California's Health Homes Program

HPSM Network Webinar

9/05/18

Goals for Today:

- Health Homes Program overview
- CB-CME requirements
- Program readiness and implementation timeline
- Gather take-away questions and discuss next steps
  - Readiness survey
  - Reach out to get involved

Key Takeaways:

1. Health Homes Program goals
2. New/different work is required! (with funding support)
3. You could be involved

Topics Covered

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- What is the Health Homes Program?
  - The Role of MCPs and CB-CMEs
  - Team Roles and Responsibilities
  - Staffing Model Options
  - Six Core Services
  - Eligibility and Enrollment
- Information Sharing and Reporting
- Payment
- Readiness and Implementation Timeline
- Next Steps

What is the Health Homes Program?

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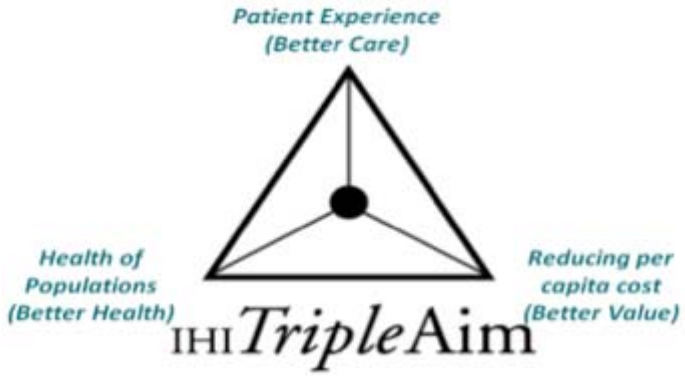
- The **Medi-Cal** Health Homes Program is a new program that provides extra care coordination services to certain Medi-Cal patients with complex medical needs and chronic conditions.
- Patients have their own **care coordinator** and **care team** to coordinate their physical and behavioral health care services and link them to community services and housing, as needed.
- Patients stay enrolled in their Medi-Cal Plan and continue to see the same doctors, but now have an extra layer of support.
- These new services are free as **part of their Medi-Cal benefits**.
- Community-Based Care Management Entities (**CB-CMEs**) will be primarily responsible for delivering HHP services.

Primary HHP Goals:

- Enhanced care coordination and linkages to social support
- Improve self-management/advocacy
- Improve quality outcomes
- Increase access for needed services
- Inherently reduce cost by achieving all of the above



HHP Six Core Services

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Members receive the following sets of 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 Supports

What is a CB-CME?

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Community-Based Care Management Entities (CB-CMEs)

- Community-based entity that ensures HHP members receive HHP services.
- Ideally, the CB-CME will be the member's assigned primary care provider (PCP) so that care coordination services are provided close to the point of care. (This will not always be the case based on our county network structure.)
- If the CB-CME is not the member's assigned PCP, HPSM and the CB-CME will work together to coordinate and collaborate with the PCP on care management for the member, including sharing relevant information.

Who can be a CB-CME?

- **Designated HHP Provider**: Can be a physician, clinic/group practice, rural health clinic, community health/mental health center, home health agency, pediatrician, OB/GYN, or other provider
- **HHP Care Team**: Can include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals
  - Can be free-standing, virtual, hospital-based, or a community/mental health center
- **CB-CME Health Team**: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractics, licensed complementary or alternative practitioners

Who qualifies for HHP enrollment?

Members must have:

1. Medi-cal coverage and be enrolled in a Medi-Cal plan (HPSM, not FFS Medi-Cal)
2. Have certain chronic health conditions i.e. asthma, diabetes, heart failure, etc.
3. Have been in the hospital, had ED visits, or be chronically homeless

Eligibility and Enrollment

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

- ✔ At least two of the following: chronic obstructive pulmonary disease (COPD), 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 disorders, bipolar disorder, or psychotic disorders (including schizophrenia).
- ☐ Asthma.

