis to provide a Targeted Engagement List of members to the MCP for engagement. MCPs will engage and inform the member that they are eligible for HHP services and can opt-in. MCP will identify their assigned CB-CME and the option to choose a different CB-CME. If the member's assigned primary care physician is affiliated with a CB-CME, the member will be assigned to that CB-CME, unless the member chooses another CB-CME.
Providers may refer eligible members to the member's assigned MCP to confirm if they are eligible for HHP services. The Targeted Engagement List will be the primary method of engaging eligible members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims/encounter history that identifies them as HHP eligible. Provider referrals will indicate that the provider has verified that the member meets the eligibility criteria stated on the referral. The provider will submit the referral form to the MCP for confirmation. CB-CMEs may not enroll new HHP members without prior approval from the MCP.
Consent to participate in HHP and consent to release of information forms will be secured and maintained by the MCP and the CB-CME.

( ) **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:

☐ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

( ) **Other**

Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**
☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed**

**for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**

☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**



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## Health Homes Providers

**Types of Health Homes Providers**

☑ **Designated Providers**

**Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:**

☐ **Physicians**

**Describe the Provider Qualifications and Standards:**

☐ **Clinical Practices or Clinical Group Practices**

**Describe the Provider Qualifications and Standards:**

☐ **Rural Health Clinics**

**Describe the Provider Qualifications and Standards:**

☐ **Community Health Centers**

**Describe the Provider Qualifications and Standards:**

☐ **Community Mental Health Centers**

**Describe the Provider Qualifications and Standards:**

☐ **Home Health Agencies**

**Describe the Provider Qualifications and Standards:**

☑ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

**Describe the Provider Qualifications and Standards:**

☐ **Community/Behavioral Health Agencies**

**Describe the Provider Qualifications and Standards:**

☐ **Federally Qualified Health Centers (FQHC)**

**Describe the Provider Qualifications and Standards:**

☑ **Other (Specify)**

| Provider | |
|---|---|
| Name: Community Based Care Management Entity (CB-CMEs)<br>Provider Qualifications and Standards:<br>1. Organizations must be: behavioral health entities, community mental health center, community health center, FQHCs, rural health center, Indian health clinic, Indian health center, hospital or hospital-based physician group or clinic, local health department, primary care or specialist physician or physician group, substance use disorder treatment provider, providers serving those that experience homelessness, other entities who meet certification and qualifications of a CB-CME may serve in this capacity if selected and certified by the MCP.<br>2. Experience serving Medi-Cal members and, as appropriate for their assigned HHP member population, experience with high-risk members such | |

| Provider | |
|---|---|
| as individuals who are homeless;<br>3. Comply with all program requirements;<br>4. Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;<br>5. Provide appropriate and timely in-person care coordination activities, as needed. If in person communication is not possible, alternative communication methods in addition to in-person such as telehealth or telephonic contacts may also be utilized if culturally appropriate and accessible for the HHP member to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;<br>6. Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;<br>7. Agree to accept any eligible HHP members assigned by the MCP, according to their contract with the MCP;<br>8. Demonstrate engagement and cooperation of area hospitals, primary care practices and behavioral health providers – through the development of agreements and processes - to collaborate with the CB-CME on care coordination;<br>9. Use HIT/HIE to link HHP services and share relevant information with other providers involved in the HHP member's care, in accordance with the HIT/HIE goals. | |
| Name:<br>Managed Care Plans (MCPs)<br>Provider Qualifications and Standards:<br>1. Qualified through review of certification criteria and through a readiness review process.<br>2. Contracts directly with the state<br>3. Have experience operating broad-based regional provider network<br>4. Have an adequate network of CB-CMEs (including behavioral health professionals) in geographic target areas for HHP to serve eligible members, maintained through contracts, MOU or MOA with organizations that are part of the HHP provider network.<br>5. Have the capacity to qualify and support organizations who meet the standards for CB-CMEs, including:<br><br>• Identifying organizations;<br>• Providing the infrastructure and tools necessary to support CB-CME in care coordination;<br>• Gathering and sharing HHP member-level information regarding health care utilization, gaps in care and medications;<br>• Providing outcome tools and measurement protocols to assess CB-CME effectiveness; and<br>• Developing and offering learning activities that will support CB-CME.<br>6. Have authority to access Medi-Cal claims/encounter data for the population served; | |

