



**Health Homes for Patients  
with Complex Needs  
California Concept Paper - Final**

**March 2016**

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## I. Introduction

The Department of Health Care Services (DHCS) has considered stakeholder input and matured various policy areas to prepare this Health Homes for Patients with Complex Needs (Health Home Program or HHP) California Concept Paper - Final. It is the culmination of policy development activities and includes enhancements to the Health Homes for Patients with Complex Needs [California Concept Paper Version 3.0 released on 12/14/2015](#). Section I of the HHP Concept Paper – Final provides a summary of the enabling legislation and guiding principles, followed by a review of the policy parameters of the HHP in Section II. Section III includes discussions about the interaction of the HHP with existing Medi-Cal programs, implementation, technical assistance (TA), program evaluation, and ongoing stakeholder engagement.

### A. Background

The [Medicaid Health Home State Plan Option](#) is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allowed states to create Medicaid health homes to coordinate the full range of physical health services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years, and, if an HHP is implemented in California, The California Endowment (TCE) has offered to fund the remaining 10 percent of funds (up to \$25 million per year) required for these additional services for that same two-year period.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the HHP will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that an evaluation of the program is completed and a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

### B. Guiding Principles

The overarching goal of the Triple Aim – better care, better health, and lower costs -- will continue to shape the HHP effort. The [Let's Get Healthy California](#) and subsequent State Health Care Innovation Plan (Innovation Plan) reports support the creation of the HHP.

#### 1. Policy Goals

A number of policy goals were established to provide a framework for policy development of the HHP, as follows:

- **Improve care coordination.** A primary function of the HHP is to provide increased care coordination for individuals with chronic conditions. This increased care coordination will be provided through the six HHP Services, described in Section II.B,

each oriented to a specific component of care coordination with the goal of improving the overall health care provided to the individual.

- **Integrate palliative care into primary care delivery.** To strengthen the foundation for palliative care delivery, palliative care will be included in an HHP member's needs assessment. Care coordinators may also emphasize the importance of using advanced directives and Physician Orders for Life-Sustaining Treatment (POLST) forms.
- **Strengthen community linkages within health homes.** Linkages to housing and social services are critical to providing comprehensive care coordination in HHP. Requirements for strong linkages to, and assistance and follow-up with, community resources will ensure that these resources are available to HHP members. In addition to linking and coordinating available social services, the multi-disciplinary care team will also encourage HHP members to participate in evidence-based prevention programs such as diabetes management and smoking cessation, and other available programs that are documented to use best practices and have positive outcomes. Information about the availability of these programs will be provided to the member.
- **Strengthen team-based care, including use of community health workers/promotores/other frontline workers.** HHPs will be required to have team-based care, including community health workers where appropriate. Because of the linkages to housing and other social services, and potential outreach activities, community health workers will have a role in providing HHP services. See Section II.F.5 for discussion on multi-disciplinary care team and community health workers.
- **Improve the health outcomes of people with high-risk chronic diseases.**
- **Reportable net cost avoidance within two years.**

## 2. DHCS Objectives

In addition to the Innovation Plan goals, DHCS established objectives for the implementation of the HHP.

- **Ensure sufficient provider infrastructure and capacity to implement HHP as an entitlement benefit.** Because ACA Section 2703 Health Homes is an optional Medicaid entitlement benefit, DHCS must ensure adequate provider infrastructure and access within each geographic area that the State selects for operation. Access must be available for all members who meet the HHP eligibility requirements and choose to access HHP services. DHCS must also ensure that the services are provided according to the Medicaid "freedom of choice of providers" requirements, which means members are allowed to choose among available providers.
- **Ensure that HHP providers appropriately serve members experiencing homelessness.** Homelessness is a major complicating factor in the health outcomes

of many chronically ill patients. The W&I Code requires that providers who serve homeless members have the specific capabilities to engage and serve these members, including creating linkages to supportive housing and other social services. Additional information about services for members experiencing homelessness is included throughout this document.

- **Increase integration of physical and behavioral health services.** Individuals with both physical and behavioral health issues tend to have a significantly worse prognosis for their conditions and incur higher health care costs than individuals who do not have behavioral health issues. Improving coordination and integration of physical and behavioral health services will improve outcomes across the Triple Aim.
- **Create synergies with the Cal Medi-Connect (CMC) Program in the seven CMC counties.** Through CMC, Medi-Cal members in CMC counties who are dually eligible for Medicare and Medi-Cal receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through an organized delivery system. The Centers for Medicare & Medicaid Services (CMS) requires that dually eligible members are included in HHP initiatives. Services in the HHP will be complementary to, and not duplicative of, the CMC program.
- **Maximize federal funding while also achieving fiscal sustainability after eight quarters of enhanced federal funding.** It is DHCS' intention and expectation that the HHP will remain cost neutral regarding state funding after the first two years and continue operation, and this intention will guide program design decisions. After eight quarters, the federal match for HHP services will be reduced from 90 percent to 50 percent (California's standard FFP rate). The eligibility criteria and other program parameters being defined for the HHP are intended to allow the program to be fiscally sustainable from the outset and to meet the following AB 361 requirements:
  - DHCS may only implement an HHP if no additional General Fund monies are used to fund the program administration, evaluation and services. DHCS may use General Fund monies to operate the program, but the program cannot result in a net increase in ongoing General Fund costs for the Medi-Cal program.
  - DHCS must ensure that an HHP evaluation is completed within two years after implementation.

### 3. Additional Focus Areas

DHCS has added goals to provide additional framework for the policy development process:

- **Focus on High-Cost Medi-Cal Members with Chronic Conditions.** The focused attention on this segment of the Medi-Cal population allows for increased care coordination across the Medi-Cal system for members meeting the program criteria.

- **Wrap Increased Care Coordination Around Existing Care.** Another goal of HHP is to provide the increased care coordination as close to the member’s usual point of care delivery as possible in the community. In most cases, it is expected to be at an appropriate site where a member chooses to receive most of their care or at an alternative site chosen by the member. Increased care coordination will be wrapped around the current care delivery for each member.

## II. California Health Homes Service Model

### A. Eligibility Criteria

#### 1. Target Population

The HHP is intended to be an intensive set of services for a small subset of members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of ICD-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

#### 2. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, either DHCS or Medi-Cal managed care health plans (MCPs) will develop a Targeted Engagement List of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The list will be refreshed on a monthly or quarterly basis, using the most recent available data. The acuity/complexity level criteria will be implemented as part of a Targeted Engagement List process. The MCP will actively attempt to engage the members on the Targeted Engagement List. (See Section II.G, Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must meet the following eligibility criteria:

- a. Have chronic conditions in at least one of the following categories (DHCS will select specific ICD 9/ICD 10 codes to further define these eligible conditions):
  - At least two of the following: asthma, chronic obstructive pulmonary disease (COPD), diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, dementia, substance use disorders (SUD) **OR**
  - Hypertension and one of the following: COPD, diabetes, coronary artery disease, chronic or congestive heart failure **OR**
  - One of the following: major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia) **OR**

- Asthma and a risk of at least one of the following: diabetes, SUD, depression, obesity
- b. Meet at least one of the following acuity/complexity criteria:
- A chronic condition predictive level above three based on a method to be determined by DHCS **OR**
  - At least one inpatient stay in the last year **OR**
  - Three or more Emergency Department (ED) visits in the last year **OR**
  - Chronic homelessness
- c. Have at least two separate claims for the eligible condition.

The Targeted Engagement List may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services.

The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community Based Care Management Entity (CB-CME):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

Chronic Renal Disease is an HHP eligible condition, but will not be included in the Targeted Engagement List. Members who have this condition may be referred for MCP approval.

### 3. Acuity

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP eligible members. The higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness.

#### **4. Eligibility Criteria Selection Data Analysis**

Prior to HHP implementation, DHCS will make available to stakeholders data on the eligible population (utilization and cost, demographics, conditions), service cost assumptions, staffing requirement assumptions, and savings assumptions.

### **B. Health Homes Program Services**

#### **1. Comprehensive Care Management**

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, palliative care, trauma-informed care needs, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers. The member will be engaged through e-mails, texts, social media, phone calls, letters, community outreach, and in-person meetings where the member lives, seeks care, or is accessible. Communication and information will meet health literacy standards and trauma-informed care standards and be culturally appropriate.

Comprehensive care management services are directly related to the development of the HAP and include, but are not limited to:

- Engaging the member in HHP and in their own care
- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's physical, mental health, substance use, and social service needs
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals

- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

## **2. Care Coordination**

Care coordination includes services to implement the HHP member's HAP, a comprehensive, individualized care plan. Care coordination services begin once the HAP is completed. For the HHP members, these care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. HHP services will be provided through e-mails, texts, social media, phone calls, letters, and in-person meetings where the member lives, seeks care, or is accessible. Communication and information will meet health literacy standards and trauma-informed care standards and be culturally appropriate.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

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

- Identifying barriers to improving their adherence to treatment and medication management
- Accompanying members to appointments

### **3. Health Promotion**

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions. HHP services will be provided through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and in-person meetings where the member lives, seeks care, or is accessible. Communication and information will meet health literacy standards and trauma-informed care standards and be culturally appropriate.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for smoking cessation management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

### **4. Comprehensive Transitional Care**

Comprehensive transitional care includes services to facilitate HHP members' transitions among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. The member and family/support persons will be assisted through e-mails, texts, social media, phone calls, letters, and in-person meetings where the member lives, seeks care, or is accessible. Communication and information will meet health literacy standards and trauma-informed care standards and be culturally appropriate.

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

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

##### **5. Individual and Family Support Services**

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

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan

- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving their adherence to treatment and medication management
- Evaluating family/support persons' needs for services

#### **6. Referral to Community and Social Supports**

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members. HHP services will be provided through e-mails, texts, social media, phone calls, letters, and in-person meetings where the member lives, seeks care, or is accessible. Communication and information will meet health literacy standards and trauma-informed care standards and be culturally appropriate.

Community and social support services may include, but are not limited to:

- Identifying the member's community and social support needs
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Identifying or developing a comprehensive resource guide for the member
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Linking to Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing

- Linking to Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

### **C. Information Technology (HIT)/Health Information Exchange (HIE)**

Health information Technology (HIT)/Health Information Exchange (HIE) are important components of the HHP. HHP services such as Care Coordination, Health Promotion, and Comprehensive Transitional Care will be enhanced by the use of Electronic Health Record (EHR) systems and HIE. MCPs and CB-CMEs will use EHR/HIT/HIE in the HHP where possible as follows:

- Provide an HHP Member Portal
- Utilize EHR/HIT/HIE to register HHP members
- Utilize EHR/HIT/HIE to perform Point of Care Charting
- Utilize EHR/HIT/HIE to prepare/send/receive/consume a summary of care record for care transitions

DHCS expects organizations that are covered by the Meaningful Use requirements to utilize EHR/HIT/HIE to meet these goals. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP or Cal MediConnect Plan (included by reference with MCP for the remainder of this paper) to support the achievement of these goals. DHCS has heard feedback that in some areas relatively few providers have EHRs; there is limited interoperability between the systems; and that where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the HHP activities noted above in some geographic areas, the MCP will demonstrate that they and their HHP network are maximizing EHR/HIT/HIE to the extent possible, and relate their plan to make any possible improvements in the near future.

### **D. Health Homes Program Network Infrastructure**

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care infrastructure as the foundational building block. HHP services will be provided through the Medi-Cal managed care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

HHP will be supported by the existing infrastructure in the managed care environment. The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. HHP will be able to utilize the MCPs' existing communication and reporting capabilities to perform health

promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate care coordination.

The HHP will be structured as a health home network with members functioning as a team to provide care coordination. This network includes the MCP, one or more Community Based Care Management Entities (CB-CMEs), and linkages to community and social support services (taken together as the HHP). The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based LTSS, palliative care, and social support needs
- Reducing avoidable health care costs, preventable hospital admissions/readmissions, avoidable ED visits, and avoidable nursing facility stays

This will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services, or through contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

### **1. Leveraging Existing Managed Care Plan Assessment Tools**

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination, including aligning with Cal MediConnect where possible. This topic was discussed with a technical workgroup as described in Section III.E, Stakeholder Engagement. MCPs have extensive experience administering Health Risk Assessments and developing care plans for current Cal MediConnect and SPD members. MCPs may use current Cal Medi-Connect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and to complete the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in the tool and/or process must be added to current MCP assessment and planning tools. Such elements could include social determinants of health, including an indicator of housing instability, and an assessment of need for palliative care.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, a member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care managers for all HHP members. The care manager will work with the HHP member and their family/support

persons to develop a HAP in conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities.

## 2. CMS Requirements

The HHP, as administered through the MCP and CB-CME, must demonstrate the ability to perform each of the eleven following functional requirements, which are general CMS requirements as outlined in the [State Medicaid Director \(SMD\) letter regarding Health Homes for Enrollees with Chronic Conditions, dated 11/16/2010](#). This includes MCP documentation of the processes used by the MCP or the CB-CME to perform these functions and the methods used to ensure service delivery takes place in the described manner. The additional MCP and CB-CME requirements listed later in this document are more detailed California-specific requirements:

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered HHP services
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and SUD
- Coordinate and provide access to mental health and substance use disorder services
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
- Coordinate and provide access to chronic disease management, including self-management support to HHP members and their families
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
- Coordinate and provide access to long-term care supports and services
- Develop a person-centered care plan for each HHP member that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate

Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. The MCP will assess potential CB-CMEs to determine if they can adequately perform the eleven functions listed above. The MCP will determine if a CB-CME that does not meet all criteria can perform the functions with assistance through MCP or other provider service agreements.

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

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician or specialist, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care manager to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (See Section II.F.5 for multi-disciplinary care team description.)

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal Medi-Connect and other programs.)

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

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community based organizations. DHCS' and MCPs' assessment of progress on these housing strategies will be an important element of assessing a county's (and MCPs') readiness to implement the HHP. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) and Cal MediConnect plans (combined Medicaid and Medicare benefit plans) are required

to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

Participation as the HHP MCP is optional for the following entities based on their ability to meet the HHP MCP qualifications, readiness, and ability to carry out all responsibilities and duties of the MCP:

- MHPs
- Drug Medi-Cal - Organized Delivery System demonstration (DMC-ODS) participants where the entity is an integrated Mental Health/SUD (MH/SUD) plan
- California Children's Services Organized Delivery System entities

### **1. Qualifications**

The MCP will meet the following qualifications:

- Have experience operating broad-based regional provider networks
- Have authority to access Medi-Cal claims data for the population served
- Have an adequate network of CB-CMEs in geographic target areas for HHP to serve eligible members, as defined by DHCS
- Have the capacity to qualify and support organizations who meet the standards for CB-CMEs, including:
  - Identifying organizations who meet the CB-CME standards
  - Providing the infrastructure and tools necessary to support CB-CMEs in care coordination
  - Gathering and sharing HHP member-level information regarding health care utilization, gaps in care and medications
  - Providing outcome tools and measurement protocols to assess CB-CME effectiveness
  - Developing and offering learning activities that will support CB-CMEs in effective delivery of HHP services

### **2. Certification**

DHCS will ensure that MCPs are qualified, both through review of certification criteria and through a readiness review process that will take place before implementation of HHP. MCP responsibilities will be incorporated into the MCP contract as an amendment and the MCP will establish clear program operational policies.

### **3. Duties**

MCPs will be expected to perform the following duties/responsibilities:

- Attribute assigned HHP members to CB-CMEs
- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals
- Notify the CB-CMEs of inpatient admissions and ED visits/discharges
- Track and share data with CB-CMEs regarding each member's health history
- Track CMS-required quality measures and state-specific measures, including those noted in Section II.J, Reporting.
- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process
- Provide member resources (e.g. customer service, member grievances) relating to HHP
- 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
- Establish and maintain a data-sharing agreement that is compliant with all federal and state laws and regulations with other providers
- Ensure access to timely services for HHP members, including seeing HHP members within established length of time from discharge from an acute care stay. (The length of time will be established by DHCS as part of the MCP Request for Application and readiness process.)
- Ensure participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care manager to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Section II.F.5 for multi-disciplinary care team description)
- Develop CB-CME training tools and reporting capabilities
- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

### **F. Community Based Care Management Entity Responsibilities**

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a

process similar to current MCP provider certification and will contract with selected entities. DHCS will provide general guidelines and requirements, including a standardized assessment tool, developed with assistance/input from a MCP technical workgroup, in order to help MCPs select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP 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
- Utilizing community health workers in appropriate roles. (For more information, see Section II.F.5, Multi-Disciplinary Care Team.)

CB-CMEs are intended to 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. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four goals noted above.

In most cases, the CB-CME 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-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 HHP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

Six to nine months before HHP implementation, HHP MCPs will submit to DHCS a detailed proposal of how the MCP will implement the HHP. This proposal will include information on the MCPs proposed HHP network structure. DHCS will review proposals to ensure that HHP goals, including the four network goals bulleted above, are being maximized to the extent possible. Prior to implementation, DHCS will perform a readiness review,

which will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may request DHCS approval to perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties, with advance approval from DHCS. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

### **1. Community-Based Care Management Models**

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which the member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not reasonable or practical. Provider HHP assessments, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP-eligible high-risk members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

#### Model I

The first and ideal model embeds care managers on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete an assessment, in conjunction with the DHCS-developed assessment tool, to determine 1) the extent to

which the community provider will need to recruit and hire additional staff to meet the HHP care manager resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

### Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care managers on site. For this model, the care management would be handled by another community-based entity or a staff member within the existing MCP care management department, which will act as the CB-CME. It will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

### Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care managers located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location will become CB-CMEs who can be geographically close to rural individuals and/or those patients who meet inclusion criteria but who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

## **2. Qualifications**

HHP CB-CMEs will meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, and as appropriate for their assigned HHP member population, experienced with high-risk members such as individuals who are experiencing homelessness
- Comply with all program requirements
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If the MCP has demonstrated to DHCS that in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized if culturally appropriate and accessible for the HHP member to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals

- Agree to accept any eligible HHP members assigned by the MCP, according to the CB-CME contract with the MCP
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination
- Use HIT/HIE to link HHP services and share relevant information with other providers involved in the HHP member's care, in accordance with the HIT/HIE goals noted in Section II.C.

### **3. Certification**

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group
- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

### **4. Duties**

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios to be determined by DHCS, and oversight of direct delivery of the core HHP services

- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination
- Ensure person-centered and integrated health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical health care related needs and services and social services needs and services
- Collaborate with and engage HHP members in developing a HAP and reinforcing/maintaining/reassessing it in order to accomplish stated goals
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and improve health
- Provide evidence-based care
- Manage referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy)
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy

##### **5. Multi-Disciplinary Care Team**

DHCS will require the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. The team will primarily be located at the CB-CME organization, except as noted above regarding organization flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and

HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member’s preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member’s service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member’s HAP. As an example, an MCP could use HHP care coordination funding to pay a member’s specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member’s HAP. The MCP may make such payments directly to the providers or through their CB-CME.

**Table 1: Multi-Disciplinary Care Team Qualifications and Roles**

| Required team members                          | Qualifications   | Role  |
|--|--|---|
| Dedicated Care Manager (CB-CME or by contract) | Paraprofessional (with appropriate training) or licensed care manager, social worker, or nurse | <ul style="list-style-type: none"> <li>• Oversee provision of HHP services and implementation of HAP</li> <li>• Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines</li> <li>• Connect HHP member to other social services he/she may need</li> <li>• Advocate on behalf of members with health care professionals</li> <li>• Use motivational interviewing and trauma-informed care practices</li> <li>• Work with hospital staff on discharge plan</li> <li>• Engage eligible HHP members</li> <li>• Accompany HHP member to office visits, as needed and according to MCP guidelines</li> <li>• Monitor treatment adherence (including medication)</li> <li>• Provide health promotion and self-management training</li> <li>• Arrange transportation</li> <li>• Assist with linkage to social supports</li> <li>• Call HHP member to facilitate HHP visit with care manager</li> </ul> |

