

**Stakeholder Comments on
Health Homes for Patients for Complex Needs
California Concept Paper 3.0
Draft-Final 12/14/15**

Organization Comments – Joint Submissions

California Association of Health Plans *and* Local Health Plans of California
Corporation for Supportive Housing *and* Western Center on Law & Poverty

Organization Comments – Single Submissions

180/2020 Initiative of Santa Cruz County
Abode Services
Alameda County Behavioral Health Care Services
American Civil Liberties Union of California
Anthem
California Academy of Family Physicians
California Association for Adult Day Services
California Association of Medical Product Suppliers
California Association of Public Hospitals and Health Systems
California Children’s Hospital Association
California Department of Social Services
California Hospital Association
California Primary Care Association
Children Now
County of San Diego Health and Human Services Agency
Dignity Health
Downtown Women’s Center
John Snow, Inc.
LA Family Housing
LeSar Development Consultants
LifeLong Medical Care
Los Angeles County Department of Public Health
Maddis, Deborah
National Alliance on Mental Illness
People Assisting the Homeless
Providence Saint John’s Health Center
Reed Health Policy Consulting
Regional Asthma Management and Prevention
SCAN Foundation
Skid Row Housing Trust
Special Service for Groups
St. John's Well Child & Family Center
St. Joseph Center
Venice Family Clinic



1415 L STREET
SUITE 850
SACRAMENTO, CA 95814
916.552.2910 P
916.443.1037 F
CALHEALTHPLANS.ORG



December 28, 2015

Hannah Katch
Assistant Deputy Director for Health Care Delivery Systems
Department of Health Care Services
1500 Capitol Ave
Sacramento, CA 95814

VIA ELECTRONIC MAIL:
Hannah.Katch@dhs.ca.gov

Re: Health Homes for Patients with Complex Needs Concept Paper 3.0

Dear Ms Katch:

On behalf of the California Association of Health Plans (“CAHP”) and the Local Health Plans of California (“LHPC”), we write today to provide comments on the Health Homes for Patients with Complex Needs Concept Paper 3.0.

CAHP represents 47 public and private health care service plans that collectively provide coverage to over 24 million Californians. LHPC represents all 16 of the public, non-profit, community based health plans in California, which provide care to over 6 million of the almost 10 million Medi-Cal managed care beneficiaries.

As indicated by the response to the recent Request for Interest (RFI) from Department of Health Care Services (“DHCS”), the Medi-Cal plans are supportive of the Department’s efforts to launch the health homes benefit for California’s Medi-Cal managed care enrollees. To that end, the plans appreciate the overall increase in flexibility provided in the updated concept paper. As with the implementation of many new programs, the plans believe such flexibility will help them achieve success and partner with DHCS to achieve our shared goal of improving the care delivered to some of Medi-Cal most vulnerable members. We appreciate the opportunity to provide feedback on the concept paper and look forward to working with you on the Health Homes Program (“HHP”). Our comments and feedback, provided below, reflect our commitment to HHP and focus on the areas of the proposal where plans continue to have concerns or seek additional clarification.

Coordination with County Behavioral/Mental Health

Plans are supportive of the focus in HHP on persons with serious mental illness (SMI) and coordination with, and increased access to, behavioral health services. To be successful, plans will need to work closely with our county mental and behavioral health partners. Plans are concerned, however, that the counties have not been involved in the discussions with plans and the Department in developing the HHP and may not be aware of their role in HHP. The timeline for the work related to SMI will need to be developed early in the process since the HHP timeline in the concept paper begins implementation with SMI population. To facilitate

discussion of how best to integrate behavioral health services into HHP, we request that the Department coordinate a meeting with the plans and the appropriate county representatives.

In addition to convening a meeting with county staff, we also request that DHCS update the HHP timeline to reflect the work necessary to bring all of the appropriate agencies and providers up to speed on HHP; in particular the timeline must acknowledge the time it will take for engagement and integration of the services for the SMI population. We believe that there is opportunity to build on what is already being done by the counties that could help to inform the HHP. For example, there are Mental Health Services Act dollars being used to implement programs that may complement the HHP. We look forward to more detailed discussion with the Department and other stakeholders.

Eligibility Criteria

The plans appreciate the additional information provided regarding the eligibility criteria developed in partnership with the technical expert workgroup. Plans are concerned, however, about the requirement that the member must have claims in the past two years for the eligible condition. Many Medi-Cal beneficiaries experience breaks in Medi-Cal eligibility over time for many different reasons; or beneficiaries may transition between plans (e.g., if they move to a new county or choose to enroll in a different plan in the same county). Additionally, beneficiaries that may get the most benefit from the HHP may not have two years of claims for a variety of reasons, i.e., those experiencing homelessness that have not been seeking care. These kinds of issues will make it very likely the plans will not know which members meet this criterion as they may not have access to two years of continuous claims data for a particular member. We suggest that the Department delete this as a criterion for eligibility in the HHP because in many instances plans will not be able to produce this information but that should not mean the member is not HHP eligible.

Furthermore, there is concern over the phrasing of the following exclusion for eligibility in the HHP: *“members whose condition management cannot be improved because the member is uncooperative.”* There is also concern over the language that would require disenrollment when members do not *“actively participate.”* We believe that this approach may incentivize not engaging the more difficult members. Rather than focus on cooperation or compliance, the plans suggest that the Department give plans the flexibility to focus on the member’s agreement to participate in the HHP, and not force plans to disenroll members who are uncooperative. Many members are likely not familiar with a coordinated system of care and will need time to adjust to, and to gain trust with, the program. This may result in uncooperative behavior at times but plans believe that many of these members can still benefit from the HHP.

Payment Methodologies

The plans appreciate the overview provided in the concept paper about the HHP rates and payment structure. We understand that payment rates have yet to be developed and look forward to working with DHCS to develop HHP rates. We request a meeting with DHCS and suggest using the Optional Expansion rate workgroup that was established by the Department, or a similar process, as the HHP rates are developed. We have previously provided substantive input on a suggested structure for the rates for the HHP (see previous comment letter from CAHP dated September 16, 2015 where we discussed the tiers and the rates). We look forward to a more in depth discussion on how to develop rates for a program that will be very resource intensive from the beginning but may not show traditional utilization data because many of the

services will be outside of the scope of regular medical care, which is likely to result in some additional challenges in establishing the appropriate rates for the HHP.

It will also be important for the rates to accurately reflect the HHP staffing model and requirements outlined in the concept paper. In particular, the plans note that the dedicated care manager (one of the required members of the multi-disciplinary team) can be licensed or a paraprofessional. While the plans support flexibility to use paraprofessionals, this flexibility may not always be appropriate and health plans will need to use licensed professionals to work with the HHP population. This flexibility must also be reflected in the HHP rate development process to provide plans with sufficient funding to pay for licensed care managers, social workers, or nurses, as well as paraprofessionals at the CB-CME.

Health Homes Program Network Infrastructure

The plans continue to request that the Department maintain flexibility on the requirement to partner with the CB-CMEs and not include mandated contractual arrangements in the HHP. It is not clear from Concept Paper 3.0 exactly what is required in the contractual arrangements between health plans and the CB-CMEs. We maintain that health plans are in the best position to determine what appropriate contracting arrangements are necessary to implement the HHP and we request that the Department acknowledge this in the design of the program.

Medi-Cal Managed Care Plan Responsibilities

The plans have raised concerns with several of the responsibilities/duties outlined in the concept paper. For example, plans anticipate that there will be challenges with meeting the requirement that they notify the CB-CMEs of inpatient admissions and emergency department (ED) visits. In a delegated model, this data may not be received in real-time by the plans, and often the data lag is several months. Further, we are concerned with some of the requirements to demonstrate engagement with certain providers. For example, health plans will not always have the leverage to require that hospitals or other providers participate in the HHP. We request additional clarification on what the health plans will have to demonstrate to meet this requirement.

The plans request to maintain the authority to pay providers directly, and to not be required to flow all funds for provider payments through the CB-CME. Again, the flexibility to pay the providers directly for both HHP and non-HHP services that will best serve this population is integral to being able to maintain a network of adequate providers. The responsibilities listed in the concept paper should be considered a starting point for ongoing discussion between the Department and the Plans, between now and implementation.

There is also concern over the statement that managed care plans will use social media, text, or e-mail. We request that the Department clarify that these modalities will be used at the plan's option when determined appropriate.

Dual Eligibles

The plans have a number of concerns with how best to provide HHP services to their dual eligible members, particularly those who are not participating in the Cal MediConnect (CMC) pilots and for whom the health plans do not have comprehensive data (which would be held by Medicare or another plan). For example, plans will not have real-time access to information on ED visits for this population. This makes implementing HHP for non-CMC duals uniquely more challenging, and we would like to further discuss with the Department how we can design a

program that meets the federal requirements to offer the HHP to all eligible individuals but also addresses these issues.

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

The plans appreciate the increased flexibility in how the CB-CMEs are organized and structured. We note, however, this it may not be appropriate to assume that CB-CMEs will primarily engage with beneficiaries in the primary care setting, and we are concerned that the Department is mandating that the health home be established at a specific location that is tied to the CB-CME. Plans want the ability to establish the health home in the location that makes the most sense for a given individual, which may range from a hospital, to a mental health provider, to a CBO that serves the homeless population. Any design that arbitrarily limits the location of the health home will risk not including many members who would benefit most from the HHP. The plans request an exception process or the ability to determine when the health home/care coordinator should be established at a location other than a CB-CME, and that it not be tied strictly to the criteria outlined in the concept paper. For example, we request a definition of “community providers” that is more inclusive and represents the various agencies or other entities that have relationships with these beneficiaries.

The plans request more detail on what they will be required to provide to certify that Model I is not available in their community. Plans feel that it is an additional and unnecessary administrative burden to have to demonstrate that Model I is not viable in order to move to Model II or III. As we have noted, the flexibility needed to engage and enroll these members into the HHP is vital to its success, and the administrative burden of having to demonstrate why plans are using a different model must be kept to a minimum to ensure that resources are going into the actual program and service delivery.

Reporting Requirements

Plans seek clarification and additional details about the cost and utilization reporting requirement. In particular, plans request additional details on how the “*number of HHP service units provided in the reporting period*” will be defined. Plans are concerned that many CB-CMEs will be manually tracking the HHP information (e.g., homeless services organizations); making detailed reporting challenging and burdensome for providers and plans. The number of HHP units that are authorized may be different at the time that service is rendered, therefore the plan may not know the total service units until invoices or claims are received. The numbers of new HHP members who previously participated in HHP and had a break in coverage may also be difficult to track, especially if they were part of the HHP with another plan. The unique challenges in reporting for the HHP must be taken into account by the Department before determining the reporting requirements that will be placed on the plans. The plans request to participate in ongoing discussions regarding the collection and analysis of data that includes financial measures, health status, and other quality measures to address the availability and feasibility of collecting these data.

Coordination with Targeted Case Management/ 1915(c) Waivers

Plans understand that beneficiaries cannot be enrolled in the HHP and Targeted Case Management or 1915 (c) waivers programs at the same time. We request clarification on how plans will help beneficiaries make the decision about which program is best for them and how plans will know if a member is already enrolled in one of these programs. We suggest that the Department incorporate this as part of the eligibility and enrollment process and identify these members on the 834 file. With this information, plans will know which members will have to choose between programs and they can better assist them.

We thank you for taking the time to review these comments. We are available at your convenience and would welcome further discussion of this letter.

Sincerely,



Athena Chapman
Director of State Programs
CAHP



Caroline Davis
Senior Policy Director
LHPC

cc (via email): Sarah Brooks, Deputy Director, Health Care Delivery Systems, DHCS
hhp@dhcs.ca.gov



January 20, 2016

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814

RE: COMMENTS ON CONCEPT PAPER 3.0: HEALTH HOME PROGRAM FOR COMPLEX PATIENTS

Dear Health Home Program Team:

Thank you for considering feedback in drafting the Health Home Program (HHP) State Plan Amendment. CSH and Western Center on Law & Poverty offer the following comments on Concept Paper 3.0, focusing on the needs of **homeless** Medi-Cal members.

We hope the HHP employs strategies proven to reach, engage, and assist highly vulnerable populations to access care. Toward that goal, we recommend avoiding policies that could have the unintended consequence of imposing barriers to engaging the Medi-Cal beneficiaries for whom this benefit is likely to have the greatest impact: those who find it most challenging to navigate complex systems without easily-accessible assistance tailored to their needs. If these populations responded well to current approaches to engagement, care coordination, or referral processes, they would not require the level of services the HHP anticipates.

ELIGIBILITY CRITERIA

We appreciate the thought and analysis in choosing chronic conditions for eligibility and we agree largely with the list of chronic conditions.

We have questions regarding two proposals in this section:

- On page 8, the Concept paper says that “Chronic Renal Disease is an HHP eligible condition” but will not be included in the Targeted Engagement List. Can you please provide more explanation for the proposed referral process for members with this condition and whether renal disease would fall under the first or second category of conditions? Also, why not include this disease among the other conditions? Who may refer these members for MCP approval?
- Are the criteria used to establish the Targeted Engagement List intended to be the same as the *eligibility* criteria for a Medi-Cal member to receive HHP services, or could a Medi-Cal member who meets some of these criteria (for example, the eligible conditions listed in the first set of bullets and one of the criteria listed in the second set of bullets) be referred for HHP services, even if s/he is not on the Targeted Engagement List because of a lack of administrative claims data? For a member to be eligible for HHP services, must *all* of the additional criteria listed in the third set of bullets (administrative criteria) be met or only one of these? How likely is it that administrative claims data available to DHCS or the MCP will accurately capture diagnosis and service code data for individuals with substance use disorders, particularly if those individuals have not received Medi-Cal-funded substance use treatment services, which have not been widely available to most adults? Some of those members who are most in

need of HHP services have substance use disorders, but have not been engaged in treatment services, so claims data related to this condition would not exist. Can you address this likelihood? Can a CB-CME use other sources of data or documentation, such as a diagnosis from a qualified clinician, to demonstrate that a person does have two diagnoses needed to establish eligibility for HHP services?

We recommend the following:

HHP Eligibility Criteria & the Targeted Engagement List.

- On page 6, Concept paper 3.0 indicates that the Managed Care Plans (MCPs) will actively engage their members on the Targeted Engagement List. We recommend that MCPs collaborate with and support the efforts of Community-Based Care Management Entities (CB-CMEs) to engage eligible members. MCP engagement typically includes calls or letters to members, strategies likely to fail to reach difficult-to-serve populations, particularly members who are experiencing homelessness or housing instability, and those who have limitations in health literacy. On the other hand, a case manager's in-person, face-to-face, repeated interactions with a member, particularly when that case manager is trained in motivational interviewing and trauma-informed care, results in trusting relationships that break down distrust of health systems, and allow members to change their own lives. These evidence-based engagement strategies result in long-term health stability. CMS has recognized the importance of face-to-face interaction in their recent, second Frequently Asked Questions, which states that care coordination should involve, "face-to-face with the health home enrollee" and others involved in the member's care.¹
- We recommend adding HIV/AIDS to the list of chronic conditions. We recognize other programs offer support to people with HIV/AIDS; yet, people with a combination of conditions that include HIV/AIDS continue to need intensive care management and coordination services they are currently unable to access. Similarly, we recommend including post-traumatic stress disorder and depression among those without serious mental illness to the list of conditions requiring two or more chronic conditions, since both are common among frequent hospital users.
- If DHCS is committed to using a predictive risk score in assessing eligibility, then we recommend the one developed by Billings and Raven at New York University. But we note that any modeling tool, including Billings and Raven's, rely on hospital admissions to predict high-costs among Medicaid populations. Because hospital admissions are already part of DHCS's acuity criteria, utilizing a risk score may be duplicative.²
- "Chronic homelessness" should be added as one of the acuity factors in conditions, as required under Welfare & Institutions Code § 14127.3(c)(2), in addition to an inpatient admission and emergency department visits.
- We recommend describing a referral process that allows other entities, outside of the MCPs and CB-CMEs, such as hospitals, homeless service or housing providers, county behavioral health providers, and other agency staff, to identify and refer members who may or may not be on the Targeted Engagement List, or who meet eligibility criteria but do not meet the administrative requirements. If a homeless service provider has developed a trusting relationship with a client and has determined the client most likely meets the eligibility criteria, the provider should be able to refer the client to a CB-

¹ CMS, "Health Homes Frequently Asked Questions: Series II." <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-homes-faq-12/2015.pdf>. Dec. 2015.

² M. Raven, J. Billings, L. Goldfrank, etc. al. "Medicaid Patients at High Risk for Frequent Hospital Admission: Real-Time Identification & Remediable Risks." *J. Urban Health*. Mar. 2009. 230-41. J. Billings. "Predictive Modeling for High-Cost Medicaid Patients in New York." *Center for Health Care Strategies*. 2008.

CME or MCP to determine whether the member is included in the Targeted Engagement List or should otherwise be eligible for HHP benefits.

- We recommend eliminating the requirement that members have claims in two years for the eligible condition or that the member show continuous Medi-Cal enrollment for at least three months. Members with the conditions that would make them eligible—traumatic brain injury, substance use disorders, and serious mental illness—often experience difficulties obtaining and maintaining Medi-Cal enrollment during recertification or due to periods of incarceration. These members need HHP services more than other members functional enough to maintain Medi-Cal eligibility without any assistance. While we believe many, if not most, homeless members who are high-cost users are Medi-Cal members, homeless high-cost users often have particular difficulties maintaining Medi-Cal enrollment. We anticipate HHP services could result in more consistent, continuous enrollment in Medi-Cal. We strongly recommend removing the last two administrative requirements in the third set of bullets.
 - As an alternative, given DHCS’ staff emphasis on eligibility through administrative data, we recommend allowing for presumptive eligibility for members who meet the chronic condition and acuity criteria (verified according to claims data or hospital data, or other documentation that is based on a qualified clinician’s assessment), but who do not meet the additional criteria related to administrative claims.
- Similarly, we recommend removing exclusions for members assessed to be “uncooperative” or “unsafe.” Instead, we recommend emphasizing the need to engage difficult-to-serve members. Excluding these members offers CB-CMEs and MCPs the opportunity to reach only those easier to serve and more compliant, as staff do not have the expertise or wherewithal to address the needs of populations who have deep-seated distrust of health care systems. In order to achieve the policy goals and objectives DHCS has articulated, to use this benefit to improve care among highly vulnerable individuals with chronic conditions, people who are “uncooperative” are exactly the population HHP should serve. Members may chose not to enroll, or to discontinue HHP services at any time, making it unnecessary for CB-CME’s to use additional “exclusion” criteria related to members who may be “uncooperative”.

Acuity

We strongly encourage DHCS to set tiered payment criteria with a homelessness modifier.

- In an effort to maintain consistency in services and outcomes across MCPs and counties, we recommend requiring a consistent, clear tiering structure.
- We further support adding the “homelessness modifier” that was included in the proposed payment tier structure released two months ago at the last Technical Assistance Committee meeting.
 - In creating the modifier, we recommend extending the modifier to persons who have been housed for two years or less. Welfare and Institutions Code § 14127(e) defines “chronic homelessness” to include people living in transitional or supportive housing for less than two years if they had been chronically homeless prior to tenancy. People experiencing chronic homelessness or cycling through hospitalization or nursing homes often require two years of sustained, consistent services before stabilizing. Considering some have spent decades or most of their adult lives homeless, managing conditions and barriers to appropriate care can require significant investment of time.
 - CB-CMEs should be eligible to receive the modifier only if they meet the requirements of Welfare and Institutions Code § 14127.3(d)(1):
 - Demonstrated experience working with frequent hospital or emergency department users.

- Demonstrated experience working with people who are chronically homeless.
- A viable plan, with roles identified among providers of the health home, to reach out to and engage frequent hospital or emergency department users and chronically homeless eligible individuals, link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing, ensure coordination and linkages to services needed to access and maintain health stability, including medical, mental health, and substance use care, as well as social services and supports to address social determinants of health.

HEALTH HOME PROGRAM SERVICES

We appreciate that you adopted several of our suggested additions to the definitions of comprehensive care management. We recommend further changes, however. Throughout the service definitions, the Concept Paper references engaging members through e-mails, texts, social media, phone calls, letters, and community outreach, as well as in-person meetings. While we greatly appreciate the clarification that in-person meetings should occur where the member lives, seeks care, or is otherwise accessible to the member, we strongly recommend clarifying consistently in the definitions that, for many of the Medi-Cal members who are most in need of HHP services, engagement involves in-person, face-to-face contact in locations most accessible to the member, particularly for the first three to six months. Many members with complex needs, who would benefit most from the HHP, are not likely to participate in the HHP unless and until service providers form trusting relationships, which often cannot occur telephonically or through letters. We recommend encouraging MCPs and CB-CMEs to rely on other modes of communication only if this is consistent with the needs and preferences of members, or after a period of intensive face-to-face contact. This recommendation is consistent with the recent CMS FAQs, which defines care coordination as requiring, “face-to-face and collateral contacts with the health home enrollee, family, informal and formal caregivers, and with primary and specialty care providers.”³

We further recommend the following changes to the specific services definitions:

Comprehensive Care Management

- The details in the description of comprehensive care management, in the bullets that begin at the bottom of page 8, clearly identify functions that we believe are critically important, including promoting the member’s self-management skills, and supporting the achievement of the members goals to improve their functional or health status. The narrative that precedes the bullets on page 8 almost exclusively emphasizes the development of the Health Action Plan (HAP), while the bullets refer to tasks related to both the development and implementation of the HAP. We recommend that the description preceding the bullets be expanded for greater consistency and clarity. Specifically we recommend that the narrative describe the need to engage the member in their own care and promote ways of achieving the member’s own goals. This important point is well identified in the bullet points.
- We recommend removing the need to “assess the HHP member’s readiness for self-management using screenings and assessments with standardized tools” as a service that must be included in the development of the HAP. While we agree that a care manager should assess the member’s needs using evidence-based assessments, as you stated elsewhere in the concept paper, we are hoping to minimize both the burden to the member and to the CB-CME in completing multiple assessments and tools prior to or in conjunction with completing a HAP.

³ CMS, “Health Homes Frequently Asked Questions: Series II.” <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-homes-faq-12/2015.pdf>. Dec. 2015.

- The HAP should be a comprehensive document that takes into account the member’s medical, behavioral health, and health-related social services needs, and, most importantly, the member’s desired goals. All providers and plans should consult and routinely modify the HAP, rather than requiring plans or CB-CMEs and the member engage in separate re-assessments and planning.
- We recommend including in-person outreach and engagement of members to form trusting relationships and to gather information from the member, similar to the definition of care coordination in CMS guidance.⁴
- The definition of care management should include housing-related activities the housing navigator and care manager should be undertaking for homeless members. We recommend adding, “Assisting members to access and maintain stable housing as a foundation for facilitating healthier behaviors, reducing health-related risks, accessing appropriate care, and following treatment regimens.” Alternatively, we recommend including language from the CMS Informational Bulletin regarding housing-related activities:
 - “Individual Housing Transition Services, including services that support an individual’s ability to prepare for and transition to housing,” and
 - “Individual Housing & Tenancy Sustaining Services, including services that support the individual in being a successful tenant in his/her housing arrangement and thus able to sustain tenancy.”⁵

Care Coordination

- We support the definition’s inclusion of, “assisting the member in navigating health, behavioral health, and social services systems, including housing.” We recommend, however, making sure overlaps in definitions between care coordination and referral to community and social services are consistent. We recommend making clear to CB-CMEs that giving a member a referral list, as described in the definition of referral to community and social services, is insufficient to link that member to housing. Data show many members with complex needs are unable to navigate a referral list, and those with the greatest functional limitations cannot access housing on their own.
- Similarly, we recommend including in the definition of care coordination accompanying members to appointments, particularly in the first six to twelve months of services. Accompanying members to appointments is necessary to act as the member’s advocate, to communicate the member’s health goals, to explain to members their diagnoses and treatment, to engage the member to follow treatment protocols, and to act as the conduit between all care providers. For these reasons, accompanying the member to appointments is not only “support,” but is a crucial means of coordinating care for members who have distrust of health care systems and difficulties navigating treatment.
- We also recommend adding, “Helping facilitate communication and understanding between HHP members and healthcare providers,” as care coordinators serve as valuable “translators.”
- Additionally, we recommend adding, “Identifying barriers to improving their adherence to treatment and medication management.”

⁴ CMS FAQs, Series II.

⁵ Vikki Wachino, Director, Center for Medicaid & CHIP Services, Centers for Medicare & Medicaid Services. “Coverage for Housing-Related Activities & Services for Individuals with Disabilities.” *Informational Bulletin*. June 26, 2015. Though this Informational Bulletin (IB) did not mention the health home option as an option states could adopt to fund housing-related services, CMS staff drafting the IB reported to CSH staff that (1) the reason for the exclusion was due to the absence of health home regulations, and (2) they are drafting another IB for homeless beneficiaries that may include the health home option.

- We recommend including, “Providing or arranging transportation for members” in the definition of care coordination activities. Though MCPs currently offer transportation to some members with enough advanced notice when medically necessary, the process for obtaining approval is prolonged and difficult. Many MCPs must have significant advanced notice, negating the goal of expediting appointments, particularly after discharge from a hospital. And MCPs cannot approve transportation to social services appointments. Reducing the burdens of providing transportation is effective care coordination for many members who otherwise cannot attend appointments because bus rides are too long or too difficult to navigate, and, in some areas, not a viable transportation option.

Health Promotion

- We recommend including, “Using evidence-based practices, such as motivational interviewing, to engage and help the member participate and manage his/her own care.”

Comprehensive Transitional Care

- We recommend clarifying “all involved parties” in the first bullet to require MCPs notify CB-CMEs of hospitalizations and emergency department visits.
- We support the inclusion of the need for homeless members to have a safe and decent place to stay post-discharge, and suggest adding, as a CB-CME requirement, relationships with interim housing or respite care providers. We further recommend replacing, “Planning appropriate care/place to stay post-discharge, including temporary transitional housing or stable housing and social services,” with, “Locating and offering to members experiencing homelessness immediate access to respite care or bridge/interim housing post-discharge until a permanent, independent housing is made available to the member.” The term “transitional housing” has a legal meaning and is inappropriate for those exiting hospitalization.
- We recommend adding active participation in discharge planning with a hospital, “to ensure consistency in meeting the goals of the enrollee’s person-centered care plan.”⁶
- Since CMS contemplates transitions to residential settings, we recommend you add, ““Providing transition support to permanent housing.”

Individual & Family Support Services

- We recommend emphasizing the member’s stated goals and wishes in connecting with family, friends, or other potential support systems guide the CB-CME’s individual and family support services.

Referral to Community & Social Supports

- We urge you to include activities that go well beyond what is contemplated in this definition. Many members with complex conditions will have great difficulties navigating a referral list. For these members, follow-up through e-mail or letter would be insufficient and unlikely to achieve the intended results. We therefore recommend removing, “Identifying or developing a comprehensive resource guide for the member” and, “Actively managing appropriate referrals to the needed resources . . .” We recommend replacing these concepts with—
 - “Create relationships with community providers offering services identified,
 - “Provide warm hand-offs, as needed, to help the member navigate through the process of obtaining services impacting the member’s health,
 - “Check in with members routinely through in-person or telephonic contacts to ensure the member is accessing the social services he or she requires, and,

⁶ CMS FAQs, Series II.

- “If the member is experiencing difficulties accessing needed services, work with social service providers to create opportunities for the member to access services.”
- If housing navigation services are not included in the definition of care management, we recommend adding housing navigation services to this category through the following:
 - “Meeting members ‘where they are’ by assisting members access housing through ‘Housing First’⁷ strategies,
 - “Assisting members gather documentation, such as identification, for housing applications,
 - “Helping members prepare housing applications,
 - “Locating housing and conducting apartment searches with members,
 - “Helping members with move-in and lease-up activities, and
 - “Building relationships with landlords, property managers, and on-site service staff to help prevent evictions.”
- We recommend adding “food security” to the list of resources in the second bullet.
- We recommend you make the definition of this service consistent with the staffing roles, including the housing navigator, in the Concept Paper, which describes active linkage to housing, rather than referral to housing.
- We further recommend following both the intent and language of Assembly Bill 361, in requiring partnerships with permanent housing providers in the list of services.

HEALTH INFORMATION TECHNOLOGY/HEALTH INFORMATION EXCHANGE

We recommend adding a requirement the CB-CME staff and health care providers engage in regular case conferencing to achieve the goals of Health Information Exchange, particularly in areas where the technology environment does not fully support data exchange for all components of a participants needs and services, including health, mental health, substance use disorder, social services, and community supports.

HEALTH HOMES PROGRAM NETWORK INFRASTRUCTURE

As indicated in the eligibility criteria, HHP in California is intended to provide services to members who are unable to access existing resources well without the intensive services HHP offers. We recommend HHP services use approaches proven to be successful in reaching, engaging, and coordinating care for populations who are unable to navigate current systems designed to serve more functional members. Several examples include the following:

Leveraging Existing Managed Care Plan Assessment Tools

- While we agree with the concept of adding elements required in the HHP to Health Risk Assessments, we recommend encouraging MCPs and CB-CMEs rely on assessments and care plans recognized as evidence-based, including sample screening forms SAMHSA lists on their website, such as the Providence Center Medical and Mental Health Screening forms,⁸ or the Social Innovation Fund Baseline Survey, developed by New York University. Considering more than half of members will have

⁷ “Housing First” is an evidence-based practice of offering housing before expecting services to address the needs of people experiencing homelessness. It is characterized by housing that is not contingent on abstinence, treatment, or participation in services, that housing is a home and not a program, and that tenants hold leases with no limit on lengths of tenancy, as long as the tenant meets the terms of tenancy.

⁸ <http://www.integration.samhsa.gov/clinical-practice/screening-tools#sample-screening-forms>. See also http://www.chcs.org/media/Initial_Health_Screens_Brief.pdf.

diagnoses of either serious mental illness or substance use disorders or both, current MCP assessments and planning tools do not sufficiently incorporate behavioral health conditions to incorporate these conditions and barriers the conditions impose.

- Rather than limiting distribution of assessments to some members and partners of the CB-CMEs, we recommend making assessments available to behavioral health providers treating HHP members.

Medi-Cal Managed Care Plan Responsibilities

- While MCPs may be exploring housing options as well, we recommend requiring that CB-CMEs must develop relationships with housing providers and must use existing homeless systems to identify and provide housing solutions for members experiencing homelessness before a CB-CME could receive a homelessness modifier. We also recommend including “homeless continuums of care” in the list of stakeholders.
- We strongly recommend gauging the progress of CB-CMEs and MCPs in partnering with housing providers, and requiring CB-CMEs to create and maintain partnerships with housing providers. As a CB-CME requirement, we recommend adding experience partnering with housing providers to move members into permanent housing.
- In the list of MCP duties, we recommend—
 - Clarifying payment will not be based on a per-encounter basis, and
 - Adding a limit on how much of the DHCS payment the MCP may retain.⁹

Community-Based Care Management Entity Requirements

- We recommend a simplified, expedited process for certifying CB-CMEs, given the timeline between DHCS’ approval of an MCP’s plan and the date by which MCPs must choose providers. Current provider certification can take a year or longer; to encourage MCPs to allow for providers and teams of providers MCPs do not currently contract with, we recommend allowing MCPs flexibility in meeting contract requirements. Considering the program would benefit from including CB-CMEs who have capacity to provide these services, such as mental health providers, allowing an expedited process for providers that are already contracting with public agencies would encourage MCPs to contract with providers outside their existing network.
- We recommend clarifying distinctions between a community primary care provider (PCP) serving many HHP members, and “high-volume PCPs.” A PCP could serve vulnerable populations and not be a high-volume provider, and vice versa.
- Because DHCS is contemplating rolling out the benefit for members with serious mental illness first, since a majority of members will have a serious mental illness or substance use disorders (many will have both), and because mental health providers will frequently have capacity to provide evidence-based services, program design should emphasize that behavioral health providers can be CB-CMEs, that CB-CMEs who are PCPs must include behavioral health partners, and that CB-CMEs could and should rely on those partners to deliver many HHP services.
- We appreciate the need to allow MCPs some flexibility in those jurisdictions with limited capacity of community-based organizations to provide HHP services. We agree with the approach on page 15, in allowing some MCP flexibility in contracting with CB-CMEs, and in promoting teams of community-based organizations to offer HHP services collectively. We recommend DHCS encourage MCPs in jurisdictions with limited capacity to exercise this flexibility. In the rare instance where lack of capacity makes these options untenable, we would recommend requiring MCPs to demonstrate success in

⁹ The New York Health Home Program, for example, limits MCP payment to 3%.

improving health outcomes and curtailing costs, and MCPs help community-based organizations build their capacity before an MCP could exclusively provide HHP services to members. Overall, we support prioritizing alternatives offered in the concept: allowing MCPs flexibility to subcontract with other entities to provide HHP services or specific HHP services.

- We disagree with Model 1 that MCP staff should provide some of the HHP services, as inconsistent with other provisions of the concept paper that require CB-CMEs to provide the full array of HHP services (other than MCP duties the concept paper identifies).
- We also recommend clarifying that, though PCP staff may provide some of the HHP services, they would be expected to offer these services outside the clinic setting in many cases. Care coordinators in clinics typically offer services to patients in the clinic, given their caseload. Yet, many members eligible for HHP are not accessing clinical services, and are failing to access appropriate care altogether. Clinics effective in addressing the needs of highly vulnerable, difficult-to-engage members partner with or employ outreach staff who ventures out of the clinic on a daily basis to meet members where they live.
- To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user members, we recommend adding a model:
 - **“Model IV:** The fourth model is a collaborative model serving homeless HHP members, and includes services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma-informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either a homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care managers and housing navigators engage members where the members live, both before and after the member moves into housing, and the CB-CME team assists the member.
 - This model will not always be viable with high-volume providers in urban areas because it takes expertise with harm reduction, motivational interviewing, trauma-informed care, and local housing systems to successfully case manage chronically ill homeless individuals. Changing the culture of high-volume providers who are by definition working with many members in short time increments to a culture of intensive services would be a big lift. For these reasons, we recommend this model as “ideal in serving homeless and frequent hospital user members, typically through mental health or homeless service providers.”
- We recommend clarifying CB-CMEs may focus solely on serving homeless HHP members, including persons who have moved into supportive housing after experiencing homelessness.
- In the CB-CME duties, we have a question on whether “evidence-based care” includes “evidence-based practices.” While we agree CB-CMEs should be required to use evidence-based practices, we disagree with the requirement CB-CMEs must provide evidence-based care. Most CB-CMEs may be treatment providers, but CB-CMEs who are not would be excluded based on this requirement. We recommend clarifying to, “Provide evidence-based practices proven to improve the outcomes and decrease costs among complex populations.”

- In describing the multidisciplinary care team, we recommend clarifying that a multidisciplinary care team could consist of staff from multiple agencies and should offer services wherever most accessible to the member. As an example, we recommend the following: “The multi-disciplinary care team consists of staff employed by the CB-CME or by CB-CME team partners that provide HHP services wherever most accessible to the member, including in the member’s home.”
- We fully support the statement, “Staffing and the day-to-day care coordination should occur in the community and in accordance with the member’s preferences,” and are hoping all statements included in the concept paper make clear services should be offered in settings most convenient to the member to remove barriers to member access. For this reason, we also recommend removing, “and within MCP guidelines” (i.e., the description of care manager on page 23 adds a qualifier), as the language implies an MCP may limit a CB-CME’s ability to deliver services outside the four walls of a clinic.
- We recommend requiring CB-CMEs include a homeless service provider and partner with a permanent housing provider, if serving homeless HHP members and before accessing the homelessness modifier.

We recommend developing additional staffing criteria, as follows:

- We recommend an aggregate care manager/housing navigator ratio of 1:15 to 1:20 (not including MCP staffing) for HHP members who are homeless. In housing and mental health systems, successful case management programs serving homeless and frequent user populations offer key features, such as in-person, individualized, frequent and flexible services, offered where the person lives, with member to staff ratios of 1:15 to 1:20. This level of staffing would require a rate of \$500-\$530 per member, per month. Study after study shows these services dramatically improve health outcomes, while also dramatically reducing Medicaid costs.¹⁰
- We recommend staffing ratios of 1:25 for other complex members beginning to receive HHP services. Again, we recommend requiring regular, in-person, face-to-face contact with members falling into this tier, particularly in the first six to twelve months. And, while members may achieve stability after a period of receiving health home services, members with complex conditions still require regular contact. For this reason, we recommend a staffing ratio of 1:35 to 1:40 once a HHP member can transition to “maintenance.”

Multi-Disciplinary Care Team Qualifications & Roles

- In the Dedicated Care Manager role, we recommend—
 - Including, “arranging and providing transportation when necessary to provide access to appointments.”
 - Clarifying the care manager role, “Call HHP member to facilitate HHP visit with care manager,” to read, “Routine contact with the member in person.”
 - Adding, “Accompanying HHP member to office visits.”
- In the Community Health Worker role, we recommend—
 - Adding to, “Distribute health promotion materials,” the important step of, “and explaining material content to member.”

¹⁰ Multiple studies demonstrate improved patterns of service utilization and decreased costs: 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. Buchanon, 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.

- Changing, “Call HHP member” to, “Work with HHP member and Care Manager to provide a warm hand-off to Care Manager.”
- In the Housing Navigator role, we recommend—
 - Including the activities of the Navigator in the services definitions.
 - Changing the first bullet to, “Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers.”
 - Changing the bullet, “Connect and assist the HHP member to get available permanent housing,” to, “Partner with housing agencies and providers to offer HHP member with permanent, independent housing options, including supportive housing, and assist member with moving into permanent housing.”
 - Adding bullets to include—
 - “Collaborate with other team members, particularly the care manager.
 - “Engage members on the Targeted Engagement List and potential HHP members to create trust with members.
 - “Assist member in participating in homeless coordinated assessment and entry systems, where such systems exist.”
 - We recommend including a list of services consistent with the housing-related activities and services identified in a CMS Informational Bulletin on housing-related activities, to include assisting the member with individual housing transition services and individual housing and tenancy sustaining services. We recommend either listing the services identified in the bulletin,¹¹ or listing the following:
 - “Meeting members ‘where they are’ by assisting members access housing through ‘Housing First’¹² strategies,
 - “Assisting members gather documentation, such as identification, for housing applications,
 - “Helping members prepare housing applications,
 - “Locating housing and conducting apartment searches with members,
 - “Helping members with move-in and lease-up activities, and
 - “Building relationships with landlords, property managers, and on-site service staff to help prevent evictions.”

¹¹ “Housing transition services to include assisting HHP member in assessing preferences and barriers, assisting with the housing application and search process, identifying resources to fund expenses, supporting a move into housing, and developing a housing support crisis plan to prevent eviction. Housing and tenancy sustaining services to include intervening to address behaviors that may jeopardize housing, training on the rights and responsibilities of the tenant, coaching on developing and maintaining key relationships with property managers to foster successful tenancy, assisting in resolving disputes with landlords and neighbors, advocating and linking member with community resources, and training in being a good tenant.” Centers for Medicare & Medicaid Services. “Coverage of Housing-Related Activities & Services for Individuals with Disabilities.” CMCS Informational Bulletin. June 26, 2015. Though this Informational Bulletin (IB) did not mention the health home option as an option states could adopt to fund housing-related services, CMS staff drafting the IB reported to CSH staff that (1) the reason for the exclusion was due to the absence of health home regulations, and (2) they are drafting another IB for homeless beneficiaries that may include the health home option.

¹² “Housing First” is an evidence-based practice of offering housing before expecting services to address the needs of people experiencing homelessness. It is characterized by housing that is not contingent on abstinence, treatment, or participation in services, that housing is a home and not a program, and that tenants hold leases with no limit on lengths of tenancy, as long as the tenant meets the terms of tenancy.

Member Assignment

- In supporting the proposition that engagement of eligible HHP members will be critical, we recommend requiring an in-person engagement process to supplement the letter engagement process. Letters typically fail to engage members with complex needs, and not beginning the “engagement period” until CB-CME staff make contact with the member.
- For the referral process, we recommend allowing agencies (in addition to providers) to refer potential members to CB-CMEs or MCPs.
- Additionally, we recommend allowing for presumptive eligibility if a PCP or behavioral health professional states a member meets the chronic condition criteria and the member reports hospitalization or emergency department use meeting the acuity eligibility criteria. Presumptive eligibility would allow a CB-CME to avoid losing contact with homeless members who are likely eligible, but also more difficult to engage.
- Before discharging a member from HHP, CB-CMEs should be required to make multiple attempts to engage members in person, including working with homeless outreach workers or navigators.

PAYMENT METHODOLOGIES

Acuity & Tiering

As DHCS develops a rate structure and rates, we recommend clarifying a consistent rate structure applicable to all MCPs, rather than allowing some MCPs to develop tiered payment and some MCPs to use a single rate.

- We recommend a DHCS-imposed risk stratification process, as we are concerned MCPs will use the CalMedi-Connect risk stratification tool to tier payment, or develop tiers primarily based on medical criteria. CalMedi-Connect’s risk stratification questions are not pertinent to determining payment tier. The risk stratification questions fail to capture the risks faced by many members who would require very intensive levels of services, such as people with serious mental illness who have not been prescribed antipsychotic medication or have not been involuntarily hospitalized. It also fails to include risks associated with substance use disorders. It leaves out people who may have experienced multiple inpatient admissions or emergency department visits over the last year, and who may not meet the specific “90-day” criteria, though evidence suggests people using significant crisis care over the course of three months are more likely to “revert to the mean” than people experiencing long-term patterns of frequent crisis care use.
 - In identifying a tool for tiering, we recommend DHCS adopt criteria similar to criteria other states adopted for intensive care and case management programs¹³ based on elements of high risk. For example, DHCS could require members meet two of the following characteristics to fall under a high intensive tier:
 - Frequent inpatient hospital admissions over the past year (i.e., three admissions) or over the past three years (i.e., over five admissions), including hospitalization for medical, psychiatric, or substance abuse related conditions.

¹³ See, for example, Illinois’ Community Support Team; Massachusetts’ Community Support Program for People Experiencing Chronic Homelessness (CSPECH); M. Raven, K. Doran, S. Kostrowski, et. al. “An Intervention to Improve Care & Reduce Costs for High-Risk Patients with Frequent Hospital Admissions: a Pilot Study.” *BioMed Central Health Services Research*. 2011, 11:270; D. Flaming, S. Lee, P. Burns, et. al. “Getting Home: Outcomes from Housing High-Cost Homeless Hospital Patients.” *Economic Roundtable*. 2013.

- Excessive use of crisis or emergency services (i.e., five emergency department visits within the last year or eight within the last two years) or inpatient hospital care with failed linkages to primary care or behavioral health care.
- Inability to meet basic survival needs: chronically homeless, homeless or at imminent risk of homelessness and unable to maintain a safe place to live in the community without support.
- History of inadequate follow-through, related to risk factors, with elements of a treatment plan, including lack of follow through in or illness interfering with consistent self-management of medications, inability to follow a treatment plan, or consistent rejection of health care providers' recommendations.
- Documented inability to sustain involvement in needed health and behavioral health services, or recent referral to a comprehensive integrated program (i.e., full service partnership).
- Co-occurring serious mental illness and substance use disorders.
- Self-harm or threats of harm to others.

DHCS Payment to MCPs

We also recommend requiring MCPs develop a per member, per month rate structure for CB-CMEs with which they contract, rather than payment on a per encounter basis, since per-encounter payment in other programs erodes service delivery due to the administrative burden and distrust it creates among beneficiaries. While we commend flexibility in contracting, we strongly recommend consistency with recognized best practices, such as administrative simplicity, to achieve service delivery outcomes. With these goals in mind, we recommend the following:

- Provide MCPs with a tiered payment structure based on acuity of HHP members, and require MCPs to provide tiered payments to CB-CMEs.
- Clarify how payment for services would be risk-based, or remove the risk-based methodology, since a number of CB-CMEs may not be PCPs, and should not be at risk for all care.
- Require staffing ratios to justify rates, rather than relying on a prospective payment rate, to ensure CB-CMEs deliver intensive services for the rate they receive.
- We recommend not using HHP payment to fund traditional MCO care coordination services. Adding these costs would decrease rates provided to CB-CMEs, while adding to the costs of HHP, making cost neutrality and ongoing state investment in HHP more challenging to achieve.
 - Instead, we recommend allowing MCPs to use a portion of their existing care coordination activities to implement HHP. Alternatively, we recommend increasing the payment rates to accommodate for these costs, and then separating these costs from the evaluation of the costs of the program.
- Here again, we recommend that CB-CMEs, rather than MCPs, should engage HHP members. Using the same process MCPs use now to engage members, when those members likely have not responded to other MCP communication, is inconsistent with concept paper principles.¹⁴ Many with complex conditions have significant distrust of the health care system and require frequent face-to-face engagement before agreeing to participate in services.

¹⁴ H. Meyer. "New York's Chronic Illness Demonstration Project: Lessons for Medicaid Health Homes." Center for Health Care Strategies. Dec. 2012 (listing difficulties locating members on a list pulled from administrative data as a significant lesson in working with complex populations).

SERVICE DELIVERY

To ensure successful outcomes in counties and among MCP members, we recommend DHCS set program requirements specific to individual service tiers and criteria for movement between tiers. Having each MCP develop their own criteria would not only result in inconsistent outcomes within counties, but also outcomes difficult to evaluate effectively.

REPORTING

In tracking operational measures, we recommend changing current housing status to, “The number of members receiving the homeless modifier who are currently living in permanent housing (their own independent apartment not limited by length of stay).” This question will require less work and will avoid uncertainty around definitions of “stability” or “shelter.”

We further recommend removing “member consent date” to avoid disincentives to CB-CMEs working with difficult-to-engage populations.

We recommend the following metrics of determining whether a CB-CME is effectively providing health home services to members who were homeless when these members agreed to participate in the health home program:

- The ability of the CB-CME to operate at full staffing levels at least 75-80% of the time.
- At least 80-85% of members who have been in the program for at least six months are now living in their own apartments with their own lease.
- At least 80-85% of members are enrolled in medical and/or behavioral care, if appropriate.
- At least a 25% decrease in utilization of emergency room visits and readmissions to hospitals.

We also recommend conducting a separate evaluation for homeless members than other members.

HHP INTERACTION WITH EXISTING MEDI-CAL PROGRAMS

We urge DHCS to consider funding housing-related activities and services identified in HHP through the 1115 Waiver Whole Person Care Pilot Programs in counties that will not be implementing HHP until July 2017 or later. With the exception of San Francisco, need for HHP services is greatest in the counties that will not be implementing until July 2017 or January 2018. The Whole-Person Care Pilot is an opportunity to build capacity and work through barriers before accessing HHP. Moreover, for counties who have not yet implemented HHP, no danger of duplication of funding exists if a county ends the use of waiver funding for this phase of services before HHP takes effect, or limits the use of waiver funding for these services to persons who do not meet the eligibility criteria for HHP at that time. In fact, Whole Person Care Pilots have a greater chance of sustaining progress they make in delivering whole-person oriented care if some of these services could be sustained as part of HHP.

CURRENT STATUS OF IMPLEMENTATION

We have concerns with the timeline as proposed by DHCS. While we understand and appreciate the need for planned and careful roll-out of HHP, the greatest need for HHP services, and sometimes the greatest capacity to deliver these services, exists in counties that are currently identified in Groups 2 and 3. Delaying these services until early to mid-2018 will certainly mean the most vulnerable members will continue to experience early mortality and avoidable hospitalizations because they fail to access appropriate care. Homeless members in these counties will continue to incur high costs and poor outcomes; though capacity exists to serve these members now, funding is lacking. Whereas less need exists in Partnership Health Plan counties, and certainly far fewer homeless members, potential CB-CMEs also have less capacity and experience with addressing the needs of Medi-Cal members with complex conditions, members who often

experience wildly different social determinants than Medicare and CalPERS members accessing the IOCP program.

Further, delaying implementation through a complex and protracted timeline has practical implications. Several State initiatives will not work as well without HHP services to integrate care at the systems and individual member level, such as the Whole Person Care pilot and the Medi-Cal Drug Organized Delivery System. Further, as the State must begin to bear some of the costs of care for Medi-Cal expansion members, DHCS will have to dip further into TCE funding for HHP services, and California will have to bear the costs of poorly managed care among those expansion members with complex conditions.

If rolling out the benefit first to members with serious mental illness, some of whom will also have substance use disorders, we are concerned with provisions that do not adequately acknowledge the role of behavioral health providers in achieving the stated outcomes. Mental health providers often use evidence-based practices in serving members now.

Moreover, evaluation results may not be available until well after DHCS has to determine whether to use State General Fund resources to support the ongoing costs of HHP services for Group 1 and Group 2 counties. And results from counties/MCPs with long-standing investment in innovative models may differ from the evaluation outcomes HHP would generate elsewhere. If implementation in these counties is delayed, this could result in under-estimating the impacts of HHP during the evaluation timeframe.

Finally, beginning implementation in almost exclusively rural, Northern California counties with lower rates of poverty than other counties, under a single health plan in the majority of those counties will tell DHCS staff, legislators, and stakeholders less about what works and what needs improvement than a roll-out that is geographically diverse.

We therefore recommend the following:

- Including at least one large county with high rates of poverty and providers with capacity, like Alameda or Los Angeles, in Group 1.
- Compressing the timeline by allowing all eligible members to access the benefit by January 2018.
- Allowing the Whole-Person Care pilot funding to be used for HHP-like services in the years before HHP implementation begins in that county.

Implementation has significant ramifications for what members in Group 2 and 3 counties will receive or not receive. We recommend planning thoroughly for all implications and for allowing a longer period for stakeholder comment before submitting a State Plan Amendment that includes the timeline, revealed for the first time, from Concept Paper 3.0.

Thank you for reviewing and considering our comments. Please feel free to contact us with any questions or clarifications.

Sincerely,



Sharon L. Rapport
Associate Director, California Policy



Shirley Sanematsu
Senior Health Attorney



December 24, 2015

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov

Re: Comments on Health Home Program for People with Complex Needs, Concept Paper 3.0

Dear Health Home Program:

On behalf of the 180/2020 Initiative of Santa Cruz County, we are writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. 180/2020 is a multi-agency initiative focused on ending chronic homelessness in Santa Cruz County by 2020. Organizations participating in 180/2020 include homeless housing programs, mental health and substance use disorder treatment programs, and homeless health care programs, and many other non-profits, local jurisdictions, community groups, businesses, and individuals. Because of the focus of the 180/2020 Initiative, we are commenting primarily on the impact of provisions of Concept Paper 3.0 on Medi-Cal beneficiaries experiencing homelessness.

To summarize, our highest priority changes we request that you make are:

1. **Include chronic homelessness as a subgroup for whom the earlier implementation date applies, along with members with SMI.** Clear and extensive evidence supports the fact that the population of members experiencing chronic homelessness, regardless of SMI diagnosis, are high utilizers for whom major cost reductions can be achieved through the existing housing first-based initiative implemented in jurisdictions including Santa Cruz County. To be clear – we are most set up today to succeed with this subgroup of members and achieve the major cost savings that will demonstrate the success of this program. We therefore strongly request that this subgroup be one that counties can include in their earlier implementation date.
2. **Community-Based Care Management Models need to include a model, whether a new Model IV or an adjustment to one of the existing models in the Concept Paper, that embeds care managers where members live for those members living in Permanent Supportive Housing** (primarily those having experienced chronic homelessness). For this population, having care management take place where the member lives is a critical best practice. Along with the permanent supportive housing units in our jurisdiction today, it is worth noting that we are currently designing new construction of multiple permanent supportive housing residences that will come online within the Health Homes Program implementation timeline and that will include imbedded space for care managers, housing navigators, and other service providers. It would be most effective to design this with a management model centered around these locations and the related homeless services. (further comments are below)

3. **Include a tiered payment structure with a homeless modifier that applies through at least two years after exiting homelessness.** (more comments below)
4. **Timeline: Compressing the timeline as a whole or moving Santa Cruz County to Group 1 so that full implementation in our county can take place by July 2017.** (more comments on timeline below)

Finally, we have worked with organizations in other jurisdictions to produce the following more detailed comments, which we fully endorse and recommend. Many of these recommended changes will be critical for achieving success, including both high adoption and significant cost savings, in our jurisdiction.

Timeline: As an organization focused on reducing the number of individuals at risk for early death on the streets due to homelessness, we have great concerns with the timeline as proposed by DHCS. While we understand and appreciate the need for deliberate roll-out of HHP, a 30-month roll-out of the benefit has significant ramifications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties. Group 2 and 3 counties have, in fact, the highest rates of poverty and social barriers to accessing appropriate care. Though many of these counties have developed means of addressing these barriers to care, along with provider capacity, delaying these services until early to mid-2018 will certainly mean the most vulnerable beneficiaries will continue to experience poor health outcomes and high costs.

State initiatives will be difficult to sustain without the promise of HHP services to integrate care at the systems and individual beneficiary level, such as the Whole Person Care pilot and the Medi-Cal Drug Organized Delivery System. At the same time, California will have to bear the costs of poorly managed care among those expansion beneficiaries with complex conditions, and will be required to pay for more of the costs of HHP services for expansion beneficiaries.

Moreover, evaluation results may not be available until well after DHCS has to determine whether to use State General Fund resources to support the ongoing costs of HHP services for Group 1 and Group 2 counties. If implementation in these counties is delayed, this could result in under-estimating the impacts of HHP during the evaluation timeframe. Finally, the fate of HHP and the ACA are uncertain in 2018 and beyond. We are very concerned HHP may never reach those with the greatest need due to failures in full implementation, should services in mostly small, rural counties fail to make any measurable impact.

We therefore recommend the following:

- Including at least one large county with high rates of poverty and providers with capacity, like Alameda or Los Angeles, in Group 1.
- Compressing the timeline by allowing all eligible beneficiaries to access the benefit by October 2017.
- Allowing the Whole-Person Care pilot to fund HHP-like services in the years before HHP implementation begins in counties accessing the pilot.

Whatever DHCS is inclined to include in terms of timeline, we recommend allowing for more robust stakeholder input on the timeline and counties included in each group before finalizing California's State Plan Amendment.

Additionally, in drafting the Health Home State Plan Amendment, we recommend the following changes to proposals outlined in Concept Paper 3.0:

- **Regarding eligibility criteria**, we recommend—
 - Adding chronic renal disease, HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to your list of eligible conditions.
 - Requiring CB-CMEs be responsible for engaging, in person, members who do not respond to a letter communicating that they are eligible, and that the engagement rate be reserved for in-person, face-to-face engagement activities a CB-CME undertakes.
 - Allowing CB-CMEs to use other sources of data to refer beneficiaries to the HHP program, rather than relying exclusively on administrative data.
 - Fostering a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program.
 - Including “chronic homelessness” as an acuity factor.
 - Eliminating the exclusions.
 - Clarifying how DHCS and MCPs will ensure continuity of care for beneficiaries no longer meeting the acuity criteria.

- We recommend DHCS create a **tiered payment structure with a homelessness modifier**, similar to the structure DHCS released two months ago.
 - We recommend extending the modifier to two years or less in housing, following a period of documented chronic homelessness, as consistent with the definition of chronic homelessness in Assembly Bill 361. People experiencing chronic homelessness or cycling through hospitalization or nursing homes often require two years of sustained, consistent services before stabilizing.
 - CB-CMEs should be eligible to receive the modifier only if meeting the requirements included in AB 361 or partnering with agencies who do meet the criteria to deliver HHP services to homeless beneficiaries.

- For the **definitions of services**, we recommend the following changes:
 - For homeless beneficiaries, clarify references to “communication through e-mails, texts, social media, and phone calls” are applicable to those who are stably housed, and not only allowable until a CB-CME’s in-person contacts have established a trusting relationship with the beneficiary.
 - To the definition of *comprehensive care management*, we recommend adding in-person outreach and engagement of beneficiaries to form trusting relationships and to gather information the beneficiary, similar to the definition in CMS guidance, as well as individual housing transition and tenancy sustaining services recognized in the CMS Informational Bulletin (housing-related activities for beneficiaries experiencing chronic homelessness).
 - To the definition of *care coordination*, we recommend including, “Accompanying beneficiaries to appointments when necessary to act as the beneficiary’s advocate, to communicate the beneficiary’s health goals to care providers, to explain diagnoses and treatment to the beneficiary, and/or to engage the member to follow treatment protocols.” We further recommend adding “providing and arranging transportation to attend appointments, including appointments with social service providers.”
 - To the definition of *health promotion*, we recommend requiring CB-CMEs to use evidence-based practices to engage the beneficiary to manage his or her own care.

- To the definition of *comprehensive transitional care*, we recommend, “Locating and offering to beneficiaries experiencing homelessness immediate access to respite care or bridge/interim housing post-discharge until a permanent apartment is made available to the beneficiary,” rather than current language regarding “transitional housing.”
- To the definition of *Individual & Family Support Services*, we recommend encouraging the beneficiary’s own goals drive any connections with family, friends, or other potential support systems.
- To the definition of *Referral to Community & Social Supports*, we recommend including active linkage to social systems and services, such as requirements to create relationships with housing providers, offering warm hand-offs to help the beneficiary navigate through the process of obtaining services impacting the member’s health, and routine check-in with beneficiaries to ensure the beneficiary accesses social services he or she requires. We also recommend adding “food security services” to your list of services.
- If housing navigation services are not included in the definition of care management, we recommend adding housing navigation services to the definition of referral to community and social supports. In defining housing-related activities, we recommend following the definitions that are included in the CMS Informational Bulletin on housing-related activities.
- Regarding MCP and CB-CME responsibilities, we recommend—
 - Encouraging MCPs and CB-CMEs rely on assessments and care plans recognized as evidence-based for the specific populations of focus
 - Requiring that CB-CMEs develop relationships with housing providers and use existing homeless systems to identify and provide housing solutions for members experiencing homelessness before a CB-CME could receive a homelessness modifier.
 - Including “homeless continuums of care” and “homeless coordinated entry systems” in the list of stakeholders.
 - Requiring both MCPs and CB-CMEs develop plans to meet the treatment needs of people with substance use disorders and/or serious mental illness, as well as partnerships with behavioral health providers.
 - Requiring CB-CMEs to partner with housing providers.
 - Limiting how much of the DHCS payment the MCP may retain for performance of their duties, as other states have done.
 - Clarifying payment will not be based on a per-encounter basis.
 - Developing a simplified, expedited process for certifying CB-CMEs
 - Encouraging MCPs in jurisdictions with limited PCP capacity to contract with non-traditional providers to offer some HHP services.
 - Clarifying that, though PCP staff may provide some of the HHP services, they would be expected to offer these services outside the clinic setting where necessary.
- To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user beneficiaries, we recommend adding a model to the three models the Concept Paper identifies for service provision:
 - **“Model IV:** A collaborative model serving homeless HHP members, Model IV includes services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be composed of

community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either the homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care managers and housing navigators engage members where the members live, both before and after the member moves into housing, and the CB-CME team assists the beneficiary

- In listing CB-CME duties, we recommend clarifying—
 - CB-CMEs may focus solely on serving homeless HHP beneficiaries, including persons who have moved into supportive housing after experiencing homelessness.
 - A multidisciplinary care team could consist of staff from multiple agencies and should offer services in whichever sites or settings are most accessible to the beneficiary.
 - CB-CMEs partner with permanent housing providers and homeless service providers to reach homeless beneficiaries.

- In developing additional staffing requirements, we recommend—
 - An aggregate care manager/housing navigator ratio of 1:15 to 1:20 (not including MCP staffing) for HHP members who are homeless. In housing and mental health systems, successful case management programs serving homeless and frequent user populations offer in-person, individualized, frequent and flexible services, offered where the person lives, with beneficiary to staff ratios of 1:15 to 1:20.
 - Staffing ratios of 1:25 for other complex beneficiaries beginning to receive HHP services.
 - A staffing ratio of 1:35 to 1:40 once a HHP member can transition to “maintenance.”

- In describing the multidisciplinary team roles, we recommend the following changes:
 - In the *dedicated care manager* role, including, “arranging *and providing* transportation when necessary to provide access to appointments,” and adding, “Accompanying HHP member to office visits.”
 - In the *community health worker* role, adding a requirement the health worker explain materials provided to the beneficiary.
 - In the *housing navigator* role, requiring formation and fostering of relationships with housing agencies, engaging members and potential members in person, and, “Partnering with housing agencies and providers to offer HHP member with permanent housing options, assisting member with moving into permanent housing and promoting housing stability.” We further recommend including housing-related activities, as described in the CMS Informational Bulletin released in June regarding housing-related activities for people experiencing chronic homelessness.

- Regarding member assignment, we recommend requiring an in-person engagement process, particularly for homeless members. For others with complex needs, we recommend supplementing letters with in-person engagement. For referrals, we likewise recommend—
 - Fostering a “no wrong door” approach that allows any agency, behavioral health professional, or PCP to refer a member potentially eligible.

- Allowing for presumptive eligibility if a beneficiary meets the chronic condition and acuity criteria.
 - Requiring a CB-CME engage with a beneficiary on multiple occasions before discharging a beneficiary.
- Regarding payment methodology, we recommend clarifying a consistent rate structure applicable to all MCPs, rather than allowing some MCPs to develop tiered payment and some MCPs to use a single rate.
 - We recommend a DHCS-imposed risk stratification process, as we are concerned MCPs will use the CalMedi-Connect risk stratification tool to tier payment, or develop tiers based on medical criteria alone.
 - In identifying a tool for tiering, we recommend DHCS adopt criteria similar to criteria other states adopted for intensive care and case management programs based on elements of high risk.
 - We also recommend requiring MCPs develop a per member, per month rate structure for CB-CMEs with which they contract, rather than payment on a per encounter basis, since per-encounter payment in other programs erodes service delivery and imposes administrative burden. We further suggest clarifying how payment for services would be risk-based, or remove the risk-based methodology, since a number of CB-CMEs may not be PCPs, and should not be at risk for all care.
 - We further recommend requiring staffing ratios to justify rates, rather than relying on a prospective payment rate, to ensure CB-CMEs deliver intensive services for the rate they receive, and avoiding use of HHP payment to fund traditional MCO care coordination services.
 - In reporting housing outcomes (within operational measures), we recommend changing current housing status to, “The number of members receiving the homeless modifier who are currently living in permanent housing (their own independent apartment not limited by length of stay).” We recommend conducting a separate evaluation for homeless members apart from that for other beneficiaries.
 - Regarding HHP interaction with other Medi-Cal programs, we urge DHCS to consider funding housing-related activities and services identified in HHP through the 1115 Waiver Whole Person Care Pilot Programs in counties that will not be implementing HHP until July 2017 or later. With the exception of San Francisco, need for HHP services is greatest in the counties that will not be implementing until July 2017 or January 2018. The Whole-Person Care Pilot is an opportunity to build capacity and work through barriers before accessing HHP. Moreover, for counties that will not yet have not yet implemented HHP, there will be no danger of duplication of funding if a county ends the use of waiver funding for this phase of services before HHP takes effect, or it limits the use of waiver funding for these services to persons who do not meet the eligibility criteria for HHP at that time.

Thank you for the opportunity to comment on Concept Paper 3.0. We look forward to implementing a successful HHP in Santa Cruz County.

Sincerely,

Members of the Steering Committee for the Santa Cruz County 180/2020 Initiative

180/2020 Steering Committee

Monica Martinez, MPA monica.martinez@encompasscs.org, CEO Encompass Community Services
Christine Sippl, MPH christine.sippl@encompasscs.org, Sr. Dir. Programs and Partnerships, Encompass Community Services
Sibley Verbeck Simon sibley@180santacruz.org, President, New Way Homes
Phil Kramer, Executive Director, Homeless Services Center
Rayne Marr, Homeless Services Coordinator, Santa Cruz County
Stoney Brook, Veterans Treatment Court
John Dietz, Director, Housing Navigators

180/2020 Initiative Participants & Key Supporters (partial list)

Homeless Services Center
Encompass Community Services
City of Santa Cruz
Santa Cruz County
Housing Authority of Santa Cruz County
United Way of Santa Cruz County
Pajaro Valley Shelter Services
Santa Cruz Veteran's Resource Center
Santa Cruz Women's Health Center
Pajaro Rescue Mission
Envision Housing
New Way Homes
Appleton Foundation
Smart Solutions to Homelessness, Santa Cruz County
Community Foundation of Santa Cruz County
Dignity Health & Dominican Hospital
Front St. Inc.
Hospice of Santa Cruz
Homeless Garden Project
Volunteer Center of Santa Cruz County
Dientes Community Dental
WINGS



*Because everyone
should have a home.*

40849 Fremont Boulevard
Fremont, CA 94538
Phone (510) 657-7409
Fax (510) 657-7293
TTY (510) 252-0428
info@abodeservices.org
abodeservices.org

December 23, 2015

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov

Re: Comments on Health Home Program for People with Complex Needs, Concept Paper 3.0

Dear Health Home Program:

On behalf of Abode Services, I am writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. Abode Services is a nonprofit housing and service provider focused on ending the homelessness of the most vulnerable members of our community. We serve homeless individuals and families in Alameda, Santa Clara, Santa Cruz, and San Mateo Counties. Because of the focus of our organization, we are commenting primarily on the impact of provisions of Concept Paper 3.0 on Medi-Cal beneficiaries experiencing homelessness.

We are gravely concerned about the timeline proposed by DHCS. While we appreciate the need for deliberate approach, a 30-month roll-out of the benefit has drastic implications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties. Group 2 and 3 counties have the highest rates of poverty and social barriers to accessing appropriate care. Though many of these counties have developed means of addressing these barriers to care, along with provider capacity, delaying these services until early to mid-2018 will mean that the most vulnerable beneficiaries will continue to experience poor health outcomes and high costs.

In addition, State initiatives will be difficult to sustain without the promise of HHP services to integrate care at the systems and individual beneficiary level, such as the Whole Person Care pilot and the Medi-Cal Drug Organized Delivery System. At the same time, California will have to bear the costs of poorly managed care among those expansion beneficiaries with complex conditions, and will be required to pay for more of the costs of HHP services for expansion beneficiaries.

Moreover, evaluation results may not be available until well after DHCS has to determine whether to use State General Fund resources to support the ongoing costs of HHP services for Group 1 and Group 2 counties. If implementation in these counties is delayed, this could result in under-estimating the impacts of HHP during the evaluation timeframe.

Finally, the fate of HHP and the ACA are uncertain in 2018 and beyond. We are very concerned HHP may never reach those with the greatest need due to failures in full implementation, should services in mostly small, rural counties fail to make any measurable impact.

**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

We therefore recommend the following:

- Including at least one large county with high rates of poverty and providers with capacity, like Alameda or Los Angeles, in Group 1.
- Compressing the timeline by allowing all eligible beneficiaries to access the benefit by October 2017.
- Allowing the Whole-Person Care pilot to fund HHP-like services in the years before HHP implementation begins in counties accessing the pilot.

We also recommend allowing for more robust stakeholder input on the timeline and counties included in each group before finalizing California's State Plan Amendment.

Additionally, we recommend the following changes to proposals outlined in Concept Paper 3.0

Regarding **eligibility criteria**, we recommend—

- Adding chronic renal disease, HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to your list of eligible conditions.
- Requiring CB-CMEs be responsible for engaging, in person, members who do not respond to a letter that they are eligible, and that the engagement rate be reserved for in-person, face-to-face engagement activities a CB-CME undertakes.
- Allowing CB-CMEs to use other sources of data to refer beneficiaries to the HHP program, rather than administrative data.
- Fostering a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program.
- Including “chronic homelessness” as an acuity factor.
- Eliminating the exclusions.
- Clarifying how DHCS and MCPs will ensure continuity of care for beneficiaries no longer meeting the acuity criteria.

For the **definitions of services**, we recommend the following changes:

- For homeless beneficiaries, clarify that references to “communication through e-mails, texts, social media, and phone calls” are applicable to those who are stably housed, and not only allowable until a CB-CME's in-person contacts have established a trusting relationship with the beneficiary.
- To the definition of *comprehensive care management*, we recommend adding in-person outreach and engagement of beneficiaries to form trusting relationships and to gather information the beneficiary, similar to the definition in CMS guidance, as well as individual housing transition and tenancy sustaining services recognized in the CMS Informational Bulletin (housing-related activities for beneficiaries experiencing chronic homelessness).
- To the definition of *care coordination*, we recommend including, “Accompanying beneficiaries to appointments when necessary to act as the

beneficiary's advocate, to communicate the beneficiary's health goals to care providers, to explain diagnoses and treatment to the beneficiary, and/or to engage the member to follow treatment protocols." We further recommend adding "providing and arranging transportation to attend appointments, including appointments with social service providers."

- To the definition of *health promotion*, we recommend requiring CB-CMEs to use evidence-based practices to engage the beneficiary to manage his or her own care.
- To the definition of *comprehensive transitional care*, we recommend, "Locating and offering to beneficiaries experiencing homelessness immediate access to respite care or bridge/interim housing post-discharge until a permanent apartment is made available to the beneficiary," rather than current language regarding "transitional housing."
- To the definition of *Individual & Family Support Services*, we recommend encouraging the beneficiary's own goals drive any connections with family, friends, or other potential support systems.
- To the definition of *Referral to Community & Social Supports*, we recommend including active linkage to social systems and services, such as requirements to create relationships with housing providers, offering warm hand-offs to help the beneficiary navigate through the process of obtaining services impacting the member's health, and routine check-in with beneficiaries to ensure the beneficiary accesses social services he or she requires. We also recommend adding "food security services" to your list of services.

If housing navigation services are not included in the definition of care management, we recommend **adding housing navigation services** to the definition of referral to community and social supports. In defining housing-related activities, we recommend following definitions included in the CMS Informational Bulletin on housing-related activities.

To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user beneficiaries, we recommend **adding a fourth model to the three models the Concept Paper identifies for service provision, would be: "Model IV."** A collaborative model serving homeless HHP members, Model IV would include services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either the homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care managers and housing navigators engage members where the members live, both before and after the member moves into housing.

For **CB-CME duties**, we recommend that:

- CB-CMEs be allowed to focus solely on serving homeless HHP beneficiaries, including persons who have moved into supportive housing after experiencing homelessness.
- A multidisciplinary care team be allowed to consist of staff from multiple agencies and should offer services wherever most accessible to the beneficiary.
- CB-CMEs be encouraged to partner with permanent housing providers and homeless service providers to reach homeless beneficiaries.

With respect to **additional staffing requirements**, we recommend:

- An aggregate care manager/housing navigator ratio of 1:15 to 1:20 (not including MCP staffing) for HHP members who are homeless. In housing and mental health systems, successful case management programs serving homeless and frequent user populations offer in-person, individualized, frequent and flexible services, offered where the person lives, with beneficiary to staff ratios of 1:15 to 1:20.
- Staffing ratios of 1:25 for other complex beneficiaries beginning to receive HHP services.
- A staffing ratio of 1:35 to 1:40 once a HHP member can transition to “maintenance.”

With respect to **multidisciplinary team roles**, we recommend the following changes:

- In the *dedicated care manager* role, including, “arranging *and providing* transportation when necessary to provide access to appointments,” and adding, “Accompanying HHP member to office visits.”
- In the *community health worker* role, adding a requirement the health worker explain materials provided to the beneficiary.
- In the *housing navigator* role, requiring formation and fostering of relationships with housing agencies, engaging members and potential members in person, and, “partnering with housing agencies and providers to offer HHP member with permanent housing options, assisting member with moving into permanent housing and promoting housing stability.” We further recommend including housing-related activities, as described in the CMS Informational Bulletin released in June regarding housing-related activities for people experiencing chronic homelessness.

Regarding **member assignment**, we recommend requiring an in-person engagement process, particularly for homeless members. For others with complex needs, we recommend supplementing letters with in-person engagement. For referrals, we likewise recommend—

- Fostering a “no wrong door” approach that allows any agency, behavioral health professional, or PCP to refer a member potentially eligible.

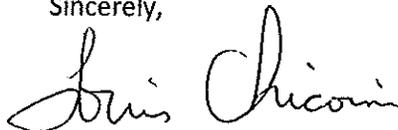
- Allowing for presumptive eligibility if a beneficiary meets the chronic condition and acuity criteria.
- Requiring a CB-CME engage with a beneficiary on multiple occasions before discharging a beneficiary.

In reporting housing outcomes (within operational measures), we recommend changing current housing status to, "The number of members receiving the homeless modifier who are currently living in permanent housing (their own independent apartment not limited by length of stay)." We recommend conducting a separate evaluation for homeless members than other beneficiaries.

Regarding HHP interaction with other Medi-Cal programs, we urge DHCS to consider funding housing-related activities and services identified in HHP through the 1115 Waiver Whole Person Care Pilot Programs in counties that will not be implementing HHP until July 2017 or later. With the exception of San Francisco, need for HHP services is greatest in the counties that will not be implementing until July 2017 or January 2018. The Whole-Person Care Pilot is an opportunity to build capacity and work through barriers before accessing HHP. Moreover, for counties who have not yet implemented HHP, no danger of duplication of funding exists if a county ends the use of waiver funding for this phase of services before HHP takes effect, or limits the use of waiver funding for these services to persons who do not meet the eligibility criteria for HHP at that time.

Thank you for the opportunity to comment on Concept Paper 3.0.

Sincerely,

A handwritten signature in black ink that reads "Louis Chicoine". The signature is fluid and cursive, with the first name "Louis" and last name "Chicoine" clearly legible.

Louis Chicoine
Executive Director

Comment received via email during comment period.

Dear DHCS staff: Thank you for your ongoing work on the Health Homes pilot project and your commitment to creating opportunities for health care innovations throughout California. I do have a few comments on the latest version of the Health Homes Concept paper:

- 1) Under the eligibility section of the document, the criteria referenced include inpatient and emergency department utilization but does not specify whether or not this includes psychiatric emergency department and psychiatric hospitalizations. I think psychiatric facilities should be included as a basis for eligibility.
- 2) A variety of criteria are listed that would allow MCP's to exclude individuals from participation in the Health Homes effort. This section of the document refers to individuals that are "uncooperative", "behavior or environment[s] that are unsafe" and "alternate care management program." Unfortunately, these criteria could be used by MCPs to exclude some of the highest cost and highest need individuals based on subjective experiences of "cooperation", "safety", and "appropriate" alternative care management resources. I would recommend developing more specific criteria for exclusion or develop formal appeal guidelines for MCPs that exclude interested members from participation. The current exclusion criteria provide MCPs with too many options for excluding homeless individuals and individuals with behavioral health issues.
- 3) The references to housing in the document only reference the link between homelessness and housing. In my experience, homelessness is not the only way in which housing status impacts health. Unhealthy neighborhoods, unsafe buildings, and institutional living environments can all adversely impact health. I would encourage you to allow for a broader range of housing-related interventions in your concept paper.
- 4) The concept paper does not adequately outline MCP expectations related to addressing homelessness and partnerships with housing providers. I believe MCPs should be required to have formalized agreements with local entities that can document their capacity to help address the housing needs of members.
- 5) Many high-cost Medi-Cal beneficiaries reside in Skilled Nursing Facilities or licensed community care facilities. The concept paper should provide some additional guidance on how counties can link Community Care Transitions and assisted living waiver opportunities with their Health Home efforts.
- 6) The concept paper appears to restrict the range of services to traditional health care interventions. In our experience, social determinants of health often have more significant impacts on the health status of Medi-Cal beneficiaries than traditional health interventions. I would like to see the state create opportunities for innovation in terms of the range of services that can be paid for with health home funds. For example, our county is implementing an evidenced-based practice known as Individualized Placement and Support (IPS) to help disabled individuals with serious mental illness find competitive employment. These interventions appear to have significant positive impacts on member's health status and utilization of acute and crisis health services. We have also found tremendous value in medical-legal partnerships that involve attorneys working alongside health practitioners to address legal barriers that impact health including public benefits, housing, domestic violence, and others. I hope the list of eligible service activities can be broadened to include some of these activities and supports.
- 7) The concept paper does not adequately address the question of eligible expenses with waiver dollars. In our experience, the availability of client support funds to address specific client

needs has proven tremendously invaluable. For example, we use such funding to help with transportation, food, clothing, security deposits/application fees/short-term rental assistance, and other key items that impact client health. I hope this effort will allow for the flexible use of funds to meet client needs.

- 8) The concept paper does not clearly outline how Medi-Cal mental health plan data will or will not be used to help identify eligible target population members. Given the research indicating the high prevalence of co-occurring behavioral health disorders among high-cost Medicaid beneficiaries, I believe it would be important to incorporate MHP data into the overall analysis of eligibility and risk.
- 9) In my experience, some of the Medi-Cal beneficiaries with high health care utilization costs often fall off Medi-Cal due to long institutional stays or an inability to complete eligibility paperwork for a variety of reasons including homelessness, language, and cognitive difficulties. I believe some protections need to be put in place to ensure MCPs help their high need, health home eligible patients to retain their Medi-Cal benefits. Many of these individuals temporarily become the responsibility of county indigent health plans. Counties need to have some role in helping to hold MCPs accountable for continuity of coverage and enrollment within the MCP.
- 10) Finally, I believe Alameda County will be ready to implement the Health Home project earlier than January 1, 2018 and would encourage the state to consider Alameda County for a July 1, 2017 start date. This coincides with our county fiscal year cycle and would ease implementation of contracting and partnership agreements between the MCPs, MHP, and other CB-CMEs.

If you would like further clarification on any of my comments, please do not hesitate to contact me.

Sincerely,

Robert Ratner, MPH, MD
Housing Services Director
Alameda County Behavioral Health Care Services



CENTER FOR ADVOCACY & POLICY

Telephone: (916) 442-1036

Fax: (916) 442-1743

December 23, 2015

California Department of Health Care Services
Health Homes Program
Sent by email: hhp@dhcs.ca.gov

**RE: ACLU of California Comments on Health Homes for Patients with Complex Needs
California Concept Paper Version 3.0**

To Whom It May Concern:

The American Civil Liberties Union of California appreciates the opportunity to provide input regarding the Health Homes for Patients with Complex Needs California Concept Paper Version 3.0 (Concept Paper). 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 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 May 2015, the ACLU of California submitted comments on Version 2.0 of the HHP Concept Paper. Building off of our previous recommendations, we urge the Department of Health Care Services to improve the current draft by:

1. Providing more clarity about the referral process for Community Based Care Management Entities (CB-CMEs);
2. Expounding on the required coordination between HHPs and institutions, specifically incarceration facilities;
3. Including reductions in incarceration as a form of institutionalization in the evaluation of the HHP;
4. Providing further guidance on in-person engagement to potential HHP beneficiaries;
5. Encouraging the use of peers with lived experience, including past justice system involvement; and
6. Creating lists of CB-CMEs by geographic region so beneficiaries can more easily select the right care provider for them.

ACLU OF NORTHERN CALIFORNIA

Abdi Soltani, Executive Director
39 Drumm Street
San Francisco, CA 94111
(415) 621-2493

ACLU OF SOUTHERN CALIFORNIA

Hector Villagra, Executive Director
1313 West Eighth Street
Los Angeles, CA 90017
(213) 977-9500

ACLU OF SAN DIEGO & IMPERIAL COUNTIES

Norma Chavez-Peterson, Executive Director
P.O. Box 87131
San Diego, CA 92138
(619) 232-2121

The ACLU of California supports the direction DHCS is moving in Concept Paper 3.0. We are pleased to see an emphasis on beneficiary-driven health goals and engagement of HHP members in their own care. We strongly support DHCS's emphasis on permanent supportive housing for HHP members as a strategy to make meaningful improvements in health and encourage DHCS to keep scrutiny on managed care plans' (MCPs) activities to ensure HHP members are quickly connected to stable housing.

Concept Paper Version 3.0 also includes some of the recommendations the ACLU of California identified as necessary in our previous comments. These will be highlighted in our recommendations below.

Provide more clarity about the referral process for CB-CMEs

The ACLU of California is pleased to see DHCS has included a referral process for individuals who are new Medi-Cal beneficiaries and do not satisfy the criteria for targeted outreach. In our previous letter, we suggested that DHCS develop an alternate process for individuals to enroll in the HHP who have limited or no Medi-Cal utilization data but may otherwise be eligible and benefit from the program. Such a referral process has been outlined on page 26 of Version 3.0. Inclusion of this referral process will help ensure individuals who can benefit from the HHP will not increase utilizations costs and deteriorate in health status while waiting for the Medi-Cal administrative claims data to identify them, but instead can promptly receive necessary HHP services.

The referral process is a welcome addition, but it can be improved by provision of further clarity. Will DHCS develop the referral form for MCPs to use, or will MCPs create them? We urge DHCS to develop these forms so they are uniform across the state. This will allow DHCS to clearly articulate the eligibility criteria for individuals in these circumstances and potentially resolve any conflicts that arise between providers and MCPs. Regardless, DHCS should provide guidance to providers on the exact criteria that individuals need to satisfy in order to qualify for HHP through the referral process. This will reduce confusion and encourage providers to take advantage of this necessary practice.

Expound on the required coordination between HHPs and institutions, specifically incarceration facilities

We are similarly heartened to see our recommendation to require HHPs to coordinate with law enforcement (at least with incarceration facilities) is a required component of HHP comprehensive transitional care duties. This addition will help with care transition for HHP members when they are entering or exiting jail or prison. However, to truly maximize the benefit of coordination with law enforcement, we urge DHCS further expound on what coordination should entail.

While receiving notification of institutionalization (including incarceration) is beneficial, the true benefit will come from working to divert individuals into the appropriate level of care for

chronic health conditions. Getting reconnected with the HHP member's CB-CME, rather than incarcerated, can prevent disruption of a treatment regimen and deterioration in health status. DHCS should encourage HHPs to establish this level of coordination among relevant agencies. This coordination should expand beyond incarceration facilities to arresting authorities, including local police (while maintaining HHP member privacy).

Similarly, we urge participating MCPs and CB-CMEs to coordinate with California Department of Corrections and Rehabilitation (CDCR), incarceration facility administrators, and probation departments so eligible but not yet enrolled individuals have the opportunity to join HHP 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,¹ and the significant burden on emergency departments presented by individuals released from incarceration without proper connection to care,² 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.³

At a minimum, DHCS should require HHPs to include contingency plans for what happens when an HHP member is incarcerated. This could be included in the Health Action Plan required as part of comprehensive care management.

Include reductions in incarceration as a form of institutionalization in the evaluation of the HHP

Rigorous evaluation of the HHP will determine the impact on health outcomes, utilization, and costs for populations with significant needs. Evaluation also presents an opportunity to determine whether intensive services provided to HHP members impacts justice system involvement. Although reducing recidivism is not DHCS' focus, it is inextricably linked to individual health status. Without following whether individuals become incarcerated, an opportunity to track the impact of an influential social determinant of health is missed. Analyzing justice involvement may even help explain discrepancies in health outcomes collected as part of this research.

¹ 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/>.

² 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/>.

³ 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.

DHCS already will require HHPs to coordinate to receive notification when HHP members are incarcerated. DHCS should require this information to be tracked and reported both to determine if it impacts health status and to see if beneficiaries reduce justice-involvement while enrolled in HHP. Such research will add to the comprehensiveness of the planned evaluation and to the body of research linking health and justice outcomes.

Provide further guidance on in-person engagement to potential HHP beneficiaries

While we appreciate the special consideration given to ensuring appropriate services for people experiencing homelessness, the Concept Paper lacks sufficient guidance for potential HHP members in this situation. As DHCS acknowledges, an in-person engagement process may be 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 to provide 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. DHCS should issue further guidance to HHPs on developing the necessary in-person engagement component.

Encourage the use of peers with lived experience, including past justice system involvement

Peer advocates can play an important role in engaging and retaining HHP members in their health plans. DHCS recognizes this by including peer advocates as eligible community health workers, which is a required component of the multi-disciplinary care team. We recommend DHCS strongly urge HHPs to include peer advocates with lived experience, including individuals with past justice system involvement. This may require organizations to review their policies on hiring or contracting with individuals with criminal records. Blanket restrictions for individuals with a record could potentially deprive beneficiaries of a valuable resource of peers who can help others through sharing their experience. The Transitions Clinic model based out of San Francisco trains individuals with past justice involvement to help individuals navigate the health care system, and has experienced very positive results.⁴ HHPs could look to the Transitions Clinic model as an example of using peers to engage HHP members.

Create lists of CB-CMEs by geographic region so beneficiaries can more easily select the right care provider for them

The concept paper states that MCPs must have an adequate network of CB-CMEs for eligible members, and that members must be able to choose which CB-CME provides services. 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

⁴ More information about the Transitions Clinic Network can be found at <http://transitionsclinic.org/>.

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 DHCS's effort to improve the proposed Health Homes Program. Our recommendations are designed to further maximize the potential benefits. Thank you again for the opportunity to participate in the stakeholder process. Please do not hesitate to contact us if you have any questions.

Sincerely,



Kellen Russoniello

Staff Attorney, ACLU of San Diego and Imperial Counties

krussoniello@aclusandiego.org

619-398-4489



December 24, 2015

Hannah Katch
Assistant Deputy Director for Health Care Delivery Systems
Department of Health Care Services
1500 Capitol Ave
Sacramento, CA 95814

VIA ELECTRONIC MAIL:
Hannah.Katch@dhcs.ca.gov

Re: Health Homes for Patients with Complex Needs Concept Paper 3.0

Dear Ms. Katch:

Anthem is in receipt of the most recent version of the Health Homes for Patients with Complex Needs (Version 3.0). Anthem appreciates the opportunity to partner with DHCS with respect to this important initiative.

Overall, Anthem is very pleased with the updated concept paper; it respects the input of the stakeholders and reflects the efforts of the smaller workgroups in developing the update. Significant clarity has been added and we feel more confident about charting our way forward with our partners in the seven counties. We thank you for the opportunity to share our feedback on the current 3.0 concept paper and hope to highlight areas of concern or areas that require greater clarity.

DHCS Objectives: Increase integration of physical and behavioral health services:

As an MCP we welcome any opportunity to integrate physical and behavioral health services. This is a key component to the overall success of the HHP. Our concern is that the county mental health agencies may not be ready to launch in accordance with the launch schedule provided in the concept paper. We are concerned that these agencies have not been brought into the HHP planning and implementation discussions to the extent that the MCPs have. Since the launch will involve the SMI population first, we request that a very clear timeline regarding exchange of information, education and training for the mental health agencies be established. The burden should not rest on the MCPs but be part of the overall implementation plan for this benefit.

Information exchange between physical and behavioral health services is of primary importance. The mental health agencies need to be engaged as soon as possible. Creating and supporting an IT infrastructure to ensure information exchange can take 9-12 months to develop once both the MCP and mental health agencies have received concise and complete requirements.

Additionally, given the county operated MH system, success will have a greater likelihood if DHCS can develop an explicit model for MCP to MHP delegation.

Eligibility Criteria

We believe eligibility needs to be initially determined by DHCS, as DHCS has access to multiple data sources that will ensure better attribution of risk criteria. Most MCP's lack data on duals and benefits administered for the SMI population. This significantly limits the MCP's ability to properly identify members who can be eligible for this benefit. For these reasons the initial risk stratification should come from DHCS, however leaving the opportunity for the MCP to adjust the risk level when the MCP has completed the full assessment.

We appreciate the fact that criteria confirmation for any referrals to the HHP benefits rests with the MCP. "Bottom up" referral is an important component and this strategy allows for efficient use of the referral system.

We would suggest a modifier to the "three or more ED visits in the year". In order to ensure consistency with a high level of acuity/complexity, we suggest that the ED visits be relevant to the targeted conditions listed in the document.

In other states the ability of members to change MCPs each month, and subsequently their Health Home has been a significant factor in reducing continuity of services and support. It would be helpful to create a mechanism for having the HH plan of care travel with the member. This would reduce avoidable redundancy and disruption in care.

Medi-Cal Managed Care Plan Responsibilities

While MHPs, DMC-ODS and CCS have the option to participate, it is important that these entities fully understand the purpose, scope and goals of the HHP. This will enable them to make informed decisions regarding "opt-in".

The goal of a HHP is to engage members with chronic health conditions in consistent care and support system, by definition this implies a need to be tied with primary care. Additionally, the intent is to move away from hospital and emergency department services. In situations where the hospital is the HH it seems as if the "fox guarding the hen house."

The MCP has the leverage of contracting to ensure that CB-CME's are capable of meeting the HHP responsibilities. However, no such leverage exists with hospitals. It may be challenging for MCPs to ensure real time notification to the CB-CMEs of inpatient admissions and ED visits. It will be especially challenging if the hospital or ED is not contracted with the MCP. Any tools DHCS may have here will be very welcome.

Community Based Care Management Entity Responsibilities

We agree that **Model I** is the preferred model for most situations. One of the benefits of the HHP is that it invites a broad variety of community based entities as options for a Health Home. For many members their perception of "site of care" may not include the PCP office but rather a CBAS center, community center, a Recuperative Care center or counselling facility. From the member's perspective, the member and the member's family may attend and engage with these other sites more frequently. The staff at these centers may know their family, care giver or support system, and can assist with communication

with their health care provider. Therefore we recommend broadening Model I to include these entities, thereby allowing the member to continue their relationship with their PCP and the option to provide resources and support to the member's provider.

Member Assignment

While DHCS considers members enrolled with an MCP as the "managed population", Anthem does have members, especially in San Francisco, who are not currently assigned to a PMG and function as FFS members. Coordinating care and services for members not connected to primary care providers will pose additional challenges to the CB-CME. Anthem is in need of clarity here to better understand whether we can require that any of our FFS members who wish to opt in for the Health Homes benefit must agree to assignment to a PCP, PMG or FQHC.

Reporting

We recommend that the final payment model align with the required reporting requirements. Many contracted entities, especially outreach groups contracted by the CB-CMEs may not have the capability of digital tracking and reporting systems or the ability and funding to develop these systems. It is likely the tracking required to support reporting will be done manually (for example, homeless services organizations). The more detailed the reporting becomes the likelihood the CB-CMEs will encounter challenges in providing the necessary data to support compliance with reporting.

Avoidance of Redundancy

We appreciate the update to address members already receiving benefits through the 1915© waiver. Limiting the member to one program ensures the avoidance of redundancy of services.

Anthem is appreciative of the opportunity to participate in the HHP. Anthem appreciates DHCS' partnership and willingness to continue the conversation specific to the design of the Health Home Program. Anthem looks forward to continued conversations with DHCS, community partners and stakeholders. Please do not hesitate to contact me should you need additional information.

Sincerely,



Beth Maldonado
Director, Regulatory Services
Anthem Blue Cross – Medicaid

Cc: Heidi Solz MD, Medical Director
Barsam Kasravi MD, Chief Medical Officer
Steve Melody, President, Medicaid Health Plan



CALIFORNIA ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

December 23, 2015

Mr. Brian Hansen
Health Program Specialist
California Department of Health Care Services
Managed Care Quality and Monitoring Division
hhp@dhcs.ca.gov

Subject: Health Homes for Patients with Complex Needs

Dear Brian:

The California Academy of Family Physicians (CAFP), representing 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 appreciates the opportunity to review the California Concept Paper Version 3.0, dated December 11, 2015, (Concept Paper) and to comment. We look forward to working with the Department of Health Care Services (DHCS) on this important effort going forward.

CAFP is pleased to see a number of positive changes in this version of the Concept Paper and we want to acknowledge two important ones. We are particularly pleased with new language emphasizing the involvement of the Health Home Program (HHP) members' primary care provider. Specifically, we appreciate the acknowledgement that "[i]n most cases, the CB-CME [Community Based Care Management Entity] will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP [Medi-Cal Managed Care Plan]-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination" (page 18). In our view, the inclusion of the community PCP is essential to a delivery system model focused on improving care coordination and improving the health outcomes of people with high-risk chronic diseases.

We appreciate the descriptions of community-based care management models on pages 19-20 of the Concept Paper and the emphasis on embedding care managers in community provider offices. In our experience building a Medical Home pilot in Fresno, the community-based primary care group hired a care manager to proactively reach out to and coordinate the care of complex, high-risk patients. Our pilot resulted in \$2 million in savings and uniform quality improvement over an 18-month period. The care manager played an essential part in achieving these outcomes. DHCS did an excellent job outlining the proposed care management models and CAFP is happy to see this made explicit in this version of the Concept Paper.

CAFP also has detailed views and concerns in the following areas:

Comprehensive Transitional Care

CAFP is pleased by the focus on comprehensive transitional care in the HHP design. We appreciate that the CB-CME's duties include "[s]upporting HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning" (page 22). Primary care physicians generally understand the expectation that they provide timely follow-up appointments and coordination of care following hospitalization and CAFP understands that transitional care is a great opportunity for quality improvement and cost savings. However, for the CB-CME to fulfill this duty, it needs real time notification of members' hospitalizations and discharges.

CAFP urges DHCS to establish some parameters around the transmission of a summary care record or discharge summary to all involved parties. In the Concept Paper, the MCPs are required to notify the CB-CME of inpatient admissions and Emergency Department visits (page 17). We urge DHCS to place a 24-hour time limit on these notifications. The information is highly useful to primary care providers, but the usefulness diminishes over time. This will also help the MCPs and CB-CMEs comply with the requirement that HHP members are seen within established lengths of time after discharge from an acute care stay.

Health Information Technology and Health Information Exchange

The transmission of usable data seems essential to this project, but also poses a real challenge, particularly as the CB-CME's are on-boarding new care team members. CAFP appreciates the flexible approach taken on page 12 of the Concept Paper and DHCS's responsiveness to previous feedback on the challenges posed by Electronic Medical Record systems and the limited interoperability between and among systems. In an 18-month pilot period, CAFP recommends a very narrow focus in the area of HIT/HIE: utilizing EMR/HIT/HIE to transmit and receive summary of care and discharge records for care transitions.

Medi-Cal Managed Care Plan Responsibilities

We recognize the propriety of MCPs taking responsibility for the overall administration of the HHP and for payment to flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. We urge DHCS to explore requirements that ensure that most of the PMPM funding available for the HHP goes toward services for HHP members. For example, DHCS might require that a portion of HHP payment be committed to HHP services as opposed to plan administration (i.e., a medical loss ratio) and thereby ensure that members are the beneficiaries of the program. We understand that New York's Section 2703 program includes requirements for the apportionment of payment and would encourage DHCS to explore this model.

Privacy

We note that in several places in the Concept Paper, DHCS refers to HHP services provided through "e-mails, texts, social media, phone calls, letters, and in-person meetings where the member lives, seeks care, or is accessible" (pages 8-11). We see great value in engaging patients using multiple channels of communication, but in a program focused on the physical health, mental health, substance use disorders and palliative care that will involve not just health plans and providers, but new team roles such as care managers, community health workers and housing navigators, serious consideration should

be given to appropriate safeguards to protect the privacy of health information, and limits and conditions on the uses and disclosures that may be made of such information.

We understand that MCPs are required to establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations. We urge DHCS to consider the need for additional safeguards in a program that emphasizes new forms of communication, sensitive health information and new providers who may not have a history of required compliance with HIPAA and state privacy laws.

Network Adequacy

CAFP appreciates the requirement that MCPs have adequate networks of CB-CMEs in geographic target areas to serve eligible members and the network goals listed on page 18 of the Concept Paper. We also understand that DHCS will perform a readiness review, which will include a detailed review of the MCP's HHP network. Stakeholders require more information about what constitutes an adequate network and how DHCS will review the MCPs' networks. We urge DHCS to make information about the readiness assessment and the networks available. As you know, there is general concern about the adequacy of MCPs' networks in the Medi-Cal program and state monitoring of these networks. In this context, we believe transparency about networks in the HHP would strengthen the program and stakeholders' support for the program.

Community-Based Care Management Models

As noted above, CAFP is pleased to see the Community-Based Care Management Models listed on pages 19-20. We are particularly supportive of Model I, in which a care manager is embedded on-site in community provider offices. We appreciate that the HHPs will only utilize Models II and III where an assessment indicates that Model I is not viable.

A growing number of care managers in primary care practices work with both Medi-Cal and commercial beneficiaries. CAFP thinks it would strengthen this model of care delivery to link these relatively new care team workers so that they could share best practices. We urge DHCS to consider the HHP program as an opportunity to create a learning network of care managers working with Medi-Cal beneficiaries in the state.

CB-CME Qualifications and Duties

In general, the qualifications for and duties of HHP CB-CME's, described on pages 20-21, seem appropriate. CAFP's concern is with the requirement that CB-CME's accompany HHP members to critical appointments, when necessary and in accordance with MCP HHP policy, to assist in achieving Health Action Plan (HAP) goals. California primary care clinics, practices and physician groups are unlikely to have the capacity for this work currently and will need support from DHCS and MCPs to begin doing it.

Unlike the community-based care management models, the model for integrating community health workers is not made explicit in the Concept Paper. We urge DHCS to develop such a model in the next iteration. CAFP seeks more information about this goal and DHCS's vision for this new role in both high and low-volume providers in urban and rural areas.

In-Home Supportive Services (IHSS) workers currently play some of the roles listed among the Multi-Disciplinary Care Team Roles on pages 23-24 of the Concept Paper. DHCS should consider the integration of these current care team members in the HHP and make this explicit in the next version of the Concept Paper. Of the duties listed, IHSS workers could:

- Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines;
- Connect HHP member to other social services he/she may need;
- Advocate on behalf of members with health care professionals;
- Work with hospital staff to plan for discharge;
- Engage eligible HHP members;
- Accompany HHP member to office visits, as needed and according to MCP guidelines;
- Arrange transportation;
- Assist with linkage to social supports;
- Health promotion and self-management training;
- Distribute health promotion materials; and
- Call HHP member to facilitate HHP visit with care manager

CB-CME Certification

CAFP urges DHCS to include primary care residency programs in the list of organizations that qualify as CB-CMEs on page 21 of the Concept Paper. More than 50 family medicine residency programs are located in California. They often are high-volume Medi-Cal providers with existing care management capacity. Some programs focus on delivery of care in the health home model (e.g., the Harbor-UCLA Family Medicine Residency Program and the UCSF Family and Community Residency Program); others focus on the integration of primary care and behavioral health (e.g., the UCSD Combined Family Medicine and Psychiatry Residency Program); still others focus on quality improvement in the delivery of care to individuals experiencing homelessness (e.g., Scripps Mercy Family Medicine Residency Program). The family medicine residency programs are formally organized in a network, the CAFP Residency Network, with elected regional leaders, facilitating outreach and education about the HHP. They have expressed interest in the HHP and may very well serve as leaders in the planned learning collaborative for this program.

Member Assignment and Engagement

CAFP agrees with the program's overall eligibility criteria and that DHCS or the MCPs should use the criteria and administrative data to determine eligible members for HHP services. However, we urge DHCS to rethink the engagement strategy described in the Concept Paper in which MCPs notify HHP members of their eligibility via letter and thereby encourage member participation. CAFP believes outreach and engagement can best be accomplished by community-based providers. Consider the high opt-out rates and low enrollment numbers in Cal-Medicconnect, which relied on MCP engagement. As the CB-CME is responsible for securing consent by the member to participate in HHP, the CB-CME should introduce the program.

Consent should be obtained from any member of the CB-CME team and not limited to the care manager. In some cases, the primary care provider may have a historical relationship with the member and be best-suited to introduce the HHP. In other cases, the community health worker may be best suited. With this vulnerable population, we should rely on pre-existing community-based relationships.

The care manager should serve as the point person for communication about consent between the CB-CME and the MCP.

CAFP was pleased to see, in this version of the Concept Paper, that providers may refer eligible members to their assigned MCP to confirm whether the member meets the clinical eligibility criteria to receive HHP services. We ask that the provider referral form be readily available online and that the MCP have an obligation to respond to the referral request in a specified time period.

Service Delivery

We note that at least one core HHP service must be provided each quarter of the ongoing service delivery period for an add-on PMPM payment to be made to the MCP for the months in the subsequent quarter, but it is not clear to us what constitutes a core HHP service. To fully evaluate the payment model, stakeholders need a better sense of the service and reporting requirements.

Technical Assistance

CAFP is happy to see that there will be an opportunity for all HHP providers to participate in a learning collaborative. CAFPP has led multiple learning collaboratives focused on improving care of chronic illnesses and we find it to be an effective model for quality improvement. We are also happy to see that Pacific Business Group on Health (PBGH) will provide practice transformation coaching to forty high-volume CB-CME entities, although we wish that they could reach more providers. We urge DHCS to consider ways to capture and spread PBGH's teachings.

As longstanding proponents of this program, CAFPP would certainly like to assist DHCS with provider outreach and education. We ask that you consider a role for associations like ours in this process.

Palliative Care

Finally, we note that integrating palliative care into primary care delivery is a policy goal for this program identified on page four of the Concept Paper. Beyond stating that goal at the outset, however, DHCS does not incorporate that goal into the Concept Paper. As this is a priority for CAFPP, we welcome more dialogue about how palliative care can be incorporated into this particular program.

Thank you for your consideration of these comments. If you have any questions, please contact CAFPP's Vice President of Health Policy Leah Newkirk at lnewkirk@familydocs.org or (415) 345-8667. 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 loop at the end.

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



CAADS

California Association for Adult Day Services

1107 9th Street
Suite 701
Sacramento, California
95814-3610

Tel: 916.552.7400
Fax: 866.725.3123
E-mail: caads@caads.org
Web: www.caads.org

December 22, 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 3.0.

Dear Director Kent,

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

We appreciate the opportunity to comment on the Department's ***Health Homes for Patients with Complex Needs Concept Paper Version 3.0*** and the state's efforts and energies to launch a health home program in California.

We offer the following feedback and suggestions on the current plans for the health home design:

Eligibility Criteria (pp. 6-7) - The eligibility criteria as outlined will work well with the health home project as envisioned, based on our three years of experience serving a highly complex costly population in our pilot Community Based Health Home model.

Acuity (p. 8) - We are hopeful that the plan for generating stratified risk groups will reflect each member's level of complexity, which we assume will relate to setting the correct rate for the level of effort necessary to provide appropriate services to each individual. Although “social determinants of health” information is challenging to obtain, it is often critically important in identifying those most at risk. We observe that there is a process for referral to the health home outside of the stratification strategy. This element should be retained as the plan moves forward.

Eligibility Criteria Selection Data Analysis (p. 8) - We note that DHCS plans to make available care manager ratio assumptions. Our experience has been that an appropriate caseload ratio for highly

complex health home participants is 1:20, with an appropriate mix of acuity within the caseload of each case manager.

Care Coordination (p. 9) - We suggest adding to this list of activities "Rapid responses to systemic problems, gaps in services or developing emergencies." We often find that our CBHH nurse navigators are the first person to learn of breakdowns in caregiving continuity, safety problems in the home environment, or developing health care emergencies. Taking immediate steps to assist in these emerging situations is one of their most useful and important roles.

Referral to Community and Social Supports (p. 11) - We echo our previous comments that more provision needs to be made for the ability to secure social supports for health home participants than simply trying to utilize already-oversubscribed social services programs in the community. We believe that the inability to secure critical social supports at the right time often results in greater health care costs. Resource guides alone will not suffice.

Community Based Care Management Entity Responsibilities (pp. 17-25) - Our most significant area of concern about the concept paper is the description and outline of models for CB-CME services. We find the rigid structure of the care models somewhat confusing, and we question the underlying assumption; namely, that the health home in "most cases" will be the primary care provider. This approach strongly favors Model I, embedded care managers on site in community physician offices, and seems to promote a medical home rather than a health home approach by allowing other arrangements only in specialized circumstances and with the need to make a special case. We disagree with this approach for a number of reasons:

- The health home is not just a "place," it is a model of care. Creating a high preference for a physician office or clinic-based approach is very limiting to the development of innovative, fluid and responsive services that meet the person where they most need coordination and care. Our experience shows that the most important health home activities are meeting with the participant in their own home and seeing them in the hospital to discuss and plan for care transitions. A nurse navigator who can carry out these activities as well as accompany the person to primary care and other specialist physician appointments, need not be attached to a clinic to successfully accomplish those functions.
- This approach conflates patient-centered medical homes with health homes. They are different models of care, and the health home is grounded in integrated social and medical approaches that include the person, his or her family, caregivers and support system, and home and community environment, where they are most likely to receive trusted services. Integration of social concerns into medical environments is not primarily an activity that can originate with medical settings. There are existing models of care such as adult day health care that specialize in integrated social and medical approaches using an interdisciplinary team approach. Limiting the vision of the health home as an add-on to medical clinics is far too restrictive and fails to leverage

the expertise of integrated programs like Community-Based Adult Services and other long-term services and supports providers.

- What exactly is a CB-CME? It is unclear how the state is operationalizing this term. While our Community-Based Health Home model appears to meet all of the qualifications of a CB-CME, it is not clear if the expectation is that health plans will contract with only one entity within a geographic region or county or with multiple entities serving special populations. We also find that adding yet another contracting layer to the health plan, which already has the capacity to directly contract with selected providers is an inefficient use of scarce resources and may be the least efficient means of delivering quality care with direct oversight and accountability to the health plan.

We find the CB-CME structure as outlined in the paper too inflexible and unnecessarily confusing. We urge the state to move beyond such rigid construction of the CB-CME, remove the strong preference for a single, clinic-based or primary-care model, and give plans the flexibility and ability to design provider networks based on a provider's ability to mount a program that meets the core expectations of a health home and the demonstrated ability to achieve the intended outcomes.

Payment Methodologies (pp. 26-27) - We are encouraged to see that engagement and ongoing service delivery are noted as having differing levels of effort, each with distinct rates attached. In general, we are quite concerned that rates overall be sufficient to ensure the sustainability and quality of health home activities for this high risk high cost population.

As the health home program continues to mature, we believe there may be confusion about the practical aspects of designing and launching a "health home." We anticipate a steep learning curve as plans, primary care, behavioral health providers and community-based organizations grapple with designing and launching a health home. Our nurse-led CBHH model has achieved significant early positive outcomes: our initial 12-month cohort showed emergency department visits were reduced by 23.6%, hospital admissions were reduced by 24.1%, and the 30-day readmission rate was only 1.8% compared to national average of 20%. We are eager and well prepared to participate in the 2703 health home program and to assist the state, plans and other community-based organizations to learn about and launch a successful health home model.

We have attached summary materials that provide a description, outline, sample tools and approaches of our Community-Based Health Home design, and we stand ready to assist others who may benefit from our experiences piloting and developing a health home model.

Please feel free to contact me at 916-552-7400 or Lydia@caads.org if we may be of assistance.

Sincerely yours,



Lydia Missaelides, MHA
Executive Director



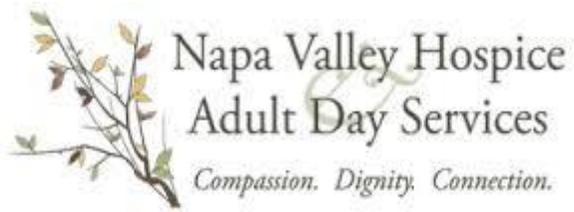
Alliance for Leadership and Education

**The Community Based Health Home:
California's Pioneering Model to Achieve the Triple Aim**

***Creating Proven Outcomes for At-Risk Persons
with Complex Conditions***

A project of the Alliance for Leadership & Education in collaboration with
California Association for Adult Day Services

Generously funded by SCAN Health Plan ~ The Thomas J. Long Foundation ~ San Francisco Foundation



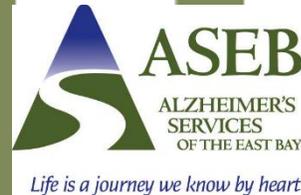
BAYVIEW HUNTERS POINT
MULTIPURPOSE SENIOR
SERVICES INC.



2015 Community Based Health Home (CBHH) Sites



SteppingStone



COMMUNITY BASED HEALTH HOME



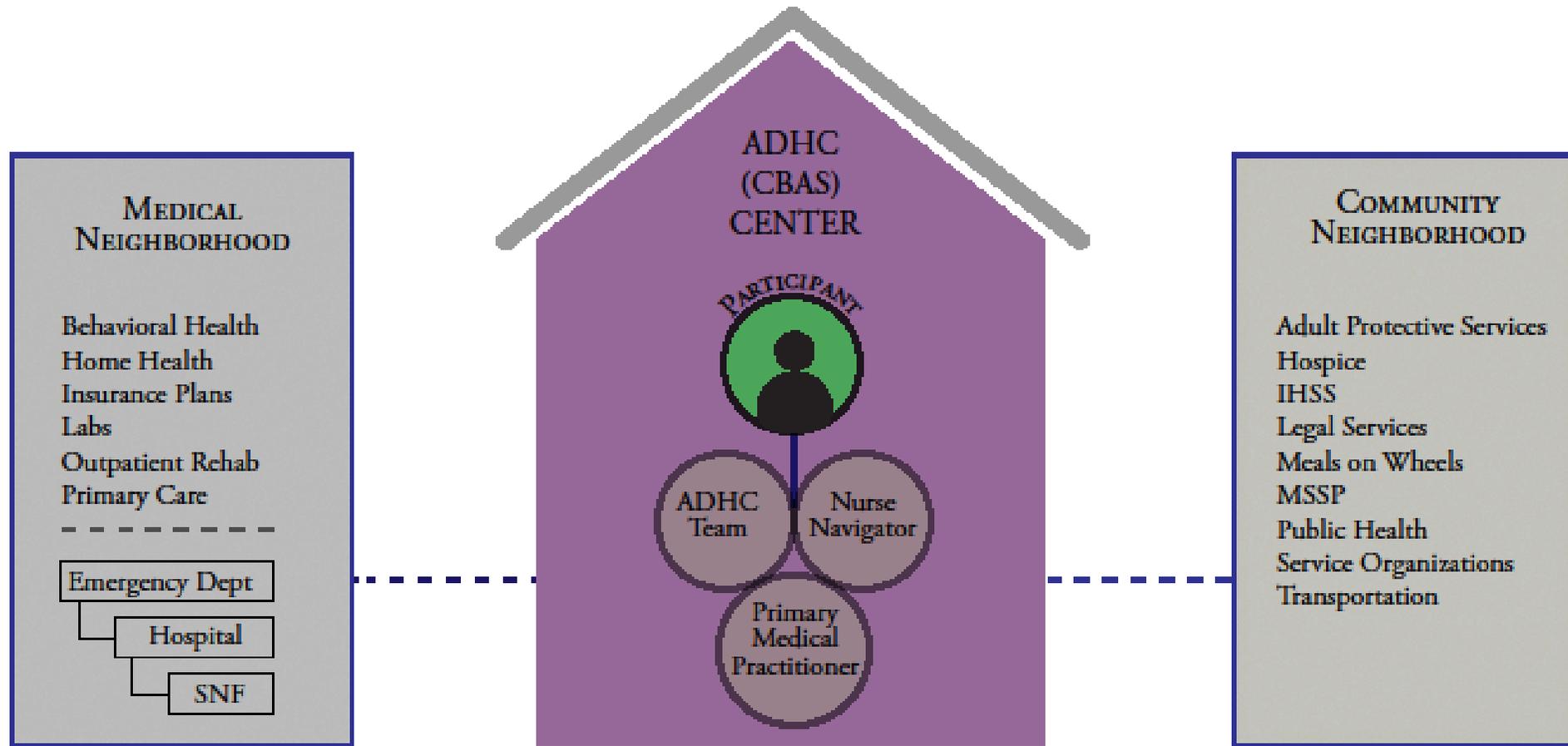
Our Vision



To improve the health and well being of people with multiple chronic conditions and disabilities across the state, particularly those who face barriers to accessing needed care, through the creation of an effective person-centered health home based in the individual's core neighborhood of services and supports.



THE COMMUNITY BASED HEALTH HOME



ALE's Community-Based Health Home Model

A comprehensive person-centered model that actively allies adult day health care/CBAS with the PCP and other community supports to create improved outcomes for adults with chronic complex needs through managed care.

- This is done by unifying the health home structure with the consistent treatment interventions offered through the interdisciplinary team-based ADHC model.
- A key feature is the addition of a highly trained Nurse Navigator, who can navigate outside of the ADHC/CBAS center walls, on behalf of and with the participant and his or her caregivers.

Our Model Today

- CBHH was developed by ALE/CAADS with support from the non-profit sector
- 3 years of pilot testing in selected centers proves CBHH to be perfect fit with ADHC model and for this high utilizer population
- “Beta phase” includes addition of 4 sites, with 1-2 more starting in January.
- CBHH sites are licensed by ALE
- Start up time is 4-6 months depending on how quickly personnel are hired.



CBHH Alignment with State's 2703 Initiative



CBHH targets individuals with multiple chronic conditions who are difficult to stabilize with traditional case management or care coordination. CBHH utilizes the six core services identified as fundamental to the 2703 health home:

- 1) Comprehensive care management
- 2) Care coordination (physical health, behavioral health, community-based LTSS)
- 3) Health promotion
- 4) Comprehensive transitional care
- 5) Individual and family support
- 6) Referral to community and social support services.

CBHH sites share data to link medical and community services and supports



Initial Target Population (2012-2015)

Dual eligibles in 6 counties who are 65 years or older and:

- Authorized by MC Plan as eligible for CBAS at one of the 6 project sites.
- Identified by the CBAS MDT as high risk using project criteria and team judgment
- Additional red flags:
 - Living alone with cognitive impairment or psych condition
 - Sudden changes in health, mental or cognitive condition
 - Changes in caregiver or living status
 - Absences from the CBAS Center

Criteria for new sites is no longer limited to “duals”



Participant CBHH Admission Criteria

Must be 18 years or older; be assessed to qualify for CBAS/ADHC and have:

At Least One Chronic Physical or Mental Health, or Cognitive Condition

(Chronic illnesses are “conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living.” In addition to comprising physical medical conditions, chronic conditions also include problems such as substance use and addiction disorders, mental illnesses, dementia and other cognitive impairment disorders, and developmental disabilities.)

AND one of the following:

A. Psycho-Social Conditions That Make the Person Vulnerable to Fragmented Systems of Care

(this may include communication difficulties, poverty, living alone, the need for conservatorship, poor or inadequate caregiving, which may appear as lack of safety monitoring, lack of access to necessary medical interventions, or mismanagement of medications)

OR

B. Poor Outcomes that Have Put the Person at Greater Risk of Institutionalization in the Past YEAR (such as multiple falls, elder abuse, suicidal ideation, extreme caregiver distress, or chronic pain)

OR

C. Recent Institutionalization

(this may include [a] two or more visits to the emergency department in the past year; [b] medical hospitalizations in the past year; [c] psychiatric hospitalization within the past five years or [d] a SNF stay in the past two years.)

AND

Be assessed as being able to benefit by the additional support provided by the CBHH



CBHH Patient Profile as of February 2015

(N = 75)

UPON ADMISSION TO CBHH

▪ Female	66%
▪ Male	34%
▪ Ave. Age	78
▪ Ave. # Meds	10
▪ Ave. # Chronic Conditions	8
▪ Hospitalizations (prior 12 mos)	63%
▪ ED visits (prior 12 mos)	97%
▪ Lives alone	42%
▪ Social Risk Factors	91%
▪ Risk for institutionalization	86%

TOP 8 CBHH CONDITIONS:

1) Arthritis	23%
2) Chronic Mental Illness	31%
3) Dementia/Alzheimer's	39%
4) Depression	37%
5) Diabetes	50%
6) Hypertension	74%
7) High Cholesterol	48%
8) Osteoporosis	30%

Participant Risk Factors

- Multiple chronic medical or psych conditions
- Polypharmacy/Medication mismanagement
- Clinical depression/Mental Health
- Self-neglect or caregiver neglect
- Poor judgment/risky decision-making
- Living alone/isolation
- History of falls
- Challenging behaviors
- Family / caregiver conflict
- Substance abuse / history of homelessness



Key CBHH System Outcomes Results

For a 12-month cohort¹ with 5 significant outliers removed (N=55):

1. Emergency Department visits **were reduced by 23.6%**
2. Hospital admissions were **reduced by 24.1%**
3. 30-day readmission rate was only **1.8%** compared to national average of 20%².

¹ Cohort included persons with 12 consecutive months of CBHH service during the years 2012-2014

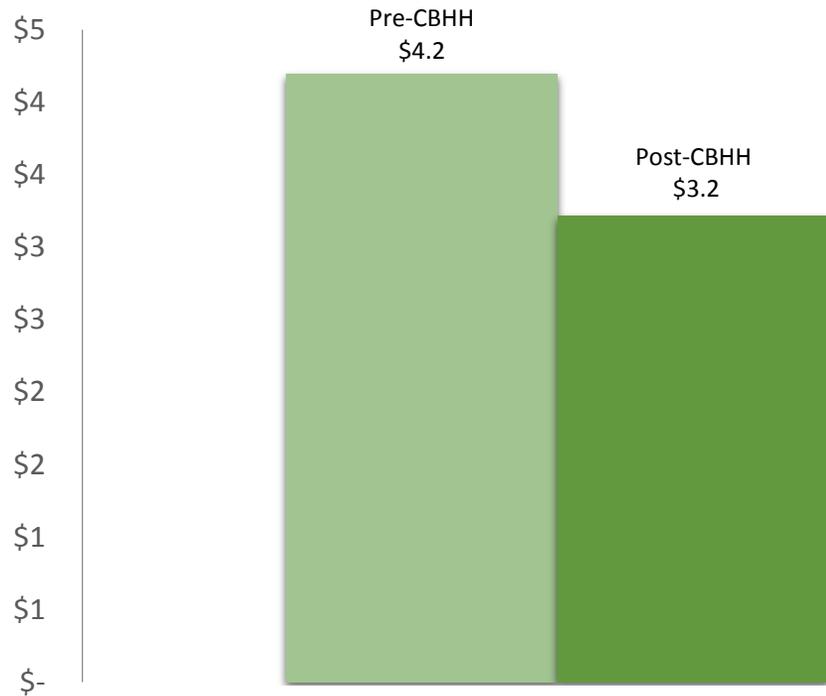
Each person served as their own control, ie, pre and post CBHH intervention data were compared

² (<http://www.academyhealth.org/files/2012/sunday/brennan.pdf>)



CBHH Intervention Reduced Emergency Department visits by 23.6%

ER Visit Costs (in Millions)



- ER Visits in the year prior to CBHH admission were **0.55** pmpy (approximately \$4.2M[†] in costs)
- ER Visits in the year subsequent to CBHH admission were **0.42** pmpy (approximately \$3.2M[‡] in costs)

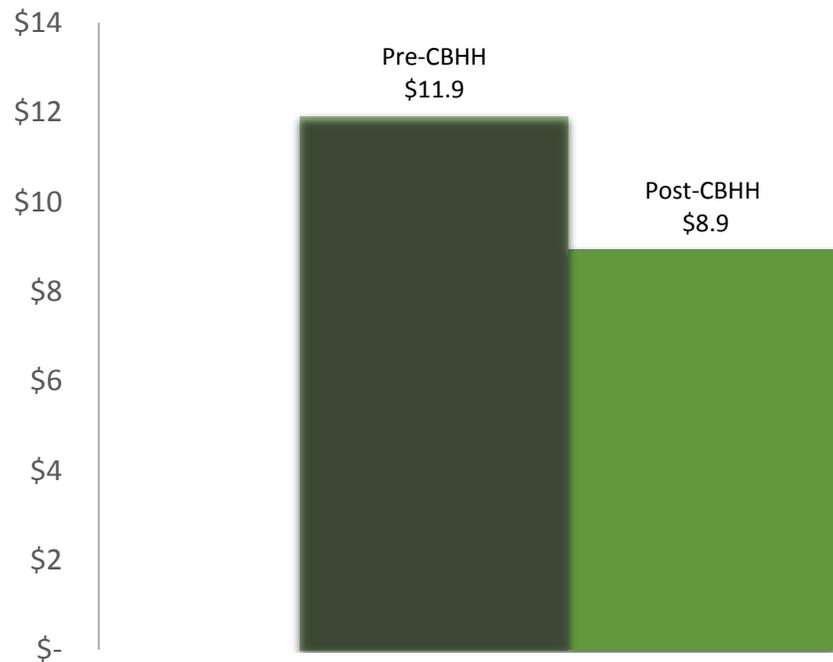
[†]ER Visits pmpy (.55) x Membership (4,888) x ER Visit Cost (\$1,573) ≈ \$4.2M

[‡]ER Visits pmpy (.42) x Membership (4,888) x ER Visit Cost (\$1,573) ≈ \$3.2M



CBHH Intervention Reduced Hospital Admissions by 24.1%

Hospital Costs (in Millions)



- Hospital Admissions in the year prior to CBHH admission were 0.29 pmpy (approximately \$11.9M[†] in costs)
- Hospital Admissions in the year subsequent to CBHH admission were 0.22 pmpy (approximately \$8.9M[‡] in costs)

[†]Hospital Admissions pmpy (.29) x Membership (4,888) x Hospital Admit Cost (\$8,378) ≈ \$11.9M

[‡]Hospital Admissions pmpy (.22) x Membership (4,888) x Hospital Admit Cost (\$8,378) ≈ \$8.9M

RN Navigator Role

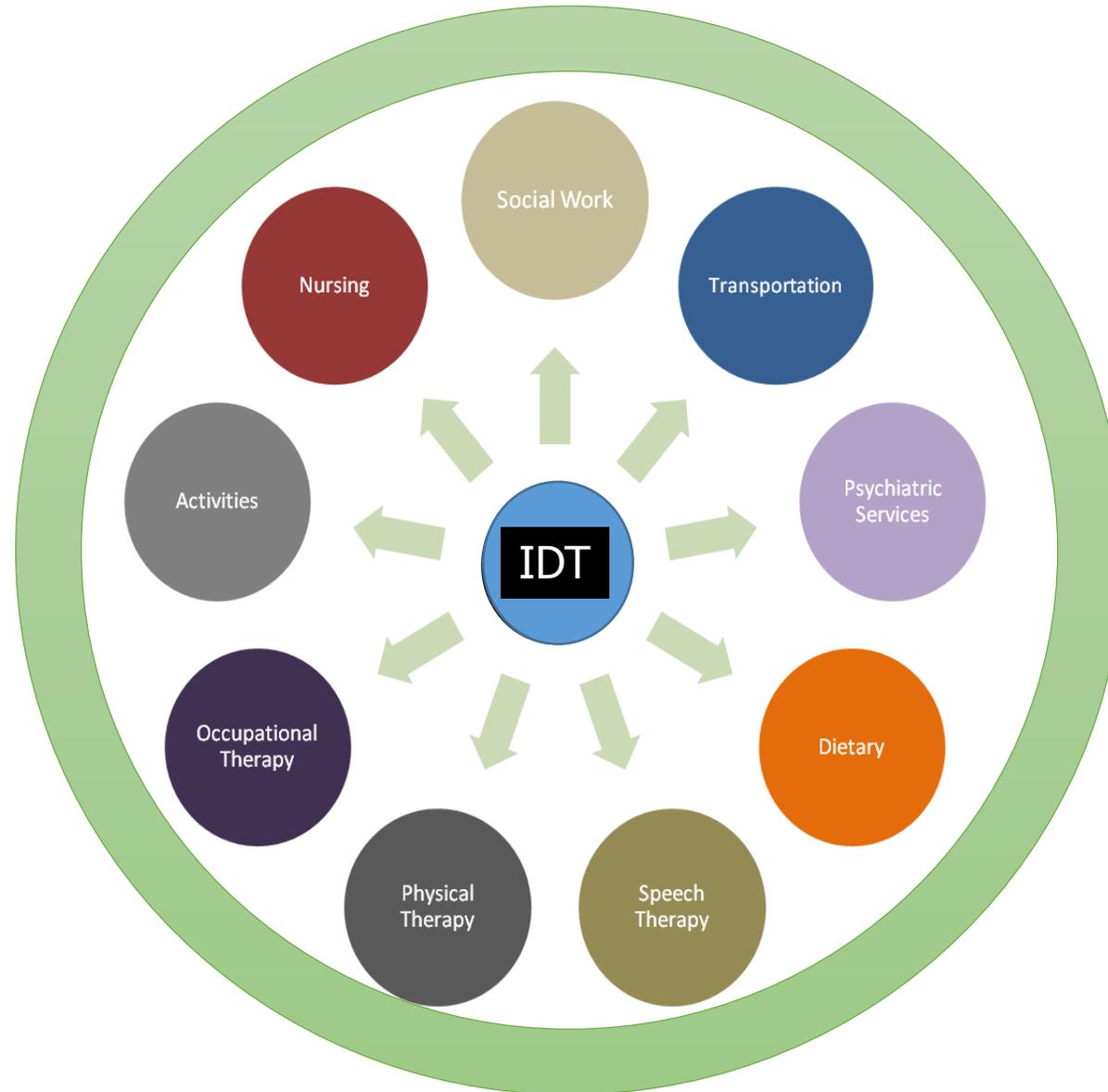
1. “High touch” care - extension of CBAS IDT, and supports PCP treatment plan and orders:
 - Home visits and education of participant and caregivers
 - Accompanies participant to PCP visits and communicates with PCP “eyes and ears”
 - Works with discharge planner at NF or hospital to facilitate care transitions
 - Ad hoc RN assessments, as needed (home or center)
 - Works to improve health literacy and self-direction skills / motivation
2. Applies uniform assessment tools, protocols and best practices to achieve positive outcomes.
3. Focuses on care transitions, changes in patient status (bio-psycho-social), close monitoring and short-term action plans.
4. Navigates and brokers Medi-Cal, Medicare, community resources, CBAS MDT and caregiver on behalf of patient and facilitates unified decision-making for person-centered care



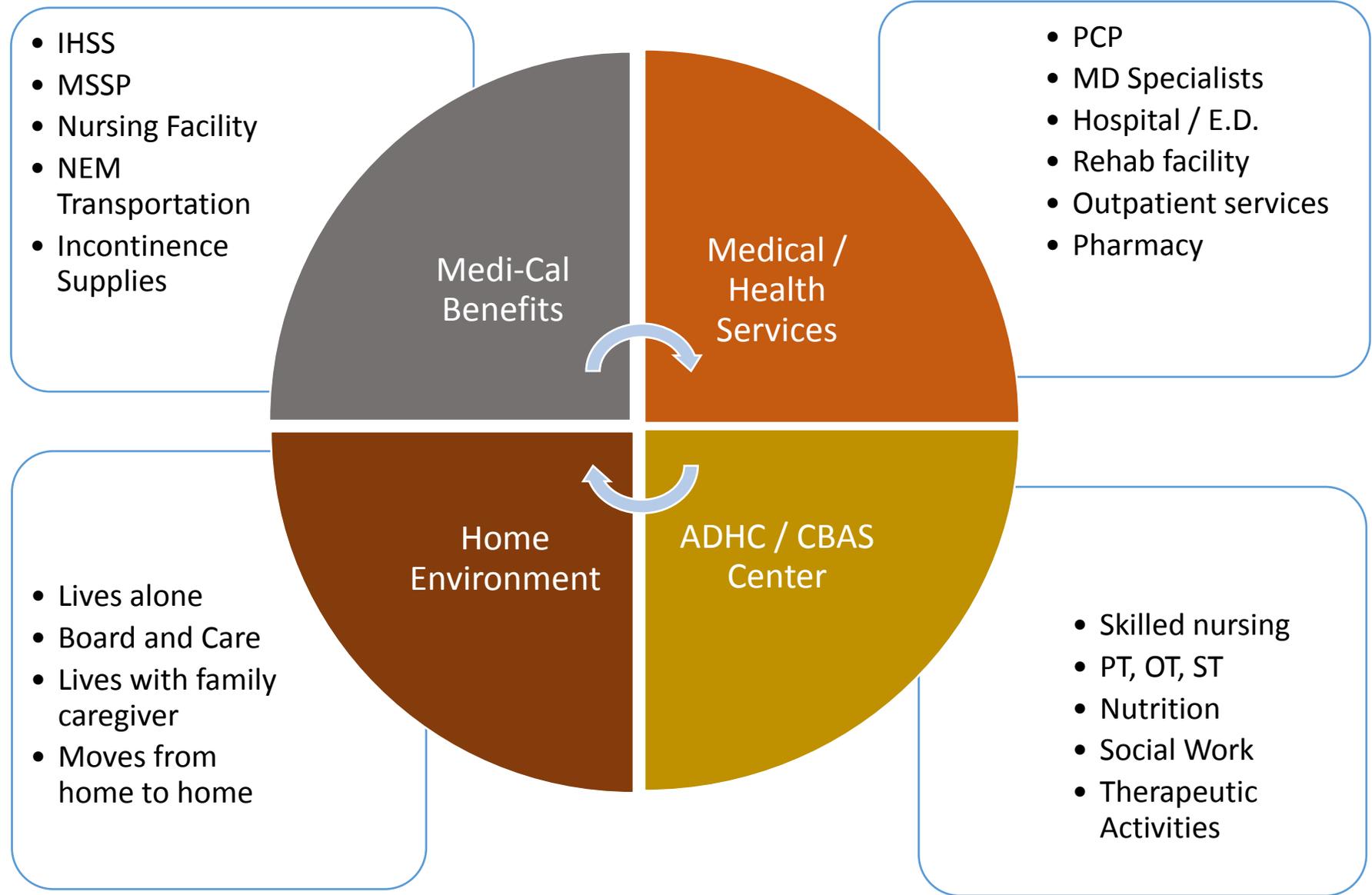
Core ADHC Inter-Disciplinary Model

Team support for CBHH participant and Caregiver:

- Skilled Assessments
- Person-Centered Plan of Care
- Planned skilled treatments/services
- Core daily ADHC services
- Team support for CBHH participant, caregiver & RN-N



RN-N CONNECTS ADHC TO THE PARTICIPANT'S ENTIRE CARE CONSTELLATION



Tools Developed for the CBHH Model



Quality and Triple Aim guide CBHH approaches:

- Health Home standards matrix cross-walks program design to national standards
- Assessment and data collection system via cloud-based TOPS™ system measures and benchmarks outcomes
- Person-centered assessment tools translated into 7 languages
- RN-N training in unbiased interview techniques and use of TOPS
- Weekly learning community meetings via webinar for training and case reviews are now in 3rd year
- Complete Operational Manual with forms, protocols and procedures ensures consistency for medication reconciliation, home visits, health literacy; health promotion; action planning, person-centered care, etc.





TOPS TRACKING OUTCOMES
FOR PROGRAM SUCCESS



*The patient centered
outcome system for
community-based
adult day services*

TOPS, Tracking Outcomes for Program Success, is an outcome measurement system developed by CAADS under a grant from the California Community Foundation in 2009-2010 and piloted among 8 adult day programs and Adult Day Health Centers in Los Angeles County.

It was adapted as the basis for conducting person centered assessments and measuring / benchmarking outcomes for the Community-Based Health Home.

Gwen Uman, RN, Ph.D, of Vital Research, helped develop TOPS, and continues to serve as project consultant.



TOPS Standardized Assessment Tools Include:



- 1) Health Status
- 2) Pain
- 3) Loneliness
- 4) Nutritional risk
- 5) Substance abuse
- 6) Perceived quality of life
- 7) Self-esteem
- 8) Depression
- 9) Mental status
- 10) Participant satisfaction
with the ADHC center services
- 11) Caregiver satisfaction
with the ADHC center services

- ✓ All assessment tools are translated into 7 languages:
(Chinese, Farsi, Korean, Russian, Spanish, Tagalog, Vietnamese)
- ✓ Most of these elements correlate to NCQA standards



Summary of CBHH Benefits and Alignment with 3.0 Concept Paper



- CBHH outcomes show great promise for cost avoidance for high risk/cost members
- 3 years of tested Health Home standards and outcomes in real world environment for high utilizing complex Plan members
- A mature Learning Collaborative is established among CBHH sites – ALE can help inform 2703 state plan project implementation
- Population served in CBHH aligns with the state’s 3.0 Concept Paper Eligibility Criteria (Pgs 6-8)
- CBHH services align with the 6 services in the state’s 3.0 Concept Paper (Pgs 8-12)
- CBHH Measures are aligned with state’s 8 core measures in 3.0 Concept Paper (Pg 30)
- Quality standards, outcomes and benchmarking are in place within CBHH model:
 - TOPS tools are adapted to this population and translated into 7 languages.



Where We Think the Model Can Go and Grow



- Ongoing support/development and quality oversight provided by ALE
- Expansion to other areas (Santa Clara and other sites will join in 2016)
- Continued adaptation of model to align with state's health home initiative and Plans' designs.
- Partnerships between CBHH and supportive housing and behavioral health providers
- Partnerships with other agencies, such as those with homeless outreach or behavioral health specialization
- Integration of further evidence-based practices, such as the IMPACT model for treating older adult depression, into the CBHH model
- Expansion of the learnings gained over 3 years can be utilized to train other agencies how to develop and launch a health home model
- Expansion to other states





Alliance for Leadership and Education



For more information about CBHH development contact:

Lydia Missaelides, MHA
Executive Director
Alliance for Leadership and Education
916.552.7400
lydia@caads.org



Comment received via email during comment period.

December 16, 2015

Health Home Program
Department of Health Care Services
1500 Capitol Mall
Sacramento, CA 95814
Submitted electronically to hhp@dhcs.ca.gov

Re: Comments on Health Homes for Patients with Complex Needs California Concept Paper Version 3.0

Dear Health Home Team:

The California Association of Medical Product Suppliers (CAMPS) appreciates the opportunity to comment on the HHP Concept Paper Version 3.0. CAMPS is a non-profit, statewide trade association representing the home medical equipment industry. Our mission is to promote access to quality home medical products and supplies for individuals living at home. CAMPS members provide service to more than 100,000 medically complex and chronically ill patients per year.

CAMPS has been following the Health Home Program (HHP) with great interest. Overall CAMPS agrees with the guiding principles and intended goals of the HHP proposal. However, as DHCS moves closer to finalizing this program CAMPS requests the following clarifications:

Section II.G.1: Member Assignment (p. 26)

The section indicates that member participation in the HHP is voluntary, however it is unclear whether members will be required to opt-in or opt-out. DHCS has utilized passive enrollment (opt-out) for SPD & CCI populations in the past with mixed results. CAMPS recommends that members be fully educated on their healthcare choices and be given the opportunity to opt-in the HHP. Regardless of the mechanism employed, stakeholders need to clearly understand how HHP participation will work.

Section III.B.2: County Readiness (p. 32)

DHCS has been clear that all plans in participating counties must be ready and willing to implement HHP at the same time. The section lays out the readiness requirements for all MCPs and other contracted entities. However, it does not explain what happens in two-plan or GMC counties if both or all health plans are not ready to implement according to the timeline. If or when that happens will implementation in that county be delayed or will that county be excluded from the HHP altogether? CAMPS suggests that DHCS add clarifying language to this section for the benefit of participants and stakeholders.

Section III.D: Program Evaluation (p. 35)

The section references cost neutrality and external program evaluation but fails to explain what happens if the program results in a net cost increase to the Medi-Cal program after two years post-implementation. If so, does the program stop immediately? What happens to the HHP participants? Does DHCS have a contingency plan to share with stakeholders? CAMPS recommends that DHCS amend this section to include specifics about what happens to HHP participants in the event that cost neutrality is not achieved.

Thank you for your dedication to making this program a success and for giving stakeholders the opportunity to comment. We look forward to engaging DHCS in future discussions related to HHP implementation.

Sincerely,

Bob Achermann
CAMPS Executive Director



December 23, 2015

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

Re: Comments on the California Concept Paper Version 3.0: 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 and questions on version 3.0 of the *California Department of Health Care Services Health Homes for Patients with Complex Needs Concept Paper*. 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 provide over 10 million outpatient visits each year, deliver 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 and questions.

We appreciate the Department of Health Care Services (the Department) releasing the next iteration of the concept paper with new and updated information. However, more detail is still needed about the specific payment methodologies and rates that will be provided to participating managed care plans and care management entities. It is critical that plan and provider rates be adequate and appropriate for the program population, requirements and expectations. We applaud the Department's efforts to ensure that plans foster the robust participation of safety net providers with experience serving the target population as the program's core Community-Based Care Management Entities (CB-CMEs). To the degree that inadequate payment rates are offered to CB-CMEs, it will be extremely challenging to achieve this goal. We would also ask that DHCS consider how much of the payments it provides to the plans should reasonably be passed on to the CB-CMEs, given how the roles and responsibilities are shared. DHCS should develop a transparent methodology to ensure that the level of payments to CB-CMEs correspond to the level of functions being provided by the CB-CMEs.

In addition, we are pleased to see the section of the concept paper noting that "as the Whole Person Care Pilot development continues, DHCS will ensure that the program and funding that are provided in counties that are also implementing HHP are complementary and not duplicative". 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 Whole Person Care Pilots in a complementary fashion, California has 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. Considering the likely overlap in goals, 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 ensure that counties can utilize either or both programs to improve the health and well-being of the target populations. As the details of both programs are developed, it will be important to have further guidance for plans and counties to ensure they can operationalize the programs in ways that avoid duplication.

Lastly, we would like to call your attention to some specific sections of the paper where we have additional comments and/or questions for the Department:

- ***Page 7: ELIGIBILITY CRITERIA***

We appreciate that the Department recognizes the importance of being able to refer beneficiaries into the program. We 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. Along these lines, can DHCS please clarify which of the criteria on page 7 patients will need to meet to be referred into the program? We recommend only applying the first set of criteria, pertaining to eligible chronic conditions. The additional criteria relate mostly to historical utilization patterns, which may not be available in the data and/or may not be predictive of current/future risk that the provider is able to identify in their assessment of the patient. In addition, has the “risk scoring tool selected by DHCS” already been selected? If so, or as soon as that information becomes available, it would be helpful to share with HHP stakeholders.

- ***Page 17: MEDI-CAL MANAGED CARE PLAN RESPONSIBILITIES***

The paper states that the MCP will “receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME.” What kind of claims/encounter reporting is DHCS envisioning from the MCPs and CB-CMEs? In addition, the paper is silent on how the CB-CMEs will be paid, i.e. bundled payment, fee-for-service, per member per month etc. Will DHCS be providing guidance to MCPs as to how to pay the CB-CMEs, or is this fully at the plan’s discretion?

- ***Page 18: COMMUNITY BASED CARE MANAGEMENT ENTITY RESPONSIBILITIES***

What is the expected timing for developing and finalizing the CB-CME assessment tool mentioned on the top of page 18? We understand it is being developed with MCP input. We recommend that it would be valuable to also have Medi-Cal provider input, particularly from those likely to serve as CB-CMEs.

- **Page 29: REPORTING**

When and how will the standardized reporting measures be finalized? It will also be helpful to clarify in future guidance the different reporting roles of the MCPs and the CB-CMEs, so both parties have time to prepare for the data collection required for program implementation.

- **Page 32: HEALTH HOMES PROGRAM TIMELINE**

The timeline states that the “first State Plan Amendment (SPA) submission to CMS” will take place in December 2015. Does this mean that the first SPA will include only Group 1 counties and subsequent SPAs will be developed and submitted for Groups 2 and 3? When does the clock start on the two years of enhanced FMAP? Does it start for each county as the county implements or by Group/SPA or some other timing?

We welcome the opportunity to discuss our comments and work collaboratively with the Department to launch a successful HHP that strategically aligns with the 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 or (510) 874-7115.

Sincerely,



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



December 23, 2015

Ms. Jennifer Kent
Director
California Department of Health Care Services
1501 Capitol Ave.
Sacramento, CA 95814

Dear Director Kent:

On behalf of the eight private, not-for-profit children's hospitals in California, the California Children's Hospital Association (CCHA) appreciates the opportunity to provide comments on the Health Homes for Patients with Complex Needs California Concept Paper Version 3.0. We appreciate that DHCS is focused on crafting a comprehensive approach to complex and chronic patients in the health care system but we remain concerned about the interaction between this proposal and the California Children's Services program.

Our concerns are two-fold. First, although the Health Homes Program (HHP) is a voluntary program, it has been mentioned as an approach to CCS redesign by state officials. This paper, however, is silent on how the HHP would interact with CCS. Second, much of the structure of the HHP is adult-oriented and inappropriate for or inattentive to the needs of children that may enter into the program.

We appreciate the opportunity to share our concerns and provide the following detailed comments:

Interaction with the California Children's Services Program

We have four recommendations related to the interaction of the HHP with CCS.

1. Consider explicitly excluding CCS from the eligibility criteria for HHP. We appreciate that the eligibility criteria identified on page 7 of the concept paper have been narrowed significantly from the first version circulated in November of 2014 and that the Department has set out some exclusion criteria. However, there is still a chance for CCS eligible children to be identified for the HHP using this set of criteria. Diabetes mellitus, chronic liver disease, hypertension, and certain Asthma presentations are all conditions which make children eligible for CCS. One approach to addressing this issue would be to amend the wording of the exclusion criteria on page 7 to include explicit reference to CCS, as follows (edits are in italics):

“Members determined to be more appropriate for an alternate care management program, *such as the California Children's Services program.*”

2. Establish a process for adding eligible conditions. It is unclear what the process will be for adding more eligible conditions to the current list. Since a number of conditions potentially eligible for inclusion in the HHP could overlap the adult and CCS population, we request that the department clarify what the stakeholder process will be for adding new conditions.
3. Communication to Health Plan Members. On page 25, the concept paper describes a member notification process that starts with DHCS running monthly or quarterly data reports to develop a list of the plan members whom managed care plans should contact in an attempt to enroll them into HHP. Because some CCS children will almost certainly be identified in the department's data reports, we strongly urge the department to work with stakeholders on the Medi-Cal Children's Health Advisory Panel and CCS Advisory Group to ensure that any communication to health plan members who are enrolled in the CCS Program are not confused about their rights or who is responsible for their care. Additionally, in the event that a CCS eligible child is enrolled in the HHP, we request that the Multi-Disciplinary Care Team should meet CCS care team criteria and that the clinical consultant be a CCS paneled physician appropriate for the child's medical condition.
4. Develop More Clarity Around "CCS Organized Delivery System Entities." The concept paper mentions that participation in the HHP is optional for "California Children's Services Organized Delivery System entities." We are unclear as to what these entities are; they do not currently exist in statute or regulation. Moreover, it is unclear why such entities would operate under different guidance than the CCS Program. For example, would HHP be limited only to children with HHP eligible conditions in the event such CCS Organized Delivery System entities opted in to the HHP? Or, would all children in CCS be eligible for HHP services? And how would that interact with CCS services? We strongly urge the Department to include a briefing on the development of the HHP concept at an upcoming CCS Advisory Group meeting in order to discuss these and any other questions about CCS interaction with the HHP.

Pediatric population in HHP

We have four recommendations regarding the appropriateness of some elements of the HHP for pediatric population.

1. Use health risk assessment tools appropriate to pediatric populations. In the description of the HHP network infrastructure, the concept paper states that the managed care plans (MCPs) and Community Based-Care Management Entities (CB-CME) should leverage existing managed care plan assessment tools and align with Cal MediConnect where possible. It identifies that MCPs have extensive experience with Health Risk Assessments for Cal MediConnect and SPD but that experience is not specific to a complex and chronic pediatric population. We respectfully request that the Department direct MCPs to use appropriate pediatric health risk assessment tools.
2. Add at least two more metrics from the Child Core Set to track quality in the pediatric population. The concept paper identifies a core set of eight quality metrics that MCPs should gather to track quality of care under the HHP. Of the eight, only one is taken from the Child Core

Set. We believe that at least two more metrics should be identified specifically for the pediatric population. The Child Core Set is currently being revised by HHS with input from the Children's Hospital Association and could provide additional appropriate quality metrics.

3. Clarify which entity is responsible for ensuring HHP member access to HHP services. Under the concepts advanced by the department, Managed Care Plans are responsible for attributing HHP members to CB-CMEs. CB-CMEs can be a number of different organizations, such as substance abuse treatment centers or public health departments. The concept of CB-CME is that they serve as the "single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services." The wording of this section creates some ambiguity as to who is ultimately responsible for HHP members receiving access to HHP services, the CB-CME or the MCP. We suggest that the Department clarify how CB-CMEs will be held accountable for providing HHP services since this is not covered in the concept paper.
4. Direct MCPs to match HHP patients with appropriate CB-CMEs. Because CB-CMEs are responsible for such an extensive amount of coordination and management of the needs of complex patients, we suggest the Department include direction to MCPs that patients should only be attributed to CB-CMEs who can adequately meet their clinical needs. For example, we would be concerned if a child with asthma and diabetes was attributed to a CB-CME run by a substance abuse disorder treatment provider.

Finally, we would note that the Center for Medicare & Medicaid Services recently released a proposed rule that greatly expands hospital and home health agency responsibilities with respect to discharge and transfer planning. We strongly suggest that the Department consider waiting to develop specific guidance around discharge and transfer planning in the Health Homes Program until the final rule is released in early 2016 to avoid duplication of effort and confusion around who is responsible for developing and transmitting discharge and transfer documents.

Thank you for the opportunity to provide our comments. If you have additional questions or require follow up information, please don't hesitate to contact me at 916-552-7116 or barellano@ccha.org.

Sincerely,



Bernardette Arellano
Director of Government Affairs

Comment received via email during comment period.

Good afternoon,

The California Department of Social Services Adult Program Division would like to submit the following comments regarding the Health Homes Program potential impact on In-Home Supportive Services (IHSS):

Implications for IHSS

The HHP is a person-centered care coordination program for high-risk, high-needs individuals with chronic health conditions.

- The HHP, as administered by the managed care plans, is required to coordinate services with available LTSS in the community. Accordingly, referrals to IHSS can be anticipated.
- County IHSS programs should be aware of the HHP as a possible means of satisfying unmet need among recipients with chronic health conditions who are at the maximum service authorization of 283 hours per month.
- IHSS social workers in the 30 HHP counties should be aware of the availability of the HHP as an alternative resource through the managed care plans (Cal Medi-Connect in the 7 CCI counties or Medicaid-only MCPs in the remaining 23 HHP counties). Note that HHP is not available through fee-for-service plans.
- Among the goals of HHP care coordination is identification of housing for HHP members who are homeless or in danger of becoming homeless. When an HHP member is temporarily or permanently housed, he or she may become eligible for services through IHSS.
- IHSS, CCT (“money follows the person”) and HHP share similar responsibilities under Olmstead, including providing LTSS that enable Californians to transition out of SNFs and into community-based settings. IHSS will need to coordinate with these programs, particularly in terms of performing pre-discharge assessments/reassessments.

Please let us know if you have questions. Thanks very much.

Aron Smith
CCI/Special Projects Coordinator
Adult Programs Policy & Quality Assurance Branch
Adult Programs Division
California Department of Social Services



December 22, 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 3.0

Via e-mail: 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 final concept paper titled, *Health Homes for Patients with Complex Needs (Version 3.0)*. 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 12.5 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) 552-7543 or akemp@calhospital.org.

Sincerely,

A handwritten signature in black ink that reads "Amber Kemp". The signature is written in a cursive, flowing style.

Amber Kemp
Vice President, Health Care Coverage



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

December 22, 2015

Re: CPCA Feedback on Draft Concept Paper 3.0 for Health Homes for Patients with Complex Needs

Dear Brian,

On behalf of the California Primary Care Association (CPCA) and more than 1,150 not-for-profit community clinics and federally qualified health centers across California, we thank you for the opportunity to comment on the draft Health Homes for Patients with Complex Needs (HHP) Concept Paper Version 3.0. Over the past many years, health center patients are increasing in complexity, many more presenting with co-occurring physical and behavioral health conditions that require increased care management by a diverse care team. California's safety net clinics have responded with by transforming their practice model to include targeted patient engagement, expanded clinical and non-clinical support services, and strengthened case management, but are working largely within a system that does not support the technology, partnerships, or additional services necessary to truly provide whole person care. It is our hope that Health Homes for Patients with Complex Needs will help CCHCs provide their patients with seamlessly coordinated services across all spectrums of their physical, behavioral, and social support providers. 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 demonstration can truly benefit the chronic and complex Medi-Cal patients that our community clinics and health centers (CCHCs) serve.

We appreciate the opportunity to comment on the State's concept paper outlining the basic tenants of the HHP. 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 7. 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). CPCA appreciates the consideration DHCS has shown in including chronic and complex conditions that have been shown to improve within a short time frame with increased interventions, like care coordination. While the program has selected conditions based on high acuity/complexity, we believe there is capacity to further improve

health outcomes by expanding the list of eligible conditions to include serious and complicated conditions like obesity and Hepatitis C.

Redwood Community Health Coalition CCHCs have piloted two health center projects for complex care management of Medi-Cal patients with multiple chronic diseases and high resource utilization, using health center employees and contracted staff for complex care management. Lessons learned from this pilot program included the need for a clinical review of managed care plan-identified eligible patients by a provider embedded in the health home. CPCA recommends that DHCS use a similar model for determining patient eligibility in the HHP, using a combination of managed care plan claims and primary care provider (PCP) clinical review. Only providers who have interfaced directly with the patient can determine which patients might be amenable and participatory in taking advantage of the extended services offered under the HHP.

Recommendations:

- CCHC providers recommend that Hepatitis C and BMI \geq 30 be added to the list of chronic conditions eligible for health home services.

Page 8. Comprehensive Care Management

The 3.0 concept paper currently lists palliative care and substance use disorder (SUD) services among required care management elements in the patient’s Health Action Plan. Current research has not shown great success in terms of primary care having a significant impact on palliative care costs over a two year time frame, and specialty providers and hospitals have traditionally been the lead entities in helping the patient manage most end-of-life conditions. However, one area where CCHCs are have experienced success relating to palliative care is in the area of Advanced Directives and/or Physician Orders for Life-Sustaining Treatment (POLST) forms, which is also a natural role for primary care and could have significant impacts on patient care coordination.¹ 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 a measure around increasing the use of Advanced Directives and POLST forms to help build the foundation for improved palliative care delivery throughout the State.

Additionally, serious mental health and SUD services overlap with existing categories of treatment available through the county mental health system, thus, county specialty mental health plan and substance use disorder plan participation in the health home network is critical to the demonstration. We recommend that DHCS develop a reportable metric that measures county MHP/SUD participation in the HHP and ensures that patients are able to access county-based SMH/SUD services.

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 require county mental health plan participation in the health home network and develop a metric to measure patient access to county-based SMH/SUD services.

¹ <http://www.chcf.org/articles/2015/02/polst-registry>

Page 10. Comprehensive Transitional Care

Specific transitional care services are clearly outlined in the concept paper. Given the high level of responsibility for care coordination, it is critical to ensure that hospitals participate in the HHP; and MOU requirements should be as streamlined as possible to ensure they do not serve as a barrier to participation and care coordination. Protocols and legal agreements for patient data transfer and information sharing should be in place between provider entities prior to the commencement of the demonstration in order to ensure that timely notification of beneficiary admittance to and discharge from the hospital occur.

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.² 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.

Recommendations:

- 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 must be in place prior to the commencement of the HHP in California.
- MCP should focus attention on technological infrastructure and tools, such as Health Information Exchanges (HIE), to mitigate proprietary challenges of different EMR systems among the HHP provider network.

Page 12. Health Information Technology (HIT)/Health Information Exchange (HIE)

We agree with DHCS' clear articulation of the importance of information technology in the success of the HHP. CPCA would like to acknowledge that while DHCS has heard feedback that in some areas relatively few providers have EHRs, this is not the case with California's CCHCs. Ninety percent (90%) of CPCA network clinic Medi-Cal patients were seen at a clinic with Meaningful Use Stage 1 attestation and 90% of CPCA network clinic Medi-Cal patients were seen at a clinic with Electronic Medical Records (EMR). It is true, however, that there is limited interoperability between systems. We believe that a high functioning, accessible HIE system is critical to the overall success of the HHP demonstration, especially as it relates to seamless transfer of care among emergency and primary care providers and a reduction in hospital admissions.

The manner in which this sections outlines EMR/HIT/HIE requirements appears to not require but rather encourage HPPs to electronically transfer data and patient information. We believe that data exchange is an absolutely critical step one to care coordination across different entities within the delivery system. Our fear is that without an HIE, there is no feasible means to support CB-CME's in accessing real-time patient health information or data sharing across the delivery system, and that lack of data exchange could be a critically disabling factor to California's success in the HPP program.

Recommendations:

² http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2478745

- Ensure that HIE with hospitals, MCPs, and other care providers is available and accessible to CB-CMEs serving HHP members.

Page 13. 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 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 as outlined in the State Medicaid Director letter dated 11/16/2010, CPCA recommends that DHCS add the following criteria for MCPs to consider 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 licensed behavioral health therapists on site and over 80% of CCCHCs report integrated behavioral health services for health promotion or crisis intervention available in primary care. DHCS notes that MCPs have existing relationships with the Medi-Cal county specialty mental health plans in each county to facilitate care coordination. In addition, many CCHCs and counties have leveraged partnerships for access projects centered on Mental Health Services Act programming.

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, Office of Statewide Health Planning Division (OSHPD) 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. Over 60% of CPCA health centers received at least one Blue Shield of California Foundation and/or New Access Point grant in 2014. These grants aim to increase access to comprehensive care/services for vulnerable populations by expanding the network of service delivery sites and by creating a more connected and collaborative network of providers.

Sources of Measurement for DHCS to consider: Blue Shield of California Foundation Safety Net grantee list, New Access Point Award list, existing Memorandums of Understanding (MOUs) with community partners

5. Data capacity 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. Ninety percent (90%) of CPCA network clinic Medi-Cal patients were seen at a clinic with Meaningful Use Stage 1 attestation and 90% of CPCA network clinic Medi-Cal patients were seen at a clinic with Electronic Medical Records (EMR).

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 60 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 15. Managed Care Plan Responsibilities

Individuals experiencing homelessness have significant barriers to treatment compliance. Achieving health stability for this population must begin with housing, and services must promote health and housing stability to improve health utilization outcomes. Across the state, CCHCs report insufficient and limited access to local resources for short and long term housing for the chronically homeless. In order to successfully provide whole-person, wrap around care, CB-CMEs will need support from HHP administrators to ensure that a housing first model is available for eligible members across all service areas.

Concept Paper 3.0 notes that many MCPs are exploring housing options with mixed stakeholder groups across various sectors to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. CPCA believes that a stakeholder group in an advisory

capacity is a great start but that resources must be invested in ensuring adequate housing is available to CB-CME patients prior to starting the HHP demonstration. With the short timeline for demonstrating success, we fear that anything other than immediate deployment of resources will consume valuable time.

Recommendations

- The stakeholder group should identify evaluation measures that demonstrate sufficient resources to meet the needs of targeted patients experiencing homelessness.

Page 17. Community Based Care Management Entity Criteria (CB-CME)

Lessons learned from similar programs for chronic and complex conditions in other states included care management as most effective when “anchored in the practices where patients receive their care.”³ We were therefore pleased to see that DHCS recognizes the importance of health home services being delivered in a continuous and on-going manner 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.”⁴

The draft Concept 3.0 paper mentions that the criteria for CB-CME selection will be determined by MCPs through a process similar to current MCP provider certification and contracting processes. MCPs will be provided with general guidelines and requirements, including a standardized assessment tool, in order to select, qualify, and contract with CB-CMEs. CPCA encourages DHCS to include the above mentioned points (see: HHP Network Infrastructure) to ensure the assessment adequately assesses key elements of patient and family centered practice.

As DHCS develops specific operational requirements with support from stakeholder workgroup(s), we believe these work groups should consist of the representatives that will be engaged in HHP in order to ensure that the program supports the CB-CMEs (primary care, supportive housing, narcotic treatment providers, etc.) and does not duplicate existing infrastructure. In addition to reviewing administrative data and criteria to determine HHP eligibility, it’s critical that primary care providers with experience serving the HHP target population be included in future technical workgroups or review described on pages 17-18 that determine the eligibility assessment criteria for participation as a CB-CME. CCHC are, by definition, community-based providers who develop programs and interventions directly in response to the unique needs of their target patient populations. The clinical knowledge and background in coordinating care for HHP eligible individuals that is available through CCHC PCPs is an important resource for DHCS and MCPs in designing this program.

CPCA applauds the flexibility that DHCS has incorporated in the three models of care management. While we agree that Model I, which embeds care managers on-site in CB-CME offices is ideal, we recognize that existing workforce limitations, especially those experienced by our rural colleagues, may necessitate alternative models of case management.

Recommendations:

- Ensure that assessment tools incorporate critical elements of patient and family centered care principles, such as
 - Health Home experience with high-risk populations

³ <http://jama.jamanetwork.com/article.aspx?articleid=2099528>

⁴ <http://jama.jamanetwork.com/article.aspx?articleid=2099528>

- Behavioral Health Integration
- Serving the Eligible Target Population:
- Strong relationships with service-delivery and community partners:
- Data capacity to track patient utilization
- Payment Reform Readiness
- Include representation of CB-CME stakeholders in the HHP technical work groups in addition to representation from DHCS and the managed care plans.
- The technical workgroup(s) mentioned on pages 17-18, which will be convened to develop a protocol for clinical review of CB-CME eligibility should include representation from providers currently serving the HPP eligible population.

Page 24. Multi-disciplinary Care Teams

We agree with the suggestions for HHP team, as presented, and believe incorporating a wide variety of professional and para-professional personnel will lead to improved patient outcomes. 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.⁵

Per our comments from draft Concept Paper Version 2.0, we are pleased that pharmacists have been included as members of the multi-disciplinary care team as clinical consultants. Medication management and adherence will be a key component in the success of improved patient care coordination.

Of note, we believe sustainable success will rely on a strong workforce of effectively trained personnel and the continuous engagement of organization leadership both at the clinic and MCP levels.

Recommendations

- 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.

Page 25. 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.⁶

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

⁵ See Page 8: <http://nyshealthfoundation.org/uploads/resources/making-the-connection-community-health-workers-sept-2012.pdf>

⁶ <http://nyshealthfoundation.org/uploads/resources/chcs-health-homes-outreach-report-april-2014-1.pdf>

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 26. 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.

CPCA notes that version 2.0 included a tiered payment model based on patient acuity, which has proven to be a best practice in health home demonstrations in other states.⁷ We note that in version 3.0, reference to a tiered payment model has been removed, though DHCS still acknowledges that tiers will be used to determine intensity of HHP services provided to patients. We hope that the removal of a tiered payment model in version 3.0 is an oversight, and that DHCS does not expect CB-CMEs to provide higher-intensity services to the most complicated and expensive populations without funding to adequately reimburse for those services.

The use of a tiered payment and acuity model is also a prime opportunity for DHCS to include metrics that reflect the impact and importance of social determinants of health, including adjustments for behavioral health co-morbidity, homelessness, and for monolingual non-English speakers.⁸ Under the managed care organization structure, risk stratification does little to account for the complexity and life circumstances of CCHC patients. Social determinants of health are already measures that can be captured and accounted for through tools available in ICD-10 and could potentially be incorporated into development of the PMPM rate via a risk stratification methodology to ensure that safety net providers receive fair rates. The rate development process and assumptions behind the final PMPM should be transparent to stakeholders, with rates appropriate to meet the needs of the patients being served. See Appendix Item 1 for a list of ICD-10 codes already in place that can be used to track social determinants of health.

Recommendations:

- DHCS should use a tiered rate development structure to ensure that payment for HHP services is on par with the intensity of the services required to meet the needs of the HHP patients.
- Metrics that account for social determinants of health should be included in the demonstration and incorporated into the development of the tiered payment structure.

⁷ <http://governor.nh.gov/commissions-task-forces/medicaid-care/documents/mm-04-03-2014-chcs-medicaid-home.pdf>

⁸ See page 48:

http://www.health.state.mn.us/healthreform/homes/payment/PaymentMethodology_March2010.pdf

Page 28. MCP Payments to CB-CMEs and Others

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.⁹ 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 to payment for services to those performed by members of the health home team, such as those listed on pages 23-25 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.

CPCA is willing to work with DHCS staff to develop processes to ensure that payments to support the HHP 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.

In developing the PMPM payment structure, we urge DHCS to consider developing safeguards to ensure that the bulk of the funding available for the demonstration flow towards supporting care coordination for the patients. New York's health home demonstration, for example, limited managed care plans to a 3% withholding of payments for program administration and evaluation.¹⁰

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.
- 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.

Page 29. Reporting

CPCA feels strongly that diversion from emergency department for non-emergency visits should be a core measure, not a utilization measure. The implications of this diversion with respect to cost, specialist intervention, and avoidable hospitalizations are at the heart of the HHP.

Recommendation:

- Incorporate emergency department visits as a core reporting measure as opposed to utilization measure.

Page 30. HHP Interaction with Existing Medi-Cal Programs

We appreciate the recognition on page 31 that HHP patients without conditions that are appropriate for specialty mental health services should receive behavioral health treatment at their CB-CME. We believe

⁹ <http://www.gpo.gov/fdsys/pkg/FR-2014-05-02/html/2014-09908.htm>

¹⁰ https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm

this is one of the core reasons why physical and behavioral health integration is a key eligibility criteria for MCPs selecting CB-CMEs.

Page 32. County Rollout Schedule

CPCA agrees with DHCS' choice to phase-in HHP implementation. There will undoubtedly be lessons learned from phase one participants that will help to inform future iterations of the HHP implementation. We do question, however, the logic behind which counties have been chosen for implementation at each phase. For example, Alameda County is well prepared for systematic, complex care management, but is slated for phase three implementation. Given their experience and high functioning managed care infrastructure and ability of CCHCs in Alameda to serve as CB-CMEs, it seems logical to include them at the start.

Recommendation:

- Reconsider the inclusion of Alameda County in phase 3 of the HHP. Alameda county CCHCs feel prepared to participate in an earlier phase and take on the responsibility of CB-CMEs in partnership with their MCPs.

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 and we look forward to continuing to partner with DHCS as this program is further refined. For questions or clarifications relating to the comments above, please contact Meaghan McCamman, Associate Director of Policy at CPCA (mmccamman@cpca.org), and she'd be happy to assist you.

Thank you,

Meaghan McCamman
Assistant Director of Policy
California Primary Care Association

CHILDREN NOW

December 21, 2015

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

1404 FRANKLIN STREET \ SUITE 700
OAKLAND CALIFORNIA 94612
T.510 763 2444 F.510 763 1974

CHILDRENNOW.ORG

ADDITIONAL OFFICES
LOS ANGELES SACRAMENTO

Re: Health Homes for Patients with Complex Needs California Concept Paper Version 3.0 (Draft-Final)

Dear Health Home Program Team,

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 have commented on previous draft concept papers that DHCS has produced and appreciate that significant progress has been made in developing policies concerning eligibility criteria, Health Homes Program (HHP) services, HHP network participant responsibilities, and the implementation schedule that are included in the latest draft, the "Health Homes for Patients with Complex Needs California - Concept Paper Version 3.0 (Draft-Final)" ("concept paper"). We would like to take the opportunity to comment on the concept paper and the importance of serving California's children through the state's HHP. A subset of the following comments are potentially relevant for informing the mandatory consult of DHCS with Substance Abuse and Mental Health Services Administration (SAMHSA) and for the submission of California's State Plan Amendment (SPA), scheduled for late December, 2016. We intend the remaining comments to be helpful for developing additional policy and implementation plan details that will be determined following submission of the SPA.

Trauma-informed care. Given the high incidence of trauma, the link between trauma and chronic physical and behavioral conditions,¹ and the Department's focus on persons with high costs, high risks, and high utilization – and specifically on individuals experiencing homelessness – it is exceedingly likely that a large fraction of the target population will have experienced significant trauma. In fact, high rates of Adverse Childhood Experiences (ACEs), which include specific types of abuse, neglect, and household dysfunction, have been linked in California to elevated rates of asthma, chronic obstructive pulmonary disease (COPD), diabetes, coronary artery disease, dementia, substance abuse (linked to substance use disorder),

¹ A Hidden Crisis: Findings on Adverse Childhood Experiences in California (2014, November 6). Retrieved from <https://app.box.com/s/nf7lw36hjr5kdfx4ct9> on September 4, 2015.

and depression – nearly every condition listed as an eligible chronic condition for HHP membership. Adopting a trauma-informed approach and providing trauma-informed care can provide many benefits for members, families, communities, service organizations, and staff, including benefits that support the goals of the HHP – e.g., the overarching goal of the Triple Aim (p.4), strengthening team-based care (p.4), and ensuring that health home providers appropriately serve members experiencing homelessness (p.5). These benefits include improved screening and assessment processes, treatment planning, and placement; a reduced risk for re-traumatization; enhanced communication between clients and treatment providers, thus decreasing risks associated with misunderstanding the member’s reactions and presenting problems or underestimating the need for appropriate referrals for evaluation or trauma-specific treatment; and increased cost-effectiveness resulting from a better initial and ongoing match between clients and services.² Success in recruiting eligible HHP members will be unnecessarily limited without the adoption of a trauma-informed approach; e.g., adopting this approach will limit the number of members are excluded because the member is uncooperative (per the exclusion list on p.7).

We recommend that the trauma-informed approach be noted in the concept paper’s definitions of Health Homes Program Services. This would be very simple to include by changing each reference of “Communication and information will meet health literacy standards and be culturally appropriate” to “Communication and information will meet health literacy standards and be culturally appropriate and trauma-informed.” In addition to modifying this phrase, which appears under Care Coordination (p.9), Health Promotion (p.10), Comprehensive Transitional Care (p.10), Individual and Family Support Services (p.11), and Referral to Community and Social Supports (p.12), we suggest its inclusion under Comprehensive Care Management (pp.8-9). Furthermore, we urge the explicit inclusion, under Referral to Community and Social Supports (p.11), of “rape, domestic violence, and other trauma services” in addition to “housing, food and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services.”

Managed Care Plans (MCPs) and Community-Based Care Management Entities (CB-CMEs) should be required to incorporate the trauma-informed approach, perhaps by adding additional bullets under MCP Duties (p.17) and CB-CME duties (pp.21-22) describing how MCPs and CB-CMEs will require and support Multi-Disciplinary Care Team Members in using a trauma-informed approach in their interactions with HHP members. CB-CMEs should explicitly include organizations that specialize in treating trauma; i.e., we recommend including as an additional bullet under “Certification” on p.21: “Providers serving survivors of rape, domestic violence, and other trauma.” We appreciate that the concept paper includes trauma-informed care practices as part of the role of a Dedicated Care Manager (p.23). We urge that this suggestion be strengthened into 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 HHP members, including Community Health Workers and Housing Navigators. To support MCPs and CB-CMEs, trauma-informed approaches should be incorporated as a part of the technical assistance available to health home network providers (pp.34-35). Finally, 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.31).

We further recommend, in support of the above recommendations, that DHCS require or encourage participating providers to adopt the trauma-informed approach developed by SAMHSA, i.e., “A program, organization, or system that is trauma-informed: 1. *Realizes* the widespread impact of trauma and

² Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801, p. 9. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. Retrieved from <http://store.samhsa.gov/shin/content/SMA14-4816/SMA14-4816.pdf> on September 4, 2015.

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*.” A trauma-informed approach reflects adherence to key principles: 1. Safety; 2. Trustworthiness and transparency; 3. Peer support; 4. Collaboration and mutuality; 5. Empowerment, voice, and choice; and 6. Cultural, historical, and gender issues.⁸

Eligible populations. Children Now recognizes that DHCS has conducted feasibility studies and consulted with experts to select the chronic conditions upon which health homes eligibility will be based. The list of eligible physical and behavioral health conditions (p.7) includes asthma and diabetes, which we believe are critical for targeting pediatric populations who could benefit the most from the benefits provided by health homes. We are disappointed, however, that trauma- and stressor-related disorders are not included. We believe that the myriad of long-term, costly health effects of toxic stress caused by childhood trauma, ACEs, and homelessness merit the inclusion of these conditions, especially since those long-term negative health effects include the very conditions that *are* included as eligible conditions. We urge for this decision to be reconsidered, and think there are multiple ways that this population could be included in the state’s HHP, including:

- Adding “Trauma- and Stressor-Related Disorders” as an eligible chronic condition on the list of conditions for which at least two are required (p.7, first bullet)
- Adding “Trauma- and Stressor-Related Disorders” as an eligible chronic condition on the list of conditions for which one is required (p.7, third bullet)
- Adding trauma- and stressor-related disorders or an alternate criterion intended to capture this population (e.g., 4 or more ACEs) as a factor in the specific risk-scoring tool selected by DHCS (p.7, fourth bullet)
- Adding “A Trauma- and Stressor-Related Disorder” or an alternate criterion intended to capture this population (e.g., 4 or more ACEs) as an additional Targeted Engagement List criterion (p.7, after the sixth bullet)
- Adding “Trauma- and Stressor-Related Disorders” to “Chronic Renal Disease” as a HHP eligible condition that is not included in the Targeted Engagement List but may be referred for MCP approval (p.8)

We believe that excess BMI (>30) warrants similar inclusion as an eligible condition given the link between obesity and eligible chronic diseases (as well as trauma- and stressor-related diseases) and the potential for improved health outcomes and cost savings for individuals with excess BMI – and can be included in essentially the same variety of ways as described above. Finally, we believe that developmental disabilities and autism spectrum disorders (e.g., see Maine and Missouri’s approved health home SPA), fetal alcohol syndrome, and neonatal withdrawal symptoms from maternal use of drugs, merited consideration in order 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 the considerations taken into account in the decisions to exclude or not consider for analysis these conditions, and hope that any future deliberations to expand the scope of the state’s HHP to include additional eligibility criteria will include these conditions. We appreciate that the department plans to make available the data and processes used to develop the eligibility criteria (p.8) and urge that the data and processes be made available to all stakeholders – not just those participating in HHP technical workgroups – and that age is included as a demographic element to be reported.

⁸ Trauma-Informed Approaches and Trauma-Specific Interventions. (2015, August 14) Retrieved from <http://www.samhsa.gov/ncic/trauma-interventions> on September 4, 2015.

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 in its draft SPA 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.

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. We appreciate that DHCS acknowledges that "Fee-For-Service (FFS) members who meet HHP eligibility criteria will have the choice to enroll in Managed Care to receive their HHP services" (p.13), and that this iteration of the concept paper includes clarification that HHP services will not be provided through the FFS delivery system. We recommend further details regarding the process by which FFS Medical members will be identified and informed of their HHP eligibility and provided information on how they can opt in to Managed Care to access HHP services. These further details are necessary because the section on Member Assignment (p.25) states that MCPs will enroll eligible members and send a letter providing an opportunity to opt out of the HHP. No information applicable to FFS members 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.

Inclusive health homes teams. The concept paper specifies HHP Network Infrastructure, and specifically, the role of community health workers (p.24). 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., on p.25: "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." HHP members and their family members or other chosen representatives should be active participants in their care planning, and we appreciate the inclusion of a section on Health Promotion (p.10) that provides details on required health promotion services in the concept paper.

Social determinants of health. We appreciate that CB-CMEs 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.22). 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 CB-CME websites. We also appreciate the explicit reference to specific

community and social supports, i.e., “housing, food and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services” (p.12), and as noted earlier, urge the addition of transportation services and rape, domestic violence, 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 embraced and explicitly referenced, e.g., under Guiding Principles (pp.3-6), in the definition of Referral to Community and Social Support (p.12; 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.13-15; e.g., “Improving member outcomes by coordinating...social support needs that address the social determinants of health.”

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.3), and impact on the Triple Aim as a primary goal of the program evaluation (pp.35-36). 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 (pp.29-30), 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 2, p.30); and
- MMA – Medication Management for people with asthma (since asthma is included as an eligible chronic condition).

When possible – e.g., MMA and AMB (Ambulatory Care, included in Table 3, p.30) – 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 appreciate the inclusion of member and provider surveys/self-assessments as additional tools that may be used. We suggest that DHCS strengthen this language by changing “may be utilized” to “will be utilized,” and additionally consider for inclusion 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).

Timeline. DHCS had previously outlined an aggressive timeline for implementing the state’s Health Home Program, raising concerns that the timeline would not allow 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 appreciate the new timeline in the concept paper, which takes a more 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 request that similar attention be paid to ongoing health home network adequacy throughout implementation – not just at the onset. It is unclear whether network adequacy or other factors were taken into account in crafting the proposed HHP county implementation schedule (p.33), but we urge that the thinking underlying scheduling decisions be articulated, specifically 1) implementation dates for members with SMI occurring six months prior to implementation dates for

other eligible members, and 2) the specific groupings of counties by implementation date (Group 1, with an initial implementation date of January 1, 2017; Group 2, with an initial implementation date of July 1, 2017; Group 3, with an initial implementation date of January 1, 2018; and the remaining, unscheduled counties).

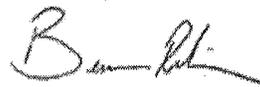
Stakeholder engagement process. We appreciate the creation of this overarching website and its inclusion of links to more detailed information, e.g., different versions of the HHP concept paper and Frequently Asked Questions. We believe that written comments submitted to DHCS on this version of the concept paper, as well as those responding to any future solicitation, should also be made available here. 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 the section devoted to HHP Interaction with Existing Medi-Cal Programs (pp.30-31) include the California Children’s Services (CCS) Program.

We thank you for your consideration of these matters, and commit to continuing to work 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 future technical workgroups that DHCS may form. If you have any questions about Children Now’s feedback, please contact Ben Rubin at 510-763-2444 x133 or brubin@childrennow.org.

Sincerely,



Kelly Hardy
Senior Managing Director, Health Policy



Ben Rubin
Senior Associate, Neurodevelopment and Health



County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
1600 PACIFIC HIGHWAY, ROOM 206, MAIL STOP P-501
SAN DIEGO, CA 92101-2417
(619) 515-6555 • FAX (619) 515-6556

DEAN ARABATZIS
CHIEF OPERATIONS OFFICER

December 28, 2015

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814

RE: COMMENTS ON CONCEPT PAPER 3.0: HEALTH HOME PROGRAM FOR PATIENTS WITH COMPLEX NEEDS

Dear Health Home Program Team:

The County of San Diego Health and Human Services Agency is writing to provide feedback and associated recommendations on Concept Paper 3.0, in the sequence of the relevant Paper section.

II A. Eligibility Criteria

Creating the Targeted Engagement List using administrative data will depend upon having timely data that include diagnostic and utilization information on Serious Mental Illness (SMI) and Substance Use Disorder (SUD) as well as physical illness. We have concerns that the Department of Health Care Services (DHCS) may not have the necessary analytic staff to merge data from the multiple Managed Care Plans (MCPs) plus the county Mental Health Plan (MHP), to deal with the volume of claims generated by the now much larger Medi-Cal population, and to provide the necessary data updates in a timely manner on an ongoing basis. To date, the only analyses that DHCS has shared with stakeholders have been on claims no more recent than 2011 at an aggregated level, so we have no evidence of the analytic capability that will provide the foundation upon which the HHP will rest. We recommend that University of California faculty who conduct health services research using Medi-Cal claims be asked to provide their expertise and work with DHCS at least for the first year of HHP implementation until the necessary claims processing procedures can be standardized and validated.

In addition to specific ICD 9/ICD 10 diagnostic codes, the Targeted Engagement List criteria will include a predictive risk score based on a risk-scoring tool still to be determined. Given the importance of this risk assessment, we recommend that the specific tool should be selected by the Technical Advisory Committee and that this Committee include behavioral health professionals with expertise in this specific subject area.

Further, the Targeted Engagement List criteria currently specify at least one inpatient stay or three or more Emergency Department (ED) visits. We request that inpatient stays in a psychiatric hospital and admissions to an Emergency Psychiatric Unit (EPU) be specifically included in these utilization criteria.

Finally, if these suggestions are accepted, these eligibility criteria should make it possible to consistently identify the highest-risk Medi-Cal beneficiaries who can be expected to benefit from the HHP. We are concerned that until you have analyzed current data and defined the population that can

be accommodated within the funding allocated, arbitrarily limiting the HHP to 3 – 5 percent of the population will compromise the transparency of the selection process.

II B. Health Home Program Services

“Referral to Community and Social Supports” (#6) specifies identifying individual and family needs and community resources to meet these needs and “actively managing appropriate referrals”, but it does not sufficiently address the importance of requiring face-to-face outreach, engagement and care coordination for HHP members. In San Diego, the CMS Community-based Care Transitions Program (CCTP) for Medicare Fee-for-Service beneficiaries and Cal MediConnect for the dually eligible population have both demonstrated that in-person interaction is essential to achieving improved clinical outcomes for complex clients. Providing “warm hand-offs” to help the member navigate through the process of obtaining services and checking in with members routinely through in-person or telephonic contacts to ensure the member is accessing the required social services are also essential.

II D. Health Homes Program Network Infrastructure

1. Leveraging Existing Managed Care Plan Assessment Tools

DHCS notes that it “will align new requirements for care management and tools with those currently being used by MCPs for care coordination, including aligning with Cal MediConnect where possible” (p. 13). The experience with Cal MediConnect to date is that a significant fraction of eligible beneficiaries are not receiving the required Health Risk Assessment that is the basis for developing the Health Action Plan (HAP). Therefore, more attention must be paid to effective outreach and engagement.

III A. HHP Interaction with Existing Medi-Cal Programs

1. Mental Health and Substance Use Disorders

As currently written, the Concept Paper indicates that “MHPs can perform MCP HHP responsibilities through a delegation contract with the MCPs in the county” (p. 31). We request that DHCS require MCPs to contract with county Mental Health Plans (MHPs) to perform MCP HHP responsibilities for HHP members who want to receive their primary HHP services from their MHP-contracted provider acting as a designated CB-CME and that the requisite reimbursement for administrative costs be provided to the county MHP.

In closing, we also request that DHCS give further consideration to managing the possible conclusion of the two-year demonstration program, especially if desirable outcomes have been achieved for HHP participants. Once a benefit has been provided, even an optional one, expectations have been created that need to be fulfilled in the future. What funding sources will be available to support continuation?

Thank you for your consideration of these comments. We welcome the opportunity to discuss them with you in detail.

Sincerely,

Peter Shih
Health Care Policy Administrator

cc: Nick Macchione, FACHE, Agency Director



251 S. Lake Avenue, Suite 800
Pasadena, CA 91101
direct (626) 774-2300
fax (626) 395-0498
dignityhealth.org

December 23, 2015

Ms. Jennifer Kent
Director, Department of Health Care Services (DHCS)
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov

Re: Comments on Health Homes for Patients with Complex Needs, Version 3.0

Dear Director Kent:

On behalf of Dignity Health and our 32 hospitals in California, I am writing to express our support for the Department of Health Care Services' (DHCS) *Health Homes for Patients with Complex Needs California Concept Paper Version 3.0 (Draft-Final)*, and gratitude for the opportunity to provide comments.

Dignity Health's mission is to deliver high-quality, compassionate affordable care to the communities we serve with preferential focus on the poor and vulnerable. Committed to reform principles and the successful implementation of the Affordable Care Act (ACA), Dignity Health is pleased with the overarching policy goals and objectives of the Health Homes Program (HHP). We appreciate 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 12.5 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 community-based long-term services and supports (LTSS).

Dignity Health appreciates DHCS' commitment to ensure sufficient provider infrastructure and capacity to implement HHP. 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, Dignity Health 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. Dignity Health is pleased with DHCS' stated intent to provide flexibility in how CB-CMEs are organized so that CB-CMEs can best achieve HHP goals.

Dignity Health offers the following specific comments and recommendations to strengthen Concept Paper Version 3.0:

Our primary concern is with the timeline of the roll-out as proposed by DHCS. While we recognize and understand the need for a deliberate roll-out of HHP by groups, a 30-month roll-out as outlined in the concept paper presents significant ramifications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties. Group 2 and 3 counties have, in fact, the highest rates of poverty and social barriers to accessing appropriate care. Though many of these counties have developed means of addressing these barriers to care, along with provider capacity, delaying these services until early to mid-2018 will certainly mean the most vulnerable beneficiaries will continue to experience poor health outcomes and high costs.

State initiatives will be difficult to sustain without the promise of HHP services to integrate care at the systems and individual beneficiary level, such as the Whole Person Care pilot and the Medi-Cal Drug Organized Delivery System. At the same time, California will have to bear the costs of poorly managed care among those expansion beneficiaries with complex conditions, and will be required to pay for more of the costs of HHP services for expansion beneficiaries.

Moreover, evaluation results may not be available until well after DHCS has to determine whether to use State General Fund resources to support the ongoing costs of HHP services for Group 1 and Group 2 counties. If implementation in these counties is delayed, this could result in under-estimating the impacts of HHP during the evaluation timeframe. We are very concerned HHP may never reach those with the greatest need due to failures in full implementation, should services in mostly small, rural counties fail to make any measurable impact.

We therefore recommend the following:

- Include at least one large county with high rates of poverty and providers with capacity, like Alameda or Los Angeles, in Group 1.
- Compress the timeline by allowing all eligible beneficiaries to access the benefit by October 2017.
- Allow the Whole-Person Care pilot to fund HHP-like services in the years before HHP implementation begins in counties accessing the pilot.

As DHCS develops the terms of the timeline and which counties by groups are included in the roll-out, we very much appreciate allowing for continued robust stakeholder input before finalizing California's State Plan Amendment.

With Medi-Cal beneficiaries experiencing homelessness particularly in mind, Dignity Health offers the following additional comments and recommendations:

Eligibility Criteria

- Allowing CB-CMEs to use, in addition to administrative data, other sources of data to refer beneficiaries to the HHP program; and fostering a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program.
- Adding chronic renal disease, HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to the list of eligible conditions
- Including “chronic homelessness” as an acuity factor.

Tiered Payment Structure with a Homelessness Modifier

- Extending the modifier to two years or less in housing, as consistent with the definition of chronic homelessness in Assembly Bill 361.
- Enabling CB-CMEs to receive the modifier only if meeting the requirements included in AB 361 or partnering with agencies who do meet the criteria of delivering HHP services to homeless beneficiaries.

Definitions of Services

- To the definition of *Comprehensive Care Management*, adding language to include in-person outreach and engagement, and gathering of information about the beneficiary, similar to the definition in CMS guidance; as well as, individual housing transition and tenancy sustaining services recognized in the CMS Informational Bulletin (housing-related activities for beneficiaries experiencing chronic homelessness).
- To the definition of *Comprehensive Transitional Care*, adding language to recognize the need for long-term/permanent supportive housing beyond “transitional housing” post-discharge to prevent avoidable admissions and readmissions.
- To the definition of *Individual & Family Support Services*, adding language to encourage the beneficiary’s own goals to drive any connections with family, friends, or other potential support systems.
- To the definition of *Referral to Community & Social Supports*, adding language to include active linkage to social systems and services, such as with housing providers offering warm hand-offs to help the beneficiary navigate through the process of obtaining services impacting the member’s health, and routine check-in with beneficiaries to ensure the beneficiary accesses social services he or she requires. If housing navigation services are not included in the definition of care management, adding housing navigation services to the definition of referral to community and social supports.

Managed Care Plans (MCPs) and Community Based Care Management Entities (CB-CMEs)

- Encouraging MCPs and CB-CMEs rely on assessments and care plans recognized as evidence-based.
- Developing a simplified, expedited process for certifying CB-CMEs.
- Including “homeless continuums of care” and “homeless coordinated entry systems” in the list of stakeholders; ensuring that providers with experience serving frequent utilizers of health services and those experiencing homelessness, are available and included in any model as needed. Dignity Health has experienced firsthand the value of such a model. Our hospitals have been actively participating in Corporation for Supportive Housing’s 10th Decile Project, partnering with various providers, including FQHCs and housing/homeless providers with highly-specialized expertise, to effectively provide services within the health-housing-healing spectrum of care for those patients who were once chronically homeless. With this model, Dignity Health together with our partners has been able to ensure that comprehensive, coordinated, patient-centered care across the health continuum was delivered and readmissions reduced.

Dignity Health is grateful for the opportunity to comment on Concept Paper 3.0. We look forward to the successful implementation of the Health Home Program.

Sincerely,



Rachelle Reyes Wenger
Director, Public Policy & Community Advocacy

DOWNTOWN WOMEN'S CENTER



442 South San Pedro Street
Los Angeles, California 90013
T: 213.680.0600 | F: 213.680.0844
www.DowntownWomensCenter.org

December 22, 2015

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov

Re: Comments on Health Home Program for People with Complex Needs, Concept Paper 3.0

Dear Health Home Program:

On behalf of Downtown Women's Center (DWC) I am writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. Founded in 1978, DWC's mission is to end homelessness for women in Los Angeles. To achieve this, we provide gender-responsive services including access to basic needs and resources, health and well-being services, education and job readiness programs, and permanent supportive housing. Because of the focus of our organization, we are commenting primarily on the impact of provisions of Concept Paper 3.0 on Medi-Cal beneficiaries experiencing homelessness.

We have great concerns with the timeline as proposed by DHCS for the beneficiaries in Los Angeles County. Given that Los Angeles County has the largest amount of people experiencing homelessness who would qualify for the Health Home benefit, delaying these services until early to mid-2018 will certainly mean the most vulnerable beneficiaries will continue to experience poor health outcomes and generate high costs. DWC recommends to DHCS to compress the timeline by allowing all eligible beneficiaries to access the benefit by October 2017 at the latest. Whatever DHCS is inclined to include in terms of timeline, we recommend allowing for more robust stakeholder input on the timeline and counties included in each group before finalizing California's State Plan Amendment.

Additionally, in drafting the Health Home State Plan Amendment, we recommend the following changes to proposals outlined in Concept Paper 3.0:

- Regarding eligibility criteria, we recommend—
 - Adding chronic renal disease, HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to your list of eligible conditions.
 - Requiring CB-CMEs be responsible for engaging, in person, members who do not respond to a letter that they are eligible, and that the engagement rate be reserved for in-person, face-to-face engagement activities a CB-CME undertakes.
 - Allowing CB-CMEs to use other sources of data to refer beneficiaries to the HHP program, rather than administrative data.
 - Fostering a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program.
 - Including “chronic homelessness” as an acuity factor.
 - Eliminating the exclusions.
 - Clarifying how DHCS and MCPs will ensure continuity of care for beneficiaries no longer meeting the acuity criteria.

DOWNTOWN WOMEN'S CENTER



442 South San Pedro Street
Los Angeles, California 90013
T: 213.680.0600 | F: 213.680.0844
www.DowntownWomensCenter.org

- We recommend DHCS create a tiered payment structure with a homelessness modifier, similar to the structure DHCS released two months ago.
 - We recommend extending the modifier to two years or less in housing, as consistent with the definition of chronic homelessness in Assembly Bill 361. People experiencing chronic homelessness or cycling through hospitalization or nursing homes often require two years of sustained, consistent services before stabilizing.
 - CB-CMEs should be eligible to receive the modifier only if meeting the requirements included in AB 361 or partnering with agencies who do meet the criteria to deliver HHP services to homeless beneficiaries.
- For the definitions of services, we recommend the following changes:
 - For homeless beneficiaries, clarify references to “communication through e-mails, texts, social media, and phone calls” are applicable to those who are stably housed, and not only allowable until a CB-CME’s in-person contacts have established a trusting relationship with the beneficiary.
 - To the definition of *comprehensive care management*, we recommend adding in-person outreach and engagement of beneficiaries to form trusting relationships and to gather information the beneficiary, similar to the definition in CMS guidance, as well as individual housing transition and tenancy sustaining services recognized in the CMS Informational Bulletin (housing-related activities for beneficiaries experiencing chronic homelessness).
 - To the definition of *care coordination*, we recommend including, “Accompanying beneficiaries to appointments when necessary to act as the beneficiary’s advocate, to communicate the beneficiary’s health goals to care providers, to explain diagnoses and treatment to the beneficiary, and/or to engage the member to follow treatment protocols.” We further recommend adding “providing and arranging transportation to attend appointments, including appointments with social service providers.”
 - To the definition of *health promotion*, we recommend requiring CB-CMEs to use evidence-based practices to engage the beneficiary to manage his or her own care.
 - To the definition of *comprehensive transitional care*, we recommend, “Locating and offering to beneficiaries experiencing homelessness immediate access to respite care or bridge/interim housing post-discharge until a permanent apartment is made available to the beneficiary,” rather than current language regarding “transitional housing.”
 - To the definition of *Individual & Family Support Services*, we recommend encouraging the beneficiary’s own goals drive any connections with family, friends, or other potential support systems.
 - To the definition of *Referral to Community & Social Supports*, we recommend including active linkage to social systems and services, such as requirements to create relationships with housing providers, offering warm hand-offs to help the beneficiary navigate through the process of obtaining services impacting the member’s health, and routine check-in with beneficiaries to ensure the beneficiary accesses social services he or she requires. We also recommend adding “food security services” to your list of services.
- If housing navigation services are not included in the definition of care management, we recommend adding housing navigation services to the definition of referral to community and social supports. In defining housing-related activities, we recommend following definitions included in the CMS Informational Bulletin on housing-related activities.



- Regarding MCP and CB-CME responsibilities, we recommend—
 - Encouraging MCPs and CB-CMEs rely on assessments and care plans recognized as evidence-based.
 - Requiring that CB-CMEs develop relationships with housing providers and use existing homeless systems to identify and provide housing solutions for members experiencing homelessness before a CB-CME could receive a homelessness modifier.
 - Including “homeless continuums of care” and “homeless coordinated entry systems” in the list of stakeholders.
 - Requiring both MCPs and CB-CMEs develop plans to meet the treatment needs of people with substance use disorders and/or serious mental illness, as well as partnerships with behavioral health providers.
 - Requiring CB-CMEs to partner with housing providers.
 - Limiting how much of the DHCS payment the MCP may retain for performance of their duties, as other states have done.
 - Clarifying payment will not be based on a per-encounter basis.
 - Developing a simplified, expedited process for certifying CB-CMEs.
 - Encouraging MCPs in jurisdictions with limited PCP capacity to contract with non-traditional providers to offer some HHP services.
 - Clarifying that, though PCP staff may provide some of the HHP services, they would be expected to offer these services outside the clinic setting where necessary.

- To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user beneficiaries, we recommend adding a model to the three models the Concept Paper identifies for service provision:
 - **“Model IV:** A collaborative model serving homeless HHP members, Model IV includes services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either the homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care managers and housing navigators engage members where the members live, both before and after the member moves into housing, and the CB-CME team assists the beneficiary

- In listing CB-CME duties, we recommend clarifying—
 - CB-CMEs may focus solely on serving homeless HHP beneficiaries, including persons who have moved into supportive housing after experiencing homelessness.
 - A multidisciplinary care team could consist of staff from multiple agencies and should offer services wherever most accessible to the beneficiary.
 - CB-CMEs partner with permanent housing providers and homeless service providers to reach homeless beneficiaries.

DOWNTOWN WOMEN'S CENTER



442 South San Pedro Street
Los Angeles, California 90013
T: 213.680.0600 | F: 213.680.0844
www.DowntownWomensCenter.org

- In developing additional staffing requirements, we recommend—
 - An aggregate care manager/housing navigator ratio of 1:15 to 1:20 (not including MCP staffing) for HHP members who are homeless. In housing and mental health systems, successful case management programs serving homeless and frequent user populations offer in-person, individualized, frequent and flexible services, offered where the person lives, with beneficiary to staff ratios of 1:15 to 1:20.
 - Staffing ratios of 1:25 for other complex beneficiaries beginning to receive HHP services.
 - A staffing ratio of 1:35 to 1:40 once a HHP member can transition to “maintenance.”
- In describing the multidisciplinary team roles, we recommend the following changes:
 - In the *dedicated care manager* role, including, “arranging *and providing* transportation when necessary to provide access to appointments,” and adding, “Accompanying HHP member to office visits.”
 - In the *community health worker* role, adding a requirement the health worker explain materials provided to the beneficiary.
 - In the *housing navigator* role, requiring formation and fostering of relationships with housing agencies, engaging members and potential members in person, and, “Partnering with housing agencies and providers to offer HHP member with permanent housing options, assisting member with moving into permanent housing and promoting housing stability.” We further recommend including housing-related activities, as described in the CMS Informational Bulletin released in June regarding housing-related activities for people experiencing chronic homelessness.
- Regarding member assignment, we recommend requiring an in-person engagement process, particularly for homeless members. For others with complex needs, we recommend supplementing letters with in-person engagement. For referrals, we likewise recommend—
 - Fostering a “no wrong door” approach that allows any agency, behavioral health professional, or PCP to refer a member potentially eligible.
 - Allowing for presumptive eligibility if a beneficiary meets the chronic condition and acuity criteria.
 - Requiring a CB-CME engage with a beneficiary on multiple occasions before discharging a beneficiary.
- Regarding payment methodology, we recommend clarifying a consistent rate structure applicable to all MCPs, rather than allowing some MCPs to develop tiered payment and some MCPs to use a single rate.
 - We recommend a DHCS-imposed risk stratification process, as we are concerned MCPs will use the CalMedi-Connect risk stratification tool to tier payment, or develop tiers based on medical criteria alone.
 - In identifying a tool for tiering, we recommend DHCS adopt criteria similar to criteria other states adopted for intensive care and case management programs based on elements of high risk.
 - We also recommend requiring MCPs develop a per member, per month rate structure for CB-CMEs with which they contract, rather than payment on a per encounter basis, since per-encounter payment in other programs erodes service delivery and imposes administrative burden. We further suggest clarifying how payment for services would be



- risk-based, or remove the risk-based methodology, since a number of CB-CMEs may not be PCPs, and should not be at risk for all care.
- We further recommend requiring staffing ratios to justify rates, rather than relying on a prospective payment rate, to ensure CB-CMEs deliver intensive services for the rate they receive, and avoiding use of HHP payment to fund traditional MCO care coordination services.
 - In reporting housing outcomes (within operational measures), we recommend changing current housing status to, “The number of members receiving the homeless modifier who are currently living in permanent housing (their own independent apartment not limited by length of stay).” We recommend conducting a separate evaluation for homeless members than other beneficiaries.
 - Regarding HHP interaction with other Medi-Cal programs, we urge DHCS to consider funding housing-related activities and services identified in HHP through the 1115 Waiver Whole Person Care Pilot Programs in counties that will not be implementing HHP until July 2017 or later. With the exception of San Francisco, need for HHP services is greatest in the counties that will not be implementing until July 2017 or January 2018. The Whole-Person Care Pilot is an opportunity to build capacity and work through barriers before accessing HHP. Moreover, for counties who have not yet implemented HHP, no danger of duplication of funding exists if a county ends the use of waiver funding for this phase of services before HHP takes effect, or limits the use of waiver funding for these services to persons who do not meet the eligibility criteria for HHP at that time.

Thank you for the opportunity to comment on Concept Paper 3.0.

Sincerely,

Amy Turk, LCSW
Acting CEO
Downtown Women's Center



John Snow, Inc.

260 California Street
Suite 500 • San Francisco
California • 94111

415 400 • 0020 Voice
415 400 • 0019 Fax
jinfo@jsi.com Email

To: CHCS Health Home Program Staff
From: Jeremy Cantor & Rachel Tobey, JSI San Francisco
RE: Feedback on Draft Concept Paper 3.0 for Health Homes for Patients with Complex Needs
Date: December 24, 2015

We appreciate the efforts of DHCS and all stakeholders to move the HHP toward reality. The comments below are intended to support that effort and implementation in a manner that maximizes benefits for high-need Californians. Please don't hesitate to contact us if we can clarify these comments or assist you in any way.

Implementation Schedule and Site Preparation: The decision to roll out HHP implementation over time by geography is one we've previously encouraged and continue to support. The phasing will potentially enable more successful implementation, learning across sites, and implementation of clear readiness criteria and capacity development processes. On this latter point, Concept Paper 3.0 does not provide adequate detail of the readiness and technical assistance processes. In particular, it is not clear what the respective responsibilities are for completing the readiness assessment and then addressing deficits prior to project initiation. It is clear that much of this work is "to be developed"; however, it would be helpful to have at least some roles and responsibilities defined, and in particular to require MCP's to oversee the capacity development. Additionally, while DHCS and PBGH are slated to develop and deliver TA, it is not clear that MCPs and CBCMEs will be provided resources to participate in TA processes and to follow up with systems development that supports practice transformation.

Target Population Identification: The general principles that underlie the described process align well with our recent research on care management best practices: develop a hybrid quantitative/qualitative approach that uses criteria to develop a potential-participant list that is then reviewed by plans and providers to "identify the highest-risk...Medi-Cal population who present the best opportunity for improved health outcomes through HHP services." However, our research also indicated that selecting based solely on high cost in the recent past is likely to miss identifying the best opportunities for future cost avoidance. The process as described will likely catch many patients at the peak of their utilization, from which point there will be a natural regression to the mean. We strongly encourage expanding the limitation beyond the top 3-5% to a slightly wider strata (ex. Top 10%) paired with the flexibility for providers to refer patients who are in a stage of rising risk. The goal of expanding the strata is to catch patients for intervention before they become high cost rather than after.

In addition, the criteria and engagement process described in Concept Paper 3.0 does not reflect any capture of non-clinical social factors and conditions. Given the strong and growing evidence of the importance of factors such homelessness, exposure to trauma, poverty, and food insecurity in determining health outcomes—particularly for high-complexity, low-income populations—this represents a significant missed opportunity. Without this initial tracking of social factors, it is less likely that interventions will be tailored to support patients in addressing non-clinical issues that influence, if not trump, medical conditions driving high utilization and cost. Collecting this information would also provide extremely useful data about the populations, their risks, and other sectors that MCPs should engage as part of the HHP. ICD-10 includes a set of Z-codes that relate to non-clinical factors, which could be used to capture non-medical risk factors in a standardized fashion. In addition, the National Association of Community Health Centers has designed the PRAPARE tool to support collection of data on social determinants.

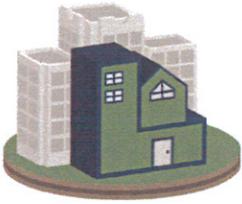
Payment methodologies: Engagement will be a significant challenge, and we support the inclusion of additional resources to enroll, orient, assess, and develop care plans for new participants as an identified best practice from other states. Learning from both other states and the Coordinated Care Initiative in California, we would caution against the continued reliance on outreach letters for engagement. Two of California's largest FQHC-led risk-based Medi-Cal IPAs report that 30-40% of member contact information is incorrect within the first three months due to the relative instability associated with living in poverty. The HHP should respond to the lessons from high-risk, low-income patient engagement initiatives, to employ a more intensive, personal outreach process.

The move away from the tiered payment structure proposed in Concept Paper 2.0 is unfortunate. Risk stratification and payment tiering could help to focus resources and strategies on select sub-populations and ensure adequate resources for the most complex patients. For example, chronically homeless individuals identified in AB 361 will likely require a higher level of support beyond the engagement period. Tiering would also facilitate tailoring services to acuity levels and adjusting to participant needs by providing a lower level of HH service to maintain stabilized participants. This could also support involving a larger number of participants, which in turn would support MCPs and CBCMEs adopting organization-wide changes that are building blocks for broader system transformation. Numerous states, including Washington, New York, and North Carolina, have implemented tiered payment structures based on health status/acuity.

MCP and CBCME responsibilities: The described responsibilities and relationship between the MCPs and CBCMEs reflects a fairly comprehensive and flexible approach to HHP development. It is particularly encouraging to see that MCPs would have the ability to subcontract with other community-based entities to achieve HHP goals. Given the focus on homelessness detailed in AB 361, the description of supports for homeless populations is surprisingly narrow. On the one hand, the importance of "stable housing for HHP members" is detailed on pg. 16. On the other, the extent of "whatever it takes" support and habilitative services that experts in the field say is necessary to alter the trajectory for homeless populations with multiple chronic conditions are not reflected. In particular, the required "housing navigators" should have a more detailed and expansive set of qualifications and roles. Additionally, there is no housing-related outcome measure described; that would be an important inclusion in order to maintain focus on this priority population.

Given the complexity of potential participants and the need to provide a "health home," it makes sense to focus resources with the providers who have existing relationships with patients and community resources. Building on mounting evidence, recent research has concluded: "High-risk care management programs are most effective when they are anchored in the practices where patients receive their care."¹ Other states, such as New York, decided that provider-based health home activity held the most promise for achieving improved results. There is a key role for MCPs to support the development and implementation of the HHP through capacity building, population identification, data management and reporting, and more direct HH team management in rural contexts and among urban low-volume Medi-Cal providers. However, as suggested in prior feedback, we would recommend that the Health Home Initiative limit overall use of HHP resources at the MCP level either through a percentage cap (as other states have done) or specific percentages for Health-Home support activities (such as participant identification).

¹ Powers BW, Chaguturu SK, Ferris TG. Optimizing High-Risk Care Management. *JAMA*. 2015; 313(8):795-796.



LA FAMILY HOUSING

BOARD OF DIRECTORS
President & CEO
Stephanie Klasky-Gamer

Chair
Gary Meisel
Warner Bros.

Vice Chair
Michele Breslauer
Children's Law Center
of Los Angeles

Treasurer
David Doyle
Bank of America

Secretary
Daniel M. Howard, CPA
Lodgen, Lacher, Golditch, Sardi,
Saunders & Howard, LLP

Wayne Brander
U.S. Bank

Steve M. Brown
Hoffman Brown Company

Audie Chamberlain
Partners Trust

Zeeda Daniele
Fannie Mae

Wendy Greuel

Matthew B. Irmas
Partners Trust

Deborah Kazenelson Deane
Edelman Public Relations &
Communications

Robyn Lattaker-Johnson

Albert Lemus
Lowe Enterprises

Bonnie Litowsky

Blair Rich
Warner Bros. Pictures

Nick Segal
Partners Trust

Ross E. Winn, Esq.
Wolf, Rifkin, Shapiro,
Schulman & Rabkin, LLP

Michael Ziering
Diagnostic Products Corp.

ADVISORY COMMITTEE

Martha de la Torre
David Fleming
Jeff Lee
George Minter
Steven A. Nissen
Lawrence H. Parks
Robert N. Ruth
Dorothea Scattaglia
Peter Tilden
Peter Villegas
Betty Winn

LIFETIME DIRECTORS

Audrey Irmas
Robert J. Irmas (1951-2015)
Rev. John Simmons (1917-2013)
Sydney M. Irmas (1925-1996)
Trudy Louis (1914-2004)

December 24, 2015

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov

Re: Comments on Health Home Program for People with Complex Needs, Concept Paper 3.0

Dear Health Home Program:

On behalf of LA Family Housing I am writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. LA Family Housing is a leading provider of services for homeless and low income individuals and families in Los Angeles. We operate emergency bridge housing and permanent housing programs; we annually place 600 households into permanent housing. Because of the focus of our organization, we are commenting primarily on the impact of provisions of Concept Paper 3.0 on Medi-Cal beneficiaries experiencing homelessness.

We have great concerns with the timeline as proposed by DHCS. While we understand and appreciate the need for deliberate roll-out of HHP, a 30-month roll-out of the benefit has significant ramifications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties. Group 2 and 3 counties have, in fact, the highest rates of poverty and social barriers to accessing appropriate care. Though many of these counties have developed means of addressing these barriers to care, along with provider capacity, delaying these services until early to mid-2018 will certainly mean the most vulnerable beneficiaries will continue to experience poor health outcomes and high costs.

State initiatives will be difficult to sustain without the promise of HHP services to integrate care at the systems and individual beneficiary level, such as the Whole Person Care pilot and the Medi-Cal Drug Organized Delivery System. At the same time, California will have to bear the costs of poorly managed care among those expansion beneficiaries with complex conditions, and will be required to pay for more of the costs of HHP services for expansion beneficiaries.

Moreover, evaluation results may not be available until well after DHCS has to determine whether to use State General Fund resources to support the ongoing costs of HHP services for Group 1 and Group 2 counties. If implementation in these counties is delayed, this could result in under-estimating the impacts of HHP during the evaluation timeframe. Finally, the fate of HHP and the ACA are uncertain in 2018 and beyond. We are very concerned HHP may never reach those with the greatest need due to failures in full implementation, should services in mostly small, rural counties fail to make any measurable impact.

We therefore recommend the following:

- Including at least one large county with high rates of poverty and providers with capacity, like Alameda or Los Angeles, in Group 1.

- Compressing the timeline by allowing all eligible beneficiaries to access the benefit by October 2017.
- Allowing the Whole-Person Care pilot to fund HHP-like services in the years before HHP implementation begins in counties accessing the pilot.

Whatever DHCS is inclined to include in terms of timeline, we recommend allowing for more robust stakeholder input on the timeline and counties included in each group before finalizing California's State Plan Amendment.

Additionally, in drafting the Health Home State Plan Amendment, we recommend the following changes to proposals outlined in Concept Paper 3.0:

- **Regarding eligibility criteria, we recommend—**
 - Adding chronic renal disease, HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to your list of eligible conditions.
 - Requiring CB-CMEs be responsible for engaging, in person, members who do not respond to a letter that they are eligible, and that the engagement rate be reserved for in-person, face-to-face engagement activities a CB-CME undertakes.
 - Allowing CB-CMEs to use other sources of data to refer beneficiaries to the HHP program, rather than administrative data.
 - Fostering a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program.
 - Including “chronic homelessness” as an acuity factor.
 - Eliminating the exclusions.
 - Clarifying how DHCS and MCPs will ensure continuity of care for beneficiaries no longer meeting the acuity criteria.
- **We recommend DHCS create a tiered payment structure with a homelessness modifier, similar to the structure DHCS released two months ago.**
 - We recommend extending the modifier to two years or less in housing, as consistent with the definition of chronic homelessness in Assembly Bill 361. People experiencing chronic homelessness or cycling through hospitalization or nursing homes often require two years of sustained, consistent services before stabilizing.
 - CB-CMEs should be eligible to receive the modifier only if meeting the requirements included in AB 361 or partnering with agencies who do meet the criteria to deliver HHP services to homeless beneficiaries.
- **For the definitions of services, we recommend the following changes:**
 - For homeless beneficiaries, clarify references to “communication through e-mails, texts, social media, and phone calls” are applicable to those who are stably housed, and not only allowable until a CB-CME's in-person contacts have established a trusting relationship with the beneficiary.
 - To the definition of *comprehensive care management*, we recommend adding in-person outreach and engagement of beneficiaries to form trusting relationships

and to gather information the beneficiary, similar to the definition in CMS guidance, as well as individual housing transition and tenancy sustaining services recognized in the CMS Informational Bulletin (housing-related activities for beneficiaries experiencing chronic homelessness).

- To the definition of *care coordination*, we recommend including, “Accompanying beneficiaries to appointments when necessary to act as the beneficiary’s advocate, to communicate the beneficiary’s health goals to care providers, to explain diagnoses and treatment to the beneficiary, and/or to engage the member to follow treatment protocols.” We further recommend adding “providing and arranging transportation to attend appointments, including appointments with social service providers.”
 - To the definition of *health promotion*, we recommend requiring CB-CMEs to use evidence-based practices to engage the beneficiary to manage his or her own care.
 - To the definition of *comprehensive transitional care*, we recommend, “Locating and offering to beneficiaries experiencing homelessness immediate access to respite care or bridge/interim housing post-discharge until a permanent apartment is made available to the beneficiary,” rather than current language regarding “transitional housing.”
 - To the definition of *Individual & Family Support Services*, we recommend encouraging the beneficiary’s own goals drive any connections with family, friends, or other potential support systems.
 - To the definition of *Referral to Community & Social Supports*, we recommend including active linkage to social systems and services, such as requirements to create relationships with housing providers, offering warm hand-offs to help the beneficiary navigate through the process of obtaining services impacting the member’s health, and routine check-in with beneficiaries to ensure the beneficiary accesses social services he or she requires. We also recommend adding “food security services” to your list of services.
- **If housing navigation services are not included in the definition of care management, we recommend adding housing navigation services to the definition of referral to community and social supports.** In defining housing-related activities, we recommend following definitions included in the CMS Informational Bulletin on housing-related activities.
- **Regarding MCP and CB-CME responsibilities, we recommend—**
 - Encouraging MCPs and CB-CMEs rely on assessments and care plans recognized as evidence-based.
 - Requiring that CB-CMEs develop relationships with housing providers and use existing homeless systems to identify and provide housing solutions for members experiencing homelessness before a CB-CME could receive a homelessness modifier.
 - Including “homeless continuums of care” and “homeless coordinated entry systems” in the list of stakeholders.

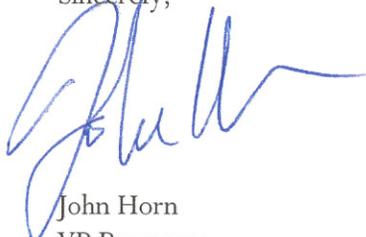
- Requiring both MCPs and CB-CMEs develop plans to meet the treatment needs of people with substance use disorders and/or serious mental illness, as well as partnerships with behavioral health providers.
 - Requiring CB-CMEs to partner with housing providers.
 - Limiting how much of the DHCS payment the MCP may retain for performance of their duties, as other states have done.
 - Clarifying payment will not be based on a per-encounter basis.
 - Developing a simplified, expedited process for certifying CB-CMEs
 - Encouraging MCPs in jurisdictions with limited PCP capacity to contract with non-traditional providers to offer some HHP services.
 - Clarifying that, though PCP staff may provide some of the HHP services, they would be expected to offer these services outside the clinic setting where necessary.
- **To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user beneficiaries, we recommend adding a model to the three models the Concept Paper identifies for service provision:**
 - **“Model IV:** A collaborative model serving homeless HHP members, Model IV includes services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either the homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care managers and housing navigators engage members where the members live, both before and after the member moves into housing, and the CB-CME team assists the beneficiary
- **In listing CB-CME duties, we recommend clarifying—**
 - CB-CMEs may focus solely on serving homeless HHP beneficiaries, including persons who have moved into supportive housing after experiencing homelessness.
 - A multidisciplinary care team could consist of staff from multiple agencies and should offer services wherever most accessible to the beneficiary.
 - CB-CMEs partner with permanent housing providers and homeless service providers to reach homeless beneficiaries.
- **In developing additional staffing requirements, we recommend—**
 - An aggregate care manager/housing navigator ratio of 1:15 to 1:20 (not including MCP staffing) for HHP members who are homeless. In housing and mental health

- systems, successful case management programs serving homeless and frequent user populations offer in-person, individualized, frequent and flexible services, offered where the person lives, with beneficiary to staff ratios of 1:15 to 1:20.
- Staffing ratios of 1:25 for other complex beneficiaries beginning to receive HHP services.
 - A staffing ratio of 1:35 to 1:40 once a HHP member can transition to “maintenance.”
- **In describing the multidisciplinary team roles, we recommend the following changes:**
 - In the *dedicated care manager* role, including, “arranging *and providing* transportation when necessary to provide access to appointments,” and adding, “Accompanying HHP member to office visits.”
 - In the *community health worker* role, adding a requirement the health worker explain materials provided to the beneficiary.
 - In the *housing navigator* role, requiring formation and fostering of relationships with housing agencies, engaging members and potential members in person, and, “Partnering with housing agencies and providers to offer HHP member with permanent housing options, assisting member with moving into permanent housing and promoting housing stability.” We further recommend including housing-related activities, as described in the CMS Informational Bulletin released in June regarding housing-related activities for people experiencing chronic homelessness.
 - **Regarding member assignment, we recommend requiring an in-person engagement process, particularly for homeless members. For others with complex needs, we recommend supplementing letters with in-person engagement. For referrals, we likewise recommend—**
 - Fostering a “no wrong door” approach that allows any agency, behavioral health professional, or PCP to refer a member potentially eligible.
 - Allowing for presumptive eligibility if a beneficiary meets the chronic condition and acuity criteria.
 - Requiring a CB-CME engage with a beneficiary on multiple occasions before discharging a beneficiary.
 - **Regarding payment methodology, we recommend clarifying a consistent rate structure applicable to all MCPs, rather than allowing some MCPs to develop tiered payment and some MCPs to use a single rate.**
 -
 - We recommend a DHCS-imposed risk stratification process, as we are concerned MCPs will use the CalMedi-Connect risk stratification tool to tier payment, or develop tiers based on medical criteria alone.
 - In identifying a tool for tiering, we recommend DHCS adopt criteria similar to criteria other states adopted for intensive care and case management programs based on elements of high risk.

- We also recommend requiring MCPs develop a per member, per month rate structure for CB-CMEs with which they contract, rather than payment on a per encounter basis, since per-encounter payment in other programs erodes service delivery and imposes administrative burden. We further suggest clarifying how payment for services would be risk-based, or remove the risk-based methodology, since a number of CB-CMEs may not be PCPs, and should not be at risk for all care.
- We further recommend requiring staffing ratios to justify rates, rather than relying on a prospective payment rate, to ensure CB-CMEs deliver intensive services for the rate they receive, and avoiding use of HHP payment to fund traditional MCO care coordination services.
- **In reporting housing outcomes (within operational measures), we recommend changing current housing status to, “The number of members receiving the homeless modifier who are currently living in permanent housing (their own independent apartment not limited by length of stay).”** We recommend conducting a separate evaluation for homeless members than other beneficiaries.
- **Regarding HHP interaction with other Medi-Cal programs, we urge DHCS to consider funding housing-related activities and services identified in HHP through the 1115 Waiver Whole Person Care Pilot Programs in counties that will not be implementing HHP until July 2017 or later.** With the exception of San Francisco, need for HHP services is greatest in the counties that will not be implementing until July 2017 or January 2018. The Whole-Person Care Pilot is an opportunity to build capacity and work through barriers before accessing HHP. Moreover, for counties who have not yet implemented HHP, no danger of duplication of funding exists if a county ends the use of waiver funding for this phase of services before HHP takes effect, or limits the use of waiver funding for these services to persons who do not meet the eligibility criteria for HHP at that time.

Thank you for the opportunity to comment on Concept Paper 3.0.

Sincerely,



John Horn
VP Programs



December 23, 2015

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov

Re: Comments on Health Home Program for People with Complex Needs, Concept Paper 3.0

Dear Health Home Program:

On behalf of LeSar Development Consultants, I am writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. LeSar Development Consultants (LDC) has been actively engaged in efforts to end chronic and veteran's homelessness in both Los Angeles and San Diego. Since 2014 we have been working with the San Diego Housing Commission to develop strategies to match housing resources with health services available through the expansion of Medi-Cal. LDC has represented the San Diego Housing Commission at meetings of the Whole Person Care Working Group in San Diego. Because of the focus of our organization, we are commenting primarily on the impact of provisions of Concept Paper 3.0 on Medi-Cal beneficiaries experiencing homelessness.

We have great concerns with the timeline as proposed by DHCS. While we understand and appreciate the need for deliberate roll-out of HHP, a 30-month roll-out of the benefit has significant ramifications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties. Group 2 and 3 counties have, in fact, the highest rates of poverty and social barriers to accessing appropriate care.

We are particularly concerned that the proposed implementation date for San Diego County will mean that we will miss an important opportunity to leverage HHP services with housing subsidies that would be of great benefit to individuals with complex health needs who are homeless. The San Diego Housing Commission has made a commitment to release tenant and sponsor based rental subsidies over the next three years and these subsidies must be matched with comprehensive services, and especially care coordination, in order to successfully result in moving high need individuals into stable supportive housing. Though San Diego County has developed some means of addressing these barriers to care, along with provider capacity, delaying these services until early to mid-2018 will certainly mean the most vulnerable beneficiaries will continue to experience poor health outcomes and high costs.

State initiatives will be difficult to sustain without the promise of HHP services to integrate care at the systems and individual beneficiary level, such as the Whole Person Care pilot and the Medi-Cal

San Diego Office
404 Euclid Ave, Suite 212
San Diego, CA 92114
619-236-0612 phone
619-236-0613 fax

Sacramento Office
1400 N Street, Suite 7
Sacramento, CA 95814
619-459-6292 phone

Los Angeles Office
448 S. Hill Street, Suite 618
Los Angeles, CA 90013
213-612-4545 phone
213-488-3468 fax

www.lesardevelopment.com

Drug Organized Delivery System. At the same time, California will have to bear the costs of poorly managed care among those expansion beneficiaries with complex conditions, and will be required to pay for more of the costs of HHP services for expansion beneficiaries.

Moreover, evaluation results may not be available until well after DHCS has to determine whether to use State General Fund resources to support the ongoing costs of HHP services for Group 1 and Group 2 counties. If implementation in these counties is delayed, this could result in under-estimating the impacts of HHP during the evaluation timeframe. Finally, the fate of HHP and the ACA are uncertain in 2018 and beyond. We are very concerned HHP may never reach those with the greatest need due to failures in full implementation, should services in mostly small, rural counties fail to make any measurable impact.

We therefore recommend the following:

- Including at least one large county with high rates of poverty and providers with capacity, like San Diego, Alameda or Los Angeles, in Group 1.
- Compressing the timeline by allowing all eligible beneficiaries to access the benefit by October 2017.
- Allowing the Whole-Person Care pilot to fund HHP-like services in the years before HHP implementation begins in counties accessing the pilot.

Whatever DHCS is inclined to include in terms of timeline, we recommend allowing for more robust stakeholder input on the timeline and counties included in each group before finalizing California's State Plan Amendment.

Additionally, in drafting the Health Home State Plan Amendment, we recommend the following changes to proposals outlined in Concept Paper 3.0:

- Regarding eligibility criteria, we recommend—
 - Adding chronic renal disease, HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to your list of eligible conditions.
 - Requiring CB-CMEs be responsible for engaging, in person, members who do not respond to a letter that they are eligible, and that the engagement rate be reserved for in-person, face-to-face engagement activities a CB-CME undertakes.
 - Allowing CB-CMEs to use other sources of data to refer beneficiaries to the HHP program, rather than administrative data.
 - Fostering a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program.
 - Including “chronic homelessness” as an acuity factor.
 - Eliminating the exclusions.
 - Clarifying how DHCS and MCPs will ensure continuity of care for beneficiaries no longer meeting the acuity criteria.
- We recommend DHCS create a tiered payment structure with a homelessness modifier, similar to the structure DHCS released two months ago.
 - We recommend extending the modifier to two years or less in housing, as consistent with the definition of chronic homelessness in Assembly Bill 361. People experiencing

chronic homelessness or cycling through hospitalization or nursing homes often require two years of sustained, consistent services before stabilizing.

- CB-CMEs should be eligible to receive the modifier only if meeting the requirements included in AB 361 or partnering with agencies who do meet the criteria to deliver HHP services to homeless beneficiaries.
- For the definitions of services, we recommend the following changes:
 - For homeless beneficiaries, clarify references to “communication through e-mails, texts, social media, and phone calls” are applicable to those who are stably housed, and not only allowable until a CB-CME’s in-person contacts have established a trusting relationship with the beneficiary.
 - To the definition of *comprehensive care management*, we recommend adding in-person outreach and engagement of beneficiaries to form trusting relationships and to gather information on the beneficiary, similar to the definition in CMS guidance, as well as individual housing transition and tenancy sustaining services recognized in the CMS Informational Bulletin (housing-related activities for beneficiaries experiencing chronic homelessness).
 - To the definition of *care coordination*, we recommend including, “Accompanying beneficiaries to appointments when necessary to act as the beneficiary’s advocate, to communicate the beneficiary’s health goals to care providers, to explain diagnoses and treatment to the beneficiary, and/or to engage the member to follow treatment protocols.” We further recommend adding “providing and arranging transportation to attend appointments, including appointments with social service providers.”
 - To the definition of *health promotion*, we recommend requiring CB-CMEs to use evidence-based practices to engage the beneficiary to manage his or her own care.
 - To the definition of *comprehensive transitional care*, we recommend, “Locating and offering to beneficiaries experiencing homelessness immediate access to respite care or bridge/interim housing post-discharge until a permanent apartment is made available to the beneficiary,” rather than current language regarding “transitional housing.”
 - To the definition of *Individual & Family Support Services*, we recommend encouraging the beneficiary’s own goals drive any connections with family, friends, or other potential support systems.
 - To the definition of *Referral to Community & Social Supports*, we recommend including active linkage to social systems and services, such as requirements to create relationships with housing providers, offering warm hand-offs to help the beneficiary navigate through the process of obtaining services impacting the member’s health, and routine check-in with beneficiaries to ensure the beneficiary accesses social services he or she requires. We also recommend adding “food security services” to your list of services.
- If housing navigation services are not included in the definition of care management, we recommend adding housing navigation services to the definition of referral to community and social supports. In defining housing-related activities, we recommend following definitions included in the CMS Informational Bulletin on housing-related activities.

- Regarding MCP and CB-CME responsibilities, we recommend—
 - Encouraging MCPs and CB-CMEs rely on assessments and care plans recognized as evidence-based.
 - Requiring that CB-CMEs develop relationships with housing providers and use existing homeless systems to identify and provide housing solutions for members experiencing homelessness before a CB-CME could receive a homelessness modifier.
 - Including “homeless continuums of care” and “homeless coordinated entry systems” in the list of stakeholders.
 - Requiring both MCPs and CB-CMEs develop plans to meet the treatment needs of people with substance use disorders and/or serious mental illness, as well as partnerships with behavioral health providers.
 - Requiring CB-CMEs to partner with housing providers.
 - Limiting how much of the DHCS payment the MCP may retain for performance of their duties, as other states have done.
 - Clarifying payment will not be based on a per-encounter basis.
 - Developing a simplified, expedited process for certifying CB-CMEs
 - Encouraging MCPs in jurisdictions with limited PCP capacity to contract with non-traditional providers to offer some HHP services.
 - Clarifying that, though PCP staff may provide some of the HHP services, they would be expected to offer these services outside the clinic setting where necessary.

- To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user beneficiaries, we recommend adding a model to the three models the Concept Paper identifies for service provision:
 - **“Model IV:** A collaborative model serving homeless HHP members, Model IV includes services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either the homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care managers and housing navigators engage members where the members live, both before and after the member moves into housing, and the CB-CME team assists the beneficiary

- In listing CB-CME duties, we recommend clarifying—
 - CB-CMEs may focus solely on serving homeless HHP beneficiaries, including persons who have moved into supportive housing after experiencing homelessness.
 - A multidisciplinary care team could consist of staff from multiple agencies and should offer services wherever most accessible to the beneficiary.
 - CB-CMEs partner with permanent housing providers and homeless service providers to reach homeless beneficiaries.

- In developing additional staffing requirements, we recommend—
 - An aggregate care manager/housing navigator ratio of 1:15 to 1:20 (not including MCP staffing) for HHP members who are homeless. In housing and mental health systems, successful case management programs serving homeless and frequent user populations offer in-person, individualized, frequent and flexible services, offered where the person lives, with beneficiary to staff ratios of 1:15 to 1:20.
 - Staffing ratios of 1:25 for other complex beneficiaries beginning to receive HHP services.
 - A staffing ratio of 1:35 to 1:40 once a HHP member can transition to “maintenance.”

- In describing the multidisciplinary team roles, we recommend the following changes:
 - In the *dedicated care manager* role, including, “arranging *and providing* transportation when necessary to provide access to appointments,” and adding, “Accompanying HHP member to office visits.”
 - In the *community health worker* role, adding a requirement the health worker explain materials provided to the beneficiary.
 - In the *housing navigator* role, requiring formation and fostering of relationships with housing agencies, engaging members and potential members in person, and, “Partnering with housing agencies and providers to offer HHP member with permanent housing options, assisting member with moving into permanent housing and promoting housing stability.” We further recommend including housing-related activities, as described in the CMS Informational Bulletin released in June regarding housing-related activities for people experiencing chronic homelessness.

- Regarding member assignment, we recommend requiring an in-person engagement process, particularly for homeless members. For others with complex needs, we recommend supplementing letters with in-person engagement. For referrals, we likewise recommend—
 - Fostering a “no wrong door” approach that allows any agency, behavioral health professional, or PCP to refer a member potentially eligible.
 - Allowing for presumptive eligibility if a beneficiary meets the chronic condition and acuity criteria.
 - Requiring a CB-CME engage with a beneficiary on multiple occasions before discharging a beneficiary.

- Regarding payment methodology, we recommend clarifying a consistent rate structure applicable to all MCPs, rather than allowing some MCPs to develop tiered payment and some MCPs to use a single rate.
 - We recommend a DHCS-imposed risk stratification process, as we are concerned MCPs will use the CalMedi-Connect risk stratification tool to tier payment, or develop tiers based on medical criteria alone.
 - In identifying a tool for tiering, we recommend DHCS adopt criteria similar to criteria other states adopted for intensive care and case management programs based on elements of high risk.
 - We also recommend requiring MCPs develop a per member, per month rate structure for CB-CMEs with which they contract, rather than payment on a per encounter basis, since per-encounter payment in other programs erodes service delivery and imposes administrative burden. We further suggest clarifying how payment for services would be

- risk-based, or remove the risk-based methodology, since a number of CB-CMEs may not be PCPs, and should not be at risk for all care.
- We further recommend requiring staffing ratios to justify rates, rather than relying on a prospective payment rate, to ensure CB-CMEs deliver intensive services for the rate they receive, and avoiding use of HHP payment to fund traditional MCO care coordination services.
 - In reporting housing outcomes (within operational measures), we recommend changing current housing status to, “The number of members receiving the homeless modifier who are currently living in permanent housing (their own independent apartment not limited by length of stay).” We recommend conducting a separate evaluation for homeless members than other beneficiaries.
 - Regarding HHP interaction with other Medi-Cal programs, we urge DHCS to consider funding housing-related activities and services identified in HHP through the 1115 Waiver Whole Person Care Pilot Programs in counties that will not be implementing HHP until July 2017 or later. With the exception of San Francisco, need for HHP services is greatest in the counties that will not be implementing until July 2017 or January 2018. The Whole-Person Care Pilot is an opportunity to build capacity and work through barriers before accessing HHP. Moreover, for counties who have not yet implemented HHP, no danger of duplication of funding exists if a county ends the use of waiver funding for this phase of services before HHP takes effect, or limits the use of waiver funding for these services to persons who do not meet the eligibility criteria for HHP at that time.

Thank you for the opportunity to comment on Concept Paper 3.0.

Sincerely,

Jonathan C. Hunter
Senior Principal



Leading the Way to a Healthier Community

LifeLong Over 60 Health Center • LifeLong Berkeley Primary Care • LifeLong Downtown Oakland
LifeLong East Oakland • LifeLong West Berkeley • LifeLong Howard Daniel Clinic • LifeLong Dental Care
LifeLong Brookside Richmond • LifeLong Brookside San Pablo • LifeLong Brookside Dental Care
LifeLong Richmond Health Center • LifeLong Dr. William M. Jenkins, Jr. Pediatric Center
LifeLong Marin Adult Day Health Center • LifeLong School-Based Health Services

December 24, 2015

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov

Re: Comments on Health Home Program for People with Complex Needs, Concept Paper 3.0

Dear Health Home Program:

On behalf of LifeLong Medical Care I am writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. LifeLong Medical Care is a Federally Qualified Health Center providing primary care services in Alameda and Contra Costa Counties. From our inception almost 40 years ago LifeLong has provided care tailored to the needs of high risk, high cost individuals and families including the elderly, homeless and people with disabilities.

We are commenting on several aspects of Concept Paper 3.0 with an emphasis on its impact on Medi-Cal beneficiaries experiencing homelessness. **We are most concerned about 1) the rollout timeline and its relationship to implementation of the 1115 Whole Person Care Pilot Program; 2) eligibility criteria; and 3) the payment model.**

- **Timeline**

We have great concerns with DHCS' proposed timeline. While we understand and appreciate the need for deliberate roll-out of HHP, a 30-month roll-out of the benefit has significant ramifications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties, such as Alameda. Group 2 and 3 counties have, in fact, the highest rates of poverty and social barriers to accessing appropriate care. Delaying these services until early to mid-2018 will mean the most vulnerable beneficiaries will continue to experience poor health outcomes and high costs. As a provider in both Alameda and Contra Costa Counties I believe that Alameda should be in an earlier implementation group and Contra Costa should be added. There is a high need in both of these counties for intensive case management and we, and other providers, are ready to provide the care.

Whatever timeline DHCS is inclined to adopt, we recommend allowing for robust stakeholder input on the timeline and counties included in each group before finalizing California's State Plan Amendment.

Regarding HHP interaction with other Medi-Cal programs, we urge DHCS to consider funding housing-related activities and services identified in HHP through the 1115 Waiver Whole Person Care Pilot Programs in counties that will not be implementing HHP until July 2017 or later. With the exception of San Francisco, need for HHP services is greatest in the counties that will not be implementing until July 2017 or January 2018. The Whole-Person Care Pilot is an opportunity to build capacity and work through barriers before accessing HHP. Moreover, for counties who have not yet implemented HHP, no danger of duplication of funding exists if a county ends the use of waiver funding for this phase of

services before HHP takes effect, or limits the use of waiver funding for these services to persons who do not meet the eligibility criteria for HHP at that time.

Additionally, in drafting the Health Home State Plan Amendment, we recommend the following changes to the proposals outlined in Concept Paper 3.0:

- **Eligibility criteria**
 - Include “chronic homelessness” as an acuity factor
 - Require CB-CMEs to engage, in person, members who do not respond to a letter that they are eligible, and reserve the engagement rate for in-person, face-to-face engagement activities.
 - Foster a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program and using other sources of data, in addition to administrative data, to refer beneficiaries
 - Add chronic renal disease, HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to your list of eligible conditions.
 - Eliminate the exclusions.

- **Payment:**
 - We recommend DHCS create a tiered payment structure with a homelessness modifier and that the modifier be extended to two years or less in housing, as consistent with the definition of chronic homelessness in Assembly Bill 361. People experiencing chronic homelessness or cycling through hospitalization or nursing homes often require two years of sustained, consistent services before stabilizing.
 - CB-CMEs should be eligible to receive the modifier only if meeting the requirements included in AB 361 or partnered with agencies meeting HHP homeless services criteria.
 - Limit how much of the DHCS payment the MCP may retain for performance of their duties
 - Clarify that payment will not be based on a per-encounter basis.

- **To encourage implementation of evidence-based strategies for chronically homeless or homeless frequent user beneficiaries:**
 - Add a model to the three models the Concept Paper identifies for service provision:
Model IV: A collaborative model serving homeless HHP members, Model IV includes services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members.
 - Require that CB-CMEs develop relationships with housing providers and use existing homeless systems to identify and provide housing solutions for members experiencing homelessness before a CB-CME could receive a homelessness modifier.
 - Require MCPs and CB-CMEs to develop plans to meet the treatment needs of people with substance use disorders and/or serious mental illness
 - Set a standard, required aggregate care manager/housing navigator ratio of 1:15 to 1:20 (not including MCP staffing) for HHP members who are homeless.

Thank you for the opportunity to comment on Concept Paper 3.0.

Sincerely,



Marty Lynch

Chief Executive Officer



CYNTHIA A. HARDING, M.P.H.
Interim Director

JEFFREY D. GUNZENHAUSER, M.D., M.P.H.
Interim Health Officer

BUREAU OF HEALTH PROMOTION

Wesley L. Ford, M.A., M.P.H.
Deputy Director
1000 South Fremont Avenue
Building A-9 East, Third Floor
Alhambra, CA 91803
TEL (626) 299-4101 • FAX (626) 458-7637

www.publichealth.lacounty.gov

December 24, 2015

BOARD OF SUPERVISORS

Hilda L. Solis
First District
Mark Ridley-Thomas
Second District
Sheila Kuehl
Third District
Don Knabe
Fourth District
Michael D. Antonovich
Fifth District

Dear Health Homes Program:

Thank you for distributing *Health Homes for Patients with Complex Needs California Concept Paper Version 3.0* for stakeholder review and comment. The Los Angeles County Department of Public Health, Substance Abuse Prevention and Control (LAC DPH-SAPC) is glad to see the Health Homes Program (HHP) move toward implementation to serve some of our most vulnerable beneficiaries with complex needs. However, we have a concern about language regarding DMC-ODS demonstration participants on page 31 of the concept paper.

This section of the document explicitly states that county mental health plans (MHPs) can serve as managed care plans (MCPs) with responsibility for overseeing HHPs for beneficiaries who prefer to have their health home within those delivery systems. The document also specifies that "*Drug Medi-Cal - Organized Delivery System (DMC-ODS) demonstration participants can perform MCP HHP responsibilities where the entity is an integrated MH/SUD plan.*" Under this exclusion of DMC-ODS plans that are not integrated with MHPs, LAC DPH-SAPC would not be eligible to serve as an MCP for this program, because LAC's MHP and substance use disorder (SUD) service delivery systems are administered separately by the LAC Department of Mental Health and LAC DPH-SAPC, respectively.

LAC DPH-SAPC plans to participate in the DMC-ODS demonstration and would also like to facilitate the participation of our contracted SUD service providers in the HHP. While LAC DPH-SAPC has not made a decision about serving as an MCP for the HHP, this restriction precludes LAC DPH-SAPC from exploring this option. We feel that this programmatic design unnecessarily excludes and singles out LAC DPH-SAPC, and we urge you to reconsider this language to allow all DMC-ODS participants to have the option of serving as an MCP for the HHP.

Sincerely,

A handwritten signature in blue ink that reads "Wesley L. Ford".

Wesley L. Ford, M.A., M.P.H.
Deputy Director, Bureau of Health Promotions

c: Cynthia A. Harding
Wayne K. Sugita

To DHCS Health Homes Program Staff,

I am providing feedback for consideration in the HHP final concept paper.

Of primary concern is the timetable for implementation, especially for Group 3 beginning only in 2018, for major urban areas with the highest concentration of homeless individuals. This proposed roll out would start five years after the passage of the State's AB 361 Health Homes Program, and potentially jeopardize the opportunities and benefits of the 'whole person pilot' and Drug Medi-Cal Organized Delivery System. DHCS should consider revising this roll out to begin in 2017 which should allow the State and MCPs sufficient time for implementation to begin.

Health Homes concept paper 3.0 omits key provisions in AB 361- Health Homes for Medi-Cal enrollees (adopted in 2013). Article 14127 specifically targets the homeless and chronic homeless population:

- **'chronic homelessness' was named as a severity condition(2.C) and should be included irrespective of the list of eligible specified medical conditions.** CB-CMEs should be able to establish eligibility by using other sources of data to refer beneficiaries to the HHP program, as administrative data is often not current. The national evidenced-based, best practice standard of 'no wrong door' referral process should be used, allowing for a wide range of providers across health and social service entities. A tiered payment rate with a homeless modifier should be included for a two year period applicable to individuals in housing.
- **'reach out and engage chronically homeless eligible individuals' (D.i)** - A designated 'outreach/engagement' period and rate is critical for success with CB-CMEs required to do in-person/face-to-face engagement in lieu of letter/mail outreach.
- **'link eligible individuals who are homeless or experiencing housing instability, to permanent housing' (ii) and 'connections to housing should be made for persons who are homeless'** - To meet this requirement, 'Housing navigation services' should be added to one of the 6 core services such as Care Management or Individual/Family Support with suggested detail to include the provision of 'housing placement and retention services' and adherence to CMS bulletins pertaining to housing guidance is recommended.

To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user beneficiaries, I recommend adding an additional 'homeless specific' model to the three models the Concept Paper identifies for service provision:

- o **Model IV: (A collaborative model serving homeless beneficiaries)** Includes services to secure and retain permanent housing and intensive care management using evidence-based practices of harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-

Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either the homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care managers and housing navigators engage members where the members live, both before and after the member moves into housing, and the CB-CME team assists the beneficiary with individualized needs.

In describing the multidisciplinary team roles, I recommend the following changes:

- o In the *dedicated care manager* role, including, “arranging *and providing* transportation when necessary to provide access to appointments,” and adding, “Escort member to office visits.”
- o In the *community health worker* role, adding a requirement the health worker explain materials provided to the beneficiary.
- o In the *housing navigator* role, requiring facilitation of relationships with housing agencies, engaging members and potential members in person, and, “Partnering with housing agencies and providers to offer HHP member with permanent housing options, assisting member with housing placement including moving into permanent housing and promoting housing stability.”

Regarding evaluation and payment methodology, I recommend a separate evaluation for homeless beneficiaries, and clarifying a consistent rate structure applicable to all MCPs to include:

- o DHCS-imposed risk stratification process with ‘chronic homelessness’ given a high acuity factor
- o Adopt criteria based upon other states’ use of intensive care and case management programs based on elements of high risk.
- o Require MCPs to develop a per member, per month rate structure for CB-CMEs with which they contract, rather than payment on a per encounter basis, since per-encounter payment in other programs erodes service delivery and imposes administrative burden.
- o Require staffing ratios to justify rates (consider 1:15 until a maintenance period is achieved with a suggested 1:25 ratio) rather than relying on a prospective payment rate, to ensure CB-CMEs deliver intensive services for the rate they receive, and avoid use of HHP payment to fund traditional MCO care coordination services.

Thank you for your consideration of this feedback on HHP Concept Paper 3.0.

Deborah Maddis, MPH
Consultant

Integrating Healthcare and Supportive Housing



December 23, 2015

Jennifer Kent, Director
Department of Health Care Services
1500 Capitol Avenue
Sacramento, CA 95899

Dear Director Kent:

The National Alliance on Mental Illness (NAMI) California is the state's largest grassroots mental health organization, representing 62 local affiliates and 19,000 members, individuals and family members whose lives are impacted by serious mental illness.

We would like to commend the Department on applying for and receiving federal approval to proceed with the Medicaid Health Home State Plan Option. We appreciate having the opportunity to offer comments on the Health Homes for Patients with Complex Needs (HHPN) Concept Paper Version 3.0, circulated to stakeholders on December 11th, 2015.

NAMI California strongly supports the inclusion of and focus on individuals living with serious mental illness for HHPN services. Due to the stigma and discrimination surrounding serious mental illness, individuals who live with these conditions face numerous barriers to accessing appropriate and timely health care and support services. The consequences of this are seen in repeat hospitalizations, homelessness and incarceration.

The HHPN proposal is formulated to address the barriers individuals with serious mental illness face in accessing a variety of supportive services and coordinating care; NAMI California strongly supports this goal. We additionally offer the below suggestions on the final draft of the proposal:

- Encourage health promotion services to include mental health awareness and stigma reduction education for all populations served by health homes. Mental illness often co-exists with acute and chronic medical conditions. For example, in July 2015 DHCS presented data that showed that of the most costly 5% of individuals treated for diabetes and eligible for Medi-Cal only participating in FFS, serious mental illness was present among more than 50%. Mental illness is also underdiagnosed and undertreated, and it is therefore critical to provide prevention and intervention services to all health home participants. This is consistent with the CMS requirements.
- Include peer support specialists as an integral part of team-based care for individuals living with serious mental illness, as originally proposed in the 1115 waiver concept paper. NAMI California strongly supports including community health workers in this program, and specifying peer advocates as qualified community health workers. However, we encourage clarification of the qualifications of a peer, specifically the importance of lived experience with mental illness and

recovery. We also encourage an expansion of the role to include coaching, mentoring, and motivation services that are critical to the success of the HHPCN proposed services.

- Lastly, we recommend that the exclusion criteria be further defined, particularly “members whose condition management cannot be improved because the member is uncooperative”. Due to the prevalence of stigma and discrimination regarding serious mental illness, we recommend that this exclusion criterion be further evaluated. Individuals who have experienced challenges in previous treatment programs may be more successful with the services provided through the health homes program. Therefore, we recommend not excluding an individual on this basis until he/she has had the opportunity to participate in the HHPCN services.

Once again, NAMI California wishes to thank the Department for your work on the HHPCN proposal. We offer our programs and services as a resource for this program, particularly to assist in the development and provision of the individual and family support services component. If you have any questions regarding our comments, please contact Kiran@namica.org or 916-567-0163.

Sincerely,



Kiran Savage-Sangwan

Director of Legislation and Advocacy

NAMI California

January 21, 2016

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov



Re: Comments on Health Home Program for People with Complex Needs, Concept Paper 3.0

Dear Health Home Program:

On behalf of PATH, People Assisting the Homeless, I am writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. PATH is a statewide agency working to end homelessness for individuals, families, and communities throughout California. We strive to do this by prioritizing housing while providing customized supportive services for people in need. Our agencies each address homelessness in a different way—supportive services, permanent housing development, support for homeless families, and community engagement—all of which ultimately help the people we serve make it home. Because of the focus of our organization, we are commenting primarily on the impact of provisions of Concept Paper 3.0 on Medi-Cal beneficiaries experiencing homelessness.

We have great concerns with the timeline as proposed by DHCS. While we understand and appreciate the need for deliberate roll-out of HHP, a 30-month roll-out of the benefit has significant ramifications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties. Group 2 and 3 counties have, in fact, the highest rates of poverty and social barriers to accessing appropriate care. Though many of these counties have developed means of addressing these barriers to care, along with provider capacity, delaying these services until early to mid-2018 will certainly mean the most vulnerable beneficiaries will continue to experience poor health outcomes and high costs.

State initiatives will be difficult to sustain without the promise of HHP services to integrate care at the systems and individual beneficiary level, such as the Whole Person Care pilot and the Medi-Cal Drug Organized Delivery System. At the same time, California will have to bear the costs of poorly managed care among those expansion beneficiaries with complex conditions, and will be required to pay for more of the costs of HHP services for expansion beneficiaries.

Moreover, evaluation results may not be available until well after DHCS has to determine whether to use State General Fund resources to support the ongoing costs of HHP services for Group 1 and Group 2 counties. If implementation in these counties is delayed, this could result in under-estimating the impacts of HHP during the evaluation timeframe. Finally, the fate of HHP and the ACA are uncertain in 2018 and beyond. We are very concerned HHP may never reach those with the greatest need due to failures in full implementation, should services in mostly small, rural counties fail to make any measurable impact.

We therefore recommend the following:

- Including at least one large county with high rates of poverty and providers with capacity, like Alameda or Los Angeles, in Group 1.

- Compressing the timeline by allowing all eligible beneficiaries to access the benefit by October 2017.
- Allowing the Whole-Person Care pilot to fund HHP-like services in the years before HHP implementation begins in counties accessing the pilot.

Whatever DHCS is inclined to include in terms of timeline, we recommend allowing for more robust stakeholder input on the timeline and counties included in each group before finalizing California's State Plan Amendment.

Additionally, in drafting the Health Home State Plan Amendment, we recommend the following changes to proposals outlined in Concept Paper 3.0:

- Regarding eligibility criteria, we recommend—
 - Adding chronic renal disease, HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to your list of eligible conditions.
 - Requiring CB-CMEs be responsible for engaging, in person, members who do not respond to a letter that they are eligible, and that the engagement rate be reserved for in-person, face-to-face engagement activities a CB-CME undertakes.
 - Allowing CB-CMEs to use other sources of data to refer beneficiaries to the HHP program, rather than administrative data.
 - Fostering a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program.
 - Including “chronic homelessness” as an acuity factor.
 - Eliminating the exclusions.
 - Clarifying how DHCS and MCPs will ensure continuity of care for beneficiaries no longer meeting the acuity criteria.
- We recommend DHCS create a tiered payment structure with a homelessness modifier, similar to the structure DHCS released two months ago.
 - We recommend extending the modifier to two years or less in housing, as consistent with the definition of chronic homelessness in Assembly Bill 361. People experiencing chronic homelessness or cycling through hospitalization or nursing homes often require two years of sustained, consistent services before stabilizing.
 - CB-CMEs should be eligible to receive the modifier only if meeting the requirements included in AB 361 or partnering with agencies who do meet the criteria to deliver HHP services to homeless beneficiaries.
- For the definitions of services, we recommend the following changes:
 - For homeless beneficiaries, clarify references to “communication through e-mails, texts, social media, and phone calls” are applicable to those who are stably housed, and not only allowable until a CB-CME's in-person contacts have established a trusting relationship with the beneficiary.
 - To the definition of *comprehensive care management*, we recommend adding in-person outreach and engagement of beneficiaries to form trusting relationships and to gather information the beneficiary, similar to the definition in CMS guidance, as well as individual housing transition and tenancy sustaining services recognized in the CMS Informational Bulletin (housing-related activities for beneficiaries experiencing chronic homelessness).
 - To the definition of *care coordination*, we recommend including, “Accompanying beneficiaries to appointments when necessary to act as the beneficiary's advocate, to communicate the beneficiary's health goals to care providers, to explain diagnoses and treatment to the beneficiary, and/or to engage the member to follow treatment protocols.” We further recommend adding “providing and arranging transportation to attend appointments, including appointments with social service providers.”
 - To the definition of *health promotion*, we recommend requiring CB-CMEs to use evidence-based practices to engage the beneficiary to manage his or her own care.
 - To the definition of *comprehensive transitional care*, we recommend, “Locating and offering to beneficiaries experiencing homelessness immediate access to respite care or bridge/interim housing

post-discharge until a permanent apartment is made available to the beneficiary,” rather than current language regarding “transitional housing.”

- To the definition of *Individual & Family Support Services*, we recommend encouraging the beneficiary’s own goals drive any connections with family, friends, or other potential support systems.
- To the definition of *Referral to Community & Social Supports*, we recommend including active linkage to social systems and services, such as requirements to create relationships with housing providers, offering warm hand-offs to help the beneficiary navigate through the process of obtaining services impacting the member’s health, and routine check-in with beneficiaries to ensure the beneficiary accesses social services he or she requires. We also recommend adding “food security services” to your list of services.
- If housing navigation services are not included in the definition of care management, we recommend adding housing navigation services to the definition of referral to community and social supports. In defining housing-related activities, we recommend following definitions included in the CMS Informational Bulletin on housing-related activities.
- Regarding MCP and CB-CME responsibilities, we recommend—
 - Encouraging MCPs and CB-CMEs rely on assessments and care plans recognized as evidence-based.
 - Requiring that CB-CMEs develop relationships with housing providers and use existing homeless systems to identify and provide housing solutions for members experiencing homelessness before a CB-CME could receive a homelessness modifier.
 - Including “homeless continuums of care” and “homeless coordinated entry systems” in the list of stakeholders.
 - Requiring both MCPs and CB-CMEs develop plans to meet the treatment needs of people with substance use disorders and/or serious mental illness, as well as partnerships with behavioral health providers.
 - Requiring CB-CMEs to partner with housing providers.
 - Limiting how much of the DHCS payment the MCP may retain for performance of their duties, as other states have done.
 - Clarifying payment will not be based on a per-encounter basis.
 - Developing a simplified, expedited process for certifying CB-CMEs
 - Encouraging MCPs in jurisdictions with limited PCP capacity to contract with non-traditional providers to offer some HHP services.
 - Clarifying that, though PCP staff may provide some of the HHP services, they would be expected to offer these services outside the clinic setting where necessary.
- To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user beneficiaries, we recommend adding a model to the three models the Concept Paper identifies for service provision:
 - **“Model IV:** A collaborative model serving homeless HHP members, Model IV includes services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either the homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care managers and housing navigators engage members where the members live, both before and after the member moves into housing, and the CB-CME team assists the beneficiary

- In listing CB-CME duties, we recommend clarifying—
 - CB-CMEs may focus solely on serving homeless HHP beneficiaries, including persons who have moved into supportive housing after experiencing homelessness.
 - A multidisciplinary care team could consist of staff from multiple agencies and should offer services wherever most accessible to the beneficiary.
 - CB-CMEs partner with permanent housing providers and homeless service providers to reach homeless beneficiaries.

- In developing additional staffing requirements, we recommend—
 - An aggregate care manager/housing navigator ratio of 1:15 to 1:20 (not including MCP staffing) for HHP members who are homeless. In housing and mental health systems, successful case management programs serving homeless and frequent user populations offer in-person, individualized, frequent and flexible services, offered where the person lives, with beneficiary to staff ratios of 1:15 to 1:20.
 - Staffing ratios of 1:25 for other complex beneficiaries beginning to receive HHP services.
 - A staffing ratio of 1:35 to 1:40 once a HHP member can transition to “maintenance.”

- In describing the multidisciplinary team roles, we recommend the following changes:
 - In the *dedicated care manager* role, including, “arranging *and providing* transportation when necessary to provide access to appointments,” and adding, “Accompanying HHP member to office visits.”
 - In the *community health worker* role, adding a requirement the health worker explain materials provided to the beneficiary.
 - In the *housing navigator* role, requiring formation and fostering of relationships with housing agencies, engaging members and potential members in person, and, “Partnering with housing agencies and providers to offer HHP member with permanent housing options, assisting member with moving into permanent housing and promoting housing stability.” We further recommend including housing-related activities, as described in the CMS Informational Bulletin released in June regarding housing-related activities for people experiencing chronic homelessness.

- Regarding member assignment, we recommend requiring an in-person engagement process, particularly for homeless members. For others with complex needs, we recommend supplementing letters with in-person engagement. For referrals, we likewise recommend—
 - Fostering a “no wrong door” approach that allows any agency, behavioral health professional, or PCP to refer a member potentially eligible.
 - Allowing for presumptive eligibility if a beneficiary meets the chronic condition and acuity criteria.
 - Requiring a CB-CME engage with a beneficiary on multiple occasions before discharging a beneficiary.

- Regarding payment methodology, we recommend clarifying a consistent rate structure applicable to all MCPs, rather than allowing some MCPs to develop tiered payment and some MCPs to use a single rate.
 - We recommend a DHCS-imposed risk stratification process, as we are concerned MCPs will use the CalMedi-Connect risk stratification tool to tier payment, or develop tiers based on medical criteria alone.
 - In identifying a tool for tiering, we recommend DHCS adopt criteria similar to criteria other states adopted for intensive care and case management programs based on elements of high risk.
 - We also recommend requiring MCPs develop a per member, per month rate structure for CB-CMEs with which they contract, rather than payment on a per encounter basis, since per-encounter payment in other programs erodes service delivery and imposes administrative burden. We further suggest clarifying how payment for services would be risk-based, or remove the risk-based methodology, since a number of CB-CMEs may not be PCPs, and should not be at risk for all care.
 - We further recommend requiring staffing ratios to justify rates, rather than relying on a prospective payment rate, to ensure CB-CMEs deliver intensive services for the rate they receive, and avoiding use of HHP payment to fund traditional MCO care coordination services.

- In reporting housing outcomes (within operational measures), we recommend changing current housing status to, “The number of members receiving the homeless modifier who are currently living in permanent housing (their own independent apartment not limited by length of stay).” We recommend conducting a separate evaluation for homeless members than other beneficiaries.
- Regarding HHP interaction with other Medi-Cal programs, we urge DHCS to consider funding housing-related activities and services identified in HHP through the 1115 Waiver Whole Person Care Pilot Programs in counties that will not be implementing HHP until July 2017 or later. With the exception of San Francisco, need for HHP services is greatest in the counties that will not be implementing until July 2017 or January 2018. The Whole-Person Care Pilot is an opportunity to build capacity and work through barriers before accessing HHP. Moreover, for counties who have not yet implemented HHP, no danger of duplication of funding exists if a county ends the use of waiver funding for this phase of services before HHP takes effect, or limits the use of waiver funding for these services to persons who do not meet the eligibility criteria for HHP at that time.

Thank you for the opportunity to comment on Concept Paper 3.0.

Sincerely,



Katie Hill
Chief Operating Officer

January 21, 2016

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov

Re: Comments on Health Home Program for People with Complex Needs, Concept Paper 3.0

Dear Health Home Program:

On behalf of Providence Saint John's Health Center I am writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. Providence Saint John's Health Center is a 266 bed general acute Catholic hospital serving Santa Monica and the Westside of Los Angeles. Our Mission includes a strong commitment to the poor and vulnerable, and we have a special focus on the homeless. Because this, we are commenting primarily on the impact of provisions of Concept Paper 3.0 on Medi-Cal beneficiaries experiencing homelessness.

We have great concerns with the timeline as proposed by DHCS. While we understand and appreciate the need for deliberate roll-out of HHP, a 30-month roll-out of the benefit has significant ramifications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties. Group 2 and 3 counties have, in fact, the highest rates of poverty and social barriers to accessing appropriate care. Though many of these counties have developed means of addressing these barriers to care, along with provider capacity, delaying these services until early to mid-2018 will certainly mean the most vulnerable beneficiaries will continue to experience poor health outcomes and high costs.

State initiatives will be difficult to sustain without the promise of HHP services to integrate care at the systems and individual beneficiary level, such as the Whole Person Care pilot and the Medi-Cal Drug Organized Delivery System. At the same time, California will have to bear the costs of poorly managed care among those expansion beneficiaries with complex conditions, and will be required to pay for more of the costs of HHP services for expansion beneficiaries.

Moreover, evaluation results may not be available until well after DHCS has to determine whether to use State General Fund resources to support the ongoing costs of HHP services for Group 1 and Group 2 counties. If implementation in these counties is delayed, this could result in under-estimating the impacts of HHP during the evaluation timeframe. Finally, the fate of HHP and the ACA are uncertain in 2018 and beyond. We are very concerned HHP may never reach those with the greatest need due to failures in full implementation, should services in mostly small, rural counties fail to make any measurable impact.

We therefore recommend the following:

- Including at least one large county with high rates of poverty and providers with capacity, like Alameda or Los Angeles, in Group 1.
- Compressing the timeline by allowing all eligible beneficiaries to access the benefit by October 2017.
- Allowing the Whole-Person Care pilot to fund HHP-like services in the years before HHP implementation begins in counties accessing the pilot.

Whatever DHCS is inclined to include in terms of timeline, we recommend allowing for more robust stakeholder input on the timeline and counties included in each group before finalizing California's State Plan Amendment.

Additionally, in drafting the Health Home State Plan Amendment, we recommend the following changes to proposals outlined in Concept Paper 3.0:

- Regarding eligibility criteria, we recommend—
 - Adding chronic renal disease, HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to your list of eligible conditions.
 - Requiring CB-CMEs be responsible for engaging, in person, members who do not respond to a letter that they are eligible, and that the engagement rate be reserved for in-person, face-to-face engagement activities a CB-CME undertakes.
 - Allowing CB-CMEs to use other sources of data to refer beneficiaries to the HHP program, rather than administrative data.
 - Fostering a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program.
 - Including “chronic homelessness” as an acuity factor.
 - Eliminating the exclusions.
 - Clarifying how DHCS and MCPs will ensure continuity of care for beneficiaries no longer meeting the acuity criteria.

- We recommend DHCS create a tiered payment structure with a homelessness modifier, similar to the structure DHCS released two months ago.
 - We recommend extending the modifier to two years or less in housing, as consistent with the definition of chronic homelessness in Assembly Bill 361. People experiencing chronic homelessness or cycling through hospitalization or nursing homes often require two years of sustained, consistent services before stabilizing.
 - CB-CMEs should be eligible to receive the modifier only if meeting the requirements included in AB 361 or partnering with agencies who do meet the criteria to deliver HHP services to homeless beneficiaries.

- For the definitions of services, we recommend the following changes:
 - For homeless beneficiaries, clarify references to “communication through e-mails, texts, social media, and phone calls” are applicable to those who are stably housed, and not only allowable until a CB-CME’s in-person contacts have established a trusting relationship with the beneficiary.
 - To the definition of *comprehensive care management*, we recommend adding in-person outreach and engagement of beneficiaries to form trusting relationships and to gather information the beneficiary, similar to the definition in CMS guidance, as well as individual housing transition and tenancy sustaining services recognized in the CMS Informational Bulletin (housing-related activities for beneficiaries experiencing chronic homelessness).
 - To the definition of *care coordination*, we recommend including, “Accompanying beneficiaries to appointments when necessary to act as the beneficiary’s advocate, to communicate the beneficiary’s health goals to care providers, to explain diagnoses and treatment to the beneficiary, and/or to engage the member to follow treatment protocols.” We further

- recommend adding “providing and arranging transportation to attend appointments, including appointments with social service providers.”
- To the definition of *health promotion*, we recommend requiring CB-CMEs to use evidence-based practices to engage the beneficiary to manage his or her own care.
 - To the definition of *comprehensive transitional care*, we recommend, “Locating and offering to beneficiaries experiencing homelessness immediate access to respite care or bridge/interim housing post-discharge until a permanent apartment is made available to the beneficiary,” rather than current language regarding “transitional housing.”
 - To the definition of *Individual & Family Support Services*, we recommend encouraging the beneficiary’s own goals drive any connections with family, friends, or other potential support systems.
 - To the definition of *Referral to Community & Social Supports*, we recommend including active linkage to social systems and services, such as requirements to create relationships with housing providers, offering warm hand-offs to help the beneficiary navigate through the process of obtaining services impacting the member’s health, and routine check-in with beneficiaries to ensure the beneficiary accesses social services he or she requires. We also recommend adding “food security services” to your list of services.
- If housing navigation services are not included in the definition of care management, we recommend adding housing navigation services to the definition of referral to community and social supports. In defining housing-related activities, we recommend following definitions included in the CMS Informational Bulletin on housing-related activities.
 - Regarding MCP and CB-CME responsibilities, we recommend—
 - Encouraging MCPs and CB-CMEs rely on assessments and care plans recognized as evidence-based.
 - Requiring that CB-CMEs develop relationships with housing providers and use existing homeless systems to identify and provide housing solutions for members experiencing homelessness before a CB-CME could receive a homelessness modifier.
 - Including “homeless continuums of care” and “homeless coordinated entry systems” in the list of stakeholders.
 - Requiring both MCPs and CB-CMEs develop plans to meet the treatment needs of people with substance use disorders and/or serious mental illness, as well as partnerships with behavioral health providers.
 - Requiring CB-CMEs to partner with housing providers.
 - Limiting how much of the DHCS payment the MCP may retain for performance of their duties, as other states have done.
 - Clarifying payment will not be based on a per-encounter basis.
 - Developing a simplified, expedited process for certifying CB-CMEs
 - Encouraging MCPs in jurisdictions with limited PCP capacity to contract with non-traditional providers to offer some HHP services.
 - Clarifying that, though PCP staff may provide some of the HHP services, they would be expected to offer these services outside the clinic setting where necessary.
 - To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user beneficiaries, we recommend adding a model to the three models the Concept Paper identifies for service provision:

- **“Model IV:** A collaborative model serving homeless HHP members, Model IV includes services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either the homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care managers and housing navigators engage members where the members live, both before and after the member moves into housing, and the CB-CME team assists the beneficiary
- In listing CB-CME duties, we recommend clarifying—
 - CB-CMEs may focus solely on serving homeless HHP beneficiaries, including persons who have moved into supportive housing after experiencing homelessness.
 - A multidisciplinary care team could consist of staff from multiple agencies and should offer services wherever most accessible to the beneficiary.
 - CB-CMEs partner with permanent housing providers and homeless service providers to reach homeless beneficiaries.
- In developing additional staffing requirements, we recommend—
 - An aggregate care manager/housing navigator ratio of 1:15 to 1:20 (not including MCP staffing) for HHP members who are homeless. In housing and mental health systems, successful case management programs serving homeless and frequent user populations offer in-person, individualized, frequent and flexible services, offered where the person lives, with beneficiary to staff ratios of 1:15 to 1:20.
 - Staffing ratios of 1:25 for other complex beneficiaries beginning to receive HHP services.
 - A staffing ratio of 1:35 to 1:40 once a HHP member can transition to “maintenance.”
- In describing the multidisciplinary team roles, we recommend the following changes:
 - In the dedicated care manager role, including, “arranging and providing transportation when necessary to provide access to appointments,” and adding, “Accompanying HHP member to office visits.”
 - In the community health worker role, adding a requirement the health worker explain materials provided to the beneficiary.
 - In the housing navigator role, requiring formation and fostering of relationships with housing agencies, engaging members and potential members in person, and, “Partnering with housing agencies and providers to offer HHP member with permanent housing options, assisting member with moving into permanent housing and promoting housing stability.” We further recommend including housing-related activities, as described in the CMS Informational Bulletin released in June regarding housing-related activities for people experiencing chronic homelessness.

- Regarding member assignment, we recommend requiring an in-person engagement process, particularly for homeless members. For others with complex needs, we recommend supplementing letters with in-person engagement. For referrals, we likewise recommend—
 - Fostering a “no wrong door” approach that allows any agency, behavioral health professional, or PCP to refer a member potentially eligible.
 - Allowing for presumptive eligibility if a beneficiary meets the chronic condition and acuity criteria.
 - Requiring a CB-CME engage with a beneficiary on multiple occasions before discharging a beneficiary.

- Regarding payment methodology, we recommend clarifying a consistent rate structure applicable to all MCPs, rather than allowing some MCPs to develop tiered payment and some MCPs to use a single rate.
 - We recommend a DHCS-imposed risk stratification process, as we are concerned MCPs will use the CalMedi-Connect risk stratification tool to tier payment, or develop tiers based on medical criteria alone.
 - In identifying a tool for tiering, we recommend DHCS adopt criteria similar to criteria other states adopted for intensive care and case management programs based on elements of high risk.
 - We also recommend requiring MCPs develop a per member, per month rate structure for CB-CMEs with which they contract, rather than payment on a per encounter basis, since per-encounter payment in other programs erodes service delivery and imposes administrative burden. We further suggest clarifying how payment for services would be risk-based, or remove the risk-based methodology, since a number of CB-CMEs may not be PCPs, and should not be at risk for all care.
 - We further recommend requiring staffing ratios to justify rates, rather than relying on a prospective payment rate, to ensure CB-CMEs deliver intensive services for the rate they receive, and avoiding use of HHP payment to fund traditional MCO care coordination services.

- In reporting housing outcomes (within operational measures), we recommend changing current housing status to, “The number of members receiving the homeless modifier who are currently living in permanent housing (their own independent apartment not limited by length of stay).” We recommend conducting a separate evaluation for homeless members than other beneficiaries.

- Regarding HHP interaction with other Medi-Cal programs, we urge DHCS to consider funding housing-related activities and services identified in HHP through the 1115 Waiver Whole Person Care Pilot Programs in counties that will not be implementing HHP until July 2017 or later. With the exception of San Francisco, need for HHP services is greatest in the counties that will not be implementing until July 2017 or January 2018. The Whole-Person Care Pilot is an opportunity to build capacity and work through barriers before accessing HHP. Moreover, for counties who have not yet implemented HHP, no danger of duplication of funding exists if a county ends the use of waiver funding for this phase of services before HHP takes effect, or limits the use of waiver funding for these services to persons who do not meet the eligibility criteria for HHP at that time.

Thank you for the opportunity to comment on Concept Paper 3.0.

Sincerely,

Mary P. Luthy
Director of Community Benefits
Providence Saint John's Health Center

**Health Homes for Patients with Complex Needs
Version 3.0 (Final)**

12/18/15

Version 3.0 presents the first full blueprint of the California health home model, an accomplishment clearly achieved through significant effort by the DHCS, their data analysts, experts and many stakeholder groups. This paper demonstrates the DHCS's commitment to using Medi-Cal data analysis and stakeholder input to develop the California health home model. The list of chronic conditions clearly derives from both these sources of information.

The State has also chosen a roll out sequence, which will allow for the health home program to unfold in such a way that lessons from the first counties' implementation can inform the program start-up in the second and third cohorts. This staging seems to offer the overall health home program a longer timeframe to realize its intended health improvement and cost reduction.

Given that the first HHP's to begin providing integrated care in each geographic roll out of the program are those who will serve Medi-Cal patients with SMI, this analysis suggests that the DHCS initiate engagement and assessment activities with Counties and their contracted CMHP and SUD providers as expeditiously as possible. Suggested approaches for working with these providers appear on page four of this analysis.

In response to the blueprint presented in this DHCS document, this analysis focuses on potential approaches to strengthen the health home plan. Analysis is organized to follow the sections and pages laid out in the DHCS Health Homes for Patients with Complex Needs California Concept Paper Version 3.0.

Suggested HHP Refinements for DHCS Consideration

A. Eligibility Criteria – Chronic Conditions, p. 7

The list of qualifying chronic diseases seems quite logical and looks to derive from careful MediCal data analysis. The eligibility list appears, however, to exclude children, unless they have both Asthma and a Substance Use Disorder, or one of the SMI conditions, for which onset occurs after the age of 15, or more commonly between the ages of 20-35.

Further, because there is no standard diagnosis code for Trauma nor are those codes for excess BMI readily used, the strong correlation between these and the chronic diseases included on the list would not have featured in the IDC 9/ IDC 10 code study. The following list suggests related modifications to the list of chronic conditions.

- A. Include excess BMI scores (>30) as a qualifying condition among those listed in the first bullet point. Elevated BMI has a strong correlation to trauma and mental health issues.
- B. Screen children with Asthma, excess BMI or substance use disorder for Trauma.
- C. Screen adults with one of the qualifying physical conditions and either a hospitalization or three visits to the Emergency Department within the last year for Trauma.
- D. Include risk score assessment for ACES to the list of assessments for all HHP patients who meet the qualifying conditions.
- E. Add an ACE's score of four or more to the category of qualifying behavioral health disorders.

REED

HEALTH POLICY CONSULTING, LLC

- F. Alternatively, in the case that an ACE's score is four or higher, allow MediCal providers the same discretion to refer these patients into the MCP as they have for patients with Chronic Renal Disease. (p. 8)

B. Health Home Program Services

Care Coordination, p. 9

In terms of creating a high performance HHP team, other states have found that the more closely imbedded in the clinic the community support services are, the better. Regular interaction among full range of providers and community outreach and patient support staff facilitate care integration and appropriate use of staff skills and capacities. Debate exists whether off site MCP care coordinators can provide sufficient engagement with health care team. In rural areas, shared care coordinators may be essential, but where possible this role needs to be imbedded in the clinic team.

On a financial level, making sure care coordinators have in person access to both patients and the clinical team allows them to handle patient issues directly when appropriate. Efficient delegation of patient care activities to the most appropriate skill level has resulted in lower patient costs in other states' health homes.

Amend these sections to include text added in *red below*:

- p. 9, #2 Care Coordination
- p. 10, Comprehensive Transitional Care, last line
- p. 11, Individual and Family Supports
- p. 11, #6 Referral to Community Supports

Communication and information will meet health literacy standards*, **trauma informed care standards*** and be culturally appropriate.

C. Health Homes Program Network Infrastructure, p. 13

p. 13 Paragraph 1, last sentence: In relation to the Fee-For Service exclusion, how will Foster Youth in FFS learn whether they are eligible for the health home option?

Leveraging Existing MCP Health Assessment Tools, paragraph 4, p. 14: **addition**

The assessments must be available to the primary care physicians, ***mental health service providers and substance use disorder services providers.***

D. Medi-Cal Managed Care Plan Responsibilities p. 17

Bullet #3 MCP's will need to also report hospital discharges to the HHP.

E. Community Based Care Management Entity Responsibilities, p. 17

Community Based Care Management Models:

Overall commentary on Models I-III: the most effective HHP designs in states, which have already rolled out their programs come from co-location of BH, SUD and PCP care, whether these services be offered by one single entity or a group of organizations providing services in the same

REED

HEALTH POLICY CONSULTING, LLC

location. This approach may be especially effective for health homes where the patient has SMI and has chosen a CMHP or SUD provider as his HHP. In some cases, for SUD providers and CMHP's hiring a Nurse Practitioner may prove an effective approach to offer physical health care services within the mental health setting.

Additional options include a partnership among health care agencies in reasonably close proximity, and the use of Telehealth for BH services.

p. 22, final bullet **Add:**

- Provide quality-driven, cost-effective HHP services in a culturally competent ***and trauma informed*** manner that addresses health disparities and improves health literacy

q. 23, Table, Dedicated Care Manager, bullet 5: **strike:**

- Use ***tools like*** motivational interviewing and trauma informed care practices

r. 23, Table, HHP Director

Skills with clinic and health data management are critical for this oversight role. Other states have found hiring a PCP Nurse into this role to be highly effective.

F. Service Delivery

p. 28, Second paragraph:

See last comment about necessity for HHP Director capacity to manage health data.

P. 30, **replace**

Additional tools such as member and provider surveys/self-assessments ***change "may" to "will"*** be utilized to inform the evaluation on subjects such as member satisfaction...

p. 30, Table 2

Utilize the BMI Core Measures in decision-making process for inclusion of a Medi-Cal patient in the HHP program as discussed in commentary on "Section A" of this document. Add the original ACE's survey tool from the CDC and Kaiser Permanente study, unless a new tool including these historical data points comes available during the HHP program.

G. A HHP Integration with Existing Medi-Cal Programs, Mental Health and Substance Use Disorder, p. 30

In order to assure preparedness of organizations who will care for HHP members with SMI, the DHCS would do well to assess MHP's and their contracted CMHP's, as well as SUD providers in relation to the following:

- CMHP and SUD network and individual agency capacity to take on additional patients and to transform their service approach.
- What type of care coordination they already offer their patients and how this can be adapted to include physical health care as well.
- CMHP's and SUD's EHR/EHI systems.
- Cooperation or integration of SUD and CMHP with local FQHC's, PCP provider groups, and hospitals.

REED

HEALTH POLICY CONSULTING, LLC

- Integration standards for communication and data exchange among PCP, BH and SUD providers and the hospital in a health home network.

H. Technical Assistance, p. 35

The Technical Assistance program would be a good place to include Trauma Informed Care training for all CB-CBME's.

To ensure the success of the California health home program, it would be highly beneficial to transforming the TA effort with the forty CB-CBME's into an on-going learning group or incubator made up of select representatives from the DHCS, MHP's, MCP's, CB-CME providers and care coordinators, patients, etc.

The group would focus on replicable aspects of HHP successes and on trouble shooting common implementation issues. As part of this incubator effort findings of this group would go to all entities participating in the California HHP. Additionally, making TA available to individual organizations on an as needed basis throughout the eight quarters would help stabilize this complex program.

December 21, 2015

California Department of Health Care Services (DHCS)
Via email: hhp@dhcs.ca.gov

Re: Comments on Health Homes Concept Paper Version 3.0 – support for inclusion of asthma

Dear DHCS staff:

Thank you for the opportunity to comment on the recently released Concept Paper Version 3.0 for California's Health Homes for Patients with Complex Needs program (HHP). The undersigned organizations and individuals are in strong support of the promise of the Health Home model, and have specific recommendations for making it as effective as possible for the high-need members within the Medi-Cal system.

Maintain inclusion of asthma as a qualifying condition but loosen overall eligibility requirements.

We are very pleased that asthma is included as one of the chronic conditions eligible for services under the HHP. Addressing asthma within the HHP can help achieve the state's triple aim goal of better health, better care, and lower costs. Consistent with the Health Home approach, there is a strong evidence base of effective asthma interventions leading to improved health outcomes and costs savings, both of which are realized in a very short amount of time. Additionally, as you undoubtedly know asthma is of particular concern to California's Medi-Cal population: low income is associated with higher asthma severity, poorer asthma control, and higher rates of asthma emergency department visits and hospitalizations. According to the California Department of Public Health, "Medi-Cal beneficiaries represent a high-risk population for asthma,"ⁱ while 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%).ⁱⁱ

However, we are concerned that the new concept paper effectively limits the member eligibility pool by requiring, in most cases, that members have two chronic conditions, e.g., asthma and another condition such as diabetes, chronic liver disease, or congestive heart failure. Previous concept papers suggested that a greater number of Medi-Cal members would be eligible based on having one chronic condition while being at-risk for another. While the concept paper does note that "the HHP is intended to be an intensive set of services for a small subset of members who require coordination at the highest levels," evidence indicates that individuals with severe asthma would benefit from HHP services even if they're not diagnosed with another condition. For example, 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."ⁱⁱⁱ Such qualities can also be extended to treating adult asthma per the HHP 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.^{iv}

Comprehensive care management

- "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

- “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.”¹⁰ 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.

Support for use of Community Health Workers within the HHP

We were pleased to see the latest concept paper include Community Health Workers (CHWs) as a key part of the HHP’s multi-disciplinary care team, with roles such as engaging eligible HHP members, health promotion and self-management training, distributing health promotion materials, and assisting with linkages to social supports (Concept Paper pg24). There is extensive evidence showing that CHWs play a key role in helping patients manage their asthma in a culturally competent manner, improving health outcomes, and reducing health care expenditures by avoiding more costly hospitalizations and emergency room visits.^{vi} As California continues to expand and explore the use of CHWs and other front-line providers in order to improve delivery of better and cost-effective care, the HHP will hopefully be a useful source of information and lessons that can be applied to other programs.

In closing, 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 appreciate that asthma is included within the HHP. We look forward to working with you to implement an effective Health Home Program that serves the needs of Medi-Cal members.

Regards,

Joel Ervice
Regional Asthma Management and Prevention (RAMP)

Scott Takahashi
Asthma Coalition of Los Angeles County

Mindy Benson
Primary Care Clinic, UCSF Benioff Children's Hospital Oakland

Karen Cohn
San Francisco Asthma Task Force

Loretta Jones
Healthy African American Families

Linda Kite
Healthy Homes Collaborative

Jim Mangia
St. John's Well Child & Family Center

Carlos Bello and Jeffrey Cao
Kern County Asthma Coalition

Sylvia Betancourt
Long Beach Alliance for Children with Asthma

Marielena Lara
Professor of Pediatrics, USC School of Medicine

Cary Sanders
California Pan-Ethnic Health Network

Elsa Chagolla
Inquilinos Unidos (Tenants United)

Meryl Bloomrosen
Asthma and Allergy Foundation of America

Juan Tafolla
Kings County Tobacco-Free Partnership

Brenda Rueda-Yamashita
Chronic Disease Program, Alameda County Public Health Department

Dottie Vera-Weis
Former Chair, San Mateo County Asthma Task Force

Leticia Ibarra
Clinicas de Salud del Pueblo, Inc.

ⁱ *Ibid*

ⁱⁱ California Health Interview Survey data. 2011. UCLA Center for Health Policy Research.

<http://ask.chis.ucla.edu/main/default.asp>

ⁱⁱⁱ 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

^{iv} 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.

^v 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>

^{vi} For a variety of resources on the effectiveness of CHWs, see the U.S. Environmental Protection Agency's Asthma Community Network website:

<http://www.asthmacommunitynetwork.org/search/node/community%20health%20workers>.



December 21, 2015

Jennifer Kent, Director
California Department of Health Care Services (DHCS)
P.O. Box 997413, MS0000
Sacramento, CA 95899-7413

Dear Director Kent:

The SCAN Foundation commends the state's evolving effort to develop the health home concept, as embodied in version 3.0 of *Health Homes for Patients with Complex Needs (HHP)*, and appreciate the opportunity to comment. We have identified some areas where additional specificity could help the concept's clarity, with the following comments addressing various aspects of person-centered care and synergy with the Coordinated Care Initiative.

Identify synergies with the Coordinated Care Initiative (CCI). Version 3.0 underscores the objective to create synergies with the Cal MediConnect (CMC) program. We also believe that the state's HHP concept has synergies with the managed LTSS program (MLTSS) serving individuals who are dual eligible and not enrolled in CMC as well as those only eligible for Medi-Cal. According to [All Plan Letter 14-010](#), Medi-Cal managed care plans in CCI counties are required to develop individual care plans and coordinate services for older adults and people with disabilities who are covered only by Medi-Cal. Therefore, we recommend that this HHP objective be expanded to create clear and consistent synergies with the entirety of CCI. Further, 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 program requirements.

Define person-centered care to communicate clear expectations. We are pleased to see that Version 3.0 continues to include reference to person-centered care. Because this term is defined differently across the system, we recommend that the state clearly define and establish standards for person-centered care. In 2015, the Foundation partnered with the American Geriatrics Society and University of Southern California to convene experts to create a formal, actionable definition of person-centered care. Recent [articles](#) published in the *Journal of the American Geriatrics Society* defined person-centered care, which means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals. These articles also describe ways organizations are using a person-centered care approach for a high-need/high-risk older populations.

Include individuals' personal goals in the health action plan (HAP). Version 3.0 identifies that one role of comprehensive care management is to “support the achievement of the member’s self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines (p. 9).” We recommend re-phrasing this definition to include goals of health and well-being as we believe that improving health status relies equally on the broader set of a person’s goals relating to functional capacity and independence.

Include people at risk for homelessness when defining “homelessness.” The HHP specifically focuses on individuals who are homeless. We recommend that the state defines homelessness and includes people exiting a publicly funded institution or system of care who are at risk for homelessness, per the [Code of Federal Regulations Title 24](#). This inclusion in Version 3.0 will allow people who desire to transition from institutions facing housing barriers to access the care coordination and transition services available through the HHP.

Specifically include transitions from nursing homes in the definition of comprehensive transitional care. The paper specifies that comprehensive transitional care “includes services to facilitate HHP members’ transitions among treatment facilities, including admissions and discharges... (and) to ensure prompt notification...and tracking of member’s admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required (p. 10).” We recommend that transitions from nursing home to home/community be mentioned explicitly in the definition of comprehensive transitional care, consistent with the state’s interest in ensuring individuals have the opportunity to live in the least restrictive environment according to their needs, values, and preferences.

Use person-centered communication strategies to support successful outcomes. HHP services include several opportunities to communicate with individuals through development of the HAP, health promotion, and transition services. In order to address literacy barriers, we recommend including questions to assess for education attainment and potential learning disabilities. Such information would be helpful in shaping communication mechanisms to meet the individual’s needs and help ensure successful outcomes for health promotion and transitions.

Reduce confusion with clear beneficiary notifications. Version 3.0 indicates that the Medi-Cal managed care plans will connect enrollees with a community-based care management entity, and notify individuals by letter. We appreciate that by law eligible individuals must be notified by letter. Given challenges in previous transitions Medi-Cal beneficiaries have experienced, we include two recommendations. First we recommend that the state seek significant stakeholder feedback on HHP notifications to develop the most effective form of communication possible. This could include focus groups with individuals who have participated in CMC and/or the Seniors and Persons with Disabilities (SPD) transitions. It should also include a readability assessment from the [Health Research for Action](#) at University of California, Berkeley. Second, previous transition efforts also demonstrated that Medi-Cal beneficiaries may not read or respond to notices sent by mail. Therefore, we recommend implementing a process whereby

trusted information sources are utilized to assist in the outreach/enrollment process. To this end, the individual's primary care physician and/or staff in the physician's office could provide information and explain the HHP during an office visit.

Develop provider education to support successful implementation. The success of CMC has been challenged by confusion among providers about CMC implementation and processes. We recommend that DHCS develop and implement a wide ranging education and outreach strategy 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.

Require key providers to participate in the multi-disciplinary care team. Version 3.0 specifically requires a dedicated care manager, the HHP director, clinical consultant, community health workers, and housing navigator (for homeless) to participate in the multi-disciplinary care team. While other providers may participate, they are not required. For example, the primary care physician is not a required member of the team, but needs to be made aware of the HHP. A recent [report](#) elevating practice issues in the duals demonstration identified primary care physician participation in the individual care teams as a challenge. The report calls for providing incentives, such as compensation for participation. Version 3.0 suggests that physicians could be compensated for their participation in the multi-disciplinary team as part of the HHP. We support a limited use of such incentives to help providers initiate with this new model of care.

The Foundation appreciates the continued opportunity to inform development of integrated models of care through information sharing and feedback on the state's proposals. As you know, we support models of care that are integrated and place individuals and their families at the center of the decision-making process. We appreciate the thoughtful approach and level of detail outlined in Version 3.0, demonstrating the state's commitment to integrated care through the HHP.

Sincerely,

A handwritten signature in black ink, appearing to read 'Bruce A. Chernof', with a stylized flourish at the end.

Bruce A. Chernof, M.D.
President and CEO

December 22, 2015

1317 E. 7th Street
Los Angeles, CA 90021
213.683.0522 Tel
213.683.0781 Fax
www.skidrow.org

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov

Board of Directors

Patrick Spillane
IDS Real Estate
Chairman

Adam Handler
PricewaterhouseCoopers
Secretary

Robert Morse
Treasurer

Jennifer Caspar

Paul Gregerson, MD
JWCH Institute

Simon Ha
Steinberg

Marc Hayutin
Sidley Austin LLP

Cheryl Hayward

Curtis Hessler

Vivienne Lee
REDF

Elsa Luna
Los Angeles Universal Preschool

Michael Alvidrez
Executive Director

Re: Comments on Health Home Program for People with Complex Needs,
Concept Paper 3.0

Dear Health Home Program:

On behalf of Skid Row Housing Trust, I am writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. Skid Row Housing Trust is a non-profit organization based in Downtown Los Angeles that preserves, creates and operates permanent supportive housing so that people who have experienced homelessness, prolonged extreme poverty, poor health, disabilities, mental illness and/or addiction can lead safe, stable lives in wellness. We currently manage a portfolio of 25 properties totaling 1,784 units of affordable and permanent supportive housing.

Access to safe, quality, affordable housing – and the supports necessary to maintain that housing – constitute one of the most basic and powerful social determinants of health. For individuals and families trapped in a cycle of crisis and housing instability due to extreme poverty, trauma, violence, mental illness, addiction or other chronic health conditions, permanent supportive housing (PSH) can entirely dictate their health and health trajectory. Because of the focus of our organization, we are commenting primarily on the impact of provisions of Concept Paper 3.0 on Medi-Cal beneficiaries experiencing homelessness.

We have great concerns with the timeline as proposed by DHCS. While we understand and appreciate the need for deliberate roll-out of HHP, a 30-month roll-out of the benefit has significant ramifications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties. Group 2 and 3 counties have, in fact, the highest rates of poverty and social barriers to accessing appropriate care. Though many of these counties have developed means of addressing these barriers to care, along with provider capacity, delaying these services until early to mid-2018 will certainly mean the most vulnerable beneficiaries will continue to experience poor health outcomes and high costs.

State initiatives will be difficult to sustain without the promise of HHP services to integrate care at the systems and individual beneficiary level, such as the Whole Person Care pilot and the Medi-Cal Drug Organized Delivery System. At the same time, California will have to bear the costs of poorly managed care among those expansion beneficiaries with complex conditions, and will be required to pay for more of the costs of HHP services for expansion beneficiaries.

Moreover, evaluation results may not be available until well after DHCS has to determine whether to use State General Fund resources to support the ongoing costs of HHP services for Group 1 and Group 2 counties. If implementation in these counties is delayed, this could result in under-estimating the impacts of HHP during the evaluation timeframe. Finally, the fate of HHP and the ACA are uncertain in 2018 and beyond. We are very concerned HHP may never reach those with the greatest need due to failures in full implementation, should services in mostly small, rural counties fail to make any measurable impact.

We therefore recommend the following:

- Including at least one large county with high rates of poverty and providers with capacity, like Alameda or Los Angeles, in Group 1.
- Compressing the timeline by allowing all eligible beneficiaries to access the benefit by October 2017.
- Allowing the Whole-Person Care pilot to fund HHP-like services in the years before HHP implementation begins in counties accessing the pilot.

Whatever DHCS is inclined to include in terms of timeline, we recommend allowing for more robust stakeholder input on the timeline and counties included in each group before finalizing California's State Plan Amendment.

Thank you for the opportunity to comment on Concept Paper 3.0

Sincerely,

A handwritten signature in blue ink that reads "Mike Alvidrez". The signature is fluid and cursive, with a long, sweeping underline that extends to the right.

Mike Alvidrez
Chief Executive Officer



Herbert K. Hatanaka, DSW

Executive Director

December 23, 2015

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov

Re: Comments on Health Home Program for People with Complex Needs, Concept Paper 3.0

Dear Health Home Program:

On behalf of Special Service for Groups, I am writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. SSG is a human and social service organization founded in 1952. We serve the most disenfranchised and marginalized members of society, with particular emphasis on the homeless and severely mentally ill across Los Angeles County. Because of the focus of our organization, we are commenting primarily on the impact of provisions of Concept Paper 3.0 on Medi-Cal beneficiaries experiencing homelessness.

We have great concerns with the timeline as proposed by DHCS. While we understand and appreciate the need for deliberate roll-out of HHP, a 30-month roll-out of the benefit has significant ramifications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties. Group 2 and 3 counties have, in fact, the highest rates of poverty and social barriers to accessing appropriate care. Though many of these counties have developed means of addressing these barriers to care, along with provider capacity, delaying these services until early to mid-2018 will certainly mean the most vulnerable beneficiaries will continue to experience poor health outcomes and high costs.

We therefore recommend the following:

- Including at least one large county with high rates of poverty and providers with capacity, like Alameda or Los Angeles, in Group 1.
- Compressing the timeline by allowing all eligible beneficiaries to access the benefit by October 2017.
- Allowing the Whole-Person Care pilot to fund HHP-like services in the years before HHP implementation begins in counties accessing the pilot.

Whatever DHCS is inclined to include in terms of timeline, we recommend allowing for more robust stakeholder input on the timeline and counties included in each group before finalizing California's State Plan Amendment.

Additionally, in drafting the Health Home State Plan Amendment, we recommend the following changes to proposals outlined in Concept Paper 3.0:

- Regarding eligibility criteria, we recommend—
 - Adding HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to your list of eligible conditions.
 - Requiring CB-CMEs be responsible for engaging, in person, members who do not respond to a letter that they are eligible, and that the engagement rate be reserved for in-person, face-to-face engagement activities a CB-CME undertakes.
 - Allowing CB-CMEs to use other sources of data to refer beneficiaries to the HHP program, rather than administrative data.
 - Fostering a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program.
 - Including “chronic homelessness” as an acuity factor.
 - Eliminating the exclusions.
 - Clarifying how DHCS and MCPs will ensure continuity of care for beneficiaries no longer meeting the acuity criteria.

- We recommend DHCS create a tiered payment structure with a homelessness modifier, similar to the structure DHCS released two months ago.
 - We recommend extending the modifier to two years or less in housing, as consistent with the definition of chronic homelessness in Assembly Bill 361. People experiencing chronic homelessness or cycling through hospitalization or nursing homes often require two years of sustained, consistent services before stabilizing.
 - CB-CMEs should be eligible to receive the modifier only if meeting the requirements included in AB 361 or partnering with agencies who do meet the criteria to deliver HHP services to homeless beneficiaries.

- For the definitions of services, we recommend the following changes:
 - For homeless beneficiaries, clarify references to “communication through e-mails, texts, social media, and phone calls” are applicable to those who are stably housed, and not only allowable until a CB-CME’s in-person contacts have established a trusting relationship with the beneficiary.
 - To the definition of *comprehensive care management*, we recommend adding in-person outreach and engagement of beneficiaries to form trusting relationships and to gather information the beneficiary, similar to the definition in CMS guidance, as well as individual housing transition and tenancy sustaining services recognized in the CMS Informational Bulletin (housing-related activities for beneficiaries experiencing chronic homelessness).
 - To the definition of *care coordination*, we recommend including, “Accompanying beneficiaries to appointments when necessary to act as the beneficiary’s advocate, to communicate the beneficiary’s health goals to care providers, to explain diagnoses and treatment to the beneficiary, and/or to engage the member to follow treatment protocols.” We further recommend adding “providing and arranging transportation to attend appointments, including appointments with social service providers.”
 - To the definition of *health promotion*, we recommend requiring CB-CMEs to use evidence-based practices to engage the beneficiary to manage his or her own care.

- To the definition of *comprehensive transitional care*, we recommend, “Locating and offering to beneficiaries experiencing homelessness immediate access to respite care or bridge/interim housing post-discharge until a permanent apartment is made available to the beneficiary,” rather than current language regarding “transitional housing.”
- To the definition of *Individual & Family Support Services*, we recommend encouraging the beneficiary’s own goals drive any connections with family, friends, or other potential support systems.
- To the definition of *Referral to Community & Social Supports*, we recommend including active linkage to social systems and services, such as requirements to create relationships with housing providers, offering warm hand-offs to help the beneficiary navigate through the process of obtaining services impacting the member’s health, and routine check-in with beneficiaries to ensure the beneficiary accesses social services he or she requires. We also recommend adding “food security services” to your list of services.
- If housing navigation services are not included in the definition of care management, we recommend adding housing navigation services to the definition of referral to community and social supports. In defining housing-related activities, we recommend following definitions included in the CMS Informational Bulletin on housing-related activities.
- Regarding MCP and CB-CME responsibilities, we recommend—
 - Encouraging MCP’s to contract with CB-CME organizations that have successful track records of serving the hardest to reach, most complex clients and those organizations with accreditation or seals of approval from national/international accrediting bodies such as Council on Accreditation, CARF, The Joint Commission, etc.
 - Encouraging MCPs and CB-CMEs rely on assessments and care plans recognized as evidence-based.
 - Requiring that CB-CMEs develop relationships with housing providers and use existing homeless systems to identify and provide housing solutions for members experiencing homelessness before a CB-CME could receive a homelessness modifier.
 - Including “homeless continuums of care” and “homeless coordinated entry systems” in the list of stakeholders.
 - Requiring both MCPs and CB-CMEs develop plans to meet the treatment needs of people with substance use disorders and/or serious mental illness, as well as partnerships with behavioral health providers.
 - Requiring CB-CMEs to partner with housing providers.
 - Limiting how much of the DHCS payment the MCP may retain for performance of their duties, as other states have done. We also recommend a cap of 12%.
 - Clarifying payment will not be based on a per-encounter basis.
 - Developing a simplified, expedited process for certifying CB-CMEs
 - Encouraging MCPs in jurisdictions with limited PCP capacity to contract with non-traditional providers to offer some HHP services.
 - Clarifying that, though PCP staff may provide some of the HHP services, they would be expected to offer these services outside the clinic setting where necessary.
- To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user beneficiaries, we recommend adding a model to the three models the Concept Paper identifies for service provision:

- **“Model IV:** A collaborative model serving homeless HHP members, Model IV includes services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either the homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care managers and housing navigators engage members where the members live, both before and after the member moves into housing, and the CB-CME team assists the beneficiary
- In listing CB-CME duties, we recommend clarifying—
 - CB-CMEs may focus solely on serving homeless HHP beneficiaries, including persons who have moved into supportive housing after experiencing homelessness.
 - A multidisciplinary care team could consist of staff from multiple agencies and should offer services wherever most accessible to the beneficiary.
 - CB-CMEs partner with permanent housing providers and homeless service providers to reach homeless beneficiaries.
- In developing additional staffing requirements, we recommend—
 - An aggregate care manager/housing navigator ratio of 1:15 to 1:20 (not including MCP staffing) for HHP members who are homeless. In housing and mental health systems, successful case management programs serving homeless and frequent user populations offer in-person, individualized, frequent and flexible services, offered where the person lives, with beneficiary to staff ratios of 1:15 to 1:20.
 - Staffing ratios of 1:25 for other complex beneficiaries beginning to receive HHP services.
 - A staffing ratio of 1:35 to 1:40 once a HHP member can transition to “maintenance.”
- In describing the multidisciplinary team roles, we recommend the following changes:
 - In the dedicated care manager role, including, “arranging and providing transportation when necessary to provide access to appointments,” and adding, “Accompanying HHP member to office visits.”
 - In the community health worker role, adding a requirement the health worker explain materials provided to the beneficiary.
 - In the housing navigator role, requiring formation and fostering of relationships with housing agencies, engaging members and potential members in person, and, “Partnering with housing agencies and providers to offer HHP member with permanent housing options, assisting member with moving into permanent housing and promoting housing stability.” We further recommend including housing-related activities, as described in the CMS Informational Bulletin released in June regarding housing-related activities for people experiencing chronic homelessness.

- Regarding payment methodology, we recommend clarifying a consistent rate structure applicable to all MCPs, rather than allowing some MCPs to develop tiered payment and some MCPs to use a single rate.
 - We recommend a DHCS-imposed risk stratification process, as we are concerned MCPs will use the CalMedi-Connect risk stratification tool to tier payment, or develop tiers based on medical criteria alone.
 - In identifying a tool for tiering, we recommend DHCS adopt criteria similar to criteria other states adopted for intensive care and case management programs based on elements of high risk.
 - We also recommend requiring MCPs develop a per member, per month rate structure for CB-CMEs with which they contract, rather than payment on a per encounter basis, since per-encounter payment in other programs erodes service delivery and imposes administrative burden. We further suggest clarifying how payment for services would be risk-based, or remove the risk-based methodology, since a number of CB-CMEs may not be PCPs, and should not be at risk for all care.
 - We further recommend requiring staffing ratios to justify rates, rather than relying on a prospective payment rate, to ensure CB-CMEs deliver intensive services for the rate they receive, and avoiding use of HHP payment to fund traditional MCO care coordination services.

- In reporting housing outcomes (within operational measures), we recommend changing current housing status to, “The number of members receiving the homeless modifier who are currently living in permanent housing (their own independent apartment not limited by length of stay).” We recommend conducting a separate evaluation for homeless members than other beneficiaries.

- Regarding HHP interaction with other Medi-Cal programs, we urge DHCS to consider funding housing-related activities and services identified in HHP through the 1115 Waiver Whole Person Care Pilot Programs in counties that will not be implementing HHP until July 2017 or later. With the exception of San Francisco, need for HHP services is greatest in the counties that will not be implementing until July 2017 or January 2018. The Whole-Person Care Pilot is an opportunity to build capacity and work through barriers before accessing HHP. Moreover, for counties who have not yet implemented HHP, no danger of duplication of funding exists if a county ends the use of waiver funding for this phase of services before HHP takes effect, or limits the use of waiver funding for these services to persons who do not meet the eligibility criteria for HHP at that time.

Thank you for the opportunity to comment on Concept Paper 3.0.

Sincerely,



Herbert K. Hatanaka, DSW

Executive Director



December 22, 2015

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhes.ca.gov

Re: Comments on Health Home Program for People with Complex Needs, Concept Paper 3.0

Dear Health Home Program:

On behalf of St. John's Well child and Family center, I am writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. St. John's Well child and Family center, is a medical clinic in South Los Angeles that through the 50 years of service in the community, continues to promote health care and social justice. Because of the focus of our organization, we are commenting primarily on the impact of provisions of Concept Paper 3.0 on Medi-Cal beneficiaries experiencing homelessness.

We have great concerns with the timeline as proposed by DHCS. While we understand and appreciate the need for deliberate roll-out of HHP, a 30-month roll-out of the benefit has significant ramifications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties. Group 2 and 3 counties have, in fact, the highest rates of poverty and social barriers to accessing appropriate care. Though many of these counties have developed means of addressing these barriers to care, along with provider capacity, delaying these services until early to mid-2018 will certainly mean the most vulnerable beneficiaries will continue to experience poor health outcomes and high costs.

State initiatives will be difficult to sustain without the promise of HHP services to integrate care at the systems and individual beneficiary level, such as the Whole Person Care pilot and the Medi-Cal Drug Organized Delivery System. At the same time, California will have to bear the costs of poorly managed care among those expansion beneficiaries with complex conditions, and will be required to pay for more of the costs of HHP services for expansion beneficiaries.

Moreover, evaluation results may not be available until well after DHCS has to determine whether to use State General Fund resources to support the ongoing costs of HHP services for Group 1 and Group 2 counties. If implementation in these counties is delayed, this could result in under-estimating the impacts of HHP during the evaluation timeframe. Finally, the fate of HHP and the ACA are uncertain in 2018 and beyond. We are very concerned HHP may never reach those with the greatest need due to failures in full implementation, should services in mostly small, rural counties fail to make any measurable impact.

We therefore recommend the following:

- Including at least one large county with high rates of poverty and providers with capacity, like Alameda or Los Angeles, in Group 1.
- Compressing the timeline by allowing all eligible beneficiaries to access the benefit by October 2017.
- Allowing the Whole-Person Care pilot to fund HHP-like services in the years before HHP implementation begins in counties accessing the pilot.

Whatever DHCS is inclined to include in terms of timeline, we recommend allowing for more robust stakeholder input on the timeline and counties included in each group before finalizing California's State Plan Amendment.

Additionally, in drafting the Health Home State Plan Amendment, we recommend the following changes to proposals outlined in Concept Paper 3.0:

- Regarding eligibility criteria, we recommend—
 - Adding chronic renal disease, HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to your list of eligible conditions.
 - Requiring CB-CMEs be responsible for engaging, in person, members who do not respond to a letter that they are eligible, and that the engagement rate be reserved for in-person, face-to-face engagement activities a CB-CME undertakes.
 - Allowing CB-CMEs to use other sources of data to refer beneficiaries to the HHP program, rather than administrative data.
 - Fostering a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program.
 - Including “chronic homelessness” as an acuity factor.
 - Eliminating the exclusions.
 - Clarifying how DHCS and MCPs will ensure continuity of care for beneficiaries no longer meeting the acuity criteria.
- We recommend DHCS create a tiered payment structure with a homelessness modifier, similar to the structure DHCS released two months ago.
 - We recommend extending the modifier to two years or less in housing, as consistent with the definition of chronic homelessness in Assembly Bill 361. People experiencing chronic homelessness or cycling through hospitalization or nursing homes often require two years of sustained, consistent services before stabilizing.
 - CB-CMEs should be eligible to receive the modifier only if meeting the requirements included in AB 361 or partnering with agencies who do meet the criteria to deliver HHP services to homeless beneficiaries.
- For the definitions of services, we recommend the following changes:
 - For homeless beneficiaries, clarify references to “communication through e-mails, texts, social media, and phone calls” are applicable to those who are stably housed, and not only allowable until a CB-CME's in-person contacts have established a trusting relationship with the beneficiary.

- To the definition of *comprehensive care management*, we recommend adding in-person outreach and engagement of beneficiaries to form trusting relationships and to gather information the beneficiary, similar to the definition in CMS guidance, as well as individual housing transition and tenancy sustaining services recognized in the CMS Informational Bulletin (housing-related activities for beneficiaries experiencing chronic homelessness).
- To the definition of *care coordination*, we recommend including, “Accompanying beneficiaries to appointments when necessary to act as the beneficiary’s advocate, to communicate the beneficiary’s health goals to care providers, to explain diagnoses and treatment to the beneficiary, and/or to engage the member to follow treatment protocols.” We further recommend adding “providing and arranging transportation to attend appointments, including appointments with social service providers.”
- To the definition of *health promotion*, we recommend requiring CB-CMEs to use evidence-based practices to engage the beneficiary to manage his or her own care.
- To the definition of *comprehensive transitional care*, we recommend, “Locating and offering to beneficiaries experiencing homelessness immediate access to respite care or bridge/interim housing post-discharge until a permanent apartment is made available to the beneficiary,” rather than current language regarding “transitional housing.”
- To the definition of *Individual & Family Support Services*, we recommend encouraging the beneficiary’s own goals drive any connections with family, friends, or other potential support systems.
- To the definition of *Referral to Community & Social Supports*, we recommend including active linkage to social systems and services, such as requirements to create relationships with housing providers, offering warm hand-offs to help the beneficiary navigate through the process of obtaining services impacting the member’s health, and routine check-in with beneficiaries to ensure the beneficiary accesses social services he or she requires. We also recommend adding “food security services” to your list of services.
- If housing navigation services are not included in the definition of care management, we recommend adding housing navigation services to the definition of referral to community and social supports. In defining housing-related activities, we recommend following definitions included in the CMS Informational Bulletin on housing-related activities.
- Regarding MCP and CB-CME responsibilities, we recommend—
 - Encouraging MCPs and CB-CMEs rely on assessments and care plans recognized as evidence-based.
 - Requiring that CB-CMEs develop relationships with housing providers and use existing homeless systems to identify and provide housing solutions for members experiencing homelessness before a CB-CME could receive a homelessness modifier.
 - Including “homeless continuums of care” and “homeless coordinated entry systems” in the list of stakeholders.

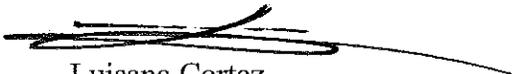
- Requiring both MCPs and CB-CMEs develop plans to meet the treatment needs of people with substance use disorders and/or serious mental illness, as well as partnerships with behavioral health providers.
 - Requiring CB-CMEs to partner with housing providers.
 - Limiting how much of the DHCS payment the MCP may retain for performance of their duties, as other states have done.
 - Clarifying payment will not be based on a per-encounter basis.
 - Developing a simplified, expedited process for certifying CB-CMEs
 - Encouraging MCPs in jurisdictions with limited PCP capacity to contract with non-traditional providers to offer some HHP services.
 - Clarifying that, though PCP staff may provide some of the HHP services, they would be expected to offer these services outside the clinic setting where necessary.
- To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user beneficiaries, we recommend adding a model to the three models the Concept Paper identifies for service provision:
 - **“Model IV:** A collaborative model serving homeless HHP members, Model IV includes services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either the homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care managers and housing navigators engage members where the members live, both before and after the member moves into housing, and the CB-CME team assists the beneficiary
- In listing CB-CME duties, we recommend clarifying—
 - CB-CMEs may focus solely on serving homeless HHP beneficiaries, including persons who have moved into supportive housing after experiencing homelessness.
 - A multidisciplinary care team could consist of staff from multiple agencies and should offer services wherever most accessible to the beneficiary.
 - CB-CMEs partner with permanent housing providers and homeless service providers to reach homeless beneficiaries.
- In developing additional staffing requirements, we recommend—
 - An aggregate care manager/housing navigator ratio of 1:15 (not including MCP staffing) for HHP members who are homeless. In housing and mental health systems, successful case management programs serving homeless and frequent user

- populations offer in-person, individualized, frequent and flexible services, offered where the person lives, with beneficiary to staff ratios of 1:15.
- Staffing ratios of 1:20 for other complex beneficiaries beginning to receive HHP services.
 - A staffing ratio of 1:25 to 1:35 once a HHP member can transition to “maintenance.”
- In describing the multidisciplinary team roles, we recommend the following changes:
 - In the *dedicated care manager* role, including, “arranging *and providing* transportation when necessary to provide access to appointments,” and adding, “Accompanying HHP member to office visits.”
 - In the *community health worker* role, adding a requirement the health worker explain materials provided to the beneficiary.
 - In the *housing navigator* role, requiring formation and fostering of relationships with housing agencies, engaging members and potential members in person, and, “Partnering with housing agencies and providers to offer HHP member with permanent housing options, assisting member with moving into permanent housing and promoting housing stability.” We further recommend including housing-related activities, as described in the CMS Informational Bulletin released in June regarding housing-related activities for people experiencing chronic homelessness.
 - Regarding member assignment, we recommend requiring an in-person engagement process, particularly for homeless members. For others with complex needs, we recommend supplementing letters with in-person engagement. For referrals, we likewise recommend—
 - Fostering a “no wrong door” approach that allows any agency, behavioral health professional, or PCP to refer a member potentially eligible.
 - Allowing for presumptive eligibility if a beneficiary meets the chronic condition and acuity criteria.
 - Requiring a CB-CME engage with a beneficiary on multiple occasions before discharging a beneficiary.
 - Regarding payment methodology, we recommend clarifying a consistent rate structure applicable to all MCPs, rather than allowing some MCPs to develop tiered payment and some MCPs to use a single rate.
 - We recommend a DHCS-imposed risk stratification process, as we are concerned MCPs will use the CalMedi-Connect risk stratification tool to tier payment, or develop tiers based on medical criteria alone.
 - In identifying a tool for tiering, we recommend DHCS adopt criteria similar to criteria other states adopted for intensive care and case management programs based on elements of high risk.
 - We also recommend requiring MCPs develop a per member, per month rate structure for CB-CMEs with which they contract, rather than payment on a per encounter basis, since per-encounter payment in other programs erodes service delivery and imposes administrative burden. We further suggest clarifying how payment for services would be risk-based, or remove the risk-based methodology, since a number of CB-CMEs may not be PCPs, and should not be at risk for all care.

- We further recommend requiring staffing ratios to justify rates, rather than relying on a prospective payment rate, to ensure CB-CMEs deliver intensive services for the rate they receive, and avoiding use of HHP payment to fund traditional MCO care coordination services.
- In reporting housing outcomes (within operational measures), we recommend changing current housing status to, “The number of members receiving the homeless modifier who are currently living in permanent housing (their own independent apartment not limited by length of stay).” We recommend conducting a separate evaluation for homeless members than other beneficiaries.
- Regarding HHP interaction with other Medi-Cal programs, we urge DHCS to consider funding housing-related activities and services identified in HHP through the 1115 Waiver Whole Person Care Pilot Programs in counties that will not be implementing HHP until July 2017 or later. With the exception of San Francisco, need for HHP services is greatest in the counties that will not be implementing until July 2017 or January 2018. The Whole-Person Care Pilot is an opportunity to build capacity and work through barriers before accessing HHP. Moreover, for counties who have not yet implemented HHP, no danger of duplication of funding exists if a county ends the use of waiver funding for this phase of services before HHP takes effect, or limits the use of waiver funding for these services to persons who do not meet the eligibility criteria for HHP at that time.

Thank you for the opportunity to comment on Concept Paper 3.0.

Sincerely,


Luisana Cortez
Homeless Services Case Manager
St. John's Well child and Family center



December 23, 2015

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov

Re: Comments on Health Home Program for People with Complex Needs, Concept Paper 3.0

Dear Health Home Program:

On behalf of St. Joseph Center in Los Angeles, I am writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. Since 1976, St. Joseph Center has been meeting the needs of low-income and homeless individuals and families in Venice, Santa Monica, Mar Vista, and other communities in Los Angeles County. Because of the focus of our organization, we are commenting primarily on the impact of provisions of Concept Paper 3.0 on Medi-Cal beneficiaries experiencing homelessness.

We have great concerns with the timeline as proposed by DHCS. While we understand and appreciate the need for deliberate roll-out of HHP, a 30-month roll-out of the benefit has significant ramifications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties. Group 2 and 3 counties have, in fact, the highest rates of poverty and social barriers to accessing appropriate care.

If implementation in these counties is delayed, this could result in under-estimating the impacts of HHP during the evaluation timeframe. Finally, the fate of HHP and the ACA are uncertain in 2018 and beyond. We are very concerned HHP may never reach those with the greatest need due to failures in full implementation, should services in mostly small, rural counties fail to make any measurable impact.

We therefore recommend the following:

- Including Los Angeles county. Los Angeles has the highest rates of poverty, but also has providers with capacity.
- Compressing the timeline by allowing all eligible beneficiaries to access the benefit by October 2017.
- Allowing the Whole-Person Care pilot to fund HHP-like services in the years before HHP implementation begins in counties accessing the pilot.

Whatever DHCS is inclined to include in terms of timeline, we recommend allowing for more robust stakeholder input on the timeline and counties included in each group before finalizing California's State Plan Amendment.

Additionally, in drafting the Health Home State Plan Amendment, we recommend the following changes to proposals outlined in Concept Paper 3.0:

- Regarding eligibility criteria, we recommend—
 - Adding chronic renal disease, HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to your list of eligible conditions.

St. Joseph Center

204 Hampton Drive
Venice, CA 90291-8633

telephone:
310-396-6468

facsimile:
310-392-8402

www.stjosephctr.org

Tax ID 95-3874381



- Requiring CB-CMEs be responsible for engaging, in person, members who do not respond to a letter that they are eligible, and that the engagement rate be reserved for in-person, face-to-face engagement activities a CB-CME undertakes.
 - Allowing CB-CMEs to use other sources of data to refer beneficiaries to the HHP program, rather than administrative data.
 - Fostering a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program.
 - Including “chronic homelessness” as an acuity factor.
 - Eliminating the exclusions.
 - Clarifying how DHCS and MCPs will ensure continuity of care for beneficiaries no longer meeting the acuity criteria.
- We recommend DHCS create a tiered payment structure with a homelessness modifier, similar to the structure DHCS released two months ago.
 - We recommend extending the modifier to two years or less in housing, as consistent with the definition of chronic homelessness in Assembly Bill 361. People experiencing chronic homelessness or cycling through hospitalization or nursing homes often require two years of sustained, consistent services before stabilizing.
 - CB-CMEs should be eligible to receive the modifier only if meeting the requirements included in AB 361 or partnering with agencies who do meet the criteria to deliver HHP services to homeless beneficiaries.
- For the definitions of services, we recommend the following changes:
 - For homeless beneficiaries, clarify references to “communication through e-mails, texts, social media, and phone calls” are applicable to those who are stably housed, and not only allowable until a CB-CME’s in-person contacts have established a trusting relationship with the beneficiary.
 - To the definition of *comprehensive care management*, we recommend adding in-person outreach and engagement of beneficiaries to form trusting relationships and to gather information the beneficiary, similar to the definition in CMS guidance, as well as individual housing transition and tenancy sustaining services recognized in the CMS Informational Bulletin (housing-related activities for beneficiaries experiencing chronic homelessness).
 - To the definition of *care coordination*, we recommend including, “Accompanying beneficiaries to appointments when necessary to act as the beneficiary’s advocate, to communicate the beneficiary’s health goals to care providers, to explain diagnoses and treatment to the beneficiary, and/or to engage the member to follow treatment protocols.” We further recommend adding “providing and arranging transportation to attend appointments, including appointments with social service providers.”
 - To the definition of *health promotion*, we recommend requiring CB-CMEs to use evidence-based practices to engage the beneficiary to manage his or her own care.
 - To the definition of *comprehensive transitional care*, we recommend, “Locating and offering to beneficiaries experiencing homelessness immediate access to respite care or bridge/interim housing post-discharge until a permanent apartment is made available to the beneficiary,” rather than current language regarding “transitional housing.”
 - To the definition of *Individual & Family Support Services*, we recommend encouraging the beneficiary’s own goals drive any connections with family, friends, or other potential support systems.

St. Joseph Center

204 Hampton Drive
Venice, CA 90291-8633

telephone:
310-396-6468

facsimile:
310-392-8402

www.stjosephctr.org

Tax ID 95-3874381



- To the definition of *Referral to Community & Social Supports*, we recommend including active linkage to social systems and services, such as requirements to create relationships with housing providers, offering warm hand-offs to help the beneficiary navigate through the process of obtaining services impacting the member's health, and routine check-in with beneficiaries to ensure the beneficiary accesses social services he or she requires. We also recommend adding "food security services" to your list of services.
- If housing navigation services are not included in the definition of care management, we recommend adding housing navigation services to the definition of referral to community and social supports. In defining housing-related activities, we recommend following definitions included in the CMS Informational Bulletin on housing-related activities.

- Regarding MCP and CB-CME responsibilities, we recommend—
 - Encouraging MCPs and CB-CMEs rely on assessments and care plans recognized as evidence-based.
 - Requiring that CB-CMEs develop relationships with housing providers and/or use existing homeless systems to identify and provide housing solutions for members experiencing homelessness before a CB-CME could receive a homelessness modifier.
 - Including "homeless continuums of care" and "homeless coordinated entry systems" in the list of stakeholders.
 - Requiring both MCPs and CB-CMEs develop plans to meet the treatment needs of people with substance use disorders and/or serious mental illness, as well as partnerships with behavioral health providers.
 - Limiting how much of the DHCS payment the MCP may retain for performance of their duties, as other states have done.
 - Clarifying payment will not be based on a per-encounter basis.
 - Developing a simplified, expedited process for certifying CB-CMEs
 - Encouraging MCPs in jurisdictions with limited PCP capacity to contract with non-traditional providers to offer some HHP services.
 - Clarifying that, though PCP staff may provide some of the HHP services, they would be expected to offer these services outside the clinic setting where necessary.

- To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user beneficiaries, we recommend adding a model to the three models the Concept Paper identifies for service provision:
 - **“Model IV:** A collaborative model serving homeless HHP members, Model IV includes services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either the homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care

St. Joseph Center

204 Hampton Drive
Venice, CA 90291-8633

telephone:
310-396-6468

facsimile:
310-392-8402

www.stjosephctr.org

Tax ID 95-3874381



managers and housing navigators engage members where the members live, both before and after the member moves into housing, and the CB-CME team assists the beneficiary

- In listing CB-CME duties, we recommend clarifying—
 - CB-CMEs may focus solely on serving homeless HHP beneficiaries, including persons who have moved into supportive housing after experiencing homelessness.
 - A multidisciplinary care team could consist of staff from multiple agencies and should offer services wherever most accessible to the beneficiary.
 - CB-CMEs partner with permanent housing providers and homeless service providers to reach homeless beneficiaries.
- In developing additional staffing requirements, we recommend—
 - An aggregate care manager/housing navigator ratio of 1:15 to 1:20 (not including MCP staffing) for HHP members who are homeless. In housing and mental health systems, successful case management programs serving homeless and frequent user populations offer in-person, individualized, frequent and flexible services, offered where the person lives, with beneficiary to staff ratios of 1:15 to 1:20.
 - Staffing ratios of 1:25 for other complex beneficiaries beginning to receive HHP services.
 - A staffing ratio of 1:35 to 1:40 once a HHP member can transition to “maintenance.”
- In describing the multidisciplinary team roles, we recommend the following changes:
 - In the *dedicated care manager* role, including, “arranging *and providing* transportation when necessary to provide access to appointments,” and adding, “Accompanying HHP member to office visits.”
 - In the *community health worker* role, adding a requirement the health worker explain materials provided to the beneficiary.
 - In the *housing navigator* role, requiring formation and fostering of relationships with housing agencies, engaging members and potential members in person, and, “Partnering with housing agencies and providers to offer HHP member with permanent housing options, assisting member with moving into permanent housing and promoting housing stability.” We further recommend including housing-related activities, as described in the CMS Informational Bulletin released in June regarding housing-related activities for people experiencing chronic homelessness.
- Regarding member assignment, we recommend requiring an in-person engagement process, particularly for homeless members. For others with complex needs, we recommend supplementing letters with in-person engagement. For referrals, we likewise recommend—
 - Fostering a “no wrong door” approach that allows any agency, behavioral health professional, or PCP to refer a member potentially eligible.
 - Allowing for presumptive eligibility if a beneficiary meets the chronic condition and acuity criteria.
 - Requiring a CB-CME engage with a beneficiary on multiple occasions before discharging a beneficiary.

St. Joseph Center

204 Hampton Drive
Venice, CA 90291-8633

telephone:
310-396-6468

facsimile:
310-392-8402

www.stjosephctr.org

Tax ID 95-3874381



- Regarding payment methodology, we recommend clarifying a consistent rate structure applicable to all MCPs, rather than allowing some MCPs to develop tiered payment and some MCPs to use a single rate.
- We recommend a DHCS-imposed risk stratification process, as we are concerned MCPs will use the CalMedi-Connect risk stratification tool to tier payment, or develop tiers based on medical criteria alone.
- In identifying a tool for tiering, we recommend DHCS adopt criteria similar to criteria other states adopted for intensive care and case management programs based on elements of high risk.
- We also recommend requiring MCPs develop a per member, per month rate structure for CB-CMEs with which they contract, rather than payment on a per encounter basis, since per-encounter payment in other programs erodes service delivery and imposes administrative burden. We further suggest clarifying how payment for services would be risk-based, or remove the risk-based methodology, since a number of CB-CMEs may not be PCPs, and should not be at risk for all care.
- We further recommend requiring staffing ratios to justify rates, rather than relying on a prospective payment rate, to ensure CB-CMEs deliver intensive services for the rate they receive, and avoiding use of HHP payment to fund traditional MCO care coordination services.
- In reporting housing outcomes (within operational measures), we recommend changing current housing status to, “The number of members receiving the homeless modifier who are currently living in permanent housing (their own independent apartment not limited by length of stay).” We recommend conducting a separate evaluation for homeless members than other beneficiaries.
- Regarding HHP interaction with other Medi-Cal programs, we urge DHCS to consider funding housing-related activities and services identified in HHP through the 1115 Waiver Whole Person Care Pilot Programs in counties that will not be implementing HHP until July 2017 or later. With the exception of San Francisco, need for HHP services is greatest in the counties that will not be implementing until July 2017 or January 2018. The Whole-Person Care Pilot is an opportunity to build capacity and work through barriers before accessing HHP. Moreover, for counties who have not yet implemented HHP, no danger of duplication of funding exists if a county ends the use of waiver funding for this phase of services before HHP takes effect, or limits the use of waiver funding for these services to persons who do not meet the eligibility criteria for HHP at that time.

Thank you for the opportunity to comment on Concept Paper 3.0.

Sincerely,

Va Lecia Adams Kellum, Ph.D.
Executive Director

St. Joseph Center

204 Hampton Drive
Venice, CA 90291-8633

telephone:
310-396-6468

facsimile:
310-392-8402

www.stjosephctr.org

Tax ID 95-3874381

Venice Family Clinic
Board of Directors

William Flumenbaum, Chair
Jeffrey E. Sinaiko, Chair Elect
Brian D. Kan, MD, Immediate Past Chair
Stewart Seradsky, Treasurer
Ashley Johnson, Secretary
Mayer B. Davidson, MD
Paula Davis
Aime Espinosa
David T. Feinberg, MD, MBA
Luis Galvez
LoEte Loshak
Rich Markey
Wendy Smith Meyer, PhD, LCSW
Neil H. Parker, MD
Bill Resnick, MD, MBA
Paul Saben
Flora M. Santacruz
Lourdes Servin
Nadia Shaheen
Carmen Thomas-Paris
Karina Wagle
Leisa Wu

Venice Family Clinic Foundation

Board of Trustees
Susan Adelman
Carol L. Archie, MD
Neal Baer, MD
Rick Bradley
Lowell C. Brown, Esq.
David M. Carlisle, MD, PhD
Mayer B. Davidson, MD
Susan Fleischman, MD
William Flumenbaum
John R. Geresi
Chester F. Griffiths, MD, FACS
Jimmy H. Hara, MD
Joan E. Herman
Ashley Johnson
Brian D. Kan, MD
Deborah Laub
Constance Lawton
Lou Lazatin
Harley Liker, MD, MBA
Tracey Loeb
Gail Margolis, Esq.
Melissa R. Martinez
Frank Matricardi, Dr PH
Viren Mehta
Wendy Smith Meyer, PhD, LCSW
Jeff Nathanson
William D. Parente
Hutch Parker
Neil H. Parker, MD
Bill Resnick, MD, MBA
Paul Saben
Mike Sanian
Fern Seizer
Alan Sieroty
Jeffrey E. Sinaiko
Russel Tyner, AIA
Michael S. Wilkes, MD, PhD
Leisa Wu

Venice Family Clinic
Philanthropy Board

Kathleen Aikenhead
Lou Colen
Marjorie Fasman
Ruth Flinkman-Marandy
Hilary & Robert Nelson Jacobs
Glorya Kaufman
Susanne & Paul Kester
Shawn & Larry King
Deborah Laub
Susan Adelman & Claudio Llanos
Chuck Lorre
Laurie MacDonald
Anita May Rosenstein
Victoria & Ronald Simms
Richard Squire
Eva Vollmer
Billie Milam Weisman
Sylvia Weisz
Ruth Ziegler
Manilyn Zierring
Diane & Michael Zierring
Janet & Jerry Zucker

January 21, 2016

Health Home Program
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814
hhp@dhcs.ca.gov

Re: Comments on Health Home Program for People with Complex Needs, Concept Paper 3.0

Dear Health Home Program:

On behalf of Venice Family Clinic, I am writing with feedback regarding the Health Home Program (HHP) Concept Paper 3.0. The Venice Family Clinic provides comprehensive primary and specialty health care that is affordable, accessible, and compassionate to people who have no other access to such care. We are a community health center, licensed by the State of California and affiliated with the University of California at Los Angeles, and provide over 100,000 patient visits a year. Since we serve a significant homeless population most of our comments will focus on Medi-Cal beneficiaries experiencing homelessness.

In general, we have great concerns with the timeline as proposed by DHCS. While we understand and appreciate the need for deliberate roll-out of HHP, a 30-month roll-out of the benefit has significant ramifications for the success of the program and for the State. The greatest need for HHP services exists in Group 3 counties. Group 2 and 3 counties have, in fact, the highest rates of poverty and social barriers to accessing appropriate care. Though many of these counties have developed means of addressing these barriers to care, along with provider capacity, delaying these services until early to mid-2018 will certainly mean the most vulnerable beneficiaries will continue to experience poor health outcomes and high costs.

State initiatives will be difficult to sustain without the promise of HHP services to integrate care at the systems and individual beneficiary level, such as the Whole Person Care pilot and the Medi-Cal Drug Organized Delivery System. At the same time, California will have to bear the costs of poorly managed care among those expansion beneficiaries with complex conditions, and will be required to pay for more of the costs of HHP services for expansion beneficiaries.

Moreover, evaluation results may not be available until well after DHCS has to determine whether to use State General Fund resources to support the ongoing costs of HHP services for Group 1 and Group 2 counties. If implementation in these counties is delayed, this could result in under-estimating the impacts of HHP during

Venice Family Clinic
Board of Directors

William Flumenbaum, *Chair*
Jeffrey E. Sinaiko, *Chair Elect*
Brian D. Kan, MD, *Immediate Past Chair*
Stewart Seradsky, *Treasurer*
Ashley Johnson, *Secretary*
Mayer B. Davidson, MD
Paula Davis
Aime Espinosa
David T. Feinberg, MD, MBA
Luis Galvez
LoEte Loshak
Rich Markey
Wendy Smith Meyer, PhD, LCSW
Neil H. Parker, MD
Bill Resnick, MD, MBA
Paul Saben
Flora M. Santacruz
Lourdes Servin
Nadia Shaheen
Carmen Thomas-Paris
Karina Wagle
Leisa Wu

Venice Family Clinic Foundation

Board of Trustees

Susan Adelman
Carol L. Archie, MD
Neal Baer, MD
Rick Bradley
Lowell C. Brown, Esq.
David M. Carlisle, MD, PhD
Mayer B. Davidson, MD
Susan Fleischman, MD
William Flumenbaum
John R. Geresi
Chester F. Griffiths, MD, FACS
Jimmy H. Hara, MD
Joan E. Herman
Ashley Johnson
Brian D. Kan, MD
Deborah Laub
Constance Lawton
Lou Lazatin
Harley Liker, MD, MBA
Tracey Loeb
Gail Margolis, Esq.
Melissa R. Martinez
Frank Matricardi, Dr PH
Viren Mehta
Wendy Smith Meyer, PhD, LCSW
Jeff Nathanson
William D. Parente
Hutch Parker
Neil H. Parker, MD
Bill Resnick, MD, MBA
Paul Saben
Mike Saian
Fern Seizer
Alan Sieroty
Jeffrey E. Sinaiko
Russel Tyner, AIA
Michael S. Wilkes, MD, PhD
Leisa Wu

Venice Family Clinic
Philanthropy Board

Kathleen Aikenhead
Lou Colen
Marjorie Fasman
Ruth Flinkman-Marandy
Hilary & Robert Nelson Jacobs
Gloria Kaufman
Susanne & Paul Kester
Shawn & Larry King
Deborah Laub
Susan Adelman & Claudio Llanos
Chuck Lorre
Laurie MacDonald
Anita May Rosenstein
Victoria & Ronald Simms
Richard Squire
Eva Vollmer
Billie Milam Weisman
Sylvia Weisz
Ruth Ziegler
Marilyn Zierring
Diane & Michael Zierring
Janet & Jerry Zucker

the evaluation timeframe. Finally, the fate of HHP and the ACA are uncertain in 2018 and beyond. We are very concerned HHP may never reach those with the greatest need due to failures in full implementation, should services in mostly small, rural counties fail to make any measurable impact.

We therefore recommend the following:

- Including at least one large county with high rates of poverty and providers with capacity, like Alameda or Los Angeles, in Group 1.
- Compressing the timeline by allowing all eligible beneficiaries to access the benefit by October 2017.
- Allowing the Whole-Person Care pilot to fund HHP-like services in the years before HHP implementation begins in counties accessing the pilot.

Whatever DHCS is inclined to include in terms of timeline, we recommend allowing for more robust stakeholder input on the timeline and counties included in each group before finalizing California’s State Plan Amendment.

Additionally, in drafting the Health Home State Plan Amendment, we recommend the following changes to proposals outlined in Concept Paper 3.0:

- Regarding eligibility criteria, we recommend—
 - Adding chronic renal disease, HIV/AIDS, mild or moderate depression, and Post-Traumatic Stress Disorder to your list of eligible conditions.
 - Final ICD 9/ICD 10 selections be subject to a provider stakeholder process.
 - Requiring CB-CMEs be responsible for engaging, in person, members who do not respond to a letter that they are eligible, and that the engagement rate be reserved for in-person, face-to-face engagement activities a CB-CME undertakes.
 - Fostering a “no wrong door” approach by allowing any entity, primary care physician (PCP), behavioral health provider, or social service provider to refer a beneficiary to the program.
 - Including “chronic homelessness” as an acuity factor.
 - Eliminating the exclusions.
 - Clarifying how DHCS and MCPs will ensure continuity of care for beneficiaries no longer meeting the acuity criteria.

Venice Family Clinic
Board of Directors

William Flumenbaum, *Chair*
Jeffrey E. Sinaiko, *Chair Elect*
Brian D. Kan, MD, *Immediate Past Chair*
Stewart Seradsky, *Treasurer*
Ashley Johnson, *Secretary*
Mayer B. Davidson, MD
Paula Davis
Aime Espinosa
David T. Feinberg, MD, MBA
Luis Galvez
LoEte Loshak
Rich Markey
Wendy Smith Meyer, PhD, LCSW
Neil H. Parker, MD
Bill Resnick, MD, MBA
Paul Saben
Flora M. Santacruz
Lourdes Servin
Nadia Shaheen
Carmen Thomas-Paris
Karina Wagle
Leisa Wu

Venice Family Clinic Foundation
Board of Trustees

Susan Adelman
Carol L. Archie, MD
Neal Baer, MD
Rick Bradley
Lowell C. Brown, Esq.
David M. Carlisle, MD, PhD
Mayer B. Davidson, MD
Susan Fleischman, MD
William Flumenbaum
John R. Geresi
Chester F. Griffiths, MD, FACS
Jimmy H. Hara, MD
Joan E. Herman
Ashley Johnson
Brian D. Kan, MD
Deborah Laub
Constance Lawton
Lou Lazatin
Harley Liker, MD, MBA
Tracey Loeb
Gail Margolis, Esq.
Melissa R. Martinez
Frank Matricardi, Dr PH
Viren Mehta
Wendy Smith Meyer, PhD, LCSW
Jeff Nathanson
William D. Parente
Hutch Parker
Neil H. Parker, MD
Bill Resnick, MD, MBA
Paul Saben
Mike Sanian
Fern Seizer
Alan Sieroty
Jeffrey E. Sinaiko
Russel Tyner, AIA
Michael S. Wilkes, MD, PhD
Leisa Wu

Venice Family Clinic
Philanthropy Board

Kathleen Aikenhead
Lou Colen
Marjorie Fasman
Ruth Flinkman-Marandy
Hilary & Robert Nelson Jacobs
Gloria Kaufman
Susanne & Paul Kester
Shawn & Larry King
Deborah Laub
Susan Adelman & Claudio Llanos
Chuck Lorre
Laurie MacDonald
Anita May Rosenstein
Victoria & Ronald Simms
Richard Squire
Eva Vollmer
Billie Milam Weisman
Sylvia Weisz
Ruth Ziegler
Manilyn Zierring
Diane & Michael Zierring
Janet & Jerry Zucker

- We recommend DHCS create a tiered payment structure with a homelessness modifier, similar to the structure DHCS released two months ago.
 - We recommend extending the modifier to two years or less in housing, as consistent with the definition of chronic homelessness in Assembly Bill 361. People experiencing chronic homelessness or cycling through hospitalization or nursing homes often require two years of sustained, consistent services before stabilizing.
 - CB-CMEs should be eligible to receive the modifier only if meeting the requirements included in AB 361 or partnering with agencies who do meet the criteria to deliver HHP services to homeless beneficiaries.

- For the definitions of services, we recommend the following changes:
 - To the definition of comprehensive care management, we recommend adding in-person outreach and engagement of beneficiaries to form trusting relationships and to gather information the beneficiary, similar to the definition in CMS guidance, as well as individual housing transition and tenancy sustaining services recognized in the CMS Informational Bulletin (housing-related activities for beneficiaries experiencing chronic homelessness).
 - To the definition of health promotion, we recommend requiring CB-CMEs to use evidence-based practices to engage the beneficiary to manage his or her own care.
 - To the definition of comprehensive transitional care, we recommend, “Locating and offering to beneficiaries experiencing homelessness immediate access to respite care or bridge/interim housing post-discharge until a permanent apartment is made available to the beneficiary,” rather than current language regarding “transitional housing.”

- If housing navigation services are not included in the definition of care management, we recommend adding housing navigation services to the definition of referral to community and social supports. In defining housing-related activities, we recommend following definitions included in the CMS Informational Bulletin on housing-related activities.

- Regarding MCP and CB-CME responsibilities, we recommend—

Venice Family Clinic
Board of Directors

William Flumenbaum, *Chair*
Jeffrey E. Sinaiko, *Chair Elect*
Brian D. Kan, MD, *Immediate Past Chair*
Stewart Seradsky, *Treasurer*
Ashley Johnson, *Secretary*
Mayer B. Davidson, MD
Paula Davis
Aime Espinosa
David T. Feinberg, MD, MBA
Luis Galvez
LoEte Loshak
Rich Markey
Wendy Smith Meyer, PhD, LCSW
Neil H. Parker, MD
Bill Resnick, MD, MBA
Paul Saben
Flora M. Santacruz
Lourdes Servin
Nadia Shaheen
Carmen Thomas-Paris
Karina Wagle
Leisa Wu

Venice Family Clinic Foundation
Board of Trustees

Susan Adelman
Carol L. Archie, MD
Neal Baer, MD
Rick Bradley
Lowell C. Brown, Esq.
David M. Carlisle, MD, PhD
Mayer B. Davidson, MD
Susan Fleischman, MD
William Flumenbaum
John R. Geresi
Chester F. Griffiths, MD, FACS
Jimmy H. Hara, MD
Joan E. Herman
Ashley Johnson
Brian D. Kan, MD
Deborah Laub
Constance Lawton
Lou Lazzatin
Harley Liker, MD, MBA
Tracey Loeb
Gail Margolis, Esq.
Melissa R. Martinez
Frank Matricardi, Dr PH
Viren Mehta
Wendy Smith Meyer, PhD, LCSW
Jeff Nathanson
William D. Parente
Hutch Parker
Neil H. Parker, MD
Bill Resnick, MD, MBA
Paul Saben
Mike Saian
Fern Seizer
Alan Sieroty
Jeffrey E. Sinaiko
Russel Tyner, AIA
Michael S. Wilkes, MD, PhD
Leisa Wu

Venice Family Clinic
Philanthropy Board

Kathleen Aikenhead
Lou Colen
Marjorie Fasman
Ruth Flinkman-Marandy
Hilary & Robert Nelson Jacobs
Gloria Kaufman
Susanne & Paul Kester
Shawn & Larry King
Deborah Laub
Susan Adelman & Claudio Llanos
Chuck Lorre
Laurie MacDonald
Anita May Rosenstein
Victoria & Ronald Simms
Richard Squire
Eva Vollmer
Billie Milam Weisman
Sylvia Weisz
Ruth Ziegler
Marilyn Zierring
Diane & Michael Zierring
Janet & Jerry Zucker

- Encouraging MCPs and CB-CMEs rely on assessments and care plans recognized as evidence-based.
 - Requiring that CB-CMEs develop relationships with housing providers and use existing homeless systems to identify and provide housing solutions for members experiencing homelessness before a CB-CME could receive a homelessness modifier.
 - Including “homeless continuums of care” and “homeless coordinated entry systems” in the list of stakeholders.
 - Requiring both MCPs and CB-CMEs develop plans to meet the treatment needs of people with substance use disorders and/or serious mental illness, as well as partnerships with behavioral health providers.
 - Requiring CB-CMEs to partner with housing providers.
 - Limiting how much of the DHCS payment the MCP may retain for performance of their duties, as other states have done.
 - Clarifying payment will not be based on a per-encounter basis.
 - Developing a simplified, expedited process for certifying CB-CMEs
- To encourage the implementation of evidence-based strategies for engaging and providing HHP services to chronically homeless or homeless frequent user beneficiaries, we recommend adding a model to the three models the Concept Paper identifies for service provision:
 - **“Model IV:** A collaborative model serving homeless HHP members, Model IV includes services to secure permanent housing and intensive care management using harm reduction, motivational interviewing, and trauma informed strategies. CB-CMEs would be comprised of community-based homeless services providers, behavioral health providers, and PCPs (typically Federally-Qualified Health Centers) with experience treating homeless members. CB-CMEs have partnerships with local hospitals, housing providers, and homeless service providers, from which they receive referrals. Care managers in this model would be hired by and located at either the homeless services provider and/or behavioral health provider agency. Housing navigators would be hired by and located at the homeless services provider agency. Care managers and housing navigators engage members where the members live, both before and after the member moves into housing, and the CB-CME team assists the beneficiary

Venice Family Clinic
Board of Directors

William Flumenbaum, *Chair*
Jeffrey E. Sinaiko, *Chair Elect*
Brian D. Kan, MD, *Immediate Past Chair*
Stewart Seradsky, *Treasurer*
Ashley Johnson, *Secretary*
Mayer B. Davidson, MD
Paula Davis
Aime Espinosa
David T. Feinberg, MD, MBA
Luis Galvez
LoEtte Loshak
Rich Markey
Wendy Smith Meyer, PhD, LCSW
Neil H. Parker, MD
Bill Resnick, MD, MBA
Paul Saben
Flora M. Santacruz
Lourdes Servin
Nadia Shaheen
Carmen Thomas-Paris
Karina Wagle
Leisa Wu

Venice Family Clinic Foundation
Board of Trustees

Susan Adelman
Carol L. Archie, MD
Neal Baer, MD
Rick Bradley
Lowell C. Brown, Esq.
David M. Carlisle, MD, PhD
Mayer B. Davidson, MD
Susan Fleischman, MD
William Flumenbaum
John R. Geresi
Chester F. Griffiths, MD, FACS
Jimmy H. Hara, MD
Joan E. Herman
Ashley Johnson
Brian D. Kan, MD
Deborah Laub
Constance Lawton
Lou Lazzatin
Harley Liker, MD, MBA
Tracey Loeb
Gail Margolis, Esq.
Melissa R. Martinez
Frank Matricardi, Dr PH
Viren Mehta
Wendy Smith Meyer, PhD, LCSW
Jeff Nathanson
William D. Parente
Hutch Parker
Neil H. Parker, MD
Bill Resnick, MD, MBA
Paul Saben
Mike Saian
Fern Seizer
Alan Sieroty
Jeffrey E. Sinaiko
Russel Tyner, AIA
Michael S. Wilkes, MD, PhD
Leisa Wu

Venice Family Clinic
Philanthropy Board

Kathleen Aikenhead
Lou Colen
Marjorie Fasman
Ruth Flinkman-Marandy
Hilary & Robert Nelson Jacobs
Gloria Kaufman
Susanne & Paul Kester
Shawn & Larry King
Deborah Laub
Susan Adelman & Claudio Llanos
Chuck Lorre
Laurie MacDonald
Anita May Rosenstein
Victoria & Ronald Simms
Richard Squire
Eva Vollmer
Billie Milam Weisman
Sylvia Weisz
Ruth Ziegler
Marilyn Zierring
Diane & Michael Zierring
Janet & Jerry Zucker

- In listing CB-CME duties, we recommend clarifying—
 - CB-CMEs may focus solely on serving homeless HHP beneficiaries, including persons who have moved into supportive housing after experiencing homelessness.
 - A multidisciplinary care team could consist of staff from multiple agencies and should offer services wherever most accessible to the beneficiary.
 - CB-CMEs partner with permanent housing providers and homeless service providers to reach homeless beneficiaries.

- Regarding member assignment, we recommend requiring an in-person engagement process, particularly for homeless members. For others with complex needs, we recommend supplementing letters with in-person engagement. For referrals, we likewise recommend—
 - Fostering a “no wrong door” approach that allows any agency, behavioral health professional, or PCP to refer a member potentially eligible.
 - Allowing for presumptive eligibility if a beneficiary meets the chronic condition and acuity criteria.
 - Requiring a CB-CME engage with a beneficiary on multiple occasions before discharging a beneficiary.

- Regarding payment methodology, we recommend clarifying a consistent rate structure applicable to all MCPs, rather than allowing some MCPs to develop tiered payment and some MCPs to use a single rate.
 - We recommend a DHCS-imposed risk stratification process, as we are concerned MCPs will use the CalMedi-Connect risk stratification tool to tier payment, or develop tiers based on medical criteria alone.
 - In identifying a tool for tiering, we recommend DHCS adopt criteria similar to criteria other states adopted for intensive care and case management programs based on elements of high risk.
 - We also recommend requiring MCPs develop a per member, per month rate structure for CB-CMEs with which they contract, rather than payment on a per encounter basis, since per-encounter payment in other programs erodes service delivery and imposes administrative burden.
 - We further recommend requiring staffing ratios to justify rates, rather than relying on a prospective payment rate, to ensure CB-CMEs deliver



Providing quality primary health care to people in need

604 Rose Avenue
Venice, CA 90291
310.392.8630
www.venicefamilyclinic.org

**Venice Family Clinic
Board of Directors**

- William Flumenbaum, *Chair*
- Jeffrey E. Sinaiko, *Chair Elect*
- Brian D. Kan, MD, *Immediate Past Chair*
- Stewart Seradsky, *Treasurer*
- Ashley Johnson, *Secretary*
- Mayer B. Davidson, MD
- Paula Davis
- Aime Espinosa
- David T. Feinberg, MD, MBA
- Luis Galvez
- LoEtte Loshak
- Rich Markey
- Wendy Smith Meyer, PhD, LCSW
- Neil H. Parker, MD
- Bill Resnick, MD, MBA
- Paul Saben
- Flora M. Santacruz
- Lourdes Servin
- Nadia Shaheen
- Carmen Thomas-Paris
- Karina Wagle
- Leisa Wu

intensive services for the rate they receive, and avoiding use of HHP payment to fund traditional MCO care coordination services.

Thank you for the opportunity to comment on Concept Paper 3.0.

Sincerely,

Elizabeth Benson Forer, MSW, MPH
Chief Executive Officer
Venice Family Clinic

Venice Family Clinic Foundation

Board of Trustees

- Susan Adelman
- Carol L. Archie, MD
- Neal Baer, MD
- Rick Bradley
- Lowell C. Brown, Esq.
- David M. Carlisle, MD, PhD
- Mayer B. Davidson, MD
- Susan Fleischman, MD
- William Flumenbaum
- John R. Geresi
- Chester F. Griffiths, MD, FACS
- Jimmy H. Hara, MD
- Joan E. Herman
- Ashley Johnson
- Brian D. Kan, MD
- Deborah Laub
- Constance Lawton
- Lou Lazatin
- Harley Liker, MD, MBA
- Tracey Loeb
- Gail Margolis, Esq.
- Melissa R. Martinez
- Frank Matricardi, Dr PH
- Viren Mehta
- Wendy Smith Meyer, PhD, LCSW
- Jeff Nathanson
- William D. Parente
- Hutch Parker
- Neil H. Parker, MD
- Bill Resnick, MD, MBA
- Paul Saben
- Mike Sanian
- Fern Seizer
- Alan Sieroty
- Jeffrey E. Sinaiko
- Russel Tyner, AIA
- Michael S. Wilkes, MD, PhD
- Leisa Wu

**Venice Family Clinic
Philanthropy Board**

- Kathleen Aikenhead
- Lou Colen
- Marjorie Fasman
- Ruth Flinkman-Marandy
- Hilary & Robert Nelson Jacobs
- Gloria Kaufman
- Susanne & Paul Kester
- Shawn & Larry King
- Deborah Laub
- Susan Adelman & Claudio Llanos
- Chuck Lorre
- Laurie MacDonald
- Anita May Rosenstein
- Victoria & Ronald Simms
- Richard Squire
- Eva Vollmer
- Billie Milam Weisman
- Sylvia Weisz
- Ruth Ziegler
- Manilyn Zierring
- Diane & Michael Zierring
- Janet & Jerry Zucker