

**Stakeholder Comments on  
Health Homes for Patients with Complex Needs  
California Concept Paper Version 2.0  
Draft 4/10/15**

Abode Services  
ACLU of San Diego and Imperial Counties  
Alzheimer's Association  
Ascencia  
California Academy of Family Physicians  
California Alliance of Child and Family Services  
California Association for Adult Day Services  
California Association of Health Plans  
California Association of Public Hospitals & Health Systems  
California Department of Public Health  
California Hospital Association  
California Housing Partnership Corporation  
California Primary Care Association  
California State Association of Counties  
Children Now  
Congress of California Seniors  
Corporation for Supportive Housing  
County Behavioral Health Directors Association of California  
Dignity Health  
Downtown Women's Center  
Economic Roundtable  
Health Net  
Inland Empire Health Plan (IEHP)  
Local Health Plans of California  
Los Angeles Christian Health Centers  
Los Angeles Homeless Services Authority  
Lucile Packard Foundation for Children's Health  
McConnell, Michael  
Mental Health America of Los Angeles  
MidPen Housing Corporation  
Non-Profit Housing Association of Northern California  
Pacific Clinics  
Prevention Institute  
Regional Asthma Management and Prevention  
Rattan, Suneel  
San Francisco Department of Public Health  
Satellite Affordable Housing Associates  
SCAN Foundation, The  
Senior Services Coalition of Alameda County  
Slavkin, Hal  
Tenderloin Neighborhood Development Corporation  
Western States Regional Hemophilia Network



*Because everyone  
should have a home.*

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**Abode Services believes  
everyone should have a home**

Every day we provide  
housing and services to  
homeless people in our  
community while working to  
end the cycle of homelessness

May 6, 2015

Health Home Program  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, Ca 95814  
[HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov)

Re: Comments on DHCS' Concept Paper Version 2.0 on Health Homes

Dear Health Home Team:

On behalf of Abode Services, I thank you for the opportunity to comment on Concept Paper 2.0 regarding Section 2703 of the Affordable Care Act, the health home option. Abode Services is a non-profit housing and service provider serving Alameda, Santa Clara, and Santa Cruz counties. Through our programs, we serve more than 4,000 people per year, at least 30% of whom are chronically homeless and living with significant disabling conditions. We are greatly interested in the Health Home initiative.

We appreciate the work of DHCS staff in incorporating supportive housing into the concept paper, and in including housing navigators, tiered payment, and a focus on serving Medi-Cal beneficiaries experiencing homelessness. We have provided specific comments and recommendations for strengthening your concepts for the Health Home Program below.

#### **Section B1: Eligibility & Section B6: Beneficiary Assignment**

It is really important that we prioritize homelessness in addition to "high cost" utilization. Administrative data may accurately identify Medi-Cal beneficiaries incurring high costs, but, because Medi-Cal administrative data does not accurately identify beneficiaries experiencing homelessness, I recommend using a combination of administrative data and a referral process to identify beneficiaries experiencing homelessness. I agree with the list of chronic conditions in the concept paper, and recommend the State narrow by acuity according to hospital use or homelessness. Managed care plans would not be able to identify homeless beneficiaries through administrative data, but a referral process could identify additional criteria administrative data cannot. Additionally, I recommend using existing research data to identify indicators of high costs and poor outcomes among those experiencing homelessness. For instance, data indicate Medicaid beneficiaries with frequent hospital admissions experiencing homelessness will continue to be admitted to the hospital frequently over time, and will continue to incur high costs.

Regardless of eligibility criteria selected, I recommend a process of referral that allows homeless service, housing, hospital, health center, and homeless service systems to screen beneficiaries for potential eligibility, according to eligibility criteria the State adopts.

Finally, I recommend eliminating the requirement that MCPs approve adding beneficiaries to a health home. Waiting for approval could impact a health home's ability to engage homeless beneficiaries. Homeless beneficiaries will have no way of knowing they are eligible for health home services, unless the beneficiary seeks other services or is hospitalized. Potentially eligible homeless beneficiaries often present a brief window to engage. Most would be lost to follow-up in waiting for an MCP approval process. For this reason, I recommend establishing a process for receiving referrals from hospitals, homeless service and housing providers, health centers, or a region's homeless service system, for easily verifying eligibility, and for granting health homes serving homeless beneficiaries the ability to approve beneficiaries provisionally. These health homes should get reimbursed a portion of the engagement rate while waiting for final MCP approval.

### **Section B2: Health Home Services**

In the definition of services, I recommend greater emphasis on services that work to engage beneficiaries to achieve and maintain health stability on an ongoing basis. Many of the services identified in the concept paper are provided in supportive housing, and are critical to improving health outcomes. Yet, linking a beneficiary to treatment and to social services alone is insufficient to achieving those outcomes. Improving health among homeless beneficiaries and beneficiaries who are frequent hospital users is contingent on services that engage beneficiaries on an ongoing basis, promote healthy behaviors, and allow for self-management.

To incorporate these concepts into the definitions, I specifically recommend including the following:

- In the definitions of care management and care coordination, engagement services to motivate beneficiaries to collaborate in drafting and executing the Health Action Plan (HAP),
- Regular and ongoing communication, including case conferencing among team members, housing providers, and, when necessary, health providers,
- Transportation to and from appointments,
- Assistance in pursuing healthier behaviors and following treatment regimens,
- Help in obtaining and improving self-management skills to prevent negative health outcomes,
- Assistance in maintaining Medi-Cal,
- Advocacy with health care professionals,
- Accompanying beneficiaries to appointments when needed (including appointments with social service providers),
- Partnerships with organizations offering existing resources a beneficiary requires to improve health outcomes,
- Warm hand-offs to staff at partner organizations, and
- Connections to affordable permanent housing (when the beneficiary is experiencing homelessness).

**Section B5: Community-Based Care Management Entities (CB-CMEs)**

I recommend allowing MCPs to designate specific health homes as health home predominantly serving beneficiaries experiencing homelessness. I also recommend clarifying MCPs should refer beneficiaries to these designated health homes if the beneficiary is homeless in that geographic area, unless the beneficiary otherwise requests assignment to a different health home.

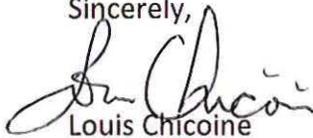
I recommend allowing MCPs flexibility in contracting with CB-CMEs, rather than requiring an administratively burdensome and difficult process to obtain certification. Alternatively, certification should simply involve ensuring CB-CMEs meet the qualifications outlined in the concept paper. I recommend further, in health home staff roles, that Community Health Workers not be required to mail health promotion materials.

**Section B7: Payment Methodologies**

I support DHCS intent to implement a three-tier payment process, as well as the enhanced member engagement tier rate. To ensure consistency, the State should offer MCPs a per member, per month case rate that allows Health Home Programs flexibility in identifying and providing health home services each benefit requires. I further recommend limiting how much an MCP may retain, consistent with other states' state plan amendments, to ensure the vast majority of funding offers services to eligible beneficiaries, rather than administrative process. The health home should be expected to achieve the outcomes the State identifies, and not be expected to expend significant staff time on administration of the health home program required with a fee-for-service type process.

Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. I look forward to engaging further in discussions on strengthening the Health Home Program.

Sincerely,



Louis Chicoine  
Executive Director



May 6, 2015

California Department of Health Care Services  
Health Homes Program  
Sent by email: [hhp@dhcs.ca.gov](mailto:hhp@dhcs.ca.gov)

**RE: ACLU of California Comments on Health Homes for Patients with Complex Needs  
California Concept Paper Version 2.0**

To Whom It May Concern:

The American Civil Liberties Union of California appreciates the opportunity to provide input in regards to the Health Homes for Patients with Complex Needs California Concept Paper Version 2.0. The Health Homes Program (HHP) will serve eligible Medi-Cal beneficiaries with multiple chronic conditions who may benefit from enhanced care management and coordination. The current version of the Health Homes Concept Paper provides the policy parameters of the HHP.

The ACLU of California is dedicated to protecting and advancing the civil rights and liberties of all Californians, regardless of race, wealth, health, or housing status. We work to reduce the number of people entering or returning to the criminal justice system for reasons relating to the health conditions of psychiatric disabilities and substance use disorders. The HHP not only has the potential to benefit individuals with chronic health conditions, but could also facilitate a shift away from our harmful and counterproductive approach of criminalizing health problems and towards a more inclusive, effective, and cost-effective, public health approach.

In order to improve the HHP's effectiveness, we urge the Department of Health Care Services to revise the policy parameters of the HHP to

1. Develop a process for identifying and enrolling individuals into the HHP that is not solely based on Medi-Cal administrative claims data;
2. Include incarceration as a social determinant of health that would help determine who is eligible for the HHP;
3. Coordinate with law enforcement so HHP beneficiaries
  - a. are referred to their Health Home team rather than incarcerated for reasons pertaining to their health conditions; and
  - b. have the opportunity to enroll in the program prior to or immediately after release from incarceration;
4. Encourage use of in-person outreach to reach individuals experiencing homelessness; and
5. Create lists of community-based care management entities (CB-CME) by geographic region so beneficiaries can more easily select the right care provider for them.

We caution against exclusively using Medi-Cal administrative utilization data to identify eligible HHP beneficiaries. Relying solely on this data would exclude many individuals who are not yet Medi-Cal beneficiaries or who have not been beneficiaries long enough to generate sufficient utilization data to identify them as eligible for the HHP. Many individuals with chronic illnesses who would be eligible for the HHP only became eligible for Medi-Cal after eligibility expanded in January of 2014. This is particularly true of chronically homeless single adults. Despite the frequency of eligible chronic conditions within this population, most only became eligible for Medi-Cal under the expansion and many have not yet enrolled. It would be cost-ineffective and detrimental to health outcomes to wait until individuals utilized a high enough amount of services before being identified and enrolled in the program. We recommend that DHCS develop an alternative process to identify and enroll eligible Health Home beneficiaries who have limited or no Medi-Cal utilization data due to the fact that they only became eligible for Medi-Cal under the expansion.

We strongly recommend that DHCS includes incarceration as one of the social determinants of health when determining eligibility for the HHP. History of incarceration may be particularly likely for HHP beneficiaries who have a chronic psychiatric disability and/or substance use disorder. Incarceration also significantly correlates with health status. Not only do individuals in jails and prisons have much higher rates of chronic physical<sup>1</sup> and behavioral<sup>2</sup> health conditions than the general population, but incarceration itself strongly increases the likelihood of severe health limitations.<sup>3</sup> Individuals with a history of incarceration more likely suffer from infectious disease and illnesses associated with stress.<sup>4</sup> Incarceration can also exacerbate existing health conditions, particularly psychiatric disabilities.<sup>5</sup> Incarceration affects and is effected by homelessness, a category of special consideration in the concept paper.<sup>6</sup> Because of a

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<sup>1</sup> Compared to the general population, the prevalence of HIV infection among incarcerated people is eight to nine times higher, hepatitis C is nine to 10 times higher, and tuberculosis is four times higher. RAND Corporation. (2009). *Understanding the Public Health Implications of Prisoner Reentry in California: Phase One Report*, pp. 18-19. Retrieved from [http://www.rand.org/content/dam/rand/pubs/technical\\_reports/2009/RAND\\_TR687.pdf](http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR687.pdf).

<sup>2</sup> 56 percent of people in state prison and 64 percent of people in local jails had a psychiatric disability in the past 12 months. James, D. J. & Glaze, L. E., Bureau of Justice Statistics. (September 2006). *Mental Health Problems of Prison and Jail Inmates*, p. 1. Retrieved from <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>; 14.5 percent of men and 31 percent of women in local jails have a serious psychiatric disability; three to six times the rate of serious psychiatric disability in the general population. Council of State Governments Justice Center. (June 1, 2009). *Justice Center Study Brief: Prevalence of Serious Mental Illness among Jail Inmates*, p. 1. Retrieved from [http://csgjusticecenter.org/wp-content/uploads/2012/12/MH\\_Prevalence\\_Study\\_brief\\_final-1.pdf](http://csgjusticecenter.org/wp-content/uploads/2012/12/MH_Prevalence_Study_brief_final-1.pdf); About 65 percent of individuals in state prisons and local jails have a substance use disorder. National Center on Addiction and Substance Abuse at Columbia University. (February 2010). *Behind Bars II: Substance Abuse and America's Prison Population*, p. 25. Retrieved from [www.casacolumbia.org/download/file/fid/487](http://www.casacolumbia.org/download/file/fid/487).

<sup>3</sup> Schnittker, J. & John, A. (2007). Enduring Stigma: The Long-Term Effects of Incarceration on Health. *Journal of Health & Social Behavior*, 48(2). Retrieved from <http://hsb.sagepub.com/content/48/2/115.short>.

<sup>4</sup> Massoglia, M. (2008). Incarceration as Exposure: The Prison, Infectious Disease, and Other Stress-Related Illnesses. *Journal of Health & Social Behavior*, 49(1). Retrieved from <http://hsb.sagepub.com/content/49/1/56.abstract>.

<sup>5</sup> National Research Council. (April 2014). *The Growth of Incarceration in the United States: Exploring Causes and Consequences*, p 174. Retrieved from [http://www.nap.edu/download.php?record\\_id=18613](http://www.nap.edu/download.php?record_id=18613).

<sup>6</sup> Of all people in jail, 15.3 percent were homeless at some point during the year prior to their incarceration, with 10 percent experiencing homelessness immediately prior to incarceration. Among incarcerated people with psychiatric

heightened likelihood that HHP beneficiaries will have a history of incarceration, and the significant impact that incarceration can have on an individual's health, we urge you to include incarceration as a social determinant of health for purposes of determining eligibility.

We urge DHCS to encourage Medi-Cal Managed Care Plans (MCPs) and community-based care management entities (CB-CMEs) to coordinate with law enforcement agencies, such as police and sheriff's departments, district attorneys, and probation departments (while adhering to privacy and confidentiality standards) so that beneficiaries are not incarcerated as a result of their chronic health condition. Individuals with serious psychiatric disabilities and/or substance use disorders are at an elevated risk of incarceration due to their health status. Incarceration can disrupt a treatment regimen, stalling or regressing improvements in health outcomes and increasing costs. Coordination with law enforcement could coincide with existing local pre- or post-booking jail diversion programs.

Similarly, we urge participating MCPs and CB-CMEs to coordinate with California Department of Corrections and Rehabilitation (CDCR), jail administrators, and probation departments so eligible individuals have the opportunity to join a Health Home prior to or immediately after release from incarceration. Given the impacts incarceration has on health status, the fact that individuals within a short period of time of release from incarceration are significantly more likely to die than the general population,<sup>7</sup> and the significant burden on emergency departments presented by individuals released from incarceration without proper connection to care,<sup>8</sup> it would be prudent to coordinate eligible persons with care management before or immediately after release. Health Home enrollment could dovetail on current efforts within CDCR and other jurisdictions to enroll eligible individuals into Medi-Cal prior to and/or immediately after release from incarceration and connect them with appropriate community resources.<sup>9</sup>

While we appreciate the special consideration given in the concept paper to ensuring appropriate services for people experiencing homelessness, we suggest increasing the means of outreach and communication to effectively reach this population. Mail and telephone alone will not be sufficient. As the concept paper acknowledges, an in-person engagement process may be

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disabilities, 20 percent were homeless prior to incarceration. Substance Abuse and Mental Health Services Administration. (July 2011). *Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States*, p. 17. Retrieved from [http://homeless.samhsa.gov/ResourceFiles/hrc\\_factsheet.pdf](http://homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf); Incarceration has been demonstrated to increase the likelihood of homelessness after release. National Healthcare for the Homeless Council. (November 2013). *Incarceration and Homelessness: A Revolving Door of Risk*, p. 1. Retrieved from [http://www.nhchc.org/wp-content/uploads/2011/09/infocus\\_incarceration\\_nov2013.pdf](http://www.nhchc.org/wp-content/uploads/2011/09/infocus_incarceration_nov2013.pdf).

<sup>7</sup> Dumont, D. M., Brockmann, B., Dickman, S., Alexander, N., & Rich, J. D. (2012). Public Health and the Epidemic of Incarceration. *Annual Review of Public Health*, 33. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3329888/>.

<sup>8</sup> Rich, J. D., Wakeman, S. E., & Dickman, S. L. (2011). Medicine and the Epidemic of Incarceration in the United States. *New England Journal of Medicine*, 364(22). Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3154686/>.

<sup>9</sup> A recent survey found that 75 percent of counties were currently providing Medi-Cal enrollment assistance and the remaining 25 percent planned to begin providing enrollment assistance in 2015. Californians for Safety and Justice. (2014). *Health Coverage Enrollment of California's Local Criminal Justice Populations*, p. 2. Retrieved from [http://libcloud.s3.amazonaws.com/211/ac/6/484/CountyEnrollmentSurvey\\_singles.pdf](http://libcloud.s3.amazonaws.com/211/ac/6/484/CountyEnrollmentSurvey_singles.pdf).

required in certain situations. In-person outreach will be necessary to achieve enrollment and sustained participation for individuals experiencing homelessness. MCPs and CB-CMEs should be expected and appropriately compensated for such in-person outreach. Given that a significant number of chronically homeless single adults are newly eligible for Medi-Cal, it would also be valuable to include outreach to individuals who would be eligible for the HHP but who are not yet enrolled in Medi-Cal.

The concept paper states that MCPs will link enrolled beneficiaries to one of their contracted CB-CMEs based on state-determined, CMS-approved criteria. To best facilitate care driven by the beneficiary, it would be valuable for DHCS to develop a resource that lists CB-CMEs by geographic region. Although this may need to be continuously updated, it will help individuals select a Health Home team that is accessible and with which they are comfortable. This may ultimately improve adherence and health outcomes. The list should be made available to eligible individuals through letter, electronic media, and in-person outreach.

We applaud the effort to ensure the HHP and 1115 Waiver renewal process are complementary. Supportive housing services, which are proposed in the 1115 waiver, are critical to improving health outcomes for individuals experiencing chronic homelessness. Without an increase in these crucial resources, it will be difficult to achieve the full potential of the HHP.

Thank you again for the opportunity to participate in the stakeholder process. Please do not hesitate to contact me if you have any questions.

Sincerely,



Kellen Russoniello

Staff Attorney, ACLU of San Diego and Imperial Counties

[krussoniello@aclusandiego.org](mailto:krussoniello@aclusandiego.org)

619-398-4489



May 5, 2015

Jennifer Kent, Director  
California Department of Health Care Services  
1501 Capitol Mall  
P.O. Box 997413  
Sacramento, CA 95899-7413

**Re: Comments on Health Homes for Patients with Complex Needs**

Dear Director Kent:

Thank you for the opportunity to participate in revision of Concept Paper version 2.0, the foundation for the California Health Home Service Model. The Alzheimer's Association shares the department's goal of a system of care that yields better care, better health and lower costs for Medi-Cal beneficiaries with complex chronic conditions, such as Alzheimer's disease. We know costs are 19 times higher for Medi-Cal beneficiaries with dementia, and we see triple the rate of hospitalizations and nursing facility placements within the population we serve.

We commend the department for applying for and receiving federal approval to proceed with the Medicaid Health Home State Plan Option, and we appreciate the generosity of The California Endowment in matching up to \$25 million per year to carry out the legislative intent of AB 361. This option is much needed as evidenced by specific recommendations in the 2015 Senate Select Committee on Aging and Long Term Care report, the 2014 California Wellness Plan and the 2011 California State Plan for Alzheimer's Disease.

The Alzheimer's Association looks forward to working closely with your team as you refine the concept and move closer to implementation. As you make further progress, we offer our expertise with the specialized population we serve – individuals at risk of or living with a cognitive impairment and their family caregivers. Through our involvement in the Administration on Community Living grant to the California Department of Aging for the Coordinated Care Initiative/Cal MediConnect, we have gained new knowledge of the challenges faced by consumers, community based organizations, health plans and providers. In order for the health home concept to succeed, we need to actively work on several areas to enhance communication and coordination. Our suggestions are as follows:

### **Better detection of patients with dementia**

We appreciate the challenge DHCS had in identifying beneficiaries with cognitive impairments based on Medi-Cal claims data and utilization reports. In fact, there is wide variance in estimates of the number of dual eligible seniors in California who have Alzheimer's disease or a related dementia ranging between 60,000 and 84,000 due to incomplete or inaccurate data. We know this disease is under-recognized, under-diagnosed, and under-documented in the medical record. Therefore, we recommend:

- Adoption and consistent use of screening tools, such as AD8
- Integration of cognitive assessment into E-HR
- Follow-up protocol if cognitive screen is positive

### **Better Post-Diagnostic Assessment, Treatment, Support and Education by Physicians**

In our recent work with primary care physicians, case managers and care coordinators, we have found willing partners who lack evidence-based guidelines for dementia care management. In many instances, we are working to identify appropriate tools, pathways and protocols for use where none had existed previously. Recent data indicates that fewer than 50% of patients who meet all of the criteria for Alzheimer's disease were informed of their diagnosis by a health professional. This compares with 92% for all leading cancers. Therefore, we recommend:

- Adopt the California Wellness Plan goal to update the Physician Guideline for Alzheimer's Disease Management by 2015 and increase training and education for both physicians and family caregivers
- This goal is also achieved by passage of Senate Bill 613 (Allen)

### **Better partnership between health system and informal caregivers/families**

Prevention and chronic disease management models rely heavily on self-management and self-direction. With Alzheimer's disease, a progressive, degenerative disease that is always fatal, informal caregivers and family support are critical to care management. Therefore, we recommend:

- Ability to identify informal/family caregiver and document this in the charts
- Ability to briefly assess informal/family caregiver's needs
- Integration of informal/family caregiver education
- Active engagement of informal/family caregiver in hospital discharge upon admission
- Assignment to Dementia Care Specialists
- Adoption of standardized care plans

### **Better partnership with Community-Based Organizations**

This model relies heavily on community partner readiness, capacity and competency. Therefore, we recommend:

- Direct investment in capacity building and competency development
- Adoption of standardized assessments and care plans
- Ongoing education and training
- Adoption of ALZ Direct Connect, a referral service for medical offices for support through care consultations, support groups, patient and family education, clinical trials

## Ongoing Issues

These issues warrant special attention as they are ongoing in the healthcare delivery/long-term services and supports system:

- Lack of clarity around mental and behavioral health access and coverage at the county level for individuals with a primary diagnosis of Alzheimer's disease or a related dementia. In an ideal system, integrating medical and behavioral health services will resolve this longstanding "carve out," but recent experience indicates the challenges remain even in an integrated delivery system.
- Alzheimer's disease is rarely the primary diagnosis of a complex, chronically ill patient, but the underlying dementia presents challenges in the home, community settings and hospitals. Uncovering and acknowledging the dementia is key to whole person care.
- Hospital stays and discharges are particularly difficult for patients with Alzheimer's disease and their family members. While avoiding unnecessary emergency room visits and hospitalizations is the leading objective, managing care transitions is of paramount importance.
- Alzheimer's disease is the 5<sup>th</sup> leading cause of death in California, so the emphasis on integrating palliative care into the primary care practice is an important development. Yet, individuals with Alzheimer's disease and their families often have added barriers with conservatorship, guardians, POLST forms, and other advance directives due to capacity issues. Moreover, meeting Hospice criteria is often difficult when the primary condition is Alzheimer's disease.

Again, the Alzheimer's Association is pleased California is pursuing the Health Home Service Model for Medi-Cal beneficiaries with complex chronic conditions. We are committed to serving as a resource to the department throughout the planning and implementation of this two-year initiative. Please feel free to call on the Alzheimer's Association for expertise and outreach in the 21 communities we serve. I can be reached at 916-447-2731 or via email at [sdemarois@alz.org](mailto:sdemarois@alz.org).

Sincerely,



Susan DeMarois  
State Policy Director

May 4, 2015

Health Home Program  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, Ca 95814  
[HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov)

Re: Comments on DHCS' Concept Paper Version 2.0 on Health Homes

Dear Health Home Team:

On behalf of Ascencia, thank you for the opportunity to comment on Concept Paper 2.0 regarding Section 2703 of the Affordable Care Act, the health home option. Ascencia is a nonprofit homeless services organization in Glendale, CA. We are part of the Los Angeles 10<sup>th</sup> Decile project, working with local hospitals to identify homeless frequent users, move them to permanent supportive housing and help them connect to a medical home. We have successfully maintained 90% of our chronically homeless clients in permanent housing for a year or longer. To accomplish this, our agency provides the types of services identified in the Health Homes legislation.

We appreciate the work of DHCS staff in incorporating supportive housing into the concept paper, and in including housing navigators, tiered payment, and a focus on serving Medi-Cal beneficiaries experiencing homelessness. Below, I offer specific comments and recommendations for strengthening your concepts for the Health Home Program.

**Section B1: Eligibility & Section B6: Beneficiary Assignment**

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Regardless of eligibility criteria selected, I recommend a process of referral that allows homeless service, housing, hospital, health center, and homeless service systems to refer beneficiaries for potential eligibility, according to eligibility criteria the State adopts.

Finally, I recommend eliminating the requirement that MCPs approve adding beneficiaries to a health home. Waiting for approval could impact a health home's ability to engage homeless beneficiaries. Homeless beneficiaries will have no way of knowing they are eligible for health home services, unless the beneficiary seeks other services or is hospitalized. Potentially eligible homeless beneficiaries often present a brief window to engage. Most would be lost to follow-up in waiting for an MCP approval process. For this reason, I recommend establishing a process for receiving

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referrals from hospitals, homeless service and housing providers, health centers, or a region's homeless service system, for easily verifying eligibility, and for granting health homes serving homeless beneficiaries the ability to approve beneficiaries provisionally. These health homes should get reimbursed a portion of the engagement rate while waiting for final MCP approval. I further recommend that if the referral is ultimately approved, that reimbursement at the full engagement rate be retroactive to the time the health home entity submitted the referral.

### **Section B2: Health Home Services**

In the definition of services, I recommend greater emphasis on services that work to engage beneficiaries to achieve and maintain health stability on an ongoing basis. Many of the services identified in the concept paper are provided in supportive housing, and are critical to improving health outcomes. Yet, linking a beneficiary to treatment and to social services alone is insufficient to achieving those outcomes. Improving health among homeless beneficiaries and beneficiaries who are frequent hospital users is contingent on services that engage beneficiaries on an ongoing basis, promote healthy behaviors, and allow for self-management.

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- Advocacy with health care professionals,
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### **Section B5: Community-Based Care Management Entities (CB-CMEs)**

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I recommend allowing MCPs flexibility in contracting with CB-CMEs, rather than requiring an administratively burdensome and difficult process to obtain certification. Alternatively, certification should simply involve ensuring CB-CMEs meet the qualifications outlined in the concept paper.

I also recommend several changes to the duties outlined in the concept paper for CB-CMEs:

- Revising number 7, in assuring the receipt of evidence-based care, to require instead partnering with and referring beneficiaries to treatment providers offering evidence-based care.
- Eliminating number 12, providing 24-hour, seven days a week information and emergency consultation services, as inconsistent with both the definitions of services included in the concept paper and with the intent of health home services. Since MCPs already offer these services, health homes should not need to.
- Revising number 8 to replace the need for a directory of community partners with partnerships with community partners offering resources in the community.

I recommend further, in health home staff roles, that Community Health Workers not be required to mail health promotion materials.

**Section B7: Payment Methodologies**

I support the DHCS intent to implement a three-tier payment process, as well as the enhanced member engagement tier rate. To ensure consistency, the State should offer MCPs a per member, per month case rate that allows Health Home Programs flexibility in identifying and providing health home services each benefit requires. I further recommend limiting how much an MCP may retain, consistent with other states' state plan amendments, to ensure the vast majority of funding offers services to eligible beneficiaries, rather than administrative process. The health home should be expected to achieve the outcomes the State identifies, and not be expected to expend significant staff time on administration of the health home program required with a fee-for-service type process.

Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. I look forward to engaging further in discussions on strengthening the Health Home Program.

Sincerely,



Natalie Komuro  
Executive Director



CALIFORNIA ACADEMY OF  
**FAMILY PHYSICIANS**  
**STRONG MEDICINE FOR CALIFORNIA**

May 6, 2015

Mr. Brian Hansen  
Health Program Specialist  
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[hhp@dhcs.ca.gov](mailto:hhp@dhcs.ca.gov)

Subject: Health Homes for Patients with Complex Needs

Dear Brian:

The California Academy of Family Physicians (CAFP), representing more than 9,000 family physicians and medical students in the state, thanks you for your commitment to the Health Homes for Patients with Complex Needs Initiative, made available through Section 2703 of the Affordable Care Act. As a longstanding proponent of the Medical Home or Health Home model, CAFP was pleased to review the California Concept Paper Version 2.0, dated April 10, 2015 (Concept Paper) and appreciates the opportunity to comment on it. We look forward to working with the Department of Health Care Services (DHCS) in this important effort going forward.

Transforming family physicians' clinics and practices into Patient Centered Medical Homes has been CAFP's main strategic goal for many years. We appreciate that a distinction is made between Medical Homes and Health Homes, with the latter focused on integrating community and social services into the care of patients. Many of the Health Home Services identified in the Concept Paper and elsewhere – care management, care coordination and health promotion, comprehensive transitional care, use of Health Information Technology (HIT) and Health Information Exchange (HIE) – are all services we have promoted in our Medical Home model, however.

As part of our effort to advance the Medical Home model in California, CAFP developed a Medical Home Initiative in Fresno in collaboration with the Fresno Unified School District and a Fresno primary care medical group. Our goal was to use the model to strengthen primary care, improve quality, manage chronic illness and optimize use of HIT. In an 18-month pilot period, we made improvements in every quality measure and generated cost savings – from reduced emergency room visits and hospital admissions as well as reduced pharmaceutical costs – of about \$2.5 million. We attribute our success to the development of a care management program for the highest-risk, highest-cost patients, among other changes in the practice.

Additionally, CAFP has sponsored legislation focused on promoting the Medical Home model and advocated for payment reform that supports the model. We have been offering technical assistance to

our members who wish to transform to Medical Homes for years. Given this experience and our strong interest in this Initiative, we ask that a representative of CAFP participate in the technical workgroup meetings referenced on page 26 of the Concept Paper.

CAFP appreciates the Guiding Principles for this Initiative and approves of the eligibility criteria for beneficiaries who will be given the option to receive Health Home Services. We also were happy to see the Health Home Services identified on pages 8-10 of the Concept Paper. In particular, we are pleased by the inclusion of the following, which have been goals of California's family physicians for years:

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Transitional Care
- Use of HIT and HIE

Our specific comments on the Concept Paper are as follow:

#### **Community Based Care Management Entity**

Perhaps our greatest concern with the Concept Paper is the failure to ensure that Health Home Program (HHP) beneficiaries' primary care providers play a central role in the Community Based Care Management Entities (CB-CMEs). Each HHP beneficiary is assigned a primary care provider by his or her Medi-Cal Managed Care Plan; however, there is no assurance that that provider is a part of the Health Home Team despite the goals of better managing chronic illness, developing comprehensive transitional care, better managing referrals and follow-up on needed services, using HIT such as Electronic Medical Records, integrating palliative care into primary care delivery and wrapping increased care coordination around existing care and despite research that shows primary care providers' role in driving down costs in the health care system.<sup>1</sup>

We appreciate that primary care physicians, physician groups and community health centers, where primary care providers are generally employed, are eligible to be CB-CMEs. We understand that this beneficiary population may see other organizations or providers as their main source of care. However, given the goals of this project and the research on primary care providers' role in the health care system, we strongly urge DHCS to require that the beneficiaries' assigned primary care providers be required team members on the CB-CME. Further, we urge DHCS to define the role of assigned primary care providers in the next iteration of this Concept Paper. To provide one important example, each HHP beneficiary is required to have a Health Action Plan that incorporates the HHP beneficiary's physical health needs, among other things. The assigned primary care physician must play a role in developing that Plan.

#### **HHP Network Infrastructure**

CAFP appreciates the inclusion of the requirement that DHCS and the Medi-Cal Managed Care Plans must ensure an adequate provider infrastructure so that all beneficiaries who: 1) meet the Health Home eligibility requirements; and 2) choose to access Health Home services can do so. The Concept

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<sup>1</sup> See, e.g., Chernow, M. E., Sabik, L., Chandra, A., & Newhouse, J. P. (2009). *Would Having More Primary Care Doctors Cut Health Spending Growth?* Health Affairs, 28(5), 1327-1335; B. Starfield, L. Shi, and J. Macinko, *Contribution of Primary Care to Health Systems and Health*, Milbank Quarterly, Sept. 2005 83(3):457-502; and S. J. Spann, *Report on Financing the New Model of Family Medicine*, Annals of Family Medicine, Dec. 2004 2(2 Suppl. 3):S1-S21.

Paper provides limited information about how and when this assessment of network infrastructure will be made. A readiness assessment is not, for example, part of the timeline on page 23 of the Concept Paper. We hope to see more information about this soon as DHCS prepares for a January launch of this Initiative.

The Concept Paper describes the managed care infrastructure as a critical building block for the HHP and how the HHP will benefit from Managed Care Plans' existing relationships and communication and reporting capabilities. The lists of organizations eligible to be CB-CMEs and required Health Home Team members, however, include service providers that are not, as far as we know, traditionally contracted with or communicating with Medi-Cal Managed Care Plans. We are concerned that this will make a readiness assessment of the network infrastructure particularly challenging. The state will need to allocate sufficient time and resources.

### **Health Information Technology**

In CAFP's experience building a Medical Home Pilot in Fresno, HIT was a powerful driver of improved care coordination, transitions of care and overall quality improvement. We were happy to see the use of HIT and HIE included in the Concept Paper and generally agree with the established goals for EMR/HIT/HIE use listed on page 10. We recommend expanding this list to include the use of data to drive quality improvement, particularly in the management of chronic illnesses, and the development of some requirements for health plans to deliver data to Health Homes to use in internal quality improvement efforts.

It seems important to assess whether the different organizations and team members included in the HHP can use HIT to link services and communicate with other team members, the beneficiary and family caregivers. While the majority of California physicians are now using EMRs and meeting the requirements of the Meaningful Use Program, other eligible CB-CMEs (e.g., providers servicing those who experience homelessness) and Health Home Team Members (e.g., Community Health Workers) may not be. In the next iteration of the Concept Paper, we ask DHCS to describe more explicitly how the HIT of the Managed Care Plan will be used by these Team Members. We also urge DHCS to consider a requirement that the dedicated care manager and HHP Director use an EMR. It seems especially important that individuals in these lead roles have access to beneficiaries' data, information about transitions of care and the beneficiaries themselves.

HIE infrastructure in California is fairly limited. When it comes to offering comprehensive transitional care, CAFP wonders how Health Homes will have access to prompt notification of HHP beneficiaries' admissions or discharges to or from emergency departments, hospital inpatient facilities, residential facilities or treatment facilities. This is hard to achieve if technological infrastructure is not already in place. It is even harder to achieve if all participating groups in the HHP are on different systems that cannot talk to one another. DHCS should assess the existing HIE infrastructure and create realistic requirements for utilizing HIE and developing transitional care.

### **Technical Assistance**

CAFP very much appreciates the inclusion of technical assistance for CB-CMEs and Managed Care Plans in this Concept Paper. We think it will be a heavy lift for these various providers to align themselves and

operate as true Health Homes. We also appreciate the commitment to use part of the Centers for Medicare and Medicaid State Innovation Model design grant for Health Home Technical Assistance.

CAFP agrees that technical assistance should begin with an assessment and bifurcate based on need. We would very much like to see more detail on what technical assistance in the HHP will entail in coming months. CAFP has experience developing technical assistance for providers transforming to the Medical Home model and would like to offer our help in developing programming. Educational programming for physicians and some other providers should be accredited as Continuing Medical Education as further incentive to participate. CAFP may be able to assist DHCS in getting the programming accredited.

The timeline on page 23 of the Concept Paper describes provision of technical assistance starting in July 2015. This is an ambitious timeline given that the programming must be developed and Team Members identified and recruited. There is also the process of plans negotiating contracts and setting rates with CB-CMEs. Some modification of that timeline may be necessary. CAFP may also be able to help DHCS in promoting the Health Home program and making primary care providers aware of the opportunity for assistance.

### **Care Management**

CAFP appreciates the recognition that improved care management is a core Health Home service and one of the primary goals of the HHP. We also appreciate the statement, on page 10, that “DHCS will align care management methods and tools with those currently used by [Managed Care Plans] for care coordination.” We note that other payers are starting to reward the development of care management programs in primary care clinics and practices. Perhaps most prominently, the Centers for Medicare and Medicaid Services began paying primary care physicians for care management of patients with multiple chronic illnesses in the Medicare program this year. There are, of course, very specific requirements for utilizing these Medicare codes. We urge DHCS to align HHP, as much as possible, with the requirements of CMS’s care management program. It creates greater incentives and lessens administrative burdens for providers if multiple payers are aligned.

We appreciate the emphasis on providing increased care management and coordination as close to the point of care delivery as possible in the community. As stated in the Concept Paper, DHCS expects these HHP services to be at appropriate sites where beneficiaries choose to receive most of their care. We urge DHCS to maintain this criterion in the HHP and to avoid disruptions in current beneficiary-provider relationships.

### **Payment**

CAFP agrees with DHCS’s plan to offer an enhanced payment for the first three months of the HHP. In our experience, the first months of a Medical Home project are more time- and resource- intensive. We appreciate the need for tiered payment based on acuity of beneficiaries. We urge DHCS and the Managed Care Plans to be as explicit about payment as possible, as soon as possible, and to include non-volume based payments in your/their payment methodology, so that providers can make the investments in their infrastructure (e.g., hiring care managers) that are necessary to this Initiative. Payment to the Health Homes should be clear and predictable.

We understand that payment must flow through the Managed Care Plan to the Health Homes. We urge DHCS to include some requirements to ensure payment flows to the point of care delivery in the next

iteration of this Concept Paper. Such requirements may help CB-CMEs predict return on investments in HHP infrastructure.

CAFP is concerned by the statement, in the Payment Methodologies Section, that “When the [Managed Care Plan] has demonstrated that community-based providers are not available, not willing, or do not have the capacity, to provide Health Home services, the [Managed Care Plan] may directly provide one or more components of the HHP services.” We would like more information to understand this statement better. We also urge DHCS to consider that Health Home services provided by primary care physicians and their teams have been shown to improve quality and drive down overall health care costs. In CAFP’s view, great benefit exists in ensuring that these services are delivered at the provider, and not the plan level.

Thank you for your consideration of these comments. Please let us know if we can provide any further information or can support DHCS’s efforts to bring these needed innovations to California.

Sincerely,

A handwritten signature in black ink, appearing to read "Susan Hogeland". The signature is fluid and cursive, with a large, stylized "S" and "H".