*continued*

| Required team members  | Qualifications   | Role  |
|--|--|---|
| HHP Director (CB-CME)  | Ability to manage multi-disciplinary care teams  | <ul style="list-style-type: none"> <li>• Have overall responsibility for management and operations of the team</li> <li>• Have responsibility for quality measures and reporting for the team</li> </ul>  |
| Clinical Consultant (CB-CME or MCP)  | Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional | <ul style="list-style-type: none"> <li>• Review and inform HAP</li> <li>• Act as clinical resource for care manager, as needed</li> <li>• Facilitate access to primary care and behavioral health providers, as needed to assist care manager</li> </ul>  |
| Community Health Workers (CB-CME or by contract)                                     | <p>Paraprofessional or peer advocate</p> <p>Administrative support to care manager</p>   | <ul style="list-style-type: none"> <li>• Engage eligible HHP members</li> <li>• Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines</li> <li>• Health promotion and self-management training</li> <li>• Arrange transportation</li> <li>• Assist with linkage to social supports</li> <li>• Distribute health promotion materials</li> <li>• Call HHP member to facilitate HHP visit with care manager</li> </ul>  |
| For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract) | Paraprofessional or other qualification based on experience and knowledge of the population and processes  | <ul style="list-style-type: none"> <li>• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers</li> <li>• Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing</li> <li>• Connect and assist the HHP member to get available permanent housing</li> <li>• Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)</li> </ul> |

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

## **G. Member Assignment**

### **1. Assignment**

DHCS will develop the overall eligibility criteria and either DHCS or the MCP will use these criteria and administrative data to determine members who are eligible for HHP services. The eligibility criteria will be run on a monthly or quarterly basis, using the most recent available data, to provide a Targeted Engagement List of members to the MCP for engagement. (For more information, see Section II.A.2, HHP Eligibility Criteria and the Targeted Engagement List.)

MCPs will be responsible for engaging eligible members, using state-determined, CMS-approved criteria. MCPs will link HHP members to one of their contracted CB-CMEs and notify the HHP member via a letter. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME. The letter will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. The letter will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. The letter will also explain the process for participation. A telephone and/or in-person engagement process may be developed to supplement or replace the letter engagement process in certain situations. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies. Engagement of eligible HHP members will be critical for the program success.

### **2. Referral**

HHP services must be made available to all full scope Medi-Cal members who meet the DHCS-developed eligibility criteria, including those dually eligible for Medicaid and Medicare. Providers may refer eligible members to the member's assigned MCP to confirm if the member meets the clinical eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method of engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referrals will indicate that the provider has verified that the member meets the eligibility criteria stated on the referral form. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and eligible to receive HHP services from a CB-CME.

### **3. Consent**

The member will be considered enrolled in the HHP once the member has given consent to participate in the program. The CB-CME care manager will secure consent by the member to participate in HHP and authorize release of information. The MCP and the CB-CME will maintain these consent forms/records.

### **4. Discharge**

If an eligible member cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be discharged from the HHP and the MCP will discontinue CB-CME HHP funding for that member. The eligible member may choose to participate in the HHP at any time. DHCS will define required activities to attempt to engage member prior to discharge.

## **H. Payment Methodologies**

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

### DHCS Payments to MCPs

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

MCPs will receive a payment for HHP services through the capitation rates based on a prospective, risk-based methodology that uses a hybrid approach of payment through the existing capitation rate structure for all MCP members and a new monthly add-on risk-based per member per month (PMPM) payment for HHP members during the ongoing service delivery period. Within the existing capitation rate structure, DHCS will identify the amount currently included in capitation payments that reflects DHCS' assessment of the overlap between HHP requirements and requirements currently in the MCP contracts. This amount will be counted as HHP services to be claimed at 90% FFP match (for traditional populations – expansion populations will align to the applicable FFP match). The new add-on PMPM monthly payment will reflect the additional amounts necessary to account for the full package of HHP services and the projected costs to successfully engage and manage HHP members. This add-on PMPM monthly payment will also be claimed at 90% or expansion level FFP match. The add-on PMPM payments are turned on/off based upon each individual's status as an HHP member.

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

## I. Service Delivery

The PMPM add-on monthly payment is triggered by enrollment and disenrollment from the HHP. At least one core HHP service must be provided each quarter of the ongoing service delivery period in order for an add-on PMPM payment to be made to the MCP for the months in the subsequent quarter. The MCP will report every quarter that they have provided a core service to each member for whom they are receiving an HHP payment. DHCS will develop specific engagement activity requirements for the engagement period.

As part of the MCP proposal and readiness review process, DHCS will develop program outcome requirements to verify that the HHP is delivering appropriate services on an aggregate and member-specific basis, which may include completion of certain activities within certain timeframes (HAP completion, in-person visits, etc.), aggregate staffing ratios, and dashboard metric reporting. Within the service and staffing requirements that DHCS will develop, MCPs will have flexibility to develop service requirements for their CB-CMEs and target resources as appropriate based on information developed by CB-CME assessments of each member's needs. DHCS will not set program requirements for criteria specific to individual service tiers or criteria for movement between tiers.

