Health Homes for Patients with Complex Needs

Stakeholder Webinar

November 17, 2014

Webinar Overview

- **Welcome**
- CalSIM Update
- DHCS Overview
- Background ACA 2703 and AB361
- Key Components of Draft HHPCN Concept Paper
- Stakeholder Engagement Process and Q&A

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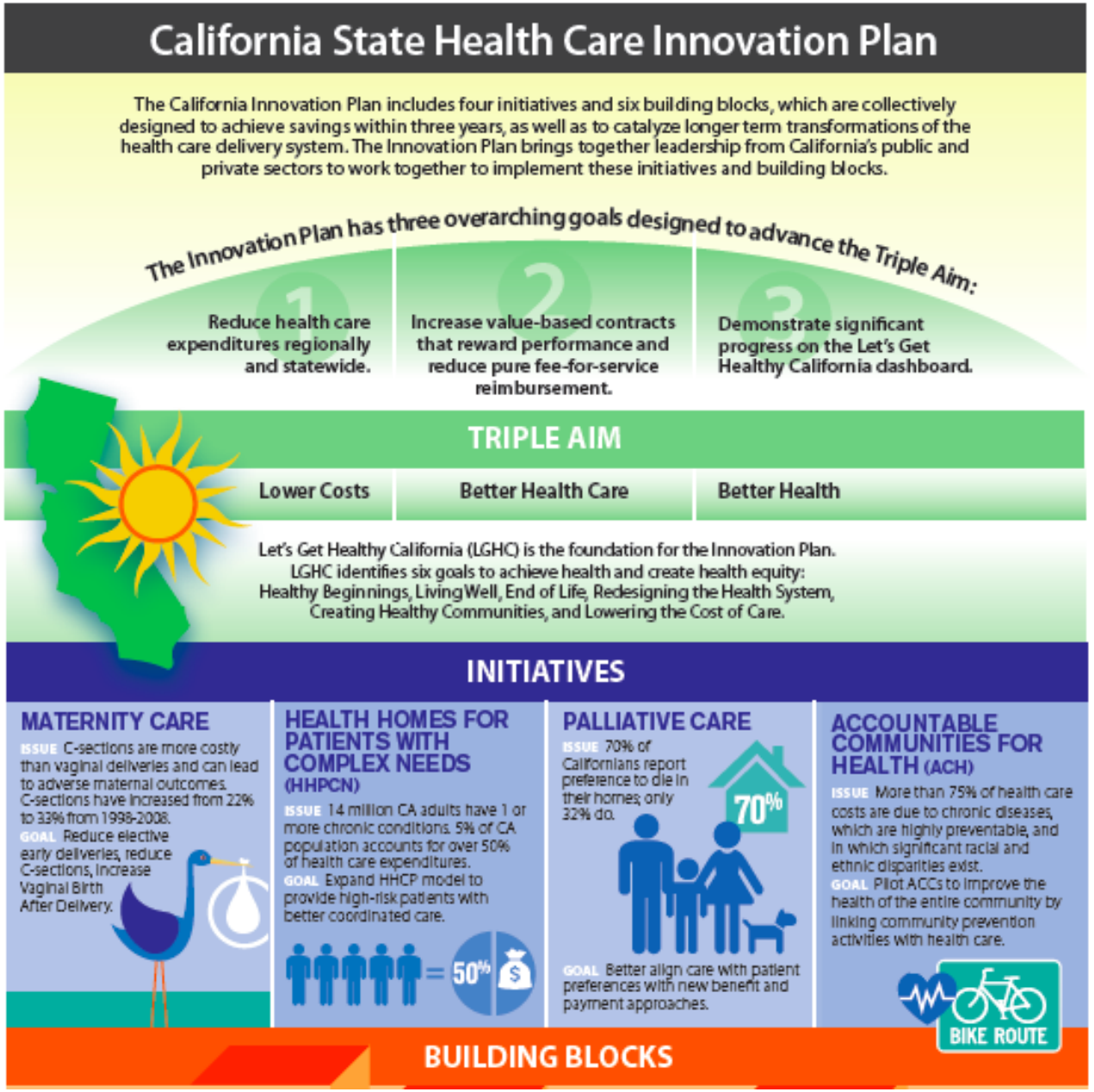

CHHS
California Health & Human Services Agency

California State Innovation Model (CalSIM) Components

Four Initiatives:

1. Maternity Care
2. **Health Homes for Patients with Complex Needs**
3. Palliative Care
4. Accountable Communities for Health

Six Building blocks:

1. Workforce
2. Health Information Technology (HIT) and Health Information Exchange (HIE)
3. Enabling Authorities
4. Cost and Quality Reporting System
5. Reporting
6. Payment Reform Innovation Incubator

CHHS
California Health & Human Services Agency

CalSIM Timeline and Budget

Timing

- Federal Testing awards expected this month
- If awarded, grant period expected to be January 2015 - December 2018
- First year allows for continued planning

Budget

- Grant proposal totals $99.7M; $20M for HHPCN initiative
- Significant provider technical assistance, including monies from other SIM building blocks

CalSIM Health Homes for Patients with Complex Needs (HHPCN)

- Aims: Let's Get Healthy California goals of Living Well:
  - Preventing and managing chronic disease
  - Improving care experience
  - Improving population health
  - Lowering costs
- Who: Patients with multiple, complex needs who may benefit from enhanced care coordination
- What: Enhanced care coordination, team-based care, palliative care, and other services
- Participants: DHCS, CalPERS, Covered California

CHHS
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CalSIM HHPCN Initiative Details

Multiple payers are involved:

- DHCS taking the lead
- Aligned with Covered California and CalPERS (only DHCS will offer a health home payment)

Multiple providers will be involved:

- Includes Community Health Workers
- Providers will receive technical assistance supported by CalSIM

Links to many other CalSIM efforts:

- Palliative Care
- Workforce
- Health Information technology and exchange

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CA HHPCN Policy Goals

Lower Cost

- Achieve net cost savings (avoidance) within 18 months

Better Care

- Improve care coordination
- Integrate palliative care into primary care delivery
- Strengthen community linkages within health homes
- Strengthen team-based care, including use of community health workers/promotores/other frontline workers

Better Population Health

- Improve the health outcomes of people with multiple chronic diseases

Additional Medi-Cal Objectives

1. Ensure sufficient provider infrastructure and capacity to implement HHPCN as an entitlement program
2. Ensure that health home providers appropriately serve members experiencing homelessness
3. Increase integration of physical and behavioral health services
4. Create synergies with the Coordinated Care Initiative (CCI) in the eight participating counties
5. Maximize federal funding while also achieving fiscal sustainability after eight quarters of federal funding

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ACA Section 2703

Creates the new **health home** optional Medicaid benefit:

- For intensive care coordination for people with chronic conditions
- The new benefit includes a package of six care coordination services, but does not fund direct medical or social services
- 90% federal funding for eight quarters, and 50% thereafter

Health Home Services

- DHCS is assessing the care coordination MCOs currently provide
  - What would have to be added to complete the health homes benefit
  - There can be no duplication of care coordination services
- In addition to medical coordination, other potential focus areas are:
  - Mental health and substance use disorder services
  - Services for homeless members, including linkages to supportive housing
  - Coordination and referral for palliative care services

AB 361 – enacted in 2013

- Authorizes implementation of ACA Section (§) 2703:
  - Provides flexibility in developing program elements
  - Requires DHCS complete a health home program evaluation within two years after implementation
  - Requires that DHCS implement only if no additional General Fund moneys will be use.
- Requires inclusion of a specific target population of <u>frequent utilizers</u> and <u>those experiencing homelessness</u>
- For the target population, the program must include providers with experience serving frequent hospital/ED users and homeless members

The Health Home Population

- AB 361 and the CalSIM proposal focus on:
  - Frequent utilizers of health services
  - Conditions that are likely to be responsive to intensive care coordination
  - Goals of reducing inpatient stays, ED visits, and negative health outcomes, and improving patient engagement
- Regardless of the specific chronic conditions that are selected:
  - A large percentage of enrollees with SMI and SUD, or who are homeless will be included
  - Whole-person care will include coordination of behavioral health (BH) services and includes linkages to social services, such as supportive housing

Geography and Phasing

- Federal rules allow CA to select specific geographies for implementation
  - CA must have adequate provider infrastructure to serve the target population in the selected geographies
  - Implementation can be staged in different geographies
- Some considerations:
  - CA could leverage previous care coordination improvements to give the health homes program every chance for success
  - Many initiatives in CA have enhanced primary care through practice transformation, PCMH, and health home-like efforts
  - CCI counties have higher care coordination standards, including enhanced coordination with long-term care and BH services
  - Provider readiness will be a key consideration

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Who Is Eligible?