Susan Hogeland, CAE  
Executive Vice President  
California Academy of Family Physicians



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May 11, 2015

Jennifer Kent, Director  
Department of Health Care Services  
1501 Capitol Avenue  
Sacramento, CA 95899

**SUBJECT: CACFS Comments on Medi-Cal 2020: 1115 Waiver Renewal Concept Paper**

Dear Director Kent;

The California Alliance of Child and Family Services, a statewide association of accredited, private nonprofit, community-based organizations providing care and services to vulnerable children, youth and families, is appreciative for the opportunity to comment upon the *California Concept Paper Version 2.0 – Health Homes for Patients with Complex Needs* for California’s 1115 Medicaid Waiver renewal. On our members behalf, I will offer our thoughts on the role of health care and the challenges of adapting “adult models” to the dynamic and diverse world of children and youth who are also dependent upon the many community and state “bridges” to their ensure their futures.

Having tracked the incremental roll out of the Health Home concept since the initial stages of the federal health care implementation began, the children’s advocates across the state have been waiting for an opportunity to discuss the possibilities of developing a child centered home, which includes the robust presence of health care. The current DHCS concept paper provides an excellent platform for stakeholders and advocates to become involved with the next steps, and to develop the innovations that will drive improved health care outcomes-for adult populations. However, the concept paper and accompanying power point slide set illustrated the “home court advantage” for the adults in terms of federal design guidance and the framing principles. As the deadline for comments came up on our calendars, we wondered how the existence of two chronic conditions within our child/youth would be possible, and qualify this age group for the health home considerations.

The use of integrated or collaborative child and youth focused publically funded programs is not new. Over the last three decades we have seen the concept of a centralized location with multiple partners providing the core services and care management for children and families dealing with a variety of challenges. The majority of these integrated programing efforts have been to reduce long term impacts of specific health, behavioral health, educational achievement gaps and disparities in “opportunities” for success. The very best of these collaborative designs recognize that children and youth are not only dependent upon appropriate community services and supports, but that their parents/caregivers also can access needed supports as well. The child perspective on “person centered” is a very complex picture due to the many public partners.

The Alliance doesn’t need to reiterate the connections between childhood health status and the future trends in health costs, unemployment and poor community participation for this response. The Department has some of the best public policy experts in the nation, and very informed about childhood health and the need to prevent the onset of potentially “chronic” and confounding conditions. The data over the past many years continues to highlight the very high costs to the State that come from a very small percentage of our children and youth. The promotion of health, early detection and intervention in high risk conditions, and improving the overall health of the family are critical components of successful childhood health programs. Can California make these connections and design a health home that is part of a larger community home?

There are a few sites in other states that have taken the necessary steps to broaden the health home vision for children and youth. They have built child centered programs, and brought together more resources under a single roof. Notably, the efforts of Rhode Island reflect the innovations required to translate the federal health home option to a compatible framework for children and families. Within the early implementers of California's Coordinated Care Initiative, could we possibly find cross system partners that could identify specific communities with many apparent challenges? Is it possible that child and youth serving agencies, both county and private, could bring together their collective resources, and construct a health home similar to projects in other states? It would seem timely to bring together collaborators, to include the foundations within our state that work for the success of children and youth, to discuss the health home requirements as understood by the Department and determine if it is possible and necessary to develop a model of health homes that pushes on the conventional models. The concept paper's Regional Integrated Whole Person Care Pilots on pages 27-28 offer an excellent beginning point to develop the nuances that could reflect the larger, more complicated world of a child and his/her family.

The Alliance membership looks forward to supporting the Department's efforts to improve our health care services in California, including the access to behavioral health services for children and youth with a broad range of conditions and needs. We would welcome any opportunity to discuss with you and your staff our hopes that health homes pilots can be developed that fully reflect "child centered" homes. If you have additional questions, please do not hesitate to have staff email me or contact me at (916) 449-2273 ext. 204.

Sincerely,



Senior Mental Health Policy Advocate

Brian Hansen, Department of Health Care Services  
Mari Cantwell, Department of Health Care Services  
Karen Baylor, Department of Health Care Services  
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Hannah Katch, Department of Health Care Services  
Sarah Brooks, Department of Health Care Services  
Bob Baxter, Department of Health Care Services  
Efrat Eilat, Department of Health Care Services  
Kiyomi Burchill, California Health & Human Services Agency  
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**CAADS**

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May 1, 2015

Jennifer Kent, Director  
California Department of Health Care Services  
1501 Capitol Mall  
P.O. Box 997413  
Sacramento, CA 95899-7413

**RE: Health Homes for Patients with Complex Needs Concept Paper Version 2.0.**

Dear Director Kent,

The California Association for Adult Day Services is the leading state association advocating for quality adult day services. In collaboration with our subsidiary training and technical assistance organization, the Alliance for Leadership and Education, we have over the past two years developed and piloted a grant-funded Community-Based Health Home in six sites throughout the state.

Our nurse-led model leverages the strengths of the multi-disciplinary Community Based Adult Services (CBAS) team, adding the special skills of a nurse navigator for enhanced medical case management such as in-home assessment, medication reconciliation at the kitchen counter, coordination with care transitions and hospital discharge planners, accompanying patients to medical and specialist visits, and doing "whatever it takes" to assist and support the patient and their family or caregivers to successfully learn about, manage and take control of their complex health conditions. Our pilot project was designed to national core health home standards issued by the Centers for Medicare and Medicaid Services and the National Committee for Quality Assurance. While the final project evaluation is underway, we show impressive impacts on reducing hospital re-admissions and especially on preventing emergency department utilization.

Drawing from the strengths of our practical experiences on the ground, we offer our comments and suggestions on the Department of Health Care Services' proposal set forth in the ***Health Homes for Patients with Complex Needs Concept Paper Version 2.0***. Our input begins with general clarifying questions about paper and moves on to feedback on ten specific issues.

## General Questions

There are a number of issues in the paper that it would be helpful to amplify and clarify. Especially given the short timeframe, we suggest that the state release a tracked changes version of revisions to the concept paper as each new iteration is released, to show changes that have been adopted and facilitate clear communication about the program. Some general questions include:

- The paper states that the Health Home program will be implemented as an entitlement. What are the implications of this? How will the entitlement and beneficiary choice of provider work? (For example, will each qualified beneficiary receive a certificate that they are entitled to be a member of a Health Home, and a list of qualified Health Homes to choose from?) The paper also states that a Community Based Care Management Entity (CB-CME) must *"agree to accept any eligible HHP beneficiaries assigned by the MCP."* Could you please explain more about how this requirement will be operationalized?
- How does the department envision the Health Home program and the new plans for housing for the homeless being requested as part of the latest 1115 waiver proposal working together? Would these 1115 waiver housing resources be linked or available to the Health Home project?
- We note that federal participation for the Health Home is greater for the expansion population than for the traditional Medi-Cal population. Will these populations be treated differently in any way in the program design or implementation?

## Specific Feedback

### 1) Timeframe, Activities and Network Adequacy

We believe that the timeframe is too aggressive - the department is envisioning the launch of this program *8 months from today*. As the first of the long-term services and supports programs to be integrated into managed care, CBAS programs have real experience with the complexity of small community-based organizations and large managed healthcare organizations working together. It takes time and a major effort, and the attention of all parties is divided between initiatives like this and other important systemic changes already underway, like the Coordinated Care Initiative (CCI). The Health Home program is by design personalized and close to the ground, but it also has a firm set of core standards that need adherence. It will take time for the managed care plans and California's diverse community-based providers to understand the program and how they will work together, and to power up and hit the ground running. Failure to allow adequate time for community-based providers to understand and participate in the program will lead to inadequate health home networks and a huge

missed opportunity to leverage the person-centered philosophy of care that resides in the community-based care network.

**We suggest that the launch date for the initial counties be pushed back to July 1, 2016 and the second wave be implemented on January 1, 2017.**

## 2) Lack of Social Services and Housing

We believe the failure to provide any resources for social services and housing in the Health Home program is most disappointing aspect of the concept paper and the weakest link in the plan. There is good research showing that "[the health care sector is bearing the brunt of an inadequate social service sector](#)" and that saving on health care costs involves two discrete activities:

- 1) Ongoing support and coordination
- 2) Provision of social services.

The Health Home concept paper provides only for coordination - it makes no plans for investments in social services or housing, assuming that they are already available in the community. There is ample evidence that this assumption is flawed. Care coordination is not magic, it does not create new services - it requires services be available to coordinate. Furthermore, the department's plan to capture Medi-Cal claims data to target Health Home beneficiaries will provide zero information about social determinants of health, so there is a real danger that the people who need to be part of the Health Home will be missed and when they are included, they will not be stratified accurately to reflect the acuity of their needs. We believe that if social services and housing are not adequately addressed and provided for, the Health Home will fail to achieve its intended outcomes.

**We suggest that the CB-CME have access to financial resources to purchase social services and housing for Health Home participants. These investments should be meaningful and flexibly deployed. We also suggest that the referral process needs to include input from community-based providers about the participants' social service needs, and that Health Home participants with high social services needs be placed into the highest acuity-levels in order to accurately reflect the intensive level of service they require. Finally, we suggest that the stakeholder community consider sponsoring legislation that would capture all General Fund savings that are created in the Health Home program to be re-invested in social services that are linked to the program.**

## 3) Duplication of Effort and Coordination with CCI and Other Initiatives

The concept paper does not give clear direction about how the Health Home is distinct from other programs and initiatives, especially the Coordinated Care Initiative (CCI). How specifically do the Health Home program and activities overlay with other care coordination efforts and eligibility for other programs? While we can see that in the future the model may be shaped in many directions, for the limited time envisioned to launch the 2703 Health Home and the high bar for evaluation, we believe the

state should have a clear and specific plan for how these programs work together. With the short timeframe available, confusion will undermine success.

**We recommend a clear and understandable framework be developed as soon as possible for eligibility and coordination between the Health Home, the CCI and related programs and activities.**

#### 4) Certification of CB-CME Providers

The Community Based Adult Services (CBAS) program is an integrated medical and social model program that is founded on an established multi-disciplinary team approach and is experienced in person-centered planning. We have over 40 years' experience serving complex populations with multiple chronic conditions, and we have already developed a Health Home model led by nurse-navigators which is designed to national standards and has been actively serving high-needs participants for two years.

**We recommend that CBAS be included specifically in the list of organizations who qualify for certification as a Health Home CB-CME.**

#### 5) Rates

We understand that the department plans to set the rates for managed care plan (MCP) Health Home payments in the next few months, and that each MCP will then set differing rates with individual providers by contract.

**We recommend that given the short timeframe, CB-CME providers need information about how much they will be paid in order to understand how to structure their program. Provider rates cannot be set in December for program launch in January. We suggest that the department and the managed care organizations publish a range of recommended rates that CB-CME providers will be paid as soon as practical, so that information can inform planning and allow adequate time for networks to be constructed.**

#### 6) Strengthen Emphasis on Caregiver Supports

While the concept paper describes Individual and Family Support Services (p. 9), the program design would benefit from greater emphasis on family and caregiver supports, including training, health risks, self-care, depression screening, respite, group support, mindfulness exercises and activities that assist caregivers to maintain employment.

**We recommend that caregiver and family supports be expanded and given greater emphasis in the program design.**

#### 7) Electronic Medical Records

We understand that Health Information Technology (HIT)/Health Information Exchange (HIE) are a key feature of the Health Home; we also see that there will be 18 months to make the Health Home program a success. Attention is also beginning to focus on unintended consequences of EMR requirements that negatively impact small, community-based and ethnic providers and complicate

access to their services. Many people have spent many years trying to implement HIT/HIE and many more will yet be spent before it is achieved.

**We recommend that, to the extent possible, the first 18 months of Health Home implementation be spent focused on high-touch patient services rather than lengthy systemic discussions of implementation of Electronic Medical Records, and that requirements for EMR be as flexible as possible in accommodating community-based providers.**

#### 8) Behavioral Health Care

Although the concept paper states that "*mental health services will be a major component*" of the Health Home program, we believe the planning for this important element is underdeveloped. There are a number of problems with the lack of attention to this critical area, including:

- Continued focus on accommodating the needs of managed county mental health plans puts the Health Home design in danger of creating a separate and unequal structure. The Health Home program should be focused on outcomes and how the program structure achieves them.
- Building in assumptions that participants will desire services in pre-ordained settings limits their choices before they are even given choices.
- All Health Homes should be subject to the same essential standards, outcome measures and payment methodologies.
- All eligible Health Home participants should be able to choose any provider they desire to deliver services.
- The paper attends to system features like how to ensure that managed county mental health plans may participate in the Health Home project but is silent about all aspects of how participants will be able to successfully access mental health and substance use services, including whether there are enough providers to even meet the level of need. This is the wrong focus.
- Many people who will qualify and benefit from Health Homes are unserved or underserved by managed county behavioral health systems. For the Health Home project to achieve its intended outcomes, how people will be able to access high quality, adequate behavioral health services should be the key focus of planning.

**We recommend that the state give greater attention to the quality and programmatic aspects of behavioral health for all Health Homes, including careful attention to how all Health Home participants will realistically be able to access high-quality behavioral health services. We recommend that managed county behavioral health plans who wish to develop Health Homes be treated the same as all Health Home providers.**

#### 9) Health Homes Should be Community-Based

We note with concern the provision (p. 14, paragraph 3) that permits an MCP to *perform the duties of the CB-CME or subcontract with other entities to perform these duties*, with advance approval from DHCS. We believe that the Health Home program should be rooted in community-based organizations.

With only eight months to develop the program and bring it up to speed, there is a real danger that many valuable community-based organizations will be left with insufficient time to develop a Health Home program. If MCPs are permitted to leapfrog over the labor-intensive effort involved in fully developing California's community-based organizations into a fully prepared network of Health Homes, there is a real danger that many valuable organizations that are deeply rooted in communities will fail to make the transition to the managed care environment. This is likely to leave behind many organizations with valuable relationships and services, particularly those with ethnic, cultural or other person-centered expertise. The Health Home program is the opportunity to develop California's community-based network of providers as full participants in health care reform. We should not open the door for private healthcare entities and large chain businesses to deliver these services before we fully realize the potential that resides in our networks of community-based organizations.

**We recommend that this provision be deferred until after the initial 2-year Health Home roll-out.**

#### 10) Strong Provisions

We applaud several provisions in the concept paper and believe they will strengthen the Health Home program. Notably, the ability of MHP to pay medical providers for their time to work with the CB-CME to collaborate, do case consultation and provide input (p. 12, p. 16) is a valuable addition. We hope that discharge planners are included. We also appreciate the ability to add team members such as pharmacist or nutritionist (p 18), and believe that adding a housing navigator is also positive addition (p 18).

**We recommend these provisions be retained in the next version of the concept paper and believe that this type of innovative thinking will strengthen the Health Home program.**

We appreciate the opportunity to participate in the development of California's California Health Home program and believe that it represents an important opportunity to strengthen person-centered care for the state's most vulnerable citizens. We would be glad to offer any assistance that the department may need as the planning unfolds. If you have questions or would like more information, please feel free to contact me, or our policy consultant Laurel Mildred, [Laurel.Mildred@mildredconsulting.com](mailto:Laurel.Mildred@mildredconsulting.com), 916-862-4903.

Sincerely,



Lydia Missaelides, MHA  
Executive Director



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May 6, 2015

Ms. Hannah Katch

Department of Health Care Services  
1500 Capitol Avenue  
Sacramento, CA

VIA ELECTRONIC MAIL  
[Hannah.Katch@dhcs.ca.gov](mailto:Hannah.Katch@dhcs.ca.gov)

**Re: Health Homes Concept Paper 2.0**

Dear Ms. Katch:

The California Association of Health Plans (“CAHP”) represents 43 public and private health care service plans that collectively provide coverage to over 21 million Californians. We write today to provide feedback on the Health Homes for Patient with Complex Needs California Concept Paper Version 2.0 (the Concept Paper). We appreciate the opportunity to provide feedback on the draft concept paper and look forward to meeting with the Department of Health Care Services (the Department) on May 19<sup>th</sup> to discuss the issues and recommendations outlined in this letter in more detail.

Timeline

CAHP and its member plans have concerns about the timeline outlined in the concept paper. An implementation date of January 1, 2016 for plans in the Coordinated Care Initiative (CCI) counties, and July 2016 for the remaining interested counties, is very aggressive, and potentially not even feasible. Plans need time to recruit and train staff and to establish the relationships necessary to achieve the health homes model as outlined in the concept paper. Additionally, launching a new program with a high degree of service overlap with the CCI could materially impact CCI member communication and opt-out rates due to understandable confusion. Plans need a very clear and detailed description of what exactly being “ready to implement” means before they can commit to a certain timeframe.

Additionally, there is some concern about the requirement that a county will not be able to implement until all of the plans in that county are determined “ready”. We believe that this may create pressure on some plans to implement before they are actually ready and at the same time delay plans that have invested the time and resources to implement this program at an earlier date. A checklist that outlines the specific requirements that must be met in order to be “ready” to launch the health homes program may be something the Department should consider to ensure consistency and transparency.

We share in the goal of developing health homes and believe that it will take time to set this up correctly. However, it is essential that all of the appropriate pieces are in place prior to implementation. For example, plans will need real time mental health data regarding utilization and medications and Medicare utilization data in order to truly create a health home as

envisioned under the concept paper. The Department will need to work with plans to test member files and ensure that the transmissions are timely and accurate prior to implementation. And member outreach and education by both the plans and the Department will be essential to avoid the high opt-out rates seen in the CCI.

**Recommendation: The Department should delay implementation until no earlier than July 1, 2016. Implementation cannot occur until after the concept paper has been fully developed so that plans are clear on the expectations and have the data they need from the Department. This will allow plans to develop programs that will be successful and meet the goals of the Department and the Centers for Medicare & Medicaid Services (CMS). Some plans estimate that it will take up to 9 months from the date of the final concept paper to develop, staff, and train personnel.**

### Eligibility

We request that the Department provide more detail on how it will identify the eligible population and on what frequency. Additionally, plans will need to know how the Department will transmit eligibility information to them so that the IT infrastructure can be in place. The current criteria are too broad and should be focused in order to avoid confusion and duplication. The experience of the CCI program has demonstrated how difficult it is for the Department to identify and stratify the eligible populations and get the correct detail to the plans.

We believe that identifying the homeless population will prove to be an especially difficult task and we would like to understand how the Department will establish the eligibility criteria. If the Department expects that plans will be able to accept community referrals those details need to be worked out with the plans prior to implementation. We also request clarification on if the CCS population will be carved-in or out of the health homes program.

The Department could work with plans to develop a discrete list of specific conditions to determine eligibility. Another approach suggested by some plans is that the Department could use a functional status assessment, which would trigger eligibility regardless of the chronic condition. There are standard tools such as the Lawton Instrumental Activities of Daily Living Scale (IADL), which assesses independent living skills that could be used by the Department and plans to determine eligibility criteria.

If the Department determines that eligibility based on specific conditions is appropriate following is a list of diagnoses we believe the Department should consider:

- Chronic Heart Failure Decompensated.
- End Stage Cardiomyopathy/CHF
- End Stage Chronic Hepatic Liver Disease/Failure with evidence of treatment for esophageal varices.
- End Stage Renal Failure (with or without prior transplant)
- Chronic Obstructive Pulmonary Disease( COPD) and Oxygen Dependent
- Diabetes Mellitus, Type 2 (with manifestations involving renal, nephrology, neurology and ophthalmic)
- Behavioral Health conditions, i.e., schizophrenia, severe depression etc.
- Atrial Fibrillation with other cardiovascular conditions or co-morbidities
- Traumatic Brain Injury

- HIV/AIDS

**Recommendation: The Department must specifically identify its target population and eligibility criteria. The Department must also have a robust plan for outreach, education, and enrollment efforts. The Department should consider allowing the plans to determine that members are eligible according to established triggers for conditions and utilization. For behavioral health, the Department must clarify the data sharing process between the Counties and the plan for the seriously mentally ill who may not have utilization on the plan side.**

#### Rates

We request more detail on the 3 tier rate structure that is outlined in the concept paper. Will these rates be added to an existing aid code for an enrollee that is determined eligible for health homes or will they be placed in a new aid that is specific to the health homes program?

The health homes program will undoubtedly overlap with other initiatives implemented by the Department and the plans, such as CCI and other integration models proposed in the 1115 Waiver Medi-Cal 2020. It appears that an enrollee will have the option to choose which program they would like to enroll in if eligible for more than one program. We request that the Department clarify how an enrollee makes that choice and how the rate development process will recognize that an enrollee may choose a program that has a lower rate to the plan but requires the same services to be provided.

We would also like to better understand how the Department plans to ensure that services in the health homes program are not duplicated given the various efforts and requirements around care coordination and integration across all levels of the managed care program. We are concerned that the Department may assume in the rate development process that plans are already providing many of these services and not properly account for the true cost of implementing a health home in the rates.

**Recommendation: We request a transparent and collaborative process on this issue, similar to what has been established with the optional expansion rates.**

#### Cost Savings Calculations

Another concern is that it will be difficult to determine where the cost savings should be captured or what initiative they will be attributed in situations with overlapping programs and for the dual eligible population. Plans often do not have all of the data (for example behavioral health services beyond mild to moderate are carved out and plans do not have access to that utilization data) and may not be able to show all of the savings that are achieved as the result of the health home. Additionally, for duals the majority of the savings for work being done by the Medi-Cal plan may actually accrue on the Medicare side and Medi-Cal plans will be unable to account for or share in those savings.

Because the health homes program is expected to have no general fund impact it is vital that the expectations for the savings goals and accounting are clearly articulated and agreed to by the plans and the Department prior to implementation. It is especially critical to look carefully at cost savings calculations, since the California Endowment funding is only for two years.

**Recommendation: The Department must provide clarity on how it will calculate the savings associated with the health homes program and how it will address the services that are carved-out of the health plans and may negatively impact the ability of the plan to be effective in health home efforts.**

#### Community Based Care Management Entity (CB-CME)

We would like to further discuss this concept with the Department. We believe that this is an approach that has been used in other states and we appreciate that it is important to build on existing local resources and infrastructure. However, we have several questions about how this will work in California.

The concept paper does not explain how the CB-CMEs will be paid and what responsibility the plan has to pay a specific rate or contract with specific CB-CMEs. It is also not clear how the CB-CMEs will bill the health plans. If they submit an attestation that will provide only limited information and make an evaluation of their impact more difficult; if the CB-CMEs have the ability to submit claims then billing processes and codes will need to be established and in place prior to implementation. We request more detail on how the Department envisions the funds flowing to these entities and what flexibility plans will have in determining their networks and payments.

We also request additional clarification on the situations where a plan can provide these services directly, rather than through a CB-CME. It is not clear what a plan would have to demonstrate in order for the Department to determine that it is unable to build a CB-CME network and must therefore provide the health homes services directly.

There are also significant IT implications and costs associated with implementing the health homes program and there is concern that the current funding arrangements will not be sufficient for the less sophisticated CB-CMEs to achieve the level of integration that will be make this program successful. Does the Department envision providing any start-up funding for plans and CB-CMEs?

**Recommendation: We request that the Department provide a list of the CB-CMEs it believes will be ready and should be part of the health homes program. This will allow plans to build a full service health homes program and identify readiness gaps. The Department should give plans the flexibility to determine if they would like to contract with CB-CMEs or provide the services directly. If a plan does contract with a CB-CME plans should have the ability to negotiate rates with these entities.**

#### Quality Measures/Program Evaluation

Because this is a new program, and it will overlap with many other efforts by the Department and plans, it will be difficult at the start of the program to determine the appropriate quality and outcome measures. The concept paper should be explicit in the requirements it expects plans to meet so that they can be developed in a manner that is both reasonable and attainable.

**Recommendation: We would like to work with the Department to determine the specific measures and outcome data that will be part of the evaluation process. Any measures should recognize the complexity of implementing the health homes model and acknowledge that significant changes in health outcomes will take time.**

We want to thank you again for taking the time to review these comments and recommendations and we look forward to working with you as the concept paper is more fully developed and the this proposal moves forward. Please let me know if you need additional information or would like to discuss any of these items in more detail prior to our meeting on May 19<sup>th</sup>.

Sincerely,

A handwritten signature in black ink, appearing to read "Athena Chapman", with a long horizontal flourish extending to the right.

Athena Chapman  
Director of State Programs

cc:

Mari Cantwell, DHCS  
Sarah Brooks, DHCS  
Brian Hansen, DHCS  
Caroline Davis, LHPC



May 6, 2015

Health Home Program  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, CA 95814

**Re: Comments on the California Concept Paper Version 2.0: Health Homes for Patients with Complex Needs**

Dear Health Home Team:

The California Association of Public Hospitals and Health Systems (CAPH) appreciates the opportunity to submit comments on the *California Department of Health Care Services Health Homes for Patients with Complex Needs Concept Paper Version 2.0*. CAPH represents California's 21 public health care systems, which deliver a comprehensive range of health care services to more than 2.85 million patients annually. They deliver over 10 million outpatient visits each year, provide approximately 30% of all hospital-based care to the state's Medi-Cal population, and serve as the primary care provider for over one half-million newly eligible Medi-Cal enrollees. Public health care systems have long functioned on a medical/health home model of care and operate programs specifically designed to meet the needs of high-risk, high-need patients, such as care management for frequent utilizers, emergency department navigators, care transition and chronic disease self-management support. It is through the lens of this experience and expertise that we offer the following comments.

We appreciate the Department of Health Care Services' (the Department) intent to facilitate several engagement events between now and the anticipated August state plan submission to CMS. We respectfully request that public health care systems be one of the key stakeholder groups represented in the technical workgroup meetings outlined in the concept paper to continue development of the HHP. We hope this process of further engagement will provide clarification regarding some important details about the design of the Health Home Program (HHP) that are not included in the current version of the concept paper. In particular, more detail is needed about the specific payment methodologies and rates that will be provided to participating managed care plans and care management entities, and about the State's plan for sustaining the program beyond the eight quarters of enhanced federal match.

In addition, we greatly appreciate the Department's efforts to ensure that "as the 1115 Waiver development continues... the services that are provided in counties that are also implementing Health Homes are complementary." As strong supporters of statewide and local efforts to promote Whole Person Care, we are particularly interested in the Health Home Program as it relates to these efforts. By implementing the HHP and the Regional Integrated Whole Person Care Pilots outlined in the State's 1115 waiver renewal proposal in a complementary fashion, we have a tremendous opportunity to

leverage the two programs together in order to maximize the impact they will have in improving the health and well-being of high-need Medi-Cal beneficiaries and achieving more efficient and effective use of resources. Like the HHP, the Whole Person Care Pilots seek to provide comprehensive services to Medi-Cal beneficiaries that support each “whole person” through the integration of physical and behavioral health services, along with robust care coordination with social supports, housing, and other services that are critical to holistically and comprehensively addressing the needs of high-risk patients. Considering the likely overlap in eligible populations and services provided under the Whole Person Care Pilots and the HHP, CAPH looks forward to working closely with the Department and other stakeholders to help define the target populations and ensure that counties can benefit from either or both programs.

Lastly, we would like to call your attention to a few provisions in the concept paper that we find particularly important for ensuring program success. We are therefore strongly supportive of efforts to ensure these provisions are fully embraced and upheld in implementation of the HHP.

- **SECTION B5: COMMUNITY BASED CARE MANAGEMENT ENTITY**

We appreciate the Department’s inclusion of specific goals to guide Medi-Cal Managed Care Plans (MCPs) in the Community Based Care Management Entity (CB-CME) network development process. MCP contracting practices and health home reimbursement rates to CB-CMEs should foster the robust participation of safety net providers with experience serving the target population as the program’s core CB-CMEs. Along these lines, we strongly support the following goals from the concept paper:

- *“Ensuring that care management delivery and sufficient health home funding are provided at the point of care in the community.*
- *Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed.*
- *Leveraging existing county and community provider care management infrastructure and experience where possible and appropriate.”*

- **SECTION B6: BENEFICIARY ASSIGNMENT**

While we agree MCPs should be responsible for enrolling eligible beneficiaries, using state-determined, CMS-approved criteria, we strongly support referral as another avenue into the program, and recommend a flexible and simple referral process to ensure providers can easily refer high-need patients into the HHP. For various reasons, including data lags, life changes, and lack of historical data for new enrollees, it will not always be possible to identify high-need patients solely through the data available to the State and MCPs; a user-friendly, expeditious referral process will help fill this gap and ensure that all eligible individuals are given the opportunity to access HHP services and supports.

- **SECTION B7: PAYMENT METHODOLOGIES**

Payments to CB-CMEs should be stratified to fit the needs of the populations served, recognizing that some enrollees will require higher levels of support and resources to serve. We therefore fully support the Department’s intent to implement a tiered payment process, as well as the

enhanced member engagement tier rate. The goal of tier development should be to ensure that payment rates within each tier are adequate to meet the demand for services of the population served within that tier.

- **SECTION C2: CURRENT STATUS OF IMPLEMENTATION**

We appreciate and thank the Department for their decision to allow non-CCI counties to participate in phase one of the HHP. All counties willing and able to implement health homes should be allowed to participate.

Thank you for your continued commitment to improving the Medi-Cal delivery system through health homes. We welcome the opportunity to discuss our comments and work collaboratively with the Department to launch a successful HHP in 2016 that strategically aligns with a renewed 1115 waiver to strengthen California's capacity to care for individuals with complex needs. If you have any additional questions, please do not hesitate to contact our Associate Director of Policy, Allison Homewood, at [ahomewood@caph.org](mailto:ahomewood@caph.org)

Sincerely,



Erica Murray  
President and CEO  
California Association of Public Hospitals and Health Systems

**Comment received via email during comment period.**

Dear DHCS Colleagues:

Thanks for the opportunity to comment on the draft health homes concept paper 2.0. This continues to be an exciting development with great potential to improve the lives of Medi-Cal beneficiaries. I have only minor comments:

-- Family

In several places, family is mentioned. Many homeless people have been estranged from their blood/birth families for many years and may instead have "chosen" family or "street" family. It is important these individuals be included as well, and that participants be able to define their family, which may or may not include relatives.

-- Multi-disciplinary teams

If there are truly six different people playing each of these roles, there may be "too many cooks in the kitchen," when it comes to serving folks who are chronically homeless and who may be slow to trust with providers. A community health worker or lay professional could play more than one of these roles, such as acting as the housing navigator, CHW, and/or care manager.

-- Communication with beneficiaries

There is mention of mailing materials to the homes of beneficiaries, calling them on the phone, etc. Many homeless people do not have phones or mailing addresses. Effectively engaging people who are chronically homeless often requires conducting street outreach, finding people in shelters, parks, under bridges, street corners, wherever they hang out, to develop rapport, help them get ID, enroll them in coverage, help them select a health plan and a primary care provider, travel with them to appointments, and engage them in care. Re-phrasing these bullets as "contacting" beneficiaries would leave the mode of contact flexible enough to include situations in which contact needs to occur in-person, by text, by email/facebook, writing notes on shelter bulletin boards, etc. (while adhering to patient privacy and confidentiality standards).

-- Assignment/enrollment

Would it be possible to give beneficiaries a list upon enrollment of all the CB-CMEs in their area, in case there is a particular organization with which they are already comfortable? Some people access case management and outreach services at multiple organizations based on their needs & geographic location on any given day, and may be auto-assigned to a provider that they sometimes see, but may prefer services somewhere else.

-- Consultation on serving homeless individuals

It is unclear how organizations with experience serving these populations can contribute to the consultation. Please advise.

Thanks again,

Rachel

Rachel McLean, MPH

Viral Hepatitis Prevention Coordinator/

STD Healthcare Policy Analyst

STD Control Branch

California Department of Public Health



May 5, 2015

Jennifer Kent  
Director  
California Department of Health Care Services  
1501 Capitol Avenue  
Sacramento, CA 95814

**SUBJECT: Health Homes for Patients with Complex Needs California Concept Paper 2.0**

Via e-mail: [jennifer.kent@dhcs.ca.gov](mailto:jennifer.kent@dhcs.ca.gov)

Dear Director Kent:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) is pleased to express support for the California Department of Health Care Services' (DHCS) draft concept paper titled, *Health Homes for Patients with Complex Needs (Version 2.0)*. We believe there is a great need to create Medi-Cal health homes to coordinate the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) to treat the whole-person across the lifespan.

CHA appreciates the Department's emphasis in this initiative to implement and spread care models which include coordinated, team-based care for individuals with chronic conditions, with an emphasis on persons with high-costs, high-risks, and high utilization who can benefit most from increased care coordination, resulting in reduced hospitalizations and emergency department visits, improved patient engagement and decreased costs. With DHCS programs now serving over 12 million Medi-Cal members, and as the number of enrollees in Medi-Cal continues to increase, this continued emphasis on coordinated care will help the Department to achieve its mission of providing Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use disorder services, and LTSS.

CHA appreciates DHCS' commitment to ensure sufficient provider infrastructure and capacity to implement the Health Home Program (HHP) as an entitlement program. Hospitals are the first place in which many individuals with chronic conditions seek care. As such, the partnership of hospitals is integral to this initiative's success given their place within the medical neighborhood. Hospitals are leaders in providing core HHP services - comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support, referral to community and social supports and use of health information technology and exchange (HIT/HIE) to link services – and their partnership should be considered essential to the success of this care model.

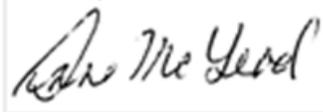
Given the critical role that hospitals have played – and will continue to play – in partnering with local communities to provide coordinated, whole-person care to this medically complex population, CHA appreciates DHCS' inclusion of hospitals as organizations that may be certified as a community-based care management entity (CB-CME), serving as the single entity with overall responsibility for ensuring that an assigned HHP beneficiary receives access to the full range of HHP services. CHA also appreciates

DHCS' stated intent to provide flexibility in how CB-CMEs are organized so that CB-CMEs can best achieve HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient health home funding are provided at the point of care in the community;
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed;
- Leveraging existing county and community provider care management infrastructure and experience where possible and appropriate; and
- Utilizing community health workers in appropriate roles.

CHA commends DHCS for its commitment to improve the health of all Californians; enhance quality, including the patient care experience, in all of its programs; and reduce its per capita health care program costs. We look forward to collaborating with DHCS to promote hospital participation in this initiative and to assist with provider education. If you have any questions, please contact me at (916) 552-7536 or [amcleod@calhospital.org](mailto:amcleod@calhospital.org).

Sincerely,

A handwritten signature in black ink that reads "Anne McLeod". The signature is written in a cursive style and is positioned above a thin horizontal line.

Anne McLeod  
Senior Vice President, Health Policy & Innovation



May 1, 2015

Health Home Program  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, Ca 95814  
[HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov)

Re: Comments on DHCS' Concept Paper Version 2.0 on Health Homes

Dear Health Home Team:

we am writing on behalf of the California Housing Partnership to comment on Concept Paper 2.0 regarding Section 2703 of the Affordable Care Act, the health home option. The California Housing Partnership was created by the State of California in 1988 to provide leadership on affordable housing financing and related policies. Our board is appointed by the Governor and the Legislative leaders.

We appreciate the work of DHCS staff in incorporating supportive housing into the concept paper, and in including housing navigators, tiered payment, and a focus on serving Medi-Cal beneficiaries experiencing homelessness. We support the specific comments and recommendations below for strengthening the concepts for the Health Home Program.

**Section B1: Eligibility & Section B6: Beneficiary Assignment**

Administrative data may accurately identify Medi-Cal beneficiaries incurring high costs, but, because Medi-Cal administrative data does not accurately identify beneficiaries experiencing homelessness, we recommend using a combination of administrative data and a referral process to identify beneficiaries experiencing homelessness. We agree with the list of chronic conditions in the concept paper, and recommend the State narrow by acuity according to hospital use or homelessness. Managed care plans would not be able to identify homeless beneficiaries through administrative data, but a referral process could identify additional criteria administrative data cannot. Additionally, we recommend using existing research data to identify indicators of high costs and poor outcomes among those experiencing homelessness. Data, for example, indicate Medicaid beneficiaries with frequent hospital admissions experiencing homelessness will continue to be admitted to the hospital frequently over time, and will continue to incur high costs.

Regardless of eligibility criteria selected, we recommend a process of referral that allows homeless service, housing, hospital, health center, and homeless service systems refer beneficiaries for potential eligibility, according to eligibility criteria the State adopts.

Finally, we recommend eliminating the requirement that MCPs approve adding beneficiaries to a health home. Waiting for approval could impact a health home's ability to engage homeless beneficiaries. Homeless beneficiaries will have no way of knowing they are eligible for health home services, unless the beneficiary seeks other services or is hospitalized. Potentially eligible homeless beneficiaries often present a

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brief window to engage. Most would be lost to follow-up in waiting for an MCP approval process. For this reason, we recommend establishing a process for receiving referrals from hospitals, homeless service and housing providers, health centers, or a region's homeless service system, for easily verifying eligibility, and for granting health homes serving homeless beneficiaries the ability to approve beneficiaries provisionally. These health homes should get reimbursed a portion of the engagement rate while waiting for final MCP approval.

## **Section B2: Health Home Services**

In the definition of services, we recommend greater emphasis on services that work to engage beneficiaries to achieve and maintain health stability on an ongoing basis. Many of the services identified in the concept paper are provided in supportive housing, and are critical to improving health outcomes. Yet, linking a beneficiary to treatment and to social services alone is insufficient to achieving those outcomes. Improving health among homeless beneficiaries and beneficiaries who are frequent hospital users is contingent on services that engage beneficiaries on an ongoing basis, promote healthy behaviors, and allow for self-management.

To incorporate these concepts into the definitions, we specifically recommend including the following:

- In the definitions of care management and care coordination, engagement services to motivate beneficiaries to collaborate in drafting and executing the Health Action Plan (HAP),
- Regular and ongoing communication, including case conferencing among team members, housing providers, and, when necessary, health providers,
- Transportation to and from appointments,
- Assistance in pursuing healthier behaviors and following treatment regimens,
- Help in obtaining and improving self-management skills to prevent negative health outcomes,
- Assistance in maintaining Medi-Cal,
- Advocacy with health care professionals,
- Accompanying beneficiaries to appointments when needed (including appointments with social service providers),
- Partnerships with organizations offering existing resources a beneficiary requires to improve health outcomes,
- Warm hand-offs to staff at partner organizations, and
- Connections to affordable permanent housing (when the beneficiary is experiencing homelessness).

## **Section B5: Community-Based Care Management Entities (CB-CMEs)**

We recommend allowing MCPs to designate specific health homes as health home predominantly serving beneficiaries experiencing homelessness. We also recommend clarifying MCPs should refer beneficiaries to these designated health homes if the beneficiary is homeless in that geographic area, unless the beneficiary otherwise requests assignment to a different health home.

We recommend allowing MCPs flexibility in contracting with CB-CMEs, rather than requiring an administratively burdensome and difficult process to obtain certification. Alternatively, certification should simply involve ensuring CB-CMEs meet the qualifications outlined in the concept paper.

We also recommend several changes to the duties outlined in the concept paper for CB-CMEs:

- Revising number 7, in assuring the receipt of evidence-based care, to require instead partnering

with and referring beneficiaries to treatment providers offering evidence-based care.

- Eliminating number 12, providing 24-hour, seven days a week information and emergency consultation services, as inconsistent with both the definitions of services included in the concept paper and with the intent of health home services. Since MCPs already offer these services, health homes should not need to.
- Revising number 8 to replace the need for a directory of community partners with partnerships with community partners offering resources in the community.

We recommend further, in health home staff roles, that Community Health Workers not be required to mail health promotion materials.

### **Section B7: Payment Methodologies**

We support DHCS intent to implement a three-tier payment process, as well as the enhanced member engagement tier rate. To ensure consistency, the State should offer MCPs a per member, per month case rate that allows Health Home Programs flexibility in identifying and providing health home services each benefit requires. We further recommend limiting how much an MCP may retain, consistent with other states' state plan amendments, to ensure the vast majority of funding offers services to eligible beneficiaries, rather than administrative process. The health home should be expected to achieve the outcomes the State identifies, and not be expected to expend significant staff time on administration of the health home program required with a fee-for-service type process.

Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. We look forward to engaging further in discussions on strengthening the Health Home Program.

Sincerely,



Matt Schwartz  
President & CEO



Brian Hansen  
Medi-Cal Managed Care Division  
Department of Health Care Services  
1501 Capitol Avenue, MS 4050  
P.O. Box 997413  
Sacramento, CA 95899-7413

May 5, 2015

**Re: CPCA Feedback on Draft Concept Paper 2.0 for Health Homes for Patients with Complex Needs**

Dear Brian,

On behalf of the California Primary Care Association (CPCA) and more than 1,100 not-for-profit community clinics and federally qualified health centers (FQHCs) across California, we thank you for the opportunity to comment on the draft Health Homes for Patients with Complex Needs (HHP) California Concept Paper Version 2.0. CPCA is pleased to see the Department of Healthcare Services (DHCS) continuing to move forward with implementation of the demonstration and are confident that thoughtful design of this program can truly benefit the chronic and complex Medi-Cal patients that our community clinics and health centers (CCHCs) serve. The following comments are organized by page number and based upon lessons learned in other State demonstrations, conversations with our national partners at the National Association of Community Health Centers (NACHC), engagement of Primary Care Associations in other Health Home demonstration states, and the feedback and expertise of our CCHC members.

**Page 6. Recommendations for Eligible Populations**

The Centers for Medicare and Medicaid Services (CMS) requires that the HHP demonstrate cost neutrality within a two-year timeframe. In order to achieve this, enrollment prioritization should target patients whose health status and utilization can be improved by the end of the two year demonstration period through care coordination services as defined in the State Plan Amendment (SPA). Selected program metrics for success should therefore target chronic and complex conditions that can be improved through better care coordination. While we understand that DHCS is still in the process of analyzing which populations would have the highest return on investment if targeted in HHP, we are concerned about the ability of the program to achieve cost savings within a two year time frame under the current structure that DHCS is considering.

**Recommendations:**

- Some of the chronic conditions currently listed, such as chronic renal disease and cancer, may take longer than two years of investment to realize savings. The demonstration should replace those long-term conditions with conditions which have been shown to improve within a short time frame with care coordination. CCHC providers recommend that Hepatitis C and BMI  $\geq$  30 be added to the list of chronic conditions eligible for health home services.
- Some of the disease categories listed (i.e. psychotic disorders) currently overlap with categories eligible for treatment through the county mental health system. DHCS should consider

coordinating with the county mental health plans to ensure no duplicative payments for services are occurring.

#### **Page 7. Tiered Payment Based on Risk & Eligibility Criteria Selection Data Analysis**

CPCA applauds the inclusion of a tiered payment model based on patient acuity, which has proven to be a best practice in health home demonstrations in other states.<sup>1</sup> DHCS has broadly outlined in the draft concept paper that rates will be determined using “historical Medi-Cal data to identify the administrative data elements and criteria that can be used to determine HHP eligibility.” While this is a necessary first step towards developing an appropriate rate, we encourage DHCS to use claims data from the past year rather than relying solely on data from OSHPD and UDS, which only displays data from as recent as two years ago and would not capture the effects of the 2014 Medi-Cal carve-in of mental health services. We recommend DHCS work with the managed care plans to facilitate the inclusion of the most recent claims data.

This is also a prime opportunity for DHCS to include metrics that reflect the impact and importance of social determinants of health (SDOH), including adjustments for behavioral health co-morbidity, homelessness, and for monolingual non-English speakers.<sup>2</sup> SDOH are already measures that can be captured and accounted for through tools available in ICD-10 (See Appendix 1), yet risk stratification under the current managed care organization structure does little to account for the complexity and life circumstances of our patients. The CMS final rule on ICD-10, released in July 2014, requires HIPAA-covered entities to transition to ICD-10 on or after October 1, 2015, meaning that this tool will be available prior to the expected implementation date of the HHP. CPCA recommends that DHCS require providers to track SDOH with the intention that a risk stratification tool that accounts for SDOH be developed and applied to future rates. This will help to ensure that providers receive appropriate rates and that quality care is appropriately incentivized. Further, we encourage DHCS to engage stakeholders in the rate development process to ensure transparency.

Lessons learned from The Redwood Community Health Community Clinics Initiative, which piloted complex care management of Medi-Cal patients with multiple chronic diseases and high resource utilization, included the importance of having the providers embedded in the health home conduct a clinical review post the managed care plan identification of eligible patients. This subsequent review is critical because while managed care plan claims can identify patients with high utilization of emergency services and certain chronic conditions, it does not always capture the patients among that pool that can benefit from increased coordination of care or distinguish inappropriate emergency room use from appropriate utilization. CPCA recommends that DHCS use a similar model of a combined clinical review by a provider in addition to managed care plan claims to determine patient eligibility in the HHP. In addition to reviewing administrative data and criteria to determine HHP eligibility, primary care providers and the staff coordinating the care of these individuals should be included in the technical work groups to finalize the criteria for eligibility.

#### **Recommendations:**

- For rate development, CPCA recommends DHCS coordinate with the managed care plans to use the most recent claims data from the past year.

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<sup>1</sup> <http://governor.nh.gov/commissions-task-forces/medicaid-care/documents/mm-04-03-2014-chcs-medicaid-home.pdf>

<sup>2</sup> See page 48:

[http://www.health.state.mn.us/healthreform/homes/payment/PaymentMethodology\\_March2010.pdf](http://www.health.state.mn.us/healthreform/homes/payment/PaymentMethodology_March2010.pdf)

- Social determinants of health metrics should be captured by providers in the demonstration to inform the development of risk stratification tool for future rates.
- Require managed care plans to work with the health home providers for clinical review of HHP demonstration eligibility in addition to the administrative claims review.

### **Page 8. Comprehensive Care Management**

While current research does not indicate that primary care has a significant impact on palliative care costs over a two year time frame, one area where CCHCs have experienced success relating to palliative care is in the area of Advanced Directives and/or Physician Orders for Life-Sustaining Treatment (POLST) forms. This is a natural role for primary care and could have significant impacts on improved patient care coordination.<sup>3</sup> Rather than adding a requirement for new lines of service that have not traditionally been a role of the health home entities, CPCA recommends that DHCS consider improving the use of Advanced Directives and POLST forms to help build the foundation for improved palliative care delivery throughout the State.

#### **Recommendations:**

- DHCS should build the foundation for improved palliative care delivery through strengthening the services appropriate and feasible for the primary care setting that can lead to improved patient outcomes in a two year timeframe, through improved use of resources such as Advanced Directives and POLST forms.
- DHCS should avoid adding palliative care itself as a requirement for HHP participation.

### **Page 9. Comprehensive Transitional Care**

Evaluations of health home pilots in New York focusing on Medicaid patients with chronic and complex conditions found that the requirement that projects execute a prescribed memorandum of understanding (MOU) with hospitals before sharing patient information with partners made it difficult for some projects to convert existing relationships into formal ones. However, hospital participation in the network was a critical factor in the success or failure of these programs, as Health Home networks without the participation or cooperation of a hospital were less likely to be successful in catching patients that ended up in the emergency room and redirecting them to their primary care health home.<sup>4</sup> It is therefore critical to ensure that hospitals participate and that MOU requirements are as streamlined as possible to ensure they do not serve as a barrier to participation and care coordination. Additionally, because the Affordable Care Act's Medicare's Hospital Readmissions Reduction Program (HRRP) penalizes hospitals with excess 30-day readmissions that could be avoided with improved post-discharge planning and care coordination, hospitals have a significant incentive to participate as part of the HHP. Conversations with Primary Care Associations (PCAs) that have participated in Section 2703 demonstrations in other states encouraged that protocols and legal agreements for patient data transfer and information sharing be in place between entities participating in the network prior to the commencement of the demonstration in order to ensure that timely notification of beneficiary admittance to and discharge from the hospital and other high cost settings can occur.

#### **Recommendations:**

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<sup>3</sup> <http://www.chcf.org/articles/2015/02/polst-registry>

<sup>4</sup> [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2478745](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2478745)

- Flexible MOU arrangements to allow for meaningful participation of hospitals in the HHP is critical to ensuring that care management entities receive timely notification of HHP beneficiary hospital utilization.
- Protocols and legal agreements pertaining to patient sharing of information should be in place prior to the commencement of the HHP in California.

**Page 10. HHP Network Infrastructure**

Patient-centered health homes are not a novel concept for safety-net clinics and the majority of CPCA’s membership are already engaged in activities that provide the building blocks for successful HHP implementation. Given that a majority of our CCHC patients are Medi-Cal eligible, safety net clinics have extensive experience with low-income, high-need populations. HHP offers the potential resources and incentives to focus, integrate, and scale these activities while achieving cost savings and improved health outcomes.

**Recommendations:**

- In addition to the metrics for readiness from the Coordinated Care Initiative (CCI), CPCA recommends that DHCS consider the following criteria for participation in the HHP demonstration:

**1. Health Home experience with high-risk populations:** Many safety net clinics have achieved recognition from national entities and have participated in statewide initiatives that have explicit or implicit health home components (e.g., empanelment of patients, team based care). Over 300 safety net clinic sites in California have received health home recognition from an external certifying body and safety net clinics in all 58 counties in the state have participated in funded initiatives that required health home capacity building.

**Sources of Measurement for DHCS to consider:** National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) recognition level 1-3; Joint Commission on Accreditation of Healthcare Organizations (JCAHO certification), Accreditation Association for Ambulatory Health Care (AAAHC) certification, Center for Care Innovation grantees, Low-Income Health Program (LIHP) participation, Achieved Delivery System Reform Incentive Payments (DSRIP) "health home" goal.

**2. Behavioral Health Integration:** Integration of primary care and behavioral health has been a focal point of 2703 demonstrations in other states and makes sense for California given the high prevalence of behavioral health conditions among populations that also suffer from multiple chronic conditions. Over 45% of safety-net clinics have behavioral health full time equivalents (FTE) on staff and more than 50 safety net clinics have received additional federal funding to integrate behavioral health and primary care infrastructure and build capacity.

**Sources of Measurement for DHCS to consider:** FTE for behavioral health staff; managed care claims data; DHCS claims for codes 11, 12, 13; Health Resources and Services Administration (HRSA) Health Center Program: Behavioral Health Integration; Substance Abuse and Mental Health Services Administration (SAMHSA) primary and behavioral health grantees; County Medical Services Program Behavioral Health pilot sites.

**3. Serving the Eligible Target Population:** In order to achieve the goals of a 2703 health home, an organization will need to have existing patients who meet the criteria for the target population. Having a high percentage of patients who meet the target population criteria also means that an organization is more likely to be oriented toward and have the experience required to serve that population (e.g., staff training and capacity, relationships with relevant social service providers).

FQHCs see approximately two-thirds of all primary care Medi-Cal visits in the state and over 50% of CPCA network clinic patients are Medi-Cal beneficiaries.

**Sources of Measurement for DHCS to consider:** DHCS utilization data; Uniform Data System (UDS) reporting.

**4. Strong relationships with service-delivery and community partners:** HHP success will be bolstered by strong relationships with other health service delivery organizations, including clinical providers, hospitals, and community partners. These relationships are instrumental in coordinating approaches that address the social needs that underlie and/or exacerbate health conditions.

**Sources of Measurement for DHCS to consider:** Existing Memorandums of Understanding (MOUs) and relationships with community partners.

**5. Electronic Medical Records (EMR) to track patient utilization:** Effective systems for tracking patients would serve to support HHP implementation by monitoring and evaluating care coordination and case management, utilization and health status, and referral efficiency.

**Sources of Measurement for DHCS to consider:** DHCS EMR data; California Health Information Partnership & Services Organization (CalHIPSO) Meaningful Use attestations

**6. Payment Reform Readiness:** The CPCA payment reform demonstration requires that clinics meet readiness criteria as a condition of participation. This readiness criteria positions safety net clinics to operate effectively in a capitated environment and could be cross-walked with the needs of the HHP demonstration. Over 90 county and community sites across 17 counties have volunteered to be part of the CPCA Alternative Payment Methodology (APM) demonstration. Payment reform creates flexibility to use FQHC base payments to deliver care in innovative ways and would complement the additional resources for care coordination beyond the walls of the clinic provided from HHP.

**Sources of Measurement for DHCS to consider:** CPCA APM Pilot Participation.

### **Page 13. Community Based Care Management Entity Criteria (CB-CME)**

Lessons learned from programs for chronic and complex conditions in other states included care management as being most effective when “anchored in the practices where patients receive their care.”<sup>5</sup> We were therefore pleased to see that DHCS recognizes the importance of health home services being delivered at the provider level. In programs focusing on the Medicare populations, those in which care managers have “direct, in-person with patients and their physicians reduced expenditures by 7%, whereas those in which payer-based or third party care managers interacted with patients via telephone had no effect.”<sup>6</sup> The draft Concept 2 paper mentions that the criteria for CB-CME selection will be determined through MCP technical work groups at a later date. CPCA strongly recommends the inclusion of community clinic and health center representatives in these technical work groups in addition to participation by the MCPs, as providers have experience with the patient populations and can speak to the current barriers that could be addressed through improved care coordination. There are currently a broad range of entities included as CB-CMEs and each of these entities comes with a unique financing structure and differing levels of experience with MCPs. Technical work groups should consist of the representatives from the provider community that will be engaged in HHP in order to ensure that the program wraps around clinical practices and does not duplicate existing infrastructure.

### **Recommendations:**

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<sup>5</sup> <http://jama.jamanetwork.com/article.aspx?articleid=2099528>

<sup>6</sup> <http://jama.jamanetwork.com/article.aspx?articleid=2099528>

- Include representation of community clinics and health centers in the HHP technical work groups in addition to representation from DHCS and the managed care plans.

#### **Page 15. Duties**

The draft HHP concept paper currently lists the provision of 24-hour/seven days a week availability of information and emergency consultation services to HHP beneficiaries, in coordination with the HHP beneficiary's MCP nurse advice line, as a CB-CME duty. CPCA encourages DHCS to be flexible in its definition of 24-hour availability for this requirement, as most CCHCs will be able to address the requirement for 24/7 coverage by using some combination of more intensive availability during clinic hours (i.e. care coordinator with cell phone access) and leveraging the health center on-call systems for off hours.

#### **Recommendations:**

- Allow for flexibility in CB-CME criteria for 24-hour availability of information and emergency consultation services available to HHP beneficiaries.

#### **Page 16. Multi-Disciplinary Health Home Team Qualifications and Roles**

In the final Medicare PPS regulation that was published last spring, CMS clearly articulates that care coordination services are not paid to health centers as a part of the Medicare PPS rate. Since the services covered under the Medicaid PPS link back to the definition of Medicare FQHC services, this is clear evidence that CMS does not think that FQHCs are being paid for these services as a part of their bundle of PPS eligible FQHC services.<sup>7</sup> From discussions with other Primary Care Associations, a best practice for ensuring that the PMPM health home services remained separate from FQHC PPS rates was to tie the PMPM payment for services to those performed by members of the health home team, such as those listed on pages 16-17 that are not currently supported in a PPS rate. The payment methodology should be developed to support and strengthen services provided by the CCHCs while ensuring that duplicative payment does not occur.

#### **Recommendation:**

- CMS has clearly articulated that HHP services are services that go beyond what is currently paid for through PPS. DHCS should therefore work with CPCA on a payment methodology for HHP that supports and strengthens services provided by the CCHCs while ensuring that duplicative payment does not occur and that FQHCs can participate in the health home network.

#### **Page 17. Community Health Workers and Other Health Home Providers**

CPCA was pleased to see the emphasis on community health workers (CHWs) as part of the health home demonstration. Since CHWs tend not to have standardized training, we recommend that DHCS develop training resources, under the guidance of the technical work groups, to help CB-CMEs with recruiting and integrating CHW team members. Health Home demonstrations from other States, such as New York, have already developed extensive recommendations for the effective use of CHWs as part of the health home team, which could easily be adapted to a California version of the demonstration.<sup>8</sup> In addition to further refining the role of CHWs in the demonstration, CPCA highly recommends that pharmacists be included as a member of the multi-disciplinary team, since medication management and adherence will be a key component in the success of improved patient care coordination.

#### **Recommendations**

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<sup>7</sup> <http://www.gpo.gov/fdsys/pkg/FR-2014-05-02/html/2014-09908.htm>

<sup>8</sup> See Page 8: <http://nyshealthfoundation.org/uploads/resources/making-the-connection-community-health-workers-sept-2012.pdf>

- Use the guidance and expertise of the technical workgroups to develop standardized resources for training and integrating CHW team members into the HHP care team.
- Include pharmacists as a member of the multi-disciplinary health home team.

### **Page 18. Beneficiary Assignment**

Under the current draft proposal, MCPs are expected to link enrolled HHP beneficiaries to the program through a mailed letter that will explain the HHP and give the beneficiary information on opting out of the program. CPCA is very concerned with this approach, namely because the program focuses on individuals with chronic and complex conditions, with a special emphasis on homeless populations. Relying on a mail campaign to inform beneficiaries about the program is clearly not the best way to engage the homeless. We encourage the Department to work with homeless and housing advocates to develop a unique plan of action to ensure that outreach and engagement of these populations is effective. CPCA encourages DHCS to use lessons learned from the New York demonstration, which also included a strong emphasis on homeless populations, in the development of this outreach and engagement effort.<sup>9</sup>

We recommend that DHCS consider the lessons learned from the Pacific Business Group on Health’s Intensive Outpatient Care Program (IOCP) model, which found that it took, on average, 5-6 conversations to enroll a patient into the program, with several of those contacts taking place outside the provider setting. We encourage the Department to work closely with providers and MCPs on a marketing strategy appropriate for the target population chosen to avoid the problems with program opt-out that occurred in the CCI demonstration, which had an enrollment strategy similar to that described for HHP.

### **Recommendations:**

- Work with HHP stakeholders to develop outreach and engagement tools appropriate for the patient populations targeted in HHP.
- Use lessons learned from the CCI program to avoid high rates of program opt-out.

### **Page 19. Payment Methodologies**

We were encouraged to see that DHCS has incorporated our recommendations for a tiered payment system into the current draft and applaud DHCS’ incorporation of a “member engagement tier” to help offset the costs associated with the initial roll out of the program. We believe that this will be a great step in ensuring that rates are appropriate for the populations served and that the demonstration has a high level of participation. Primary care providers will be the key to successful coordination of HHP patients and to ensuring that cost savings is achieved by the end of the two year demonstration. Because CCHCs will be doing the heavy lifting required to make the program a success, we urge DHCS to consider developing safeguards to ensure that the bulk of the PMPM funding available for the demonstration flows towards supporting direct care coordination for the patients at the health home level. New York’s health home demonstration, for example, limited managed care plans to a 3% withholding of payments for program administration and evaluation.<sup>10</sup>

As mentioned earlier, health home services are by CMS definition not services that are currently available through the Medi-Cal program and thus, should not be included as part of FQHC annual reconciliation. CPCA is willing to work with DHCS staff to develop processes to ensure that payments to support the HHP

<sup>9</sup> <http://nyshealthfoundation.org/uploads/resources/chcs-health-homes-outreach-report-april-2014-1.pdf>

<sup>10</sup> [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/questions\\_and\\_answers.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm)

are kept separate from the reconciliation process for FQHCs and to assure the Department and CMS that duplicative payment is not occurring in the program.

**Recommendations:**

- Ensure that the bulk of HHP payments directly benefit patient care by capping the amount that can be withheld by MCPs for administrative purposes.
- Work with CPCA to develop a process to ensure that the HHP PMPM is excluded from the PPS reconciliation process, since these payments are separate and distinct from the PPS rate.

CPCA will continue to work closely with DHCS and other stakeholders in the health home network to ensure that the HHP is successfully implemented as a benefit for Medi-Cal members. We look forward to continuing to partner with DHCS and other stakeholders in this process as this program is further refined. For questions or clarifications relating to the comments above, please contact Erynne Jones, Associate Director of Policy at CPCA ([ejones@cpc.org](mailto:ejones@cpc.org)), and she'd be happy to assist you.

Thank you,



Carmela Castellano-Garcia, Esq.

President and CEO, California Primary Care Association

## Appendix Item 1: ICD-10 Chapter XXI: Factors influencing health status and contact with health services (Z00-Z99)

### (Z55-Z65) Persons with potential health hazards related to socioeconomic and psychosocial circumstances

Code category	Specific	Notes
<b>Z55 Problems related to education and literacy</b>	<ul style="list-style-type: none"> <li>Z55.0 Illiteracy and low-level literacy</li> <li>Z55.1 Schooling unavailable and unattainable</li> <li>Z55.2 Failed school examinations</li> <li>Z55.3 Underachievement in school</li> <li>Z55.4 Educational maladjustment and discord with teachers and classmates</li> <li>Z55.8 Other problems related to education and literacy</li> <li>Z55.9 Problems related to education and literacy, unspecified</li> </ul>	
<b>Z56 Problems related to employment and unemployment</b>	<ul style="list-style-type: none"> <li>Z56.0 Unemployment, unspecified</li> <li>Z56.1 Change of job</li> <li>Z56.2 Threat of job loss</li> <li>Z56.3 Stressful work schedule</li> <li>Z56.4 Discord with boss and workmates</li> <li>Z56.5 Uncongenial work environment</li> <li>Z56.6 Other physical and mental strain related to work</li> <li>Z56.8 Other problems related to employment                             <ul style="list-style-type: none"> <li>Z56.81 Sexual harassment on the job</li> <li>Z56.82 Military deployment status</li> <li>Z56.89 Other problems related to employment</li> </ul> </li> <li>Z56.9 Unspecified problems related to employment</li> </ul>	
<b>Z57 Occupational exposure to risk factors</b>	<ul style="list-style-type: none"> <li>Z57.0 Occupational exposure to noise</li> <li>Z57.1 Occupational exposure to radiation</li> <li>Z57.2 Occupational exposure to dust</li> <li>Z57.3 Occupational exposure to other air contaminants                             <ul style="list-style-type: none"> <li>Z57.31 Occupational exposure to environmental tobacco smoke</li> <li>Z57.39 Occupational exposure to other air contaminants</li> </ul> </li> <li>Z57.4 Occupational exposure to toxic agents in agriculture</li> <li>Z57.5 Occupational exposure to toxic agents in other industries</li> <li>Z57.6 Occupational exposure to extreme temperature</li> <li>Z57.7 Occupational exposure to vibration</li> <li>Z57.8 Occupational exposure to other risk-factors</li> <li>Z57.9 Occupational exposure to unspecified risk-factor</li> </ul>	
<b>Z58 Problems related to physical environment</b>	<ul style="list-style-type: none"> <li>Z58.0 Exposure to noise</li> <li>Z58.1 Exposure to air pollution</li> <li>Z58.2 Exposure to water pollution</li> <li>Z58.3 Exposure to soil pollution</li> <li>Z58.4 Exposure to radiation</li> <li>Z58.5 Exposure to other pollution</li> <li>Z58.6 Inadequate drinking-water supply</li> <li>Z58.8 Other problems related to physical environment</li> <li>Z58.9 Problem related to physical environment, unspecified</li> </ul>	

Code category	Specific	Notes
<b>Z59 Problems related to housing and economic circumstances</b>	Z59.0 Homelessness Z59.1 Inadequate housing Z59.2 Discord with neighbors, lodgers and landlord Z59.3 Problems related to living in residential institution Z59.4 Lack of adequate food and safe drinking water Z59.5 Extreme poverty Z59.6 Low income Z59.7 Insufficient social insurance and welfare support Z59.8 Other problems related to housing and economic circumstances Z59.9 Problem related to housing and economic circumstances, unspecified	
<b>Z60 Problems related to social environment</b>	Z60.0 Problems of adjustment to life-cycle transitions Z60.2 Problems related to living alone Z60.3 Acculturation difficulty Z60.4 Social exclusion and rejection Z60.5 Target of (perceived) adverse discrimination and persecution Z60.8 Other problems related to social environment Z60.9 Problem related to social environment, unspecified	
<b>Z61 Problems related to negative life events in childhood</b>	Z61.0 Loss of love relationship in childhood Z61.1 Removal from home in childhood Z61.2 Altered pattern of family relationships in childhood Z61.3 Events resulting in loss of self-esteem in childhood Z61.4 Problems related to alleged sexual abuse of child by person within primary support group Z61.5 Problems related to alleged sexual abuse of child by person outside primary support group Z61.6 Problems related to alleged physical abuse of child Z61.7 Personal frightening experience in childhood Z61.8 Other negative life events in childhood Z61.9 Negative life event in childhood, unspecified	

Code category	Specific	Notes
<b>Z62 Problems related to upbringing</b>	Z62.0 Inadequate parental supervision and control Z62.1 Parental overprotection Z62.2 Upbringing away from parents Z62.21 Child in welfare custody Z62.22 Institutional upbringing Z62.29 Other upbringing away from parents Z62.3 Hostility towards and scapegoating of child Z62.6 Inappropriate (excessive) parental pressure Z62.8 Other specified problems related to upbringing Z62.81 Personal history of abuse in childhood Z62.810 Personal history of physical and sexual abuse in childhood Z62.811 Personal history of psychological abuse in childhood Z62.812 Personal history of neglect in childhood Z62.819 Personal history of unspecified abuse in childhood Z62.82 Parent-child conflict Z62.820 Parent-biological child conflict Z62.821 Parent-adopted child conflict Z62.822 Parent-foster child conflict Z62.89 Other specified problems related to upbringing Z62.890 Parent-child estrangement NEC Z62.891 Sibling rivalry Z62.898 Other specified problems related to upbringing Z62.9 Problem related to upbringing, unspecified	
<b>Z63 Other problems related to primary support group, including family circumstances</b>	Z63.0 Problems in relationship with spouse or partner Z63.1 Problems in relationship with in-laws Z63.3 Absence of family member Z63.31 ..... due to military deployment Z63.32 Other absence of family member Z63.4 Disappearance and death of family member Z63.5 Disruption of family by separation and divorce Z63.6 Dependent relative needing care at home Z63.7 Other stressful life events affecting family and household Z63.71 Stress on family due to return of family member from military deployment Z63.72 Alcoholism and drug addiction in family Z63.79 Other stressful life events affecting family and household Z63.8 Other specified problems related to primary support group Z63.9 Problem related to primary support group, unspecified	
<b>Z64 Problems related to certain psychosocial circumstances</b>	Z64.0 Problems related to unwanted pregnancy Z64.1 Problems related to multiparity Z64.4 Discord with counselors	
<b>Z65 Problems related to other psychosocial circumstance</b>	Z65.0 Conviction in civil and criminal proceedings without imprisonment Z65.1 Imprisonment and other incarceration Z65.2 Problems related to release from prison Z65.3 Problems related to other legal circumstances Z65.4 Victim of crime and terrorism Z65.5 Exposure to disaster, war and other hostilities Z65.8 Other specified problems related to psychosocial circumstances Z65.9 Problem related to unspecified psychosocial circumstances	



May 14, 2015

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**Re: Comments on the Health Homes for Patients with Complex Needs - California Concept Paper Version 2.0**

Dear Director Kent:

The California State Association of Counties (CSAC), representing California's 58 counties, is writing to provide formal comments on the April 10, 2015 California Health Homes for Patients with Complex Needs (HHPCN) concept paper version 2.0. We appreciate the opportunity to weigh in during the infancy of this program and appreciate the Department of Health Care Services' (DHCS) efforts to have a robust stakeholder engagement process.

Counties would like to offer the following comments for your consideration:

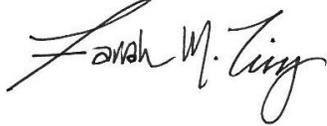
**Medicaid Section 1115 Waiver Renewal.** While the concept paper acknowledges that there are a number of proposals in the Medicaid Section 1115 Waiver renewal that complement the HHPCN proposal, CSAC is particularly interested in the Waiver Renewal's Whole Person Care (WPC) Pilots – which counties strongly support. Counties believe that both the WPC pilots and the HHPCN should be constructed in a manner that maximizes resources and improves the well-being of these high-need patients. Similar to the HHPCN, the WPC pilots are intended to provide comprehensive services to a Medi-Cal beneficiary through the coordination of health, behavioral health and social services and supports. CSAC looks forward to working with DHCS and other interested stakeholders to ensure that these programs are complementary and beneficial to those we serve.

**Financing.** CSAC acknowledges the need for additional details beyond those currently included in the concept paper. Counties recognize that costs associated with treating patients may vary based on their acuity and support the use of a tiered methodology. However, we look forward to additional details regarding tiered rates and payments for those participating in the health home infrastructure, including managed care plans and community-based care management entities. Counties are also interested in the fiscal sustainability beyond the eight-quarter enhanced match period and look forward to learning more as the proposal is further developed.

**Stakeholder Process.** CSAC would like to commend DHCS on their attention to the stakeholder engagement process. We respectfully request to be included in the technical workgroups to further develop the HHPCN proposal.

Thank you once again for the opportunity to provide comments regarding the second iteration of the HHPCN concept paper. Should you have any concerns regarding our comments, please feel free to contact me at (916) 650-8110 or [fmcdaid@counties.org](mailto:fmcdaid@counties.org). Thank you.

Sincerely,

A handwritten signature in black ink that reads "Farrah M. Ting". The signature is written in a cursive style with a large, sweeping initial "F".

Farrah McDaid Ting  
Legislative Representative

May 6, 2015

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LOS ANGELES SACRAMENTO

## **Re: Health Homes for Patients with Complex Needs (HHPCN) California Concept Paper (4/10/15 draft)**

Dear Brian and Bob,

Children Now has been developing policy recommendations on how health homes might best serve California's children and families in a number of contexts, including the release of *Child-Centered Health Homes in California: An Opportunity to Better Coordinate Care and Improve Outcomes for the State's Most Vulnerable Kids*, co-leading the Let's Get Healthy California Healthy Beginnings Work Group, and contributing to implementation of AB 361 (Chapter 642, Statutes of 2013). We recently participated in the DHCS Health Homes Webinar that presented a draft "Health Homes for Patients with Complex Needs (HHPCN) California Concept Paper Version 2.0" ("concept paper"). We appreciate many of the changes that have been incorporated in this updated version of the concept paper and would like to take the opportunity to comment on the paper and the importance of serving California's children through the state's Health Home Program (HHP).

**Triple Aim and program evaluation.** The concept paper includes the Triple Aim of better care, better health, and lower costs as the overarching goal of California's Health Home Program (p.4), and impact on the Triple Aim as a primary goal of the program evaluation (p.25). We support the use of the Triple Aim as an overarching framework for the health homes concept, as well as the particular attention given to the goals of improved health outcomes and lower costs, as these are critical for the ultimate success and sustainability of the Health Home Program. To achieve these goals and the additional stated goals of tracking state-specific quality measures related to health home service delivery and leveraging existing managed care evaluation tools (p.20), we urge that DHCS adopt the following reporting requirements from the External Quality Review Organization (EQRO) audited Healthcare Effectiveness Data and Information Set (HEDIS) measures that have been reported on the DHCS Medi-Cal Managed Care Performance Dashboard:

- WCC – Weight assessment and counseling for nutrition and physical activities for children and adolescents (related to the Adult Body Mass Index (BMI) Assessment measure included in the CMS Health Home Recommended Core Measures, Table 1, p.21); and
- MMA – Medication Management for people with asthma (assuming that asthma is retained as an eligible chronic condition).

When possible – e.g., MMA and AMB (Ambulatory Care, included in Table 2, p.21) – we urge that data be stratified by age to help assess how health homes are serving different subsets of the patient population and provide the basis, if needed, for targeted quality improvement measures. We believe that it is also important to measure the patient experience, and suggest that DHCS consider items on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan survey 5.0H (e.g., coordination of care and shared decision making).

**Eligible populations.** Children Now recognizes that DHCS is conducting feasibility studies to select the chronic conditions upon which health homes eligibility will be based. The list of physical and behavioral health conditions being considered (p.7) includes asthma, diabetes, cognitive disorders, and major depressive disorders, which we believe are critical for targeting pediatric populations who could benefit the most from the benefits provided by health homes. We believe that cognitive disorders would be more appropriately included under behavioral health, as per the first version of the concept paper. Children Now particularly appreciates the inclusion of Trauma and Stressor-Related Disorders, given the myriad of long-term, costly health effects of toxic stress caused by childhood trauma, adverse childhood experiences, and homelessness. New York is currently negotiating with the Centers for Medicare and Medicaid Services to better serve children by including trauma itself as a chronic condition in its health home plan, and we urge DHCS to consider a similar approach. We believe that the list of chronic conditions under consideration should also include developmental disabilities and autism spectrum disorders (e.g., see Maine and Missouri’s approved health home State Plan Amendments (SPAs)), fetal alcohol syndrome, and neonatal withdrawal symptoms from maternal use of drugs, so as to capture individuals with severe and costly chronic conditions that benefit from early coordination and interventions that health homes could enable. We look forward to learning more about how DHCS plans to further specify eligible conditions and acuity levels, and urge that an inclusive approach be taken in analyzing targeted conditions, risk assessments, and administrative utilization data. We appreciate that the department plans to make available the data and processes used to develop the eligibility criteria (p.8) and urge the inclusion of age as a demographic element to be reported.

**Definition of homelessness.** Section 2703 of the Affordable Care Act provides states with tremendous opportunities to provide more holistic, coordinated care to patients with complex care needs. Children Now appreciates the department’s focus on serving persons with high costs, high risks, and high utilization. Given that a significant part of the aim of health homes as determined by Section 2703 of the Affordable Care Act is to expand beyond the medical model to address social determinants of health, we believe that health homes could be particularly valuable for eligible children and youth with the most social instability as well as those with the most complex health needs, including those who are homeless, in or at risk of entering the child welfare system, and youth on juvenile probation. We appreciate the attention paid to individuals experiencing homelessness in the concept paper, and recommend that DHCS specify that the definition of homelessness from the McKinney-Vento Homeless Assistance Act be used in order to capture all

eligible individuals whose housing instability is likely to be a barrier to achieving health stability instead of a more restrictive definition.

**Trauma-informed care.** Given the focus on individuals experiencing homelessness as well as the possible inclusion of individuals with Trauma and Stressor-Related Disorders, it is critical that care is delivered using a trauma-informed approach. We recommend that DHCS requires participating providers to adopt the concept developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), i.e., “A program, organization, or system that is trauma-informed: 1. Realizes the widespread impact of trauma and understands potential paths for recovery; 2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and 4. Seeks to actively resist re-traumatization” (<http://www.samhsa.gov/nctic/trauma-interventions>). We appreciate that the concept paper includes trauma-informed care practices as part of the role of a Dedicated Care Manager (p.16). We recommend that this suggestion be made a requirement by changing “Use tools like...trauma informed care practices” to “Use trauma informed care practices,” and to include this requirement for all members of multi-disciplinary health home teams who may interact with beneficiaries. We further recommend that the trauma-informed approach be noted in the concept paper in the definition of Comprehensive Care Management (p.8), as it is particularly important to properly assess enrollee needs and risks during the development of comprehensive, individualized care plans, or Health Action Plans. Feedback on incorporating a trauma-informed approach into California’s HHP, including applicable lessons from other states, should be solicited during the required consult with SAMHSA (p.23), and trauma-informed approaches should be incorporated as a part of the technical assistance available to health home network providers (p.24).

**Enrolling eligible foster youth.** Current and former foster youth may benefit from health homes given their high rates of physical and behavioral health care needs resulting from childhood abuse, neglect, and trauma. But consideration needs to be given as to how to include these youth, who tend to be highly mobile, in health homes while ensuring they continue to have the option to choose Fee-For-Service Medi-Cal. We appreciate that DHCS acknowledges that “Fee-For-Service (FFS) Beneficiaries who meet HHP eligibility criteria will have the choice to enroll in Managed Care to receive their HHP services” (p.10). However, we request further clarification on the beneficiary assignment process (p. 18) for HHP eligible individuals enrolled in FFS. Specifically, we request an explicit statement that FFS beneficiaries eligible for HHP will not be dis-enrolled from FFS Medi-Cal and enrolled in managed care without their informed and affirmative consent. Additionally, we recommend further details regarding the process by which FFS Medi-Cal Beneficiaries will be informed of their HHP eligibility and provided information on how they can either (1) opt in to Managed Care to access HHP services or (2) receive HHP services while remaining in FFS. These further details are necessary because the section on Beneficiary Assignment (p.18) states that MCPs will enroll eligible beneficiaries and send a letter providing an opportunity to opt out of the HHP. No information applicable to FFS Beneficiaries is currently provided in this section. Finally, efforts should be made to engage foster youth stakeholders and create synergies to ensure HHP services are aligned with and complementary to services provided through other initiatives impacting foster youth. For example, some youth eligible for HHP services may also be eligible for and receiving intensive care coordination or targeted case management through other initiatives, such as implementation of the Katie A. settlement.

**Community-Based Care Management Entities.** The concept paper specifies that a health home network include one or more Community-Based Care Management Entities (CBCME), which will contract with a qualifying Medi-Cal Managed Care plan to provide core health homes services. We appreciate that the concept paper has been updated from the previous version to include more entities eligible for CBCME status, and suggest the additional inclusion of child welfare agencies that provide health coordination and referral follow-up, among other services, through the Health Care Program for Children in Foster Care. CBCMEs are tasked with supporting enrollees and families during discharge from hospital and institutional settings, including the provision of evidence-based transition planning (p. 15). CBCMEs should also provide support during other transitions that eligible individuals may encounter, including the transition to and from transitional or group housing and from pediatric to adult providers.

**Social determinants of health.** We appreciate that CBCMEs are not only required to manage referrals, coordination, and follow-up to needed services and supports, but also to actively maintain a directory of community partners for referrals (p.15). We suggest that additional specificity be added to the referral process (e.g., warm handoffs) and that community partner directories be made readily available to enrollees through both printed materials and CBCME websites. We also appreciate the explicit reference to specific community and social supports, i.e., “housing, food and nutrition, employment, child care, community-based LTSS, school and faith-based services, and disability services” (p.9). We additionally recommend the inclusion of transportation services and rape and other trauma services. Similar to how the Triple Aim is incorporated into the concept paper, we recommend that the social determinants of health concept be further embraced and explicitly referenced (beyond existing references on pp.7,8), e.g., under Guiding Principles (pp.4-6), in the definition of Referral to Community and Social Support (p.9; e.g., “Community and social supports *address the social determinants of health and* include, but are not limited to...”), and under HHP Network Infrastructure (pp.10-11; e.g., “Improving beneficiary outcomes by coordinating...social support need that address the social determinants of health.”

**Inclusive health homes teams.** The concept paper specifies HHP Network Infrastructure, and specifically, the role of community health workers (pp.17-18). Given that youth exiting foster care and juvenile probation are at very high risk for homelessness, and that the majority of homeless youth in transitional housing are still in school, we recommend that this potential need be acknowledged, e.g., “Additional team members, such as a pharmacist or nutritionist, *or a community health worker with experience in the child welfare, juvenile justice, or public education system*, may be included...” To allow for flexible health home teams, DHCS should additionally consider adding inclusive definitional language such as the language included in Idaho’s health home SPA: the state “anticipates family members and other support involved in the patient’s care to be identified and included in the plan and executed as requested by the patient.” Beneficiaries and their family members or other chosen representatives should be active participants in their care planning. We therefore recommend changing the definition of Care Coordination and Health Promotion (p.9) to reflect an active role, i.e., “...sharing options with the HHP beneficiary...” should be changed to “...*discussing* options...” and “...providing information to the HHP beneficiary...” should be changed to “...*discussing* information *with* the HHP beneficiary...”

**Stakeholder engagement process.** Children Now appreciates that DHCS further elaborated its stakeholder engagement process from the initial version of the concept paper. We believe that organizations and individuals providing written comments to the concept paper or any future solicitation should be able to opt into having their comments made available to the public on a

DHCS webpage. Currently, multiple webpages are devoted to the Health Home Program, e.g., one for the version 1.0 of the concept paper and one for version 2.0. These pages should be accessible from an overarching webpage devoted to California's ACA Section 2703 health homes proposal that should also include any other relevant information, e.g., fiscal, utilization, or other analyses that are used to inform the department's decisions about how eligibility will be determined. Relevant information and links should also be provided for existing Medi-Cal programs that may interact with the Health Home Program. We recognize that details of how programs may interact – and how stakeholder processes affecting the development of programs may interact – require further explanation, and request that this section (p.21-22) include the California Children's Services (CCS) Program. Finally, we believe the stakeholder engagement process would be facilitated by a consolidation of the Guiding Principles (pp.4-6), which currently include the Triple Aim, six policy goals from the Let's Get Healthy California and State Health Care Innovation Plan efforts, five objectives for the implementation of the HHP, and two additional goals.

**Timeline.** DHCS has outlined an aggressive timeline for implementing the state's Health Home Program (p.23). We are concerned that this timeline will not allow enough time for the development of robust health home networks with sufficient network adequacy to meet the needs of the eligible individuals who will be automatically enrolled. We recognize the department's emphasis on determining county readiness (p.24) and urge a conservative approach to initiating implementation given the desire to 1) maximize the benefits of health homes to eligible individuals during the time-limited period of enhanced federal funding for health home services, and 2) create a program that will be demonstrably cost neutral and thus sustainable beyond the period of enhanced federal match. We additionally request that similar attention be paid to ongoing health home network adequacy beyond the start of implementation.

We thank you for your consideration of these matters, and would like to continue working with the department through its stakeholder process to provide feedback on California's health homes concept and program design. In addition to other opportunities, we would like to be considered for inclusion in the technical workgroup dedicated to assessment, HAP, reporting requirements, metrics, and referrals. If you have any questions about Children Now's feedback, please contact Ben Rubin at 510-763-2444 x133 or [brubin@childrennow.org](mailto:brubin@childrennow.org).

Sincerely,



Kelly Hardy  
Senior Managing Director, Health



Ben Rubin  
Senior Policy Associate, Health



# CONGRESS OF CALIFORNIA SENIORS

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May 4, 2015

Jennifer Kent, Director  
California Department of Health Care Services  
1501 Capitol Avenue  
P.O. Box 997413  
Sacramento, CA 95899-7413

Dear Director Kent:

I am writing on behalf of the many members of the Congress of California Seniors and in response to your invitation to comment to your department's Concept Paper Version 2.0 Regarding Health Homes for Patients with Complex Needs. We appreciate the department's efforts to hear comments from stakeholders, first in the presentation to the California Collaborative for Long Term Services and Supports and the opportunity to provide written comments to the concept paper.

As you know, we have been intensely engaged in the development and oversight of the Coordinated Care Initiative, supporting that concept and working with other advocates to develop a program which meets the state's goals and the needs of hundreds of thousands of seniors and persons with disabilities, many with special care needs. Our review and comments on the Health Home proposal is made from that perspective.

Given the short timeframe for comment we focus on some of the broader issues raised by the Health Home (HH) paper.

1. We understand that the state intends to focus the HH program in the seven counties where the Coordinated Care Initiative (CCI) is underway or beginning. With that geographic target, it's not clear to us how the two programs will differ and whether they will be coordinated or be in conflict. The populations targeted seem similar or the same...high user, high need, and special needs. Given the unacceptably high opt-out rate in the CCI, does HH create an incentive for future participants to choose one over the other, or move out of one into the other? What incentives exist for providers? Will rates reward managed care organizations (mco) the same or will there be incentives to assign members to one or another based on capitated rates? How will the state explain the different options available to consumers? Will the state or plans direct individuals with slightly different needs into the different models?

We believe the state must insure that development of the HH model in CCI counties doesn't add to the confusion that exists among consumers and providers, and implementation allows us to compare results to see whether outcomes from the two approaches differ, as an extension of the "demonstration".

2. The Concept Paper describes the timeframe for implementation to be eight months long and funding for the HH model to last two years, with an evaluation beginning in 18 months. The great lesson of the CCI is that we followed a timeline that was too aggressive given the complexities of provider and consumer outreach/information and state and plan readiness. Without sufficient lead time, the confusion surrounding implementation of the CCI will be magnified. If it is truly to be a person-centered program, the department needs to develop a more reasonable timeline. Further, we should begin now to determine how we will evaluate the outcomes and whether the state will pursue the model with regular Medi-Cal funding after the two-year demonstration.

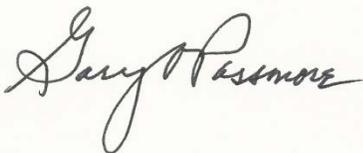
We should extend the start phase to be a minimum of twelve months and delay the initial evaluation to begin in the twentieth month, with data-driven reports to a stakeholder advisory group and the Legislature organized before the first consumer is enrolled.

3. As in the CCI, there is no clear statement of what effective care coordination is...no standards against which to measure performance. We have some statements in an all-plan letter, but we do not have specific measurable standards, nor consumer protections for care coordination (as we have for other services under Knox-Keene).

We would urge the state to consider the HH demonstration as an opportunity for creating those standards and practices, determining their costs, testing in-house assessment and coordination against delegating these activities to outside entities (such as MSSP) and designing them as discreet parts of the rate structure for mco's.

Thanks again for the opportunity to comment. The Congress of California Seniors looks forward to engaging further in the development and implementation of this new Health Home State Plan Option. We are happy to answer any questions you may have regarding these comments.

Sincerely,

A handwritten signature in black ink on a light yellow background. The signature is cursive and reads "Gary Passmore".

Gary Passmore  
Vice President and Legislative Advocate



May 6, 2015

Health Home Program  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, Ca 95814

Re: Comments on The California Department of Health Care Services' Concept Paper Version 2.0: Health Homes for Patients with Complex Needs

Dear Health Home Program Staff:

The Corporation for Supportive Housing (CSH) and Western Center on Law & Poverty (WCLP) appreciate efforts of the California Department of Health Care Services' (DHCS) staff to reflect core concepts of Assembly Bill 361 (Mitchell) in Concept Paper 2.0. Overall, the concept paper incorporates AB 361's intent of funding evidence-based practices that improve health outcomes among homeless beneficiaries and beneficiaries who are frequent hospital users. Our comments offer specific suggestions for ensuring all provisions of the health home program are consistent with the vision and principles identified in the concept paper. We hope our comments clarify further how a health home program, on a practical level, could address the needs of the populations identified in AB 361.

As indicated in AB 361, the health home option allows funding for services known to benefit chronically homeless beneficiaries and frequent hospital users, services that advance ongoing engagement with beneficiary care.<sup>1</sup> We agree health home services are intended to connect beneficiaries to medical care, behavioral health treatment, and the social services that allow beneficiaries to access care in a meaningful way. However, health home services are intended to be even more comprehensive, supporting a beneficiary's ability to comply with treatment, to achieve health stability, and to learn to manage their own care. Achieving these outcomes requires far more than traditional coordination of care models, typified by telephonic reminders and referrals to social services; achieving these outcomes requires services that remove beneficiary's obstacles to appropriate care, typified by accompanying beneficiaries to appointments, warm hand-offs to partner social services agencies, and ongoing engagement in ensuring a beneficiary does not return to homelessness. While the 1115 Waiver proposal also offers the promise of similar services for a similar population, the health home program offers a more certain approach to addressing the needs of high-need populations.

The concept paper appropriately acknowledges the role of health homes in addressing the whole needs of a beneficiary. We recommend incorporating the following suggestions to offer beneficiaries with complex needs a more comprehensive approach to addressing these needs.

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<sup>1</sup> The U.S. Department of Health & Human Services recognized the Health Home option as a source for Medicaid funding for services to beneficiaries experiencing homelessness. C. Wilkins, M. Burt. "A Primer for Using Medicaid for People Experiencing Chronic Homelessness & Tenants in Supportive Housing." *Office of Assistant Secretary for Planning & Evaluation, U.S. Dept. of Health & Human Servs.* 2014. <http://aspe.hhs.gov/daltcp/reports/2014/PSHprimer.pdf>.

## SECTION A3. GUIDING PRINCIPLES

We appreciate the concept paper's inclusion of team-based care, recognition of social service providers as team members, and integration of the goal of serving beneficiaries experiencing homelessness in the Concept Paper's Guiding Principles and Goals for Implementation. We further agree that care coordination should be delivered in the community.

**Recommendation #1:** *The Concept Paper reflects an expectation health homes will deliver services, "where a beneficiary chooses to receive most of their care or at an alternative site chosen by the beneficiary." We recommend DHCS emphasize in this and other sections that services be delivered where most easily accessible to a beneficiary. In many cases, the most easily accessible site may be a beneficiary's home, or on the street through a mobile health home.*

## SECTION B1: ELIGIBILITY CRITERIA

**Eligibility Criteria Selection Data Analysis:** CSH and WCLP have concerns the data analysis proposed to ascertain eligibility factors will fail to recognize beneficiaries with negative social determinants accurately. First, administrative data characteristics will most likely fail to identify a comprehensive or representative list of people experiencing homelessness. The only current indicator of homelessness is the zip code indicator, which has inherent flaws. Homeless people often provide a friend's, a service provider's, or an incorrect address to hospital staff, who then either do not enter the indicator or enter an incorrect zip code. And, even when a patient says he or she is homeless, hospital staff typically do not probe further to reject the indicator for someone sleeping on a friend's couch, or to add for someone sleeping on a storefront.

Second, administrative data will not capture all relevant data for newly-eligible beneficiaries. A lag exists in claims data. Data will also not capture a longitudinal history for these beneficiaries. While inpatient costs continue to rise for populations identified in AB 361,<sup>2</sup> other high-cost beneficiaries can "regress to the mean." Two to three years of costs are critical in assessing the differences between a frequent user who will "regress to the mean" and a frequent user who requires health home services to reduce hospital admissions.<sup>3</sup>

Finally, characteristics of people experiencing homelessness and patterns of utilization of people who are frequent hospital users may significantly resemble other populations who would not benefit from health home services. Administrative data may look similar for a beneficiary with cancer or end-stage liver disease, for example, who is not homeless and for a beneficiary who is homeless, but the latter's health may benefit from health home services while the former's would not.

**Recommendation #2:** *Absent a comprehensive match of data between Medi-Cal and homeless management information systems in implementation counties, a match that would accurately identify beneficiaries experiencing homelessness, CSH and WCLP recommend DHCS identify the specific chronic conditions listed in the concept paper, and narrow by homeless status, using a referral process that would identify people experiencing homelessness. Additionally, DHCS could narrow eligibility through indicators reflected in existing research, indicators like a specified number of hospital admissions, emergency department visits, and inpatient days. Regardless of eligibility criteria selected, we strongly recommend a bi-directional eligibility system that permits eligibility assessment and referral through a triage tool (discussed further in Beneficiary Assignment).*

## SECTION B2: HEALTH HOME SERVICES

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<sup>2</sup> Medicaid beneficiaries identified as frequent hospital users, particularly those experiencing housing instability, are prone to acquire higher inpatient costs over time. M. Raven, J. Billings, M. Gourevitch. "Medicaid Patients at High Risk for Frequent Hospital Admission: Real-Time Identification & Remediable Risks." *J. Urban Health*. Mar. 2009. 86(2); 230-241.

<sup>3</sup> *Id.* J. Billings, J. Dixon, T Mijanovich. "Case Finding for Patients at Risk of Readmission to Hospital: Development of Algorithm to Identify High Risk Patients. *BMJ*. 2006. 333; 327-32.

**Definitions of Services:** CSH and WCLP are concerned with the concept paper’s emphasis on coordination of care. The Affordable Care Act Section 2703 and CMS guidance on health homes indicate health home services are intended to incorporate more than care coordination. We agree that ensuring care is coordinated across medical, behavioral health, and social services systems is critical to promoting health among complex patients. However, we recommend acknowledging in the definitions the need for services that engage beneficiaries in care on an ongoing basis, remove impediments to meaningful care, overcome distrust of health professionals, promote healthier behaviors, and allow for self-management.

We support the inclusion of a Housing Navigator for homeless beneficiaries, and hope DHCS reflects those functions in the services definitions. We also hope services, as defined, promote ongoing stability to prevent beneficiaries from returning to homelessness. For a beneficiary with compromised executive functioning who has experienced years—sometimes decades—of homelessness, housing stability is a health intervention. As an example of a health home program offering services in supportive housing, BronxWorks, a health home provider participating in New York’s health home network,<sup>4</sup> delivers case management to keep beneficiaries stably housed as part of a team of health providers, hospitals, and Common Ground, a supportive housing provider. BronxWorks found their health home program’s care manager duplicated the efforts of their supportive housing case managers, and so is now incorporating their health home program into their supportive housing program.

Study after study shows a package of services designed to offer both care coordination and services promoting stability in housing and health dramatically improves health outcomes, while also dramatically reducing Medicaid costs.<sup>5</sup> These types of services, however, are largely unreimbursed in California. Resources for these services for beneficiaries without serious mental illness do not exist.

Taking these factors into consideration, we recommend changes to the services definitions.

- **Comprehensive Care Management:** Care management should ensure the Health Action Plan (HAP) is a dynamic document that reflects all of the beneficiary’s health-related needs, and that the beneficiary and his/her care team makes progress in meeting those needs on an ongoing basis.  
**Recommendation #3:** We recommend including the following provisions to the definition of comprehensive care management:
  - *Engaging and collaborating with beneficiaries to—*
    - *Create the HAP and*
    - *Participate in health home services (consistent with the role of the Dedicated Care Manager, as described in Section B5).*
  - *Communicating goals identified in the HAP and changes to the HAP with other health home team members and with the beneficiary’s treatment and service providers,*
  - *Facilitating a beneficiary’s access to the services a beneficiary needs to stay healthy.*
  - *Assisting beneficiaries to access and maintain stable housing as a foundation for facilitating healthier behaviors, reducing health-related risks, accessing appropriate care, and following treatment regimens.*
  - *Supporting the beneficiary in obtaining and improving self-management skills to prevent negative*

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<sup>4</sup> <http://www.bronxworks.org/health-home>.

<sup>5</sup> M. Larimer, D. Malone. “Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems.” *Journal Am. Medical Assoc.* 2009; 301(13):1349-1357 (2009). D. Buchanan, R. Kee. “The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial.” *Journal Am. Medical Assoc.* (June. 2009) 99;6; D. Buchanan, R. Kee, L. Sadowski, et. al. “Effect of a Housing & Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Controlled Trial.” *Am. Journal Public Health.* (May 2009) 301;17.

health outcomes (as described as duties in Section B5, number 6).

- Assisting the beneficiary in maintaining Medicaid benefits.

Similarly, we recommend aligning the description of roles of the Dedicated Care Manager in Section B5 with how a health home would deliver comprehensive care management:

- Offering services where the beneficiary lives, seeks care, or is otherwise most accessible.
- Using tools like motivational interviewing and trauma informed care practices.

- **Care Coordination and Health Promotion:** We agree that care coordination should include working with the beneficiary to implement a person-centered HAP.

**Recommendation #4:** We recommend the definitions of care coordination and health promotion go beyond monitoring treatment adherence, and incorporate services that remove barriers to treatment:

- Requiring (rather than allowing) case conferences to ensure a beneficiary's care is coordinated, as communication differentiates integration from co-location.
- Including initial and regular follow-up meetings with partner organizations.
- Using evidence-based practices to engage and help the beneficiary participate and manage his/her own care, rather than simply providing information or referral, proven ineffective to addressing the full range of a beneficiary's health-related needs.
- Acting as an advocate with the beneficiary's health care professionals to help the beneficiary navigate his/her care (consistent with Section B5's description of roles).

Similarly, we recommend aligning other roles outlined for the Dedicated Care Manager in Section B5, within the definition of Care Coordination and Health Promotion, including—

- Offering services where the beneficiary lives and seeks care.
- Accompanying beneficiaries to office visits, as needed.
- Providing health promotion and self-management training.
- Arranging transportation. For beneficiaries who are homeless or formerly homeless, difficulties getting to appointments or transportation that requires hours of travel are significant barriers to appropriate access to medical or behavioral health care.

**Recommendation #5:** Monitoring medication is a medical function that a physician or other health care professional should perform during the course of medical care, and is therefore not an appropriate responsibility of a health home. We recommend eliminating excluding medication monitoring and instead including a service that reminds beneficiaries to take medications.

- **Comprehensive Transitional Care:** We agree with the overall goal of preventing beneficiary readmissions through communication of admissions and discharge. And we endorse the concept of guidelines to identify an appropriate place to stay post-discharge for homeless beneficiaries.

**Recommendation #6:** We recommend the following changes to the definition of comprehensive transitional care:

- Removing medication reconciliation, as a function typically required of a primary care physician. While health home staff should ensure a beneficiary receives and can get to follow-up appointments, a health home should not be responsible for determining appropriate or contraindicated medication.
- Clarifying that managed care plans would notify health homes of hospital admissions, discharges and emergency department visits, since health homes are less likely to be able to access this information.

- **Individual and Family Support Services:** We support the paper's acknowledgement of peer supports to promote improved health outcomes.

- **Referral to Community and Social Supports:** We agree active referral and follow-up to existing resources are necessary to ensure beneficiaries are able to access these community resources in a meaningful way.

**Recommendation #7:** We recommend defining “active referral and follow-up” to ensure health homes do more than hand the beneficiary a list. We further recommend including in this definition the activities of the Housing Navigator, which are not otherwise included in the health homes services definitions. To achieve these recommendations, we suggest adding the following:

- Developing partnerships with organizations offering resources a beneficiary needs to improve his/her health outcomes, including food security and housing needs.
- Collaborating with beneficiaries to identify needed community connections.
- Developing protocols to offer beneficiaries “warm hand-offs” to health home team partners (including homeless service and housing providers), such as connecting to a single point of contact and accompanying beneficiaries to initial and/or follow-up meetings when needed.
- Including community partners in regular case conferencing to resolve issues that are resulting or may result in threats to the beneficiary’s health stability.
- Assisting the beneficiary with completing applications, obtaining documents necessary to complete applications, accompanying beneficiaries to interviews for housing vouchers and with housing providers, and assisting the beneficiary with integration into the community, including adjustments to move in.
- Connecting beneficiaries who are homeless to decent, affordable permanent housing, and linking beneficiaries to appropriate recuperative care or bridge housing until permanent housing becomes available.
- Following-up to ensure beneficiaries remain stably housed.

### SECTION B3: HHP NETWORK INFRASTRUCTURE

**Managed Care Plans (MCPs):** We agree that MCPs have a critical role in administering a health home benefit. MCPs control data that health home programs would not be able to otherwise access. Additionally, through their existing care coordination activities, managed care organizations that are MCPs could assign dedicated health home staff to coordinate, facilitate, and approve specialty services, like In Home Support Services, medical equipment, palliative care, board and care, and skilled nursing facility care.

**Recommendation #8:** We recommend clarifying an MCP’s role in identifying and communicating data to health homes and reporting data to DHCS to meet reporting requirements. We further recommend MCPs continue to offer certain care coordination activities health home providers cannot do as well or at all, again in alignment with health home activities.

**County MCPs:** CSH and WCLP also support inclusion of mental health and drug Medi-Cal plans operating in the organized delivery system demonstration as optional MCPs. In many communities, county MCPs have significant experience addressing the needs of homeless beneficiaries, and are well-positioned to align county-controlled resources, such as Mental Health Services Act (Proposition 63) resources, with health home program resources.

**Recommendation #9:** We recommend clarifying or differentiating health information technology and exchange goals for county MCPs versus managed care organizations, different duties for county MCPs, and potentially different caps on amounts county MCPs may retain in administering a health home benefit.

**Administration of Benefit:** The percentage of the health home rate that managed care plans may keep for administrative responsibilities should be specified, as in other states’ health home State Plan Amendment. This issue is absent from this section and the section on payment methodologies, Section B.7.

**Recommendation #10:** *We recommend DHCS specify a percentage of the health home rate MCPs can keep. Clarifying payment rate limits will ensure MCPs administer the benefit consistently in each county and across jurisdictions.*

## **SECTION B5: COMMUNITY-BASED CARE MANAGEMENT ENTITY**

CSH and WCLP support the creation of Community-Based Care Management Entities (CB-CMEs) rooted in the community to serve as the frontline provider of health home services. We also support the flexibility DHCS included in the type of organizations that could become CB-CMEs. Some of the organizations identified have strong cultural competency serving homeless beneficiaries, and would be more limited in serving other populations.

**Recommendation #11:** *We recommend offering a process for designating “health homes predominantly serving homeless beneficiaries and beneficiaries who are frequent hospital users.” If an MCP designates a health home provider as a provider predominantly serving homeless beneficiaries, that provider should not receive referrals of other populations eligible for health home services unless the beneficiary chooses that health home. Conversely, health homes serving populations other than homeless beneficiaries should not be referred beneficiaries experiencing homelessness or frequent hospital use, unless a beneficiary chooses that health home.*

**Similar Certification to Existing MCP Process:** We are concerned with the arduous process MCP certification could entail and, considering health home services are not treatment services, believe this process may not serve the same purpose as the current certification.

**Recommendation #12:** *We recommend a certification or contracting process less arduous than certification required of treatment providers. At a minimum, we recommend DHCS offer technical assistance to organizations hoping to become certified.*

**MCPs as CB-CMEs:** We do not support the concept paper’s proposal that MCPs may serve as CB-CMEs. In fact, AB 361 specifically requires health home providers to be rooted in the community.

**Recommendation #13:** *We recommend eliminating the option for MCPs to act as a health home. We support MCP flexibility to contract with entities that may not meet all certification requirements if insufficient entities exist in the community that are capable or willing to meet certification requirements.*

**Qualifications:** In-person communication is critical to addressing complex issues high-need beneficiaries face. The CB-CME qualifications in the concept paper included a statement indicating that a CB-CME may be able to communicate with beneficiaries telephonically in certain situations. The concept paper also included no qualifications the health home have experience addressing the needs of specific populations the SPA makes eligible for health home benefits.

**Recommendation #14:** *To clarify, we recommend stating in number 4 of the CB-CME qualifications that a health home must provide in-person communication on a regular basis, but that other forms of communication are acceptable “on occasion” when in-person communication is not practical or necessary.*

*We also recommend specifying health homes serving homeless beneficiaries must have experience addressing the needs of homeless beneficiaries and partnerships with housing providers. We recommend DHCS staff work in collaboration with MCPs and the homeless work group to develop criteria for designation as a health home addressing the needs of homeless and frequent hospital user beneficiaries.*

**Duties:** We agree with the list of duties as a whole, particularly number 6, to support the beneficiary in obtaining and improving self-management skills to prevent negative health outcomes. We hope to see greater emphasis on ongoing, active engagement with beneficiaries in this section. At the same time, we are concerned with listed duties that overlap with treatment providers’ responsibilities.

**Recommendation #15:** We recommend changes to the list of duties of the CB-CME, including—

- In number 4, clarifying that the Dedicated Care Manager must collaborate with the beneficiary in creating and implementing the HAP, and requiring health home staff engage, reassess, and motivate the beneficiary on an ongoing basis to participate in modifying the HAP.
- Removing duties that are the responsibility of medical treatment providers, such as—
  - Removing Number 7, in assuring the receipt of evidence-based care. We recommend instead partnering with and referring beneficiaries to treatment providers offering evidence-based care. Requiring health homes to make sure beneficiaries only receive evidence-based care is beyond the purview, scope, and payment of health home services.
  - Removing Number 12, providing 24-hour, seven days a week information and emergency consultation services. Health home services, as defined in the concept paper and as described in federal guidance, are not treatment services and should not duplicate services other entities offer. Because managed care organizations already offer nurse advice lines, a health home line is duplicative.
- For number 8, “actively maintaining a directory of community partners” would serve little purpose for beneficiaries with complex needs, and would unnecessarily add administrative duties to the health home. Instead, we recommend requiring health homes maintain active partnerships with community partners. A directory without a relationship with community providers may result in health home referrals without active follow up, contrary to the concept paper’s vision.

**Multi-Disciplinary Health Home Team:** For beneficiaries experiencing or formerly experiencing homelessness, beneficiaries will receive health home services more often than medical or behavioral health care. Beneficiaries should not be required to travel to an office to receive health home services.

**Recommendation #16:** We recommend aligning language in the “Multi-Disciplinary Health Home Team” paragraphs with the defined role of the Dedicated Care Manager under Team Qualifications and Roles, which indicates the health home must provide services where the beneficiary lives and seeks care. We again recommend clarifying that services should be made available to beneficiaries in the most easily accessible setting, which often will not be the beneficiary’s point of care.

**Multi-Disciplinary Health Home Team Qualifications and Roles:** We support the roles identified for the Dedicated Care Manager, and have recommended in previous comments incorporating descriptions of these roles into the services definitions. We also appreciate inclusion of the Housing Navigator. Without housing navigation, other health home services would be ineffective in reducing costs and improving care.

**Recommendation #17:** In furthering the goals of the health home program, we recommend the following changes to the descriptions of staff roles:

- Removing “mailing health promotion materials” in the Community Health Worker description of roles. Requiring health homes to mail materials adds unnecessary administrative functions to the health home, with little to no pay-off. This requirement is inconsistent with other requirements intended to engage beneficiaries in managing health.
- Expanding the role of Community Health Workers to allow for mobile teams to engage potentially eligible beneficiaries on the street.
- Clarifying in the Housing Navigator role that assisting beneficiaries to, “get housing” must include assisting the beneficiary in obtaining identification, completing applications, and accompanying beneficiaries to meetings and interviews.

## SECTION B6: BENEFICIARY ASSIGNMENT

**Assignment/Enrollment & Referral:** While we agree MCPs should be responsible for enrolling eligible beneficiaries in many cases, we recommend encouraging a bi-directional referral process. The best quality data on who is homeless comes from staff culturally competent in identifying and understanding the needs of homeless beneficiaries.

Furthermore, as we argued earlier, basing eligibility on claims data alone is problematic. Similar to other state practice, a SPA should require health homes to work with hospitals, clinics, behavioral care providers, county agencies, coordinated homeless assessment and intake systems, and social service agencies to establish a referral processes for potentially-eligible health home beneficiaries. The U.S. Department of Housing & Community Development now requires homeless systems to assess the right housing intervention for each homeless person, along with eligibility for benefits. These “coordinated assessment and entry systems” also coordinate all housing resources to move beneficiaries into permanent housing as quickly as possible. Health home staff could work with these “coordinated assessment and entry systems” to ensure all homeless beneficiaries are assessed for eligibility for the health home benefit, and health home beneficiaries access the county’s housing resources. Similarly, health home outreach workers could be deployed to hospitals, recuperative care, homeless service, housing partners, and coordinated assessment systems to assess for eligibility for health homes through an eligibility screening tool.

**Recommendation #18:** *We recommend a more flexible enrollment and referral process that could incorporate data not available to MCPs. MCPs could use claims data to identify enrollees who meet inpatient admission criteria.*

With regard to approval of eligibility, while we understand the need for an administrative process for triggering additional payment, MCP-required approval may cause significant delay, which could result in losing access to a beneficiary who is homeless. Because homeless beneficiaries are more difficult to locate, waiting for provider verification of eligibility and MCP approval could result in failure to serve the most complex, chronically homeless beneficiaries in favor of beneficiaries who are easier to find.

Prior to implementing a health home SPA, New York ran a Chronic Illness Demonstration Program (CIPD), designed to coordinate care for beneficiaries with complex conditions. The pilot generated a list of eligible beneficiaries, similar to the list the DHCS concept paper proposes. CIPD staff reported difficulties locating homeless beneficiaries and significant time spent attempting to locate beneficiaries, often unsuccessfully, as one of the leading barriers to successful implementation of CIPD.<sup>6</sup>

**Recommendation #19:** *We recommend allowing for greater flexibility in approving health home services. Based on the lessons of New York’s CIPD program, and other programs across the nation, we recommend DHCS allow for provisional approval of beneficiaries experiencing homelessness when a beneficiary receives hospital care or seeks services with a health home partner, when the hospital, social service partner, or health home staff screen for eligibility and determine the beneficiary is eligible. Further, we recommend MCPs develop an expedited approval process.*

**Discharge:** This section of the concept paper addresses when a health home program may discharge a beneficiary from health home program services. Beneficiaries often require several attempts to engage after the beneficiary first declines services. Engaging the beneficiary in subsequent hospital visits or outreach encounters on the street is critical to developing trusting relationships, as some beneficiaries do not participate without trusting the health worker approaching him/her.

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<sup>6</sup> Center for Health Care Strategies. “New York’s Chronic Illness Demonstration Project: Lessons for Medicaid Health Homes.” Dec. 2012. [http://www.chcs.org/media/NY\\_RCP\\_CIDP\\_Profile\\_122112.pdf](http://www.chcs.org/media/NY_RCP_CIDP_Profile_122112.pdf).

**Recommendation #20:** We recommend clarifying health homes should engage a beneficiary actively for the full term of the engagement rate, using evidence-based methods of engagement, such as motivational interviewing, with repeated in-person contact before a health home may discharge the beneficiary, as consistent with other sections of the concept paper.

#### **SECTION B7: PAYMENT METHODOLOGIES**

We support the concept paper’s proposal to implement a three-tier payment process and an enhanced member engagement tier rate. However, we are concerned with the description of payment in the first paragraph of this section. Other states have implemented case rates with limits on how much an MCP may retain for administering the benefit, which allows for consistency in health home services across the implementation counties. The State has a role ensuring health home programs are consistently administered and funded at equal or near-equal rates.

**Recommendation #21:** We recommend a per member, per month case rate paid to MCPs, with percentage limits an MCP may retain to perform the MCP roles of the health home program.

**Continuity of Care:** Though many health home participants will not meet initial eligibility criteria after a period of participation in a health home program, evidence shows participants would continue to use acute care services (and are likely, in fact, have escalating hospital costs) without health home services.

**Recommendation #22:** Beneficiaries who are initially eligible should remain eligible to receive the benefit at the same tier until the beneficiary’s health remains stable for at least one year. After the beneficiary no longer requires the same frequency of contact, the beneficiary should be able to continue to access services from the same health home provider at a “maintenance rate” identified in the SPA. Considering relapse is part of recovery, and health homes should be allowed flexibility to return the beneficiary to a higher level of services when needed.

#### **SECTION C5: STAKEHOLDER ENGAGEMENT PRIOR TO SPA SUBMISSION**

CSH and WCLP look forward to working with DHCS and other stakeholders to further develop concepts critical to providing health home services to people experiencing homelessness, and to incorporating these recommendations into a SPA. We also hope to participate in other technical workgroup meetings, as these aspects will be critical to identifying issues and offering guidance on the health home program overall in addressing the needs of the populations AB 361 identified.

Thank you for the opportunity to comment.

Sincerely,



Sharon L. Rapport  
Associate Director, California Policy



Shirley Sanematsu  
Senior Health Attorney



May 6, 2015

Jennifer Kent, Director  
Department of Health Care Services  
1501 Capitol Avenue  
Sacramento, California 95899

**SUBJECT: CBHDA Comments on California Concept Paper Version 2.0 – Health Homes for Patients with Complex Needs (Draft 4/10/2015)**

Dear Director Kent:

On behalf of the County Behavioral Health Directors Association of California (CBHDA), which represents the public mental health and substance use disorder programs in counties throughout California, I offer its perspective on the California Concept Paper Version 2.0 – *Health Homes for Patients with Complex Needs* – that was circulated for stakeholder review on April 10, 2015.

CBHDA strongly supports California’s inclusion of individuals with serious and persistent mental illness as eligible for health home services under the proposed *Health Homes for Patients with Complex Needs* (HPCN) concept. CBHDA also strongly supports the inclusion of a substance use disorder in the definition of eligible chronic conditions. CBHDA further supports the emphasis on persons with high-costs and high utilization who can benefit from increased care coordination between physical health, behavioral health (mental health and substance use treatment), community-based long-term care, and social supports to reduce hospitalizations and emergency department visits, improve patient engagement and decrease costs.

Research clearly shows that high healthcare costs and poor health outcomes associated with individuals with serious mental health and substance use conditions are primarily due to significantly higher rates of chronic health conditions, including diabetes, heart disease, and chronic respiratory diseases. According to the recent report commissioned by the Reforming States Group and released by the Milbank Memorial Fund in December 2014:

Individuals with serious mental illness or substance use disorders have higher rates of acute and chronic medical conditions, shorter life expectancies (by an average of 25 years), and worse quality of life than the general medical population. They also have higher utilization of emergency and inpatient resources, resulting in higher costs. For example, 12 million visits (78/10,000 visits) annually to emergency departments are by people with serious mental illness and chemical dependency. For schizophrenia alone, the estimated annual cost in the United States is \$62.7 billion dollars. Many of these expenditures could be reduced through routine health promotion activities; early identification and intervention; primary care screening, monitoring, and treatment; care

coordination strategies; and other outreach programs. However, people with serious mental illness and substance use disorders have limited access to primary care due to environmental factors and stigma and are often underdiagnosed and undertreated.”<sup>1</sup>

There are many factors that contribute to the poor physical health of people with severe mental illness, including lifestyle factors and medication side effects. However, there is increasing evidence that disparities in healthcare provision contribute to poor physical health outcomes.<sup>2</sup> These inequalities have been attributed to a variety of factors, including systemic issues (e.g., the separation of mental health services from other medical services, healthcare provider issues including the pervasive stigma associated with mental illness, and consequences of mental illness and side effects of its treatment).

The HHPCN concept addresses the whole health needs of complex populations through the direct provision of services and development of formal partnerships with other service providers, including primary care, social service agencies, and housing providers. CBHDA agrees that a number of important elements should be included in the HHPCN implementation in California to assure that the needs of beneficiaries with serious mental health and substance use conditions are appropriately met, including:

- 1) **Support Alternative Health Home Strategies for Target Populations with Serious Mental Health and Substance Use Conditions.** In recognition of the disparities in healthcare provision for individuals with serious mental health and substance use conditions, the HHPCN model must allow for alternative structures designed to meet the unique needs of this target population. CBHDA strongly supports the provision in the concept paper to allow county mental health plans and Drug Medi-Cal Organized Delivery System (DMC-ODS) demonstration sites to serve as the “health home managed care plan” for target populations with serious mental health and substance use conditions in participating counties. CBHDA also supports that proposed concept in which participation as the “health home managed care plan” for this target population would be voluntary on the part of the county. If the county declines, the health home managed care plan for this population would reside with the identified managed care plan in the participating county. Managed care plans should then contract with counties and/or their provider network to serve as community-based care management entities for the target population. The county or mental health/substance use provider would be responsible for providing the core health home services to the target population and receive payment for health home services via a contract with the designated “health home managed care plan.”

CBHDA also offers a small clarification on the description of eligible entities for voluntary participation as the health home managed care plan, as described on page 12 of the concept paper.

- *MHPs and Drug Medi-Cal Organized Delivery System demonstration participants (DMC-ODS) where the entity is an integrated Mental Health / Substance Use Disorder plan. (Page 12, 3<sup>rd</sup> paragraph)*

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<sup>1</sup> Gerrity, Martha. (2014). Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness.

<sup>2</sup> Lawrence, D. & Kisely, S. (2010). Inequalities in healthcare provision for people with severe mental illness. *Journal of Psychopharmacology*. (Oxford, England), 24 (4-supplement), 61-68.

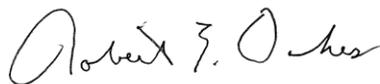
CBHDA agrees that voluntary participation as the health home managed care plan should be limited to DMC-ODS pilot sites for substance use populations, rather than any county operating a Drug Medi-Cal program. However, the intent of the DMC-ODS pilot is not to create “Integrated Mental Health/Substance Use Disorder County Plans.” Rather, the pilot will allow participating counties to administer the Drug Medi-Cal program as an organized delivery system under the authority of the 1115 Bridge to Reform waiver and make available to beneficiaries in participating counties certain benefits that are not currently included in our state plan, such as residential treatment. As such, CBHDA recommends amending the description as follows:

- *MHPs and Drug Medi-Cal Organized Delivery System demonstration participants (DMC-ODS) where the entity is an integrated Mental Health/ Substance Use Disorder plan.* (Page 12, 3<sup>rd</sup> paragraph)

- 2) **Alignment with 1115 Waiver Renewal and Other Delivery System Reform Initiatives.** CBHDA strongly urges DHCS to identify and pursue opportunities for alignment with other delivery system improvement initiatives, including those outlined in the state’s 1115 waiver extension request. Specifically, CBHDA strongly urges DHCS to consider how the proposed implementation of the HHPCN concept aligns with the proposed 1115 waiver initiatives to test regional integrated “Whole Person Care” pilots, increase access to housing and supportive services, and improve coordination of behavioral and physical health care. For example, the proposed incentive approach under the waiver to increase physical and behavioral health coordination at the systems-level should be complementary with any strategies developed as part of the HHPCN concept to support “point-of-care” coordination.
- 3) **Plan for Sustainability.** There must be a plan for sustaining the HHPCN after the initial two years of enhanced federal financial participation and foundation support end.

Thank you for your continued commitment to California’s community mental health and substance use systems. CBHDA welcomes the opportunity to discuss its comments and work collaboratively with DHCS for a successful rollout of the HHPCN concept. Please do not hesitate to contact Molly Brassil, Director of Public Policy, at [mbrassil@cbhda.org](mailto:mbrassil@cbhda.org).

Sincerely,



Robert E. Oakes, J.D., M.B.A.  
Executive Director  
County Behavioral Health Directors Association of California

cc: Mari Cantwell, Department of Health Care Services  
Karen Baylor, Department of Health Care Services  
Claudia Crist, Department of Health Care Services  
Hannah Katch, Department of Health Care Services  
Sarah Brooks, Department of Health Care Services

Brian Hansen, Department of Health Care Services  
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Via E-Mail: [Jennifer.Kent@dhcs.ca.gov](mailto:Jennifer.Kent@dhcs.ca.gov)

May 6, 2015

Ms. Jennifer Kent  
Director  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, Ca 95814

**Re: Health Homes for Patients with Complex Needs  
California Concept Paper Version 2.0 - Draft 4/10/2015**

Dear Director Kent:

On behalf of Dignity Health and our 32 hospitals in California, thank you for the opportunity to comment on the Health Homes for Patient with Complex Needs California Concept Paper Version 2.0. Dignity Health has long believed in health care reform principles and is committed to the Affordable Care Act and its triple aim. Foundational to transformation is the recognition that access to high quality, compassionate, patient-centered care must be available to those who are poor and vulnerable, particularly those with chronic conditions that can benefit from increased care coordination and meaningful patient engagement support. Dignity Health believes there is a great need for Medi-Cal health homes and appreciates the Department's leadership in creating a Health Home Program (HHP) that honors dignity of the whole person across her/his lifespan, ensures the provision of a full range of physical health, behavioral health, and community-based long-term services and supports (LTSS), and requires coordination and stewardship of resources from partners working as a team to improve health outcomes.

Dignity Health is pleased with the objective established by the Department to ensure sufficient provider infrastructure and capacity. Our 32 hospitals up and down the state are the first point of entry for many with chronic conditions seeking care. We daily see our healing mission come alive—in the various services we deliver, the resources and capacities we bring to our patients and the broader community, and the essential linkages and relationships we've developed in the communities we serve. We appreciate the Department's focus on partnerships and hospitals' integral place in the success of this care model—as a vital member of a HHP team or as a community-based care management entity (CB-CME).

Dignity Health wholeheartedly supports the health homes concept paper and offers the following specific comments and recommendations to strengthen it:

**Section B1: Eligibility & Section B6: Beneficiary Assignment**

Dignity Health recommends using a combination of administrative data and a referral process to identify beneficiaries experiencing homelessness. Medi-Cal administrative data may accurately identify beneficiaries incurring high costs, but this data does not capture which beneficiaries may be experiencing homelessness. Managed care plans (MCPs) would not be able to identify homeless beneficiaries through administrative data, but a referral process could identify additional criteria administrative data cannot. Additionally, we recommend using existing research data to identify indicators of high costs and poor outcomes among those experiencing homelessness.

Recognizing at the outset that timing of engagement with homeless individuals is critical, Dignity Health also recommends eliminating the requirement that MCPs first approve adding beneficiaries to a health home. Instead, we urge the Department to establish a process for receiving referrals from hospitals, homeless service and housing providers, health centers, or a region's homeless service system, to easily verify eligibility, and to allow health homes serving homeless beneficiaries the ability to approve beneficiaries provisionally. These health homes should get reimbursed a portion of the engagement rate while waiting for final MCP approval.

### **Section B2: Health Home Services**

Dignity Health urges greater emphasis be placed on services that work to engage beneficiaries to achieve and maintain health stability on an ongoing basis. To this end, Dignity Health specifically requests the following be included:

- In the definitions of care management and care coordination, engagement services to motivate beneficiaries to collaborate in drafting and executing the Health Action Plan (HAP)
- Transportation to and from appointments and accompanying beneficiaries as needed, including providing warm hand-offs to staff at partner organizations
- Assistance to obtain and improve self-management skills, pursue healthier behaviors, follow treatment regimens, connect to affordable permanent housing as needed
- Assistance to maintain Medi-Cal coverage

### **Section B5: Community-Based Care Management Entities (CB-CMEs)**

Dignity Health recommends MCPs to designate specific health homes that predominantly serve beneficiaries experiencing homelessness. MCPs should refer beneficiaries to these designated health homes if the beneficiary is homeless in that geographic area, unless the beneficiary otherwise requests assignment to a different health home. Moreover, we urge the Department to allow MCPs flexibility in contracting with CB-CMEs, rather than requiring an administratively burdensome and difficult process to obtain certification. Certification should simply involve ensuring CB-CMEs meet the qualifications outlined in the concept paper.

### **Section B7: Payment Methodologies**

Dignity Health supports DHCS's intent to implement a three-tier payment process, as well as the enhanced member engagement tier rate. To ensure consistency, we urge the Department to offer MCPs a per member, per month case rate that allows Health Home Programs flexibility in identifying and providing health home services each beneficiary requires. We further recommend limiting how much an MCP may retain, consistent with other states' state plan amendments, to ensure the vast majority of funding is dedicated to services, rather than administrative process.

Dignity Health commends DHCS for its efforts to develop the Health Home Program concept. We very much appreciate the opportunity to comment and look forward to the successful implementation of this promising care model.

Sincerely,



Rachelle Reyes Wenger  
Director, Public Policy & Community Advocacy

# DOWNTOWN WOMEN'S CENTER



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May 5, 2015

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[HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov)

Re: Comments on DHCS' Concept Paper Version 2.0 on Health Homes

Dear Health Home Team:

On behalf of Downtown Women's Center, thank you for the opportunity to comment on Concept Paper 2.0 regarding Section 2703 of the Affordable Care Act, the health home option. Downtown Women's Center (DWC) provides permanent supportive housing and a safe and healthy community for homeless women fostering dignity, respect, and personal stability, and advocates ending homelessness among women. We are located in downtown Los Angeles' Skid Row and serve 4,000 homeless and extremely low-income women annually.

We appreciate the work of DHCS staff in incorporating supportive housing into the concept paper, and in including housing navigators, tiered payment, and a focus on serving Medi-Cal beneficiaries experiencing homelessness. Below, DWC offers specific comments and recommendations for strengthening your concepts for the Health Home Program.

## **Section B1: Eligibility & Section B6: Beneficiary Assignment**

Administrative data may accurately identify Medi-Cal beneficiaries incurring high costs, but, because Medi-Cal administrative data does not accurately identify beneficiaries experiencing homelessness, DWC recommends using a combination of administrative data and a referral process to identify beneficiaries experiencing homelessness. DWC agrees with the list of chronic conditions in the concept paper, and recommends the State narrow by acuity according to hospital use or homelessness. Managed care plans would not be able to identify homeless beneficiaries through administrative data, but a referral process that allows housing, hospital, health center, and homeless service systems to refer beneficiaries for potential eligibility, according to eligibility criteria the State adopts, would ensure that this vulnerable population is served.

Finally, DWC recommends eliminating the requirement that MCPs approve adding beneficiaries to a health home. Waiting for approval could impact a health home's ability to engage homeless beneficiaries. Homeless beneficiaries will have no way of knowing they are eligible for health home services, unless the beneficiary seeks other services or is hospitalized. Potentially eligible homeless beneficiaries often present a brief window to engage. Most would be lost to follow-up in waiting for an MCP approval process. For this reason, DWC recommends establishing a

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process for receiving referrals from hospitals, homeless service and housing providers, health centers, or a region's homeless service system, for easily verifying eligibility, and for granting health homes serving homeless beneficiaries the ability to approve beneficiaries provisionally. These health homes should get reimbursed a portion of the engagement rate while waiting for final MCP approval.

## **Section B2: Health Home Services**

In the definition of services, DWC recommends greater emphasis on services that work to engage beneficiaries to achieve and maintain health stability on an ongoing basis. Many of the services identified in the concept paper are provided in supportive housing, and are critical to improving health outcomes. Yet, linking a beneficiary to treatment and to social services alone is insufficient to achieving those outcomes. Improving health among homeless beneficiaries and beneficiaries who are frequent hospital users is contingent on services that engage beneficiaries on an ongoing basis, promote healthy behaviors, and allow for self-management.

To incorporate these concepts into the definitions, DWC specifically recommends including the following:

- In the definitions of care management and care coordination, engagement services to motivate beneficiaries to collaborate in drafting and executing the Health Action Plan (HAP),
- Regular and ongoing communication, including case conferencing among team members, housing providers, and, when necessary, health providers,
- Transportation to and from appointments,
- Assistance in pursuing healthier behaviors and following treatment regimens,
- Help in obtaining and improving self-management skills to prevent negative health outcomes,
- Assistance in maintaining Medi-Cal,
- Advocacy with health care professionals,
- Accompanying beneficiaries to appointments when needed (including appointments with social service providers),
- Partnerships with organizations offering existing resources a beneficiary requires to improve health outcomes,
- Warm hand-offs to staff at partner organizations, and
- Connections to affordable permanent housing (when the beneficiary is experiencing homelessness).

## **Section B5: Community-Based Care Management Entities (CB-CMEs)**

DWC recommends allowing MCPs to designate specific health homes as a health home predominantly serving beneficiaries experiencing homelessness. DWC also recommends clarifying that MCPs should refer beneficiaries to these designated health homes if the beneficiary is homeless in that geographic area, unless the beneficiary otherwise requests

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assignment to a different health home.

DWC recommends allowing MCPs flexibility in contracting with CB-CMEs, rather than requiring an administratively burdensome and difficult process to obtain certification. Alternatively, certification should simply involve ensuring CB-CMEs meet the qualifications outlined in the concept paper.

DWC also recommends several changes to the duties outlined in the concept paper for CB-CMEs:

- Revising number 7, in assuring the receipt of evidence-based care, to require instead partnering with and referring beneficiaries to treatment providers offering evidence-based care,
- Eliminating number 12, providing 24-hour, seven days a week information and emergency consultation services, as inconsistent with both the definitions of services included in the concept paper and with the intent of health home services. Since MCPs already offer these services, health homes should not need to, and
- Revising number 8 to replace the need for a directory of community partners with partnerships with community partners offering resources in the community.

DWC recommends further, in health home staff roles, that Community Health Workers not be required to mail health promotion materials.

## **Section B7: Payment Methodologies**

DWC supports DHCS intent to implement a three-tier payment process, as well as the enhanced member engagement tier rate. To ensure consistency, the State should offer MCPs a per member, per month case rate that allows Health Home Programs flexibility in identifying and providing health home services each benefit requires. DWC further recommends limiting how much an MCP may retain, consistent with other states' state plan amendments, to ensure the vast majority of funding offers services to eligible beneficiaries, rather than administrative process. The health home should be expected to achieve the outcomes the State identifies, and not be expected to expend significant staff time on administration of the health home program required with a fee-for-service type process.

Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. Downtown Women's Center looks forward to engaging further in discussions on strengthening the Health Home Program.

Sincerely,

A handwritten signature in black ink, appearing to read 'Sylvia Rosenberger', written in a cursive style.

Sylvia Rosenberger  
Chief Executive Officer  
Downtown Women's Center



June 2, 2015

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**Subject: Comments on DHCS' Concept Paper Version 2.0 on Health Homes**

Dear Health Home Team:

On behalf of the Economic Roundtable, we thank you for the opportunity to comment on Concept Paper 2.0 regarding Section 2703 of the Affordable Care Act, the health home option. The Economic Roundtable is a nonprofit public policy research organization based in Los Angeles. The Economic Roundtable has developed the only tool for prioritizing the needs of homeless individuals, based upon cost data for the 10 percent of homeless patients with the highest public and hospital costs in Los Angeles and Santa Clara Counties.

We appreciate the work of DHCS staff in incorporating supportive housing into the concept paper, and in including housing navigators, tiered payment, and a focus on serving Medi-Cal beneficiaries experiencing homelessness. Below, we offer specific comments and recommendations for strengthening your concepts for the Health Home Program.

**Section B1: Eligibility & Section B6: Beneficiary Assignment**

- Create a **flexible, expedited, multi-directional referral** process. (SAMHSA EBP: 'No wrong door') Referrals should be initiated by multiple entities in addition to the MCP, to include the CB-CME, PCP, homeless service systems, housing providers and hospitals in order to maximize the identification of potentially eligible homeless beneficiaries.
- Following referral of eligible beneficiaries, granting **immediate provisional enrollment** is key to successful engagement of individuals who are difficult to locate due to a lack of stable housing, often with no mailing address and whereabouts unknown.



- HHP serving homeless beneficiaries should begin receiving a **reimbursement rate for the Outreach and Engagement period commencing at the time of immediate provisional enrollment**, with pending final approval to follow at the completion of enrollment.
- **Combine administrative level data with a referral process to include research data** that specifically identifies beneficiaries experiencing homelessness who are high risk but may or may not have contact with the crisis health system (eg. consider Fire Department paramedic contacts not necessarily reflected in Medi-Cal utilization data). Include eligibility criteria that takes into account frequent use of public systems to identify current high need individuals that will become future high cost beneficiaries.
- For eligibility determination, **utilize research data conducted by the Economic Roundtable in the development of the Crisis Triage Tool**, designed to identify homeless individuals in LA County's 10<sup>th</sup> highest decile of public and hospital costs with similar research conducted in Santa Clara County.

## Section B2: Health Home Services

- In addition to the services described in the concept paper, expanded core HHP services for people experiencing homelessness should emphasize 'care integration' to include additional assistance in **Instrumental Areas of Daily Living (IADLs)** to promote health stability, improve care coordination and health outcomes, (in particular, for Cal MediConnect beneficiaries):
  - **Accessing Community Resources** – Benefits establishment, advocacy with social service and health care providers, Medi-Cal enrollment/preservation, housing navigation, tenancy support and housing retention services; access to community resources for recovery, wellness and health improvement.
  - **Hygiene** - Provide access to sanitary facilities to promote self care management, health promotion and disease prevention
  - **Medications Management** – Facilitate safe medication storage, medication reconciliation, self-management in treatment regimen (with or without medication)



- **Money Management** – Promote self-management in bill paying, arrange options for representative payee as needed
- **Transportation** – to and from medical and social service appointments, with and without escort/accompaniment based upon individualized needs.
- **Care coordination ‘must’ include communication and case conferences with partner agencies** to promote ongoing and continuous care integration.

## Section B5: Community-Based Care Management Entities (CB-CMEs)

- **CB-CMEs serving homeless beneficiaries should demonstrate substantial experience with homeless populations, utilizing evidence-based practices.**
- Multi-Disciplinary Health Home Teams should include **staff representation of persons with ‘lived experience’** in any of the required team positions (not to be restricted to Community Health Worker).
- The provision of **24/7 services is neither feasible nor necessary**, as this requirement would likely exceed state funding levels and MCPs typically provide a nurse hotline to its membership.

## Section B7: Payment Methodologies

- Design a three-tier payment structure with the **highest rate assigned to individuals experiencing homelessness** at the highest acuity level, as these individuals will require intensive care coordination including assistance at varying levels with IADLs.
- **A per member, per month case rate is essential** to provide the flexibility of HHPs to match the necessary services to the individualized needs of homeless beneficiaries.
- **Create a payment contracting arrangement that flows directly from MCP to CB-CME thereby eliminating another layer of payment for IPA and MSO contracting.** The nature and scope of HHP services do not require this additional level of administrative oversight. CB-CMEs should take the place of IPAs and MSOs similar to the current contracting arrangements of MCPs with the ADHC-CBAS program.



# ECONOMIC ROUNDTABLE

✈ @EconomicRT

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📍 economicrt.org

315 West Ninth Street, Suite 502  
Los Angeles, CA 90015

Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. We look forward to engaging further in discussions on strengthening California's Health Home Program.

Sincerely,

Daniel Flaming, PhD

President

Deborah Maddis, MPH

Consultant



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May 13, 2015

Hannah Katch, Assistant Deputy Director,  
Health Care Delivery Systems  
Department of Health Care Services  
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Via Email: Hannah.Katch@dhcs.ca.gov

**Re: Health Homes for the Homeless**

Dear Ms. Katch,

Health Net, Inc. is proud to serve more than 1.6 million Medi-Cal managed care beneficiaries across the state. We appreciate the opportunity to provide the Department of Health Care Services (DHCS) our feedback on the Health Homes for Patients with Complex Needs Program (Health Homes Program or HHP) concept paper. We consider this program a potential opportunity to better serve members in need of high touch services. As envisioned by DHCS, the HHP is designed to improve health outcomes for individuals with chronic health care needs through more intensive care coordination and a hands-on, individualized approach to care. Health Net is fully supportive of finding innovative ways of ensuring patients' needs are met in the most effective manner possible. We agree with DHCS's desire to craft a program built on the managed care model and efforts already underway to provide member-centered care.

In reviewing the Health Homes Concept Paper, we have identified several potential opportunities and recommendations to increase the programs potential impact on patient care. However, we also believe that our recent experience serving in the Arizona Medicaid Program demonstrates the potential for cost savings if the Health Home concept is more specifically tailored to meet the needs of the homeless population and builds off of the opportunities envisioned in the 1115 Wavier Renewal.

### **The Arizona Experience**

Health Net Inc. participates in the Arizona Health Care Cost Containment System (AHCCCS) with approximately eighty thousand members. As new entrants into Arizona, a large portion of our membership is the result of the expansions under the Affordable Care Act. These previously uninsured individuals were, in large part, unfamiliar with the health care system and, in many instances, later identified as homeless. In particular, during discharge planning process and concurrent chart review, Health Net identified a large number of individuals in Maricopa County who were homeless and unable to be discharged for treatment into a home setting. Continued inpatient care was cost-prohibitive particularly given that the level of care delivered through in a hospital was no longer necessary.

However, release prior to full amelioration of the condition for which the individual was admitted would lead to readmission.

In order to provide targeted intervention with the population, Health Net began contracting with Circle the City, a 501(c)(3) nonprofit, non-denominational public charity which acts as a medical respite center. Circle the City is uniquely positioned to act as a short-term medical home for individuals in need of intensive interventions in a controlled setting. With an on-site physician, physical therapists, behavioral health workers as well as a variety of counsellors and case managers, Circle the City provides housing while meeting the needs of the population it serves. Moreover, as a 80 bed shelter, Circle the City staff has close ties with the housing sector and has the ability to identify and assist individuals in accessing longer term housing options.

Under the arrangement with Health Net, individuals are referred either by Health Net concurrent review nurses or by the hospital discharge nurse from an inpatient stay to Circle the City when identified as being homeless and in need of respite care. A full case review and evaluation are performed by Circle the City to ensure that individuals referred to the program agree to participate and are willing to remain free from drug or alcohol use. Identified members are not candidates for Skilled Nursing Facilities as the level of their need does not meet skilled criteria. Alternatively, if the member does not wish to go to the SNF and is compliant with the entry criteria they would be referred.

A typical stay at Circle the City lasts between four to nine weeks depending upon the severity of the condition. During that period, the individual receives hands on medical treatment as well as wrap around support services to get them back on their feet. Members enrolled with Circle the City receive ongoing wound care and treatment of conditions requiring oral medications that would normally be completed in a home setting. Some individuals receive behavioral health counseling as well as assistance with post-treatment placement. Circle the City receives a per day bundled case rate depending on severity of the individual. Currently, there are four tiers of payment.

The initial outcomes of the intervention have been positive with the limited population we have served thus far - 43 members to date. A review of the six months of claims data for these members prior to the intervention and three months post-intervention have found post intervention utilization of emergency services and readmissions rates are significantly lower. As a result, the overall claims experience for the population receiving the intervention was reduced and resulted in overall savings to the plan.

Based on our experience, we believe a concerted effort to develop a Health Home for the Homeless in Los Angeles County could help to improve outcomes for homeless Medi-Cal patients while reducing unnecessary utilization of high cost services.

### **Health Home for the Homeless Concept**

DHCS should pursue specialized Health Homes for the Homeless population in Los Angeles. The overall goal would be to provide on the ground care for individuals experiencing homelessness through an innovative network of experienced providers. Identification and outreach to the homeless will require an intricate strategy including but not limited to health care, social services and housing. No single community based entity will have all of the expertise or resources available to meet the population's needs. The health plan would act as the convening entity, responsible for identification and

development of strategic partners and ensuring members receive the appropriate services. Health Net believes this approach will maximize resources across the program and better target the population.

In order to develop the appropriate model, health plans will require sufficient implementation time in advance of the program start date in order to identify appropriate partners and put in place the necessary administrative mechanism for Health Home program contracting, payment and administration. Consequently, Health Net recommends pushing out the start date until July 1, 2016. This additional time will ensure DHCS and the participating plans have made the changes necessary to implement the program.

In addition, prior to implementation, DHCS must set prospective rates for the additional services required under the Health Home program as well as provide startup funding to allow appropriate investment in infrastructure at the plan and partner level. The current provider community does not generally have the required relationships or organizational structure in place to address the needs of the homeless population. Providing initial investment in the Health Home development will assist in the successful roll out as well as long term patient engagement in the program.

Key Elements:

### **1) Identification and evaluation of population**

In the development of a Health Home for the Homeless, the most significant stumbling block will be identifying the population appropriately. The data available on the health plans' enrollment file provides only cursory indicators of homelessness such as a lack of address, more than 20 individuals registered at the same "home" or use of a county address. Our experience in Arizona has shown that the discharge planning process from an inpatient stay may be the best opportunity to identify homeless members and actually connect them with the appropriate health care intervention rather than attempting to seek out individuals on the street or in the emergency room. Secondly, health plans would need to work closely with providers and community base organizations to identify homeless members using a multi-pronged approach to outreach in the community. See below for more detailed discussion.

In order to track these members for evaluation and payment purposes, DHCS will need to develop a specific indicator for reporting on the 834 file. The plan would report to DHCS monthly which members had been identified and assigned to the Health Home which would then be reflected in the 834 file. Without such an indicator, data pulls will be extremely difficult particularly if the intervention is successful in connecting the individual with housing opportunities.

### **2) Use of Health Plan as the Coordinating Entity**

The Health Home for the Homeless will require an innovative set of strategic partners with the health plan as the coordinating entity. In some instance, Health Home services will need to be provided by the health plan when acceptable community-based care management entities are not available. Health plans already have extensive care management experience particularly in those areas where delegation to provider groups is not well established. Direct payment to health plans for those specified Health Home benefits may also be necessary as an interim measure while the individual is being stabilized and connected to a permanent Health Home.

### **3) Transitions of Care**

Identification of members for the Health Home for the Homeless during an inpatient stay will require a two-step process to ensure enrollment and engagement with the Health Home can be successful. First, the acute condition for which the individual was hospitalized must be stabilized appropriately. As we have seen in Arizona, many homeless members are readmitted to the hospital shortly after discharge due to the lack of appropriate follow up and at home care. Basic wound care, medication management, and access to follow up care can be impossible when living on the street.

In order to move homeless individuals from hospitals to a lower level of care, health plans will need to identify local recuperative care providers with available capacity to meet the population's needs. While recuperative care is not generally a benefit in Medi-Cal managed care, DHCS should consider use of the 1115 Waiver Renewal to provide funding for this benefit as a cost avoidance strategy. The health plans could contract directly with the recuperative care provider as the first step to settling into an outpatient Health Home or, if partnered with a provider organization with the appropriate expertise, the recuperative care benefit could be a part of the overall Health Home benefit package.

Under the Health Home for the Homeless, the health plan would engage those hospital partners identified as having the highest level of utilization by potentially homeless members to enhance the discharge planning and referral process to the Health Home. When a member is identified by the hospital as homeless, the member's health plan would be contacted for evaluation and eligibility review. A dedicated nurse or discharge planner would evaluate the individual for eligibility for the Health Home including identification of the specified chronic conditions, willingness to participate in the program and abstain from alcohol and drug use or accept treatment if a substance use disorder exists. If the patient agrees to participate in the intervention, the health plan would have the individual transferred to the appropriate recuperative care provider as an interim step before a warm hand-off would occur with the assigned Health Home.

Plans would develop a tiered payment structure for the transitional period including specific criteria for interventions at each tier. To the extent that these services are reflective of the Health Home core benefits, the recuperative care provider would receive the Health Home payment while the individual resides within the facility. Upon discharge into the community, the Health Home assignment and payment would transfer to the assigned participating provider group (PPG) and its Health Home partners.

The health plan or assigned outpatient Health Home would be informed by the recuperative care provider that the individual is medically sound enough to be discharged from care. Upon notification, the health plan, if applicable, would contact the Health Home and a warm hand-off between the providers would occur. Prior to the transfer of responsibility, a case manager from the assigned Health Home would be required to meet with the individual, assess their needs and determine appropriate next steps. When possible, housing solutions would be identified in advance of discharge either by the recuperative care or Health Home provider.

### **4) Boots on the Ground Partnerships**

The health plans already contract with PPGs and clinics with special expertise and experience with high risk populations. However, not all providers have experience in addressing the unique needs of the

homeless. Ideally, a Health Home should have a specific focus on primary and preventive care but individuals experiencing homelessness must have more immediate needs met before chronic medical conditions can be ameliorated.

The member's assigned PPG will continue to be responsible for medical care but, in order to be designated as a Health Home, would be required to partner with an identified community based "boots on the ground" organization (CBO) charged with addressing the social and environmental factors preventing the individual from achieving the appropriate health care outcomes. The PPG/CBO team would engage in team management of the individual, reviewing both the physical health and social needs of the individual. Each individual enrolled in the Health Home would have a case manager, preferably a social worker, to provide one-on-one support when necessary and assist the individual in accessing community and housing services appropriately.

In addition, the CBO would act as a second entry point into the Health Home program. With direct ties into the community, the CBO would be charged with identification and engagement of similarly eligible homeless members. Using claims and encounter information as well as the state's 834 file, the plans can support the PPG/CBO teams' efforts to appropriately seek out these members to engage them in care.

The CBO, upon identification and engagement of eligible members, would obtain written consent to enroll the member into the Health Home and connect the individuals with the PPG. The PPG/CBO teams would be charged with evaluating the member and creating a care plan based on the member need in the same manner as those individuals identified during an inpatient stay. In order to provide a full picture of the individual, the care plan should include safety and environmental assessment as well as physical and psychosocial needs.

PPGs engaged in the Health Home program would also be responsible for coordinating with the county mental health system. Many individuals experiencing homelessness also have mental health or substance use disorder issues making the intersection between these conditions and both physical health and social needs a necessary component to stabilizing the individual in the community. The PPG/CBO team would engage directly with the county mental health providers to ensure services rendered in the county align with the level of need and that the patient is adhering to treatment protocols.

## **5) Evaluation and Data Collection**

As referenced above, data collection and evaluation of the project require investment on the part of DHCS. For each individual participating in the Health Home, a minimum of 6 months of claims experience pre-intervention will be necessary including review of inpatient admissions and emergency room utilization. After enrolled in the Health Home, multiple measurement periods may help provide a more comprehensive long term look at outcomes. Initial quarterly reviews of readmission and emergency room utilization will be indicators of immediate term success. While long term change in patient health will become evident further into the program through improvements in indicators such as medication adherence and preventive screenings.

Thank you for the opportunity to partner with you on the development of the Health Home concepts. Health Net is excited by the potential opportunity to better serve our members through strategic initiatives identified in the 1115 Waiver Renewal and the Health Home concept papers. These two initiatives, while moving forward separately, both seek to improve patient outcomes through innovative models of care. As we described above, alignment and integration of these programs can better leverage our efforts and funding to meet these goals in a cost effective manner.

Please feel free to contact me if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Abbie A. Totten". The signature is written in a cursive style and is contained within a thin black rectangular border.

Abbie A. Totten  
Director, Government Programs Policy & Strategic Initiatives

CC: Claudia Crist, Deputy Director, Health Care Delivery Systems, DHCS  
Sarah Brooks, Chief, Managed Care Quality and Monitoring, DHCS



## **Health Homes for Patients with Complex Needs Concept Paper**

### ***Introduction***

Over the last several years, the health care industry has focused on the establishment of Health Homes. Beginning in the pediatric setting and then expanding to the primary care setting, many medical practices large and small have sought certification for Patient Centered Medical Home (PCMH).

Following the enactment of the Affordable Care Act (ACA) the health home has gained greater importance as this act created a Medicaid Health Home State Plan Option. This is allowed under Affordable Care Act Section 2703. The purpose of the Health Home concept is to create a health home that provides a full range of physician, behavioral and community based long term services and support (LTSS) for beneficiaries who have chronic health conditions. IEHP has been engaged in several health home initiatives and is uniquely poised to actively participate in the proposed Section 2703 Health Homes for Patients with Complex Needs Program (HHP) project as IEHP serves over 1 million low income residents or 1 in 4 residents in San Bernardino and Riverside Counties. IEHP has been providing a medical and behavioral health safety net for this vulnerable population for over 18 years. The health home concept fits well with IEHP's mission. The HHP overarching goals align well with the Triple Aim for better care, lower cost of care and Better health.

The Federal government will fund 90% for the first 2 years and the California Endowment will fund the remaining 10%. California plans to submit a Section 2703 state plan amendment (SPA) in spring/summer 2015.

Per Federal requirements, states can choose to define one or more of the following groups of eligible individuals for Section 2703 health home amendment:

1. Individuals with 2 or more chronic conditions
2. Individuals with 1 chronic condition and at risk for another
3. Individuals with serious and persistent Mental Illness.

This will target all age groups and the state intends to target all three categories with emphasis on high cost, high utilization persons that can benefit from increased care coordination of physical, behavioral and LTSS services.

The state has asked for input from Health Plans to guide the SPA.

IEHP is in a credible position to provide input because it serves 2 of 7 counties across the state participating in the Coordinated Care Initiative (Cal MediConnect) and is one of the few Medicaid Health plans that has Behavioral Health in-house. The co-location of behavioral and physical health entities has maximized the ability to reach patients in a whole person way. In addition, the plan has an active record of support and coordination of numerous community resources in both counties and has a solid relationship with all county health related agencies.

Additionally, IEHP is awaiting award confirmation from CMS for Practice Transformation grant and has experience with the IEHP Tides Grant for Riverside County Practice Transformation Experience. Both of these initiatives add additional resources and potential funding for the Health Home model. Another model IEHP is actively pursuing is the Whole Person Care Initiative with the goal to co-locate behavioral and medical resources at a single site.

### ***Program Description***

The intent of the HHP is to ultimately provide more intense care coordination of resources and care to those individuals who meet the criteria outlined in the concept paper. If successful, the program will result in reduced hospital admission and emergency visits, more engaged patients and decreased costs.

The goals of the program are:

1. Improved care coordination
2. Integrated palliative Care in Primary care delivery
3. Strengthen community linkages within health homes
4. Strengthened team-based care with the implementation of community health workers, promoters and other frontline workers
5. Improved health outcomes for people with chronic and high risk conditions
6. Ability to provide data to support the decrease in cost over an 18 month timeframe

The Objectives of the Health Home are:

1. Ensure and build provider infrastructure to provide capacity to implement HHP as an entitlement program
2. Ensure Health Home providers appropriately serve members experiencing homelessness
3. Increase Integration of physical and mental health services
4. Create synergies with the CCI initiatives counties

5. Maximize federal funding while achieving fiscal sustainability after 8 quarters of federal funding
6. Focus on High cost beneficiaries with Chronic Conditions
7. Wrap Increased care coordination around existing care

The State anticipates that 3-5% of the highest risk Medi-Cal population will benefit from enhanced case management services based on their enrollment criteria. We estimate that about 10% of IEHP enrollment will meet the criteria for inclusion.

### ***IEHP High Level Concept Evaluation***

IEHP supports the concept goals and believes the model proposed to achieve the goals represent the best method to achieve the goals. We do have some concerns and questions about the currently drafted plan. Most concern pragmatic issues related to implementation given the local environmental realities.

We believe the funding should flow through the Health Plan in order to ensure care coordination.

1. Most of the document implies or states that Health Plans will be funded, but page 12 first section uses the wording "it is anticipated" that funding will come through the health plans so we need clarification.
2. There is some language that county Mental Health could be directly funded for their sites for SMI Members that would "prefer" getting home health services at their behavioral health clinic. It would be better for the funds to come through the health plan to those sites to ensure coordination.

There is significant language regarding the Community Based Care Management Entities including assessing them, certifying them, etc. Sites are tied to this concept, e.g. FHQCs (community clinics), primary care clinics, specialty clinics, local health departments, hospitals, mental or substance abuse clinics, etc. These are sites of care, not care management entities. There will be significant effort required to assess and certify. It appears that what DHCS desires at the core is some additional care management/care coordination resources at point of care. The concept paper makes this process very complicated (expensive).

DHCS is focused on point of care services for care management, which is good, but there are issues:

1. There are many geographic areas that will not have entities with the capability to do these services, so wrap around services from the plan will be required. It is not realistic that all or even most care sites will be capable or willing to provide this level of care management and/or will not have enough qualified/eligible Members to make it work logistically or financially.

2. The cost for point of care, Care Management for our network would be enormous. The staffing requirements for CB CME are unrealistic for most sites.
  - a. Program Director
  - b. Care Manager
  - c. Health Navigator
  - d. Housing Advocate
3. DHCS states that fully enrolled Dual eligible's are included in the program. This will be very complicated to integrate with our Model of Care and requirements under Cal MediConnect. This complication will add significant administrative cost. Cal MediConnect requires health plans to provide intensive case management services. The requirement could cause service duplication if case management is being performed by the health plan, clinics, IPAs and elsewhere.

The concept paper has language regarding "selecting a health home" for the Members. All Members have established (or at least assigned) PCP relationships. Many of our PCPs will not meet the Health Home criteria (unless again they allow the Health Plan to do the wrap around services). The concept paper implies that they would have to change PCPs which is contrary to regulatory provision for Member choice.

Overall, we believe there are three major impediments to implementing the concept as currently proposed:

- 1) Cost. We believe the cost for staffing to support the concept is between \$83-130 PMPM.
- 2) Resources. There are not enough qualified people in the area to fill the roles even if the dollars are made available.
- 3) Technology environment. The EHR meaningful use penetration and interoperability required for the concept is 3-5 years away in this geographic region.

#### ***IEHP Proposed Health Home Program Description***

The main driver of the Health Home Program is Comprehensive Case Management. The IEHP program acting as administrator and oversight will build a health home network in which the member can choose the CM-CBE they want to join for their care coordination.

IEHP suggests 3 community based care management models to address the realities that exist in our Provider network. Given the geographical challenges of San Bernardino and Riverside counties, the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population in these counties, one main approach is not reasonable or practical.

The first and ideal tier is embedding case managers on-site in Provider offices. The second tier would be case management provided by the health plan and the third tier is a hybrid of regional on-site staff, telehealth and technology to serve those beneficiaries who live in remote regions.

### *Tier I*

IEHP has already identified 30 clinics that would be considered first for the Tier 1 complex case management with embedded Case Managers. We would need to do a capabilities assessment to determine if existing staff is available or additional staff would be need to be recruited and hired to meet the requirements of the CM-CBE and certification requirements. Based on our experience with the PTN Grant at this time only 1 of the 30 clinics would meet the strict criteria for CB-CME.

### *Tier II*

The second tier of eligible beneficiaries would be handled by IEHP health plan case management. A Health Home Department within the existing case management department will act as the CB-CME. It will handle Health Home members who are not assigned to a county clinic or medical practices in Tier I.

### *Tier III*

Tier III would be a hybrid model where case managers, located in regional offices, utilizing technology and other monitoring and communication devices will become CM-CBEs who can be geographically close to rural individuals and/or those patients who meet inclusion criteria but who are assigned to a solo practitioner who may not have enough membership to meet Tier I or II.

The three tiers will allow greater participation for high risk members regardless of location and type of provider empanelment.

Once the data set is defined by the state and the identified population has been determined, that subset of IEHP members will receive a comprehensive assessment and an individualized care plan/Health Action Plan (HAP) will be created. The HAP will be reassessed as there are changes in the beneficiary's progress or status and health care needs. The HAP will be the central point for directing patient-centered care and is intended to:

1. Improve outcomes through coordinated physical, mental health, substance abuse, community based LTSS, palliative care and social services support.
2. Reduce avoidable health care costs, especially admissions, readmissions and ER Department visits and preventable nursing home stays.

IEHP has extensive experience administering Health Risk Assessments as they are a current Cal-MediConnect requirement. IEHP currently utilizes a vendor to conduct these assessments and also performs a portion in case management using available health plan data sources to provide additional physical, pharmaceutical and behavioral information. This assessment is available to the primary care physicians and delegated managed care partners via the IEHP secure web portal upon completion. The completed assessment can be downloaded and then the case manager in any of the 3 tiers can reach out to the Member and develop a HAP in conjunction with the Member, care giver, family, primary care physician and any other additional interdisciplinary team care team members such as county agencies and volunteer support entities.

The requirements outlined in the most recent Concept Paper 2.0 for the MCP and the CB-CME will need to be vetted and analyzed as CB-CMEs are identified to determine if they can meet the 11 functions. IEHP can meet the outlined requirements. It will need to be determined if a CB-CME that does not meet all criteria can be made whole through health plan or other provider service agreements. Time and resources will need to be allocated to ensure there are enough CB-CME resources available to serve the area.

