Health Homes for Patients with Complex Needs (HHP)

Stakeholder Webinar - Concept Paper Version 2.0

April 15, 2015

Webinar Overview

- **Welcome and Introductions**
- HHP Interaction with Other Current Initiatives
- Background
- CA Service Model
- Additional Program Elements and Timeline
- Questions & Answers

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ACA Section 2703

Creates the new **health home** optional Medicaid benefit:

- For intensive care coordination for people with chronic conditions
- The new benefit includes a package of six care coordination services, but does not fund direct medical or social services
- 90% federal funding for eight quarters, and 50% thereafter

AB 361 – enacted in 2013

- Authorizes implementation of ACA Section (§) 2703:
  - Provides flexibility in developing program elements
  - Requires DHCS complete a health home program evaluation within two years after implementation
  - Requires that DHCS implement only if no additional General Fund moneys will be used
- Requires inclusion of a specific target population of frequent utilizers and those experiencing homelessness
- For the target population, the program must include providers with experience serving frequent hospital/ED users and homeless members

CA HHPCN Policy Goals

Better Care

- Improve care coordination
- Integrate palliative care into primary care delivery
- Strengthen community linkages within health homes
- Strengthen team-based care, including use of community health workers/promotores/other frontline workers

Better Population Health

- Improve health outcomes of people with multiple chronic diseases

Lower Cost

- Achieve net cost savings (avoidance) within 18 months

Additional Medi-Cal Objectives

1. Ensure sufficient provider infrastructure and capacity to implement HHPCN as an entitlement program
2. Ensure that health home providers appropriately serve members experiencing homelessness
3. Increase integration of physical and behavioral health services
4. Create synergies with the Coordinated Care Initiative (CCI) in the seven participating counties
5. Maximize federal funding while also achieving fiscal sustainability after eight quarters of federal funding

DHCS Goals

- **Focus Program on High-Cost Beneficiaries with Chronic Conditions** to allow for increased care coordination across Medi-Cal for eligible beneficiaries
- **Wrap Increased Care Coordination Around Existing Care** in order to provide increased care coordination as close as possible to the current point of care delivery for each beneficiary

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Eligibility Overview

- 2703 eligibility categories
  - 2 or more chronic conditions
  - 1 condition and at risk of a second
  - Serious mental illness (SMI)
- All age groups
  - Cannot exclude children or dually eligible beneficiaries
- All Medicaid categorically-needy beneficiaries
  - DHCS will include the ACA Optional Expansion population at 100% federal match

The Health Home Population

- AB 361 and the DHCS proposal focus on:
  - Frequent utilizers of health services
  - Chronic conditions that are likely to be responsive to intensive care coordination
  - Goals of reducing inpatient stays, ED visits, and negative health outcomes, and improving patient engagement
- Individuals with mental health and/or SUD conditions, and individuals who experience chronic homelessness will be included in the program
- Whole-person care will include coordination of physical health, behavioral health, community-based LTSS, palliative care and linkages to social supports, such as supportive housing

HHP Target Conditions

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

Beneficiary Acuity

- Beneficiary eligibility will be determined by
  1) Target conditions, and
  2) Acuity level as determined by risk analysis software or utilization data
- Beneficiary acuity and intensity of service needs will inform tiering of services and payments
- For beneficiaries who are experiencing chronic homelessness, HHP will have specific requirements to address their unique needs

Eligibility Criteria Determination

- DHCS is analyzing a Medi-Cal data set to identify the eligibility criteria that match all beneficiaries who have:
  - Avoidable negative health outcomes, and
  - Conditions and social determinants of health that can be better managed through HHP services
- The goal is to identify the eligibility criteria that can be used to identify HHP eligible beneficiaries through administrative data
- A technical workgroup will be convened to further develop the topics related to beneficiary eligibility

Health Home Services

- Each state defines the core services:
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care
  - Individual and family support
  - Referral to community and social support services
  - The use of HIT/HIE to link services, as feasible and appropriate
- Definitions are in the DHCS Concept Paper Version 2.0

Health Home Services

- DHCS is assessing the care coordination currently provided in Medi-Cal:
  - What would have to be added to complete the health homes benefit
  - There can be no duplication of care coordination services or payment across Medi-Cal and the HHP
- In addition to medical coordination, other potential focus areas are:
  - Mental health and substance use disorder services
  - Services for homeless members, including linkages to supportive housing
  - Coordination and referral for palliative care services