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

- ☐ Has three or more of the HHP-eligible chronic conditions.
- ✔ Has stayed in the hospital in the last year.
- ☐ Has visited the emergency department three or more times in the last year.
- ☐ Has chronic homelessness.

Eligibility and Enrollment

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Three ways for members to join:

1. HPSM or CB-CME will attempt to contact their eligible members to discuss the program, including through mail, calls, and/or in-person outreach.
2. Providers can refer members by submitting a referral to the HPSM.
3. Members can self-refer by asking HPSM if they can join the program.

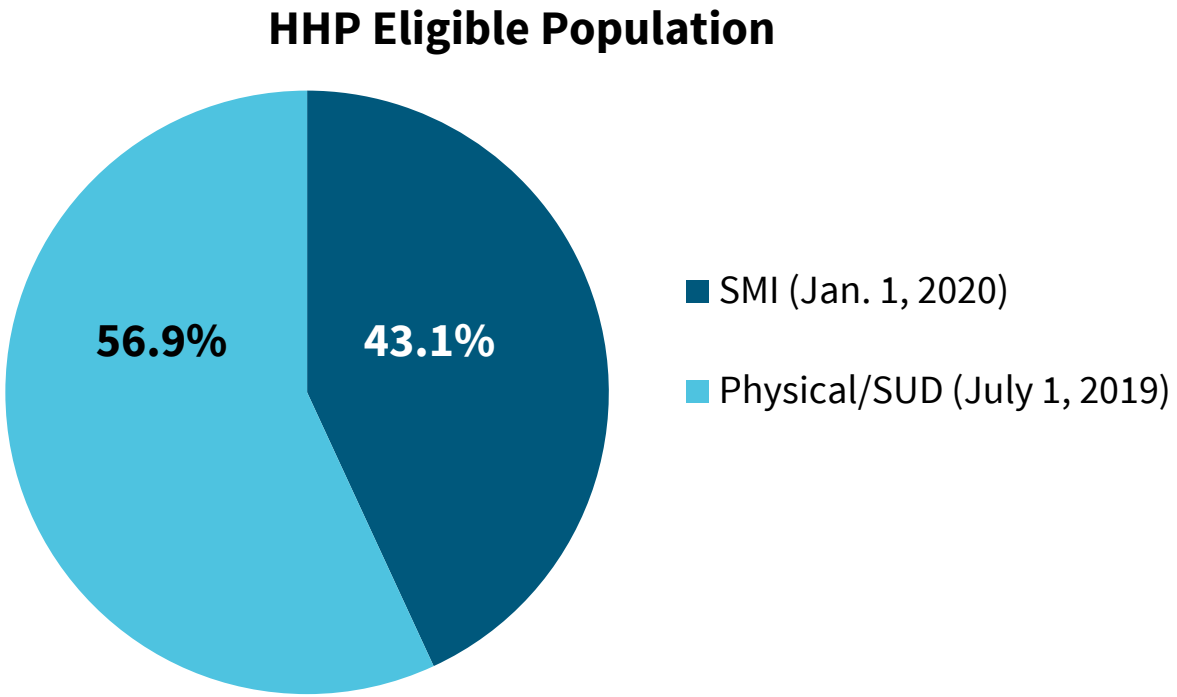
Please note:

- Members must consent to be enrolled in the HHP program.
- A patient must be a member of HPSM to join the program.
- Fee-for-Service (FFS) members who meet the eligibility criteria can enroll in HPSM to receive HHP services.

General HHP Eligibility Stats

- Total Eligible: 5170
- Physical/SUD (**July 1, 2019**): 2942
- SMI (**Jan. 1, 2020**): 2229
- **4.85% total Medi-Cal membership**
- 76 PCP panels with eligible members (77.6% MC PCP network)
- Average PCP panel eligibility: 4.78% {0.45% - 20%}
- Median PCP panel eligibility: 3.36%

HHP Eligible Population (Preliminary)



General HHP Eligibility Stats

- Homeless population: 943 (18.24%)
  - Physical/SUD: 401 (7.76%)
  - SMI: 542 (10.48%)

