Health Homes for Patients with Complex Needs (HHPCN)
California Concept Paper
DRAFT 11/17/14

The purpose of this paper is to share DHCS's proposed concept for the Affordable Care Act (ACA) Section 2703 health homes with the California stakeholder community in order to seek questions and comments that will inform further development of the model.

Background

The Medicaid Health Home State Plan Option, authorized under ACA Section 2703, allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by beneficiaries with chronic conditions. Federal matching funds are available for two years at 90%, and, if implemented in California, The California Endowment (TCE) has offered to fund the remaining 10% of funds (up to $25 million per year) required for these additional services for that same two year period. Assembly Bill 361 (AB361), enacted in 2013, authorized California to submit a Section 2703 application, subject to several conditions, including cost neutrality and an evaluation after the first two years.

Through a complementary planning process, the California State Innovation Model (CalSIM) initiative, developed a recommendation to create "Health Homes for Patients with Complex Needs" (HHPCN). This HHPCN is one of four initiatives in the CalSIM Testing application that California made to the Center for Medicare and Medicaid Innovation (CMMI). These initiatives are multi-payer. Highlights of the testing grant application are included in the attached webinar slides. Approval of the testing grant application is expected to be announced in the fall of 2014.

In collaboration with the CalSIM initiative and with respect to the requirements of Section 2703 and California's AB 361, the state has developed a set of policy goals (see Addendum A) that will guide the planning and implementation of the HHPCN.

Key Components of HHPCN

Medi-Cal intends to submit a Section 2703 state plan amendment (SPA) application in summer/fall of 2015, which would provide federal regulatory authority for implementing the HHPCN model for Medicaid beneficiaries. HHPCN has several key components, which are outlined below.

Target Population

Per federal requirements, states can choose to define one or more of the following groups of eligible individuals for Section 2703 health home enrollment:

1. Individuals with two or more chronic conditions;
2. Individuals with one chronic condition and at risk for another;
3. Individuals with serious and persistent mental illness.

HHPCN will target all three categories for health home eligibility with an emphasis on persons with high-costs, high-risks, and high utilization who can benefit from increased care coordination of physical health, behavioral health, community-based LTSS and social supports, resulting in reduced hospitalizations and emergency department (ED) visits, improved patient engagement and decreased costs. Specific eligible conditions have not yet been finalized; however, the following list of eligible chronic conditions (see Table 1) is being used to develop estimates of the eligible population and their current health care costs.

Table 1: Eligible Chronic 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	Substance Use Disorder Major Depression Bipolar Disorder Anxiety Disorder Psychotic Disorders (including Schizophrenia) Personality Disorders Cognitive Disorders Post-Traumatic Stress

The state will develop the overall eligibility criteria; either the state or the health plans will use these criteria to determine individual eligibility. Providers may have an ability to refer individuals into the eligibility determination process that is run by the state or the plans. DHCS also anticipates health home enrollment will follow an opt-out approach, with eligible individuals being assigned to a health home provider and given the opportunity to choose not to participate in this voluntary program.

Health home services must be made available to all categorically-needy Medi-Cal enrollees who meet the eligibility criteria. DHCS plans to include all full scope Medi-Cal enrollees, including the Medicaid expansion aid category for patients who meet the eligibility criteria of HHPCN. For the individuals eligible via the Medicaid expansion, the state will receive 100% federal match (gradually decreasing to 90% in 2020) rather than the enhanced federal match of 90% during the first eight quarters.

Acuity

DHCS anticipates that eligibility criteria will be based on: a) targeted conditions, and b) specified acuity level as determined by risk analysis software and/or administrative utilization data. Patient acuity and intensity of service needs will inform tiering of services and payment.

In addition, anyone who has the qualifying chronic conditions and is also chronically homeless will have specific provider requirements for care management that would otherwise be unnecessary for those who are already stably housed.

Geographic Phasing Considerations

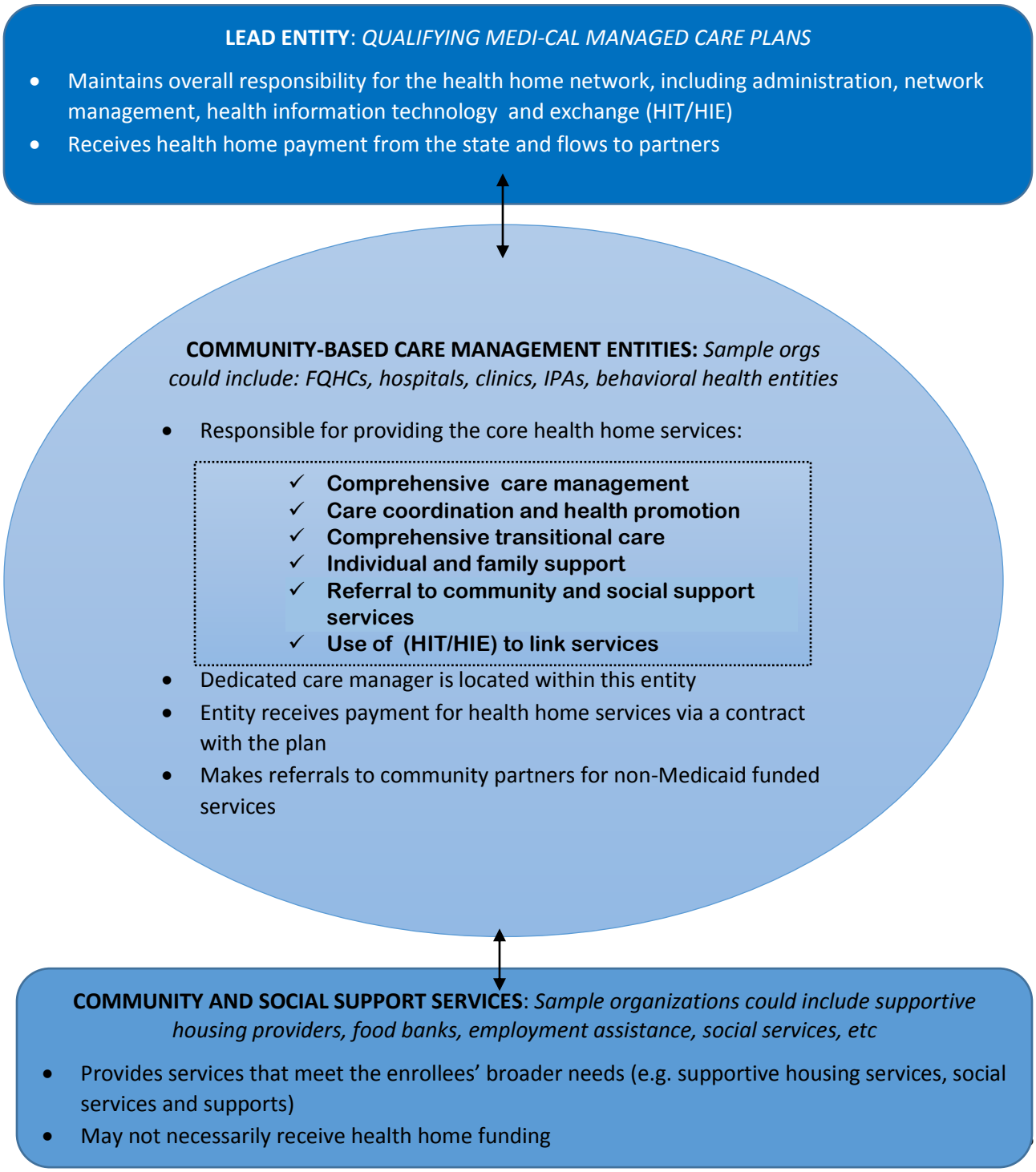
The state will likely roll out health homes in a phased approach, starting with the Coordinated Care Initiative (CCI) counties (see Table 2). CCI counties are being targeted for the HHPCN initiative given that dually eligible individuals are already enrolled in managed care plans and providers in those counties already have experience with higher care coordination standards, enhanced coordination with behavioral health and community-based LTSS, and an established Medicare shared savings arrangement.

Table 2: Potential HHPCN Geography Roll-Out

Date	County
January 2016	CCI counties as readiness allows
July 2016	Remaining CA counties as readiness allows

Health Home Network Infrastructure

Health homes as envisioned by California will be structured as a *health home network* with members functioning as a team to provider whole-person care coordination. This network would include *a lead entity, one or more community based care management entities, and community and social support services.* The care management entity must include a *dedicated care manager* assigned to each enrollee. DHCS will leverage California's existing managed care, behavioral health, and community-based LTSS system infrastructure in the implementation of health homes. A visual model of the Health Homes for Patients with Complex Needs (HHPCN) Network follows:



The *health home network* will serve as the central point for directing patient-centered care and will be accountable for:

- Reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits;
- Providing timely post discharge follow-up, and
- Improving patient outcomes by coordinating physical health, behavioral health and community-based LTSS.