Role of Managed Care

- California's managed care infrastructure is a critical building block to the HHP
  - FFS beneficiaries that meet HHP eligibility will have the choice to enroll in managed care and receive HHP services
  - Managed care serves approx. 85% of full scope beneficiaries and is available statewide
  - Provider networks, communication and reporting capabilities, and relationships with county mental health plans (MHP) will be leveraged in the HHP

HHP Network Infrastructure

- HHP network will provide whole-person care coordination, key team members include:
  - Medi-Cal managed care plans (MCP) and CalMediConnect Medicare-Medicaid plans (MMP),
  - Community based care management entities (CB-CME), and
  - Community and social support services
- Must meet CMS health home functional requirements
- A technical workgroup will be convened to further develop the topics related to HHP network

CA Health Home Network

MEDI-CAL MANAGED CARE PLANS (MCPs)

Mandatory: MCP and MMP in target HHP counties
Optional: MHP and county integrated MH/SUD plans in target HHP counties

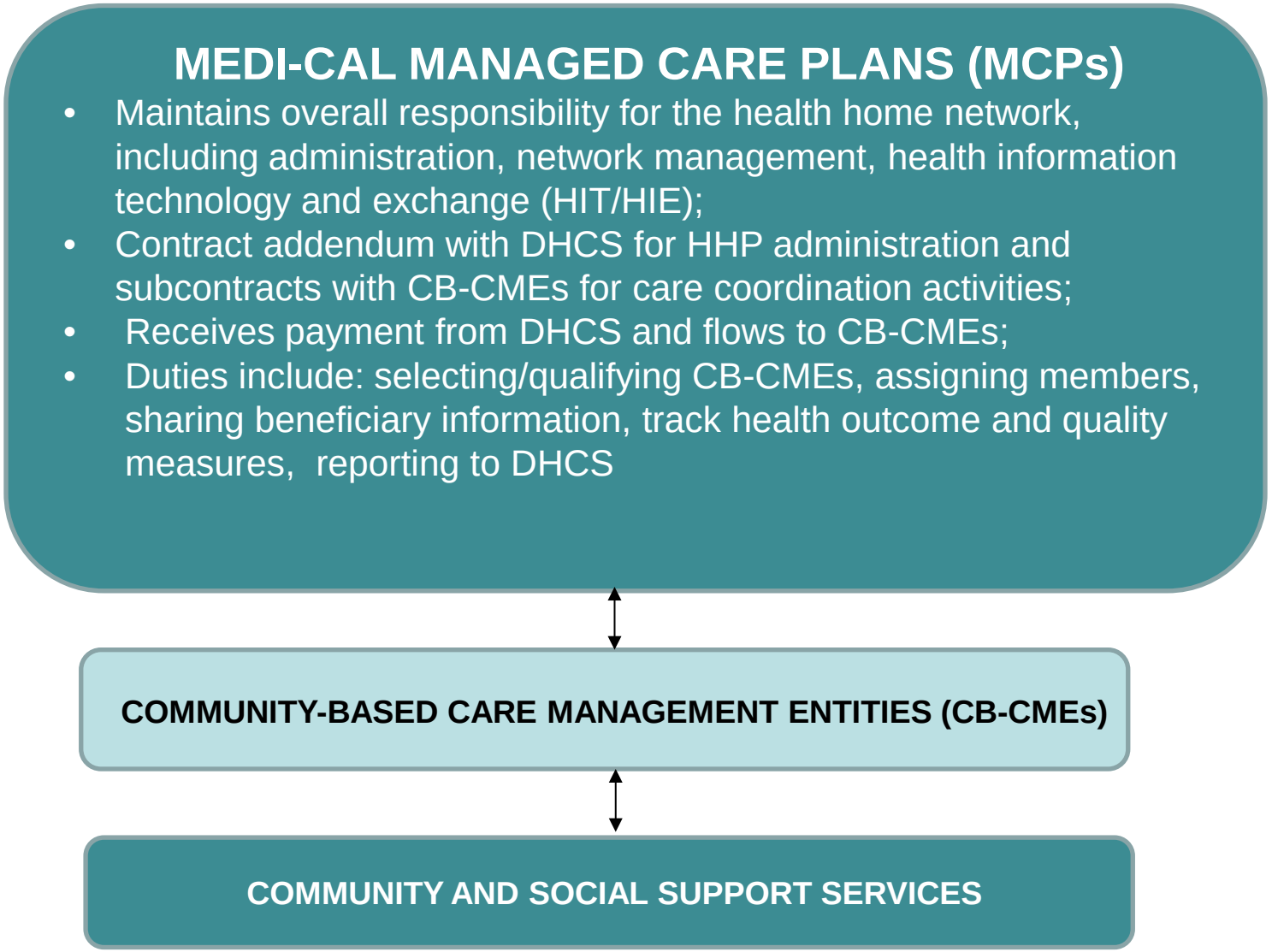
COMMUNITY-BASED CARE MANAGEMENT ENTITIES (CB-CMEs)

Qualifying organizations include: Community health centers, community mental health centers, hospitals, local health departments, primary care or specialist physician or group, SUD treatment providers, providers serving individuals experiencing homelessness or those diagnosed with HIV/AIDS, or other organizations who meet CB-CME requirements and are selected by the MCP

COMMUNITY AND SOCIAL SUPPORT SERVICES

Sample organizations could include supportive housing providers, food banks, employment assistance, social services

CA Health Home Network



MCP Overview

- Responsible for overall administration of the health home network and will have a HHP addendum to existing DHCS contract
- HHP participation is mandatory for MCPs
- HHP participation is optional for:
  - Medi-Cal county specialty mental health plans (MHPs)
  - Medi-Cal county integrated MH/SUD plans (Drug Medi-Cal organized delivery system demo participants)

MCP Qualifications

- Authority to access Medi-Cal claims data for eligible population,
- Adequate network of CB-CMEs in HHP target counties,
- Capacity to support CB-CMEs, including:
  - Identify and qualify partner organizations
  - Sharing health information as appropriate
  - Providing tools and processes to support effective delivery of HHP services

MCP Certification

- DHCS will ensure MCPs meet HHP qualifications via an initial certification as well as readiness review before implementation
- DHCS will incorporate MCP responsibilities in contracts and provide guidance for development of HHP operational policies established by MCPs

MCP Duties

- Responsible for overall administration of HHP network, including:
  - Assign members, track and share beneficiary information with subcontracted CB-CMEs,
  - Support CB-CMEs in their frontline care coordination activities,
  - Receive payment and flow to CB-CMEs with collection of claims;
  - Track quality and financial measures, health status and other measures for evaluation
- See concept paper for detailed list of duties

CA Health Home Network

MEDI-CAL MANAGED CARE PLANS (MCPs)

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COMMUNITY-BASED CARE MANAGEMENT ENTITIES (CB-CMEs)

- Responsible for providing the core health home services:
  - ✓ Comprehensive care management
  - ✓ Care coordination (physical health, behavioral health, community-based LTSS) and health promotion
  - ✓ Comprehensive transitional care
  - ✓ Individual and family support
  - ✓ Referral to community and social support services
  - ✓ Use of HIT/HIE to link services
- Must qualify and have contract with a MCP to serve as CB-CME
- Rooted in the community and able to provide in-person care management
- Oversees the development and implementation of the Health Action Plan
- Responsible for the multi-disciplinary health home team
- Communicates with beneficiaries' other Medi-Cal providers to ensure whole person care coordination
- Makes referrals to community partners for non-Medicaid funded services

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COMMUNITY AND SOCIAL SUPPORT SERVICES

CB-CME

- CB-CME serve as frontline provider of HHP and will be rooted in the community
- MCP will certify, select and contract with partner orgs to serve as CB-CMEs
- DHCS will provide general guidance on requirements of this HHP partnership
- HHP to provide flexibility in how CB-CME are organized to best provide services to beneficiaries

CB-CME (con't)

- MCP goals for CB-CME network development:
  - Ensure care management and related funding is provided at the point of care in the community,
  - Ensure providers with experience serving frequent utilizers, people experiencing homelessness, and people diagnosed with HIV/AIDS are available as needed,
  - Leverage existing local care management infrastructure where possible/appropriate,
  - Utilize community health workers in appropriate roles

CB-CME Qualifications

- Must have experience with Medi-Cal population and engaged organizational leadership committed to HHP activities,
- Ability to provide in-person HHP care coordination and HHP services, as needed
- Oversee development and implementation of beneficiary's Health Action Plan (HAP),
- Coordinate with hospitals and beneficiary's other providers to provide whole person care coordination

CB-CME Certification

- MCP will select and certify entities that meet required qualifications and duties of CB-CME
- List of organization types that may meet the certification in the concept paper – a broad list
- Other entities who meet qualifications may also serve as CB-CMEs if selected and certified by the MCP

