Health Homes Program

CALIFORNIA'S HEALTH HOMES PROGRAM: OVERVIEW

April 2019

Health Homes Program

TOPICS COVERED

- Health Homes Program Overview
- Community-Based Care Management Entity and Managed Care Plan Roles
- HHP Care Team
- Eligibility and Enrollment
- Six Core Services
- Information Sharing, Reporting, and Payment
- Implementation Schedule
- Information and Resources

HEALTH HOMES PROGRAM OVERVIEW

- The Medi-Cal Health Homes Program (HHP) offers extra services to Medi-Cal managed care members with certain chronic health and/or mental health conditions who have high health care needs or experience chronic homelessness

- Members are given a **care team** – including a **care coordinator** – that works together to help them get the health care and social services they need

HEALTH HOMES PROGRAM OVERVIEW

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

CB-CME & MCP ROLES

Community-Based Care Management Entities (CB-CMEs)

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

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

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CB-CME & MCP ROLES

Community-Based Care Management Entities (CB-CMEs)

- Where CB-CME provider gaps exist, MCPs fill the role of CB-CMEs in delivering HHP services

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

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CB-CME & MCP ROLES

CB-CME Examples	
• Primary care or specialist physician or physician group	• Hospital or hospital-based physician group or clinic
• Federally Qualified Health Center	• Local health department
• Community Health Center	• Behavioral health entity
• Rural health center	• Community mental health center
• Providers serving members experiencing homelessness	• Substance use disorder treatment provider
• Indian health center or clinic	

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CB-CME & MCP ROLES

MCPs Choose Care Management Models

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

CB-CME & MCP ROLES

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

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

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CB-CME & MCP ROLES

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

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

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

CB-CME & MCP ROLES

Model 3. Hybrid model:

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

HHP CARE TEAM

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

Care Coordinator

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

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HHP CARE TEAM

HHP Director

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

Clinical Consultant

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

Housing Navigator (for members experiencing homelessness)

- Develop and maintain relationships with housing agencies and permanent housing providers
- Connect members to permanent housing options, including supportive housing

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HHP CARE TEAM

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

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

Community-Based Organizations (CBOs)

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

ELIGIBILITY & ENROLLMENT

To access HHP services, members must meet all 3 of the following requirements:

1) Be enrolled in a Medi-Cal managed care health plan

Fee-for-Service (FFS) members who meet the HHP eligibility criteria may contact their local MCP(s) to obtain information about the HHP, see if they qualify, and enroll with the MCP if they would like to join the HHP

ELIGIBILITY & ENROLLMENT

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

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

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

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

- ❑ Asthma

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ELIGIBILITY & ENROLLMENT

3) The member meets at least one acuity or complexity criteria.

The member can check at least 1 box below:

- ❑ Has 3 or more of the HHP-eligible chronic conditions
- ❑ Has stayed in the hospital in the last year
- ❑ Has visited the emergency department 3 or more times in the last year
- ❑ Is experiencing chronic homelessness

ELIGIBILITY & ENROLLMENT

Definition of Chronic Homelessness

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

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

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

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

ELIGIBILITY & ENROLLMENT

Examples of Potential HHP Members

ALBERT

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

ELIGIBILITY & ENROLLMENT

Examples of Potential HHP Members

SUSAN

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

ELIGIBILITY & ENROLLMENT

Examples of Potential HHP Members

JOSE

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

ELIGIBILITY & ENROLLMENT

Three ways for members to join the HHP:

1. Many members who may qualify will be contacted about the program

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

3. Members can ask their MCP for information and to see if they qualify

Members can **choose** to access HHP services if they qualify

ELIGIBILITY & ENROLLMENT

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

ELIGIBILITY & ENROLLMENT

When engaging members about the HHP, consider sharing:

- You will have a **care team** – including a care coordinator – that helps you get the health care and social services you need
- You can **keep your doctors** and you can get connected to other doctors you might need
- You will receive extra services at **no cost** as part of your Medi-Cal benefits
- Your current Medi-Cal benefits **will not be taken away or change**

MEMBERS ENROLLED IN HHP & OTHER CA PROGRAMS

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

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

- Whole Person Care Pilot
- California Children's Services Program
- Specialty Mental Health (including Targeted Case Management) and Drug Medi-Cal
- Long-term services and supports benefits, such as Community-Based Adult Services and In-Home Supportive Services
- Medicare
  - Members who have both Medi-Cal and Medicare can qualify for HHP services, but there may be other health care choices available that will work better for them

MEMBERS ENROLLED IN HHP & OTHER CA PROGRAMS

Members must choose HHP **OR**:

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

Members cannot receive HHP services if they are:

- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month (i.e. members are only eligible within the first 2 months of admission to the SNF)
- Hospice services recipients

