TRANSCRIPTION OF RECORDED STAKEHOLDER CALL

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- MEETING -

1
2 **Ms. Haycock:** Good morning, everyone. Welcome to today's
3 California Health Homes Program
4 Implementation Update Stake Holder Webinar.
5 We really appreciate everyone joining us
6 this morning to get an update on the Health
7 Homes Program. Just -- we're going to do a
8 bit of housekeeping before we get started.
9 If you can hear me okay, please raise your
10 hand. It's the little raised hand icon.
11 All right. Looks like folks can hear us
12 okay. So, it's great. We are -- if we get
13 disconnected for any reason. If for any
14 reason the that eye of the satellite, or
15 something funky happens with the technology,
16 please just give us a minute and dial back
17 in using the same link and phone number, and
18 we will get back with you as soon as we are
19 able. Just, hopefully, that won't happen,
20 but that's what we'll have you do. And
21 then, with that, I'm going to hand things
22 over to Brian Hansen (phonetic) from the
23 Department of Healthcare Services to give us
24 -- to get us started. We'll go through the
25 presentation, and then we'll open for a

1 question and answer period. Brian
2 (phonetic).
3 **Mr. Hansen:** Thank you, Hilary (phonetic). Hello,
4 everyone. Again, my name is Brian Hansen. I
5 work with the Healthcare Delivery Systems
6 area of the Department of Healthcare
7 Services. I have worked on the Health Homes
8 Program Development and Implementation for a
9 few years now. We will be answering
10 questions at the end of my presentation.
11 So, we will be taking only questions as
12 they're typed in through the webinar
13 application. So, if you have a question,
14 you can go ahead and type that question in
15 at any time. And if it's technical in
16 nature, we might answer it as we go, but any
17 -- any of the program clarification
18 questions, we'll be answering at the end of
19 the presentation. So, what we're going to
20 go through today is, we're going to give a
21 quick refresher on what the program is. As
22 an overview, it might spur some questions in
23 your minds. We will give then an
24 implementation update of where we're at
25 currently. We'll talk about the recent

1 policy on the intersection of Health Homes
2 Program and our Whole Person Care pilot
3 programs which do some of the similar types
4 of activities in the -- in the same areas.
5 We will talk about a learning collaborative
6 that we have for our managed care plans for
7 Health Homes. Outreach and education
8 activities that we are doing to inform
9 folks. And we'll have a slide on resources
10 and information for follow up. One thing I
11 want to mention is, as I give the overview,
12 it's extremely high level. We have a
13 program guide that's about 70 pages long on
14 our website. I think we'll provide a link
15 to the website at the end of the webinar.
16 But if -- just so you know as I'm going
17 through this, if you have questions, you're
18 welcome to as clarifying questions at the
19 end of me, but there is a lot more detail on
20 all the topics I'm covering in that program
21 guide. So, you're welcome to look there as
22 well. Okay. First slide -- next slide,
23 there we go. So, the Health Homes Program
24 is the new program that offers extra care
25 coordination services to certain Medi-Cal

1 members with complex medical needs and
2 chronic conditions. Primarily, those who
3 are often called frequent utilizers of
4 healthcare services. People who -- who are
5 in the, maybe, top one to three percent of -
6 - of -- level of Medi-Cal members using
7 services, and with complexity of chronic
8 conditions, and other co-morbidities and
9 social determinants of health. So, members
10 who fit into this and who join this program
11 will be given a care team, including a care
12 coordinator who coordinates their physical
13 and behavioral healthcare services, and
14 social services to connect them, to
15 community services, housing, if they are
16 unstably housed or homeless, as needed,
17 that's available, and other -- other
18 services relating to social determinants of
19 health or other social services. Next
20 slide. So, members, when they join, they
21 will stay enrolled in their Medi-Cal managed
22 care program, and continue to see the same
23 doctors. They don't have to change their
24 doctors, or their plan, or anything like
25 that. Now, they will have an extra layer of

1 coordination, and support, and help that is
2 sort of wrapped around their current care
3 delivery system. Members receive these
4 services at no cost. They're part of Medi-
5 Cal benefits. This is a Medi-Cal State
6 plan, optional entitlement benefit for
7 people who are eligible in the area's where
8 it operates. Community based care
9 management entities are primarily
10 responsible for delivering the Health Homes
11 Program services, and we will talk about
12 what these community-based care management
13 entities are. And the next slide, the
14 emphasis in the name is on community based,
15 which is intended to communicate that this
16 is a little bit different from what has
17 frequently happened in the past where often
18 care coordination is provided
19 telephonically, or maybe remotely by the
20 managed care plan or others. This is
21 intended, primarily, to be delivered in the
22 community by community-based providers.
23 Okay. So, CBCME's are the single community-
24 based entity with responsibility in
25 coordination with the managed care plan for

1 insuring that the members receive all the
2 health services that they need -- care and
3 coordination. I want to mention that these
4 services are only care coordination. They
5 do in -- incorporate any additional direct
6 services or additional services. It’s just
7 care coordination link to connect people to
8 what they need. In most cases, the CBCME is
9 going to be the member’s assigned primary
10 care provider, such as a community clinic or
11 practice that serves a high volume of Health
12 Homes eligible members. Next slide. Let me
13 go back one slide. Oh, great. If the CBCME
14 is not the member’s assigned PCP, then the
15 managed care plan CBCME will work together
16 to coordinate and collaborate with the
17 assigned PCP on care management for the
18 member, including sharing relative
19 information. There we go. Eligibility for
20 the program. It is -- there are two layers
21 of eligibility. The first is based around
22 the member having, and us verifying, that
23 they have certain chronic conditions. These
24 chronic conditions are determined based on
25 those that are very often related to folks

1 having a poorly managed conditions and
2 avoidable utilization, and negative health
3 outcomes. So, there are four categories of
4 conditions. I'm not going to read through
5 them all, but you can see that there is --
6 the first category is having at least two of
7 a list of physical chronic conditions;
8 diabetes, chronic obstructive pulmonary
9 disease, others. The second is having just
10 hypertension and, in combination with, one
11 of a -- a few conditions; chronic
12 obstructive pulmonary disease, diabetes,
13 coronary artery disease, or chronic or
14 congestive heart failure. The third
15 category relates to serious and persistent
16 mental health conditions, and there are
17 three categories that qualify of those
18 conditions; depression, major depression
19 disorders, bi-polar disorder, and psychotic
20 disorders, including schizophrenia. A
21 fourth category is asthma on its own. The
22 second layer of eligibility is an acuity
23 factor that indicates that folks may be
24 having challenges managing their condition.
25 They may have an avoidable utilization

