

Health Homes Program Town Hall



Agenda

Schedule	Presentation	Presenters
12:30 p.m. to 1 p.m.	Check in and networking lunch	
1 p.m. to 1:10 p.m.	Welcome	Beau Hennemann, Anthem Scott Crawford, Health Net
1:10 p.m. to 1:55 p.m.	Health Homes Program overview and preview	Beau Hennemann, Anthem Scott Crawford, Health Net Terry Reiser, Molina
1:55 p.m. to 2:20 p.m.	San Francisco Implementation — lessons learned	Jill Donnelly, Anthem Caity Haas, Anthem
2:20 p.m. to 2:40 p.m.	Value of Health Homes	Fabbi Cruz, Aetna June Kim, Kaiser
2:40 p.m. to 2:50 p.m.	Questions and answers	All
2:50 p.m. to 3 p.m.	Next steps	Beau Hennemann, Anthem Scott Crawford, Health Net

Objectives

- Collaborate and engage with Sacramento County stakeholders in planning for the implementation of the Health Homes Program (HHP) in July 2019.
- Inform public health, health care, Social Services, housing and community stakeholders, including Medi-Cal Managed Care (Medi-Cal) providers, about the HHP:
 - Implementation timeline.
 - Program requirements.
 - Community-based care management entity network.
- Obtain feedback from key Sacramento County stakeholders to help in HHP planning.

HHP overview and preview

Presented by:

Beau Hennemann, Anthem Blue Cross

Scott Crawford, Health Net

Terry Reiser, Molina

What is the HHP?

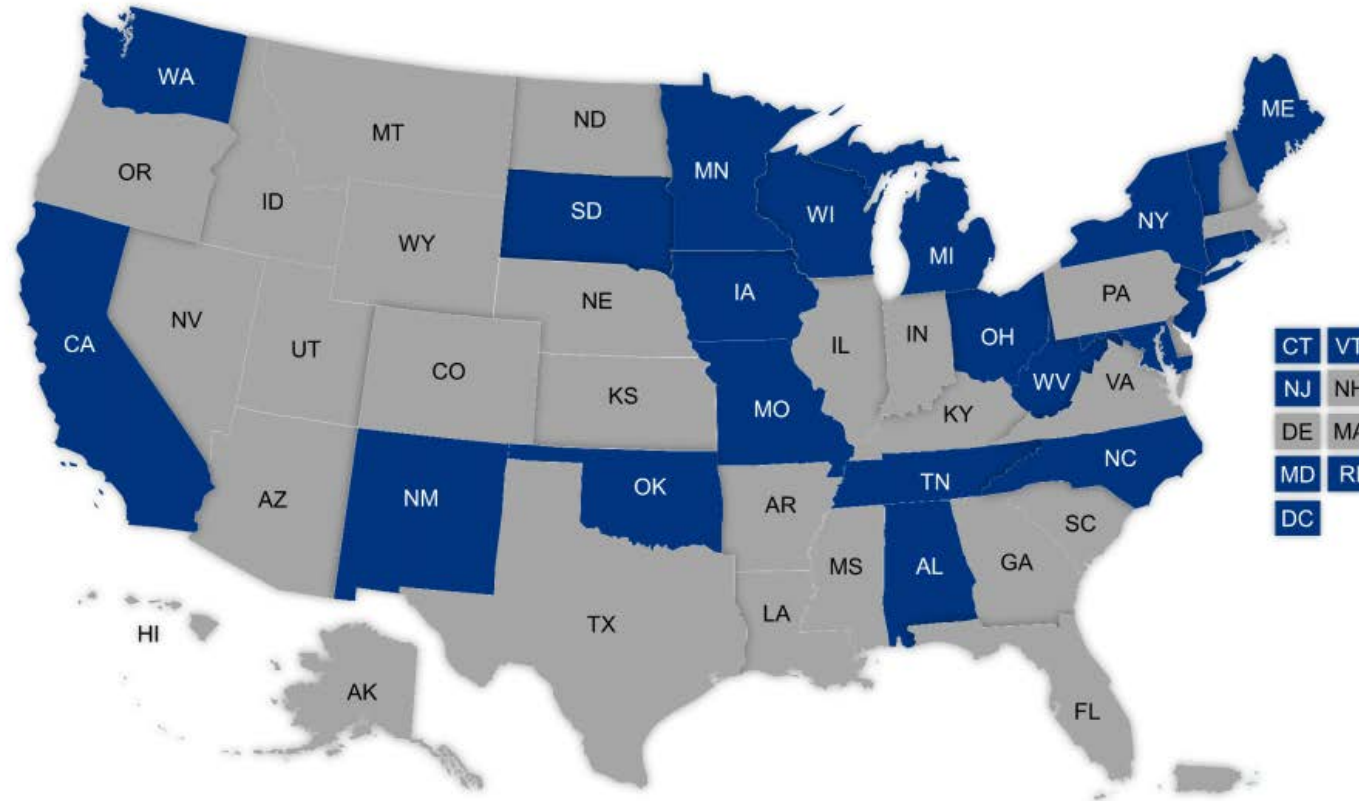
The HHP is:

- A team-based, in-person care management and care coordination program targeting chronically ill and high-acuity Medi-Cal members that aims to:
 - Ensure participation of providers experienced with serving frequent users of health services and individuals experiencing homelessness.
 - Leverage the existing county and community provider care management infrastructure and experience.
- A Department of Health Care Services (DHCS) mandated Medi-Cal benefit authorized under Section 2703 of the *Affordable Care Act*.

HHP background

- The Medicaid Health Home State Plan Option is authorized under the *Affordable Care Act*, Section 2703.
- The HHP offers enhanced federal funding during the first eight quarters of implementation.
- There is a California State Plan Amendment for target populations with:
 - Chronic physical health conditions.
 - Serious mental illness (SMI).

HHP background (cont.)



As of April 2018, 22 states and the District of Columbia have a total of 34 approved Medicaid health home models.

HHP implementation in California

Group one:	July 1, 2018 (physical/substance use disorder [SUD]) January 1, 2019 (SMI)	San Francisco		
Group two:	January 1, 2019 (physical/SUD) July 1, 2019 (SMI)	Riverside San Bernardino		
Group three:	July 1, 2019 (physical/SUD) January 1, 2020 (SMI)	Alameda Fresno Kern Los Angeles Sacramento San Diego Tulare Imperial* Merced*	Monterey* Orange* San Mateo* Santa Clara* Del Norte* Humboldt* Lake* Marin*	Mendocino* Napa* Shasta* Solano* Sonoma* Yolo* Lassen* Siskiyou* Santa Cruz*

* Counties that moved to group three.

Who is eligible?



- Two eligible physical health conditions *or*
- Hypertension + at-risk of 2nd condition *or*
- SMI *or*
- Asthma



- Three or more eligible chronic conditions *or*
- At least one inpatient stay within one year *or*
- Three or more emergency department visits within one year *or*
- Chronic homelessness



- Identification:
- Top-down (by DHCS via a *Targeted Engagement List*) *or*
 - Bottom-up (by health plans, providers and/or CB-CMEs)

Only Medi-Cal members are eligible; Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) members do not qualify.