- Eligibility requirements of 2703 are tied to chronic conditions
  - 2 or more chronic conditions
  - 1 condition and at risk of a second
  - Serious mental illness (SMI)
- All age groups
  - Cannot exclude children or dually eligible beneficiaries
- All Medicaid categorically-needy enrollees

2703 Link to Chronic Conditions

SEC. 2703. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.

(a) STATE PLAN AMENDMENT.—Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

"SEC. 1945. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.—

HHPCN Target Population

- HHPCN will target all three categories for health home eligibility with an emphasis on high-cost, high-risk, high-utilizers
- Specific chronic conditions of focus are being determined; however, the following conditions are being included in current feasibility analysis

HHPCN Target Population

Chronic Conditions	
Physical Health	**Behavioral Health**
Asthma /COPD	Substance Use Disorder
Diabetes	Major Depression
Traumatic Brain Injury	Bipolar Disorder
Hypertension	Anxiety Disorder
Congestive Heart Failure	Psychotic Disorders (including
Coronary Artery Disease	Schizophrenia)
Chronic Liver Disease	Personality Disorders
Chronic Renal Disease	Cognitive Disorders
Chronic Musculoskeletal	Post-Traumatic Stress
HIV/AIDS	
Seizure Disorders	
Cancer	

HHPCN Target Population

- Eligibility criteria will be developed by the state and eligibility determination process will by run by the state or the health plans
- Providers may be able to refer individuals into the program
- Health homes will follow an opt-out approach
- Eligible individuals in the Medicaid expansion will be included

HHPCN Target Population

- Acuity will also factor into eligibility determination process
- Patient acuity and intensity of service needs will inform tiering of services and payments
- Health home-eligible individuals who are also chronically homeless will have specific care management requirements in addition to those who are already stably housed

What are Federal Geographic Phasing Requirements?

- Health homes may be statewide or limited to a smaller geography within the state
- States may utilize a phased approach to strategically roll out across target regions
- Each new geographical area requires a new state plan amendment (SPA), and will be allowed a new 90/10 match clock for first eight quarters

HHPCN Geographic Phasing

- State intends to start with the Coordinated Care Initiative (CCI) counties as readiness allows beginning in January 2016
  - Dually eligible beneficiaries are already in managed care
  - Providers more likely to have experience with enhanced coordination requirements
- Remaining CA counties as readiness allows starting in July 2016

Health Home Network Infrastructure

- California envisions developing a health home network with the following components:
  - Lead entities
  - Community based care management entities
  - Community and social support services

CA Health Home Network

LEAD ENTITY: *QUALIFYING MEDI-CAL MANAGED CARE PLANS*

- Maintains overall responsibility for the health home network, including administration, network management, health information technology and exchange (HIT/HIE)
- Receives health home payment from the state and flows to partners

COMMUNITY-BASED CARE MANAGEMENT ENTITIES: *Sample orgs could include: FQHCs, hospitals, clinics, IPAs, behavioral health providers*

- Responsible for providing the core health home services:
  - ✓ Comprehensive care management
  - ✓ Care coordination (physical health, behavioral health, community-based LTSS) and health promotion
  - ✓ Comprehensive transitional care
  - ✓ Individual and family support
  - ✓ Referral to community and social support services
  - ✓ Use of HIT/HIE to link services
- Dedicated care manager is located within this entity
- Entity receives payment for health home services via a contract with the plan
- Makes referrals to community partners for non-Medicaid funded services

COMMUNITY AND SOCIAL SUPPORT SERVICES: *Sample organizations could include supportive housing providers, food banks, employment assistance, social services*

- Provides services that meet the enrollees' broader needs (e.g. supportive housing services, social services and supports)
- May not necessarily receive health home funding

