Health Homes for Patients with Complex Needs
California Concept Paper Version 2.0
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A. Introduction

This Health Homes for Patients with Complex Needs (herein referred to as Health Home Program or HHP) California Concept Paper Version 2.0 is the culmination of policy development activities to date on this important project. HHP Concept Paper Version 2.0 is an enhancement to the HHPCN California Concept Paper released on 11/17/2014. DHCS has matured various policy areas and considered stakeholder input to prepare this paper. HHP Concept Paper Version 2.0 Section A. provides a recap of the enabling legislation and guiding principles, and is followed in Section B. by a review of the policy parameters of the Health Home Program. Section C. provides information about the interaction of the Health Home Program with existing Medi-Cal programs, project status and a discussion of ongoing stakeholder engagement.

1. 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 allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by beneficiaries with chronic conditions. Federal matching funds are available for two years, and, if 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. Assembly Bill 361 (AB 361), enacted in 2013, authorized California to submit a Section 2703 application, subject to several conditions, including cost neutrality and an evaluation after the first two years.

With respect to the requirements of Section 2703 and AB 361, the State has developed a set of policy goals (see Section A.3, Guiding Principles) that will guide the planning and implementation of the HHP.

2. Statutory Authority

Although The Center for Medicare and Medicaid Services (CMS) is obligated to develop federal regulations for ACA 2703 Health Homes there is no information currently available regarding this rulemaking process.

In California, AB 361 authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for beneficiaries with chronic conditions. AB 361 provides that those provisions shall not be implemented unless federal financial participation is available and that the program is cost neutral regarding State General Funds. AB 361 also requires that if DHCS implements the program, DHCS ensures that an evaluation of the program is completed and that DHCS submits a report to the appropriate policy and fiscal committees of the Legislature 2 years after implementation of the program.

3. Guiding Principles

Overarching Goal: Triple Aim – Better Care, Better Health, Lower Costs
The overarching goal of the Triple Aim will continue to shape the health home effort. The Let's Get Healthy California (LGHC) and subsequent State Health Care Innovation Plan reports supported the creation of health homes for persons with chronic conditions. A number of policy goals were established to provide a framework for policy development of health homes, as follows:

- **Improve care coordination.** A primary function of Health Homes is to provide increased care coordination for individuals with chronic conditions. This increased care coordination is provided through the six Health Home Services, described in Section B.2, each oriented to a specific component of whole person care coordination with the goal of improving the overall health care provided to the individual.
- **Integrate palliative care into primary care delivery.**
- **Strengthen community linkages within health homes.** Linkages to housing and social services are critical to providing whole person care in Health Homes. Requirements for strong linkages, assistance and follow-up to community resources will ensure that these resources are available to this population. In addition to linking and coordinating available social services, the multi-disciplinary care team will also encourage the HHP beneficiary to participate in evidence-based prevention programs such as diabetes management, 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 beneficiary.
- **Strengthen team-based care, including use of community health workers/promotores/other frontline workers.** Health homes will be required to have team-based care, including community health workers. Because of the linkages to housing and other social services, and potential outreach activities, community health workers can have a role in providing Health Home services. See Section B.5 for information 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, which will require reporting period to be 18 months.**

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

1. **Ensure sufficient provider infrastructure and capacity to implement HHP as an entitlement program**. Because ACA Section 2703 Health Homes is an optional Medicaid entitlement benefit, DHCS must ensure adequate provider infrastructure and access within the geographic areas that the State selects for operation. Access must be available for all beneficiaries who 1) meet the health home eligibility

requirements and 2) choose to access health home services. DHCS must also provide the services according to the Medicaid "freedom of choice of providers" requirements, which means beneficiaries are allowed to choose among available providers.

2. **Ensure that health home providers appropriately serve members experiencing homelessness**. Homelessness is a major complicating factor in the health outcomes of many chronically ill patients. California recognized this through the enactment of AB 361, which authorizes DHCS to create a health home program for enrollees with chronic conditions. AB 361 requires that providers who serve homeless members have the specific capabilities to engage and serve these members, including making linkages (referrals) to supportive housing and other social services. There is additional information about services for homeless members throughout this document.

3. **Increase integration of physical and behavioral health services**. Beneficiaries with both physical and behavioral health issues tend to have a significantly worse prognosis for their conditions and incur higher health care costs. Improving coordination or integration of physical and behavioral health services will improve outcomes across the Triple Aim.