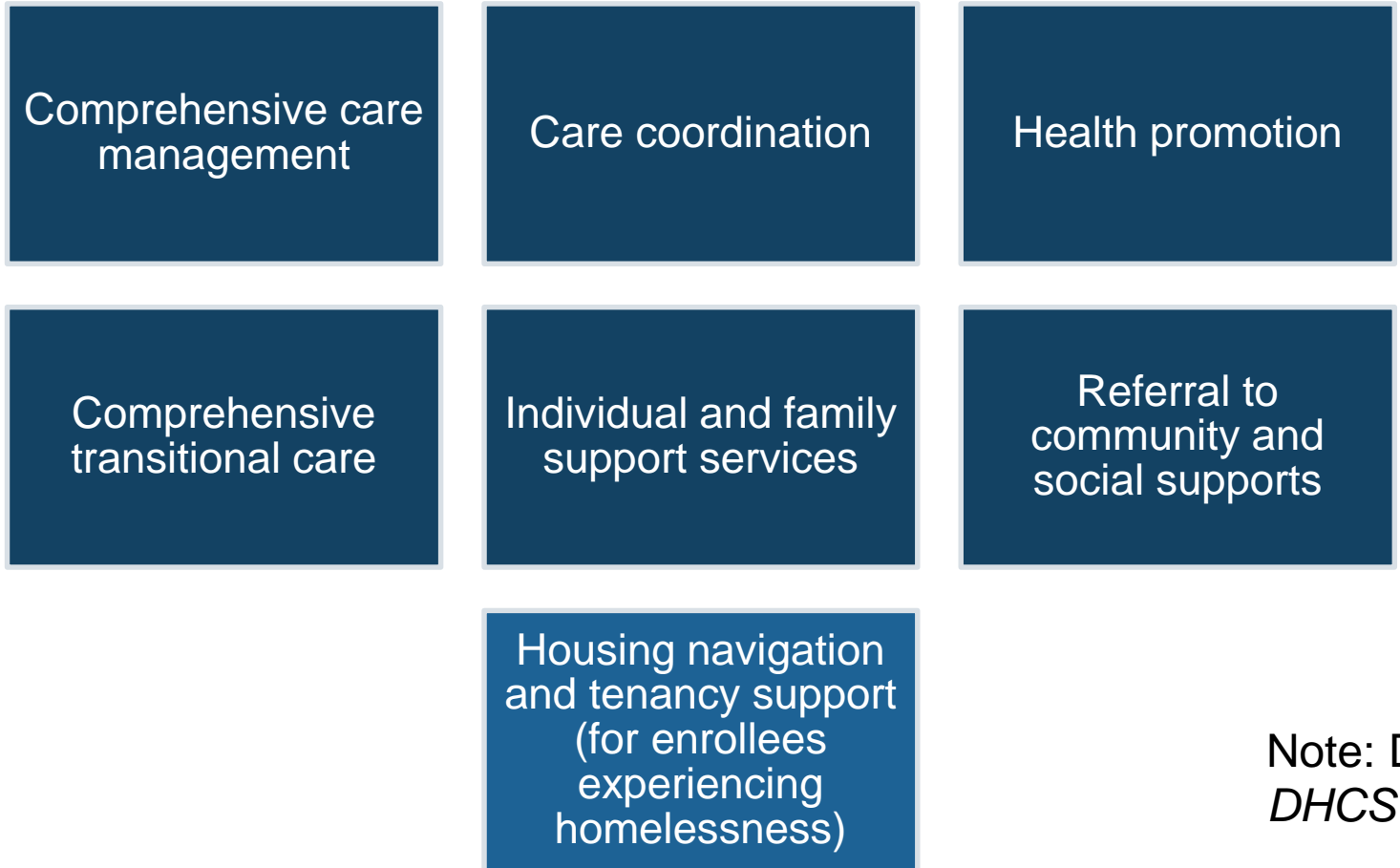


Eligible chronic conditions

Eligibility requirement	Criteria details
1. Chronic condition criteria	<p>Has a chronic condition in <u>at least one</u> of the following categories:</p> <ul style="list-style-type: none">• 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 renal (kidney) disease, dementia, SUD• Hypertension and one of the following: COPD, diabetes, coronary artery disease, chronic or congestive heart failure• One of the following: major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia)• Asthma
2. Meets at least one acuity/complexity criteria	<ul style="list-style-type: none">• Has at least three or more of the HHP eligible chronic conditions• At least one inpatient hospital stay in the last year• Three or more emergency department visits in the last year• Chronic homelessness