☐ **Teams of Health Care Professionals**

**Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:**

☐ **Physicians**

**Describe the Provider Qualifications and Standards:**

☐ **Nurse Care Coordinators**

**Describe the Provider Qualifications and Standards:**

☐ **Nutritionists**

**Describe the Provider Qualifications and Standards:**

☐ **Social Workers**

**Describe the Provider Qualifications and Standards:**

☐ **Behavioral Health Professionals**

**Describe the Provider Qualifications and Standards:**

☐ **Other (Specify)**

☐ **Health Teams**

**Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:**

☐ **Medical Specialists**

**Describe the Provider Qualifications and Standards:**

☐ **Nurses**

**Describe the Provider Qualifications and Standards:**

☐ **Pharmacists**

**Describe the Provider Qualifications and Standards:**

☐ **Nutritionists**

**Describe the Provider Qualifications and Standards:**

☐ **Dieticians**

**Describe the Provider Qualifications and Standards:**

☐ **Social Workers**

**Describe the Provider Qualifications and Standards:**

☐ **Behavioral Health Specialists**

**Describe the Provider Qualifications and Standards:**

☐ **Doctors of Chiropractic**

**Describe the Provider Qualifications and Standards:**

☐ **Licensed Complementary and Alternative Medicine Practitioners**

**Describe the Provider Qualifications and Standards:**

☐ **Physicians' Assistants**

**Describe the Provider Qualifications and Standards:**

**Supports for Health Homes Providers**

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

**Description:**

1.Require MCPs to have an adequate network.

2.Providers will follow existing managed care contractual requirements and guidance including maintenance of a quality improvement program, and provider training on evidenced-based practice guidelines.

3.DHCS will provide guidelines/requirements, including readiness tools to determine if MCPs and their network are ready to implement the HHP. The readiness tools will be used to conduct assessments of provider organizations identified by MCPs and the State as potential CB-CMEs. The assessment tool addresses staff composition,data infrastructure, etc.

4.An instructional program for care coordinators is being developed to include a series of instructional sessions for a patient-centered, high touch model of care management including, but not limited to online instruction, peer sharing through webinars, and multiple sessions on advanced care coordination beginning prior to implementation and continuing after implementation. Each stage of the care coordinator-patient partnership will be addressed in the curriculum (outreach, engagement, assessment, care plan development, and coordination of all services).

5.Materials developed under #4 above will be used as a base with the addition of new materials to establish a learning collaborative to educate providers before and after implementation with the appropriate tools and materials for successful program operation and to guarantee participation in quality improvement activities

designed to improve performance of the HHPs and outcomes for the HHP members. Best practices and lessons learned will be analyzed and shared during teleconferences to support their usage. Topics will include development and implementation of communication techniques, engagement strategies, and care coordinator training. This learning collaborative will consist of a combination of statewide and regional meetings, webinars, teleconferences, and a provider's section of the State's HHP webpage.

**Provider Infrastructure**

**Describe the infrastructure of provider arrangements for Health Homes Services.**

HHP services and care team providers will be added to California's managed care plan (MCP) infrastructure to facilitate the expansion needed for enhanced HHP services to members enrolled in managed care. HHP is supported by the existing services provided in the managed care environment. The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including the assignment of each HHP member to a Primary Care Provider. The MCPs also have existing relationships with the Medi-Cal County Specialty Mental Health plans (MHP) in each county to facilitate care coordination.

The HHP will be structured as a HHP network to provide care coordination. This network includes MCP, one or more Community Based Care Management Entity (CB-CME), and community and social support services (taken together as the health home). The delivery of HHP services will be accomplished through the partnership between MCP and CB-CME either through direct provision of HHP services, or through contractual arrangements with appropriate providers who will be providing components of the HHP services and planning and coordination of other services. MCPs contract directly with the State and will be responsible for the overall administration of the HHP, maintain overall responsibility for the HHP network, and receive HHP payment from the State. CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs. The CB-CMEs serve as the single community-based entities with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide for the full range of CB-CME duties, the MCP can perform duties of the CB-CME, or subcontract with other entities to perform these duties, with advance approval from DHCS. In addition, the MCP may provide, or subcontract with another community based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals.

DHCS will require the following team members on a multi-disciplinary care team:
• dedicated care manager,
• HHP director,
• clinical consultant,
• community health workers and
• housing navigator for HHP members experiencing homelessness.