4. **Create synergies with the Coordinated Care Initiative (CCI) in the seven participating counties.** Through Cal Medi-Connect, Medi-Cal beneficiaries in seven selected 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. CMS requires that dually-eligible beneficiaries are included in health home initiatives. It will be important to ensure that any services under the health home initiative are complementary to the Medi-Connect program**.**

5. **Maximize federal funding while also achieving fiscal sustainability after eight quarters of federal funding.** After eight quarters, the federal match for health home services will be reduced from 90 percent to 50 percent. The eligibility criteria and other program parameters being defined for the Health Home Program are intended to allow the program to be fiscally sustainable from the outset. To ensure this goal, AB 361 has the following two requirements:
    a. DHCS must complete a health home program evaluation within two years after implementation.
    b. DHCS may only implement a health home program if 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 can not result in a net increase in ongoing General Fund costs for the Medi-Cal program.

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

- **Focused Program on High-Cost Beneficiaries with Chronic Conditions**. The DHCS HHP will focus on a Medi-Cal population that has chronic conditions and increased utilization and cost of health care. The focused attention on this segment of the population allows for increased care coordination across the Medi-Cal system for beneficiaries 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 point of care delivery as possible in the community. In most cases it is expected to be at an appropriate site where a beneficiary chooses to receive most of their care or at an alternative site chosen by the beneficiary. Increased care coordination will be wrapped around the current care delivery for each beneficiary.

B. California Health Home Service Model

1. Eligibility Criteria

Target Population
Per federal requirements, states can choose to define one or more of the following groups of eligible individuals for Section 2703 health home enrollment:

1. Individuals with two or more chronic conditions;
2. Individuals with one chronic condition and at risk for another;
3. Individuals with serious and persistent mental illness.

HHP will target all three categories for health home eligibility with an emphasis on beneficiaries with high-costs, high-risks, and high utilization who can benefit from increased care coordination of physical health, behavioral health, community-based LTSS, palliative care, and social supports, resulting in reduced hospitalizations and emergency department (ED) visits, improved HHP beneficiary engagement and decreased costs. Specific eligible conditions have not yet been finalized; however, the following list of eligible chronic conditions (see Table 1) is being used to develop estimates of the eligible population and their current health care costs.

Table 1: Eligible Chronic Conditions

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

Health Home services must be made available to all categorically-needy Medi-Cal beneficiaries who meet the eligibility criteria. All full scope Medi-Cal beneficiaries who meet the eligibility criteria of HHP will be included. For the beneficiaries eligible via the new Medicaid ACA optional expansion eligibility category, the State will receive 100 percent federal match (gradually decreasing to 90 percent in 2020) rather than the enhanced federal match of 90 percent during the first eight quarters.

Acuity

DHCS anticipates that eligibility criteria will be based on: a) targeted conditions, and b) specified acuity level as determined by risk analysis software and/or administrative utilization data. 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) would receive more intensive HHP services.

In addition, for HHP beneficiaries who are experiencing homelessness, the HHP will include requirements to address the unique needs of this specific population.

Eligibility Criteria Selection Data Analysis

DHCS will review historical Medi-Cal data to identify the administrative data elements and criteria that can be used to determine HHP eligibility. The goal of the data analysis is to identify <u>all</u> beneficiaries who have both:

- High levels of negative health outcomes/utilization; and
- Specific chronic conditions and social determinants of health that present the best opportunity for better care management (with Health Home services) that will improve health outcomes and reduce avoidable, frequent, high-cost utilization.

After this population is identified, DHCS will determine the administrative data characteristics that 1) are unique to this group, and 2) can be used to identify eligible beneficiaries through an administrative data, or referral, eligibility process.

In general, DHCS expects that this process will identify an eligible group that represents approximately 3-5 percent of the highest risk Medi-Cal population who can benefit from additional intensive care management. DHCS will make available to stakeholders the data and 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 describe the following elements for the proposed eligible population:

1. Description of the Data Set used for the analysis and what is included and excluded from the data set.
2. Specific Eligibility Criteria - used to identify the proposed Health Home population, including the acuity criteria and target chronic conditions.
3. Descriptive statistics regarding Health Costs and utilization for total per-member-per-month (PMPM) costs and by major cost categories.
4. Descriptive statistics for Avoidable Utilization, such as inpatient days at various levels, ED visits, and short-stay Skilled Nursing Facility days.
5. Demographics, including the total number eligible, percentage of Medi-Cal population, and percentages for geographic location, race, and gender, and Medi-Cal eligibility category.
6. Descriptive statistics for chronic conditions and other social determinants of health, including percentages for specific chronic conditions, homelessness, foster care, and those who have conditions that are appropriate for specialty mental health treatment, Substance Use Disorder (SUD), and California Children's Services (CCS) services.