1 that’s -- that’s not good for -- for
2 anybody. So, they have to have one of these
3 four acuity criteria in addition to the
4 chronic condition cri -- criteria. Three or
5 more ED visits -- sorry. Three or more of
6 the eligible chronic conditions is the first
7 one. They had to have to have had a
8 hospital stay in the last year, three or
9 more ED visits in the last year, or they
10 have chronic homelessness. And the
11 definition for chronic homelessness relates
12 to our authorizing legislation at the State
13 level, which was AB361, and it references
14 back to the Federal definition of chronic
15 homelessness for this eligibility criteria.
16 Next. Okay. Next slide, yeah. So, there
17 are three ways for a member to get connected
18 with the -- this program. We are sifting
19 through our administrative data to check for
20 the eligibility criteria here, our claims
21 data, our eligibility file, etcetera, to
22 look for things that qualify somebody. We
23 are putting together a list that we are
24 sending to the managed care plans of people
25 that we think are likely to qualify for this

1 program. Plans will be prioritizing that
2 list and -- and doing proactive outreach and
3 engagement to -- to ask those folks if they
4 want these additional extra services.
5 Again, optional and voluntary services. The
6 member does have to -- the member does have
7 to consent to be enrolled. There is no
8 passive enrollment for this program. The
9 provider also, or the member, the provider
10 on behalf of the member can refer folks to
11 the managed care plan. managed care plan
12 will then go through a process of verifying
13 eligibility criteria and -- and enrolling
14 the member if they consent to be enrolled.
15 Okay. The other -- two other things to
16 know, is a person must be a member of a
17 managed care plan to the join the Health
18 Homes Program, must be a member in the
19 implementing counties. We'll talk about
20 which -- what the staging is for those
21 counties in a little bit. Fee for Service
22 members can join the program, but they will
23 have to leave the Fee for Service delivery
24 system and join a managed care plan to be
25 enrolled in the program. Health Homes

1 Services are not able to be provided through
2 the Fee for Service Program. They rely on
3 the coordination provided by the managed
4 care plan, MS Network System. There are six
5 core services. These are all different
6 variations of care coordination. So, we've
7 got comprehensive care management, which is
8 essentially developing the plan and
9 assessing per need. There is providing the
10 care coordination and linkages based on that
11 plan, referral to community, and social
12 services as needed. This is a whole --
13 yeah, it's supposed to address needs of the
14 whole person, so the assessment process will
15 address, like we said, physical health
16 conditions, behavioral health conditions,
17 social determinants health, housing, other
18 social needs, etcetera, to the extent that
19 it's feasibly possible, of course. And
20 where -- where these things are provided by
21 Medi-Cal, managed care plan will arrange and
22 make sure those services happen, where
23 social services are provided outside the
24 Medi-Cal system. The care coordinator will
25 make linkages and follow up to try to ensure

1 that those things happen. Regarding
2 housing, the Health Home Program actually
3 provides housing navigation at tenancy
4 sustaining services. The Health Home
5 Program itself provides these services, so
6 they will be connected with housing
7 providers in the community to facilitate
8 that. Health promotion; member and family
9 supports and comprehensive transitional care
10 for those high-risk transitions from
11 hospital to nursing facility, and nursing
12 facility to the community, other types of
13 transitions. Next slide. So, information
14 sharing and reporting are -- particularly
15 information sharing critical for care
16 coordination. For care management
17 activities to be successful, the entire
18 health -- or Health Home Program caring team
19 must be able to share and access information
20 about a member’s services and care. managed
21 care plans are responsible for establishing
22 and maintaining data sharing agreements and
23 processes to make sure that critical
24 information is shared in a timely manner
25 with the Health Home Program partners.

1 Providers are encouraged to use technology
2 to ensure timely, accurate, and secure
3 sharing of information. It's encouraged,
4 it's not required, but it's often the best
5 way to do it, but -- but there are realities
6 throughout the system about what is possible
7 around technology, as I'm sure we all know.
8 Regarding reporting, the managed care plans
9 are required to report data on enrollment,
10 utilization, cost, and quality of care
11 across the Health Home Program care team for
12 all the members. We will be monitoring that
13 information to track the success of the
14 program for these process and outcome
15 measures. And I think a -- a list of seven
16 measures are required by CMS quality
17 measures, so. Next slide. So, Health Home
18 Program payments are made directly from DHCS
19 to the managed care plans through a
20 capitation rate. A set amount per member
21 per month. And its managed care plans, and
22 that is for each enrolled Health Home
23 Program member. There's a specific rate
24 that's paid per enrolled member. managed
25 care plans negotiate individual contracts

1 and payment terms with CBCME's, our
2 community providers, and other providers as
3 needed to ensure the delivery of all
4 services, care coordination, housing
5 navigation, etcetera. The managed care
6 plan, and the CBCME, or other providers,
7 will determine payment terms. Payment terms
8 may be from the plan to the community
9 provider. Could be a per member per month,
10 or a fee per service payment, it may vary by
11 provider, by plan. Next slide. So, this is
12 our phasing chart of -- of how the program's
13 going to roll out and be phased. We have
14 three different groups of counties, and
15 within each of those three groups of
16 counties, Group One, Two, and Three. There
17 are two separate phases. One for the
18 eligible physical health chronic conditions,
19 and six months later in each county, there's
20 a implementation for the folks who are
21 eligible based on serious and persistent
22 mental illness. So, the first group is San
23 Francisco. They started July of 2018, and
24 we are coming up on the second wave of
25 implementation, which is SMI for San

1 Francisco, and physical conditions for
2 Riverside and San Bernardino Counties. You
3 will see Group Three has a -- a number of
4 counties in it, including Los Angeles and
5 several other larger counties. They start
6 July 1st of 2019, and their SMI phase is
7 January 1st of 2020. Okay. Next slide. So,
8 for the implementation update items. As I
9 mentioned, San Francisco Health Plan and
10 Anthem went live in San Francisco County on
11 July 1st. Members are being enrolled
12 currently in San Francisco -- San Francisco
13 County. Approximately, 120 members have
14 been engaged and enrolled so far. I just
15 want to stress that this is not really sort
16 of a transition program, where we have a big
17 group of people who move into the program on
18 day one. This is a program where we will be
19 trying to outreach and engage folks, and
20 enroll them in a program. Oft times, these
21 folks are difficult to engage and enroll, so
22 we would expect kind of a slow, gradual ramp
23 up of enrollment, which -- which is what
24 we're seeing. These plans San Francisco
25 County are preparing for the SMI eligibility

1 launch in January of 2019. We have -- DHCS
2 has ongoing bi-weekly implementation and TA
3 calls, technical systems calls with these
4 Group One plans on a bi-weekly basis. So,
5 Group Two is Molina and Inland Empire Health
6 Plan in Riverside and San Bernardino
7 Counties for the physical health condition
8 eligible folks. This will launch January,
9 2019. They'll add the SMI eligible folks
10 July of 2019. DHCS is currently reviewing
11 readiness deliverables that are -- have been
12 submitted by both plans for the January 2019
13 implementation. Everything is moving along
14 smoothly. We also have ongoing bi-weekly
15 implementation and TA calls with these two
16 plans. The Group Three, large list of
17 counties, will be implementing physical
18 conditions July, 2019, and have SMI January,
19 2020. We also have regular calls with these
20 sort of all plan implementation calls to
21 spread information. DHCS is, right now,
22 working with CMS to -- for the review and
23 approval of the State Plan Amendment
24 relating to approval of the SMI phase for
25 Health Homes Program. We have two SPAs,

1 essentially, one is for the physical health,
2 chronic conditions, and the second SPA is
3 for the SMI conditions. And then, each of
4 those SPAs will be updated twice for the
5 additional groups of counties. The reason
6 for this kind of complicated SPA structure
7 is that we wanted to sort of maximize the
8 amount and timing of the available enhanced
9 Federal funding. There is 90 percent
10 Federal match available for the first eight
11 quarters of this program. And by doing
12 this, we will get the full eight-quarters
13 for each of these, essentially, six
14 different phases of implementation. Okay.
15 So, DHCS, around technical systems, DHCS
16 spent a great deal of time with San
17 Francisco Health Plan and Anthem in
18 discussions for the San Francisco launch.
19 They have been great partners in helping us
20 develop a lot of the details for the
21 program. We answered a lot of questions and
22 developed a lot of templates that can be now
23 shared with other managed care plans to
24 assist them in their launch of this fairly
25 complicated program. And we intend to share

1 those learnings with those additional plans.
2 We'll continue that type of TA with them.
3 We are just starting -- you know what, I'm
4 going to skip that one. So, we did talk
5 about reporting. The managed care plans
6 will be reporting encounters for these
7 Health Home services, which will be one data
8 source we will have. DHCS just to provide a
9 little more detail on the recording. DHCS
10 will track metrics for enrollment, referrals
11 for enrollment, inpatient, ED and SNIP
12 utilization. The other CMS quality metrics,
13 including controlling blood pressure, all
14 cause readmissions, and others. Reasons
15 people leave the program, homeless members
16 who are receiving housing services, and
17 members who become housed. Care plan
18 completion and timeliness, and provider
19 network partici -- participants, and
20 capacity. So, who constitutes those
21 provider networks. Okay. And on this list,
22 we also have the UCLA Health Homes Program
23 evaluation design is underway of being
24 developed. They have been contracted by
25 DHCS to perform a four to five-year

1 independent evaluation encompassing all
2 phases of the Health Homes Program
3 implementation. The evaluation design, the
4 sort of draft, high level evaluation design
5 will be available for stakeholder review
6 later this year, fairly soon. And UCLA will
7 get encounter claims data from DHCS, and the
8 evaluation will have a focus on cost
9 effectiveness analysis, this package of
10 services. Policy guidance we have issued
11 include the program guide, which I
12 mentioned, 70 pages, very detailed about
13 what -- what program, how it should operate,
14 what our DHCS guidance's are around that.
15 It has been officially incorporated as an
16 all-plan letter. So, it is official DHCS
17 guidance for our management care plans. We
18 updated the Continuity of Care All-Plan
19 Letter to note that anybody who does
20 transition from the Fee for Service delivery
21 system to a managed care plan, so that they
22 can get help on program services, will have
23 access to continuity of care rights with
24 their prior providers in the Fee for Service
25 system for a period of time. Of course,

1 that does not include Heath Home Program
2 services. There are no Health Home Program
3 services in Fee for Service, so it would be
4 other services of their doctors they had
5 seen prior to that transition. The -- so,
6 the MOU requirements listed there. That
7 refers to the memorandum of understanding
8 between the managed care plans and county
9 mental health plans about how they
10 coordinate care for specific members. And
11 we have updated that guidance to our managed
12 care plans to ensure that that MOU includes
13 references to and accounts for Health Homes
14 Program as new thing that everyone will have
15 to coordinate around. And then, Health
16 Homes Program Whole Person Care Policy. Do
17 we have an additional slide on this, or is
18 this --
19 **Ms. Haycock:** Uh-huh. I have a couple slides --
20 **Mr. Hansen:** Okay. There we go --
21 **Ms. Haycock:** -- right here.
22 **Mr. Hansen:** Thanks. Intersection of Health Home Program
23 and Whole Person Care. So, our Whole Person
24 Care Program for those who are -- are
25 unfamiliar with it, is a -- a county-based

1 program that DHCS administers. In a lot of
2 ways, it's similar to the goals in the
3 Health Home Program in coordinating care and
4 providing additional services for people who
5 are frequent users of services, need
6 additional assistance, have complex
7 conditions, social determinates of health,
8 concerns, etcetera. And our Health Homes
9 Program -- the Whole Person Care pilot
10 programs in each -- in the counties that
11 have launched them, they are, I think, 27 or
12 so counties that have these pilot programs.
13 Each of them are a little bit different.
14 Each county can design it a little bit
15 different, so the eligibility and the
16 services they provide. But in most cases,
17 the Whole Person Care pilots are providing
18 care coordination, in addition to, maybe,
19 some other services that are more direct
20 services matrix. All those services Whole
21 Person Care provides are intended to be
22 services that Medi-Cal does not provide.
23 It's kind of to fill gaps and test
24 innovative strategies. So, Health Homes
25 Program is now coming online, and will be

1 launching in some counties that have Whole
2 Person Care, and you have a potential
3 situation of duplication between the care
4 coordination that Health Homes provides, and
5 care coordination that Whole Person Care
6 provides. So, that's why we developed this
7 guidance structure to -- to govern that
8 relationship. Beneficiaries who are
9 eligible to receive services from Whole
10 Person Care and Health Homes, can be
11 enrolled in either program or both based on
12 the beneficiary's choice. If the
13 beneficiary is eligible for both programs,
14 they may choose which program's care
15 coordination services they want to receive,
16 which assumes that -- that the pilot
17 program, Whole Person Care, provides some
18 duplicate type of care coordination services
19 that would be similar to Health Homes. If
20 the beneficiary wants to receive care
21 coordination services from their Whole
22 Person Care Program, they can't receive the
23 same care coordination services from HHP.
24 Which would mean they would not be enrolled
25 in the HHP. The beneficiary can receive

1 both Health Homes Program care coordination
2 services and the WPC services as long as the
3 WPC services they're getting are not
4 duplicative or similar to the Health Homes
5 care coordination services. So, in a lot of
6 cases, the Whole Person Care pilots provide
7 services in addition to care coordination.
8 An example would be, sobering (phonetic)
9 center services, or respite care, or other
10 types of non-care coordination services.
11 And -- and a member could choose to stay in
12 the Health Homes Program and get the care
13 coordination there, and get some of these
14 additional wrap-around services from the
15 Whole Person Care pilot that -- that can be
16 helpful. Harbage Consulting, who is our
17 outreach and engagement consultant for this
18 program to develop the Health Homes Program,
19 WPC crosswalk tool. I think there is a link
20 there that you can click on to compare;
21 primarily, so you can see what the Health
22 Homes Program services are. It's mostly
23 designed so -- so the pilots can try to
24 determine what of -- what it is that they
25 provide that might be duplicative of those

1 Homes Health Services. Okay, next slide.
2 Okay. So, the beneficiary, as we said, may
3 not receive duplicative care coordination
4 services from Health Homes and Whole Person
5 Care. If the beneficiary is receiving care
6 coordination services through the Health
7 Home Program, it's the responsibility of the
8 WPC pilot to ensure that the member does not
9 received duplicative -- duplicative services
10 from the Whole Person Care pilot. So, the
11 burden there is on -- on the pilot to ensure
12 that -- the pilot may not claim
13 reimbursement of care coordination services
14 that are duplicative and that are provided
15 during the same month as Health Homes
16 Program duplicate coordination services.
17 Okay. And with that, I'm going to hand it
18 over to Hilary Hickock (phonetic).
19 **Ms. Haycock:** Great. Thank you, Brian. My name is Hilary
20 Hickock (phonetic). I'm with Harbage
21 Consulting. And we are working with DHCS on
22 Health Homes Program to provide a number of
23 support services to the participating
24 managed care plans within the organization.
25 One of the things that we are doing is

1 running a learning collaborative for the
2 Health Homes Program. And the goal of this
3 is to give the health plans the
4 opportunities to share lessons learned and
5 best practices with each other. And so, we
6 are deeply grateful to the Phase I and Phase
7 II Plans that are moving through early
8 stages of implementation and trying to get -
9 - pull out those learnings and best
10 practices and share them with the other
11 health plans. So, we've planned about six
12 collaborative learning sessions for this
13 fall and into the spring of next year. And
14 as I said, some of those topics are going to
15 include some of those early lessons learned.
16 And some of the exciting things that we're
17 seeing are the managed care plans within a
18 county are collaborating with each other,
19 and just developing their CBCME networks and
20 the trainings. Some of the CBCME's re-
21 certification processes and approaches to
22 the health action plan, and other -- other
23 activities. So, it's exciting to see that
24 collaboration of the health plans to try to
25 make the program easy to be implemented

1 across the county for -- for providers that
2 are working with multiple health plans.
3 They're helping share that type of learning,
4 which the later phased plans were also
5 helping them think through some of the
6 implementation hurdles. So, lots of things
7 that the plans are working through are how
8 to develop MOUs. How to develop -- how to
9 work with -- work with their CBCME's to do
10 capacity building, to do the types of
11 detailed data reporting required under the
12 Health Homes Program. We're also helping
13 the plans think through that intersection
14 with Whole Person Care that Brian outlined.
15 We're also working on a learning
16 corroborative with the Whole Person Care
17 pilots, so there's some pretty good
18 alignment there where we're helping, so it's
19 on both sides, to understand that
20 intersection to speed up implementation.
21 We're also working with the plans to start
22 thinking through the SMI implementation at
23 that sort of -- the six-month lag behind the
24 chronic conditions implementations as well
25 as the intersection between Health Homes and

1 direct Medi-Cal. Some of those early
2 topics, we're -- we're thinking through for
3 the learning collaborative. Some of the
4 other works that we're doing to provide
5 supports around this program, is outreach
6 and education. We know that since this is
7 really designed to be targeted at a very
8 specific population in the Medi-Cal
9 population. We're working to develop
10 targeted and appropriate messaging and
11 materials for the plans to use for the
12 (inaudible) year to help educate providers,
13 community-based organizations, and
14 beneficiaries about what this program is,
15 was it -- what it isn't, and to try to help
16 create that broader understanding of the
17 Health Homes Program. So, we started with
18 doing some focus groups with Medi-Cal
19 beneficiaries and providers to see what are
20 the best ways to talk about the Health Homes
21 Program and care coordination. One thing
22 that we know from our work is that it's --
23 you ask someone if they have a care
24 coordinator. Even if they have a care
25 coordinator, they don't know what that is,