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

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's service providers for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

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

**Provider Standards**

**The State's minimum requirements and expectations for Health Homes providers are as follows:**

MCPs

1. Attribute assigned HHP members to CB-CMEs
2. Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;
3. Notify the CB-CME of inpatient admissions and emergency department visits/discharges;
4. Track and share data with CB-CMEs regarding each participant's health history;
5. Track CMS-required quality measures and state-specific measures;
6. Collect, analyze and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process;
7. Provide member resources (e.g. customer service, member grievances) relating to HHP;
8. Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and CB-CME;
9. Establish and maintain a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers;
10. Ensure access to timely services for HHP members, including seeing HHP members within established length of time from discharge from an acute care stay (The length of time will be established by DHCS as part of the MCP Request for Application and readiness process);
11. Ensure participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary HHP team but who are responsible for coordinating with the CB-CME care manager to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary HHP team.
12. Develop CB-CME training tools and reporting capabilities.
13. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

CB-CMEs

1. Responsible for care team staffing, according to HHP required staffing ratios to be determined by DHCS, and oversight of direct delivery of the core HHP services;
2. Implement systematic processes and protocols to ensure member access to the multi-disciplinary HHP team and overall care coordination;
3. Ensure person-centered and integrated health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical health care related needs and services and social services needs and services;
4. Collaborate with and engage HHP members in developing a HAP and reinforcing/maintaining/reassessing it in order to accomplish stated goals;
5. Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure HHP member care is integrated among providers;
6. Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and improve health;
7. Provide evidence-based care;
8. Manage referrals, coordination and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow up;
9. Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
10. Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
11. Provide service in the community in which the HHP member lives so services can be provided in-person, if needed;
12. Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven days a week

availability of information and emergency consultation services to HHP members;
13. Provide quality-driven, cost-effective HHP services in a culturally competent and trauma informed manner that addresses health disparities and improves health literacy.

***Transmittal Number: CA-16-007 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2017 Approval Date:***

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## Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

- ☐ **Fee for Service**
- ☐ **PCCM**

  - ○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

  - ○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

    **The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:**

    - ☐ **Fee for Service**

    - ☐ **Alternative Model of Payment (describe in Payment Methodology section)**

    - ☐ **Other**
      Description:

    - ☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

      If yes, describe how requirements will be different:

- ☑ **Risk Based Managed Care**

○ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

☐ **Other**

Describe:

◉ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

MCP contract language will include but not be limited to staffing requirements, HHP network adequacy, relationship for SMI/SED services with county mental health plans, monitoring and reporting requirements, and standards for the six HHP services- Comprehensive Care Management. Care Coordination, Health Promotion, Transitional Care, Individual and Family Support, and Referrals to the Community; hospitals instructed to establish procedures for referring eligible to HHP providers; receive payment from DHCS and disperse funds to CB-CMEs; use of multi-disciplinary care teams, provide cost effective, culturally appropriate, and person and family centered HHP services, coordinate access to high-quality health care services informed by evidence-based clinical practice guidelines, develop a person-centered care plan; use of health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate: establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

**The State intends to include the Health Homes payments in the Health Plan capitation rate.**

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

◉ **No**

**Indicate which payment methodology the State will use to pay its plans:**

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☑ **Other**

Description:
MCPs will receive a payment for HHP services through the capitation rates based on a prospective, risk-based methodology that uses a hybrid approach of payment through the existing capitation rate structure for all MCP members and a new monthly add-on risk based PMPM payment for HHP enrolled members during the ongoing service delivery period. Within the existing capitation rate structure, DHCS will identify the amounts currently included in capitation payments that reflect DHCS' assessment of the overlap between HHP requirements and requirements currently in the MCP contracts. This amount will be counted as HHP services to be claimed at 90% FFP match (for traditional populations-expansion populations will align to the applicable FFP match). The new add-on PMPM monthly payment will reflect the additional amounts necessary to account for the full package of HHP services and the projected costs to successfully engage and manage HHP members. This add-on PMPM monthly payment will also be claimed at 90% or expansion level FFP match. The add-on PMPM payments are turned on/off based upon each member's enrollment/disenrollment from the HHP.
HHP services when provided by an FQHC or RHC, shall be compensated separately from, and in addition to, the prospective payment rate received by an FQHC or RHC. This additional rate shall be deemed a supplemental rate for services not already included in the PPS rate calculation and shall therefore not be subject to a reconciliation or other reductions.