The topics addressed within this Eligibility Criteria Section will be part of the technical workgroup meetings identified in the Stakeholder Engagement Prior to SPA Submission Section of this paper.

2. Health Home Services

Comprehensive Care Management

Comprehensive care management primarily involves the activities related to developing the HHP beneficiary's comprehensive, individualized care plan, called a Health Action Plan (HAP). HAPs should incorporate the HHP beneficiary's physical health, mental health and substance use disorder, community-based LTSS, palliative care, and social support needs. Care management services include screenings and assessments with standardized tools, and issues identified will be included in the HAP. The HAP is a person-centered plan based on the needs and desires of the beneficiary. HAPs will be reassessed based on the HHP beneficiary's progress or changes in their needs. Comprehensive care management includes assessing the HHP beneficiary's readiness for self-management and promoting self-management skills so that the HHP beneficiary is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals to attain recovery, improve functional or health status, or prevent or slow declines in

functioning. As appropriate, the HHP beneficiary's family should be incorporated in the initial health assessments and subsequent reassessments. Referrals and HAP goals should also be tracked via the HAP.

Care Coordination and Health Promotion
Care coordination includes the implementation of the HHP beneficiary's comprehensive, individualized care plan, or HAP. At a minimum, the care coordination function includes: working with HHP beneficiary to implement a person-centered HAP; sharing options with the HHP beneficiary for accessing care; providing information to the HHP beneficiary regarding care planning; monitoring medications and treatment adherence by HHP beneficiaries; and managing referrals, coordination and follow-up to needed services and supports. Care coordination may include case conferences in order to ensure that the HHP beneficiary's care is continuous and integrated among all service providers.

Comprehensive Transitional Care
Comprehensive transitional care addresses the activities related to preventing HHP beneficiary admissions and readmissions. It requires the health home to have a process in place for prompt notification of the HHP beneficiary's admission or discharge to/from an emergency department, hospital inpatient facility, residential/treatment facility, or other. At a minimum, the care transition function includes: receipt of a summary care record or discharge summary; medication reconciliation; planning related to the timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners; and appropriate care/place to stay post-discharge.

Individual and Family Support Services
Individual and family support services include activities that ensure that the HHP beneficiary and their family are knowledgeable about the HHP beneficiary's conditions with the overall goal of improving the HHP beneficiary's adherence to treatment. Communication and information shared with the HHP beneficiary and their family and care givers should meet health literacy standards and be culturally appropriate. At a minimum, individual and family support services could include: use of peer supports and/or support groups to work with the HHP beneficiary and their family; and use of self-care programs to help increase the HHP beneficiary's understanding of their conditions and care plan. In addition, this service may include advocacy for the HHP beneficiary and their family to identify and obtain needed resources (e.g. transportation) that support their ability to meet goals.

Referral to Community and Social Supports
Referral to community and social supports addresses the identification of community-based resources to meet the whole-person needs of the HHP beneficiary and active referral and follow-up to these resources. Communication and information shared with the HHP beneficiary should meet health literacy standards and be culturally appropriate. Community and social supports include, but are not limited to: housing, food and nutrition, employment, child care, community-based LTSS, school and faith-based services, and disability services.

Use of Health Information Technology and Exchange to Link Services
Health information Technology (HIT)/Health Information Exchange (HIE) are important components of the HHP. Health Home services such as Care Coordination, Health Promotion, and Comprehensive Care Transition will be enhanced by the use of Electronic

Medical Record (EMR) systems, and HIE. DHCS has established goals for EMR/HIT/HIE use in the HHP as follows:

- Provide a HHP Beneficiary Portal
- Utilize EMR/HIT/HIE to register HHP beneficiaries
- Utilize EMR/HIT/HIE to perform Point of Care Charting
- Utilize EMR/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 EMR/HIT/HIE to meet these goals. Organizations that are not covered by Meaningful Use may need a Medi-Cal Managed Care Plan (MCP) or Cal MediConnect Plan (included by reference with MCP for the remainder of this paper) to support the achievement of these goals.

