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- MEETING -

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

question and answer period. Brian (phonetic).

Mr. Hansen: Thank you, Hilary (phonetic). Hello, everyone. Again, my name is Brian Hansen. I work with the Healthcare Delivery Systems area of the Department of Healthcare Services. I have worked on the Health Homes Program Development and Implementation for a few years now. We will be answering questions at the end of my presentation. So, we will be taking only questions as they're typed in through the webinar application. So, if you have a question, you can go ahead and type that question in at any time. And if it's technical in nature, we might answer it as we go, but any -- any of the program clarification questions, we'll be answering at the end of the presentation. So, what we're going to go through today is, we're going to give a quick refresher on what the program is. As an overview, it might spur some questions in your minds. We will give then an implementation update of where we're at currently. We'll talk about the recent

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

members with complex medical needs and chronic conditions. Primarily, those who are often called frequent utilizers of healthcare services. People who -- who are in the, maybe, top one to three percent of -- of -- level of Medi-Cal members using services, and with complexity of chronic conditions, and other co-morbidities and social determinants of health. So, members who fit into this and who join this program will be given a care team, including a care coordinator who coordinates their physical and behavioral healthcare services, and social services to connect them, to community services, housing, if they are unstably housed or homeless, as needed, that's available, and other -- other services relating to social determinants of health or other social services. Next slide. So, members, when they join, they will stay enrolled in their Medi-Cal managed care program, and continue to see the same doctors. They don't have to change their doctors, or their plan, or anything like that. Now, they will have an extra layer of

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

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

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

that's -- that's not good for -- for anybody. So, they have to have one of these four acuity criteria in addition to the chronic condition cri -- criteria. Three or more ED visits -- sorry. Three or more of the eligible chronic conditions is the first one. They had to have to have had a hospital stay in the last year, three or more ED visits in the last year, or they have chronic homelessness. And the definition for chronic homelessness relates to our authorizing legislation at the State level, which was AB361, and it references back to the Federal definition of chronic homelessness for this eligibility criteria. Next. Okay. Next slide, yeah. So, there are three ways for a member to get connected with the -- this program. We are sifting through our administrative data to check for the eligibility criteria here, our claims data, our eligibility file, etcetera, to look for things that qualify somebody. We are putting together a list that we are sending to the managed care plans of people that we think are likely to qualify for this

program. Plans will be prioritizing that list and -- and doing proactive outreach and engagement to -- to ask those folks if they want these additional extra services. Again, optional and voluntary services. The member does have to -- the member does have to consent to be enrolled. There is no passive enrollment for this program. The provider also, or the member, the provider on behalf of the member can refer folks to the managed care plan. managed care plan will then go through a process of verifying eligibility criteria and -- and enrolling the member if they consent to be enrolled. Okay. The other -- two other things to know, is a person must be a member of a managed care plan to the join the Health Homes Program, must be a member in the implementing counties. We'll talk about which -- what the staging is for those counties in a little bit. Fee for Service members can join the program, but they will have to leave the Fee for Service delivery system and join a managed care plan to be enrolled in the program. Health Homes

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

that those things happen. Regarding housing, the Health Home Program actually provides housing navigation at tenancy sustaining services. The Health Home Program itself provides these services, so they will be connected with housing providers in the community to facilitate that. Health promotion; member and family supports and comprehensive transitional care for those high-risk transitions from hospital to nursing facility, and nursing facility to the community, other types of transitions. Next slide. So, information sharing and reporting are -- particularly information sharing critical for care coordination. For care management activities to be successful, the entire health -- or Health Home Program caring team must be able to share and access information about a member’s services and care. managed care plans are responsible for establishing and maintaining data sharing agreements and processes to make sure that critical information is shared in a timely manner with the Health Home Program partners.

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

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

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

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

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

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

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

that does not include Heath Home Program services. There are no Health Home Program services in Fee for Service, so it would be other services of their doctors they had seen prior to that transition. The -- so, the MOU requirements listed there. That refers to the memorandum of understanding between the managed care plans and county mental health plans about how they coordinate care for specific members. And we have updated that guidance to our managed care plans to ensure that that MOU includes references to and accounts for Health Homes Program as new thing that everyone will have to coordinate around. And then, Health Homes Program Whole Person Care Policy. Do we have an additional slide on this, or is this --

Ms. Haycock: Uh-huh. I have a couple slides --

Mr. Hansen: Okay. There we go --

Ms. Haycock: -- right here.

Mr. Hansen: Thanks. Intersection of Health Home Program and Whole Person Care. So, our Whole Person Care Program for those who are -- are unfamiliar with it, is a -- a county-based

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

launching in some counties that have Whole Person Care, and you have a potential situation of duplication between the care coordination that Health Homes provides, and care coordination that Whole Person Care provides. So, that's why we developed this guidance structure to -- to govern that relationship. Beneficiaries who are eligible to receive services from Whole Person Care and Health Homes, can be enrolled in either program or both based on the beneficiary's choice. If the beneficiary is eligible for both programs, they may choose which program's care coordination services they want to receive, which assumes that -- that the pilot program, Whole Person Care, provides some duplicate type of care coordination services that would be similar to Health Homes. If the beneficiary wants to receive care coordination services from their Whole Person Care Program, they can't receive the same care coordination services from HHP. Which would mean they would not be enrolled in the HHP. The beneficiary can receive

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

Homes Health Services. Okay, next slide. Okay. So, the beneficiary, as we said, may not receive duplicative care coordination services from Health Homes and Whole Person Care. If the beneficiary is receiving care coordination services through the Health Home Program, it's the responsibility of the WPC pilot to ensure that the member does not received duplicative -- duplicative services from the Whole Person Care pilot. So, the burden there is on -- on the pilot to ensure that -- the pilot may not claim reimbursement of care coordination services that are duplicative and that are provided during the same month as Health Homes Program duplicate coordination services. Okay. And with that, I'm going to hand it over to Hilary Hickock (phonetic).

Ms. Haycock: Great. Thank you, Brian. My name is Hilary Hickock (phonetic). I'm with Harbage Consulting. And we are working with DHCS on Health Homes Program to provide a number of support services to the participating managed care plans within the organization. One of the things that we are doing is

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

across the county for -- for providers that are working with multiple health plans. They're helping share that type of learning, which the later phased plans were also helping them think through some of the implementation hurdles. So, lots of things that the plans are working through are how to develop MOUs. How to develop -- how to work with -- work with their CBCME's to do capacity building, to do the types of detailed data reporting required under the Health Homes Program. We're also helping the plans think through that intersection with Whole Person Care that Brian outlined. We're also working on a learning corroborative with the Whole Person Care pilots, so there's some pretty good alignment there where we're helping, so it's on both sides, to understand that intersection to speed up implementation. We're also working with the plans to start thinking through the SMI implementation at that sort of -- the six-month lag behind the chronic conditions implementations as well as the intersection between Health Homes and

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

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

hopefully, one on script -- targeting member with asthma. So, we're excited about the targeted trainings that will be coming up. And then, of course, we're developing the lessons learned information out of the learning collaborative and -- and sharing that with the plan. So, again, we would definitely point you to the DHCS website. We created a slightly shorter link here on the page, because it is a, otherwise, a little bit of a -- of a mouthful. But there you can find all kinds of program information, as well as there's outreach and education material that we covered so far. Addition -- additionally, the email inbox on the screen, HHP@DHCS.ca.com is another resource for folks who have questions, if we don't get them all here today, but we do have quite a long list of questions. So, Brian, why don't we get moving with that.

Mr. Hansen: Yeah. While we're sorting those questions, I'll just say that we really appreciate -- this program, again, it's fairly complicated. It's doing new things that a lot of providers have not done before, so we

really appreciate the opportunity to have a learning collaborative and the additional outreach assistance, which Harbage Consulting is providing. It's provided, with support from the California Endowment, which has been very supportive of this program overall. So, I just want to say thank you for that.

Ms. Haycock: Yeah, thank you to the California Endowment. So, one of the questions is about housing navigation, and looking for a little bit more information about -- about housing navigation. In addition to sort of the details that are available online in terms of provider guide as well as the program guide, do you have one or two things you want to say about housing navigation?

Mr. Hansen: Sure. Yeah, so housing navigation is one of those things that will be new for Medi-Cal to be providing through this program itself. And its housing navigation, which is intended to have a member of the Health Homes team as part of their care coordination, assist the member to look for available housing for homeless members,

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

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

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

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

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

about guidance the DHCS has given to the plans about data sharing and consent and MOUs.

Mr. Hansen: Yes. So, I think we have identified through working with this program and, particularly, even earlier working through the Whole Person Care pilot program that legalities, HIPAA, other laws related to information sharing is often challenging to negotiate. Although, it has good intentions behind it, and SUD information sharing is governed by specific Federal Laws that add probably the highest barrier for sharing, often, in some cases between certain entities. It's a case-by-case consent that is required. So, I think this will be an area, definitely, for the learning collaborative to take on and to try to build on what has been developed from a best practice standpoint through the Whole Person Care pilots, because in many cases it's a very similar activity. And all -- what we have told the managed care plans is that, you know, information sharing needs to happen for good care coordination. We expect them to figure

out a way to do it within the realities of the law, and technical capabilities in their local areas. And in some cases, you know, things may require individual consents, and we -- we expect them to follow the law, and -- and negotiate that process as best they can. In some cases, a general consent may -- may work. So, we at DHCS are careful about providing anything that appears to be legal advice about what's legal around consent. So, we are telling folks to just follow the law, and we will help them negotiate challenges where we can, and how we can, and share best practices where one entity has found a way to achieve something. We can spread that best practice route to other entities and help them understand how they're doing it. But this is a challenge we will all -- all confront with this program.

Ms. Haycock: Great. Definitely, a big challenge for folks in a number of programs trying to do improved care coordination. We have a -- a couple questions about if the department has sort of developed in sharing a template --

materials, two plans. One is about if there's a -- a population or health or care management tools for investigative CMEs, which we think may be building on the -- the health action plan requirement. And then, a question around a template CBCME contract.

Mr. Hansen: Yeah. So, we -- Hilary, we can --

Ms. Haycock: Yeah.

Mr. Hansen: -- (inaudible) but we do not have a DHCS template for community provider contracts for Health Homes. Each managed care plan is developing those on their own. In some cases, they're best practices that are being shared, but for the most part, the plans are developing those are their own. DHCS reviews and approves those templates from each plan as part of the launch process to make sure they comply with everything. As far as population health or care management tool, I -- I would -- the only thing I can say is that if you look at the program guide, the sum total of the program guide is, essentially, what we have provided around strategies and expectations. And that incorporates the tenants of the Health

Homes Program, what we expect to happen. The program requirements, or specific, quantifiable requirements about what has to happen. The health action plan, timeliness, in-person visits, all the services that are available, and then it goes, also, to the readiness review documents and a list of what we require from readiness is also in an appendix of the program guide. So, we are reviewing a number of specific policies from the managed care plans on things like outreach and engagement of homeless members, areas where they -- that -- that are a little more complicated, and then we want to make sure are -- are following the -- the intent of the program to its full extent. And -- and then, the learning collaborative, I keep bringing up --

Ms. Haycock: Yeah.

Mr. Hansen: -- learning collaboratives.

Ms. Haycock: Yeah.

Mr. Hansen: We cannot -- I mean, we’re not going to provide guidance or criteria --

Ms. Haycock: Right.

Mr. Hansen: -- for everything. A lot of this is going

to be done by us voting, and sharing, and helping people share best practices about health action plan tools and strategies, etcetera.

Ms. Haycock: And I would say that what we've learned already from the learning collaborative is (inaudible) first plans are taking. Because CBCME's often are already in the health plan provider networks, particularly, if they're a clinic or a large PC -- you know, PCP for -- for a number of members, plans are building on their existing contracts to incorporate the Health Home Program requirement. It doesn't necessarily have to be a new contract. And then, in terms of being purged to a health action plan, and how -- how CBCME's are -- are actively approaching care management for members, so far, a part of what we've seen is the health plans are allowing CBCME's to use their existing care management tools and software, and -- and care planning platform, and not trying to require them to develop a brand new Health Home specific platform. But what the plans are doing is requiring, if there

was existing care management platforms, to be updated to make sure that they fully incorporate every aspect of the Health Homes Program. One of the things that plans are finding is that, you know, a lot of CBCME's think that they're doing care coordination on par with Health Home. But Health Homes really is a next level to coordination care management programs. Incorporating the social determinants of housing incorporating -- that housing navigation, but to try to make this actually implementable for the range of CBCME's that are participating, allowing them to build on those existing care management platforms is an early best practice, because it sort of reduces the burden for the CBCME, but it still, you know, requiring them to -- to think about how to do the -- the access of their (inaudible) development program.

Mr. Hansen: Yeah, and just the sum total of -- of what you will see in the program guide really, I think, quantifies how this program is next level and above and beyond what -- what has been done previously. When you talk about

what has to be included into the health action plan; things like assessment for, you know, housing services, other social services, behavioral health, etcetera, to quantifying some of the program requirements like measuring in-person visits, and making sure there's aggregate standards for that, and for the case manager ratio that -- that these folks have. And then, to the reporting requirements, measuring timeliness of that health action plan, and -- and many other things. Yeah.

Ms. Haycock: Yeah. All right. So, we're going to talk about a couple of implementation questions. So, the -- the second phase for each county is -- is the SMI phase. And so, that is the -- that set of -- maybe we could go back to the eligibility slide. That really is that --

Mr. Hansen: Yeah, that major --

Ms. Haycock: -- third --

Mr. Hansen: -- depression, bi-polar disorders --

Ms. Haycock: Yeah.

