Frequently Asked Questions
on Health Homes for Patients with Complex Needs
California Concept Paper Version 2.0

1. **What opportunities will stakeholders have to engage with DHCS in the development process of the Health Homes Program?**

   Stakeholder engagement is critical to the development of the Health Homes Program (HHP). Stakeholders have opportunities to engage with the Department of Health Care Services (DHCS) regarding the HHP in many ways including webinars, web pages, event listings on the DHCS Stakeholder Calendar of Events, an email distribution list, and an HHP email inbox. DHCS will continue to work closely with our stakeholder community as we develop and submit our State Plan Amendment (SPA) submission to Centers for Medicare & Medicaid Services (CMS). DHCS is also reaching out to specific stakeholders with identified areas of expertise to assist with program development.

   DHCS will release a DRAFT-FINAL concept paper for stakeholder review prior to the SPA submission to CMS later in 2015.

   For more information on stakeholder engagement opportunities, visit the Health Homes Program web page.

2. **When will the Health Homes Program be implemented?**

   Our goal is to have an approved SPA and be ready for implementation by January 2016. DHCS will work closely with our partners and stakeholders to ensure plan and provider readiness for implementation, and will not move forward until we are sure that plans and our other partners are ready in each county.

3. **When and how will DHCS determine readiness criteria and timelines for implementation of the Health Homes Program in a specific geographic area? Will all Medi-Cal managed care plans in the county have to participate for a county to be considered ready?**

   DHCS is currently formulating readiness criteria that will be used to determine if plans and providers are ready for implementation of HHP. The readiness criteria will focus on the Medi-Cal Managed Care Plans and Cal MediConnect Plans (together referred to as 'MCPs' for the remainder of this document) and their network development for delivery of HHP services. Additional criteria may include the readiness of providers and organizations that will serve HHP clients. DHCS will be working to establish the readiness criteria, with stakeholder input, over the next few months.

Per federal requirements, all MCPs in a county will need to be ready to participate in HHP in order for any plan in the county to be considered ready for implementation of HHP.

4. **How will a provider show readiness to participate in the Health Homes Program? When will DHCS share provider readiness requirements? Will the health plan or other community entities be able to assist a CB-CME with fulfilling the requirements, or will each CB-CME have to fulfill all of the CB-CME requirements?**

   MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current managed care plan provider certification and will contract with selected entities. DHCS will provide general guidelines and requirements, including a standardized assessment tool to help MCPs select, certify and contract with CB-CMEs. DHCS will develop the standardized provider assessment tool over the next few months. DHCS will share information about the assessment process and tool with stakeholders when it is developed.

   It is DHCS's intent that CB-CMEs serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP beneficiary receives access to HHP services. It is also DHCS's intent 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 service or subcontracted service. DHCS encourages MCPs and CB-CMEs to use this flexibility, where needed, to achieve HHP goals.

   In situations where the MCP can demonstrate that there are insufficient community-based entities that are capable, or willing, to perform the full range of CB-CME duties, the MCP may perform whatever duties of the CB-CME are needed to fill a demonstrated service gap, or subcontract with other community-based entities to perform these duties, with advance approval from DHCS, when this MCP assistance is the best organizational arrangement to promote HHP goals.

   Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP beneficiaries will receive access to the same level of service, in accordance with the service tiers that will be developed by DHCS.

5. **If a provider has not demonstrated readiness when the Health Homes Program starts in their county, will they have the opportunity to become a Health Homes Program provider when they are ready? May a provider increase their level of participation as they develop additional capabilities?**

   Ultimately, these two questions will be addressed by the MCPs in the county. The MCPs will have responsibility for developing a network of HHP providers for the

MCPs eligible members. DHCS will allow flexibility for the MCPs to develop and expand their networks, which could include adding additional providers and expanding the scope of a provider's HHP responsibility after program implementation. As noted in the Provider Readiness response (Question #4), DHCS will provide MCPs with the flexibility to include providers in the HHP delivery system who have varying levels of capacity to take on the various components of HHP service. However, the MCP must assemble a HHP provider network that is capable of providing the full level of HHP service to all HHP enrolled members throughout the county.

6. What technical assistance will be available for plans and providers, and when, and for which providers?

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 technical assistance (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) has been named as the provider for the following Center for Medicare and Medicaid Innovation (CMMI) California State Innovation Model (CalSIM) design grant funded TA. PBGH will provide individual practice transformation coaching for approximately 40 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 CalSIM selective practice transformation project; after development, these tools may be leveraged for all HHP providers.