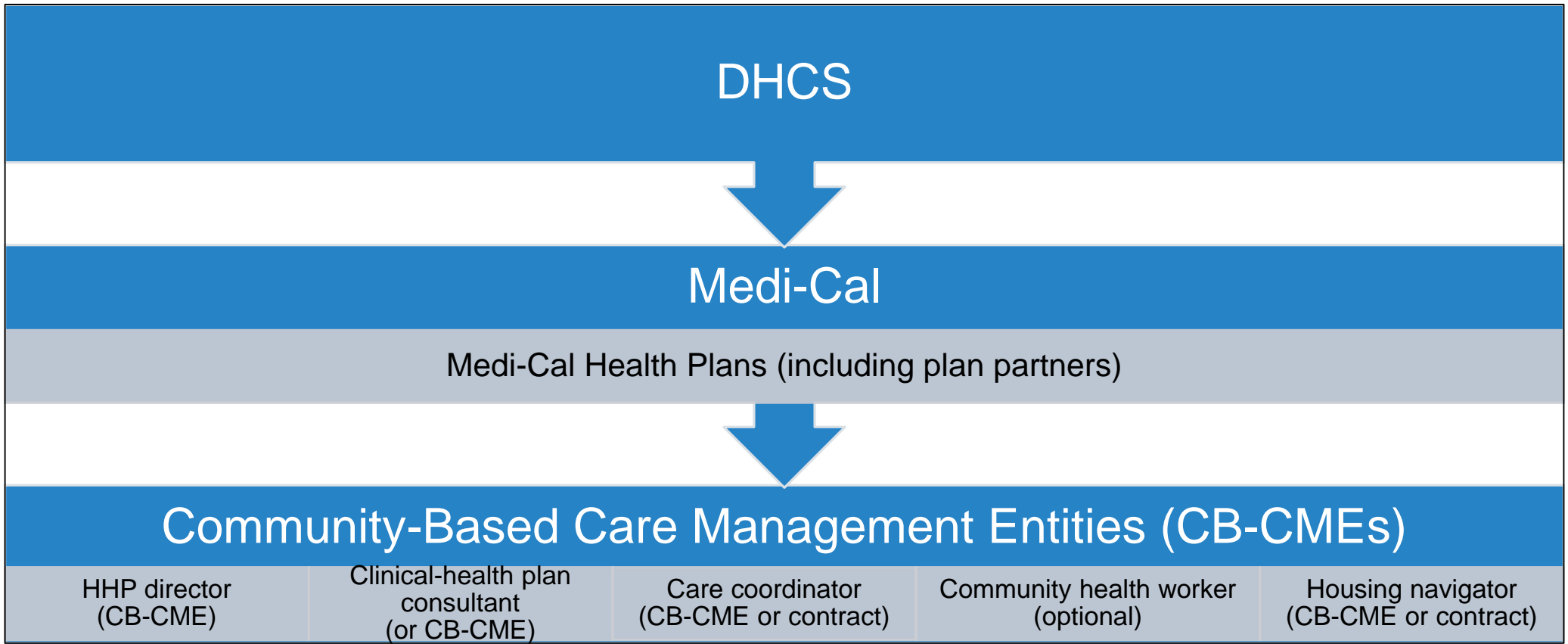
Required HHP services



Note: Details available in *DHCS Program Guide*



HHP structure



Health Plan responsibilities

- Validate HHP eligibility and assign HHP members to CB-CMEs.
- Ensure members have access to a network of CB-CME providers and HHP services.
- Share member health information (history and emergency department visits) with CB-CMEs.
- Support CB-CMEs in effective delivery of HHP services.
- Collect, analyze and report to DHCS various programmatic measures.
- Conduct regular auditing and monitoring.

What is a CB-CME?

- Existing clinic or community organization
- Contracted with the health plan
- Provides all core services
- Established care team, including:
 - Physicians
 - Nurse care coordinators
 - Social workers
 - Behavioral health professional
 - Housing navigator
 - Community health worker
- In many cases, the member is already receiving services from an established care team.

St. Anthony's
San Francisco, CA



CB-CME responsibilities

- Outreach and engagement
- Care management
- Development of individual *Health Action Plans (HAPs)*
- Care coordination
- Health promotion
- Transitions of care including discharge planning
- Support for member and family
- Referrals to community services and supports
- Housing navigation
- Reporting to health plan

CB-CME eligibility

To serve as a CB-CME, organizations must meet the qualifications outlined by DHCS and must perform specific duties. The following organizations may act as CB-CMEs:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health clinic
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group
- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the managed care provider (MCP)

CB-CME qualifications

- Strong and engaged organizational leadership who agree to participate in learning activities including in-person sessions and regularly scheduled calls
- Capacity to provide appropriate and timely care coordination activities as needed in various settings to assist in achieving *HAP* goals
- Accept enrolled HHP members assigned by the MCP according to the CB-CME contract with the MCP
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination
- Link members to HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care

CB-CME requirements

- Ensure adequate care team staffing, based on staffing ratios outlined by DHCS.
- Provide oversight of the direct delivery of core HHP services.
- Implement systematic processes and protocols to ensure member access to the multidisciplinary care team and overall care coordination.
- Collaborate with and engage HHP members in developing and maintaining a *HAP* that supports members to meet to their goals.
- Deliver person-centered coordination and integration of the HHP member's clinical and nonclinical physical and behavioral health care needs and services as well as Social Services needs.
- Support HHP members and families with transitions of care using evidence-based transition planning.
- Coordinate with the HHP member's MCP nurse advice line, which provides 24/7 availability of information and emergency consultation services.
- Provide quality-driven, cost-effective HHP services within the member's community in a culturally competent and trauma-informed manner to address health disparities and improve health literacy.