This will be accomplished by the lead entity and the community based care management entity either through direct provision of health home services, or through contractual arrangements with appropriate providers who will be providing integration through care coordination and planning of heath care services.

- Qualifying Medi-Cal Managed Care Plans can serve as *health home lead entities* and must partner with one or more *community based care management entities* for the provision of health home services. The lead entity remains responsible for all health home program requirements, including services performed by the contracted health home providers. Payment for health home services will be paid by the state to the lead entity, which will then flow payment to appropriate network partners.
- *Community based care management entities* will provide care coordination and planning of the core health care services to all health home enrollees and will assign each enrollee a *dedicated care manager.*
- Care management entities will utilize *community and social support services* to facilitate referrals, provide resource information, and provide services that meet the enrollees' broader needs.
- The enrollee's health action plan will be under the direction of a dedicated care manager who is accountable for facilitating access to physical health care, behavioral health care, and community-based LTSS. In addition the dedicated care manager will provide linkages to community social supports, and coordinate with entities that authorize these services as necessary to support the achievement of individualized health action goals.
- The intensity of services provided will correspond to the need of the enrollee, and this may be formalized through program requirements in "service tiers."
- Hospitals that are part of a health home network must have procedures in place for referring beneficiaries who seek or need treatment in a hospital emergency department or inpatient department to the enrollee's qualified health home.
- DHCS will continue to explore the models for Medi-Cal beneficiaries who are receiving services for behavioral health conditions and children who are receiving services through the California Children's Services (CCS). Behavioral health service providers and the CCS delivery system must be substantially integrated into the health home model for beneficiaries who meet health home eligibility requirements and access services through behavioral health and CCS providers.

General Health Home Network Qualifications

Lead entity requirements - Qualifying managed care plans will serve as the lead entities of the health home network, and will be accountable for the administration of the health home. Some administrative functions may be able to be performed by a designee. Administrative functions could include:

- Collecting encounter data from health homes and submitting service encounters to DHCS, payment disbursement, quality monitoring, contracting, reporting;
- Collecting, analyzing and reporting financial, health status and performance and outcome measures to objectively determine progress towards meeting health home goals;
- Establishing procedures for referring any health home enrollee who seeks or needs treatment/services to a Medicaid designated provider.
- Connecting enrollees to a care management entity and dedicated care manager who can address the full breadth of clinical and social service needs for enrollees who require assistance due to complex chronic conditions, mental health and substance use disorder issues and community-based LTSS needs.
- Assembling the health home network to also include partners that provide local *community and social services* such as facilitating referrals, sharing resource information, and providing services that meet the enrollees' broader needs.

Community based care management entity requirements – Care management entities will include organizations such as FQHCs, hospitals, clinics, IPAs, and behavioral health entities. To qualify, organizations must demonstrate the ability to:

- Actively engage the enrollee in developing a Health Action Plan; this shall be done in person whenever possible;
- Reinforce and support the enrollee's Health Action Plan;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the enrollee's health action goals;
- Advocate, educate and support the enrollee to attain and improve self-management skills
- Ensure the receipt of evidence-based care;
- Support enrollees and families during discharge from hospital and institutional settings, including providing evidence-based transition planning; and,
- Accompany the enrollee to critical appointments.

Certification Process

The health home lead entity will certify care management entities through a process similar to managed care plan provider certification. DHCS will provide general guidelines and requirements and the plans will certify qualified providers to serve as partner care management entities.

Provider Education and Technical Assistance (TA)

The state will leverage a TA program designed through the CalSIM HHPCN program, with additional TA provided as needed. Programs will likely be available through multiple modalities with webinars and a learning collaborative for all health home network partners, and selective individual practice coaching for providers who serve a high volume of the target population.

Service Definitions

DHCS is assessing gaps between what Medi-Cal managed care plans and Medi-Cal behavioral health service providers currently provide and the services required under the health home provision. In the coming months, DHCS will finalize the definitions for the following core health home services (see Addendum B for draft service definitions):

- Comprehensive care management;
- Care coordination and health promotion;

- Comprehensive transitional care from inpatient to other settings, including appropriate follow up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and,
- The use of health information technology to link services, as feasible and appropriate.

Some of the population targeted for the health homes program could benefit from palliative care, and DHCS intends to include coordination and referrals for palliative care in the health home model. CalSIM will support DHCS in developing ways to enhance delivery of palliative care as a specific initiative linked to health homes.