Health Home Network: Lead Entity

- Maintains overall responsibility for the health home network (administration, network management, HIT support/data exchange
- Receives health home payment from the state and flows to the partners
- Must partner with one or more community-based care management entities
- Qualifying Medi-Cal managed care plans serve as lead entities

Health Home Network: Community-Based-Care Management Entities

- Responsible for providing the core health home services and maintaining a health action plan for each enrollee
- Dedicated care manager is located within this entity
- Entity receives payment for health home services via a contract with the plan
- Makes referrals to community partners for non-Medicaid funded services
- Sample orgs could include: FQHCs, hospitals, clinics, IPAs, behavioral health providers

Health Home Network: Community and Social Support Services

- Provides services that meet the enrollees' broader needs
- May not necessarily receive health home funding
- Sample organizations could include: supportive housing providers, food banks, employment assistance, social services, etc.

Network Qualifications

Lead Entity must demonstrate ability to:

- Assemble the overall health home network
- Administer and be accountable for the health home network
- Collect, analyze and report on financial, health status and performance measures
- Connect enrollees to care management entity and dedicated care manager

Network Qualifications

Community-based care management entity must demonstrate ability to:

- Actively engage the enrollees in developing, reinforcing and supporting their health action plans
- Coordinate physical health, behavioral health and community based long-term supports and services with other providers
- Advocate for and educate enrollees to attain and improve self-management skills
- Assure the receipt of evidence based care

Provider Education

- Provider education and technical assistance will be available to support health home network providers
- Multiple modalities will be used, including: webinars, learning collaborative, and individual practice coaching
- Coordinate with CalSIM initiative

Federal Health Home Service Requirements

- Each state defines the core services:
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care
  - Individual and family support
  - Referral to community and social support services
  - The use of HIT/HIE to link services, as feasible and appropriate
- Must provide at least one service per quarter in order to receive payment

HHPCN Service Definitions

- DHCS definitions are currently under development
- DHCS requests stakeholder input on draft definitions included in concept paper
- Each service definition must be linked to providers within the health home network

Quality Measures and Evaluation

- CMS established a recommended core set of eight health care quality measures that align with existing core sets for adults and children
- States are encouraged to also develop state-specific quality measures
- CMS also identified three utilization measures to assist with the overall federal health home evaluation
- California will also conduct state specific evaluations of the health home initiative
- DHCS requests stakeholder input on state-specific quality measures and evaluation plans

Payment Methodology

- Payment method will likely be a per member per month (PMPM) carved in to the managed care plan capitation payment
- Payment methodology intended to include tiering based on patient acuity
- Payments would flow through the lead entities to qualified care management entities via a contract
- DHCS will further develop the health home payment methodology once the target population, geographic area, network partner standards and service definitions have been finalized

Timeline

9/14-1/16	DESIGN AND DECISION-MAKING
9/14 - 3/15	Ongoing meetings and stakeholder input focusing on aligning model development with a multi-payer strategy
1/15	SIM test grant starts (anticipated)
3/15	Finalize SPA and remaining details of payment methodology
4/15	Required consult with Substance Abuse and Mental Health Services Administration (SAMHSA)
4/15-7/15	CMS consultation on coverage issues and reimbursement model
8/15-1/16	Ongoing stakeholder communication and early preparations
8/15	Formal submission to CMS
1/1/16	CMS approval of 2703 SPA

7/15 – 7/18	IMPLEMENTATION AND PROVIDER TECHNICAL ASSISTANCE
7/15 – 12/15	Begin to provide TA, build health home networks, and prepare for program implementation
1/16	Begin operating health homes (SPA effective date for enhanced match purposes)
12/17	End of enhanced match for first 2703 health home SPA
1/18	Completion of initial AB 361 evaluation timeframe

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Stakeholder Engagement Process

- DHCS, in coordination with CalSIM, will continue the stakeholder engagement process initiated with today's webinar
- Please contact us via the DHCS health home mailbox HHP@dhcs.ca.gov to:
  - Send comments or questions about the presentation or concept paper, or
  - If you wish to be included in future notices of stakeholder engagement opportunities
- For information about the CalSIM plan and process: http://www.chhs.ca.gov/pages/pritab.aspx