HHP SIX CORE SERVICES

1. Comprehensive Care Management

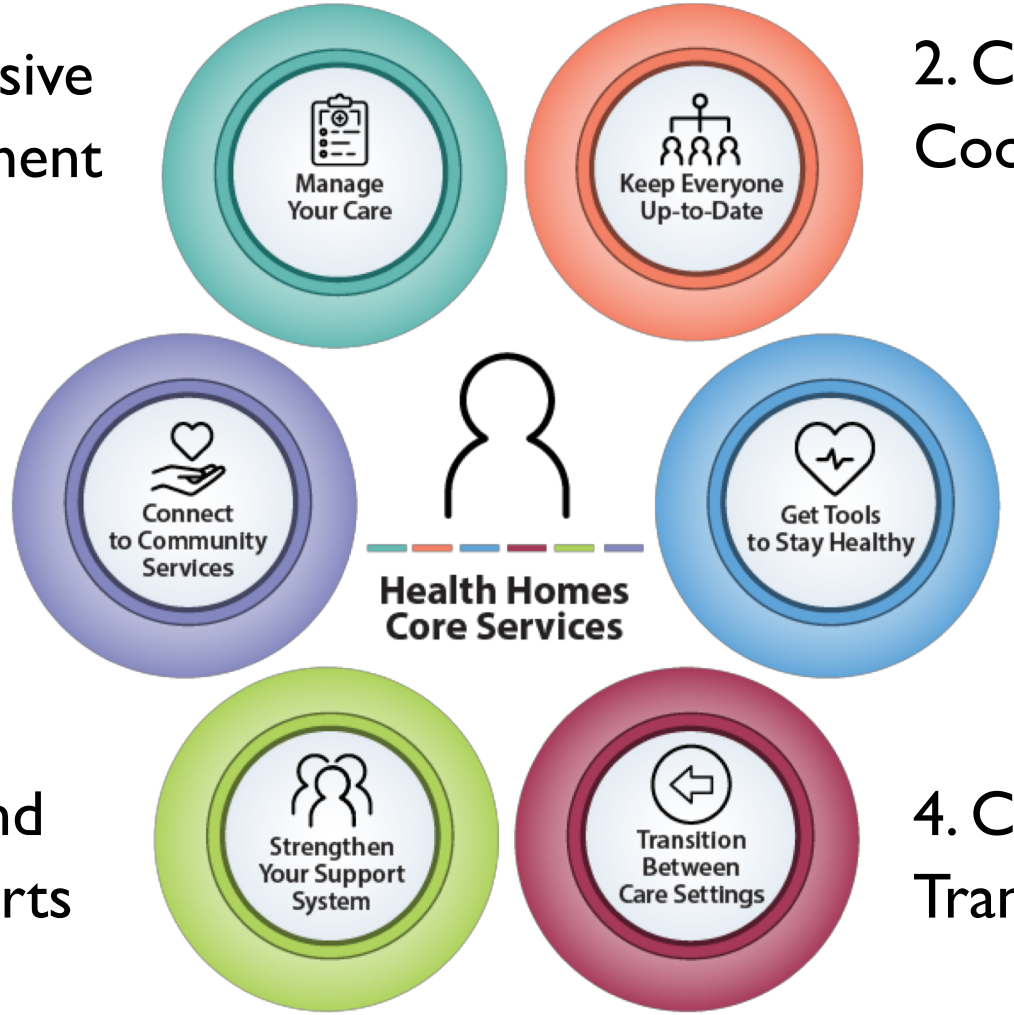
2. Care Coordination

3. Health Promotion

4. Comprehensive Transitional Care

5. Member and Family Supports

6. Referrals to Community and Social Services



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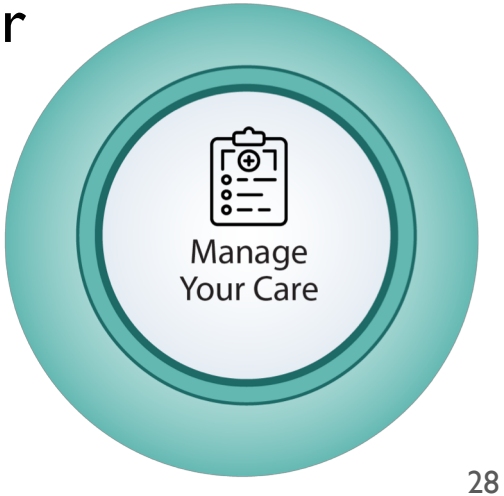
HHP SERVICES: COMPREHENSIVE CARE MANAGEMENT

The Health Action Plan (HAP)

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

- The HHP care team helps members manage their care as they implement the HAP, determine needed services, and monitor referrals and services received

- The HAP is reviewed and revised over time based on the member's progress and needs



HHP SERVICES: COMPREHENSIVE CARE MANAGEMENT

The Health Action Plan (HAP)