As part of the health home notification and enrollment process, DHCS will inform beneficiaries of the optional health home benefits and explain options if a member would need to choose between care management programs (e.g. TCM or health homes). From a monitoring perspective, DHCS will identify and track services via unique coding to ensure non duplication of services, which may include eligibility, plan enrollment, and payment systems.

Health Information Exchange and Technology (HIE/HIT)

Development of the HHPCN requires the secure exchange of information among various organizations providing services to a given enrollee. The CalSIM initiative will strive to leverage existing HIE/HIT capacity, and provide technical assistance to organizations to meet this requirement.

Quality Measures and Evaluation Plan

CMS has established a recommended core set of health care quality measures (see Addendum C, Table 1 for draft quality measures) that it intends to promulgate in the rulemaking process. This core set of eight measures was selected based on priority areas of behavioral health and preventive care and aligns with existing core sets for adults and children. Additional details can be found in the CMS technical specifications and resource manual. Three utilization measures (see Addendum C, Table 2) were also identified by CMS to assist with the overall federal health home evaluation, and will become a reporting requirement as well.

In addition to the required core measures, the state will also track state-specific quality measures which will draw from both existing Medicaid measures and multi-payer measurement that will be driven by the CalSIM process. Initial state-specific indicators for consideration are included in the HHPCN policy goals document (see Addendum A).

To the extent possible, DHCS will leverage existing managed care evaluation tools, such as a standardized patient satisfaction survey, in the health home for maximum consistency. DHCS will contract with an external evaluator prior to the start of health home program services to ensure the program is designed to allow for federal and state measurement and evaluation activities.

Payment Methodology and Rates

DHCS is considering a payment approach that would include a per member per month (PMPM) payment carved in to the managed care plan capitation payment. DHCS intends for the payment methodology to include tiering based on patient acuity. Further research regarding the eligible population will be needed to identify appropriate funding levels.

As described in the provider section, health home payments would flow through the lead entities which will then be responsible for negotiating contracts and setting rates with qualified care management entities.

DHCS will further develop the health home payment methodology and funding once the target population, geographic area, provider standards and service definitions have been finalized.

State Match

CMS provides an enhanced federal financial participation (FFP) for the first eight quarters of health home operation, starting on the effective date of the SPA. This enhanced match is 90% federal funds (10% state match). The California Endowment has offered to fund the first eight quarters of (10%) state match up to a maximum of $25 million per year.

Timeline

DHCS intends to develop the health home model over the coming months, in collaboration with stakeholders, (see the current timeline below, Table 3). A draft model will be shared in spring 2015 with the Substance Abuse and Mental Health Services Administration (SAMHSA), as required by 2703 legislation. The timeline also includes time for optional sharing with CMS for informal feedback in early summer 2015. The current timeline plans for CMS approval by January 2016 with a program start date of January 2016. This timeframe would allow for provider education activities to occur in late 2015 and throughout 2016 to prepare additional providers for health home implementation.

Table 3: Health Home Development and Implementation Timeline

9/14-1/16	*DESIGN AND DECISION-MAKING*
9/14 - 3/15	Meetings and stakeholder engagement process focusing on aligning model development with a multi-payer strategy
1/15	SIM test grant starts (anticipated)
3/15	Finalize SPA and remaining details of payment methodology
4/15	Required consult with Substance Abuse and Mental Health Services Administration (SAMHSA)
4/15-7/15	CMS consultation on coverage issues and reimbursement model
8/15-1/16	Ongoing stakeholder communication and early preparations
8/15	Formal submission to CMS
1/1/16	CMS approval of 2703 SPA

7/15 – 7/18	*IMPLEMENTATION AND PROVIDER TECHNICAL ASSISTANCE (TA)*
7/15 – 12/15	Begin to provide TA, build health home networks, and prepare for program implementation
1/16	Begin operating health homes (SPA effective date for enhanced match purposes)
12/17	End of enhanced match for first 2703 health home SPA
1/18	Completion of initial AB 361 evaluation timeframe

Stakeholder Input

DHCS, in coordination with CalSIM, will initiate a stakeholder engagement process beginning in November 2014. If you have comments or questions about this concept paper, or if you wish to be included in future notices of stakeholder engagement opportunities, please send your request to the DHCS health home mailbox: HHP@dhcs.ca.gov. For ongoing CalSIM updates, please send your information to innovate@chhs.ca.gov.