3. HHP Network Infrastructure

DHCS's Health Home implementation will utilize California's managed care infrastructure as a critical building block. DHCS will provide Health Home services through our managed care delivery system to beneficiaries enrolled in managed care. The small percentage of Fee-For-Service (FFS) beneficiaries who meet HHP eligibility criteria will have the choice to enroll in Managed Care to receive their HHP services. Managed Care serves approximately 85 percent of full scope Medi-Cal beneficiaries and is an available choice for all full-scope Medi-Cal beneficiaries statewide.

HHP is supported by the existing services provided in the managed care environment. The MCPs' connectivity with their provider networks facilitates the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP beneficiary 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. The care management and coordination services provided through the HHP will enhance the whole person care for beneficiaries with chronic conditions. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHP) in each county to facilitate care coordination.

To the extent possible and reasonable DHCS will align care management methods and tools with those currently used by MCPs for care coordination, for example DHCS will look to align with Cal MediConnect where possible. This topic is included in the issues for further discussion with a technical workgroup as described in Section C.5.

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

- Improving beneficiary outcomes by coordinating physical health, mental health and substance use disorder, community-based LTSS, palliative care and social support needs; and
- Reducing avoidable health care costs, specifically preventable hospital admissions/readmissions, avoidable emergency department visits, and avoidable nursing facility stays.

This will be accomplished through the partnership between MCP and the community-based care management entity (CB-CME) either through direct provision of health home services, or through contractual arrangements with appropriate providers who will be providing components of the health home services and planning and coordination of other services

The MCP and CB-CME must demonstrate ability to perform each of the following functional requirements as outlined in the State Medicaid Director letter on HHPs, dated 11/16/2010. This includes documentation of the processes used to perform these functions and the methods used to assure service delivery takes place in the described manner:

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to mental health and substance use disorder services;
5. 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;
6. Coordinate and provide access to chronic disease management, including self-management support to HHP beneficiaries and their families;
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a person-centered care plan for each HHP beneficiary that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
10. 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; and
11. 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.

4. Medi-Cal Managed Care Plan Responsibilities

Health Home MCPs will be responsible for the overall administration of the health home. They will have a health home addendum to an existing contract with DHCS. It is anticipated that payment will flow from DHCS to the MCP to the CB-CMEs for the provision of health home services. The MCP may also pay providers who are not included formally on the CB-CME's multi-disciplinary health home 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 health home team (see Section 6 for multi-disciplinary team description).

In counties that implement HHP, participation in HHP and serving as a Health Home MCP is mandatory for the following organizations. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness:

- Medi-Cal managed care plans (Medicaid only benefit plans); and
- Cal MediConnect plans (combined Medicaid and Medicare benefit plans)

Participation as the health home MCP is optional for the following organizations in the health home implementation counties. Based on the entities' ability to meet the health home MCP qualifications, readiness, and ability to carry out all responsibilities and duties of the MCP, optional MCPs include:

- MHPs and Drug Medi-Cal - Organized Delivery System demonstration participants (DMC-ODS) where the entity is an integrated Mental Health/Substance Use Disorder plan; and
- CCS Organized Delivery System entities

Additional information regarding these organizations is presented in Section C.1.

Qualifications
Health home MCP shall meet the following qualifications:

1. Have authority to access Medi-Cal claims data for the population served;
2. Have an adequate network of CB-CMEs in geographic target areas for HHP to serve eligible beneficiaries, as defined by DHCS;
3. 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-CME in care coordination;
    - Gathering and sharing HHP beneficiary-level information regarding health care utilization, gaps in care and medications;
    - Providing outcome tools and measurement protocols to assess CB-CME effectiveness; and

- Developing and offering learning activities that will support CB-CME in effective delivery of health home services.

Certification
DHCS will ensure that MCP 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 clear operational policies will be established by the MCP.

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

1. Attribute assigned HHP beneficiaries to CB-CMEs;
2. 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;
3. Notify the CB-CME of inpatient admissions and emergency department visits, to the extent possible;
4. Track and share data with CB-CMEs regarding each participant's health history;
5. Track quality measures;
6. Collect, analyze and report financial measures, health status and other measures and outcome date to be reported during the State's evaluation process;
7. Provide beneficiary resources (e.g. customer service, beneficiary grievances) relating to HHP;
8. 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;
9. Establish and maintain a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers;
10. Ensure access to timely services for HHP beneficiaries, including seeing HHP beneficiaries within established length of time from discharge from an acute care stay;
11. Ensure participation by HHP beneficiaries' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary HHP 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 HHP team (see Section 6 for multi-disciplinary team description).

