Sacramento County
Medi-Cal Managed Care Advisory Committee Meeting

Health Homes for Patients with Complex Needs (HHP): The Basics
March 28, 2016

ACA Section 2703

- Created new "optional" health homes Medicaid benefit for intensive care coordination for people with chronic conditions
- 90% federal funding for first eight quarters, 50% thereafter

AB 361 enacted 2013 / W&I Codes 14127 and 14128

- Authorized subject to federal approval
- Requires inclusion of specific target populations of frequent utilizers and with specific requirements for those experiencing homelessness
- DHCS implementation only if no additional State General Funds will be used

Policy Goals

- Improve care coordination
- Strengthen community linkages within health homes
- Strengthen team-based care
- Improve the health outcomes of people with high-risk chronic diseases
- Report net cost avoidance in two years

Objectives

- Ensure sufficient provider infrastructure and capacity to implement HHP as an entitlement benefit
- HHP providers appropriately serve members experiencing homelessness
- Increase integration of physical and behavioral health services
- Maximize federal funding while also achieving fiscal sustainability after eight quarters of enhanced federal funding. *DHCS expects this to be cost neutral regarding state funding after the first two years.*

Additional Focus Areas

- Focus on high cost Medi-Cal members with chronic conditions
- Wrap increased care coordination around existing care (close to the member's usual point of care delivery)

Administrator

- Managed Care Plan will be responsible for overall administration of the HHP.
- Leverage existing plan assessment tools such as the health risk assessments, etc.
- Payments flow from DHCS to Plan (risk based per member per month with two distinct periods – engagement and ongoing services)
- Reimbursement is for care coordination services/benefits

Target Population

- Intensive set of services for a small subset of members who require coordination at the highest level
- Highest risk three to five percent of the Medi-Cal population will be eligible

Eligibility Criteria

- At least two of the following: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder **OR**
- Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure **OR**
- One of the following: Major Depression Disorders, Bipolar Disorder, Psychotic Disorders (including Schizophrenia)
- In addition the member must also have (1) of the following: a predictive risk score of at least three **OR** at least one inpatient stay in the last year **OR** three or more ED visits in the last year. HHP Services
- **AND**, administrative claims data indicating both a diagnosis and service code for the eligible condition, at least two separate claims for the eligible condition, have claims in the same two years for the eligible condition and show continuous Medi-Cal enrollment for at least (3) months.

Core Services delivered through managed care

- Comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and support services.

Care Team

- Structured as a "health home network" with members functioning as a team to provide care coordination. Enrollees will have an individualized care plan AND a care manager that ensures access to all needed services
- This network includes the Plan, one or more Community Based Management Entities and linkages to community and social support services. Required for multidisciplinary care teams -

HHP director, care manager, and clinical consultant community health workers in appropriate roles. For individuals experiencing homelessness a Housing Navigator is required.
- Additional team members such as a pharmacist may be included on the multidisciplinary care team in order to meet the individual's care coordination needs

Health Action Plan (HAP)

- Individualized, comprehensive, person-centered care plan
- Incorporates members' needs – physical health, mental health, substance use, community based LTSS, social supports, and for those experiencing homeless, housing as appropriate
- Includes case conferences
- Member is engaged in multiple ways
- Care manager, member and their family, in conjunction with PCP and others modify as member's progress or status and health care needs change

Proposed Sacramento County Implementation Dates

- For members with serious mental illness > January 1, 2018
- For other eligible members > July 1, 2018
- Plans must submit to DHCS detailed proposal six to nine months before implementation.

Guidelines

- All managed care plans within the county must implement at the same time. (For selected counties)
- State Plan Amendment (SPA) timeline is eight quarters of 90 percent federal match is for the specific SPA populations and counties in each SPA. Each SPA starts a new eight quarters upon its start date.
- No funding for direct medical or social services.

Next Steps for DHCS

- Pending Federal approval.
- The SPA and Final Concept Paper will be posted on the DHCS webpage after the SPA is submitted to CMS.
- Will release a document noting comparison of Whole Person Care Pilot and Health Homes.

See DHCS document entitled, "Health Homes for Patients with Complex Needs, California Concept Paper Version 3.0 (Draft Final)," dated December 11, 2015 for details.

Link: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx