Health Homes Program

CALIFORNIA'S HEALTH HOMES PROGRAM

Overview for Managed Care Plan and Community-Based Care Management Entity(CB-CME)Staff

DHCS
California Department of Health Care Services

October 2018

Health Homes Program

TRAINING PURPOSE

- This is the 1st training in the series
- It will provide an overview of the Health Homes Program (HHP)
- Each Medi-Cal Managed Care Plan (MCP) has some flexibility in how they design their HHP
- Your MCP will have follow-up trainings to explain how its HHP will work operationally and to provide more information about your specific role within the program
- Additional program information can be found in the HHP Program Guide

Health Homes Program

TOPICS COVERED

- HHP Overview
- Community-Based Care Management Entity (CB-CME) and MCP Roles
- HHP Care Team
- Eligibility and Enrollment
- Six Core Services
- Information Sharing and Reporting
- Payment Information
- Implementation Schedule
- Additional Information and Future Trainings

HEALTH HOMES PROGRAM OVERVIEW

- The Medi-Cal HHP is a new program that offers extra services to certain Medi-Cal members with complex medical needs and chronic conditions

- Members are given a **care team** – including a **care coordinator** – that coordinates their physical and behavioral health care services and connects them to community services and housing, as needed

HEALTH HOMES PROGRAM OVERVIEW

- Members stay enrolled in their Medi-Cal Managed Care plan (MCP) and continue to see the same doctors, but now they have an extra layer of support
- Members receive these services at no cost as part of their Medi-Cal benefits
- Community-Based Care Management Entities (CB-CMEs) are primarily responsible for delivering HHP services

CB-CME AND MCP ROLES

Community-Based Care Management Entities (CB-CMEs)

- CB-CMEs are the single community-based entity with responsibility, in coordination with the MCP, for ensuring that HHP members receive HHP services

- In most cases, the CB-CME is the member's MCP-assigned primary care provider (PCP) such as a community clinic or practice that serves a high volume of HHP-eligible members

CB-CME AND MCP ROLES

Community-Based Care Management Entities (CB-CMEs)

- If the CB-CME is not the member's MCP-assigned PCP, the MCP and the CB-CME will work together to coordinate and collaborate with the PCP on care management for the member, including sharing relevant information

Health Homes Program

CB-CME AND MCP ROLES

MCPs Choose Care Management Models

Each MCP has flexibility to use one or a combination of three care management models, which determine where care management services are provided and by whom. The care team and care coordinator's roles and responsibilities are the same in each model.

CB-CME AND MCP ROLES

Model 1. CB-CME provides care management services on-site at a community health care provider's office:

- This is the most common model expected to serve HHP members receiving care from high-volume, usually urban providers. In most cases the CB-CME is the member's MCP-assigned PCP.
- The community provider, such as a large primary care practice or clinic, usually employs the CB-CME staff to provide care coordination and housing navigation
- In limited circumstances, some care coordination staff could be MCP employees that are housed at the community provider's location

CB-CME AND MCP ROLES

The following models serve fewer people who see providers with a small volume of HHP members, and therefore cannot receive CB-CME services through their MCP-assigned PCP:

Model 2. Community-based entity or MCP staff provide care management services:

- The CB-CME is a community-based entity or staff within the existing MCP care management department. Community-based entities could include health care providers or social services organizations.
- This model is designed for members who are served by low-volume providers, in rural or urban areas, who do not wish to or cannot take on the responsibility of hiring and housing care coordinators on site

CB-CME AND MCP ROLES

The following models serve fewer people who see providers with a small volume of HHP members, and therefore cannot receive CB-CME services through their MCP-assigned PCP:

Model 3. Hybrid model:

- The CB-CME is located in regional offices that are geographically close to members, and use technology and other monitoring and communication methods, such as visiting the member at their location
- This model is designed for members who live in rural areas and are served by low-volume providers

HHP CARE TEAM

Core Care Team (can include MCP and/or CB-CME staff)