1 and so, really, trying to help educate
2 beneficiaries about the benefits of this
3 program, and -- and how they can be
4 empowered to participate. And so, out of
5 that, we developed materials that are
6 available on the DHCS Health Homes webpage,
7 and other materials that are available for
8 the plans, fact sheets. We've got a really
9 detailed -- the beneficiary friendly tool
10 kits, as well as a provider guide. They're
11 all available online, and we would
12 definitely encourage folks to -- to -- to go
13 look at, and download, and -- and use,
14 however -- however it's helpful. We're also
15 developing come CBCME training for the
16 health plans to use. There's some
17 requirements that the plans must meet in
18 terms of making sure the CBCME's have been
19 educated both around the basics of the
20 Health Homes Program, but we're also going
21 to be developing some targeted trainings on
22 -- on important topics for the CBCME's in
23 working with this population. Things like
24 how to -- how to help connect folks to
25 housing, how to do trauma informed care,

1 hopefully, one on script -- targeting member
2 with asthma. So, we're excited about the
3 targeted trainings that will be coming up.
4 And then, of course, we're developing the
5 lessons learned information out of the
6 learning collaborative and -- and sharing
7 that with the plan. So, again, we would
8 definitely point you to the DHCS website.
9 We created a slightly shorter link here on
10 the page, because it is a, otherwise, a
11 little bit of a -- of a mouthful. But there
12 you can find all kinds of program
13 information, as well as there's outreach and
14 education material that we covered so far.
15 Addition -- additionally, the email inbox on
16 the screen, HHP@DHCS.ca.com is another
17 resource for folks who have questions, if we
18 don't get them all here today, but we do
19 have quite a long list of questions. So,
20 Brian, why don't we get moving with that.
21 **Mr. Hansen:** Yeah. While we're sorting those questions,
22 I'll just say that we really appreciate --
23 this program, again, it's fairly
24 complicated. It's doing new things that a
25 lot of providers have not done before, so we

1 really appreciate the opportunity to have a
2 learning collaborative and the additional
3 outreach assistance, which Harbage
4 Consulting is providing. It's provided,
5 with support from the California Endowment,
6 which has been very supportive of this
7 program overall. So, I just want to say
8 thank you for that.
9 **Ms. Haycock:** Yeah, thank you to the California Endowment.
10 So, one of the questions is about housing
11 navigation, and looking for a little bit
12 more information about -- about housing
13 navigation. In addition to sort of the
14 details that are available online in terms
15 of provider guide as well as the program
16 guide, do you have one or two things you
17 want to say about housing navigation?
18 **Mr. Hansen:** Sure. Yeah, so housing navigation is one of
19 those things that will be new for Medi-Cal
20 to be providing through this program itself.
21 And its housing navigation, which is
22 intended to have a member of the Health
23 Homes team as part of their care
24 coordination, assist the member to look for
25 available housing for homeless members,

1 members experiencing unstable housing. And
2 then, the ideal situation, although we all
3 know, I'm sure, that housing capacity is
4 very limited. It's a bit of an issue
5 statewide. But to the extent that housing
6 can be located located and secured, the
7 housing navigator will assist the member to
8 not only find it, but to help them prepare
9 to be ready to be a tenant; paperwork,
10 preparations, and coaching, assistance with
11 working with landlords to stay housed, a
12 nice tenancy sustaining portion of that. In
13 the program guide, we have a more articulate
14 list of what exactly is entailed by housing
15 navigation and tenancy sustaining services.
16 I can't see it there, but the gist of it is
17 what I (inaudible). Okay. I will -- I will
18 just add, sorry, that we do not -- this
19 program does not include payment for actual
20 housing or rental costs. And unlike the
21 Whole Person Care pilot program, this
22 program does not pay for any one-time sort
23 of startup costs either; like first month's
24 rent, or utilities, or modifications to the
25 house. So, what this program does provide

1 is the case manager who will assist with
2 housing navigation and tenancy sustaining
3 sort of activities.

4 **Ms. Haycock:** Okay. There are a couple of questions about
5 everyone's favorite topic, capitation rates
6 and PMPM rates. Could you just give us a
7 brief update on the -- how the rates been
8 developed and communicated to the plan.

9 **Mr. Hansen:** Yes. Yeah, so we have rates that have been
10 developed, plan specific rates, and those
11 rates have been communicated to the managed
12 care plans. Each plan who is implementing
13 Health Homes has their rate. We -- they are
14 -- we're calling them final rates, because
15 the development process is done. However,
16 they still are going through a process
17 server view on approval, which takes a
18 considerable amount of time with CMS. We
19 don't expect any changes, but I just want to
20 mention that. So, the plans have their
21 rates.

22 **Ms. Haycock:** Great. And, again, those rates are plan
23 specific. There's a question about member
24 consent and sharing of SUD (phonetic) data
25 across providers. Can you talk a little bit

1 about guidance the DHCS has given to the
2 plans about data sharing and consent and
3 MOUs.
4 **Mr. Hansen:** Yes. So, I think we have identified through
5 working with this program and, particularly,
6 even earlier working through the Whole
7 Person Care pilot program that legalities,
8 HIPAA, other laws related to information
9 sharing is often challenging to negotiate.
10 Although, it has good intentions behind it,
11 and SUD information sharing is governed by
12 specific Federal Laws that add probably the
13 highest barrier for sharing, often, in some
14 cases between certain entities. It's a
15 case-by-case consent that is required. So,
16 I think this will be an area, definitely,
17 for the learning collaborative to take on
18 and to try to build on what has been
19 developed from a best practice standpoint
20 through the Whole Person Care pilots,
21 because in many cases it's a very similar
22 activity. And all -- what we have told the
23 managed care plans is that, you know,
24 information sharing needs to happen for good
25 care coordination. We expect them to figure

1 out a way to do it within the realities of
2 the law, and technical capabilities in their
3 local areas. And in some cases, you know,
4 things may require individual consents, and
5 we -- we expect them to follow the law, and
6 -- and negotiate that process as best they
7 can. In some cases, a general consent may -
8 - may work. So, we at DHCS are careful
9 about providing anything that appears to be
10 legal advice about what's legal around
11 consent. So, we are telling folks to just
12 follow the law, and we will help them
13 negotiate challenges where we can, and how
14 we can, and share best practices where one
15 entity has found a way to achieve something.
16 We can spread that best practice route to
17 other entities and help them understand how
18 they're doing it. But this is a challenge
19 we will all -- all confront with this
20 program.
21 **Ms. Haycock:** Great. Definitely, a big challenge for
22 folks in a number of programs trying to do
23 improved care coordination. We have a -- a
24 couple questions about if the department has
25 sort of developed in sharing a template --