5. Community Based Care Management Entity

CB-CMEs will serve as the frontline provider of health home 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 managed care plan provider certification and will contract with selected entities. DHCS will provide general guidelines and requirements, 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 health home funding are provided at the point of care in the community.
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed.
- Leveraging existing county and community provider care management infrastructure and experience where possible and appropriate.
- Utilizing community health workers in appropriate roles.

It is the intent of the HHP that CB-CMEs serve as the single entity with overall responsibility for ensuring that an assigned HHP beneficiary receives access to the full range of 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. 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 situations where the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide for the full range of CB-CME duties, the MCP can perform duties of the CB-CME, or 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, and in particular the four goals noted above.

As part of future program development work, DHCS will develop specific program requirements, with input from a stakeholder technical workgroup(s), to operationalize the four HHP goals noted above. See Section C.5 for description of technical workgroups.

Qualifications
Health home CB-CMEs shall meet the following qualifications:

1. Experience serving Medi-Cal beneficiaries;
2. Comply with all program requirements;
3. Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
4. Provide appropriate and timely in-person care coordination activities, as needed. If in person communication is not possible, alternative communication methods in addition to in-person such as telemedicine or telephonic contacts may also be utilized if culturally appropriate and accessible for the HHP beneficiary to enhance access to services for HHP beneficiaries and families where geographic or other barriers exist and according to beneficiary choice;
5. Have the capacity to accompany HHP beneficiaries to critical appointments, when necessary, to assist in achieving HAP goals;

6. Agree to accept any eligible HHP beneficiaries assigned by the MCP, according to their contract with the MCP;
7. Demonstrate engagement and cooperation of area hospitals, primary care practices and behavioral health providers to collaborate with the CB-CME on whole-person care coordination;
8. As feasible, use HIT/HIE to link health home services and share relevant information with other providers involved in the HHP beneficiary's care, in accordance with the HIT/HIE goals noted in Section 3.

Certification

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

- Community mental health center
- Community health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group
- Substance use disorder treatment provider
- Providers serving those that experience homelessness
- Providers serving individuals/persons diagnosed with HIV/AIDS
- Other entities who meet certification and qualifications of a CB-CME may serve in this capacity if selected and certified by the MCP

Duties

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

1. Responsible for care team staffing, according to HHP required staffing ratios to be determined by DHCS, and oversight of direct delivery of the core health home services;
2. Implement systematic processes and protocols to ensure beneficiary access to the multi-disciplinary health home team and overall care coordination;
3. Ensure person-centered and integrated health action planning that coordinates and integrates all of the health home beneficiary's clinical and non-clinical health care related needs and services and social services needs and services;
4. Engage HHP beneficiaries in developing a HAP and reinforcing/maintaining the care plan in order to accomplish stated goals;
5. Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP beneficiary's health action goals, conducting case conferences as needed in order to ensure HHP beneficiary care is integrated among providers;
6. Support the HHP beneficiary in obtaining and improving self-management skills to prevent negative health outcomes and improve health;
7. Assure the receipt of evidence-based care;
8. Manage referrals, coordination and follow-up to needed services and supports; actively maintain a directory of community partners for referrals;
9. Support HHP beneficiaries and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
10. Accompany the HHP beneficiary to critical appointments when necessary;

11. Provide service in the community in which the HHP beneficiary lives so services can be provided in-person, if needed;
12. Provide 24-hour, seven days a week availability of information and emergency consultation services to HHP beneficiaries in coordination with the HHP beneficiary's MCP nurse advice line;
13. Provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy.

As part of future program development work, DHCS will develop specific program requirements, with input from a stakeholder technical workgroup, to address requirements for the HAP and to guide HHP staffing ratios for case managers and other staff as needed. As previously noted, beneficiary acuity and intensity of service needs will inform tiering of services and payment. Program staffing ratios will be intended to describe the human resources that are required to be solely dedicated to the HHP services. The ratios will be specific to the various service tiers.

Multi-Disciplinary Health Home Team

DHCS will require the following team members on a multi-disciplinary health home team. The multi-disciplinary health home team consists of staff employed by the CB-CME that provide HHP funded services. The team will primarily be located at the CB-CME organization, except as noted above regarding organization flexibility. A HHP goal is to provide health home services where beneficiaries seek care and, thus, it is expected that staffing and the day-to-day care coordination should occur at the CB-CME level rather than at the MCP.