Care Coordinator

- Oversees HHP services and Health Action Plan (HAP) implementation
- Helps connect members to needed services, including arranging transportation
- Directly supports member self-management, including helping make appointments and with treatment adherence

HHP CARE TEAM

Core Care Team (can include MCP and/or CB-CME staff)

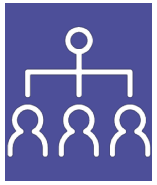
HHP Director

- Oversees management and operations of the team
- Oversees reporting for the team, including quality measures

Clinical Consultant

- Reviews and advises on HAP
- Serves as a clinical resource and assists care coordinator, as needed

HHP CARE TEAM



Additional Care Team Members (determined by member's needs)

- Community Health Workers
- Housing Navigator
- Pharmacists, nutritionists, and other specialists
- Family members, friends, and/or caregivers

Community-Based Organizations (CBOs)

- Care team identifies and works with community and social services already in place for members
- Care team identifies unmet needs and connects members to CBOs that provide community and social services

Health Homes Program

ELIGIBILITY AND ENROLLMENT

1) The has certain chronic condition(s) which are determined by specified ICD 10 codes. The member can check at least one of the boxes below:

- ❑ At least two of the following: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic kidney disease, dementia, or substance use disorders

- ❑ Hypertension (high blood pressure) and one of the following: chronic obstructive pulmonary disease, diabetes, coronary artery disease, or chronic or congestive heart failure

Health Homes Program

ELIGIBILITY AND ENROLLMENT

- One of the following: major depression disorders, bipolar disorder, or psychotic disorders (including schizophrenia)

- Asthma

Health Homes Program

ELIGIBILITY AND ENROLLMENT

2) The member meets at least one acuity/complexity criteria.
Member can check at least one box below:

- ❑ Has three or more of the HHP-eligible chronic conditions
- ❑ Has stayed in the hospital in the last year
- ❑ Has visited the emergency department three or more times in the last year
- ❑ Is experiencing chronic homelessness

ELIGIBILITY AND ENROLLMENT

Definition of Chronic Homelessness

A person is chronically homeless if they have a condition limiting his or her activities of daily living and have been homeless for:

- 12 consecutive months or more; or
- 4 or more periods of time in the last 3 years

A person who lives in transitional housing, or has been residing in permanent supportive housing, for less than 2 years is considered chronically homeless if they were chronically homeless prior to residence.

**Source: AB 361 /W&UI Code Section 14127(e)*

ELIGIBILITY AND ENROLLMENT

Examples of Potential HHP Members

ALBERT

Albert has hypertension, diabetes, and coronary artery disease. He has had several conversations with his PCP about his challenges managing his conditions; specifically, he doesn't always have a place to refrigerate his insulin.

Health Homes Program

ELIGIBILITY AND ENROLLMENT

Examples of Potential HHP Members

SUSAN

Susan overdosed on opioids six months ago, resulting in a hospital inpatient stay while she was trying to find a stable residence for discharge. She has also been diagnosed with diabetes, which she struggles to keep under control. She has spent the last two years essentially homeless, cycling through shelters and crashing with friends or family.

Health Homes Program

ELIGIBILITY AND ENROLLMENT

Examples of Potential HHP Members

JOSE

Jose has asthma and has visited the Emergency Department six times in the last year for uncontrolled asthma. Despite referrals to an outpatient clinic to help get his asthma under control, Jose hasn't been able to get that follow-up care.