ADDENDUM A

MULTI-PAYER DRAFT POLICY GOALS AND MEDI-CAL OBJECTIVES

The California State Innovation Model (SIM) initiative Workgroup #2 focused on the Let's Get Healthy California (LGHC) goal area of *Living Well: Preventing and Managing Chronic Disease*. The Workgroup's main recommendation "to create health homes for persons with multiple chronic conditions" was included in its SIM Testing application to the Center for Medicare and Medicaid Innovation (CMMI). Specifically, this initiative focuses on the promotion and sustainability of health homes designed to manage medically complex patients with patterns of high utilization and multiple chronic conditions, who live at home, and could benefit from intensive primary care services. The initiative will not fund individual services; rather, it will be used to spread and scale the provision of these services across California. Additionally, the initiative will align incentives to move away from volume-based payments toward a value-based payment model. The initiative is similar to other health home efforts across the country – especially those that focus on high-utilizers – and in particular is similar in design to a CMMI-funded California demonstration focused on Medicare beneficiaries (the Intensive Outpatient Care Program).

OVERARCHING GOAL: TRIPLE AIM – BETTER HEALTH, BETTER CARE, LOWER COSTS

The overarching goal of the Triple Aim will continue to shape the health home effort. Multi-payer policy goals will be used to guide the development of the HHPCN and other design decisions will flow from these goals. In the near future, process and outcome measures will be identified to track progress toward these goals. In addition, there are particular program requirements for Medi-Cal to implement this initiative. Both the multi-payer policy goals and the Medi-Cal specific objectives are described below.

Multi-Payer Draft Policy Goals

Aim	HHPCN Policy Goal	Draft Key Indicators
Cost	Reportable net cost avoidance within two years, which will require reporting period to be 18 months.	Projected: actual net costs
		Projected: actual ED visits, inpatient admits, and inpatient days
Care Experience	Improve care coordination	Patient experience measure; CAHPS already used in MediCal, consider patient activation measure (PAM)
		Percent of patients whose doctor's office helps coordinate their care with other providers
	Integrate palliative care into primary care delivery	Terminal hospital stays that include intensive care unit days
	Strengthen community linkages within heath homes	Demonstrated linkages with housing or other social services; demonstrated e-referral to CA Smokers' Helpline
	Strengthen team-based care, including use of community health workers/ promotores/ other frontline workers	Demonstrated inclusion of frontline workers
Population Health	Improve the health outcomes of people with high risk chronic diseases	Preventable hospitalizations, per 100,000 population
		Overall health status reported to be good, very good, or excellent

Medi-Cal Objectives

In addition to the preceding multi-payer policy goals, Medi-Cal objectives include:

1. **Ensure sufficient provider infrastructure and capacity to implement HHPCN as an entitlement program**. Because ACA Section 2703 Health Homes is an optional Medicaid entitlement benefit, DHCS must ensure adequate provider infrastructure and access within the geographic areas that the State selects for operation. Access must be available for all members who 1) meet the health home eligibility requirements and 2) choose to access health home services. DHCS must also provide the services according to the Medicaid "freedom of choice of providers" requirements.

2. **Ensure that health home providers appropriately serve members experiencing homelessness**. Homelessness is a major complicating factor in the health outcomes of many chronically ill patients. California recognized this through the enactment of Assembly Bill 361, which authorizes the state Department of Health Care Services to create a health home program for enrollees with chronic conditions. AB 361 requires that providers who serve homeless members to have the specific capabilities to engage and serve these members, including making linkages (referrals) to supportive housing and other social services.

3. **Increase integration of physical and behavioral health services**. Beneficiaries with physical and behavioral health issues tend to have a significantly worse prognosis for their illness and incur high health care costs. Improving coordination or integration of physical and behavioral health services will improve outcomes across the Triple Aim.

4. **Create synergies with the Coordinated Care Initiative (CCI) in the eight participating counties**. Through Cal Medi-Connect, up to 456,000 Medi-Cal beneficiaries in eight selected counties who are seniors or people with disabilities and also receive Medicare benefits (dual-eligibles) will receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through an organized delivery system. The Center for Medicare and Medicaid Services (CMS) requires that dually eligible beneficiaries are included in health home initiatives in order to receive enhanced federal matching funds. Because California has a waiver to provide comprehensive services to this population it will be important to ensure that any services under the health home initiative are additive to the Medi-Connect program.