1 materials, two plans. One is about if
2 there's a -- a population or health or care
3 management tools for investigative CMEs,
4 which we think may be building on the -- the
5 health action plan requirement. And then, a
6 question around a template CBCME contract.
7 **Mr. Hansen:** Yeah. So, we -- Hilary, we can --
8 **Ms. Haycock:** Yeah.
9 **Mr. Hansen:** -- (inaudible) but we do not have a DHCS
10 template for community provider contracts
11 for Health Homes. Each managed care plan is
12 developing those on their own. In some
13 cases, they're best practices that are being
14 shared, but for the most part, the plans are
15 developing those are their own. DHCS
16 reviews and approves those templates from
17 each plan as part of the launch process to
18 make sure they comply with everything. As
19 far as population health or care management
20 tool, I -- I would -- the only thing I can
21 say is that if you look at the program
22 guide, the sum total of the program guide
23 is, essentially, what we have provided
24 around strategies and expectations. And
25 that incorporates the tenants of the Health

1 Homes Program, what we expect to happen.
2 The program requirements, or specific,
3 quantifiable requirements about what has to
4 happen. The health action plan, timeliness,
5 in-person visits, all the services that are
6 available, and then it goes, also, to the
7 readiness review documents and a list of
8 what we require from readiness is also in an
9 appendix of the program guide. So, we are
10 reviewing a number of specific policies from
11 the managed care plans on things like
12 outreach and engagement of homeless members,
13 areas where they -- that -- that are a
14 little more complicated, and then we want to
15 make sure are -- are following the -- the
16 intent of the program to its full extent.
17 And -- and then, the learning collaborative,
18 I keep bringing up --
19 **Ms. Haycock:** Yeah.
20 **Mr. Hansen:** -- learning collaboratives.
21 **Ms. Haycock:** Yeah.
22 **Mr. Hansen:** We cannot -- I mean, we're not going to
23 provide guidance or criteria --
24 **Ms. Haycock:** Right.
25 **Mr. Hansen:** -- for everything. A lot of this is going

1 to be done by us voting, and sharing, and
2 helping people share best practices about
3 health action plan tools and strategies,
4 etcetera.
5 **Ms. Haycock:** And I would say that what we've learned
6 already from the learning collaborative is
7 (inaudible) first plans are taking. Because
8 CBCME's often are already in the health plan
9 provider networks, particularly, if they're
10 a clinic or a large PC -- you know, PCP for
11 -- for a number of members, plans are
12 building on their existing contracts to
13 incorporate the Health Home Program
14 requirement. It doesn't necessarily have to
15 be a new contract. And then, in terms of
16 being purged to a health action plan, and
17 how -- how CBCME's are -- are actively
18 approaching care management for members, so
19 far, a part of what we've seen is the health
20 plans are allowing CBCME's to use their
21 existing care management tools and software,
22 and -- and care planning platform, and not
23 trying to require them to develop a brand
24 new Health Home specific platform. But what
25 the plans are doing is requiring, if there

1 was existing care management platforms, to
2 be updated to make sure that they fully
3 incorporate every aspect of the Health Homes
4 Program. One of the things that plans are
5 finding is that, you know, a lot of CBCME's
6 think that they're doing care coordination
7 on par with Health Home. But Health Homes
8 really is a next level to coordination care
9 management programs. Incorporating the
10 social determinants of housing incorporating
11 -- that housing navigation, but to try to
12 make this actually implementable for the
13 range of CBCME's that are participating,
14 allowing them to build on those existing
15 care management platforms is an early best
16 practice, because it sort of reduces the
17 burden for the CBCME, but it still, you
18 know, requiring them to -- to think about
19 how to do the -- the access of their
20 (inaudible) development program.
21 **Mr. Hansen:** Yeah, and just the sum total of -- of what
22 you will see in the program guide really, I
23 think, quantifies how this program is next
24 level and above and beyond what -- what has
25 been done previously. When you talk about

1 what has to be included into the health
2 action plan; things like assessment for, you
3 know, housing services, other social
4 services, behavioral health, etcetera, to
5 quantifying some of the program requirements
6 like measuring in-person visits, and making
7 sure there's aggregate standards for that,
8 and for the case manager ratio that -- that
9 these folks have. And then, to the
10 reporting requirements, measuring timeliness
11 of that health action plan, and -- and many
12 other things. Yeah.
13 **Ms. Haycock:** Yeah. All right. So, we're going to talk
14 about a couple of implementation questions.
15 So, the -- the second phase for each county
16 is -- is the SMI phase. And so, that is the
17 -- that set of -- maybe we could go back to
18 the eligibility slide. That really is that
19 --
20 **Mr. Hansen:** Yeah, that major --
21 **Ms. Haycock:** -- third --
22 **Mr. Hansen:** -- depression, bi-polar disorders --
23 **Ms. Haycock:** Yeah.
24 **Mr. Hansen:** -- and psychotic disorders, including
25 schizophrenia.

1 **Ms. Haycock:** Okay.

2 **Mr. Hansen:** Yeah.

3 **Ms. Haycock:** So, that is the second phase. And then, so
4 there's questions about counties that aren't
5 on the implementation list, whether those
6 counties will eventually have Health Homes,
7 can folks in those counties participate in
8 the learning collaborative. My
9 understanding is that this is the universe
10 that the department current is
11 contemplating.

12 **Mr. Hansen:** Yeah, at this time, there is no plan to add
13 additional counties for implementation.
14 We'll have to go back and think about the
15 learning collaborative question, whether
16 other folks can participate. That -- that
17 may be a possibility.

18 **Ms. Haycock:** Uh-huh.