ELIGIBILITY AND ENROLLMENT

Three ways for members to join:

1. The MCP or CB-CME will attempt to contact their eligible members to discuss the program, including through mail, calls, and/or in-person outreach

2. Providers can refer members by submitting a referral to the MCP

3. Members can ask their MCP if they can join the program

ELIGIBILITY AND ENROLLMENT

Other Criteria:

- Members must consent to be enrolled in the HHP
- A person must be a member of an MCP to join the HHP
- Fee-for-Service (FFS) members who meet the HHP eligibility criteria may enroll in an MCP to receive HHP services

Health Homes Program

ELIGIBILITY AND ENROLLMENT

- Eligible members are assigned a CB-CME by their MCP that serves as their frontline provider of HHP services
- Members may choose another CB-CME if they prefer
- In most cases, the CB-CME will be a community health care provider that serves a high number of HHP-eligible members and is the member's MCP-assigned PCP *(Model 1)*
- If the CB-CME is not the member's assigned PCP, the CB-CME must maintain a strong connection to the PCP to ensure their participation in the development and implementation of care management and coordination activities *(Models 2 & 3)*

Health Homes Program

ELIGIBILITY AND ENROLLMENT

When engaging members about the HHP, consider sharing:

- You will receive extra support at no cost as part of your Medi-Cal benefits
- You can keep your doctors and you can get connected to other doctors you might need
- You will have a care coordinator who supports you and your care team to ensure everyone is on the same page about your health care and social service needs
- Your Medi-Cal benefits won't change - you'll just get extra services through the HHP

MEMBERS ENROLLED IN HHP AND OTHER CA PROGRAMS

California has multiple programs designed to coordinate care for members. Counties, MCPs, and providers will work together to coordinate services across these programs and to avoid duplicative services.

Members can receive services through both HHP **AND**:

- Whole Person Care Pilot
- California Children's Services Program
- Specialty Mental Health (including Targeted Case Management) and Drug Medi-Cal
- Long-term services and supports benefits such as CBAS and IHSS

MEMBERS ENROLLED IN HHP AND OTHER CA PROGRAMS

Members must choose HHP **OR**:

- Cal MediConnect or Fee-for-Service Delivery Systems
- 1915(c) Home and Community-Based Waiver Programs (HIV/AIDS, ALW, DD, IHO, MSSP, NF/AH, PPC)
- County-operated Targeted Case Management (excluding Specialty Mental Health services)

Members **cannot** receive HHP services if they are:

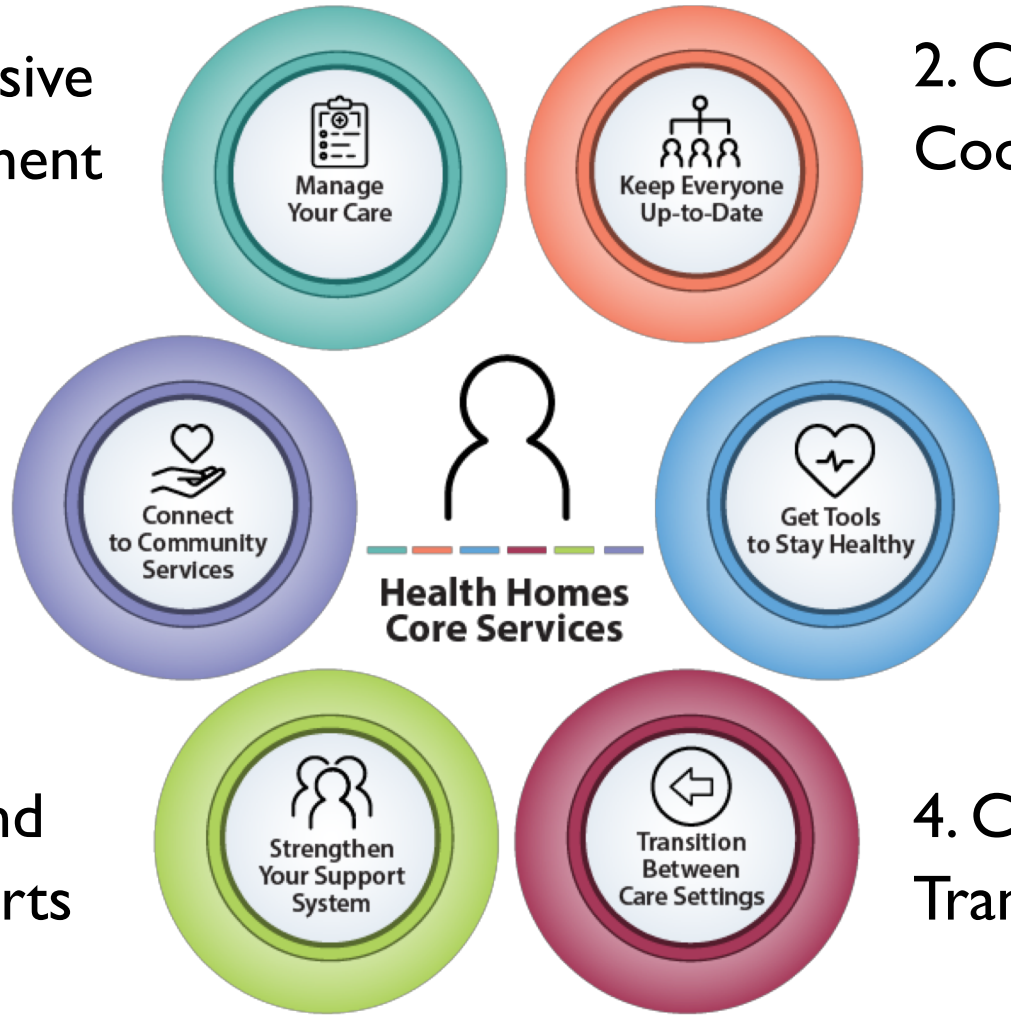
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month (e.g. members are only eligible within the first two months of admission to the SNF)
- Hospice services recipients