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

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*Transmittal Number: CA-16-007 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2017 Approval Date: Attachment 3.1-H Page Number:*

## Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☐ **Fee for Service**

☐ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

**Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

**Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:**

☐ **Other: Describe below.**

**Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.**

☐ **Per Member, Per Month Rates**

**Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.**

☐ **Incentive payment reimbursement**

**Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.**

☐ **PCCM Managed Care (description included in Service Delivery section)**

☑ **Risk Based Managed Care (description included in Service Delivery section)**

☐ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

**Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:**

☐ **Rate only reimbursement**

**Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.**

**Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.**
DHCS will ensure non duplication of services through several mechanisms. First, through policies and guidance letters to the health plans. Second, because there are similar comprehensive case management components within the targeted case management and 1915 (c) community based services waiver programs, eligible members must choose between HHP and the other programs with similar comprehensive case management components. Lastly, policies and contract language will be developed to assure that there is no duplication of payment for HHP services including, but not limited to the requirement that providers may not designate as a HHP service any activity that has already been billed to or counted towards a service requirement for another Medicaid program.

The following is a discussion of the payment methodology:
Risk-based HHP payments will be made to MCPs. The MCPs will be responsible for negotiating contracts and payment terms with qualified CB-CMEs or other providers to ensure the delivery of HHP services and will flow HHP payments to CB-CMEs or other providers.

DHCS Payments to MCPs - The rates will be developed with the assistance of DHCS' actuaries. DHCS will develop assumptions about member acuity and intensity of service needs to facilitate the development of the capitation rates.

During the first three months of the ongoing service delivery period, there will be intense provision of HHP services to conduct assessments, develop the HAP, and perform other HHP services. This period will be considered in the development of the ongoing service delivery capitation rate.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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## Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

### Health Homes Services (1 of 2)

**Category of Individuals**
**CN individuals**

**Service Definitions**

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

**Comprehensive Care Management**

**Definition:**
Comprehensive care management involves activities related to engaging and collaborating with members and their family/support persons to develop their HAP. The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, palliative care, trauma-informed care needs, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and is reassessed based on the member's progress or changes in their needs. It tracks referrals.
Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers. The member will be engaged through various electronic means, letters, community outreach, and in-person meetings where the member lives, seeks care, or is accessible. Communication/information will meet health literacy standards, trauma-informed care standards and be culturally appropriate.
Comprehensive care management services include, but are not limited to
• Engaging the member in HHP and in their own care
• Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
• Promoting the member's self-management skills to increase their ability to engage with providers
• Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
• Completing a comprehensive health risk assessment to identify the member's physical, mental health, substance use, and social service needs
• Developing a member's HAP and revising it as appropriate
• Reassessing a member's health status, needs and goals
• Coordinating and collaborating with all involved parties to promote continuity and consistency of care
• Clarifying roles and responsibilities of the multidisciplinary team, providers, member and family/support persons

**Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:**
Comprehensive care management will be supported through varying methods throughout the state. Parts of the state are very connected via health information exchange that includes providers, facilities, public health and other entities to exchange structured electronic data. Other parts of the state have minimal health information exchange infrastructure. The state and federal government have made significant investments for providers to adopt electronic health records through the EHR Incentive Programs, the Mental Health Services Act support for Specialty Mental Health, and the other HITECH programs. This will be built upon by the MCPs, CB-CMEs and external providers to support electronic health information exchange for HHP.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Nurse Care Coordinators**

**Description**

☑ **Nurses**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Medical Specialists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Physicians**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Physicians' Assistants**

**Description**

☑ **Pharmacists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Social Workers**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Doctors of Chiropractic**

**Description**

☐ **Licensed Complementary and Alternative Medicine Practitioners**

**Description**

☐ **Dieticians**

**Description**

☐ **Nutritionists**

**Description**

☑ **Other (specify):**

**Name**

Dedicated care managers, Community health worker, HHP director, Housing navigator an

**Description**

Dedicated care manager- Paraprofessional (with appropriate training) or licensed case manager, social worker, or nurse.
Community health worker- Paraprofessional or peer advocate.
HHP director- Ability to manage multi-disciplinary teams.
Housing navigator - Paraprofessional or other qualification based on experience and knowledge of the population and processes.
Other- other provider types will be included by MCPs as needed based on member's health needs.