19 **Mr. Hansen:** Other counties. We developed the county
20 implementation list based on -- or request
21 for information from -- that we put out to
22 our managed care plans recognizing this is a
23 program that's kind of a heavy lift. We
24 often have many different new initiatives
25 happening with the plans. We wanted to make

1 sure that plans felt like they could do
2 this, and do it right, and do it well. So,
3 we asked them for their thoughts about what
4 counties they would be ready to do this in
5 and have the capacity as well as the
6 capability. And we -- we maintain the
7 ability or the right to launch additional
8 counties, but we developed this list based
9 -- based heavily on that input from the
10 managed care plan. One of the things that
11 we have with this program is a cost
12 neutrality requirement that is built into
13 the state authorizing legislation, so a lot
14 of the policy that we're looking at
15 throughout the development of this program,
16 including figuring where we launch at.
17 Readiness is related to ensuring that the
18 program has every chance for success, and
19 every chance to save as much money in
20 avoidable negative health outcome
21 utilization as it expands in additional
22 program services, so we can meet that cost
23 neutrality requirement, sustain the program,
24 and continue it. So, you will see that
25 throughout our eligibility criteria and

1 trying to make sure we're picking folks who
2 -- who really need the program. Most, there
3 is an emphasis on implementation, not in
4 maximizing, necessarily, the volume of
5 people that we enroll in the program, but
6 really maximizing -- making sure that the
7 right people, people who need the program
8 most, get it first and it works really well
9 for them so.
10 **Ms. Haycock:** Yeah. Then, building on that, there was a
11 question about whether dual are included.
12 And so, our -- so, if a dual eligible
13 (inaudible) member qualifies under the
14 eligibility enrollment criteria, they are
15 eligible for the Health Homes -- Health
16 Homes benefit and -- and can be enrolled as
17 long as they are also enrolled in -- in the
18 Medi-Cal managed care plan. But what I
19 would say it, again, we're -- we -- they
20 aren't on our targeted list because -- for
21 that reason, the Medi-Cal only member where
22 the plan can manage both their medical and
23 (inaudible) their -- their full range of
24 benefits is kind of where we're going to see
25 that sweet spot of the Health Homes Program

1 being super effective in helping the member
2 and, also, achieving that cost neutrality.
3 **Mr. Hansen:** Yeah, I think -- I think we -- we all
4 understand and CMS even recognized in it's
5 initial Medicaid Director's Letter on Health
6 Homes, that -- that coordination of care for
7 duals who have most of their benefit
8 provided through Medicare, but are also in
9 Medi-Cal, and sometimes in Medi-Cal managed
10 care plans, coordination for them is -- is a
11 challenge, certainly. And we have in
12 California, that Cal MediConnect Program,
13 which is a good solution to -- to bring that
14 coordination together. And -- but the
15 ability of the managed care plan to have
16 some level of control over their providers
17 in requiring coordination throughout the
18 majority of the medical benefit is really
19 key to the success of this program. So,
20 that's -- that's where we're -- we're
21 focusing proactive outreach engagement.
22 But, again, if a dual meets the eligibility
23 criteria, they -- they will be enrolled in
24 the program and will be served.
25 **Ms. Haycock:** Great. Again, just on that theme, they're a

1 -- we have an expectation of how many
2 members will be served. Is there a limit on
3 the number of -- of members served? What
4 are we -- what are -- what are -- what is
5 the department thinking around that?
6 **Mr. Hansen:** So, it -- again, this is -- this is a state
7 plan, this isn't technically a waiver pilot
8 limited program. It is a -- a state plan
9 optional Medicaid benefit entitlement
10 program. The only difference from the
11 normal SPA program is that we are allowed to
12 pick which counties we implement in, which
13 is different. Normally, it would be
14 statewide. So, there is no limit on the
15 number of members. We do have a commitment
16 from the California Endowment to fund the
17 ten percent match for services. And -- and
18 there is a limit on that amount of funding,
19 so we are keeping a careful eye on the
20 enrollment, but based on our projections,
21 our design of the program, we do not see
22 that we will be going down that -- that
23 amount of funding. So, the expectation
24 around the number of enrollees, I would say
25 just very rough at the end of all launch of

1 all phases, and after enrollment ramp up in
2 all phases, perhaps up to 50,000 folks.
3 **Ms. Haycock:** Okay. Great. Then, there's a question
4 around will CME and medical services
5 (inaudible) need to be provided by the
6 MCP's, will those providers have to contract
7 separately with the Health Homes
8 (inaudible). So, here the -- the Medi-Cal
9 benefit and the way members of the Medi-Cal
10 managed care plan receive their -- their
11 Medi-Cal CME or medical benefits for any
12 other existing Medi-Cal benefit does not
13 change. The only thing the Health Homes
14 Program does is add this extra layer of care
15 coordination and support. Because the
16 department chose to implement the Health
17 Homes Program through the managed care plan,
18 it's going to facilitate the ability of the
19 care coordinator to know what services the
20 members are receiving, to have a
21 relationship with the providers and
22 suppliers for those Medi-Cal only members.
23 And so, none of that will change. This is a
24 benefit being provided by a member's
25 existing or chosen Medi-Cal managed care

1 plan. Do you have anything to add, Brian?

2 **Mr. Hansen:** No.

3 **Ms. Haycock:** No? Cool.

4 **Mr. Hansen:** Yeah, I will. Like I said, this -- this
5 isn't a waiver program. We do have a waiver
6 for this program. Its primary authority is
7 through the state plan amendment, but we
8 have a waiver just to limit operation to our
9 Medi-Cal managed care plan.

10 **Ms. Haycock:** We have a question about if -- if the bene -
11 - beneficiary refuses to receive Whole
12 Person Care care coordination, and they want
13 to transition to Health Homes after Whole
14 Person Care ends, is that possible, and --
15 and are we -- are we -- are we going to be
16 doing any data dives (phonetic) just to try
17 to think about how to do a large scale
18 transition of Whole Person Care enrollees
19 into the Health Homes Program?