HHP SIX CORE SERVICES

1. Comprehensive Care Management

2. Care Coordination

6. Referrals to Community and Social Services



3. Health Promotion

5. Member and Family Supports

4. Comprehensive Transitional Care

Health Homes Program

HHP SERVICES: COMPREHENSIVE CARE MANAGEMENT

Development of the Health Action Plan (HAP)

- The HAP is developed by the member and their care team to address their physical and mental health and social service needs and goals

HHP SERVICES: COMPREHENSIVE CARE MANAGEMENT

Development of the Health Action Plan (HAP)

- The HAP is based on a comprehensive assessment of the member's health status, needs, preferences, and goals regarding:
  - Physical health
  - Mental health
  - Substance use disorder
  - Dental health
  - Community-based long-term services and supports
  - Palliative care
  - Trauma-informed care needs
  - Social supports
  - Housing

Health Homes Program

HHP SERVICES: COMPREHENSIVE CARE MANAGEMENT

Development of the Health Action Plan (HAP)

- Care management is centered around implementing the plan, determining needed services, identifying supports, and monitoring referrals and care

Health Homes Program

HHP SERVICES: COMPREHENSIVE CARE MANAGEMENT

Implementation of the HAP

- Each MCP will provide guidance to their CB-CMEs on how the HAP is structured or implemented, and how HAP data is collected and shared
- Some members and CB-CMEs may already have a care coordination or case management plan template or software, which may be adapted and used for the HAP
- The HAP is reviewed and revised over time based on the member's progress and needs
- Care management services are provided using communication methods suitable to the individual member – e.g. in-person or by phone. Email and text communications are permitted, but not required

HHP SERVICES: CARE COORDINATION

Care coordination services ensure that providers are on the same page as the **HAP** is implemented. The **Care Coordinator** is the key point of contact for the member and the care team to ensure these services are provided, including:

- Helping the member navigate, connect to, and communicate with health, behavioral health, and social service systems, including housing
- Sharing options for accessing care and providing information regarding care planning
- Supporting treatment adherence, including coordinating medication management and reconciliation

HHP SERVICES: CARE COORDINATION

(continued)