DHCS will review HHP service utilization, by MCP, for future rate development and to evaluate the achievement of program requirements and goals.

### MCP Payments to CB-CMEs and Others

The MCP may contract with its community-based provider network to provide HHP services, and/or arrange (via a memorandum of understanding or similar agreements) for HHP service components. (For example, the payment methodology assumes that counties will still have responsibility for coordination of specialty mental health services; however, the MCPs will bear some HHP costs that would be associated with coordinating with the counties, on a paid or unpaid basis, dependent upon DHCS' direction or MCP's choice. See Section III.A.1, Mental Health and Substance Use Disorders, for a description of a separate county-organized HHP MCP for members with conditions that are appropriate for specialty mental health treatment and SUD needs).

### MCP Reporting — HHP Members

Members will be targeted for HHP services based on their eligible chronic conditions. The MCPs will notify members that they have been identified as eligible for HHP services. The MCPs will need to track the number of members the MCP is actively seeking to engage, and the number of participating members, and provide this via an administrative report to DHCS that will be used for prospective rate setting. MCPs will receive funding for engagement activities.

At a minimum, MCPs will need to be able to report how many of their members met the HHP criteria and are participating, by category of aid (COA) and on a member month basis. The initial month should reflect only the members that the MCP is actively seeking to engage. This information will need to be reported on a COA level. Subsequent months

should reflect any changes from the prior month and the reason for any changes, such as switching from the engagement phase to the service phase when a member has been successfully engaged and consented to participate in the HHP. This level of reporting will be utilized for future rate setting so that appropriate attrition or growth levels of qualifying members can be tracked.

#### MCP Reporting — Cost and Utilization

MCPs will also be required to provide cost and utilization reporting related to the services provided for the HHP members. This information needs to include identified numbers of services/visits/units (to be defined for each type of HHP service) and associated costs for the services/visits/units. This information will be needed at the COA level.

#### **J. Reporting**

CMS has established a recommended core set of health care quality measures (see Table 2 below for draft quality measures). This core set of eight measures was selected based on priority areas of behavioral health and preventive care and aligns with existing core sets for adults and children. Additional details can be found in the CMS technical specifications and resource manual. Three utilization measures (see Table 3 below) were also identified by CMS to assist with the overall federal health home evaluation, and will become a reporting requirement as well. In addition to the required core measures, DHCS proposes the following draft measures:

- Avoidable hospital readmissions that followed inpatient stays
- Engagement rate
- Cost avoidance that results from improved chronic care

DHCS will also track operational measures related to HHP service delivery that may include, but not be limited to, data elements reported in a format determined by DHCS on a quarterly basis such as:

- Number of HHP members
- Number of the HHP service units provided in the reporting period
- Aggregate care manager to member ratio
- CB-CME network information
- Process in place with hospitals for referral of potential HHP-eligible members
- Number of members experiencing homelessness and their current housing status by the end of the reporting period (stable, wait list, temporary shelter)
- Member consent date

- HAP completed within 90 days
- Documented discussions of care goals
- Annual reassessment completed
- Status of engagement (contacted, engaged, chose not to participate, not appropriate for HHP), HAP completed, method of contact (by mail, by phone, in person)
- Number of members no longer participating in HHP
- Number of new HHP members who previously participated in HHP and had a break in membership

To the extent possible, DHCS will leverage existing managed care evaluation tools, such as a standardized member satisfaction survey, and adjust accordingly and as needed for HHP. DHCS will contract with an external evaluator prior to the start of HHP to ensure the program is designed to allow for federal and state measurement and evaluation activities. Additional tools such as member and provider surveys/self-assessments may be utilized to inform the evaluation on subjects such as member satisfaction and members’ self-assessments of health status; program implementation, and suggestions for improvements.

**Table 2: CMS Health Home Recommended Core Measures**

| Measure  | Steward   |
|--|-----------|
| Adult Body Mass Index (BMI) Assessment                                   | HEDIS*    |
| Screening for Clinical Depression and Follow-up Plan                     | CMS*      |
| Plan All-Cause Readmission Rate  | HEDIS*    |
| Follow-up After Hospitalization for Mental Illness                       | HEDIS*#   |
| Controlling High Blood Pressure  | HEDIS*    |
| Care Transition – Timely Transmission of Transition Record               | AMA-PCPI* |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | HEDIS*    |
| Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite      | AHRQ      |

\* Adult Core Set

# Child Core Set

**Table 3: Utilization Measures for CMS Evaluation**

| Measure                                       | Steward |
|---|---------|
| Ambulatory Care – Emergency Department Visits | HEDIS   |
| Inpatient Utilization                         | CMS     |
| Nursing Facility Utilization                  | CMS     |

### **III. Additional Program Elements and Timeline**

#### **A. HHP Interaction with Existing Medi-Cal Programs**

##### **1. Mental Health and Substance Use Disorders**

DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, SUD, community-based LTSS, palliative care, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHPs contracted provider acting as a designated CB-CME. To facilitate care coordination for HHP members through a MHP designated CB-CME, DHCS is considering how to enable MHPs to perform MCP responsibilities in HHP. The current working premise is as follows (also reflected in Section II.E, Medi-Cal Managed Care Plans):

MHPs can perform MCP HHP responsibilities through a delegation contract with the MCPs in the county. Drug Medi-Cal - Organized Delivery System (DMC-ODS) demonstration participants can perform MCP HHP responsibilities where the entity is an integrated MH/SUD plan. This type of entity would perform the MCP HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of both the MCP and a CB-CME.