20 **Mr. Hansen:** So, first, I would say that it's absolutely
21 possible, and I think that would be part of
22 our -- our hope is that -- that Health Homes
23 can be available as a sustaining measure for
24 -- for a piece of what's happening in Whole
25 Person Care. We do not know what's going to

1 happen, if there's going to be a next waiver
2 or what may happen with that for additional
3 programs. But yes, it's absolutely an
4 option for Whole Person Care folks to
5 transition to Health Homes at any time based
6 on their choice. Regarding sharing data or
7 facilitating that transition on sort of a -
8 - a wide scale or a in an organized fashion.
9 I think our primary focus right now is on
10 helping the county folks manage care plans
11 and the staff who are running Whole Person
12 Care pilots talk to each other, and think
13 about how they are going to coordinate and
14 what that might look like. We are open to
15 additional ways of to facilitate that
16 coordination at the county level.
17 **Ms. Haycock:** So, there's a follow-up question that's
18 about sort of what -- what's making Whole
19 Person Care pull the outreach component in
20 engaging clients. Health Homes does have a
21 very strong outreach component as well. The
22 rates reflect that we really -- there is a
23 -- a strong requirement that the -- the
24 health plans -- actually, a lot of health
25 plans are having the CBCME's do that

1 outreach, because one of those early
2 learning best practices is building on other
3 programs is knowing that for the CBCME's
4 should be a successful care coordinator for
5 that member, you have have to develop trust
6 and a relationship with the member. And so,
7 having the CBCME's directly do that early
8 engagement and outreach to the member
9 facilitates their transition into the
10 program. It's -- it's starting that process
11 of -- of -- of pulling the member into the
12 care coordination. And so, I would say that
13 is -- that is an element.
14 **Mr. Hansen:** Yeah. So, the -- just to speak to the rates
15 and how serious we were about it. There is
16 substantial funding for, I think, up to
17 three months. They made some assumption
18 about the average amount of engagement time
19 that would happen for each person, but --
20 but like the limit was up to three months of
21 the engagement activity prior to enrollment.
22 And that funding is built into the rates.
23 And we also review and approve each plans'
24 outreach and engagement protocol, the intent
25 that we've provided to them, which you will

1 see in the program guide, is that it should
2 be sort of a progressive level of effort,
3 you know, starting at some lower level, and
4 then progressing up as needed to get folks
5 who are more challenging to find and engage.
6 You know, just getting to, eventually,
7 activities like trying to connect with their
8 providers, get their providers to connect
9 with them, connecting with housing services
10 providers, other places they may go and be
11 so that you can try and communicate with
12 them, build that trust to get them into the
13 program.
14 **Ms. Haycock:** Okay. So, the question about if there's --
15 if there are adequate PHW's and -- and --
16 and other workforce to implement this
17 program, I know that workforce is an issue
18 that folks are dealing with across Whole
19 Person Care, across -- I'm -- I'm sure that
20 the CBCME's in the Health Home, they're
21 pretty strong case manager work requirement
22 in -- or ratios in the Health Homes Program
23 that that plan must meet. And I think
24 that's something probably that -- that a
25 learning collaborative with help the plan

1 tackle. But it is something that the
2 CBCME's are actively -- actively man --
3 working on in managing.
4 **Mr. Hansen:** Yeah -- yeah, and it's definitely, you know,
5 as there are more and more programs that are
6 targeting frequent utilizers like Whole
7 Person Care, it's definitely something to
8 keep an eye on, and something we should be
9 trying to assist with as we can. One thing
10 we did do, is we provided flexibility in the
11 staffing model so that the plans have some
12 nimbleness to hire the type of staff to
13 provide care coordination services that,
14 yeah, that they think they can. So, they
15 can use community health workers, they can
16 use peer support staff, they can use other
17 types of -- of professionals, nurses, social
18 workers, etcetera, to provide this care
19 coordination services.
20 **Ms. Haycock:** Okay, great. We're going to try to wrap
21 this up, but one last question. After the
22 first eight quarters, what will the Federal
23 financial participation rate be increased
24 to?
25 **Mr. Hansen:** Yeah, and it will -- so, it will revert to

1 what would normally be our standard Federal
2 match rate, which I think, in general, is 50
3 percent -- Federal match 50 percent. Non-
4 Federal share, there are differences for
5 certain modulations. The adult expansion
6 population. It's a higher rate. In fact,
7 they get it -- they get their regular rate,
8 which is more than 90 percent currently,
9 still, for Health Homes services, but, yeah,
10 they'll, for the most part, revert to the 50
11 percent.
12 **Ms. Haycock:** Great. Because we are at 10:00 a.m., there
13 are two more questions, we'll try to hit
14 quickly. One question is, do we know what
15 proportion of enrollees will be from the
16 Medi-Cal extension population. I don't
17 think that we've done that level of data
18 analysis.
19 **Mr. Hansen:** We -- we've -- we've had some preliminary
20 looks at it, and I know that it was -- it --
21 fairly good proportion. Much, much bigger
22 of a proportion than I would have initially
23 expected. Now, that's on our target
24 engagement list. How that translates to who
25 actually gets enrolled, it will be very

1 interesting to run data and look at who
2 actually ends up getting enrolled in the
3 program based on sort of prioritized
4 enrollment engagement for people that need
5 the program most. And that is one of the
6 things we will be looking at very closely in
7 the early parts of the program to make sure
8 that that population is looking like -- it's
9 looking -- looking right on track.
10 **Ms. Haycock:** Okay. Just for folks, before we leave,
11 folks, we will be posting the slides online
12 on the DHCS website, so you can find them
13 there for reference. Our last question, if
14 the CBCME is CBO that's not one of the types
15 of organizations in the program guide, would
16 that fall under other, or would they still
17 be allowed to participate?
18 **Mr. Hansen:** Yeah, and I think that's a discussion
19 primarily -- our list of folks are people
20 that from a DHCS standpoint, we think are
21 okay for the program. Essentially, that
22 list is anyone, because there is that other
23 category. So, we did not want to limit the
24 types. It will be up to the managed care
25 plan to work with potential CBCME Health

1 Homes services providers to, again, we left
2 a great deal of flexibility for them to be
3 able to pick their providers that they think
4 best provide these services, possibly
5 cobbled together in network with different
6 types of providers. Possibly, different
7 providers providing each a piece of the
8 Health Home services. So, that discussion
9 would be very good to have with your managed
10 care plan in your area.
11 **Ms. Haycock:** Yeah. Great. Well, thanks everyone for
12 participating today in our stakeholder
13 webinar on our Health Homes Program. We
14 hope this was informative. The recording
15 and the slides will be available again on
16 the DHCS website, and so look for that
17 there. Thank you again. Have a great day.
18 (Recording Ends)
19 **- INTERVIEW CONCLUDED -**
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TRANSCRIBER'S CERTIFICATE

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This is to certify that I, Jill Droubay, transcribed the audio recording of DHCS HHP Stakeholder Update 2018; that the pages numbered 1 through 53 constitute said transcript; that the same is a complete and accurate transcription of the aforesaid to the best of my ability.

September 9, 2018

Jill Droubay
Foothill Transcription Company

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