- Monitoring referrals to needed services and supports, as well as coordination and follow-up
- Facilitating transitions among treatment facilities, including admissions and discharges, and reducing avoidable hospital admissions and readmissions
- Sharing information with all involved parties to monitor the member's conditions, health status, medications, and any side effects
- Accompanying members to critical appointments, as needed

HHP SERVICES: HEALTH PROMOTION

Members are coached on **how to monitor and manage their health** and to identify and access helpful resources, such as:

- Supporting health education for the member and their family and/or support team
- Coaching the member about chronic conditions and ways to manage them
- Using evidence-based practices to help member manage their care
- Educating the member about prevention services

HHP SERVICES: COMPREHENSIVE TRANSITIONAL CARE

Help members **move safely and easily between different care settings**, to reduce avoidable hospital admissions and readmissions, by:

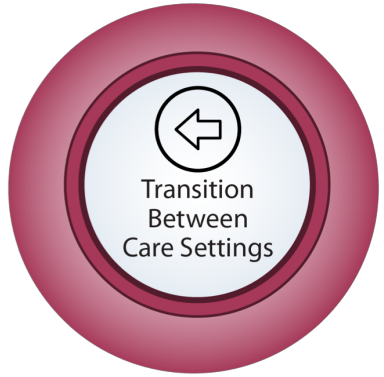
- Collaborating, communicating, and coordinating with all providers and care settings
- Sending a summary of care record or discharge summary to providers and care settings
- Planning timely follow-up appointments with outpatient and/or community providers and arranging transportation as needed
- Educating members on self-management, rehabilitation, and medication management

Health Homes Program

HHP SERVICES: COMPREHENSIVE TRANSITIONAL CARE

(continued)

- Planning appropriate care and social services post-discharge, including a place to stay
- Developing and facilitating the transition plan, evaluating the need to revise the HAP, and preventing and tracking avoidable admissions or readmission
- Providing transition support to permanent housing



HHP SERVICES: MEMBER AND FAMILY SUPPORTS

Educate members and their family/support team about their conditions to improve treatment adherence and medication management, such as:

- Assessing strengths and needs of members and the family and/or support team and promoting engagement in self-management and decision-making
- Linking members to self-care programs and peer supports to help them understand their condition and care plan
- Determining when members are ready to receive and/or act upon information provided and assist them with making informed choices

HHP SERVICES: MEMBER AND FAMILY SUPPORTS

(continued)

- Helping members identify and obtain needed resources to support their health goals
- Accompanying members to clinical appointments when necessary
- Evaluating the family and/or support team's needs for services

HHP SERVICES: REFERRALS TO COMMUNITY AND SOCIAL SERVICES

Provide referrals to community and social services and follow-up to help ensure that members are connected to the services they need, such as:

- Identifying community and social support needs and community resources
- Identifying resources and eligibility criteria for programs, including housing, food security and nutrition programs, employment counseling, child care, disability services, as needed
- Helping members obtain and maintain housing

Health Homes Program

HHP SERVICES: REFERRALS TO COMMUNITY AND SOCIAL SERVICES

(continued)

- Actively engaging with appropriate referral agencies and other community and social supports
- Routinely following up to ensure needed services are obtained

Health Homes Program

HHP SERVICES: REFERRALS TO COMMUNITY AND SOCIAL SERVICES

Through the HAP, the care team develops strategies to address **housing and transportation** needs, two of the most commonly needed supports

- Common Barriers
  - Inconsistent, unsafe, or inadequate housing
  - Inconsistent or unreliable transportation
  - Financial barriers

HHP SERVICES: REFERRALS TO COMMUNITY AND SOCIAL SERVICES

While HHP does not provide actual housing or transportation services, it does provide services to help members obtain and maintain housing or transportation, including:

- Housing navigation services, not just referrals to housing agencies
- Arranging for medical transportation, as covered by Medi-Cal, including:
  - Authorization, if needed
  - Arranging for pick-ups and drop-offs