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 serves as the HHP beneficiary's service providers for participation in case conferences and information sharing in order to support the development and maintenance of the HHP beneficiary's HAP. The MCP may make such payments directly to the providers or through their CB-CME requirements and funding.

Multi-Disciplinary Health Home Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Manager (CB-CME or by contract)	• Strong background in managing multi-disciplinary teams • Paraprofessional (with appropriate training) or licensed case manager, social worker, or nurse	• Oversees provision of health home services and implementation of HAP • Offer services where the HHP beneficiary lives and seeks care • Connect HHP beneficiary to other social services he/she may need • Advocate on behalf of beneficiaries with health care professionals • Use tools like motivational

		interviewing and trauma informed care practices • Work with hospital staff to plan for discharge • Engage eligible HHP beneficiaries • Accompany HHP beneficiary to office visits, as needed • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Calling HHP beneficiary to facilitate health home visit with care manager
HHP Director (CB-CME)	• Strong background in managing multi-disciplinary teams •	• Overall responsibility for management and operations of the team. • Responsible for quality measures and reporting for the team
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	• Review and inform HAP • Clinical resource for care manager, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care manager
Community Health Workers (CB-CME or by contract)	• Paraprofessional or peer advocate • Administrative support to care manager	• Engage eligible HHP beneficiaries • Accompany HHP beneficiary to office visits, as needed • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Mailing health promotion materials • Calling HHP beneficiary to facilitate health home visit with

		care manager
For HHP Beneficiaries Experiencing Chronic Homelessness: Housing Navigator (CB-CME or by contract)	• Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with and communication between team members, housing providers, and beneficiary advocates • Connect and assist the HHP beneficiary to get recuperative care or bridge housing • Connect and assist the HHP beneficiary to get available permanent housing

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary team in order to meet the HHP beneficiary'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 health home 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.

6. Beneficiary Assignment

Assignment/Enrollment

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 health home services.

MCPs will be responsible for enrolling eligible beneficiaries, using state-determined, CMS-approved criteria. MCPs will link enrolled HHP beneficiaries to one of their contracted CB-CMEs and notify the HHP beneficiary via a letter. If the HHP beneficiary's assigned primary care physician is affiliated with a CB-CME, the HHP beneficiary will be assigned to that CB-CME, unless the beneficiary chooses another CB-CME. The letter will inform the HHP beneficiary that they are eligible for heath home services, and identify their MCP and CB-CME. The letter will explain that health home participation is voluntary, beneficiaries have the opportunity to choose a different CB-CME, and that HHP beneficiaries can opt out at any time. The letter will also explain the process for opting out and include a form to return if a HHP beneficiary decides not to participate. A telephone and/or in-person engagement process may be developed to supplement or replace the letter enrollment process in certain situations. In counties where there are multiple MCPs available, the HHP beneficiary may change their MCP once per month in accordance with current MCP choice policies. Engagement of eligible HHP beneficiaries will be critical for the program success.

Referral
Providers may refer eligible beneficiaries to the beneficiary's assigned MCP to confirm if they are eligible for health home services. Referrals are more likely necessary in the situation of a new Medicaid beneficiary who may not have the Medi-Cal claims history that identifies them as health home eligible. Provider referrals will indicate that the provider has verified that the beneficiary meets the eligibility criteria stated on the referral form. The provider will submit the referral form to the MCP for confirmation. CB-CMEs cannot add beneficiaries to the health home rolls without prior approval from the MCP.

Consent
Consent to participate in HHP and consent to release of information forms will be secured by the CB-CME care manager during initial visit with the HHP beneficiary. These consent forms/records will be maintained by the MCP and the CB-CME.

Discharge
If an eligible beneficiary cannot be engaged within a specified period of time, opts out, or refuses or fails to participate actively in health home planning and coordination, the HHP beneficiary will be discharged from the HHP and the MCP will discontinue CB-CME health home funding for that beneficiary. If, at a later date, the eligible beneficiary decides to participate in a Health Home, the beneficiary may choose to opt-in to the HHP. DHCS will define required activities to attempt to engage beneficiary prior to discharge.

7. Payment Methodologies

As described in the provider section, health home payments will flow through the lead entities which will then be responsible for negotiating contracts and setting rates with qualified community-based care management entities or other providers to ensure the delivery of Health Home services.

DHCS intends to instruct health plans to implement a three-tier payment process for health homes, based on the acuity of the patients enrolled in the program. Rates to health plans are anticipated to be developed according to this methodology.