##### **2. Targeted Case Management / 1915(c) Waiver**

Targeted Case Management and 1915(c) Home and Community Based Services Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs and there is a federal prohibition against providing duplicative federally funded services. For members who qualify for more than one of these programs, members will be allowed to participate in only one program and they will have the choice regarding program participation selection.

**3. 1115 Waiver Whole Person Care Pilot Program**

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.

**B. Current Status of Implementation**

**1. Timeline**

The proposed dates of activities involved with the development and implementation of the HHP are outlined in Table 4 below.

**Table 4: Health Homes Program Timeline**

| Dates            | Activities   |
|------------------|--|
| 10/2015          | Released and completed Managed Care Plan Request for Information   |
| 12/2015          | Draft-final concept paper released for stakeholder comment   |
| 12/2015          | One time required consult with Substance Abuse and Mental Health Services Administration (SAMHSA)  |
| 2/2016           | Released Provider Self-Assessment for Participation in the Health Homes Program for counties implementing HHP in January 2017  |
| 3/2016           | First State Plan Amendment (SPA) submission to CMS   |
| 3/2016           | Released Application for Participation in the Health Homes Program by Medi-Cal Managed Care Health Plans and Cal MediConnect Plans for counties implementing HHP in January 2017 |
| 3/2016 – ongoing | Begin to provide TA, build health home networks, and prepare for program implementation  |
| 6/2016           | Projected CMS approval of 2703 SPA   |
| 1/2017           | Begin operating HHP (first SPA effective date for enhanced match purposes) – Proposed Health Homes Program County Implementation Schedule below                                  |

**2. County Readiness**

DHCS recognizes that readiness in a county includes the readiness of the MCPs, MHPs, and other entities that might assume MCP HHP responsibilities; the CB-CMEs; all associated social services and supports; and the existing provider community.

All MCPs and other entities noted above will be required to commit to and demonstrate their ability to meet the duties identified in Section II.E, and that they have the ability to assemble CB-CME networks to serve all eligible members in the county regarding all CB-CME requirements and duties and all other specified program goals and requirements.

DHCS will continue to develop outstanding readiness requirements, such as outcome measures and service requirements and include these in the required MCP Request for Application process and the readiness evaluation tool and process, which DHCS will share with stakeholders in the next few months.

### 3. County Implementation Schedule

ACA 2703 allows geographic phasing of HHP services. As noted in Section II.D, Health Homes Program Network Infrastructure, DHCS believes that HHP will be successful and sustainable because of the infrastructure in the managed care environment. In CCI counties, additional requirements that are aligned with HHP will allow the MCPs, MHPs, and providers to better implement and operate HHP for the benefit of eligible members.

DHCS plans to phase the HHP implementation in groups of counties. The first group of counties anticipates implementing HHP for members with chronic physical conditions and SUD in January 2017 and those with serious mental illness (SMI) in July 2017. SMI includes children with serious emotional disturbance (SED). The second group of counties anticipates implementing HHP for members with chronic physical conditions and SUD in July 2017 and for members with SMI in January 2018, and the third group of counties anticipates implementing HHP for members with chronic physical conditions and SUD in January 2018 and members with SMI in July 2018. The counties included in each group and the implementation dates are outlined in Table 5 below.

**Table 5: Proposed Health Homes Program County Implementation Schedule**

|                | Counties  |  | Implementation date for members with chronic physical conditions and SUD | Implementation date for members with SMI |
|----------------|---|--|--|--|
| <b>Group 1</b> | Del Norte<br>Humboldt<br>Lake<br>Marin<br>Mendocino<br>Napa     | San Francisco<br>Shasta<br>Solano<br>Sonoma<br>Yolo                  | January 1, 2017  | July 1, 2017                             |
| <b>Group 2</b> | Imperial<br>Lassen<br>Merced<br>Monterey<br>Orange<br>Riverside | San Bernardino<br>San Mateo<br>Santa Clara<br>Santa Cruz<br>Siskiyou | July 1, 2017   | January 1, 2018                          |
| <b>Group 3</b> | Alameda<br>Fresno<br>Kern<br>Los Angeles                        | Sacramento<br>San Diego<br>Tulare                                    | January 1, 2018  | July 1, 2018                             |

NOTE: HHP implementation in the following counties is not currently scheduled: Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Glenn, Inyo, Kings, Madera, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, San Benito, San Joaquin, San Luis Obispo, Santa Barbara, Sierra, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Ventura and Yuba

### **C. Technical Assistance**

It will be critical for program success to ensure that MCPs and providers are fully aware and educated about the HHP before it begins in any given county. DHCS will assist with provider and beneficiary outreach and education, including program implementation TA for MCPs and providers. TA will be available for both plans and providers prior to, and during, the implementation of the HHP. DHCS will have funding and begin work on these activities, with foundation and federal grant support, several months before program start dates as implementation occurs in various regions. TA will be staged according to the timeline of implementation and will continue through implementation and beyond. HHP TA will include the two separate sets of activities listed in the following paragraphs.