**Care Coordination**

**Definition:**

Care coordination includes services to implement the member's HAP. Care coordination services begin once a HAP is completed. For members, these care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all providers. Care coordination may include engagement activities notifying the individual of linkage to a CB-BME and supporting the participation process. HHP services will be provided through various electronic means, letters, and in-person meetings where the member lives, seeks care, or is accessible. Communication and information will meet health literacy standards, trauma informed care standards, and be culturally appropriate. Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to

• Working with the member to implement, update, and maintain their HAP
• Assisting the member in navigating health, behavioral health, and social services systems, including housing
• Sharing options with the member for accessing care, providing information to the member regarding care planning, facilitating communication and understanding
• Monitoring/supporting treatment adherence (including medication management and reconciliation)
• Managing referrals, coordination, and follow-up to needed services/supports to ensure needed services/supports are offered and accessed
• Sharing information with all involved parties to monitor the member's conditions, health status, and medications and side effects
• Assisting in attainment of the member's goals
• Identifying and addressing barriers to treatment adherence
• Encouraging the member's decision making and continued participation
• Creating and promoting linkages to other services/supports
• Accompanying members to appointments

**Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:**

HHP providers will work with MCPs or a qualified entity to securely access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals). HHP providers will utilize HIT to create, document, execute and update a plan of care for every patient that is accessible to the interdisciplinary team of providers. HHP providers will also be encouraged to utilize HIT to monitor patient outcomes, initiate changes in care and follow up on patient testing, treatments, services and referrals.
The HHP will promote the use of web-based health information technology registries and referral tracking systems that leverage electronic health information exchange and technology in the community.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Nurse Care Coordinators**

**Description**

☑ **Nurses**

**Description**
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☑ **Medical Specialists**

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☑ **Physicians**

**Description**
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☐ **Physicians' Assistants**

**Description**

☑ **Pharmacists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Social Workers**

**Description**

Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Doctors of Chiropractic**

**Description**

☐ **Licensed Complementary and Alternative Medicine Practitioners**

**Description**

☐ **Dieticians**

**Description**

☐ **Nutritionists**

**Description**

☑ **Other (specify):**

**Name**

Dedicated care managers, Community health worker, Housing navigator and other

**Description**

Dedicated care manager- Paraprofessional (with appropriate training) or licensed case manager, social worker, or nurse.
Community health worker- Paraprofessional or peer advocate.
Housing navigator - Paraprofessional or other qualification based on experience and knowledge of the population and processes.
Other- other provider types will be included by MCPs as needed based on member's health needs.

**Health Promotion**

**Definition:**
Health promotion includes services to encourage and support members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions. HHP services will be provided through various electronic means, letters, mailings, community outreach, and in-person meetings where the member lives, seeks care, or is accessible. Communication and information will meet health literacy standards, trauma informed care standards, and be culturally appropriate.
Health promotion services include, but are not limited to
• Encouraging and supporting health education for the member/family/support persons
• Coaching members/family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
• Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
• Promoting engagement of the member and family/support persons in self-management and decision making
• Encouraging and facilitating routine preventive care such as flu shots and cancer screenings
• Linking the member to resources for smoking cessation management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
• Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
• Using evidence-based practices, such as motivational interviewing, to engage and help member participate in and manage their care

**Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:**
HHP providers will work with MCPs or a qualified entity to securely access patient data and to develop partnerships that maximize the use of HIT across providers. HHP providers will utilize HIT to promote, link, manage and follow up on member health promotion activities. The HHP will leverage electronic health information exchange and technology in the community, including reporting regarding health promotion activities that is required as part of the EHR Incentive Program Meaningful Use and Quality Measures.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Nurse Care Coordinators**

**Description**

☑ **Nurses**

**Description**

Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Medical Specialists**

**Description**
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☑ **Physicians**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Physicians' Assistants**

**Description**

☑ **Pharmacists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Social Workers**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Doctors of Chiropractic**

**Description**

☐ **Licensed Complementary and Alternative Medicine Practitioners**

**Description**

☐ **Dieticians**

**Description**

☐ **Nutritionists**

**Description**

☑ **Other (specify):**

**Name**

Dedicated care managers, Community health worker, Housing navigator and other

**Description**

Dedicated care manager- Paraprofessional (with appropriate training) or licensed case manager, social worker, or nurse.
Community health worker- Paraprofessional or peer advocate.
Housing navigator - Paraprofessional or other qualification based on experience and knowledge of the population and processes.
Other- other provider types will be included by MCPs as needed based on member's health needs.