For the first three months, health homes will receive an enhanced "member engagement tier" reimbursement rate. This payment acknowledges the extensive up front work required from the health homes to assist with enrollees during comprehensive care management (e.g. engaging the enrollee, conducting initial assessments, developing the HAP). This rate will be provided for up to three months with an additional incentive payment to the health home upon completion of the HAP. The HAP must be completed before the health home can receive future payments based on patient acuity.

At least one core health home service must be provided each quarter in order for a payment to be made to the health home. The health home will report every quarter that they have provided a core service to each member for whom they are receiving a health home payment.

The MCP may contract with its community-based provider network to provide Health Home Services, and/or make arrangements (via a memorandum of understanding or similar agreements) for Health Home 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 choice. See also the Mental Health and Substance Use Disorder Section in this document for a description of a separate county-organized Health Home MCP for beneficiaries with conditions that are appropriate for specialty mental health treatment and Substance Use Disorder needs). When the MCP has demonstrated that community-based providers are not available, not willing, or do not have the capacity, to provide Health Home services, the MCP may directly provide one or more components of the HHP services.

8. Reporting

CMS has established a recommended core set of health care quality measures (see Table 1 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 2 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, the State will also track state-specific quality measures related to Health Home service delivery. To the extent possible, DHCS will leverage existing managed care evaluation tools, such as a standardized beneficiary satisfaction survey, in the health home for maximum consistency. DHCS will contract with an external evaluator prior to the start of HHP services to ensure the program is designed to allow for federal and state measurement and evaluation activities

Table 1: 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

* Included in Adult Core Set
\# Included in Child Core Set

Table 2: Utilization Measures for CMS Evaluation

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

C. Additional Program Elements and Timeline

1. HHP Interaction with Existing Medi-Cal Programs

Mental Health and Substance Use Disorder
DHCS recognizes that coordination of mental health services will be a major component of HHP. HHP services are required to be provided for the whole person, including mental

health care. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP beneficiaries will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP beneficiaries who receive mental health services have the capability to support the various needs of their beneficiaries.

For HHP beneficiaries 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 health home services. These CB-CMEs would typically be affiliated with an MCPs.

DHCS and stakeholders have noted that HHP beneficiaries with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary health home services from their MHPs contracted provider acting as a designated CB-CME. To facilitate care coordination for HHP beneficiaries 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 B.5 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 demonstration participants (DMC-ODS) 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 a health home eligible managed care beneficiary 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.

Targeted Case Management / 1915 C Waiver

Targeted Case Management and 1915c 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 there is a federal prohibition against providing duplicative federally funded services, more investigation is required to determine the best course of actions for each program and the beneficiaries currently served by them. However, for beneficiaries who qualify for more than one of these programs, it is likely that beneficiaries will be allowed to participate in only one program and that they will have the choice regarding program participation selection. DHCS plans to continue this investigation and work with stakeholders for these important programs.

1115 Waiver Renewal

DHCS recently submitted a proposal to CMS for the 1115 Waiver renewal. It contains numerous objectives for improving DHCS's health care delivery system through improved coordination and care delivery across physical and behavioral health. There are a number of concepts in the 1115 Waiver renewal that complement a HHP such as the use of multi-

disciplinary care teams and implementation of a coordinated "no wrong door" approach for patients with chronic conditions who need care across physical and behavioral health. The effort to renew the 1115 Waiver is an iterative process with CMS. The initial concepts included in the application are subject to change and evolution and will happen concurrently with policy development of the HHP. As the 1115 Waiver development continues, DHCS will ensure that the services that are provided in counties that are also implementing Health Homes are complementary.

2. Current Status of Implementation

Timeline

Health Home Program Timeline	
8/14 – 7/15	Ongoing program design. Solicit, evaluate, and incorporate stakeholder as needed.
4/15 – 7/15	One time required consult with Substance Abuse and Mental Health Services Administration (SAMHSA)
4/15 – 7/15	CMS consultation on coverage issues and reimbursement model
8/14 – 1/16	Ongoing stakeholder engagement
8/15	Formal State Plan Amendment (SPA) submission to CMS
10/15 – 12/15	CMS approval of 2703 SPA
7/15 – 7/18	Implementation & Provider Technical Assistance
7/15 – 12/15	Begin to provide TA, build health home networks, and prepare for program implementation
1/16	Begin operating HHP (SPA effective date for enhanced match purposes)
12/17	End of enhanced match for first 2703 health home SPA
1/18	Completion of initial AB 361 evaluation timeframe

Geographic Phasing
ACA 2703 allows geographic phasing of Health Home services. As noted above in the 'Managed Care' section, DHCS believes that HHP will be successful and sustainable because of the infrastructure in the manage care environment. In CCI counties there are additional requirements that are aligned with HHP that will allow the MCPs, MHPs, and providers to better implement and operate HHP for the benefit of eligible beneficiaries.