Mr. Hansen: -- and psychotic disorders, including schizophrenia.

Ms. Haycock: Okay.

Mr. Hansen: Yeah.

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

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

Ms. Haycock: Uh-huh.

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

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

trying to make sure we're picking folks who -- who really need the program. Most, there is an emphasis on implementation, not in maximizing, necessarily, the volume of people that we enroll in the program, but really maximizing -- making sure that the right people, people who need the program most, get it first and it works really well for them so.

Ms. Haycock: Yeah. Then, building on that, there was a question about whether dual are included. And so, our -- so, if a dual eligible (inaudible) member qualifies under the eligibility enrollment criteria, they are eligible for the Health Homes -- Health Homes benefit and -- and can be enrolled as long as they are also enrolled in -- in the Medi-Cal managed care plan. But what I would say it, again, we're -- we -- they aren't on our targeted list because -- for that reason, the Medi-Cal only member where the plan can manage both their medical and (inaudible) their -- their full range of benefits is kind of where we're going to see that sweet spot of the Health Homes Program

being super effective in helping the member and, also, achieving that cost neutrality.

Mr. Hansen: Yeah, I think -- I think we -- we all understand and CMS even recognized in it's initial Medicaid Director's Letter on Health Homes, that -- that coordination of care for duals who have most of their benefit provided through Medicare, but are also in Medi-Cal, and sometimes in Medi-Cal managed care plans, coordination for them is -- is a challenge, certainly. And we have in California, that Cal MediConnect Program, which is a good solution to -- to bring that coordination together. And -- but the ability of the managed care plan to have some level of control over their providers in requiring coordination throughout the majority of the medical benefit is really key to the success of this program. So, that's -- that's where we're -- we're focusing proactive outreach engagement. But, again, if a dual meets the eligibility criteria, they -- they will be enrolled in the program and will be served.

Ms. Haycock: Great. Again, just on that theme, they're a

-- we have an expectation of how many members will be served. Is there a limit on the number of -- of members served? What are we -- what are -- what are -- what is the department thinking around that?

Mr. Hansen: So, it -- again, this is -- this is a state plan, this isn't technically a waiver pilot limited program. It is a -- a state plan optional Medicaid benefit entitlement program. The only difference from the normal SPA program is that we are allowed to pick which counties we implement in, which is different. Normally, it would be statewide. So, there is no limit on the number of members. We do have a commitment from the California Endowment to fund the ten percent match for services. And -- and there is a limit on that amount of funding, so we are keeping a careful eye on the enrollment, but based on our projections, our design of the program, we do not see that we will be going down that -- that amount of funding. So, the expectation around the number of enrollees, I would say just very rough at the end of all launch of

all phases, and after enrollment ramp up in all phases, perhaps up to 50,000 folks.

Ms. Haycock: Okay. Great. Then, there's a question around will CME and medical services (inaudible) need to be provided by the MCP's, will those providers have to contract separately with the Health Homes (inaudible). So, here the -- the Medi-Cal benefit and the way members of the Medi-Cal managed care plan receive their -- their Medi-Cal CME or medical benefits for any other existing Medi-Cal benefit does not change. The only thing the Health Homes Program does is add this extra layer of care coordination and support. Because the department chose to implement the Health Homes Program through the managed care plan, it's going to facilitate the ability of the care coordinator to know what services the members are receiving, to have a relationship with the providers and suppliers for those Medi-Cal only members. And so, none of that will change. This is a benefit being provided by a member's existing or chosen Medi-Cal managed care

plan. Do you have anything to add, Brian?

Mr. Hansen: No.

Ms. Haycock: No? Cool.

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

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

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

happen, if there's going to be a next waiver or what may happen with that for additional programs. But yes, it's absolutely an option for Whole Person Care folks to transition to Health Homes at any time based on their choice. Regarding sharing data or facilitating that transition on sort of a -- - a wide scale or a in an organized fashion. I think our primary focus right now is on helping the county folks manage care plans and the staff who are running Whole Person Care pilots talk to each other, and think about how they are going to coordinate and what that might look like. We are open to additional ways of to facilitate that coordination at the county level.