## Health Homes Services (2 of 2)

**Category of Individuals**

**CN individuals**

**Service Definitions**

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

**Comprehensive transitional care from inpatient to other settings, including appropriate follow-up**

**Definition:**

Comprehensive transitional care includes services to facilitate HHP members' transitions among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an emergency department, hospital inpatient facility, residential/treatment facility are required. Methods to promote sharing of information on transitions to/from transitional and/or

permanent supportive housing, incarceration facility, or other treatment center are encouraged as appropriate. The member and family/support persons will be assisted through emails, texts, social media, phone calls, letters, and in-person meetings. Communication and information will meet health literacy standards, trauma informed care standards, and be culturally appropriate.

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

• Transmitting a summary care record or discharge summary to all involved parties
• Providing medication information and reconciliation
• Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
• Collaborating, communicating, and coordinating with all involved parties
• Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
• Planning appropriate care/place to stay post-discharge, including temporary housing or stable housing and social services
• Arranging transportation for transitional care, including medical appointments
• Developing and facilitating the member's transition plan
• Preventing and tracking avoidable admissions and readmissions
• Evaluating the need to revise the member's HAP
• Providing transition support to permanent housing

**Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:**
HHP providers will work with MCPs or a qualified entity to securely access patient data and to develop partnerships that maximize the use of HIT across providers. HHP providers will utilize HIT to communicate with health facilities and to facilitate interdisciplinary collaboration among all providers, the patient, family, caregivers and local supports. The HHP will leverage electronic health information exchange and technology in the community, including reporting regarding transition of care activities that is required as part of the EHR Incentive Program Meaningful Use and Quality Measures.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Nurse Care Coordinators**

**Description**

☑ **Nurses**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Medical Specialists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Physicians**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Physicians' Assistants**

**Description**

☑ **Pharmacists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Social Workers**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Doctors of Chiropractic**

**Description**

☐ **Licensed Complementary and Alternative Medicine Practitioners**

**Description**

☐ **Dieticians**

**Description**

☐ **Nutritionists**

**Description**

☑ **Other (specify):**

**Name**

Dedicated care managers, Community health worker, Housing navigator and other

**Description**

Dedicated care manager- Paraprofessional (with appropriate training) or licensed case manager, social worker, or nurse.
Community health worker- Paraprofessional or peer advocate.
Housing navigator - Paraprofessional or other qualification based on experience and knowledge of the population and processes.
Other- other provider types will be included by MCPs as needed based on member's health needs.

**Individual and family support, which includes authorized representatives**

**Definition:**
Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services. The member and family/support persons will be assisted through e-mails, texts, social media, phone calls, letters, and in-person meetings where the member lives, seeks care, or is accessible. Communication and information will meet health literacy standards, trauma informed care standards, and be culturally appropriate.

Individual and family support services include, but are not limited to
• Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
• Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
• Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
• Accompanying the member to clinical appointments, when necessary
• Assessing the strengths and needs of the member and family/support persons
• Identifying barriers to improving their adherence to treatment and medication management
• Evaluating family/support persons' needs for services.

**Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:**

HHP providers will work with MCPs or a qualified entity to securely access patient data and to develop partnerships that maximize the use of HIT across providers. HHP providers will utilize HIT to provide the patient access to care plans and options for accessing clinical information. The HHP will leverage electronic health information exchange and technology in the community, including reporting and patient services that are required as part of the EHR Incentive Program Meaningful Use and Quality Measures.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Nurse Care Coordinators**

**Description**

☑ **Nurses**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Medical Specialists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Physicians**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Physicians' Assistants**

**Description**

☑ **Pharmacists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Social Workers**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Doctors of Chiropractic**

**Description**

☐ **Licensed Complementary and Alternative Medicine Practitioners**

**Description**

☐ **Dieticians**

**Description**

☐ **Nutritionists**

**Description**

☑ **Other (specify):**

**Name**
Dedicated care managers, Community health worker, Housing navigator and other

**Description**

Dedicated care manager- Paraprofessional (with appropriate training) or licensed case manager, social worker, or nurse.
Community health worker- Paraprofessional or peer advocate.
Housing navigator - Paraprofessional or other qualification based on experience and knowledge of the population and processes.
Other- other provider types will be included by MCPs as needed based on member's health needs.