### *Medi-Cal Managed Care Plan Responsibilities*

IEHP will have ultimate accountability for the HHP. IEHP is committed to create a department specifically dedicated to oversee administrative aspects of the HHP. This would include a Program Director, CB-CME certification and monitoring CB-CME training, tools and reporting capabilities. Payment from DHCS will flow to IEHP and then to CB-CMEs. In addition, the plan will have the ability to contract with and include additional providers who may not be on the care team to participate in the multi-disciplinary care team, as needed. The Plan will have strong oversight and regular auditing and monitoring activities to ensure that case conferences occur and the HAP is updated as health care events unfold.

IEHP clearly meets the requirements for qualifications for a Health Home MCP as outlined in Version 2 Concept paper. There will need to be prompt identification of CB-CMEs, data analysis of eligible members and assignment into a CB-CME in one of the 3 Tiers. IEHP has a strong case management department that can be leveraged to train, support, and qualify CB-CMEs. IEHP currently performs similar monitoring, training and auditing for all of the IPA delegated entities that IEHP contracts with for Cal-MediConnect, S-SNP and Medi-Cal IPAs.

The IEHP utilization department will assist the CB-CMEs with information on admission, discharges and ensure timely follow up care. The IEHP Health Care Informatics (HCI) analytics team will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

IEHP will participate in the certification process and perform the outlined duties for an MCP.

### *Community Based Case Management Entities (CB-CME)*

The CB-CME is the pivotal entity of the Health Home concept. Whenever possible it will be rooted in the community and have strong affiliations with community clinics and social resources. IEHP will provide a certification process similar to the State certification for Managed Care Plans (MCP). IEHP will contract with CB-CMEs who meet the certification requirements and can provide evidence they are capable based on their program descriptions, staffing, availability of community and public resources, and on-site audits.

The Health plan has the ultimate goal to ensure the following are met either by the CB-CME or the MCP:

1. Ensure case management delivery and sufficient health home funding is provided at the point of care in the community
2. Ensure that providers who have experience serving frequent health care services users or those experiencing homelessness are available as needed
3. Leverage existing county and community care management infrastructure and experience when possible and appropriate
4. Utilize community health workers in appropriate roles.

The qualifications for the CB-CME outlined in the concept paper are reasonable with the exception of accompanying members to their critical appointments. In Tier I this should be reasonable but for more remote areas in Tier II or Tier III the use of telemedicine or other technology will need to be deployed.

Health Information Exchange (HIE) will be critical to ensure communication and information exchange. The technology environment does not currently support the HHP requirements.

- Relatively few Providers in this area have EHRs and there is no interoperability between the systems that are in place.
- There is an HIE in the area, but the configuration is not designed for the HHP requirements.
- IEHP is engaged in a selection process for an electronic medical record integration vendor for our network Providers to use. The estimated time for implementation is 2 years after selection. A Clinically Integrated Network project is in the initial development stages to coordinate services provided in the 2 county operated hospitals, their clinic systems and Loma Linda University Health's hospital and clinic system. A recently completed EHR integration assessment reveals that it will be 3-5 years before integration can be accomplished.

### ***Multi-Disciplinary Health Home Team Qualifications and Roles***

After review of the team members outlined in the concept paper, IEHP is concerned about the number of team members and the associated costs. The case manager is critical but the director and clinical consultant roles will increase cost and IEHP believes it will be more cost efficient to centralize these two positions and spread their roles over several CB-CMEs. Community health workers will need to be assessed to ensure adequacy to perform their current roles and add additional responsibilities such as outreach, clerical, advocacy, Member accompaniment to office

visits, arrange transportation, distribute educational materials, etc. This position is critical to the smooth operation, communication and coordination of member needs. But, IEHP sees this as an addition to existing staff. These staff will require on-going training and support and regular audits to ensure consistency and standard practices.

IEHP is currently exploring multiple housing options for Members who are homeless to provide immediate housing post discharge and find permanent housing. Stakeholders include the health plan, hospitals, local housing authorities and community based organizations. This initiative will be important to be formalized before the HHP starts.

### ***Eligibility and Enrollment***

IEHP will enroll eligible members into a CB-CME and notify the member via a letter. IEHP will follow the protocol outlined in the concept paper page 18.

### ***Payment Methodologies***

It is premature to comment on the payment until a more definitive payment structure for Health Homes is developed. However IEHP wanted to share some recent data for cost based on a grant proposal to CMS which is a fairly close proxy for the Tier 1 model proposed above.

CMS's initiative goals are similar to the HHP goals. Utilizing practice transformation networks, CMS intends to improve health outcomes for Medicare and Medicaid beneficiaries through care coordination; reduce costs by minimizing unnecessary hospitalizations and overutilization of other services.

As the lead agency, we determined that we would require the following resources to support the effort:

- Project Manager
- Quality Improvement Advisor
- Clinical Informatics Project Manager

The partners agreed that there would need to be a consultant / training component:

- Consultant Manager
- Trainers/Coaches – 1:10 ratio Trainers/Coach:PCPs

We asked the partners what resources they would need within their clinical systems to accomplish the goals. Their requests included:

- Care Managers
- Care Coordinators
- Pharmacists
- Dieticians

- Promotores
- Social Workers
- Change Managers
- Process Improvement Engineers
- IT Support
- Software
- Hardware
- Clinical Champion

The total cost for this model is \$130.00 PMPM in 2015 and projected to be \$150.49 in 2018. As this far exceeds the maximum grant award, we revised the model.

We submitted the following model in the grant proposal:

- Lead Agency Staff
  - Project Manager
  - Quality Improvement Advisor
  - Clinical Informatics Project Manager
- PTN Consultant
  - Consultant Manager
  - Trainers/Coaches – 1:10 ratio Trainers/Coach:PCPs
- Clinics
  - Each Clinical Partner
    - System-wide Clinical Champion (0.1 FTE)
    - System-wide Change Manager (1.0 FTE)
    - Process Improvement Engineer (1.0 FTE)
    - Data Analyst (1.0 FTE)
  - At each clinic site
    - RN/Care Manager (1.0 FTE)
    - Care Coordinator (1.0 FTE Social Worker / 4.0 FTE PCPs)

The total cost for this model is \$83.71 PMPM in 2015 and projected to be \$96.90 PMPM in 2018.

These cost estimates are for the staff to support a health home model. The costs do not include the actual cost for medical care.

### ***Reporting***

IEHP has a process currently to monitor and report a core set of Health Quality measures. IEHP currently reports on 6 of the 8 quality measures listed in Version 2. Of the utilization measures that are used to assist in the federal home health evaluation, IEHP currently reports on 3 of the 3 draft measures. Once the technical specifications are released, IEHP will strive to report the additional metrics.

## *Interactions with Medi-Cal Programs*

### *Health Home Projects Currently Underway in the Inland Empire*

Many IEHP Provider partners are in various health home implementation project phases. There are other projects our partners and IEHP have initiated independently which contribute to the health home goals. Health plan resources are being pulled in various directions to support these efforts and IEHP recommends thoughtful alignment with a number of these programs as they attempt to achieve the same goals.

#### *Riverside County Family Care Centers – Patient Centered Medical Home Initiative*

Riverside County and IEHP received a Tides Foundation Grant in 2012 to implement PCMH practices in the 10 FQHC Look-alike Family Care Centers operated at the time by the Department of Public Health. The grant provided \$1M over 2 years for implementation. PCMH implementation was only partially successful with various degrees of partial implementation across the clinic system. Barriers to full implementation include: a) There is not an EHR in place, b) Not enough resources were available for training/coaching, c) Not enough resources were available to support the desired clinical practice changes.

#### *Mental/Behavioral Health Integration*

IEHP created a Behavioral Health Department and Provider Network to meet the needs of our dual eligible population in 2010. This enabled IEHP to be better prepared than most other MCPs when the ACA's behavioral health service requirements took effect and when the Cal MediConnect program was implemented. IEHP's Behavioral Health Department has worked with the County Mental Health Plans to coordinate referrals to and between our network and the counties so that Members have access to the appropriate treatment. Our network handles the mild and moderate needs (90-95% of Members) and the counties handle severe needs.

#### *San Bernardino County Community Clinics Association – Blue Shield Behavioral Health Integration Project*

IEHP has worked with the San Bernardino Community Clinics Association for the last 2 years on succession of planning grants aimed at integrating behavioral health into primary care clinics. The project has brought to light and quantified barriers related to technology, high-speed internet access in remote locations and clinic workflows.

#### *Riverside County Behavioral Health Integration*

Riverside County operates 10 FQHC Look-alike Family Care Centers and multiple behavioral health outpatient clinics distributed across the county. Riverside County has co-located a behavioral health provider into the Rubidoux Family Care Clinic and a PCP into the Blaine Street (Riverside) behavioral health clinic. There are plans to have a fully integrated clinic operating in Temecula and clinics in close proximity in Indio. They developed a universal release of information consent that is accepted by all County operated facilities. The most

significant barrier to achieving their goals is that the ambulatory care clinics do not yet have an EMR in place.

### *San Bernardino County Public Health Integration*

San Bernardino County has 3 FQHC sites in Ontario, Adelanto and Hesperia. They have plans to include behavioral health services in these clinics and they are working to convert their other public health clinics into primary care clinics with behavioral health services. They recently selected an EMR and are in the planning phase for implementation. The most significant barrier they appear to have is finding PCPs to work in the existing clinics.

### *Behavioral Health Integration*

IEHP has hired a consultant to quantify behavioral health integration across our network and develop recommendations for how we can provide incentives for providers to develop behavioral health homes.

Phase one:

- Population segmentation
- Establish Community Health Home criteria
- Identify selected provider locations to implement established criteria
- Access provider readiness
- Develop Community Health Home Pilot Recommendations
- Project BHI Initiative costs

Phase two:

- Develop BHI Initiative dissemination Infrastructure
- Launch BHI Initiative

### *Substance Abuse*

Substance abuse has historically been a carve-out to the counties. The recent prevalence in opioid based pain medication prescriptions has led to a significant increase in Narcotic Mis-use and addiction in Members that receive pain management treatment. IEHP's behavioral health and medical directors have collaborated to initiate pilot pain management programs in Riverside County based on a "whole person" care. The pilot programs have embedded psychologists and substance use disorder providers working with pain specialists and ancillary services such as physical therapy.

## *DHCS 1115 Waiver Renewal*

DHCS has presented and asked for community feedback on the 1115 waiver proposal. The proposal has components that are similar to the proposed HHP.

- Managed Care Systems Transformation & Improvement Programs
  - Encourage shared criteria between Managed Care Plans (MCPs) and Mental Health Plans (MHPs) through incentive pools
  - Encourage MCPs to offer provider incentives for physical and behavioral health integration
- Increased Access to Housing and Supportive Services
  - Regional integrated whole person care pilots

There should be clarity and alignment on what is 1115 waiver and what is Section 2703 requirements.

### ***Summary***

In Summary, IEHP is supportive of the HH Project but kindly ask the state to consider the points raised in this concept paper and include them in any future additions, refinements or enhancements to the Health Home Project.



**LHPC**  
Local Health Plans of California

**Board Chair**  
Bob Freeman

**Members**  
**Alameda Alliance for Health**  
Scott Coffin, CEO

**Cal Optima**  
Michael Schrader, CEO

**CalViva Health**  
Gregory Hund, CEO

**CenCal Health**  
Bob Freeman, CEO

**Central California Alliance for Health**  
Alan McKay, CEO

**Community Health Group**  
Norma Diaz, CEO

**Contra Costa Health Plan**  
Patricia Tanquary, PhD, CEO

**Gold Coast Health Plan**  
Ruth Watson, Interim CEO

**Health Plan of San Joaquin**  
Amy Shin, CEO

**Health Plan of San Mateo**  
Maya Altman, CEO

**Inland Empire Health Plan**  
Bradley Gilbert, M.D., CEO

**Kern Health Systems**  
Doug Hayward, CEO

**L.A. Care Health Plan**  
John Baackes, CEO

**Partnership HealthPlan of California**  
Jack Horn, CEO

**San Francisco Health Plan**  
John Grgurina, CEO

**Santa Clara Family Health Plan**  
Elizabeth Darrow, CEO

**LHPC**

Caroline Davis, Senior Policy Director

Leah Barnett, Business Manager

May 13, 2015

Jennifer Kent, Director  
California Department of Health Care Services  
1501 Capitol Avenue  
P.O. Box 997413  
Sacramento, CA 95899-7413

RE: Medi-Cal Health Homes Concept Paper Version 2.0

Dear Jennifer:

On behalf of the Local Health Plans of California (LHPC), we are writing to offer comments on the Health Homes Project (HHP) Concept Paper Version 2.0. LHPC represents all 16 of the public, not-for-profit health plans in California that predominantly serve low-income communities through the state's Medi-Cal program. As of February 2015, LHPC plans are providing care to 5.6 million of the 9.2 million members enrolled in Medi-Cal managed care across the state.

As partners with the Department of Health Care Services (DHCS) in delivering high-quality, comprehensive care in the local communities that we serve, the local plans support the goals of the proposed health homes benefit. Our comments and suggestions reflect our commitment to work with you to ensure the successful implementation and long-term viability of the health homes benefit. We look forward to meeting with the Department on May 19<sup>th</sup> to discuss our comments in greater detail.

### **Timeline and Readiness Requirements**

Significant preparation at the plan and provider level is required to ensure readiness for the HHP. Accordingly, it is important that readiness requirements are realistic and that plans and providers be given sufficient time to meet those requirements. Additionally, the current timeline does not provide sufficient time for HHP rate approval and subsequent provider contracting by the health plans. The viability of the HHP will depend on the rates paid to the health plans and to the Community Based Care Management Entities (CB-CMEs), making it critical that the health plans have a final rate in place before engaging in contracting discussions. Lastly, the HHP requires that all plans within a geography demonstrate readiness prior to launch. This requirement may not be realistic and requires further dialog.

There is significant concern about the level and uniformity of provider requirements currently articulated by the HHP. Specific issues include the following:

- The required information technology (IT) currently is not available as many providers lack electronic health record systems and technology capacity to process eligibility files, and are not equipped to engage in registries or health information exchange such as required by the HHP;
- Provider readiness varies widely by provider type and geographic region. There are many provider types, including health centers, solo providers and medical groups, and the approach to accomplish readiness within each practice type will vary. Areas of the state that rely on solo providers, many of them rural, have significant concerns about the ability to meet readiness requirements at all. The requirement that all providers exhibit readiness is not realistic and almost certainly will not be met;
- Given varying provider capacity, providers will need time for significant training and other preparation to be ready to address the complex, intensive and often access-challenged service needs of the beneficiary population.

**Recommendation #1:** *Delay implementation by 9-12 months to allow for final rate approval by the Centers for Medicare and Medicaid Services and subsequent contracting by the plans, as well as sufficient preparation and training prior to launch. In addition, loosen provider readiness requirements related to IT, staffing and training, among other areas, to reflect a realistic expectation within the current provider environment. Further, remove requirements that all providers and all plans within a geography demonstrate readiness prior to launch.*

### **Health Homes Roll-Out**

The CCI plans are concerned that implementing the HHP first in the CCI counties may compromise the success of both the HHP and CCI. Health plans in CCI counties are immersed in the readiness, network expansion and administrative requirements necessary for CCI program success. Many CCI beneficiaries will also be eligible for the HHP. However, the overlap and similarity between the HHP and CCI, rather than being helpful, actually makes the roll-out and operation of the HHP duplicative and more difficult. CCI is governed by a different set of administrative and care coordination requirements approved by CMS and already in place. For example, CCI includes social service optional benefits that are the same as the HHP, however the requirements for how services are delivered would require plans to build duplicative administrative structures and pay for duplicative staffing expertise. In addition, plans are currently required to complete a health risk assessment; the HHP requires providers to complete a similar health action plan. Not only will the duplicative and conflicting requirements of the HHP and CCI be challenging for the plans to implement, but they will be confusing to consumers and may result in mixed evaluation results.

**Recommendation #2:** *Allow optional roll-out of the HHP in CCI counties and focus on supporting roll-out of the HHP in non-CCI counties.*

## **Beneficiary Eligibility Criteria**

It is essential to develop target population eligibility criteria that will produce a manageable number of participants and be conducive to effective and focused interventions that lead to improved health and cost savings. A beneficiary population that is too large cannot be managed at the intensive, high-touch levels intended. An overly broad set of criteria threatens overall success by including consumers who do not benefit from intensive case management and may not realize cost savings.

The health plans are concerned the proposed eligibility criteria is too broad and will result in a large and diverse beneficiary population that will exceed service capacity and available funding, as well as reduce the potential for the greatest impacts on clinical outcomes and cost. Initial analysis by individual plans using the proposed eligibility criteria resulted in large numbers of beneficiaries, beyond the capacity of local providers to serve and with unclear benefits from case management. Plans also noted that the list of diagnoses is extremely diverse with varying potential for clinical improvement and cost reduction. Additionally, they highlighted that, within different diagnoses, some beneficiaries exhibit significantly higher severity and risk factors than others and with conditions that are too advanced to be effectively managed by HHP services.

More effective eligibility criteria may consider: 1) a more focused list of diagnoses that are the most potentially responsive to the proposed intervention; and 2) a higher risk threshold to narrow the beneficiary population to numbers that are manageable from a service and resource perspective. In addition, for the purpose of determining acuity levels, we suggest the use of risk stratification techniques, such as severity of condition (e.g., uncontrolled diabetes), identification of end stage disease or refractory conditions that may not benefit from HHP intervention, and emergency department/inpatient utilization.

**Recommendation #3:** *Narrow the eligibility criteria to allow for both a smaller and more manageable population of beneficiaries, as well as ensure that those beneficiaries targeted have the highest potential for future health improvement and cost savings. We further recommend the development of eligibility criteria in coordination with the health plans and with use of additional data analysis and predictive modeling.*

## **Health Homes Staffing Structure**

To ensure the success of the HHP, LHPC appreciates the need for robust team staffing to serve high-need consumers, and the proposed staff model has many positives, including the team approach reflecting multiple disciplines and an innovative blending of expertise. However, the requirement to staff every health home with a full complement of team members is prescriptive, cost prohibitive and poses significant challenges to readiness and implementation of the program. For example, if a CB-CME has only a limited number of homeless individuals, it may be able to have another staff member fill the housing navigator role. Beyond the cost involved, we are concerned that requiring a full team complement in every health home may be unrealistic to operate, will lower provider participation and may cause unnecessary disruption in care. Further, there are many geographic areas of the state that will not have entities capable of providing the full array of health home services, and it will be necessary for the health plans to provide wrap-around services. At the same time, some health plans are already providing health home-like services that are not contracted out via a CB-CME structure

and should have the flexibility to continue as the primary provider of such services for the HHP. Language in the concept paper addresses situations in which a plan can directly provide team staffing and services to beneficiaries; however, it is unclear how much flexibility is intended. Finally, the replication of staffing between health plan and care provider, and between Cal MediConnect requirements and the HHP is duplicative and expensive. The plans have a number of suggestions that would reduce the costs of the staffing requirements while maintaining the staff model intent and provision of intensive case management services.

**Recommendation #4:** *Allow plans flexibility to design local staffing structures that meet the intensive case management service requirements and program outcomes to lower costs and decrease barriers to implementation.*

### **Long-Term Sustainability and Feasibility**

The plans are concerned about the costs of the HHP as described in the concept paper. One health plan has developed projections that indicate costs of approximately \$130 per member per month (PMPM) to operate the program. There may be insufficient funding to cover the cost of the program model, especially in light of capped overall funding and high numbers projected for the eligible target population. There are alternative staffing, technology and target population options to lower the overall cost of the program, and LHPC stands ready to partner with DHCS in this discussion. However, as written, the concept paper outlines a program that requires significant infrastructure investment, high ongoing costs and an uncertain long-term viability. Additional dialog is requested to address the feasibility concerns and outline a clear path to sustainability.

Prospective understanding of sustainability and success measures, once final program requirements are in place, will allow for timely implementation and focus on demonstrating results. Will sustainability depend on cost savings and cost avoidance overall? Locally? In a particular population or condition? Within a CB-CME? Is it possible to base cost savings on models that incorporate costs for several years preceding program implementation? Uncertain sustainability and long-term commitment to the program by DHCS coupled with high readiness needs, duplicative staffing and administrative structures create a challenging start for this important venture.

**Recommendation #5:** *Partner with the health plans to refine program requirements and determine sustainability parameters to project reasonable PMPM costs for the program.*

### **Role of County Mental Health Plans**

While the plans work closely with the county mental health plans, the proposal to allow direct contracting with county mental health plans will fragment funding and further complicate local coordination. Some HHP consumers will require intensive mental health services or benefit from health home services through mental health partners, and the overall coordination of care through a single local health plan for all beneficiaries will ensure this management.

**Recommendation #6:** *Allow only full-scope health plans to serve as the lead entities for the HHP and remove the option of direct contracting with county mental health plans to ensure continuity of care for all members.*

Thank you for providing the opportunity to submit comments on the draft health homes concept paper. We appreciate the ability to provide input and feedback and are committed to working with you in a collaborative manner. We look forward to meeting with DHCS on May 19<sup>th</sup> to continue this discussion.

Sincerely,

Caroline Davis  
Senior Policy Director

cc: LHPC Board



May 6, 2015

Health Home Program  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, Ca 95814  
[HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov)

Re: Comments on DHCS' Concept Paper Version 2.0 on Health Homes

Dear Health Home Team:

On behalf of Los Angeles Christian Health Centers, thank you for the opportunity to comment on Concept Paper 2.0 regarding Section 2703 of the Affordable Care Act, the health home option. LACHC is a federally qualified health center that has a grant to provide medical, social, dental, optometry, and mental health care to persons experiencing homelessness. Our mission is to show God's love by providing quality, comprehensive healthcare to the homeless and underserved.

We appreciate the work of DHCS staff in incorporating a focus on serving Medi-Cal beneficiaries experiencing homelessness. Below, I offer specific comments and recommendations for strengthening your concepts for the Health Home Program.

**Section B1: Eligibility & Section B6: Beneficiary Assignment**

Administrative data may accurately identify Medi-Cal beneficiaries incurring high costs, but, because Medi-Cal administrative data does not accurately identify beneficiaries experiencing homelessness, I recommend using a combination of administrative data and a referral process to identify beneficiaries experiencing homelessness. I agree with the list of chronic conditions in the concept paper, and recommend the State narrow by acuity according to hospital use or homelessness. Managed care plans would not be able to identify homeless beneficiaries through administrative data, but a referral process could identify additional criteria administrative data cannot. Additionally, I recommend using existing research data to identify indicators of high costs and poor outcomes among those experiencing homelessness. Data, for example, indicate Medicaid beneficiaries with frequent hospital admissions experiencing homelessness will continue to be admitted to the hospital frequently over time, and will continue to incur high costs.

Regardless of eligibility criteria selected, I recommend a process of referral that allows homeless service, housing, hospital, health center, and homeless service systems refer beneficiaries for potential eligibility, according to eligibility criteria the State adopts.

Finally, I recommend eliminating the requirement that MCPs approve adding beneficiaries to a health home. Waiting for approval could impact a health home's ability to engage homeless beneficiaries. Homeless beneficiaries will have no way of knowing they are eligible for health home services, unless the beneficiary seeks other services or is hospitalized. Potentially eligible homeless beneficiaries often present a brief window to engage. Most would be lost to follow-up in waiting for an MCP approval process. For this reason, I recommend establishing a process for receiving referrals from hospitals, homeless service and housing providers, health centers, or a region's homeless service system, for easily verifying eligibility, and

for granting health homes serving homeless beneficiaries the ability to approve beneficiaries provisionally. These health homes should get reimbursed a portion of the engagement rate while waiting for final MCP approval.

**Section B5: Community-Based Care Management Entities (CB-CMEs)**

I recommend, in health home staff roles, that Community Health Workers not be required to mail health promotion materials.

**Section B7: Payment Methodologies**

I support DHCS intent to implement a three-tier payment process, as well as the enhanced member engagement tier rate. To ensure consistency, the State should offer MCPs a per member, per month case rate that allows Health Home Programs flexibility in identifying and providing health home services each benefit requires. I further recommend limiting how much an MCP may retain, consistent with other states' state plan amendments, to ensure the vast majority of funding offers services to eligible beneficiaries, rather than administrative process.

Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. I look forward to engaging further in discussions on strengthening the Health Home Program.

Sincerely,



Lisa Abdishoo, MD  
President and CEO



May 6, 2015

Health Home Program  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, Ca 95814  
[HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov)

Re: Comments on DHCS' Concept Paper Version 2.0 on Health Homes

Dear Health Home Team:

**Peter Lynn**  
Executive Director

**Board of Commissioners**

Kerry Morrison  
Chair

Mike Neely  
Vice Chair

Larry Adamson

James Blunt

Elise Buik

Noah Farkas

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Thank you for the opportunity to comment on Health Homes for Patients with Complex Needs California Concept Paper Version 2.0. The following comments are submitted by the Los Angeles Homeless Services Authority (LAHSA), the Continuum of Care (LA CoC) lead in Los Angeles County which provides funding, fiscal and program management, homeless systems development, planning and policy development and outreach for homeless persons in our communities. LAHSA also coordinates the LA CoC Homeless Management Information System (HMIS) which links clients to programs and provides data for program assessment and system change.

We appreciate the work of DHCS staff in incorporating supportive housing into the concept paper, and in including housing navigators, tiered payment, and a focus on serving Medi-Cal beneficiaries experiencing homelessness. Below, we offer specific comments and recommendations for strengthening your concepts for the Health Home Program.

**Section B1: Eligibility & Section B6: Beneficiary Assignment**

Administrative data may accurately identify Medi-Cal beneficiaries incurring high costs, but, because Medi-Cal administrative data does not accurately identify beneficiaries experiencing homelessness, we recommend using a combination of administrative data and a referral process to identify beneficiaries experiencing homelessness. We agree with the list of chronic conditions in the concept paper, and recommend the State narrow by acuity according to hospital use or homelessness. Managed care plans would not be able to identify homeless beneficiaries through administrative data, but a referral process could identify additional criteria administrative data cannot. Additionally, we recommend using existing research data to identify indicators of high costs and poor outcomes among those experiencing homelessness. Data, for example, indicate Medicaid beneficiaries with frequent hospital admissions experiencing homelessness will continue to be admitted to the hospital frequently over time, and will continue to incur high costs.

Regardless of eligibility criteria selected, we recommend a process of referral that allows homeless service, housing, hospital, health center, and homeless service systems refer beneficiaries for potential eligibility, according to eligibility criteria the State adopts. Finally, we recommend eliminating the requirement that MCPs approve adding beneficiaries to a health home. Waiting for approval could impact a health home's ability to engage homeless beneficiaries. Homeless beneficiaries will have no way of knowing they are eligible for health home services, unless the beneficiary seeks other services or is hospitalized. Potentially eligible

homeless beneficiaries often present a brief window to engage. Most would be lost to follow-up in waiting for an MCP approval process. For this reason, we recommend establishing a process for receiving referrals from hospitals, homeless service and housing providers, health centers, or a region's homeless service system, for easily verifying eligibility, and for granting health homes serving homeless beneficiaries the ability to approve beneficiaries provisionally. These health homes should get reimbursed a portion of the engagement rate while waiting for final MCP approval.

## **Section B2: Health Home Services**

In the definition of services, we recommend greater emphasis on services that work to engage beneficiaries to achieve and maintain health stability on an ongoing basis. Many of the services identified in the concept paper are provided in supportive housing, and are critical to improving health outcomes. Yet, linking a beneficiary to treatment and to social services alone is insufficient to achieving those outcomes. Improving health among homeless beneficiaries and beneficiaries who are frequent hospital users is contingent on services that engage beneficiaries on an ongoing basis, promote healthy behaviors, and allow for self-management.

To incorporate these concepts into the definitions, we specifically recommend including the following:

- In the definitions of care management and care coordination, engagement services to motivate beneficiaries to collaborate in drafting and executing the Health Action Plan (HAP),
- Regular and ongoing communication, including case conferencing among team members, housing providers, and, when necessary, health providers,
- Transportation to and from appointments,
- Assistance in pursuing healthier behaviors and following treatment regimens,
- Help in obtaining and improving self-management skills to prevent negative health outcomes,
- Assistance in maintaining Medi-Cal,
- Advocacy with health care professionals,
- Accompanying beneficiaries to appointments when needed (including appointments with social service providers),
- Partnerships with organizations offering existing resources a beneficiary requires to improve health outcomes,
- Warm hand-offs to staff at partner organizations, and
- Connections to affordable permanent housing (when the beneficiary is experiencing homelessness).

## **Section B5: Community-Based Care Management Entities (CB-CMEs)**

We recommend allowing MCPs to designate specific health homes as health home predominantly serving beneficiaries experiencing homelessness. We also recommend clarifying MCPs should refer beneficiaries to these designated health homes if the beneficiary is homeless in that geographic area, unless the beneficiary otherwise requests assignment to a different health home.

We recommend allowing MCPs flexibility in contracting with CB-CMEs, rather than requiring an administratively burdensome and difficult process to obtain certification. Alternatively, certification should simply involve ensuring CB-CMEs meet the qualifications outlined in the concept paper.

We also recommend several changes to the duties outlined in the concept paper for CB-CMEs:

- Revising number 7, in assuring the receipt of evidence-based care, to require instead partnering with and referring beneficiaries to treatment providers offering evidence-based care.
- Eliminating number 12, providing 24-hour, seven days a week information and emergency consultation services, as inconsistent with both the definitions of services included in the concept paper and with the intent of health home services. Since MCPs already offer these services, health homes should not need to.
- Revising number 8 to replace the need for a directory of community partners with partnerships with community partners offering resources in the community.

We recommend further, in health home staff roles, that Community Health Workers not be required to mail health promotion materials.

#### **Section B7: Payment Methodologies**

We support DHCS intent to implement a three-tier payment process, as well as the enhanced member engagement tier rate. To ensure consistency, the State should offer MCPs a per member, per month case rate that allows Health Home Programs flexibility in identifying and providing health home services each benefit requires. We further recommend limiting how much an MCP may retain, consistent with other states' state plan amendments, to ensure the vast majority of funding offers services to eligible beneficiaries, rather than administrative process. The health home should be expected to achieve the outcomes the State identifies, and not be expected to expend significant staff time on administration of the health home program required with a fee-for-service type process.

#### **Section B8: Reporting**

Section B8 Reporting lists "Health" related core measures but does not include any "Home" related core measures. We suggest that a measure should be added regarding whether a client was housed or not during the reporting period as this may show a direct relationship to the achievement of the HAP goals. Another measure showing length of stay in housing would add another dimension to the reporting data.

Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. We look forward to engaging further in discussions on strengthening the Health Home Program.

Sincerely,



Chris Callandrillo  
Director of Programs

June 15, 2015

Bob Baxter  
Chief, Health Homes Program Section  
Medi-Cal Managed Care Quality and Monitoring Division  
Department of Health Care Services  
PO Box 997413, MS 4400  
Sacramento, CA 95899-7413

**Re: Comments on Concept Paper Version 2.0 for ACA Section 2703**

Dear Mr. Baxter:

The concept paper on health homes seems like a good basis for discussion, and it appears you have received a number of comments from various parties. We are writing to suggest ways to assure that children with serious, chronic conditions are also included in the health homes project being planned by your office.

**Eligible Conditions:** We have attached a table to simplify our first recommendation. In its first column it reiterates the eligible conditions proposed by the DHCS Health Homes Program. In the second column we have listed those conditions from the first column that also could apply to children and adolescents. In a few instances we have provided a few examples of disorders that would seem to fall within those conditions. It would be helpful if the Health Homes Program staff could confirm that these conditions in children are eligible conditions. The second column also lists six additional serious, chronic conditions that we recommend be added to the list of eligible conditions.

**Integrating Health Homes with Existing Services for Children with Chronic and Complex Conditions:** We would like to suggest two mechanisms by which additional health home funding could achieve maximum impact as applied to children's health care services. First, either directly or through managed care, health home funds could be used to enhance the capacity of existing California Children's Services (CCS) special care centers. Those centers provide an existing infrastructure with many of the required capacities.

Second, across the state and affiliated with the 11 child serving hospitals (children's hospitals and the University of California medical centers) are special primary care centers, sometimes

called complex care clinics or advanced medical homes, that have been specifically designed to serve children with medical complexity. By definition these children typically have at least two chronic health conditions, often more, and frequently have significant mental health problems. The directors of these clinics have developed a set of operating standards that coincide well with the requirements of a health home. The state could build on these specialized primary care clinics as a place to pilot health homes for children.

I would be happy to discuss these suggestions with you or your staff if that would be helpful.

Sincerely,

Edward L. Schor, MD  
Senior Vice President

Cc: Hannah Katch  
Jill Abramson, MD

**Table: Proposed Eligible Conditions for Health Homes**

<b>Eligible Conditions Proposed by DHCS</b>	<b>Equivalent Pediatric Conditions</b>
Asthma/COPD	Asthma, Cystic Fibrosis
Diabetes	Diabetes
Traumatic Brain Injury	Traumatic Brain Injury
Hypertension	Hypertension
Congestive Heart Failure	Congestive Heart Failure
Coronary Artery Disease	
Chronic Liver Disease	Chronic Liver Disease
Chronic Renal Disease	Chronic Renal Disease
Chronic Musculoskeletal	Chronic Musculoskeletal
HIV/AIDS	HIV/AIDS
Seizure Disorders	Seizure Disorders
Cancer	Cancer
Cognitive Disorders	Cognitive Disorders: Autism Spectrum Disorder; Pervasive Developmental Delay; Attention Deficit Hyperactivity Disorder
	<b>Recommended Additional Pediatric Conditions</b>
	Neuromuscular disorders; cerebral palsy; muscular dystrophy
	Post-transplantation of bone marrow and major organs
	Congenital metabolic and endocrine disorders
	Chronic hematologic disorders; sickle cell disease
	Autoimmune disorders
	Complex congenital heart disease

**Comment received via email during comment period.**

Implementing the comprehensive services called for by the health home regulations will be challenging, and few of the structures necessary to establish, implement and continuously improve health home services are in place, nor do managed care plans have experience with most of the components. Doing an evaluation after most of the program period has passed will not be especially informative, nor will it contribute to the implementation process. In order to facilitate the development and implementation of program and enhance its likelihood of success, I would like to suggest that in addition to the evaluation described in the Concept Paper, that a formative evaluation occur that monitors and informs the development of the administrative and service provision infrastructures and the service delivery processes as they are implemented.

**Edward Schor, MD**

**Senior Vice President**

Lucile Packard Foundation for Children's Health

May 5, 2015

Health Home Program  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, Ca 95814  
[HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov)

Re: Comments on DHCS' Concept Paper Version 2.0 on Health Homes

Dear Health Home Team:

Thank you for the opportunity to comment on Concept Paper 2.0 regarding Section 2703 of the Affordable Care Act, the health home option. As a downtown resident and business owner, I encounter the issue of homelessness on a daily basis and have become an advocate for solving this issue in San Diego. I am a member of Funders Together to End Homelessness San Diego, Regional Team Lead of the 25 Cities National Initiative and member of the Regional Continuum of Care Council.

I appreciate the work of DHCS staff in incorporating supportive housing into the concept paper, and in including housing navigators, tiered payment, and a focus on serving Medi-Cal beneficiaries experiencing homelessness. Below, I offer specific comments and recommendations for strengthening your concepts for the Health Home Program.

### **Section B1: Eligibility & Section B6: Beneficiary Assignment**

Administrative data may accurately identify Medi-Cal beneficiaries incurring high costs, but, because Medi-Cal administrative data does not accurately identify beneficiaries experiencing homelessness, I recommend using a combination of administrative data and a referral process to identify beneficiaries experiencing homelessness. I agree with the list of chronic conditions in the concept paper, and recommend the State narrow by acuity according to hospital use or homelessness. Managed care plans would not be able to identify homeless beneficiaries through administrative data, but a referral process could identify additional criteria administrative data cannot. Additionally, I recommend using existing research data to identify indicators of high costs and poor outcomes among those experiencing homelessness. Data, for example, indicate Medicaid beneficiaries with frequent hospital admissions experiencing homelessness will continue to be admitted to the hospital frequently over time, and will continue to incur high costs.

Regardless of eligibility criteria selected, I recommend a process of referral that allows homeless service, housing, hospital, health center, and homeless service systems refer beneficiaries for potential eligibility, according to eligibility criteria the State adopts.

Finally, I recommend eliminating the requirement that MCPs approve adding beneficiaries to a health home. Waiting for approval could impact a health home's ability to engage homeless beneficiaries. Homeless beneficiaries will have no way of knowing they are eligible for health home services, unless the beneficiary seeks other services or is hospitalized. Potentially eligible homeless beneficiaries often present a brief window to engage. Most would be lost to follow-up in waiting for an MCP approval process. For this reason, I recommend establishing a process for receiving referrals from hospitals, homeless service and housing providers, health centers, or a region's homeless service system, for easily verifying eligibility, and for granting health homes serving homeless beneficiaries the ability to approve beneficiaries provisionally.

These health homes should get reimbursed a portion of the engagement rate while waiting for final MCP approval.

## **Section B2: Health Home Services**

In the definition of services, I recommend greater emphasis on services that work to engage beneficiaries to achieve and maintain health stability on an ongoing basis. Many of the services identified in the concept paper are provided in supportive housing, and are critical to improving health outcomes. Yet, linking a beneficiary to treatment and to social services alone is insufficient to achieving those outcomes. Improving health among homeless beneficiaries and beneficiaries who are frequent hospital users is contingent on services that engage beneficiaries on an ongoing basis, promote healthy behaviors, and allow for self-management.

To incorporate these concepts into the definitions, I specifically recommend including the following:

- In the definitions of care management and care coordination, engagement services to motivate beneficiaries to collaborate in drafting and executing the Health Action Plan (HAP),
- Regular and ongoing communication, including case conferencing among team members, housing providers, and, when necessary, health providers,
- Transportation to and from appointments,
- Assistance in pursuing healthier behaviors and following treatment regimens,
- Help in obtaining and improving self-management skills to prevent negative health outcomes,
- Assistance in maintaining Medi-Cal,
- Advocacy with health care professionals,
- Accompanying beneficiaries to appointments when needed (including appointments with social service providers),
- Partnerships with organizations offering existing resources a beneficiary requires to improve health outcomes,
- Warm hand-offs to staff at partner organizations, and
- Connections to affordable permanent housing (when the beneficiary is experiencing homelessness).

## **Section B5: Community-Based Care Management Entities (CB-CMEs)**

I recommend allowing MCPs to designate specific health homes as health home predominantly serving beneficiaries experiencing homelessness. I also recommend clarifying MCPs should refer beneficiaries to these designated health homes if the beneficiary is homeless in that geographic area, unless the beneficiary otherwise requests assignment to a different health home.

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I also recommend several changes to the duties outlined in the concept paper for CB-CMEs:

- Revising number 7, in assuring the receipt of evidence-based care, to require instead partnering with and referring beneficiaries to treatment providers offering evidence-based care.
- Eliminating number 12, providing 24-hour, seven days a week information and emergency consultation services, as inconsistent with both the definitions of services included in the concept paper and with the intent of health home services. Since MCPs already offer these services, health

homes should not need to.

- Revising number 8 to replace the need for a directory of community partners with partnerships with community partners offering resources in the community.

I recommend further, in health home staff roles, that Community Health Workers not be required to mail health promotion materials.

### **Section B7: Payment Methodologies**

I support DHCS intent to implement a three-tier payment process, as well as the enhanced member engagement tier rate. To ensure consistency, the State should offer MCPs a per member, per month case rate that allows Health Home Programs flexibility in identifying and providing health home services each benefit requires. I further recommend limiting how much an MCP may retain, consistent with other states' state plan amendments, to ensure the vast majority of funding offers services to eligible beneficiaries, rather than administrative process. The health home should be expected to achieve the outcomes the State identifies, and not be expected to expend significant staff time on administration of the health home program required with a fee-for-service type process.

Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. I look forward to engaging further in discussions on strengthening the Health Home Program.

Sincerely,

Michael W. McConnell

June 2, 2015

Health Home Program  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, Ca 95814  
[HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov)

Re: Comments on DHCS' Concept Paper Version 2.0 on Health Homes

Dear Health Home Team:

I am a Licensed Clinical Social Worker employed with Mental Health America of Los Angeles County, and I've been participating in stakeholder activities related to the Health Homes option for the past eight months. I thank you for the opportunity to comment on Concept Paper 2.0 regarding Section 2703 of the Affordable Care Act, the health home option. The organization I am employed with, Mental Health America of Los Angeles County, provides county-contracted direct services to persons struggling with a mental health condition, though our directly operated community-based sites.

We appreciate the work of DHCS staff in incorporating supportive housing into the concept paper, and in including housing navigators, tiered payment, and a focus on serving Medi-Cal beneficiaries experiencing homelessness. Below, I offer specific comments and recommendations for strengthening your concepts for the Health Home Program.

**Section B1: Eligibility & Section B6: Beneficiary Assignment**

Administrative data may accurately identify Medi-Cal beneficiaries incurring high costs, but, because Medi-Cal administrative data does not accurately identify beneficiaries experiencing homelessness, I recommend using a combination of administrative data and a referral process to identify beneficiaries experiencing homelessness. I agree with the list of chronic conditions in the concept paper, and recommend the State narrow by acuity according to hospital use or homelessness. Managed care plans would not be able to identify homeless beneficiaries through administrative data, but a referral process could identify additional criteria administrative data cannot. Additionally, I recommend using existing research data to identify indicators of high costs and poor outcomes among those experiencing homelessness. Data, for example, indicate Medicaid beneficiaries with frequent hospital admissions experiencing homelessness will continue to be admitted to the hospital frequently over time, and will continue to incur high costs.

Regardless of eligibility criteria selected, I recommend a process of referral that allows homeless service, housing, hospital, health center, and homeless service systems refer beneficiaries for potential eligibility, according to eligibility criteria the State adopts.

Finally, I recommend eliminating the requirement that MCPs approve adding beneficiaries to a health home. Waiting for approval could impact a health home's ability to engage homeless beneficiaries. Homeless beneficiaries will have no way of knowing they are eligible for health home services, unless the beneficiary seeks other services or is hospitalized. Potentially eligible homeless beneficiaries often present a brief window to engage. Most would be lost to follow-up in waiting for an MCP approval process. For this reason, I recommend establishing a process for receiving referrals from hospitals, homeless service and housing providers, health centers, or a region's homeless service system, for easily verifying eligibility, and for granting health homes serving homeless beneficiaries the ability to approve beneficiaries provisionally.

These health homes should get reimbursed a portion of the engagement rate while waiting for final MCP approval.

## **Section B2: Health Home Services**

In the definition of services, I recommend greater emphasis on services that work to engage beneficiaries to achieve and maintain health stability on an ongoing basis. Many of the services identified in the concept paper are provided in supportive housing, and are critical to improving health outcomes. Yet, linking a beneficiary to treatment and to social services alone is insufficient to achieving those outcomes. Improving health among homeless beneficiaries and beneficiaries who are frequent hospital users is contingent on services that engage beneficiaries on an ongoing basis, promote healthy behaviors, and allow for self-management.

To incorporate these concepts into the definitions, I specifically recommend including the following:

- In the definitions of care management and care coordination, engagement services to motivate beneficiaries to collaborate in drafting and executing the Health Action Plan (HAP),
- Regular and ongoing communication, including case conferencing among team members, housing providers, and, when necessary, health providers,
- Transportation to and from appointments,
- Assistance in pursuing healthier behaviors and following treatment regimens,
- Help in obtaining and improving self-management skills to prevent negative health outcomes,
- Assistance in maintaining Medi-Cal,
- Advocacy with health care professionals,
- Accompanying beneficiaries to appointments when needed (including appointments with social service providers),
- Partnerships with organizations offering existing resources a beneficiary requires to improve health outcomes,
- Warm hand-offs to staff at partner organizations, and
- Connections to affordable permanent housing (when the beneficiary is experiencing homelessness).

## **Section B5: Community-Based Care Management Entities (CB-CMEs)**

I recommend allowing MCPs to designate specific health homes as health home predominantly serving beneficiaries experiencing homelessness. I also recommend clarifying MCPs should refer beneficiaries to these designated health homes if the beneficiary is homeless in that geographic area, unless the beneficiary otherwise requests assignment to a different health home.

I recommend allowing MCPs flexibility in contracting with CB-CMEs, rather than requiring an administratively burdensome and difficult process to obtain certification. Alternatively, certification should simply involve ensuring CB-CMEs meet the qualifications outlined in the concept paper.

I also recommend several changes to the duties outlined in the concept paper for CB-CMEs:

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I recommend further, in health home staff roles, that Community Health Workers not be required to mail health promotion materials.

### **Section B7: Payment Methodologies**

I support DHCS intent to implement a three-tier payment process, as well as the enhanced member engagement tier rate. To ensure consistency, the State should offer MCPs a per member, per month case rate that allows Health Home Programs flexibility in identifying and providing health home services each benefit requires. I further recommend limiting how much an MCP may retain, consistent with other states' state plan amendments, to ensure the vast majority of funding offers services to eligible beneficiaries, rather than administrative process. The health home should be expected to achieve the outcomes the State identifies, and not be expected to expend significant staff time on administration of the health home program required with a fee-for-service type process.

Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. I look forward to engaging further in discussions on strengthening the Health Home Program.

Sincerely,

John M. Glover, LCSW, CPRP

Team Leader

Mental Health America of Los Angeles

Discovery Resource Center



May 5, 2015

Health Home Program  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, Ca 95814  
[HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov)

Re: Comments on DHCS' Concept Paper Version 2.0 on Health Homes

Dear Health Home Team:

On behalf of MidPen Housing Corporation, I want to thank you for the opportunity to comment on Concept Paper 2.0 regarding Section 2703 of the Affordable Care Act, the health home option. MidPen Housing Corp. is one of nation's leading non-profit sponsors and developers of affordable rental housing. Since our founding over 40 years ago, we have developed more than 7,400 affordable homes in ten Bay Area counties, housing more than 14,200 residents - a significant number of whom have special needs.

We appreciate the work of DHCS staff in incorporating supportive housing into the concept paper, and in including housing navigators, tiered payment, and a focus on serving Medi-Cal beneficiaries experiencing homelessness. Below, we offer specific comments and recommendations for strengthening your concepts for the Health Home Program.

Section B1: Eligibility & Section B6: Beneficiary Assignment

Administrative data may accurately identify Medi-Cal beneficiaries incurring high costs, but, because Medi-Cal administrative data does not accurately identify beneficiaries experiencing homelessness, we recommend using a combination of administrative data and a referral process to identify beneficiaries experiencing homelessness. Managed care plans would not be able to identify homeless beneficiaries through administrative data, but a referral process could identify additional criteria administrative data cannot. We suggest using existing research data to identify indicators of high costs and poor outcomes among those experiencing homelessness. Data, for example, indicate Medicaid beneficiaries with frequent hospital admissions experiencing homelessness will continue to be admitted to the hospital frequently over time, and will continue to incur high costs.

Regardless of eligibility criteria selected, we recommend a process of referral that allows homeless service, housing, hospital, health center, and homeless service systems refer beneficiaries for potential eligibility, according to eligibility criteria the State adopts.

We also suggest eliminating the requirement that MCPs approve adding beneficiaries to a health home. Waiting for approval could impact a health home's ability to engage homeless beneficiaries. Homeless beneficiaries will have no way of knowing they are eligible for health home services, unless the beneficiary seeks other services or is hospitalized. Potentially eligible homeless beneficiaries often present a brief window to engage. Most would be lost to follow-up in waiting for an MCP approval process. For this reason, we recommend establishing a process for receiving referrals from hospitals, homeless service and housing providers, health centers, or a region's homeless service system, for easily verifying eligibility, and for granting health homes serving homeless beneficiaries the ability to approve beneficiaries provisionally. These health homes should get reimbursed a portion of the engagement rate while waiting for final MCP approval.

### Section B2: Health Home Services

In the definition of services, we recommend greater emphasis on services that work to engage beneficiaries to achieve and maintain health stability on an ongoing basis. Many of the services identified in the concept paper are provided in supportive housing, and are critical to improving health outcomes. Yet, linking a beneficiary to treatment and to social services alone is insufficient to achieving those outcomes. Improving health among homeless beneficiaries and beneficiaries who are frequent hospital users is contingent on services that engage beneficiaries on an ongoing basis, promote healthy behaviors, and allow for self-management.

To incorporate these concepts into the definitions, we believe in including the following:

- In the definitions of care management and care coordination, engagement services to motivate beneficiaries to collaborate in drafting and executing the Health Action Plan (HAP),
- Regular and ongoing communication, including case conferencing among team members, housing providers, and, when necessary, health providers,
- Transportation to and from appointments,
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- Assistance in maintaining Medi-Cal,
- Advocacy with health care professionals,
- Accompanying beneficiaries to appointments when needed (including appointments with social service providers),
- Partnerships with organizations offering existing resources a beneficiary requires to improve health outcomes,
- Warm hand-offs to staff at partner organizations, and
- Connections to affordable permanent housing (when the beneficiary is experiencing homelessness).

### Section B5: Community-Based Care Management Entities (CB-CMEs)

We recommend allowing MCPs to designate specific health homes as health home predominantly serving beneficiaries experiencing homelessness. We also suggest clarifying MCPs should refer beneficiaries to these designated health homes if the beneficiary is homeless in that geographic area, unless the beneficiary otherwise requests assignment to a different health home.

We would urge allowing MCPs flexibility in contracting with CB-CMEs, rather than requiring an administratively burdensome and difficult process to obtain certification. Alternatively, certification should simply involve ensuring CB-CMEs meet the qualifications outlined in the concept paper.

Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. I look forward to engaging further in discussions on strengthening the Health Home Program. If you have any questions, don't hesitate to contact our policy director, Anu Natarajan at 650.356.2963 or email her at [anatarajan@midpen-housing.org](mailto:anatarajan@midpen-housing.org).

Sincerely,

A handwritten signature in black ink, appearing to read 'Matthew O. Franklin', with a long horizontal flourish extending to the right.

Matthew O. Franklin  
President



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Amie Fishman

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May 5, 2015

Health Home Program  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, Ca 95814  
[HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov)

RE: Comments on DHCS' Concept Paper Version 2.0 on Health Homes

Dear Health Home Team:

On behalf of the Non-Profit Housing Association of Northern California (NPH), thank you for the opportunity to comment on Concept Paper 2.0 regarding Section 2703 of the Affordable Care Act, the health home option. NPH is the collective voice of those who support, build and finance affordable housing. We promote the proven methods of the non-profit sector and focus government policy on housing solutions for lower-income people who suffer disproportionately from the housing affordability crisis.

We appreciate the work of DHCS staff in incorporating supportive housing into the concept paper, and in including housing navigators, tiered payment, and a focus on serving Medi-Cal beneficiaries experiencing homelessness. Below, I offer specific comments and recommendations for strengthening your concepts for the Health Home Program.

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Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. I look forward to engaging further in discussions on strengthening the Health Home Program.

Sincerely,

**Amie Fishman**  
Executive Director  
Non-Profit Housing Association of Northern California (NPH)



**Pacific Clinics**  
ADVANCING BEHAVIORAL HEALTHCARE

800 S. Santa Anita Ave.  
Arcadia, California  
91006-3555

626.254.5000  
Fax 626.294.1077

April 30, 2015

Ms. Jennifer Kent  
Director  
California Department of Health Care Services  
Sacramento, CA 95814

Dear Director Kent:

Pacific Clinics is offering its comments in response to *Health Homes for Patients with Complex Needs Concept Paper Version 2.0*. First of all, we want to acknowledge the leadership of Senator Holly Mitchell in authoring the guiding legislation, Assembly Bill 361 that served as a catalyst for the stakeholder engagement process and policy discussions leading up to the current concept paper. As a long-standing behavioral health care provider, Pacific Clinics strongly supports the concept of health homes since many of our Medi-Cal beneficiaries have complex chronic conditions. Given that our consumers have a severe mental illness, the majority have developed a rapport with our inter-disciplinary treatment team(s). For this reason, organizations like Pacific Clinics are well positioned to serve as behavioral health homes. The use of the term behavioral health homes in addition to health homes in *Version 2.0* would reflect the nuanced understanding of different high risk, high utilization populations that DHCS hopes to target in this initiative.

While *Version 2.0* sets a broad framework for discussion, further refinement of details with local service providers and counties about implementation for clients who need specialty mental health services is critical. In addition, the practical details on the reimbursement structure and rates requires significant stakeholder engagement and separate focused discussions. While *Version 2.0* states DHCS' desire to align this initiative with the Cal Medi-Connect Program, it should be noted that the implementation challenges related to the CMC have yet to be fully addressed. We view this Health Home initiative as another opportunity to improve consumer care while simultaneously testing innovative payment reform. The majority of payment reform programs piloted, including the 1115 Wavier processes, has focused on physical health systems, managed care plans, hospitals, IPAs etc. Given the nature of the Health Home Initiative and the target populations, Pacific Clinics is respectfully requesting inclusion of a payment reform pilot for local mental health plans (MHPs) and MHP contracted providers. This will allow the public mental health system to move away from the volume based model (Cost Reimbursement) to parallel other payment reform pilots in the broader health care system.

Thank you for consideration of our comments. We look forward to the continued refinement of the Health Homes Concept Paper through the stakeholder engagement process.

Sincerely,

Susan Mandel, Ph.D.  
President  
SM:ww

C: The Honorable Holly Mitchell, 30<sup>th</sup> Senate District

May 11, 2015

Brian Hansen, Health Program Specialist  
Bob Baxter, Acting Division Chief  
Medi-Cal Managed Care Division  
Department of Health Care Services  
P.O. Box 997413, MS 4400  
Sacramento, CA 9589-74139

Re: Health Homes for Patients with Complex Medical Needs (HHPCN) California Concept Paper  
(4/10/2015 draft)

Dear Mr. Hanson and Mr. Baxter,

Prevention Institute has long been invested in the notion of the health home. Our 2011 paper, *Community-Centered Health Homes: Bridging the gap between health services and community prevention*, describes the opportunity for health homes to serve both as centers for quality medical care and as partners in community-based population health improvement efforts. The defining attribute of a Community-Centered Health Home is its active involvement in community advocacy and systems change. A Community-Centered Health Home not only acknowledges that factors outside the health system affect patient health outcomes, but actively participates in improving them. It incorporates the provision of services to the individuals who need them, while also going beyond individual services to address the social and community conditions that create injury or illness in the first place, impeding the maintenance and recovery of health.

We believe that the proposed Health Home Program (HHP) has the potential to provide a great deal of benefit to the people of California. Furthermore, it can and should serve as an important step on the road toward a health system that is community-centered, as well as patient-centered. We commend the Department of Health Care Services for adopting The Triple Aim as the primary framework for the HHP. It is widely recognized that – in order for the “improved population health” component of The Triple Aim to be realized – we must address the social and community determinants of patients’ health. We were pleased to see the social determinants of health mentioned throughout the concept paper. We would like to emphasize the expert consensus that the challenges posed by harmful social and community determinants of health cannot be addressed exclusively through individual treatment and education; those important individual efforts must be supported by work on a broader community level that addresses behavior, the physical environment, and social and economic influences.

While recognizing the constraints imposed by Section 2703 of the Affordable Care Act, CMS’s existing regulatory structure, and a mandate for cost neutrality from the state, we feel that the concept paper and California’s HHP would be strengthened by an increased focus on the role of the health home in supporting community-based population health improvement efforts. The patients who will be served under the current framework have community-based needs relating to housing, trauma, transportation, access to opportunities for healthful food and safe physical activity, and economic opportunity. To maximize its effectiveness, California’s HHP must work to address these issues on a community level, as well as on a clinical level. For example, asthma is a condition where health home beneficiaries should receive quality treatment, and it is an illness that should also be addressed through improved housing and environmental conditions – often through linked funding sources.

While the existing framework for health homes in California imposes restrictions, we believe that this initiative can and should be constructed to leverage and operationalize other resources to create the strongest possible program.

We have several specific recommendations for amendments to the concept paper that we respectfully submit below:

- 1) On page 8, in the section “Comprehensive Care Management,” we recommend that the second sentence be amended to read:

HAPs should incorporate the HHP beneficiary’s physical health, mental health and substance use disorder, community-based LTSS, palliative care, and social support needs, **including social needs impacted by community environments such as housing, trauma, transportation, access to opportunities for healthful food and safe physical activity, and economic opportunity.**

The goal of the HHP should not be limited to helping a beneficiary move out from substandard housing, for example, but also to support the work of improving housing conditions in its service area to prevent other patients from developing housing-related health problems.

- 2) On page 9, in the section “Individual and Family Support Services,” we recommend that the final sentence be amended to read:

In addition, this service may include advocacy for the HHP beneficiary and their family to identify and obtain needed resources (e.g. transportation) that support their ability to meet goals, **as well as community-based advocacy to improve the social and community determinants of health in the HHP’s service area.**

As health homes serving many of the community’s most vulnerable members, it is important to articulate a role for the HHP that includes participation in broader community transformation efforts.

- 3) On page 9, in the section “Use of Health Information Technology and Exchange to Link Services,” we recommend that the following point be added:

- **Include data collected from the HHP beneficiary and external sources (e.g., health department data corresponding to the beneficiary’s zip code) relating to social and community determinants of health such as housing, trauma, transportation, access to opportunities for healthful food and safe physical activity, and economic opportunity.**

In addition to collecting these data, it is important that the HHP share data in a bidirectional fashion with health departments and others regarding the health and social challenges facing the HHP’s service area.

- 4) On page 14, in the section “Qualifications,” we recommend that an additional numbered point be added:

- **Demonstrate engagement and cooperation with health departments and other government agencies, community-based organizations, and other stakeholders to improve community conditions in the HHP’s service area.**

5) On page 17, in the row “Community Health Workers (CB-CME or by contract),” we recommend that the following language be added to the third column describing the role of the community health workers:

- **Serve as part of the HHP’s Prevention Workforce by observing and reporting upon barriers to health in the HHP’s service area.**

Prevention Institute appreciates that DHCS has been charged with creating a concept paper within the confines of Section 2703 of the ACA, CMS’s existing regulatory structure, and a mandate for cost neutrality from the state. At the same time, we believe that the requirement that California’s HHP achieve cost-neutrality in eight quarters is an unfortunate impediment to investment in a portfolio of strategies that includes longer-term investments in health. It is our position that health homes must be not only patient-centered, but also community-centered, with the latitude to invest in strategies to improve community conditions impacting their beneficiaries.

We thank you for your consideration of this response, and hope to continue a dialogue with DHCS regarding health homes in California. If you have any questions about the points we have raised, please contact Leslie Mikkelsen at (510) 444 8027 ext. 316 or [leslie@preventioninstitute.org](mailto:leslie@preventioninstitute.org).

Sincerely,



Larry Cohen,  
Founder and Executive Director



Leslie Mikkelsen,  
Managing Director

April 29, 2015

California Department of Health Care Services

Via email: hhp@dhcs.ca.gov

Re: Inclusion of asthma in the Health Homes for Patients with Complex Needs model

Dear DHCS staff:

The undersigned stakeholders continue to have interest in the promise of the Department of Health Care Services' (DHCS) Health Homes for Patients with Complex Needs model (Health Home Program or HHP), and appreciate the additional details provided in the Concept Paper Version 2.0 (Concept Paper) released on April 10<sup>th</sup>, 2015.

Consistent with previously submitted comments, we are writing in support of the inclusion of asthma within the HPP to help achieve the stated triple aim goal of better health, better care, and lower costs. Asthma is currently one of the chronic conditions under consideration within the Concept Paper (pg. 7), and should be included in the rollout of the Health Home Program. There is a strong evidence base of effective asthma interventions (consistent with the Health Home approach) leading to improved health outcomes and costs savings, both of which are realized in a very short amount of time. This evidence base coupled with asthma's clear fit under the HHP's eligibility criteria and core health home services make asthma an ideal condition to be included in the Health Home Program.

#### *Asthma and the HHP's Eligibility Criteria*

Asthma is a chronic disease that is among the most common, costly, and preventable of all health problems in the United States. Rates of asthma have nearly doubled in the United States over the last few decades. Over 23 million people have asthma nationwide.<sup>i</sup> Over 5 million of those diagnosed with asthma live in California.<sup>ii</sup> In 2007, the U.S. spent an estimated \$19.7 billion on asthma in both direct and indirect costs. Among pediatric hospitalizations that could be prevented, asthma is responsible for the highest costs.<sup>iii</sup> In California, surveillance data show that there is much room for improvement in routine health care for people with asthma. According to the California Department of Public Health (CDPH), Environmental Health Investigations Branch, "More than half of adults with current asthma have not had a routine asthma checkup in the past year and only 40% of adults and children with asthma have received a written asthma action plan [such plans are a critical component of the national clinical guidelines for care] from their health care provider...[T]here are about 400 deaths, 35,000 hospital discharges, and 180,000 emergency department visits per year due to asthma. In addition, the costs of asthma hospitalizations are enormous—over \$1 billion in 2010. Proper prevention efforts could reduce many of these poor outcomes and costs. For example, [in California] 12% of people who were hospitalized for asthma in 2010 had at least one repeat visit during that same year. Intervening to prevent these repeat asthma hospitalizations could have saved \$156 million in medical costs."<sup>iv</sup>

Given that asthma is of particular concern to California's Medi-Cal population, the chronic condition meshes well with the eligibility criteria proposed in the Concept Paper (pgs. 6-7). Low income is associated with higher asthma severity, poorer asthma control, and higher rates of

asthma emergency department visits and hospitalizations. Again according to CDPH, “Medi-Cal beneficiaries represent a high-risk population for asthma.”<sup>v</sup> Additional data from the 2011-2012 California Health Interview Survey indicate 1,128,000 Medi-Cal beneficiaries have been diagnosed with asthma at some point in their lives. This prevalence (16.2%) is higher than those not covered by Medi-Cal (13.6%).<sup>vi</sup> In 2010, there were 90,004 asthma emergency department visits and 14,514 asthma hospitalizations among continuously enrolled Medi-Cal beneficiaries. That translates to a rate of 145.4 asthma emergency department visits per 10,000 beneficiaries (compared to 46.1 per 10,000 statewide) and a rate of 26 asthma hospitalizations per 10,000 beneficiaries (compared to 9 per 10,000 statewide). Medicare and Medicaid covered 65% of asthma hospitalizations and 50% of asthma ED visits in California in 2010.<sup>vii</sup>

Asthma is often associated with various comorbidities, a fact that fits the HHP’s requirement that eligible individuals have two or more chronic conditions or one chronic condition and at risk for another. The most frequently reported asthma comorbid conditions include rhinitis, sinusitis, gastroesophageal reflux disease, obstructive sleep apnea, hormonal disorders and psychopathologies. These conditions may share a common pathophysiological mechanism with asthma as well as influence asthma control, its phenotype and response to treatment.<sup>viii</sup> In addition to these most common comorbidities, people with current asthma report worse general health than people without asthma, including the following:

- Adults with current asthma are 8-10 times more likely to have chronic obstructive pulmonary disease (COPD) than adults who do not have asthma.
- Almost one in three adults with current asthma is obese (31% vs. 21.7% among adults who do not have asthma), and one in seven teens (age 12–17) with current asthma is obese (14.4% vs. 10.9% among teens who do not have asthma).
- Among adults with current asthma, 11.6% also have diabetes, 37% also have high blood pressure, and 9.8% also have heart disease (compared to 8.2%, 25.5%, and 5.6%, respectively, among adults who do not have asthma).
- Over 40% of adults with current asthma are disabled (compared to 26.3% among adults who do not have asthma).
- About 6% of adults and teens with current asthma have psychological distress.<sup>ix</sup>

Treating asthmatic patients in the Health Home Program would allow for addressing comorbidities more effectively.

### *Asthma and Core Health Home Services*

Asthma and the ways in which it can be treated and managed align strongly with many of the core health home services described in the Concept Paper, including comprehensive case management, care coordination and health promotion, comprehensive transitional care, individual and family support services, referral to community and social supports, and use of health information technology. According to “The Affordable Care Act, Medical Homes, and Childhood Asthma: A Key Opportunity for Progress,” “the very qualities that make a health care model a medical home are the qualities that are essential to high quality pediatric asthma care. Thus, pediatric asthma emerges as an extremely important diagnosis on which the medical home model can be built.”<sup>x</sup> Such qualities can also be extended to treating adult asthma (which in turn meets the HHP’s requirement that all services be made available to all categorically needy Medi-Cal beneficiaries). Below are several examples showcasing the clear link between asthma and the core health home services outlined in the Concept Paper (pgs. 8-10).<sup>xi</sup>

*Comprehensive care management, including screenings and assessments with standardized tools as well as health action plan assessment and reassessments:*

- “Accurate symptom evaluation is a critical component of successful asthma management. This is especially so in children and families who face extra challenges because of illness severity, sociodemographics, or health care system characteristics. It has been shown that minority and poor children with asthma benefit from utilization of symptom-time peak expiratory flow rate (PEFR) as a symptom measurement tool. Children in this population who used peak expiratory flow meters when symptomatic had a lower asthma severity score, fewer symptom days, and lower health care utilization than children who did not utilize this measurement, indicating the positive impact of accurate and objective symptom evaluations.”
- “A continuous quality improvement component, incorporating a technical assistance team and community health workers, in an intervention for children with asthma improved asthma outcomes and processes of care measures, including a reduction in emergency department visits and asthma severity assessments, and improved family-reported psychological measures.”

*Care coordination and health promotion, including developing a person-centered plan and managing referrals:*

- “Written asthma action plans are an important tool for asthma management for children and families and have been found to be most effective when they are symptom-based and include tools for self-monitoring and self-management. They have been shown to be most effective with more severe asthma and have been associated with reduced utilization of health care services such as emergency department visits.”
- “Referrals to specialty care as needed are important for proper asthma management. Among a survey of Medicaid-insured children, having seen a specialty provider and having had follow - up visits with a primary care provider were associated with less underuse of controller medications.”

*Comprehensive transitional care:*

- Various asthma programs have long recognized the need for and demonstrated the ability to conduct prompt engagement of patients admitted to or discharged from an emergency department, hospital, etc., in order to provide increased levels of coordinated care in part to avoid readmissions. For example, the renowned Boston Children’s Hospital Community Asthma Initiative specifically targeted program services to patients admitted to the emergency department with asthma, noting “Meeting the family in-person in the hospital...and having a personal hand-off from a known care provider, whenever possible, helps with acceptance of the program by the parent/guardian. Also, the asthma hospitalization or ED visit is a teachable moment when families seem receptive to additional services.”<sup>xiii</sup> Such interventions contributed to program successes like reduced hospitalizations and medical expenditure savings, and can be replicated as part of DHCS’s Health Home Program.

*Individual and family support services:*

- “Community health workers can be of great value for reaching and working with families where children have asthma. Well-trained community health workers effectively deliver health education and case management services.”
- “A dose response seems to exist between the intensity of asthma education intervention delivered and the reduction in health care utilization such as emergency department and acute care visits, with those children and families receiving more intensive education and increased time with a health educator or counselor having fewer unscheduled health care visits.”
- “Educational programs for the self-management of asthma in children and adolescents were associated with improvements in many outcome measures, including lung function, self-efficacy, absenteeism from school, number of days of restricted activity, number of visits to an emergency department, and nights disturbed by asthma, with the strongest effects seen among children with more severe asthma.”

#### *Referral to community and social supports*

- Many asthma programs throughout California have demonstrated the value of community-based linkages to address the whole-person needs of the patient. Staff and “well-trained community health workers effectively ...connect families with community and medical resources, and the formal health care system.” Such connections are often to housing resources which in turn can help patients better address their asthma (e.g., tenant legal assistance organizations to speed up asthma trigger-related code violations like moisture intrusion), but also include other social services needed by the patient.

#### *Use of health information technology*

- “Using a web-based monitoring system for children with asthma to report symptoms, asthma management, and quality of life to their health care provider resulted in improved health outcomes including a decrease in peak flow readings and fewer reports of limitations in their daily activity, when compared to a control.”
- The program “Fight Asthma Milwaukee, where Children’s Hospital and Health System collaborated with five hospitals in the Milwaukee, WI region, developed a web-based registry that monitors emergency department care for children with asthma and wheeze, and identifies asthma burden and opportunities for intervention. Key elements of the registry include reporting functions and help screens for the user.”
- “Patient registries based on claims data have been shown to be useful in helping integrated delivery systems identify patients not receiving appropriate preventive asthma care (such as using a controller medication, per HEDIS® measurements) and to then conduct follow-up and outreach for the patient.”

While these recommendations are specific to childhood asthma, adult populations can also benefit from similar health home opportunities.

Many of the individual approaches mentioned not only help improve patient outcomes, but have the added benefit of realizing health care expenditure savings within a very short period of time – which in turn can help meet the HHP’s triple aim objectives within the two year evaluation timeframe as mandated by AB 361. To use but one example, the Boston Children’s Hospital Community Asthma Initiative (CAI) mentioned above saw improved health outcomes and health

care expenditure savings within a twelve month period. Many of CAI's core components fit squarely within the type of services potentially offered by the HHP, including care coordination and health promotion and individual and family support services.

Based on the urgent need to address this prevalent and costly disease, combined with robust evidence about how to improve outcomes and reduce costs, we strongly recommend that the HHP include asthma as a targeted chronic disease. We also offer to serve as a resource to DHCS in the development of this component of the HHP. We look forward to hearing from you and to working with you to implement an effective Health Home Program that serves the needs of Medi-Cal members.

Regards,

Anne Kelsey Lamb and Joel Ervice  
Regional Asthma Management and Prevention (RAMP)

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Sonoma County Asthma Coalition

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Asthma Nurse and Educator

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Asthma Coalition of Kern County

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Central California Asthma Collaborative

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<sup>i</sup> Investing in Best Practices for Asthma: A Business Case. 2010. Health Resources in Action.  
<http://hria.org/resources/reports/asthma/best-practices-for-asthma-2010.html#sthash.ofHv4aDq.dpuf>

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- <sup>iii</sup> Investing in Best Practices for Asthma: A Business Case. 2010. Health Resources in Action. <http://hria.org/resources/reports/asthma/best-practices-for-asthma-2010.html#sthash.ofHv4aDq.dpuf>
- <sup>iv</sup> Milet M, Lutzker L, Flattery J. *Asthma in California: A Surveillance Report*. Richmond, CA: California Department of Public Health, Environmental Health Investigations Brand, May 2013. <http://www.californiabreathing.org/asthma-data/cal-asthma-report>
- <sup>v</sup> *Ibid*
- <sup>vi</sup> California Health Interview Survey data. 2011. UCLA Center for Health Policy Research. <http://ask.chis.ucla.edu/main/default.asp>
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- <sup>viii</sup> [Expert Rev Respir Med](#). 2011 Jun;5(3):377-93. doi: 10.1586/ers.11.34. Asthma-related comorbidities. [Boulet LP, Boulay MÈ](#).
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- <sup>x</sup> The Affordable Care Act, Medical Homes, and Childhood Asthma: A Key Opportunity for Progress. The George Washington University, School of Public Health and Health Services; Merck Childhood Asthma Network; and RCHN: Community Health Foundation. [http://www.mcanonline.org/static/images/files\\_AffordableCareActMedicalHomesAndChildhoodAsthmaBrief.pdf](http://www.mcanonline.org/static/images/files_AffordableCareActMedicalHomesAndChildhoodAsthmaBrief.pdf)
- <sup>xi</sup> Unless otherwise noted by additional footnotes, the additional quotations under each Health Home Service are from The Affordable Care Act, Medical Homes, and Childhood Asthma: A Key Opportunity for Progress, cited above.
- <sup>xii</sup> A Case Study in Payment Reform to Support Optimal Pediatric Asthma Care. 2015. Center for Health Policy at Brookings. <http://www.brookings.edu/research/papers/2015/04/27-case-study-pediatric-asthma-farmer>

**Comment received via email during comment period.**

I am commenting as a private citizen with extensive experience in technology-enabled care coordination and management for high-risk populations, including both older adults and low-income individuals respectively with complex conditions and needs. I have worked both in the digital health technology industry and in supporting providers in developing complex care management programs. My most recent role was as Chief Strategy Officer for Community Health Center Network (CHCN), a managed-care organization that represents eight community health center corporations in Alameda County. In that role, I supported the development of population health initiatives, specifically the development and launch of Care Neighborhood, a program targeting high utilizers of inpatient services that was based on the Intensive Outpatient Care Program model mentioned on page 24 of the DHCS Concept Paper 2.0. I am now contracting with a large delivery system on developing strategies for technology-enabled community health with a focus on Alameda County – although my comments here in no way reflect those of that organization, and are mine alone. While I am a resident of San Francisco, my work remains focused on Alameda County given its unique challenges with some of the deepest pockets of urban poverty in Northern California and the challenges that the fragmentation of its broader care delivery system represent.

I applaud the DHCS' advancement of the Health Homes initiative as a means of financing and enabling the creation of a more coordinated and effective network and system of care for Medi-Cal beneficiaries with complex needs. The organizations that touch the lives of these individuals – health care, social services, emergency services, criminal justice and corrections – are highly fragmented. The lack of a means for providing integrated views of individuals and their histories based on bringing together disparate data sets, as well as for communication and collaboration among organizations in real-time, present real barriers to effective support of individuals who have multiple, complex conditions, often compounded by homelessness, substance abuse, and mental illness. The theme of the Concept Paper 2.0 is that it takes a system to care for Medi-Cal beneficiaries with complex needs – and that the system, rather than any one provider, will be their health home.

My comments on the paper are oriented toward setting up the initiative for success in Alameda County, and other non-CCI counties with highly fragmented health care delivery systems. I believe the initiative could be a forcing function for creation of a countywide infrastructure and system to support not only successful implementation of the Health Homes program, but for programs to support other populations, such as the duals when CCI is implemented in Alameda County. The broad theme of my comments is that DHCS focus on the role of robust, technology-enabled intervention models that can promote cost-effective and effective care management

and real-time communication and collaboration that are essential to achieving the Triple Aim for Medi-Cal patients with complex needs. Specific comments on and questions about elements of the Concept Paper are as follows:

Geographic phasing, page 24: The implication of this paragraph is that the program would be implemented in Alameda County in July 2016 if its health plans and contracted providers can meet readiness requirements. How does this square with the requirement, cited on page 5, that DHCS complete its initial evaluation within two years of implementation, and thus based on 18 months of data from the counties in which the program is implemented in January 2016? Does this imply that only 12 months of data will be used from counties implemented in July 2016? This does not seem sufficient to be able to demonstrate cost savings and/or budget neutrality.

The enabling statute, AB 361, does not appear to require that DHCS implement the program on January 1, 2016. Given the magnitude of the work to be done to stand up the program, and the need to ensure an appropriate evaluation timeframe in all counties, might DHCS consider implementing the program in all counties in July 2016, extending the date of submission of the initial program evaluation to the legislature to July 2018?

Point 5, Maximize federal funding while also achieving fiscal sustainability after eight quarters, page 5, and Technical Assistance, page 24: AB 361 does require an extremely aggressive approach to requiring programs to show cost savings and/or budget neutrality within a short timeframe. Achieving cost savings will be a function of the degree to which MCPs, CB-CMEs, and contracted providers can provide cost-effective care management that effectively reduces utilization of the most expensive services – hospitals (ED and inpatient), post-acute skilled nursing, and institutional long-term care. Key factors on the cost side are staffing mix (including the use of relatively low-cost community health workers) and caseloads. The paper cites two models on which training and technical assistance for the program will be based – IOCP, which has largely been applied in commercial and Medicare populations, and the Frequent Users initiative, which has not proven sustainable. IOCP has only been implemented in a limited fashion in the safety net in California – including pilots at Partnership Health Plan and Alameda County's Community Health Center Network with embedded case management at FQHCs. I suggest that DHCS leverage the experience of these initial pilots, as well as best thinking on technology, to understand how they can be made scalable, effective, and cost-effective – and in advance of implementing the program.

CB-CME Certification, page 15: DHCS proposes a range of organizations that could serve as Community-Based Care Management Entities, including "... other entities who meet certification and qualifications of a CB-CME may serve in this capacity if selected and certified by the MCP." I have been working to develop a concept of a CB-CME that could be a joint

venture of the two local Medi-Cal MCPs, area hospitals and hospitals systems, community health centers, the county, and community-based organizations – both to constitute a provider network and to create common technology infrastructure to enable the virtually integrated system that is essential for the program to succeed. I suggest that DHCS consider explicitly adding such joint ventures and consortia of otherwise qualifying organizations to its certification list.

Use of Health Information Technology and Exchange to Link Services, pages 9 and 10; and HHP Network Infrastructure, Point 10, page 11: Both of these sections point to the critical need for information technology in enabling information exchange and promoting real-time collaboration and communication among a broadly conceived network of clinical care and non-medical providers, as well as patients and families. This HIE infrastructure currently does not exist in Alameda County, and there are innovative approaches to potentially fostering its creation to facilitate the county's readiness. Given the broad network of providers required to provide health homes to populations such as the homeless and individuals with substance-abuse disorders, HIE as currently defined may not be sufficient to facilitate these broader networks. I have been looking at innovative models such as Community Information Exchange San Diego that are designed both to facilitate a whole-person view of individuals such as the homeless, and also to foster real-time communication and collaboration among a diverse network of organizations. In addition, there are a range of other digital health innovations the department might consider – such as text-messaging based applications for both patient engagement and outreach and that can facilitate patient education and self-management – in working with MCPs and CB-CMEs to develop effective, cost-effective programs. I recommend that the Bay Area-centric digital health community and organizations such as California HealthCare Foundation be engaged to flesh out some innovative thinking in this area.

Referral to Community and Social Supports, page 9: My reading of the Concept Paper and AB 361 is that Health Homes funding can be used for care coordination and management services only – and not to pay for non-medical resources such as housing, transportation, and nutrition. While these constraints are understandable given the nature of the enabling statutes and funding, my experience in developing these programs is that better care coordination will be have some effect – particularly for high utilizers undergoing complex care transitions – and in promoting a consistent care plan among disparate organizations that can reduce duplicative and conflicting services. However, it will be difficult to shift the long-term trajectory of many of these individuals unless critical underlying resource gaps are addressed, particularly in a high-cost area like Alameda County in which housing costs are skyrocketing. This initiative needs to be paired with innovative, creative thinking under vehicles such as the 1115 Waiver for channeling public and private funding to address these issues – the success of Housing First initiatives indicates there is a high ROI for doing so.

Again, I applaud DHCS' efforts to advance the Health Homes for Patients with Complex Needs initiative to address the needs of high-risk Medi-Cal beneficiaries and families that stand to benefit greatly from cohesive, comprehensive, virtually integrated systems of care. I appreciate the opportunity to comment on the Concept Paper, and would welcome the opportunity to participate in working groups and more broadly on this initiative.

Best,

Suneel Ratan



City and County of San Francisco  
Edwin M. Lee  
Mayor

## San Francisco Department of Public Health

Barbara A. Garcia, MPA  
Director of Health

May 6, 2015

Health Home Program  
California Department of Health Care Services  
Submitted electronically to [HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov)

### Re: Health Homes for Patients with Complex Needs: California Concept Paper Version 2.0

Dear Health Home Team:

The San Francisco Department of Public Health (SFDPH) appreciates the opportunity to comment on Health Homes for Patients with Complex Needs: California Concept Paper Version 2.0. The Department of Health Care Services (DHCS) has taken a thoughtful approach to implementing the Health Homes Program (HHP), and we are pleased to see the inclusion of intensive care management services, tiered payment, and a focus on reducing high utilization.

SFDPH is a large safety net provider of health care, behavioral health services, and supportive services across San Francisco. To compliment medical services provided at our clinics and hospitals, our system of care includes case managers, care coordinators, peer navigators, supportive housing, and a dedicated care transitions team. SFDPH provides integrated care on a continuum sensitive to client needs, and our system would be well-situated to participate in the Health Homes Program.

Overall, SFDPH agrees with the aim and intended goals of the DHCS' HHP proposal. If the program is implemented in a considered manner, it has potential to improve health outcomes for those with complex chronic conditions, and also to create efficiencies in the care coordination and management of the target population.

The concept paper succinctly and clearly describes DHCS' vision for the HHP as a whole. However, **as counties and providers move forward with internal analysis and planning, SFDPH requests the following clarifications:**

**Tiered Payment.** SFDPH concurs that a tiered system would be appropriate for stratifying complexity within the target population. We currently employ a tier-based system under the Community Living Support Benefit Waiver. However, the HHP concept paper is vague about what methodology would go into determining client complexity and corresponding payment. We urge DHCS to actively engage providers in this design, to ensure that the tiers accurately reflect the populations that providers are likely to encounter and the scope of services needed for clients with complex needs.

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**Double Billing.** The concept paper understandably states that DHCS wants to avoid double billing for HHP services. We request that DHCS offer more clarification on this issue, as some HHP services may be billable under Medi-Cal Short Doyle, TCM, or the Mental Health Services Act.

**Mental Health Plan (MHP) or Drug Medi-Cal Organized Delivery System (DMC-ODS) option.** The concept paper proposes an option where the county Mental Health Plan or DMC-ODS can be designated by the managed care plan to coordinate the health home benefit. However, the proposal is unclear on how such an arrangement would work in practice. Does DHCS envision a change in fee-for-service billing by county Mental Health Plans serving as Health Home lead entities?

**Technical Assistance.** The concept paper states that DHCS will provide technical assistance to plans and providers. How will DHCS determine which counties will be eligible for technical assistance, what will be the scope of such assistance, and what would be the timeline in relation to HHP implementation in the county? Having access to the Readiness Review Tool and technical assistance would be greatly helpful for providers/counties in their planning efforts.

**Reporting.** The concept paper indicates that DHCS plans to incorporate existing measures and metrics where possible. SFDPH concurs with this approach, and urges DHCS to clearly distinguish between reporting requirements for plans versus those for providers. HHP reporting should not be cumbersome or add to the existing provider reporting requirements.

**Connection to 1115 Waiver Renewal.** The concept paper acknowledges other DHCS care coordination efforts under development, such as the Whole Person Care proposal in the 1115 Waiver Renewal. Considering that there may be overlap in the Whole Person Care and HHP populations, as well as those served by the supportive housing proposals in the 1115 Waiver Renewal, what is DHCS' vision for how these programs will function alongside one another?

In addition to the requested clarifications, **SFDPH makes the following recommendations to strengthen the Health Homes Program:**

**Eligibility and Beneficiary Assignment.** SFDPH encourages DHCS to use a combination of administrative data and a referral process to accurately identify the homeless population to be served by the HHP. Provider referral is important, as Medi-Cal administrative data alone will not fully capture persons experiencing homelessness. Furthermore, DHCS should reconsider the requirement for plans to approve referrals before providing the HHP benefit. Instead, SFDPH recommends a provisional approval process for homeless beneficiaries, to reduce loss to follow-up. Under such a process, the referring health home would be reimbursed a portion of the engagement rate while waiting for final approval from the managed care plan.

**Health Home Services.** SFDPH recommends an emphasis on services that engage beneficiaries on an ongoing basis, many of which are provided in supportive housing. Continued engagement improves health outcomes, promotes healthy behaviors, and encourages self-management. These concepts should be incorporated into the HHP services definitions as follows:

- Engagement services to motivate beneficiaries to collaborate in drafting and executing the Health Action Plan (HAP),
- Regular and ongoing communication, including case conferencing among team members, housing providers, and, when necessary, health providers,

- 
- Transportation to and from appointments,
  - Assistance in pursuing healthier behaviors and following treatment regimens,
  - Help in obtaining and improving self-management skills to prevent negative health outcomes,
  - Assistance in maintaining Medi-Cal,
  - Advocacy with health care professionals,
  - Accompanying beneficiaries to appointments when needed,
  - Warm hand-offs to staff at partner organizations, and
  - Connections to affordable permanent housing when the beneficiary is experiencing homelessness.

The San Francisco Department of Public Health thanks you for your continued work on the Health Homes Program, and looks forward to continued engagement.

Sincerely,

A handwritten signature in black ink, appearing to read "Barbara A. Garcia". The signature is fluid and cursive, with a prominent initial "B" and a long, sweeping underline.

Barbara A. Garcia



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May 7, 2015

Health Home Program  
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Re: Comments on DHCS' Concept Paper Version 2.0 on Health Homes

Dear Health Home Team:

On behalf of Satellite Affordable Housing Associates (SAHA), thank you for the opportunity to comment on Concept Paper 2.0 regarding Section 2703 of the Affordable Care Act, the health home option. SAHA is a nonprofit affordable housing developer which provides quality affordable homes and services that empower people and strengthen neighborhoods. SAHA's innovative properties provide more than 3,000 residents in seven counties in northern California with much-needed affordable housing and services.

We appreciate the work of DHCS staff in incorporating supportive housing into the concept paper, and in including housing navigators, tiered payment, and a focus on serving Medi-Cal beneficiaries experiencing homelessness. Below, I offer specific comments and recommendations for strengthening your concepts for the Health Home Program.

Section B1: Eligibility & Section B6: Beneficiary Assignment

Administrative data may accurately identify Medi-Cal beneficiaries incurring high costs, but, because Medi-Cal administrative data does not accurately identify beneficiaries experiencing homelessness, I recommend using a combination of administrative data and a referral process to identify beneficiaries experiencing homelessness. I agree with the list of chronic conditions in the concept paper, and recommend the State narrow by acuity according to hospital use or homelessness. Managed care plans would not be able to identify homeless beneficiaries through administrative data, but a referral process could identify additional criteria administrative data cannot. Additionally, I recommend using existing research data to identify indicators of high costs and poor outcomes among those experiencing homelessness. Data, for example, indicate Medicaid beneficiaries with frequent hospital admissions experiencing homelessness will continue to be admitted to the hospital frequently over time, and will continue to incur high costs.



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Regardless of eligibility criteria selected, I recommend a process of referral that allows homeless service, housing, hospital, health center, and homeless service systems refer beneficiaries for potential eligibility, according to eligibility criteria the State adopts.

Finally, I recommend eliminating the requirement that MCPs approve adding beneficiaries to a health home. Waiting for approval could impact a health home's ability to engage homeless beneficiaries. Homeless beneficiaries will have no way of knowing they are eligible for health home services, unless the beneficiary seeks other services or is hospitalized. Potentially eligible homeless beneficiaries often present a brief window to engage. Most would be lost to follow-up in waiting for an MCP approval process. For this reason, I recommend establishing a process for receiving referrals from hospitals, homeless service and housing providers, health centers, or a region's homeless service system, for easily verifying eligibility, and for granting health homes serving homeless beneficiaries the ability to approve beneficiaries provisionally. These health homes should get reimbursed a portion of the engagement rate while waiting for final MCP approval.

#### Section B2: Health Home Services

In the definition of services, I recommend greater emphasis on services that work to engage beneficiaries to achieve and maintain health stability on an ongoing basis. Many of the services identified in the concept paper are provided in supportive housing, and are critical to improving health outcomes. Yet, linking a beneficiary to treatment and to social services alone is insufficient to achieving those outcomes. Improving health among homeless beneficiaries and beneficiaries who are frequent hospital users is contingent on services that engage beneficiaries on an ongoing basis, promote healthy behaviors, and allow for self-management.

To incorporate these concepts into the definitions, I specifically recommend including the following:

- In the definitions of care management and care coordination, engagement services to motivate beneficiaries to collaborate in drafting and executing the Health Action Plan (HAP),
- Regular and ongoing communication, including case conferencing among team members, housing providers, and, when necessary, health providers,
- Transportation to and from appointments,
- Assistance in pursuing healthier behaviors and following treatment regimens,
- Help in obtaining and improving self-management skills to prevent negative health outcomes,
- Assistance in maintaining Medi-Cal,
- Advocacy with health care professionals,
- Accompanying beneficiaries to appointments when needed (including appointments with social service providers),



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- Partnerships with organizations offering existing resources a beneficiary requires to improve health outcomes,
- Warm hand-offs to staff at partner organizations, and
- Connections to affordable permanent housing (when the beneficiary is experiencing homelessness).

#### Section B5: Community-Based Care Management Entities (CB-CMEs)

I recommend allowing MCPs to designate specific health homes as health home predominantly serving beneficiaries experiencing homelessness. I also recommend clarifying MCPs should refer beneficiaries to these designated health homes if the beneficiary is homeless in that geographic area, unless the beneficiary otherwise requests assignment to a different health home.

I recommend allowing MCPs flexibility in contracting with CB-CMEs, rather than requiring an administratively burdensome and difficult process to obtain certification. Alternatively, certification should simply involve ensuring CB-CMEs meet the qualifications outlined in the concept paper.

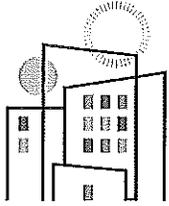
I also recommend several changes to the duties outlined in the concept paper for CB-CMEs:

- Revising number 7, in assuring the receipt of evidence-based care, to require instead partnering with and referring beneficiaries to treatment providers offering evidence-based care.
- Eliminating number 12, providing 24-hour, seven days a week information and emergency consultation services, as inconsistent with both the definitions of services included in the concept paper and with the intent of health home services. Since MCPs already offer these services, health homes should not need to.
- Revising number 8 to replace the need for a directory of community partners with partnerships with community partners offering resources in the community.

I recommend further, in health home staff roles, that Community Health Workers not be required to mail health promotion materials.

#### Section B7: Payment Methodologies

I support DHCS intent to implement a three-tier payment process, as well as the enhanced member engagement tier rate. To ensure consistency, the State should offer MCPs a per member, per month case rate that allows Health Home Programs flexibility in identifying and providing health home services each benefit requires. I further recommend limiting how much an MCP may retain, consistent with other states' state plan amendments, to ensure the vast majority of funding offers services to eligible beneficiaries, rather than administrative process. The health home should be expected to achieve the outcomes the State identifies, and not be expected to expend significant staff time on administration of the health home program required with a fee-for-service type process.



**SAHA**  
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Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. I look forward to engaging further in discussions on strengthening the Health Home Program.

Sincerely,

A handwritten signature in black ink, appearing to read 'Chris Hess', written in a cursive style.

Chris Hess  
Director of Resident Services



April 28, 2015

Jennifer Kent, Director  
California Department of Health Care Services  
P.O. Box 997413, MS0000  
Sacramento, CA 95899-7413

Dear Director Kent:

The SCAN Foundation (Foundation) commends the state's continued efforts to thoughtfully develop the health home concept in order to improve health and well-being through whole person care coordination. Upon review of *Health Homes for Patients with Complex Needs (HHP) California's Concept Paper Version 2.0* – hereinafter referred to as Version 2.0 – we have identified specific areas to elevate building upon our previously submitted comments.

HHP creates an opportunity for significant impact on how individuals experience health care and access services, as well as their health outcomes. The overall theme of our comments acknowledges that there are many lessons learned from Cal MediConnect (CMC) planning and implementation that are likely relevant to HHP. We recommend that DHCS actively consider the lessons learned from the CMC experience for this new initiative, specifically when planning for comprehensive care management and care coordination, beneficiary notification, continuity of care, and provider education.

#### Comprehensive Care Management and Care Coordination

One objective identified in Version 2.0 is to create synergies between HHP and the Coordinated Care Initiative (CCI), ensuring the services in HHP are complementary to CMC. However, the relationship between HHP and CCI is currently unclear. We recommend that DHCS articulate how the HHP would enhance CCI, including additional benefits available to individuals already enrolled in CMC and MLTSS, to ensure the HHP benefits would not duplicate existing CCI requirements. We believe this transparency will help to build confidence across providers and other stakeholders and contribute to the success of the program. We also recommend developing clear care management and care coordination standards for both CCI and HHP in

order to help develop a better understanding of the programs, create realistic expectations, and improve individuals' ability to engage in the care planning process.

### Beneficiary Notification

Version 2.0 describes that the Medi-Cal managed care plans (MCPs) will connect currently enrolled beneficiaries with one of the contracted community-based care management entities (CB-CME), and notify individuals by letter. The letter is intended to inform individuals that they are eligible for HHP, provide the name of their potential provider organizations, and describe their options. We suggest the following considerations learned from the CCI notification process be incorporated into the communications for HHP that could minimize confusion and motivate people to participate in HHP.

- *Minimize confusion:* It is important that the notifications are timely and transparent, clearly explaining the additional benefits available through HHP and the individuals' options to participate or not. This is especially true in CCI counties as individuals have undergone a similar process over the few last years, and may specifically confuse HHP notifications with former CMC notifications. In addition, it is unclear whether letters are the most effective form of communication. Despite CCI enrollment materials going through several iterations to minimize confusion, reports from individuals receiving letters still found the notifications difficult to understand. We recommend that DHCS incorporate stakeholder feedback on HHP notifications, and utilize focus groups that include CMC beneficiaries to develop the most effective form of communication possible. In addition, it may be beneficial to consider using the existing CCI care managers to connect with individuals eligible for HHP services to explain the new program in addition to written notification by letter.
- *Change fatigue:* While DHCS may view HHP as an additional benefit that complements the CMC program, eligible individuals in CCI counties may experience it as yet another Medi-Cal program change. It is important to acknowledge that change fatigue may influence an individual's choice whether or not to participate, and DHCS should create strategies to address this potential scenario. We reiterate a potential solution above of utilizing the CCI care managers to communicate the benefits of HHP and facilitate the decision making process.

### Delegation

Version 2.0 states that a goal of HHP is to provide increased care coordination wrapped around each individual's care delivery. However, Medi-Cal managed care plans vary in how they delegate responsibilities, and some medical groups also delegate to other entities as they

contract for services. There may be unintended consequences related to continuity of care and access to services and supplies depending on how these structures are developed and operationalized.

- *Continuity of care:* When considering whole person care in implementing the HHP, we recommend that DHCS consider not only changes to and choices related to health plan or primary provider, but how access to specialists and durable medical equipment providers might be affected. During the CMC implementation, individuals chose health plans that listed their primary and specialty providers as in-network and later learned that the specialist and primary physician were not in the same provider group resulting in an unexpected change of providers. We recommend that DHCS develop continuity of care protections to minimize disruption in services for those individuals passively enrolled in a new health plan or CB-CME as the health home. Additionally, we also recommend that health plans should help their members make informed choices by not only identifying which providers contract with the health plan, but the physician groups or networks they are connected with as well.
- *Provider education:* The success of CMC has been challenged by confusion among providers about CMC implementation and processes (i.e., how to bill, continuity of care policy and procedures, and the referral process). We recommend that DHCS develop and implement education and outreach for a variety of direct care providers, particularly physicians and specialists on HHP. We recommend that these trainings focus on helping them understand the program's vision, goals for more integrated care delivery to improve the overall care experience, key processes, and other conceptual and/or operational elements to support successful implementation.

The Foundation appreciates the continued opportunity to provide feedback on California's health home proposal. We encourage continued consideration of the Foundation's previously submitted comments on the health home concept paper version 1.0, as many of the comments are applicable to Version 2.0. We look forward to reviewing the final iteration of the HHP concept paper prior to submission to CMS.

Sincerely,



Bruce Chernof, MD  
President and CEO

June 2, 2015

Brian Hansen  
Department of Health Care Services  
1501 Capitol Avenue  
Sacramento, California 95899

RE: Comments on HHPCN Concept Paper V 2.0 (dated 4/10/2015)

Dear Mr. Hansen:

The Senior Services Coalition of Alameda County (SSC) represents over 41 organizations that provide health and supportive services to over 50,000 seniors in Alameda County, and partners with organizations that serve people with disabilities. On May 29, 2015, SSC convened the county's CCI Stakeholder Workgroup to review and discuss California's HHPCN Concept Paper. The Workgroup has been meeting for almost three years around coverage and care delivery issues affecting Duals and SPDs. The group on May 29 consisted of 27 stakeholders, and included consumers, as well as representatives from community-based supportive services and LTSS providers, independent living centers, skilled nursing facilities, Alameda County Behavioral Health Care, Health Care Services and Adult & Aging Services, CBAS centers and MSSP providers.

I am writing to convey to you the comments, concerns and recommendations that came out of that meeting.

- 1) Regarding Dedicated Care Manager who is assigned to a HH patient and participates on the Multi-Disciplinary Health Home Team: It is essential that the accreditation requirements for this role be flexible so that paraprofessionals with appropriate training are able to provide care management services and the CB-CME is able to bill for these services. This flexibility is necessary to avoid unnecessary cost pressures that could result in depriving patients of quality time.
- 2) Regarding provider referral of potentially eligible individuals to the MCP to confirm eligibility. The managed care plans do not have access to records and utilization data outside their own silo – for instance, the plans can't access utilization and other information for an individual in the Behavioral Health Care system, or who is receiving LTSS. This means that the plans lack much of the information that would allow them to confirm that an individual is eligible for HHPCN.

- 3) Regarding payment and rates for the core home health services. Stakeholders recognize that working successfully with persons facing mental health and homelessness challenges requires enhanced outreach. The MHSA is unique in addressing this reality and providing funding for outreach. If HHPCN is to be successful it needs to build similar costs for outreach into its rates.
- 4) Regarding payment methodology and rates. A vital ingredient to the success of a program that works with individuals with complex needs is a structure of rates and reimbursement that include purchase of services. It is unrealistic to assume that Community and Social Support Services will be available when needed. These services are underfunded and lack capacity to address the real need in their respective communities. If an HH Care Manager refers a patient to a program, only to have that patient wait listed or turned away, the opportunity for effective intervention is lost. Adequate funding must be provided to purchase community-based services if needed. We suggest looking to MSSP, the Multi-Purpose Senior Support Program which has proven success in stabilizing Duals and SPDs who have complex needs and are eligible for skilled nursing facility care. MSSP's Medi-Cal rate includes funds for purchase of services that can be used for a long list of often urgently needed interventions, from ramps to temporary Adult Day Care to relocation to safe housing.
- 5) In addition, our stakeholders had numerous questions about how HHPCN would interact with Targeted Case Management and with Full Service Partnerships. For effective implementation, that interaction needs to be spelled out in clear operational terms for MCPs, CB-CMEs and their contractors.

Thank you for providing the information and materials for our May 29 convening. Please feel free to contact me if you have questions or need further details about these comments. I would also be happy to convene Alameda County stakeholders or subgroups of stakeholders, if that would be helpful as you work to shape the health homes model so that it truly facilitates successful outcomes for patients with complex needs.

Sincerely,



Wendy Peterson  
Director, Senior Services Coalition of Alameda County

**Comment received via email during comment period.**

My name is Hal Slavkin and I am writing to suggest that the proposed “health homes” to address the special needs of California’s underserved populations with chronic diseases be designed to include mental, vision and oral health care workforce and benefits. The last two decades of biomedical research have clearly determined the value-added benefits to patients of oral health care (or the management of oral infection) with reproduction, cancer therapy (chemotherapy and radiation), pulmonary, cardiovascular and type2 diabetes. A number of recent publications have demonstrated significant cost savings and improved health outcomes for patients presenting type 2 diabetes with oral health management (approximately \$2,000/diabetic patient/year saved with management of oral infections).

Indeed, “the mouth is connected to the rest of the body” (as illuminated in the Surgeon General’s Report “Oral Health in America” and, as such, must be integrated and coordinated within comprehensive chronic disease patient care.

I am keenly interested in the integration of oral health care into primary care for all people of all ages. I have spent 46 years on the full-time faculty of USC in Los Angeles, 5 years as the 6th director of the NIDCR at the NIH (1995-2000), as dean of the USC School of Dentistry (2000-2008), and currently serve on the Board of Directors for the LA Trust for Children’s Health associated with LAUSD.

I would very much like to meet you. I will provide references on any of these topics as you might be interested. I attach a brief bio as an introduction.

Regards, Hal



May 5, 2015

Health Home Program  
Department of Health Care Services  
1500 Capitol Mall  
Sacramento, Ca 95814  
[HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov)

Re: Comments on DHCS' Concept Paper Version 2.0 on Health Homes

Dear Health Home Team:

The Tenderloin Neighborhood Development Corporation (TNDC) thanks you for the opportunity to comment on Concept Paper 2.0 regarding Section 2703 of the Affordable Care Act, the health home option. TNDC provides affordable housing and services for low-income people in the Tenderloin and throughout San Francisco, to promote equitable access to opportunity and resources. We know firsthand how housing, support services, referrals, and linkages collaborate to improve care and health while decreasing cost.

We appreciate the ways DHCS staff has incorporated supportive housing into the concept paper, as well as housing navigators, tiered payment, and a focus on serving Medi-Cal beneficiaries experiencing homelessness. Below, we offer specific comments and recommendations for strengthening the Health Home Program's attention to homeless individuals, a population which is often difficult to serve in a coordinated way despite being frequent users of high-cost, crisis health services

**Section B1: Eligibility & Section B6: Beneficiary Assignment**

While great efforts will be made to identify eligible beneficiaries through administrative data, it is TNDC's experience that using administrative data alone will not allow Managed Care Plans to effectively identify homeless beneficiaries. To mitigate this challenge we encourage an approach that includes both the use of administrative data and a referral process.

We agree with the list of chronic conditions in the concept paper, and recommend the State narrow by acuity according to hospital use or homelessness. Managed care plans would not be able to identify homeless beneficiaries through administrative data, but a referral process could identify additional criteria administrative data cannot. Additionally, we recommend using existing research data to identify indicators of high costs and poor outcomes among those experiencing homelessness. Data, for example, indicate Medicaid beneficiaries with frequent hospital admissions experiencing homelessness will continue to be admitted to the hospital frequently over time, and will continue to incur high costs.

Regardless of eligibility criteria selected, we recommend a process of referral that allows homeless service, housing, hospital, health center, and homeless service systems refer beneficiaries for potential eligibility, according to eligibility criteria the State adopts.

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We also recommend eliminating the requirement that MCPs approve adding beneficiaries to a health home. Waiting for approval could impact a health home's ability to engage homeless beneficiaries. Homeless beneficiaries will have no way of knowing they are eligible for health home services, unless the beneficiary seeks other services or is hospitalized. Potentially eligible homeless beneficiaries often present a brief window to engage. Most would be lost to follow-up in waiting for an MCP approval process. For this reason, we recommend establishing a process for receiving referrals from hospitals, homeless service and housing providers, health centers, or a region's homeless service system, for easily verifying eligibility, and for granting health homes serving homeless beneficiaries the ability to approve beneficiaries provisionally. These health homes should get reimbursed a portion of the engagement rate while waiting for final MCP approval.

We also encourage more flexibility in the way in which homeless beneficiaries are notified. Our experience is that homeless individuals often do not have stable address therefore traditional letters should not be the only approach to engagement. Letter notifications also do not take into account literacy levels of beneficiaries. To mitigate this we agree that the engagement process should also include telephone and/or in person contact. Further, to promote equitable access for all beneficiaries all engagement efforts should take into account the unique language needs of each beneficiary.

## **Section B2: Health Home Services**

In the definition of services, we recommend greater emphasis on services that work to engage beneficiaries to achieve and maintain health stability on an ongoing basis. Many of the services identified in the concept paper are provided in supportive housing, and are critical to improving health outcomes. Yet, linking a beneficiary to treatment and to social services alone is insufficient to achieving those health outcomes. Improving health among homeless beneficiaries and beneficiaries who are frequent hospital users is contingent on client-centered services that engage beneficiaries on an ongoing basis, promote healthy behaviors, and allow for self-management.

To incorporate these concepts into the definitions, we specifically recommend including the following:

- In the definitions of care management and care coordination, engagement services to motivate beneficiaries to collaborate in drafting and executing the Health Action Plan (HAP),
- The HAP reflect the cultural and linguistic needs of the beneficiaries,
- The HAP include a comprehensive assessment of housing history and needs,
- Regular and ongoing communication, including case conferencing among team members, housing providers, and, when necessary, health providers,
- Transportation to and from appointments,
- Assistance in pursuing healthier behaviors and following treatment regimens,
- Help in obtaining and improving self-management skills to prevent negative health outcomes,
- Assistance in maintaining Medi-Cal, Advocacy with health care professionals,

- Accompanying beneficiaries to appointments when needed (including appointments with social service providers),
- Partnerships with organizations offering existing resources a beneficiary requires to improve health outcomes,
- Warm hand-offs to staff at partner organizations, and
- Connections to affordable permanent housing (when the beneficiary is experiencing homelessness).

#### **Section B5: Community-Based Care Management Entities (CB-CMEs)**

We recommend allowing MCPs to designate specific health homes as health home predominantly serving beneficiaries experiencing homelessness. We also recommend clarifying MCPs should refer beneficiaries to these designated health homes if the beneficiary is homeless in that geographic area, unless the beneficiary otherwise requests assignment to a different health home.

We recommend allowing MCPs flexibility in contracting with CB-CMEs, rather than requiring an administratively burdensome and difficult process to obtain certification. Alternatively, certification should simply involve ensuring CB-CMEs meet the qualifications outlined in the concept paper.

We also recommend several changes to the duties outlined in the concept paper for CB-CMEs:

- Revising number 7, in assuring the receipt of evidence-based care, to require instead partnering with and referring beneficiaries to treatment providers offering evidence-based care.
- Eliminating number 12, providing 24-hour, seven days a week information and emergency consultation services, as inconsistent with both the definitions of services included in the concept paper and with the intent of health home services. Since MCPs already offer these services, health homes should not need to.
- Revising number 8 to replace the need for a directory of community partners with partnerships with community partners offering resources in the community.

We recommend further, in health home staff roles, that Community Health Workers not be required to mail health promotion materials.

#### **Section B7: Payment Methodologies**

We support DHCS intent to implement a three-tier payment process, as well as the enhanced member engagement tier rate. To ensure consistency, the State should offer MCPs a per member, per month case rate that allows Health Home Programs flexibility in identifying and providing health home services each benefit requires. We further recommend limiting how much an MCP may retain, consistent with other states' state plan amendments, to ensure the vast majority of funding offers services to eligible beneficiaries, rather than administrative process. The health home should be expected to achieve the outcomes the State identifies, and not be expected to expend significant

staff time on administration of the health home program required with a fee-for-service type process.

Thank you for your dedication to making the Health Home Program successful, and for the opportunity to comment. We look forward to engaging further in discussions on strengthening the Health Home Program.

Sincerely,



Yvette Robinson, Director of Tenant Services  
Tenderloin Neighborhood Development Corporation  
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E-mail: [yrobinson@tndc.org](mailto:yrobinson@tndc.org)  
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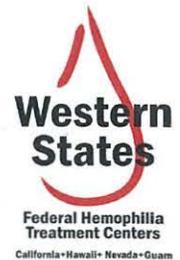


**WESTERN STATES REGIONAL HEMOPHILIA NETWORK**  
**PACIFIC REGIONAL SICKLE CELL DISEASE COLLABORATIVE**  
**The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders**

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Diane J. Nugent, M.D.  
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*Representing 14 Hemophilia Treatment Centers in California, Guam, Hawaii, and Nevada and  
Building Sickle Cell Disease Treatment Capacity  
in Alaska, Arizona, California, Guam, Hawaii, Idaho, Nevada, Oregon and Washington  
Providing comprehensive diagnostic, treatment, prevention, research, and cost effective pharmacy services for a longer, healthier life*

May 5, 2015

Sarah Brooks, Chief, Managed Care Quality and Monitoring Division  
Health Homes for Patients with Complex Needs (HHP)/ Concept Paper Version 2.0  
California Department of Healthcare Services  
Sacramento, CA

Dear Ms. Brooks: RE: Input into the HHP 2.0 Draft 4/10/2015

The Centers for Inherited Blood Disorders (CIBD) is a not for profit community specialty clinic that provides team based interdisciplinary diagnostic, treatment, prevention, education, and rehabilitation services to improve the health, quality and length of life, and reduce healthcare costs for over 1500 Californians with complex, chronic, rare and costly blood conditions, such as Hemophilia, Thalassemia, Sickle Cell Disease (SCD), and Metabolic disorders. CIBD is a nationally and regionally recognized leader: serving as the prime grantee for two federal grants from the Health Resources and Services Administration whose purposes are to build rare disorder clinical expertise, and sustain regional healthcare delivery systems transformation for over 10,000 persons with Hemophilia, SCD, and other rare chronic blood disorders who live in California and the surrounding eight Western US States and US Pacific jurisdictions.

We laud the California Department of Healthcare Services' leadership to devise a HHP for Medicaid beneficiaries that focuses on the triple aim of better care, outcomes and lower costs. We understand that the HHP seeks to accomplish this by implementing coordinated access to medical and behavioral healthcare, long-term services, and community social supports. Hemophilia, Thalassemia, SCD, and Metabolic disorders are among the most expensive (per capita) and high risk complex rare chronic diseases. Costs, morbidities, and mortality can be avoided by access to the appropriate array of health and behavioral services – which must include rare disorder specialty teams. Therefore, we appreciate this opportunity to provide input into the Health Homes for Patients with Complex Needs (HHP)/ Concept Paper Version 2.0.

Rare disorders: HHP Guiding Principals (HHP Concept Paper 2.0 - Pages 4-6); Medi-Cal Managed Care Plan Responsibilities (HHP Concept Paper 2.0 - Pages 12-13); and Community Based Care Management Entity (HHP Concept Paper 2.0 - Pages 13-14). We support the guiding principles, policy goals, and objectives for implementation. Particularly DCHS' emphasis on care coordination, team based care, focus on improved outcomes for high cost beneficiaries who have high risk chronic disorders, net cost avoidance, bolstering provider capacity, integrating physical and behavioral health, wrap around synergies with the existing delivery systems. *However, missing from this laudatory framework is specific attention to persons with high-risk, high cost diseases that are rare.* It is unrealistic to expect Medi-Cal Managed Care Plans, Cal MediConnect plans, and their contracted community workers – many operating at the County level -- to have sufficient knowledge and skill in rare disorders essential to achieving the triple aim for persons with high-risk high cost rare chronic disorders. Volume and centralization is essential, as structured in the State's California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP). GHPP is California's vitally important health insurance program, primarily for adult residents with specified inherited catastrophic disorders. Hemophilia and Sickle Cell Disease represent two thirds of GHPP beneficiaries.

We recognize that people with rare chronic, high-risk disorders also suffer from common physical and behavioral health problems. Many people with rare disorders who are in Medi-Cal Managed Care plans have benefitted greatly from access to primary care practitioners and other health care providers to address their more common and/or other health problems that are unrelated to their rare disorder. We coordinate with these healthcare providers to the extent that beneficiary insurance allows. However, coordination is a two way street. All too often, narrow insurance networks – both private and within Medi-Cal Managed Care - either outright prohibit or limit beneficiary access to our rare disorder specialty teams, and our full array of diagnostic, prevention, education, treatment, rehabilitative, and pharmacy services. These limitations and prohibitions lead to avoidable costs, morbidity and mortality. We do not wish the HHP repeat these mistakes.

**Hemophilia Treatment Centers:** Center for Inherited Blood Disorders; Children's Hospital Los Angeles; Rady Children's Hospital San Diego; City of Hope National Medical Center; Guam Department of Public Health and Social Services; Hemophilia Treatment Center Nevada; Orthopaedic Hospital Los Angeles; Stanford University Medical Center; UCSF Benioff Children's Hospital Oakland; UCSF Benioff Children's Hospital San Francisco; University of California, Davis; University of California, San Diego; Valley Children's Hospital;

**RECOMMENDATIONS: Therefore, we recommend that the HHP:**

1. Ensure uninterrupted and full access and reimbursement to rare disorder clinical specialty expertise by mandated contracting with CCS and GHPP Special Care Centers and other federally recognized specialty community clinics;
2. Mandate that only CCS and GHPP Special Care Centers and other federally recognized specialty community clinics have the authority to determine 'medical necessity' as it relates to the rare disorder condition(s) for HHP beneficiaries with rare disorders; and
3. Require Community Based Care Management Entities to contract with rare disorder patient support organizations *outside of their counties* to ensure service adequacy.

Eligibility Criteria: (HHP Concept Paper 2.0 - Pages 6-8). We support the State's decision to target all three eligibility criterion outlined by the ACA Section 2703: individuals with two or more chronic conditions; one chronic condition and at risk for another; and serious and persistent mental illness. Moreover, we support the State's decision to emphasize, "...beneficiaries with high-costs, high-risk and high utilization who can benefit from increased care coordination..." services outlined in the proposed HHP. We understand that the State expects to identify an eligible group that represents approximately 3 - 5% of the highest risk Medi-Cal population who can benefit from additional intensive care management (page 8, top paragraph). *However, we are concerned that rare high-risk chronic disorders might - inadvertently - be automatically eliminated from these eligibility calculations due to their small numbers.*

**RECOMMENDATIONS:** Therefore, as the State proceeds to finalize the eligibility criterion, based on targeted conditions and acuity levels as determined by risk analysis software and/or administrative utilization data, we recommend:

1. The State explicitly consider including rare genetic chronic high-risk disorders in its formula.
2. That Hemophilia, Thalassemia, SCD, Metabolic, and other rare chronic genetic bleeding and clotting disorders explicitly are included in the list of eligible chronic conditions.
3. The State invite a rare blood disorder health care professional on the eligibility technical workgroup
4. The State include GHPP in the programs listed on HHP Concept Paper 2.0 – Page 8, item 6.

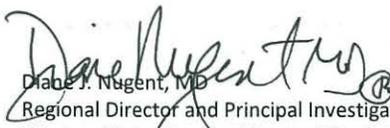
Rationale: Hemophilia, Thalassemia, SCD, and Metabolic disorders are high cost, high-risk, catastrophic rare chronic diseases. They differ in causes, symptoms, population prevalence, and treatment. Yet they share these commonalities: advances in pediatric care that improve survival to adulthood, followed by disease progression, impaired quality of life and premature mortality in adulthood often due to lack of access to specialty teams expert in disease management; high risk for unpredictable and devastating co-morbidities; potentially permanent multi-organ, tissue, and musculoskeletal, and tissue damage; chronic and debilitating pain; lifelong high cost therapies; premature mortality; a dearth of expert healthcare professionals who are specialists in diagnosis and management; high avoidable healthcare services utilization and resulting costs (e.g. emergency room visits, hospitalizations, lost work/school).

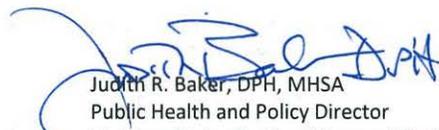
Californians with Hemophilia, Thalassemia, SCD, and Metabolic disorders are at risk for multiple co-morbid chronic conditions. Having hemophilia increases risks for chronic liver disease, namely Hepatitis B and C, plus HIV/AIDS – due to blood product contamination before viral inactivation manufacturing processes were implemented in 1990 for Hepatitis and in 1985 for HIV/AIDS. Hemophilia increases risks for progressive musculoskeletal damage - and concomitant chronic pain - from internal bleeding into the joints and soft tissues. This pain can lead to substance use disorders. SCD and Thalassemia increase risk for infections due to the spleen being compromised. SCD also intensifies risks for renal failure; bone disease; stroke and pulmonary hypertension, plus severe unpredictable and chronic pain episodes and, like hemophilia, substance use disorders. One CDC sponsored SCD Surveillance Registry documented that persons with SCD who have co-occurring mental health diagnoses are at risk for high health services utilization.

In sum – as the State refines its exciting HHP design, please consider our recommendations to preserve access to the California's existing rare blood disorder specialty teams. And include among the eligible conditions, Californians with Hemophilia, Thalassemia, SCD, Metabolic, and other rare chronic genetic bleeding and clotting disorders.

We are happy to recommend experts to serve on work groups to refine the Health Home Program design. We look forward to continuing to partner to improve health, health care, and costs for Californians with rare high cost, chronic disorders.

Sincerely,

  
Diane J. Nugent, MD  
Regional Director and Principal Investigator  
Western States Regional Hemophilia Network  
Pacific Regional Sickle Cell Disease Collaborative

  
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