DHCS is planning to phase the HHP implementation on a county by county basis, based upon readiness. Currently, two phases are planned, the first on January 1, 2016, for CCI counties and potential other counties that are ready. The second phase for remaining counties that demonstrate readiness is scheduled for July 1, 2016.

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 B.5, and that they have the ability to assemble CB-CME networks to serve all eligible beneficiaries in the county regarding all CB-CME requirements and duties and all other specified program goals and requirements.

DHCS plans to review the readiness evaluation tool with stakeholders in the next few months.

3. Technical Assistance

The HHP will provide technical assistance (TA) for Health Home network providers (CB-CME and MCPs) through multiple modalities, including webinars and a learning collaborative for all health home network partners, and to the extent funding is available, selective individual practice coaching for providers who serve a high volume of the target population. Per federal rules, TA may not be funded with ACA Section 2703 Health Home funding, though TA may be funded through regular Medicaid funding with a 50 percent federal match. California plans to use part of it's the Center for Medicare and Medicaid State Innovation Model design grant for Health Home TA as well as other external resources. DHCS is drafting a TA plan to prepare CB-CMEs to improve participants' care.

Lessons learned from the Intensive Outpatient Care Program (IOCP) and from the Frequent Users of Health Services Initiative (FUHSI), a safety net program that was funded by The California Endowment and the California Health Care Foundation from 2002-2008, will be included in the TA plan.

The TA plan will include the following:

- The design of a tool to conduct organizational assessments of provider organizations identified by health plans and the State as potential CB-CMEs. The assessment tool addresses 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.

- Provide two levels of TA:
    a. TA for existing programs qualified as CB-CMEs which includes access to care coordinator training and a learning network to share best practices;
    b. TA to build new Health Homes for complex patients which includes intensive training of organizational leaders to set up programs within their organizations and the care coordinators with responsibility for direct patient care.

4. Program Evaluation

An evaluation of the HHP within two years after implementation is required by the California authorizing legislation (AB 361). As required by CMS, the HHP must report on a core set of health care quality measures, utilization measures, and quality data. 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 can not 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 and measure enrollment, 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 health home participants will be used to measure costs and determine methodology to measure the effect of these costs on the HHP.
- 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.

5. Stakeholder Engagement Prior to SPA Submission

DHCS initiated a stakeholder engagement process beginning in November 2014.

Time Period: April 2015 to August 2015 (Anticipated SPA submission)

Stakeholder engagement has been and will continue to be critical to the development of the HHP. DHCS will facilitate several engagement events between the April release of this second iteration of the DHCS Concept Paper and the anticipated August SPA submission to CMS. DHCS will convene a series of technical workgroup meetings (likely 2-4 meetings) with a small group of key stakeholders to gain advice on detailed aspects of policy development on the following topics:

- MCP and CB-CME qualifications, duties, and organizational structures;
- Methods to promote program goals through program requirements for MCP HHP network development, including:
    - Ensuring care management delivery and funding at the point of care in the community;
    - HHP provider experience requirements for those experiencing homelessness;
    - Leveraging existing county and community provider care management infrastructure and experience where appropriate.
- Assessment, HAP, reporting requirements, metrics, referrals;
- Eligibility Criteria, Tiers, Case Manager Ratios, and Cost and Savings Assumptions.

To facilitate the workgroup process, DHCS will develop policy proposals and/or questions and provide these to the group in advance with sufficient time for review. DHCS will convene the workgroup, either by telephone or in-person, to review comments on the agenda material. DHCS will also solicit written comments from the group within a reasonable period of time after the workgroup meeting.

DHCS will convene a separate technical workgroup for one meeting to gain advice on engaging and providing HHP services to those experiencing homelessness. DHCS will work with the sponsors of AB 361, 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 will be the same as the other technical workgroup meetings.

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

If you have comments or questions about this concept paper, or if you wish to be included in future notices of stakeholder engagement opportunities, please send your request to the DHCS health home mailbox: HHP@dhcs.ca.gov.