7. What happens to the Health Homes Program after the first two years of enhanced funding and evaluation?

DHCS acknowledges that plans and providers will invest significant resources to implement the HHP. It is DHCS's intention and expectation that the HHP will be cost neutral and continue operation after the first two years when the enhanced federal funding ends. This intention will guide key program design decisions, including eligibility criteria and service requirements. After eight quarters, the federal match for HHP services will reduce from 90 percent to 50 percent. Assembly Bill 361 requires that the HHP demonstrate cost-neutrality and that DHCS complete a HHP evaluation within two years after implementation. Also, DHCS will complete a readiness review of each implementing county to ensure the county is ready for implementation.

8. How will DHCS integrate and align the Health Homes Program with the Cal Medi-Connect program for dually eligible enrollees?

DHCS's intention is to create synergies with HHP and Cal MediConnect. Through Cal MediConnect, dually eligible beneficiaries receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through an organized delivery system. Cal MediConnect plans are responsible for performing care management and coordination services that are very similar to HHP. The HHP will build on the care coordination services provided by Cal MediConnect plans to provide some additional intensive, in-person care coordination services for eligible beneficiaries.

To the extent possible, DHCS will align care management methods and tools with those currently used by MCPs for care coordination, including aligning with current Cal MediConnect and Seniors & Persons with Disabilities (SPDs) requirements where possible. MCPs may use current Cal MediConnect and SPD care management tools, such as Health Risk Assessments and Individualized Care Plans, to perform health assessments and complete the HHP's required Health Action Plan for an HHP member as long as all requirements for the HHP are incorporated into these tools. For the HHP, any assessment or planning elements that are required in Health Homes for Patients with Complex Needs California Concept Paper Version 2.0 (Concept Paper 2.0) must be added to current MCP assessment and planning tools or processes if they are not already included in the tool or process. Alignment of current MCP care management and coordination tools and processes with HHP requirements will be a topic of stakeholder workgroups over the next few months.

9. How will the Health Homes Program interact with other care management programs such as California Children's Services (CCS), Targeted Case Management (TCM) and 1915(c) Home and Community-Based Waiver programs, Whole Person Care (WPC) pilots, and Program of All-inclusive Care for the Elderly (PACE)?

California Children's Services (CCS)

The vast majority of beneficiaries who are eligible for HHP are likely to be adults; however, some children may be eligible, including some children who are also in the CCS program. HHP services are always optional for all beneficiaries who are eligible for the program. Federal requirements prohibit DHCS from carving out any population who would otherwise be eligible for HHP services. This includes children who are in the CCS program, if they are otherwise eligible for HHP. If a CCS-eligible child chooses to utilize these services, HHP will only complement their CCS services by providing additional coordination of their health care and social services. DHCS cannot change the health coverage of a CCS-eligible child through the HHP; it is solely an optional set of care coordination services. DHCS will further explore how this would be implemented with the CCS stakeholders.

Targeted Case Management (TCM) and 1915(c) Home and Community-Based Waiver programs

TCM and 1915(c) Home and Community-Based Services Waiver programs provide services to many Medi-Cal beneficiaries who will likely also meet the eligibility criteria for HHP. Because there are comprehensive case management components within these programs, and DHCS must ensure there is no duplication of services, more investigation is required to determine the best course of action for each program and the beneficiaries currently served by them. DHCS will continue this investigation and work with stakeholders for these important programs.

Whole Person Care (WPC) pilots

DHCS proposed a county-based WPC pilot concept to CMS as part of the 1115 waiver renewal. If the WPC pilot is included in the final 1115 waiver, DHCS will ensure that it would complement and not duplicate all existing care coordination services including HHP.

Program of All-inclusive Care for the Elderly (PACE)

PACE enrollees are currently provided care management and coordination services similar to the services defined for HHP. DHCS will work with PACE partners and stakeholders regarding the potential implementation of HHP for PACE members.

10. How will DHCS determine the eligibility criteria for the program and how will eligible members be identified and referred?