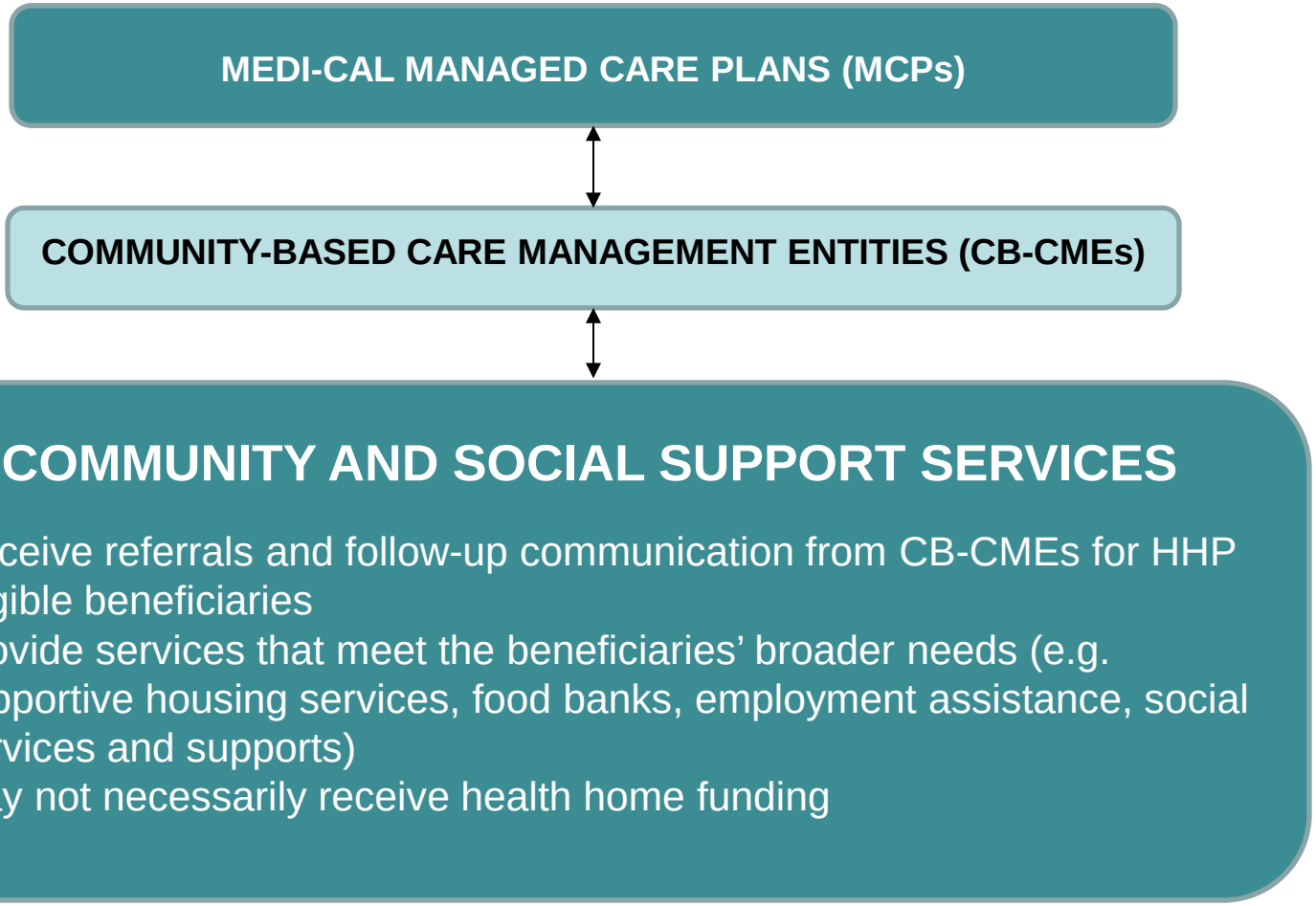
CB-CME Duties

- CB-CMEs are responsible for overall care management, including:
  - Care team staffing/training; reporting to MCP,
  - Drives all activities relating to the HAP,
  - Coordinate with other entities, conducting case conferences as needed to ensure care is integrated among providers,
  - Manage and follow up on referrals and include family in care planning and transitions,
  - See concept paper for detailed list of duties