Members Enrolled in HHP and Other California Programs

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

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

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

General HHP Eligibility Stats: Other Programs

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- Whole Person Care: 780 (15.09%)
  - Physical/SUD: 246 (4.76%)
  - SMI: 534 (10.33%)
- LTSS: 283 (5.48%)
  - Physical/SUD: 144 (2.79%)
  - SMI: 139 (2.69%)
- Whole Child Model (formerly CCS): 86 (1.66%)
  - Physical/SUD: 67 (1.3%)
  - SMI: 19 (0.44%)

Members Enrolled in HHP and Other California Programs

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Members must choose HHP **OR**:

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

Members **can't** receive HHP services if they are:

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

Eligibility and Enrollment

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When talking to members about the HHP, consider sharing the following messages:

- You receive extra support for free as part of your Medi-Cal benefits.
- You can keep your doctors and you can get connected to other doctors you might need.
- You will have a care coordinator who supports you and your care team. They make sure everyone is on the same page about your health care and community support needs.
- To receive HHP services, you must be eligible based on needing extra help with your health.
- Nothing else about your Medi-Cal benefits will change.

HHP Six Core Services

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Members receive the following sets of services:

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HHP Services:
Comprehensive Care Management

Implementation of the Health Action Plan (HAP)

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

HHP Services: Care Coordination

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

- Helping the member navigate, connect to, and communicate with health, behavioral health, and social service systems, including housing.
- Sharing options for accessing care and providing information regarding care planning.
- Monitoring and supporting treatment adherence, including coordinating medication management and reconciliation.
- Monitoring referrals to needed services and supports, as well as coordination and follow-up.
- Facilitating transitions among treatment facilities, including admissions and discharges, and reducing avoidable hospital admissions and readmissions.
- Sharing information with all involved parties to monitor the member's conditions, health status, medications and any side effects.
- Accompanying members to critical appointments.

HHP Services: Health Promotion

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

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

HHP Services:
Comprehensive Transitional Care

Facilitate transitions between treatment facilities, including admissions and discharges, to reduce avoidable hospital admissions and readmissions, such as:

- Collaborating, communicating, and coordinating with all involved parties.
- Sending a summary of care record or discharge summary to all involved parties.
- 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 Health Action Plan, and preventing and tracking avoidable admissions or readmission.
- Providing transition support to permanent housing.

HHP Services:
Member and Family Supports

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

- Assessing strengths and needs of members and the family and/or support team and promoting engagement in self-management and decision-making.
- Linking members to self-care programs and peer supports to help them understand their condition and care plan.
- Determining when members are ready to receive and/or act upon information provided and assist them with making informed choices.
- Helping members identify and obtain needed resources to support their health goals.
- Accompanying members to clinical appointments when necessary.
- Evaluating the family and/or support team's needs for services.

HHP Services:
Referrals to Community and Social Supports

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

- Identifying community and social support needs and community resources.
- Identifying resources and eligibility criteria for programs, including housing, food security and nutrition programs, employment counseling, child care, disability services, as needed.
- Actively engaging with appropriate referral agencies and other community and social supports.
- Linking to housing transition services and tenancy sustaining services.
- Routinely following up to ensure needed services are obtained.

CB-CME Team Roles and Responsibilities

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Core Care Team (can include HPSM 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 monitoring treatment adherence
- **Health Homes Program Director**
  - Oversees management and operations of the team
  - Oversees reporting for the team, including quality measures
- **Clinical Consultant**
  - Reviews and advises on HAP
  - Serves as a clinical resource and assists care coordinator, as needed

Team Roles and Responsibilities

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

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

Community-Based Organizations (CBOs)

- Care team will identify community and social supports already in place for a patients as well as their unmet needs.
- As needed, the team will link them to CBOs providing social services and housing, and work with CBO community supports that are already in place.

Staffing Model #1

HPSM will design optimal care management model for our network

Each plan has flexibility to choose a care management model, which determines where care management services are provided and by whom. No matter which model is used, the care coordinator and care team's roles and responsibilities remain consistent.