DHCS will provide, or contract for the provision of, opportunities for all HHP providers to receive TA and participate in a learning collaborative. Collaborative activities may include webinars, regional meetings, and teleconferences on best practices, lessons learned, and communication strategies. TA will also include access to care coordinator training and a learning network for care coordinator best practices.

In addition to the TA described above, the Pacific Business Group on Health (PBGH), pending final approval, has been named as the provider for the following Center for Medicare and Medicaid Innovation (CMMI) funded TA. PBGH will provide individual practice transformation coaching for approximately forty CB-CME entities that will serve a high volume of the HHP population. As part of this project, PBGH will create tools such as CB-CME best practices training, care coordinator training, and a tool to assess provider organizational capacity and readiness to serve as a CB-CME. The assessment tool will address content areas, such as staff composition and data infrastructure, which are predictors of successful implementation. The assessments will be conducted telephonically with follow-up site visits where more review is warranted. Assessments will be conducted to 1) identify existing care coordination programs already providing CB-CME services, and 2) identify organizations with the infrastructure to build new health home programs for complex patients and qualify as a CB-CME. These tools are being developed for the State Innovation Model selective practice transformation project; after development, these tools may be leveraged for all HHP providers.

### **D. Program Evaluation**

An evaluation of the HHP within two years after implementation is required by the W&I Code. As required by CMS, the HHP must report on a core set of health care quality measures, utilization measures, and quality data. Per W&I Code, DHCS may only implement an HHP if DHCS determines that no additional General Fund monies will be used to fund the program administration, evaluation, and services. DHCS may use General Fund monies to operate the program but the program cannot result in a net increase in ongoing General Fund costs for the Medi-Cal program. An external evaluator will be contracted to monitor, evaluate, and complete the final evaluation report in addition to production of various reports to inform and assess the progress of the program. The evaluation will be designed to verify the fiscal sustainability of the program design after the eight quarters of enhanced federal match; it will measure membership, utilization, expenditure, encounter, quality

indicators, and other data required for reporting purposes including, but not limited to, avoidable hospital readmissions.

- The primary goals of the evaluation will be to assess the sustainability and impact on the overarching Triple Aim goals of better health, better health care, and lower per capita costs while reporting on a core set of health care quality measures, utilization measures, and quality data.
- The evaluator will work with DHCS to design the evaluation and seek feedback from stakeholders on the design.
- Administrative data on active HHP participants will be used to measure costs and determine a methodology to measure the effect of the HHP on these costs.
- The evaluator will measure the total cost of the program. Additionally, the calculation of cost will report cost-effectiveness that result from improved coordination of care and chronic disease management achieved through the HHP.
- The receipt of timely data from all health home partners will be critical for the evaluation. Feedback to DHCS and other stakeholders throughout the program implementation period may provide strategic information to support future planning.
- The timing of the evaluation activities and products will be dependent on the speed of program implementation in each of the programs, and may be changed in order to maximize utility of evaluation findings.

DHCS anticipates contracting with an external evaluator prior to the start of HHP implementation to ensure the program is designed to allow for federal and state measurement and evaluation activities and inform the MCPs and health home providers of reporting requirements. Additional State standardized measures may be identified to track progress toward the Triple Aim goals.

#### **E. Stakeholder Engagement**

Stakeholder input has been critical in the development of the HHP. DHCS initiated a stakeholder engagement process in November 2014 that continues through the submission of the first HHP State Plan Amendment (SPA) to CMS in January 2016.

DHCS released three draft versions and held four informational webinars prior to the release of this Health Homes for Patients with Complex Needs California Concept Paper – Final. DHCS accepted feedback and comments from stakeholders after the release of each draft concept paper and webinar. Comments were thoughtfully reviewed and considered, and the comments informed each new draft of the concept paper. All published concept papers, including this final version, are available for review on the Health Homes Program web page.

DHCS facilitated a series of technical workgroup meetings with small groups of key stakeholders to gain advice on detailed aspects of policy development on topics such as:

- MCP and CB-CME qualifications, duties, and organizational structures
- HHP MCP network development to effectively promote HHP goals, including:
  - Ensuring care management delivery and funding at the point of care in the community
  - Leveraging existing county and community provider care management infrastructure and experience
- Assessments, HAPs, reporting requirements, metrics, and referrals
- Eligibility criteria, tiers, staffing requirements, and cost and savings assumptions

In addition, DHCS convened a separate technical workgroup to gain advice on engaging and providing HHP services to individuals experiencing homelessness. DHCS worked with the sponsors of AB 361, the Corporation for Supportive Housing and the Western Center on Law and Poverty, to design the membership and agenda for this workgroup. The format and process was the same as the other technical workgroup meetings.

DHCS acknowledges the significant contributions of individuals and organizations that have provided critical feedback and strategic advice during the development of the HHP. Stakeholder engagement will continue as the HHP is operationalized and implemented.