INFORMATION SHARING AND REPORTING

Information Sharing Across Entities

- For care management activities to be successful, the entire HHP care team must be able to share and access information about a members services and care
- MCPs are responsible for establishing and maintaining data-sharing agreements with HHP partners
- Providers are encouraged to use technology to ensure timely, accurate, and secure sharing of information

INFORMATION SHARING AND REPORTING

Reporting Requirements: MCPs are required to report data on enrollment, utilization, costs, and the quality of care provided across the care team to help DHCS and CMS evaluate the HHP, including but not limited to the following:

1: Program Eligibility and Enrollment

Number of members MCPs/CB-CMEs are actively seeking to engage, number of members enrolled and participating in the HHP, homelessness indicators for enrolled members, and number of HAPs completed.

PAYMENT INFORMATION

2: Costs and Utilization HHP service encounters for services provided by the MCP and CB-CMEs, following program guidelines

3: Quality of Care Program partners, including CB-CMEs, must submit reports on certain performance measures to assist with the overall state and federal HHP evaluation

Health Homes Program

INFORMATION SHARING AND REPORTING

HHP Measures

Core Service Measures
Number of members excluded from the targeted engagement list, by reason
Number of members referred to HHP who were enrolled or excluded
Average number of care coordinators
Number of members with initial HAP completed within 90 days
Number of members with HAP completed in the quarter
Number of members referred to, and receiving, housing and supportive housing services

Health Homes Program

INFORMATION SHARING AND REPORTING

HHP Measures

Operational Measures
Number of members who received services
Number of each HHP service received, by member
Number of each HHP service unit provided
Aggregate care coordinator ratio

INFORMATION SHARING AND REPORTING

CMS Core Set Measures

Adult Body Mass Index (BMI) Assessment
Screening for Clinical Depression and Follow-Up Plan*
Plan All-Cause Readmission Rate
Follow-Up After Hospitalization for Mental Illness
Controlling High Blood Pressure*
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite

*MCPs must report these measures directly to DHCS. DHCS will calculate all other measures based on MCP-provided encounters. These reporting requirements are subject to change.

INFORMATION SHARING AND REPORTING

CMS Utilization Measures

Ambulatory Care — Emergency Department Visits
Inpatient Utilization
Nursing Facility Utilization

Health Homes Program

INFORMATION SHARING AND REPORTING

HHP Service Codes

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Source: Program Guide –Appendix E

Guidance accompanying these HHP service codes provided are CB-CMEs by the MCPs

PAYMENT INFORMATION

- HHP payments are made directly from DHCS to the MCPs through capitation rates (a set amount per member, per month)
- MCPs negotiate individual contracts and payment terms with CB-CMEs and other providers to ensure the delivery of HHP services such as care coordination or housing navigation
- The MCP and the CB-CME or other providers will determine payment terms. Payment terms may be a per member, per month rate or a FFS payment, and may vary by provider

HHP IS PHASED IN BY COUNTY

Groups	County		Implementation Date for Members with Eligible Chronic Physical Conditions and SUD	Implementation Date for Members with SMI
Group 1	San Francisco		July 1, 2018	January 1, 2019
Group 2	Riverside San Bernardino		January 1, 2019	July 1, 2019
Group 3	Alameda Fresno Kern Los Angeles Sacramento San Diego Tulare Del Norte Humboldt Imperial Lake Lassen Marin	Mendocino Merced Monterey Napa Orange San Mateo Santa Clara Santa Cruz Shasta Siskiyou Solano Sonoma Yolo	July 1, 2019	January 1, 2020

ADDITIONAL INFORMATION

DHCS Health Homes Website – bit.ly/HealthHomes

Outreach and Education Materials

- Member Toolkit
- Provider Guide
- HHP Fact Sheet

FUTURE TRAININGS

- Comprehensive Care Management and the HAP
- Introduction to Care Coordination Services
- Introduction to Care Transitions
- Connecting Members to Community and Social Services

Optional trainings may be provided by DHCS or MCPs