Model 1: The CB-CME is on-site at a community health care provider

- 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 will be the member's MCP-assigned PCP.
- The community provider, such as a large primary care practice or clinic, will usually employ the CB-CME staff to provide care coordination and housing navigation.
- In limited circumstances, some care coordination staff could be MCP employees but housed at the community provider location.

Staffing Model #2

These models will serve a smaller number of members who see providers with a small volume of HHP patients, and thus cannot receive CB-CME services through their assigned PCP.

Model 2: Care management services provided by a community-based entity, HPSM or third party provider

- This model is designed for members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site.
- The CB-CME will be 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.

Information Sharing and Reporting

Reporting Requirements: HPSM is required to report data on enrollment, utilization, costs, and the quality of care provided across the care team to help DHCS and CMS evaluate the HHP.

1. **Program eligibility and enrollment**

   Number of members eligible for HHP, number of members they/CB-CMEs are actively seeking to engage, and number of members participating in the HHP, by category of aid code per month.

2. **Costs and utilization**

   Number of services/visits/units (for each type of HHP service) and associated costs by category of aid code.

3. **Quality of Care**

   Program partners, including CB-CMEs, must submit reports on certain measures.

Reporting: Enrollment/Engagement

Health Homes Program Measures

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

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

Reporting: Encounters/Utilization

HHP Service Codes

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Clinical Staff	G0506	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G0506	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G0506	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G0506	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G0506	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G0506	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G0506	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Reporting: Quality/Utilization Metrics

Health Homes Program Measures

CMS Core Set Measures
Adult Body Mass Index (BMI) Assessment
Screening for Clinical Depression and Follow-Up Plan*
Plan All-Cause Readmission Rate
Follow-Up After Hospitalization for Mental Illness
Controlling High Blood Pressure*
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite
CMS Utilization Measures
Ambulatory Care — Emergency Department Visits
Inpatient Utilization
Nursing Facility Utilization

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

Information Sharing and Reporting

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Information Sharing Across Entities

- For care management activities to be successful, the entire HHP care team must be able to share and access information about a patient's services and care.
- HPSM will establish and maintain data-sharing agreements with HHP partners.
- Providers are encouraged to use technology to ensure timely, accurate, and secure sharing of information.