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 will identify specific eligibility criteria for HHP services. These criteria will include a combination of both 1) eligible chronic condition, and 2) a required high level of acuity/complexity. DHCS will design and verify that this two-part criterion will limit the eligible population to the highest risk three-to-five percent of the Medi-Cal population who are most appropriate for HHP services (with certain exclusions, such as institutionalized members). The acuity/complexity level will be measured by either 1) predictive modeling risk score, 2) diagnosis of multiple chronic conditions, 3) high cost/utilization, or some combination of these. DHCS will use the most recently available Medi-Cal claims and encounter data, including data from the managed care plans and mental health and substance use disorder delivery systems, to identify eligible members.

Prior to submitting the SPA to CMS, DHCS will make available to stakeholders the process that was used to develop the eligibility criteria, as well as data on the proposed eligible population (utilization and cost, demographics, conditions), service cost assumptions, case-manager ratio assumptions, and savings assumptions.

DHCS will develop the overall eligibility criteria and either DHCS or the MCP will use these criteria and administrative data to determine beneficiaries who are eligible for HHP services. The eligibility process will be run on a monthly or quarterly basis to provide a list of beneficiaries to the MCP for outreach and engagement. MCPs will be responsible for enrolling eligible beneficiaries, using state-determined, CMS-approved criteria.

If a provider identifies a beneficiary who is appropriate for HHP services, the provider may refer them to the beneficiary's assigned MCP for HHP enrollment. Referrals are more likely necessary for new Medi-Cal beneficiaries 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 beneficiary meets the eligibility criteria stated on the MCP's referral form. The provider will submit the referral form to the MCP for confirmation. CB-CMEs may not enroll beneficiaries to the HHP without prior approval from the MCP. However, the MCP may, at its option, allow a provider to enroll a beneficiary in the HHP with a retroactive approval from the MCP.

If an eligible beneficiary cannot be engaged within a specified period of time, opts out, or fails to participate actively in HHP planning and coordination, the beneficiary will be discharged from the HHP.

11. How will DHCS ensure that the Health Homes Program is appropriately funded to address the high complexity of the eligible population?

HHP beneficiary acuity and intensity of service needs will inform tiering of services and payment. For example, program criteria may include three, or more, risk groupings of the HHP eligible beneficiaries. The higher risk groupings (tiers) will receive more intensive HHP services. For HHP beneficiaries who are experiencing homelessness, the HHP will include requirements to address the unique needs of this specific population.

At this time, DHCS does not have specific information about funding levels and DHCS has not released any estimates of projected funding levels. DHCS is still working on internal data analytics and has more work to do before information about the demographics and costs of the eligible population, service tiers information, and rates is released. For the most complex members, the service intensity will be quite high. With stakeholder feedback, DHCS will determine service intensity, and associated funding, for the tiers of service that will produce the greatest health benefit and cost effectiveness.

Key policy elements, such as the eligibility criteria, population description, service tiers, service costs, and savings assumptions, will be addressed as part of the technical workgroup meetings that are described in Concept Paper 2.0, "Stakeholder Engagement" section, and will be held prior to SPA submission.

12. Will community-based social services providers, such as housing navigators, receive Health Home Program funded payment for services?

In general, HHP services are care coordination services, and do not include funding of direct social services. However, community-based social services providers will receive HHP-funded payment for services if 1) the provider has an agreement in place with the MCP or the CB-CME to provide some portion of the HHP services, and 2) the services provided are within Medi-Cal's definition of HHP services and are delivered in accordance with all HHP requirements. For more information about allowable HHP services, see Concept Paper Version 2.0, "Health Home Services" section.

DHCS's HHP goals include strengthening community linkages and ensuring that HHP providers appropriately serve members experiencing homelessness. Linkages to housing and social services are critical to providing whole person care in the HHP. Requirements for strong linkages, assistance, and follow-up to community resources will ensure that these resources are available to this population. HHP-funded payment will be available for the multidisciplinary care team's housing navigators. Housing navigators are a required team member for those beneficiaries who are experiencing homelessness. The role of the housing navigator will be to assist the beneficiary to secure stable housing.

13. Will beneficiaries have to change their delivery system, health plan, or provider as part of the HHP?

A MCP member will NOT be required to change health plans or change providers to access HHP services. A fee-for-service (FFS) beneficiary will need to choose to join a MCP if they wish to access HHP services. HHP services will not be available in the FFS delivery system. If the beneficiary is in FFS, they will not be required to move to a managed care plan, unless they want HHP services, and there will be no passive transition of FFS beneficiaries to managed care. There are no required or "passive" health plan or provider transitions associated with this program.