Ms. Haycock: So, there's a follow-up question that's about sort of what -- what's making Whole Person Care pull the outreach component in engaging clients. Health Homes does have a very strong outreach component as well. The rates reflect that we really -- there is a -- a strong requirement that the -- the health plans -- actually, a lot of health plans are having the CBCME's do that

outreach, because one of those early learning best practices is building on other programs is knowing that for the CBCME's should be a successful care coordinator for that member, you have have to develop trust and a relationship with the member. And so, having the CBCME's directly do that early engagement and outreach to the member facilitates their transition into the program. It's -- it's starting that process of -- of -- of pulling the member into the care coordination. And so, I would say that is -- that is an element.

Mr. Hansen: Yeah. So, the -- just to speak to the rates and how serious we were about it. There is substantial funding for, I think, up to three months. They made some assumption about the average amount of engagement time that would happen for each person, but -- but like the limit was up to three months of the engagement activity prior to enrollment. And that funding is built into the rates. And we also review and approve each plans' outreach and engagement protocol, the intent that we've provided to them, which you will

see in the program guide, is that it should be sort of a progressive level of effort, you know, starting at some lower level, and then progressing up as needed to get folks who are more challenging to find and engage. You know, just getting to, eventually, activities like trying to connect with their providers, get their providers to connect with them, connecting with housing services providers, other places they may go and be so that you can try and communicate with them, build that trust to get them into the program.

Ms. Haycock: Okay. So, the question about if there's -- if there are adequate PHW's and -- and -- and other workforce to implement this program, I know that workforce is an issue that folks are dealing with across Whole Person Care, across -- I'm -- I'm sure that the CBCME's in the Health Home, they're pretty strong case manager work requirement in -- or ratios in the Health Homes Program that that plan must meet. And I think that's something probably that -- that a learning collaborative with help the plan

tackle. But it is something that the CBCME's are actively -- actively man -- working on in managing.

Mr. Hansen: Yeah -- yeah, and it's definitely, you know, as there are more and more programs that are targeting frequent utilizers like Whole Person Care, it's definitely something to keep an eye on, and something we should be trying to assist with as we can. One thing we did do, is we provided flexibility in the staffing model so that the plans have some nimbleness to hire the type of staff to provide care coordination services that, yeah, that they think they can. So, they can use community health workers, they can use peer support staff, they can use other types of -- of professionals, nurses, social workers, etcetera, to provide this care coordination services.

Ms. Haycock: Okay, great. We're going to try to wrap this up, but one last question. After the first eight quarters, what will the Federal financial participation rate be increased to?

Mr. Hansen: Yeah, and it will -- so, it will revert to

what would normally be our standard Federal match rate, which I think, in general, is 50 percent -- Federal match 50 percent. Non-Federal share, there are differences for certain modulations. The adult expansion population. It's a higher rate. In fact, they get it -- they get their regular rate, which is more than 90 percent currently, still, for Health Homes services, but, yeah, they'll, for the most part, revert to the 50 percent.

Ms. Haycock: Great. Because we are at 10:00 a.m., there are two more questions, we'll try to hit quickly. One question is, do we know what proportion of enrollees will be from the Medi-Cal extension population. I don't think that we've done that level of data analysis.

Mr. Hansen: We -- we've -- we've had some preliminary looks at it, and I know that it was -- it -- fairly good proportion. Much, much bigger of a proportion than I would have initially expected. Now, that's on our target engagement list. How that translates to who actually gets enrolled, it will be very

interesting to run data and look at who actually ends up getting enrolled in the program based on sort of prioritized enrollment engagement for people that need the program most. And that is one of the things we will be looking at very closely in the early parts of the program to make sure that that population is looking like -- it's looking -- looking right on track.

Ms. Haycock: Okay. Just for folks, before we leave, folks, we will be posting the slides online on the DHCS website, so you can find them there for reference. Our last question, if the CBCME is CBO that's not one of the types of organizations in the program guide, would that fall under other, or would they still be allowed to participate?

Mr. Hansen: Yeah, and I think that's a discussion primarily -- our list of folks are people that from a DHCS standpoint, we think are okay for the program. Essentially, that list is anyone, because there is that other category. So, we did not want to limit the types. It will be up to the managed care plan to work with potential CBCME Health

Homes services providers to, again, we left a great deal of flexibility for them to be able to pick their providers that they think best provide these services, possibly cobbled together in network with different types of providers. Possibly, different providers providing each a piece of the Health Home services. So, that discussion would be very good to have with your managed care plan in your area.

Ms. Haycock: Yeah. Great. Well, thanks everyone for participating today in our stakeholder webinar on our Health Homes Program. We hope this was informative. The recording and the slides will be available again on the DHCS website, and so look for that there. Thank you again. Have a great day.

(Recording Ends)

- INTERVIEW CONCLUDED -

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September 9, 2018

Jill Droubay
Foothill Transcription Company

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