Payment Information

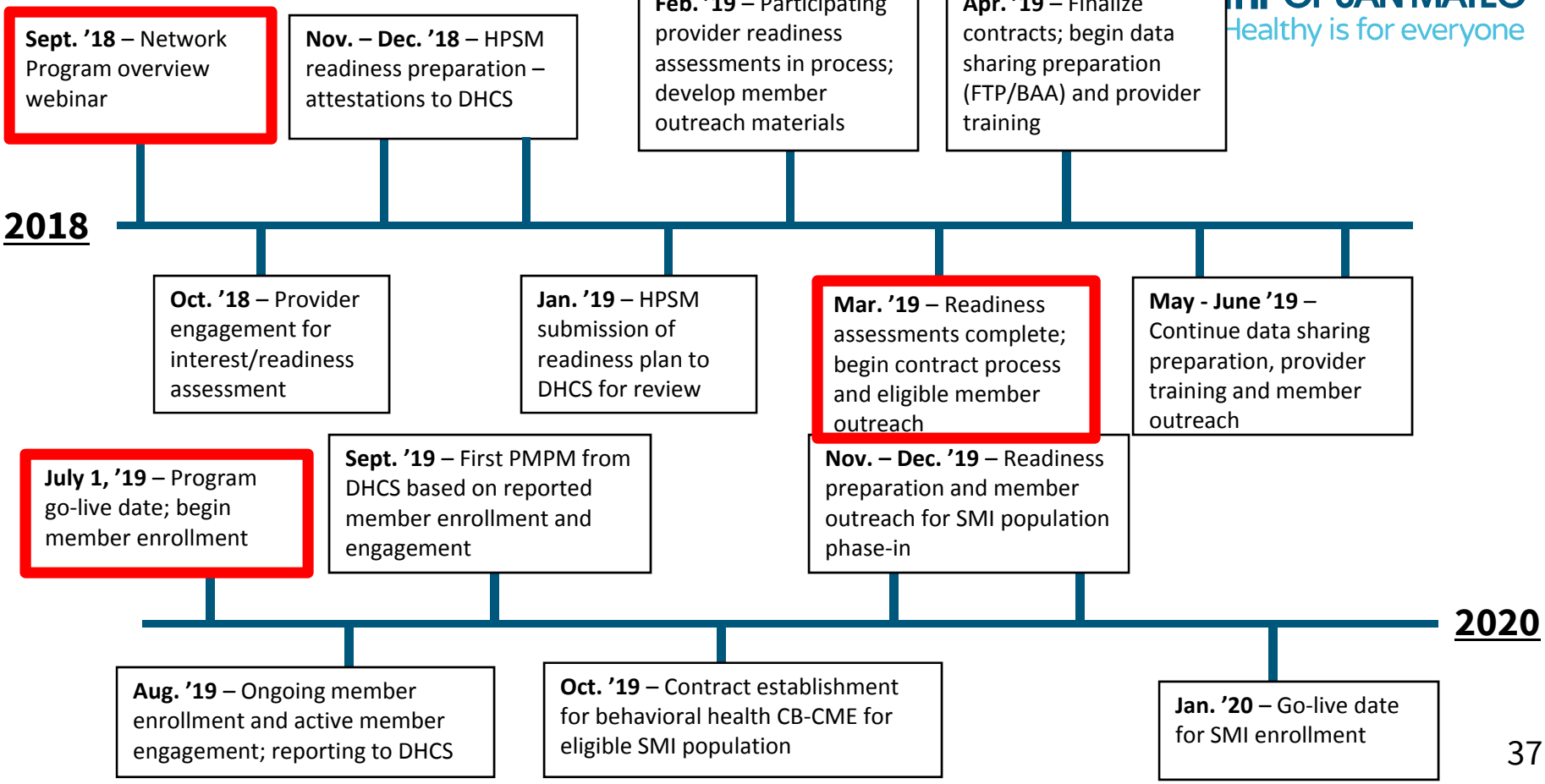
Payments

- HHP payments are made directly from DHCS to HPSM through capitation rates (a set amount per member, per month).

- HPSM will establish individual contracts and payment terms with CB-CMEs and other providers to ensure the delivery of HHP services.

- HPSM and the CB-CME or other providers will determine payment terms. Payment terms may be a per member, per month rate or a fee-for-service payment, and may vary by provider.

High-level readiness/implementation timeline



HHP Opportunities:

- Natural extension of the foundation laid by the PCP Clinical Partnership – quality improvement, data reporting, team-based care model, care management re-design
- Further build up core data infrastructure and sharing across organizations i.e. HPSM, SMMC, BHRS, PCPs, CBOs
- Build out care coordinator capacity and standardize training
- Financially and programmatically support alternative patient touches

Next Steps:

- Complete preliminary readiness/capacity survey (https://www.hpsm.org/docs/default-source/provider-forms/readiness-capacity-survey-for-potential-cb-cme-partners.pdf?sfvrsn=31bb2be7_10)
- Contact HPSM Provider Services Department if you are interested in participating in the program: https://www.hpsm.org/Home/provider/provider-services

Links: Additional Information

- **DHCS Health Homes Program Website**: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx
- **Medicaid Program Website**: https://www.medicaid.gov/medicaid/ltss/health-homes/index.html
- **HPSM Program Website**: https://www.hpsm.org/provider/care-coordination/health-homes
- **DHCS one-page program summary**: http://www.dhcs.ca.gov/services/Documents/MCQMD/HHP_Overview_7-2018.pdf

Key Takeaways:

1. Health Homes Program goals
2. New/different work is required! (with funding support)
3. You could be involved

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Questions/Discussion

Thank You

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