**Referral to community and social support services, if relevant**

**Definition:**
Referral to community and social support services involves determining appropriate services to meet the needs of members, identifying and referring members to available community resources, and following up with members. HHP services will be provided through emails, texts, social media, phone calls, letters, and in-person meetings where the member lives, seeks care, or is accessible. Communication and information will meet health literacy standards, trauma informed care standards, and be culturally appropriate.
Community and social support services may include, but are not limited to:
• Identifying the member's community and social support needs.
• Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
• Identifying or developing a comprehensive resource guide for the member
• Actively managing appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
• Following up with the member to ensure needed services are obtained
• Coordinating services and follow-up post engagement
• Checking with member routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
• Linking to individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing.
• Linking to individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in his/her housing arrangement and thus able to sustain tenancy.

**Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.**
HHP providers will work with MCPs or a qualified entity to securely access patient data and to develop partnerships that maximize the use of HIT across providers. HHP providers will utilize HIT to initiate, manage and follow up on community based and other social service referrals. The HHP will leverage electronic health information exchange and technology in the community, including reporting and patient services that are required as part of the EHR Incentive Program Meaningful Use and Quality Measures. The HHP will work with entities supporting the use of HIT to include information and links to community and social support resources. This will be synergistic to existing websites and secure email supported by the HHP network to share information with members.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Nurse Care Coordinators**

**Description**

☑ **Nurses**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Medical Specialists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Physicians**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Physicians' Assistants**

**Description**

☑ **Pharmacists**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☑ **Social Workers**

**Description**
Clinical consultant at the MCP or CB-CME. Must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered in accordance with State and Federal requirements.

☐ **Doctors of Chiropractic**

**Description**

☐ **Licensed Complementary and Alternative Medicine Practitioners**

**Description**

☐ **Dieticians**

**Description**

☐ **Nutritionists**

**Description**

☑ **Other (specify):**

**Name**

Dedicated care managers, Community health worker, Housing navigator and other

**Description**

Dedicated care manager- Paraprofessional (with appropriate training) or licensed case manager, social worker, or nurse.
Community health worker- Paraprofessional or peer advocate.
Housing navigator - Paraprofessional or other qualification based on experience and knowledge of the population and processes.
Other- other provider types will be included by MCPs as needed based on member's health needs.

**Health Homes Patient Flow**

**Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:**
The patient flow narrative will be submitted separately.

☐ **Medically Needy eligibility groups**

○ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

***Transmittal Number: CA-16-007 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2017 Approval Date:***

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*Attachment 3.1-H Page Number:*

## Health Homes Monitoring, Quality Measurement and Evaluation

**Monitoring**

**Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:**
DHCS will work with the external evaluator to track the number of avoidable hospital readmissions using HHP claims/encounter data during the year that followed inpatient stays. The Agency for Healthcare Research Quality (AHRQ) Prevention Quality Indicators may be used for defining potential preventable hospitalizations.

**Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.**
The DHCS/evaluator will calculate regional, risk adjusted, per member per month expenses in the target population in the baseline, either by applying trend factors and estimating a projected per member per month figure or by measuring expenses against a matched control group. Cost avoidance will be calculated as the difference between actual and projected risk adjusted per member per month expenditures.

**Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).**
MCPs and CB-CMEs will establish and maintain data-sharing agreements compliant with all federal & state laws/regulations. The MCP is responsible for sharing health utilization & claims/encounter data with the HHP network to facilitate care coordination and prescription monitoring for HHP members. Each MCP will have a member website available to HHP members, their families & supports. MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow up care. CB-CMEs must demonstrate a capacity to use HIT to link services, facilitate communication and provide feedback to the team members. Services will be enhanced by the use of EHR systems and HIE. DHCS has established the following goals for HHP: Provide a HHP Member Portal, Utilize EHR/HIT/HIE to register HHP members, Utilize EHR/HIT/HIE to perform Point of Care Charting, and Utilize EHR/HIT/HIE to prepare/send/receive/consume a summary of care record for care transitions. DHCS expects organizations receiving EHR Incentive Program payments to use EHR in combination with community and enterprise HIE to meet these goals. DHCS has also funded, in partnership with CMS, a California Technical Assistance Program that is assisting providers in advancing the use of EHRs and in connecting to HIE. Specific milestones include connecting to HIE that uses CalDURSA and CTEN Organizations that do not have support through the EHR Incentive Programs may need support from MCPs to support the achievement of these goals. In some areas relatively few providers have EHRs, there is limited interoperability between the systems, and HIE services may not be designed for the HHP requirements. If the technology environment