5. **Maximize federal funding while also achieving fiscal sustainability after eight quarters of federal funding.** After eight quarters, the federal match for health home services will be reduced from 90% to 50%. For the health homes initiative to continue it will be imperative to demonstrate a net return on investment within two years after implementation, per the following AB361 requirements:
    a. DHCS must complete a Health Home program evaluation within two years after implementation.
    b. DHCS may only implement a Health Home program if DHCS makes prior, and ongoing, projections that no additional General Fund monies will be used to fund the program administration, evaluation, and services. DHCS may use General Fund monies to operate the program but the program can not result in a net increase in ongoing General Fund costs for the Medi-Cal program.

ADDENDUM B

Service Definitions

Comprehensive Care Management

Comprehensive care management primarily involves the activities related to developing the enrollees' comprehensive, individualized care plan, called a health action plan (HAP). HAPs should incorporate the patient's physical health needs, behavioral health needs and any community-based LTSS. Care management services include screenings and assessments with standardized tools, and issues identified will be included in the HAP. HAPs will be reassessed based on the enrollees' progress or changes in their needs. Dedicated care managers assess enrollees' readiness for self-management and promote self-management skills so the enrollee is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals to attain recovery, improve functional or health status, or prevent or slow declines in functioning. As appropriate, the enrollee's family should be incorporated in the initial health assessments and subsequent reassessments. Referrals and HAP goals should also be tracked via the HAP. The dedicated care manager will deliver this service, primarily in-person.

Care Coordination and Health Promotion

Care coordination includes the implementation of the enrollees' comprehensive, individualized care plan, or HAP. At a minimum, the care coordination function includes: developing a person-centered plan based on needs and desires of the enrollee; sharing options with the enrollee for accessing care; providing information to the enrollee regarding care planning; monitor medications and treatment adherence by enrollees; managing referrals, coordination and follow-up to needed services and supports. Care coordination may include case conferences in order to ensure that the enrollees' care is continuous and integrated among all service providers. The dedicated care manager will deliver this service with the work occurring in a variety of settings.

Comprehensive Transitional Care

Comprehensive transitional care addresses the activities related to preventing patient admissions and readmissions. It requires the health home to have a process in place for prompt notification of an enrollees' admission or discharge to/from an emergency department, hospital inpatient facility, residential/treatment facility, or other. At a minimum, the care transition function includes: receipt of a summary care record or discharge summary; medication reconciliation; planning related to the timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners. Both the managed care plan and care management entity, led by the dedicated care manager, will be involved in the delivery of this service.

Individual and Family Support Services

Individual and family support services include activities that ensure that enrollees and their families are knowledgeable about the enrollees' conditions with the overall goal of improving the enrollees' adherence to treatment. Communication and information shared with the enrollees and their families and care givers should meet health literacy standards and be culturally appropriate. At a minimum, individual and family support services could include: use of peer supports and/or support groups to work with enrollees and their

families; use of self-care programs to help increase enrollees' understanding of their conditions and care plan. In addition, this service may include advocacy for the enrollees and their families to identify and obtain needed resources (e.g. transportation) that supports their ability to meet goals. The dedicated care manager and peer support staff would be key to the delivery of these services.

Referral to Community and Social Supports

Referral to community and social supports addresses the identification of community-based resources to meet the whole-person needs of the enrollee and active referral and follow-up to these resources. Communication and information shared with the enrollees should meet health literacy standards and be culturally appropriate. Community and social supports include but are not limited to: housing, food, employment, child care, community-based LTSS, school and faith based services, and disability services. The dedicated care manager and peer support staff would be key to the delivery of these services.

Use of Health Information Technology and Exchange to Link Services

To be determined.

ADDENDUM C

Quality Measures

Table 1: CMS Health Home Core Measures

Measure	Steward
Adult Body Mass Index (BMI) Assessment	HEDIS*
Screening for Clinical Depression and Follow-up Plan	CMS*
Plan All-Cause Readmission Rate	HEDIS*
Follow-up After Hospitalization for Mental Illness	HEDIS*#
Controlling High Blood Pressure	HEDIS*
Care Transition – Timely Transmission of Transition Record	AMA-PCPI*
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	HEDIS*
Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite	AHRQ

* Included in Adult Core Set
\# Included in Child Core Set

Table 2: Utilization Measures for CMS Evaluation

Measure	Steward
Ambulatory Care – Emergency Department Visits	HEDIS
Inpatient Utilization	CMS
Nursing Facility Utilization	CMS