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

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HHP SERVICES: COMPREHENSIVE CARE MANAGEMENT

HAP Implementation

Each MCP provides guidance to their CB-CMEs on how the HAP is structured and implemented, and how HAP data is collected and shared across the HHP care team

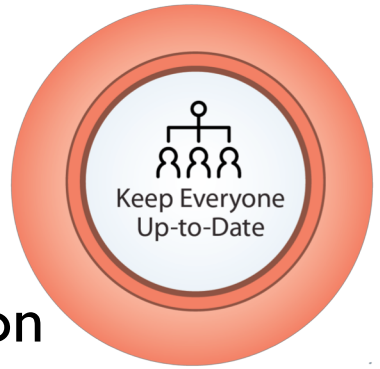
- Some members may already have a case management plan that can be adapted and used for the HAP
- CB-CMEs may already have a care coordination or case management plan template or software that can be adapted for the HAP
- Care management services are provided using communication methods that work for each member – e.g. in-person or by phone. Email and text communications are permitted, but not required

HHP SERVICES: CARE COORDINATION

Care coordination services help make ~~en~~sure that providers are on the same page as the **HAP** is implemented.

The **Care Coordinator** is the key point of contact for members and the **HHP care team** to ensure these services are provided, including:

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



HHP SERVICES: CARE COORDINATION

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

HHP SERVICES: HEALTH PROMOTION

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

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

HHP SERVICES: COMPREHENSIVE TRANSITIONAL CARE

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

- Collaborating, communicating, and coordinating with all providers and care settings
  - e.g. emergency department, hospital inpatient facility, residential/treatment facility, mental health facility, skilled nursing facility, incarceration facility, other treatment centers
- Sending a summary of care record or discharge summary to providers and care settings

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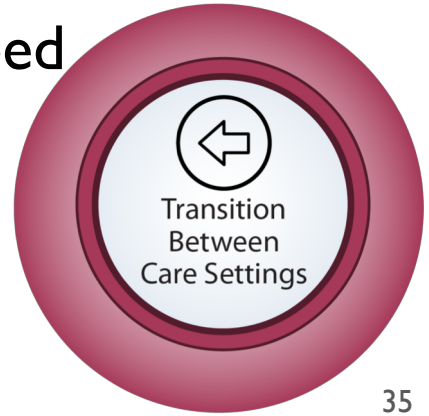
HHP SERVICES: COMPREHENSIVE TRANSITIONAL CARE

- Planning timely follow-up appointments with outpatient and/or community providers and arranging transportation as needed
- Educating members on self-management, rehabilitation, and medication management
- Planning appropriate care and social services post-discharge, including a place to stay
- Developing and facilitating the transition plan, evaluating the need to revise the HAP, and preventing and tracking avoidable admissions and readmissions
- Providing transition support to permanent housing



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HHP SERVICES: MEMBER & FAMILY SUPPORTS

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

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

HHP SERVICES: MEMBER & FAMILY SUPPORTS

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

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HHP SERVICES: REFERRAL TO COMMUNITY & SOCIAL SERVICES

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

- Identifying community and social service needs and community services/resources
- Identifying resources and eligibility criteria for programs, including for housing, food security and nutrition programs, employment counseling, child care, and disability services, as needed

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HHP SERVICES: REFERRAL TO COMMUNITY & SOCIAL SERVICES

- Helping members obtain and maintain housing
- Actively engaging with appropriate referral agencies and other community and social supports
- Routinely following up with both members and organizations to ensure needed services are obtained

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HHP SERVICES: REFERRALS TO COMMUNITY & SOCIAL SERVICES

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

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

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HHP SERVICES: REFERRALS TO COMMUNITY & SOCIAL SERVICES

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

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

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INFORMATION SHARING & REPORTING

Information Sharing Across Entities

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

Reporting

- MCPs are required to report data on enrollment utilization, costs, and health care quality measures established by CMS

PAYMENT INFORMATION

- HHP payments are made directly from DHCS to the MCPs through capitation rates (a set amount per-member, per-month)
- MCPs negotiate individual contracts and payment terms with CB-CMEs and other providers to deliver HHP services such as care coordination and housing navigation
- Payment terms with CB-CMEs and other providers may be a per-member, per-month rate or a fee-for-service payment, and may vary by provider

HHP IS PHASED IN BY COUNTY

Groups	Counties	Phase 1 Implementation date for members with eligible chronic physical conditions and substance use disorders	Phase 2 Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Fresno • Imperial • Kern • Los Angeles • Sacramento • San Diego • Santa Clara • San Mateo • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

Updated as of March 2019

INFORMATION & RESOURCES

DHCS Health Homes Website – bit.ly/HealthHomes

- Program Overview
- Outreach & Education Materials
- Trainings & Program Resources

Questions? Comments?
Email hhp@dhcs.ca.gov