does not fully support the HHP goals and requirements, the MCP will demonstrate that they, and their HHP network, are maximizing EHR/HIT/HIE to the extent possible, and relate their plan to make any possible improvements in the near future.

**Quality Measurement**

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

**States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:**

**Evaluations**

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

**Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:**

**Hospital Admissions**

Measure:
Inpatient Utilization- acute inpatient care.
Measure Specification, including a description of the numerator and denominator.
The rate of all acute inpatient care and services per 1,000 member months among HHP members. Admissions/1,000 member months.
Data Sources:
Administrative
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ◉ **Continuously**
- ○ **Other**

**Emergency Room Visits**

Measure:
Ambulatory care-emergency department visits
Measure Specification, including a description of the numerator and denominator.
The rate of emergency department visits per 1,000 member months among HHP members. Visits/1,000 member months
Data Sources:
Administrative
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ◉ **Continuously**
- ○ **Other**

**Skilled Nursing Facility Admissions**

Measure:

Nursing facility utilization

Measure Specification, including a description of the numerator and denominator.
The number of admissions to a nursing facility from the community that result in a short-term or long-term stay per 1,000 member months. Admissions/1,000 member months.
Data Sources:
Administrative
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ◉ **Continuously**
- ○ **Other**

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
Claims and encounter data for HHP enrollees will be used to determine hospital admission rates for HHP.

Chronic Disease Management
DHCS will monitor chronic disease management through measures identified in this SPA:
Adult BMI assessment;
Screening for clinical depression and follow-up plan
Controlling high blood pressure;
All-cause readmission rate;
Follow-up after inpatient hospitalization for mental illness; Initiation and engagement of alcohol and other drug dependence treatment;
Prevention quality indicator chronic condition composite.

Coordination of Care for Individuals with Chronic Conditions
In addition to the evaluation of service utilization and assessment of identified metrics for operational outcomes for HHP members, DHCS will assess and measure provision of care coordination services for individuals with chronic conditions utilizing the health homes quality measures identified in this SPA as follows:
Timely transmission of transition record to facility, HHP provider, primary physician or other health care professional designated for follow-up care when discharged from inpatient facilities to home or any other site of care;
Follow-up after inpatient hospitalization for mental illness;
Initiation and engagement of alcohol and other drug dependence treatment.

Assessment of Program Implementation
DHCS will monitor implementation using operational measures developed with the external evaluator including, but not limited to, enrollment numbers, number engaged, care plan completion, service utilization, in person contact, current housing status for those members experiencing homelessness. Additionally, DHCS will obtain HHP provider and stakeholder feedback through a learning collaborative and webinars. The evaluation plan will include these findings as well as a review of the implementation. It is anticipated that a rapid cycle assessment will be conducted

within a short time period after implementation that assesses the enrollment process, the rate of enrollment, reasons for high or low enrollment rates, challenges in outreach to potential members, and best practices.

Processes and Lessons Learned
The evaluation might include key informant surveys and interviews, provider surveys and member input from satisfaction surveys or measures on HHP will inform DHCS on ways to improve the process. As implementation progresses, guidelines and lessons learned will be documented and used for training additional HHP to further promote success statewide. DHCS anticipates at least quarterly meetings with participating HHPs, and other stakeholders as needed, to gather input on the program's success and challenges. A learning collaborative will be convened and will be utilized as necessary to glean feedback and lessons learned from a broad array of interested parties.

Assessment of Quality Improvements and Clinical Outcomes
To assess quality improvements and clinical outcomes, DHCS will collect clinical and quality of care data for the CMS core set of measures and state-specific quality goals. This assessment may include a combination of claims/encounter, administrative, and qualitative data. Where possible, DHCS will utilize metrics where benchmark data is available, such as Healthcare Effectiveness Data and Information Set (HEDIS). Data are to be compared to state and regional benchmarks and collected through defined quality processes as applicable.

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.