Multi-Disciplinary Team

- CB-CME will employ a multi-disciplinary team to provide HHP services, including:
  - Dedicated care manager
  - HHP director
  - Clinical consultant(s)
  - Community health workers
  - Housing navigator (for beneficiaries experiencing chronic homelessness)
- Additional team members may be included in order to meet an individual beneficiary's care coordination needs

CA Health Home Network



Beneficiary Assignment

- DHCS will supply eligibility criteria and tiering methodology to ensure consistency across HHP networks
- DHCS or MCPs will use administrative utilization data to identify eligible beneficiaries and MCPs will link them to a CB-CME, notifying them by letter or other engagement methods
- HHP participation is voluntary and beneficiary can opt out at any time
- Engagement of eligible beneficiaries will be critical for program success

Beneficiary Assignment (con't)

- Providers may refer potentially eligible individuals to the beneficiary's MCP to confirm if they are eligible for HHP
- If eligible, MCP will then assign to a CB-CME, CB-CME must have prior approval to provide HHP to referrals
- Consent will be secured by the CB-CME care manager during initial visit with the HHP beneficiary
- Beneficiary may be discharged from HHP if certain engagement or participation criteria are not met

Payment Methodology

- Payment methodology intended to include three tiers based on patient acuity; payment rates to MCPs to be developed according to this methodology
- Payments would flow through the MCPs to qualified CB-CMEs; rate setting and contracts to be developed between these entities
- Payment will recognize the effort required to engage identified eligible members
- At least one core service must be provided each quarter in order for payment to be made to the health home

Reporting

- CMS established a recommended core set of eight health care quality measures that align with existing core sets for adults and children
- CMS also identified three utilization measures to assist with the overall federal health home evaluation
- DHCS will track state-specific quality measures related to HHP; leveraging existing managed care evaluation tools for consistency, when possible
- DHCS will also contract with an external evaluator prior to the start of the program to provide measurement and evaluation activities to the HHP

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Interaction with Existing Medicaid Programs

- Mental Health and Substance Use Disorder
- Targeted Case Management / 1915 C Waiver
- 1115 Waiver Renewal

HHP Timeline

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8/14 – 1/16	Ongoing stakeholder engagement
4/15 – 7/15	Consultation with federal authorities (SAMHSA and CMS) on HHP model
8/15	Formal State Plan Amendment (SPA) submission to CMS
7/15-12/15	Begin provider technical assistance, build health home networks, and prepare for program implementation
10/15-12/15	CMS approval of 2703 SPA
1/16	Begin operating HHP (SPA effective date for enhanced match purposes)
12/17	End of 8 quarters of enhanced match for first SPA

Current Status of Implementation

- State planning two phases:
  - January 2016 - Coordinated Care Initiative (CCI) counties and potential other counties that are ready
  - July 2016 – Remaining counties that demonstrate readiness for HHP
- Entities will need to demonstrate HHP readiness; DHCS plans to develop the readiness evaluation tool soon

Provider Technical Assistance

- TA for HHP providers through multiple modalities, given funding availability
- Development of tool to conduct organizational assessments of potential CB-CME partners
- Two levels of TA:
  - Existing CB-CMEs (e.g. care coordinator training, learning network to share best practices)
  - Selective intensive training of organizational leaders to set up new health home programs

Program Evaluation

- HHP evaluation within two years of implementation, as required by AB 361
- External evaluator will be hired to monitor, evaluate and report on HHP to inform decisions related to fiscal sustainability and impact of Triple Aim goals

Stakeholder Engagement

- DHCS received great stakeholder input from the November webinar and concept paper release;
  - DHCS has been meeting with various stakeholders on specific areas of HHP for the last several months.
- DHCS will continue stakeholder events between April and SPA submission in August to solicit feedback on the program evolution
  - Technical workgroups
  - Stakeholder comments on concept paper

Technical Workgroups

- 2-4 technical workgroups, addressing:
  - Network Development (qualifications and duties of MCP and CB-CME)
  - Care Management Model and Providers
  - Program tools (assessments, HAP, reporting requirements)
  - Fiscal Impacts (eligibility criteria, tiering, staffing ratios)
- Additional meeting to address program components for individuals experiencing homelessness

Stakeholder Engagement Contacts

- Visit the DHCS Health Home web page http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx for:
  - DHCS HHP concept paper and recording of today's webinar (forthcoming)
- Please contact us via the DHCS Health Home mailbox HHP@dhcs.ca.gov to:
  - Send comments/questions or to ask to be included in future notices of stakeholder engagement opportunities

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