CB-CME staffing

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	<ul style="list-style-type: none"> • Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma informed care practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multidisciplinary care teams	<ul style="list-style-type: none"> • Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team

CB-CME staffing

Required Team Members	Qualifications	Role
Clinical Consultant (CB-CME or Molina)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	<ul style="list-style-type: none"> Review and inform HAP Act as clinical resource for care coordinator, as needed Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	<ul style="list-style-type: none"> Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing Connect and assist the HHP member to get available permanent housing Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

CB-CME staffing

Recommended Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) <i>(Recommended but not required)</i>	Paraprofessional or peer advocate Administrative support to care coordinator	<ul style="list-style-type: none"> • Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma informed care practices • Monitor treatment adherence (including medication)
<p>Additional team members may be included on the multidisciplinary care team in order to meet the HHP member's individual care coordination needs. Examples include pharmacist, nutritionist/dietician, behavioral health provider, health educator, etc.</p>		

CB-CME requirements

- Minimum in-person visits is approximately one visit per member per month
 - 260 visits per 100 enrolled members per quarter
 - This applies to the aggregated population. The number of in-person visits and/or contacts should be based on the acuity and needs of the member.
- The care coordinator ratio requirement is 60:1
 - This applies to the aggregated population
 - This ratio is intended to be related to the care coordination function only, but that function could be divided up among all staff – care coordinator, community health worker, housing navigator, clinical consultant, etc.

Whole-person care (WPC)

- Medi-Cal members eligible to receive services from both the WPC pilot and the HHP can be enrolled in either program or both, based on beneficiary choice.
- If a member is eligible for both programs, he/she may choose the program care coordination services they want to receive.
- If the member wants to receive care coordination services from WPC, they cannot receive the same care coordination services from the HHP.
- The member can receive both HHP care coordination services and WPC services as long as they are not duplicative or similar to HHP care coordination services.
 - Example: Member use of WPC sobering center

WPC (cont.)

- If the member is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that they do not receive duplicative care coordination services from WPC.
- The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services provided during the same month.

San Francisco implementation — lessons learned

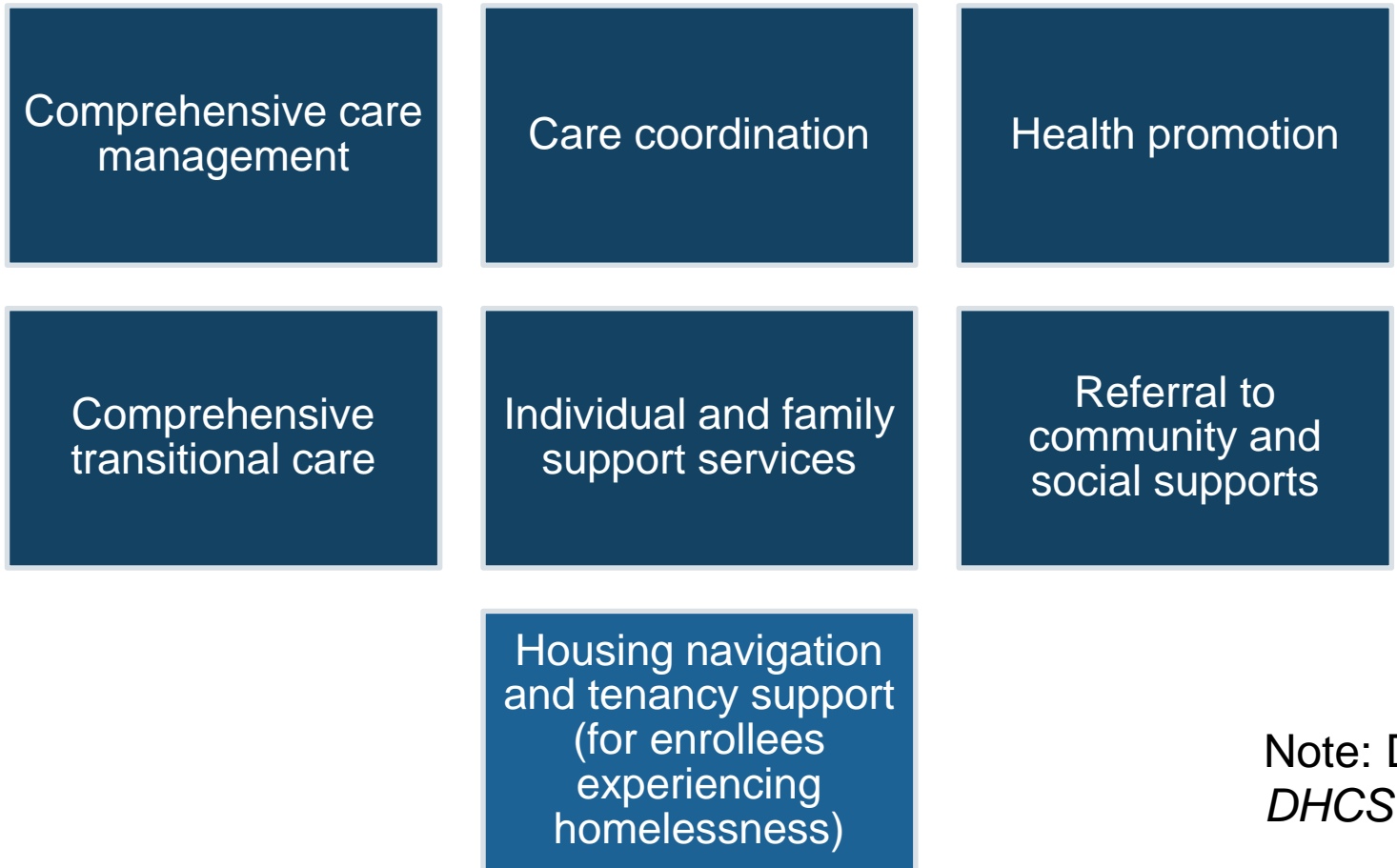
Presented by:

Jill Donnelly, Anthem Blue Cross

Caity Haas, Anthem Blue Cross



Required HHP services



Note: Details available in *DHCS Program Guide*

The devil is in the details.

~ attributed to Ludwig Mies Van Der Rohe



Example: member/family support details

- Assess needs of member and family/support persons.
- Link member and family/support persons to peer and/or group supports to educate, motivate and improve self-management.
- Connect member to self-care programs to increase understanding of health conditions and care plan.
- Engage member and family/support persons in self-management.
- Determine when member and family/support persons are ready to accept information and make decisions.
- Advocate for the member and family/support persons to obtain identified needed resources to enable member to meet their health goals.
- Identify barriers to member's adherence to treatment and medication management.

Example: housing navigation details

- Provide housing navigation services, not just referrals.
- Have a housing navigator as part of the HHP care team for members experiencing homelessness.
- Provide housing transition services including:
 - Tenant screening and housing assessment.
 - Developing housing support plans.
 - Assisting with housing application and search.
 - Providing logistical support.
- Provide housing and tenancy sustaining services:
 - Include training/coaching, advocacy and dispute resolution, eviction assistance, etc.

CB-CME gaps/challenges

Clinical

- Difficult to reach population
- Large homeless population coupled with housing shortage
- Overlapping programs
- Housing and palliative care are new
- Lack of *HAP* and assessment process
- Difficulty integrating behavioral health

Operational

- Manual processes surrounding care plans and data exchange
- Implementation cost versus anticipated revenue
- Overall system limitations
- Staffing infrastructures and policy development
- Lack of coordination among multiple programs

Provider

- Varying degrees of readiness among providers
- Many new to managed care/fee-for-service environment in San Francisco
- Lag in rates information delaying readiness activities
- Lack of state process for identification and transformation

Lessons learned

- Gauge interest and awareness.
- Engage CB-CMEs early — town hall collaborations.
- Collaborate with other health plans — minimize differences.
- Discuss rates and resources early.
- Focus on details.
- Treat CB-CMEs as partners — add resources to supplement efforts.
- Understand this won't be easy.

Value and challenges

Presented by:

Fabbi Cruz, Aetna

June Kim, Kaiser

Value of Health Homes

Local goals:

- Increase coordination between medical and behavioral health, and community support systems and services.
- Create infrastructure to support multisystem coordination and delivery of care.
- Address and support access to housing for eligible homeless members and members with unstable housing.

Statewide goals:

- Increase health status and quality of life.
- Enhance quality of service.
- Reduce hospital inpatient admits/length of stays.
- Reduce emergency department use.
- Reduce test and procedure redundancy.

Opportunities

- State mandate to improve coordination for most vulnerable and highest cost populations
- Opportunity to enhance care management model by expanding point of care services and leveraging health technology
- Support the provider network and promote connections to Social Services, behavioral health and housing services across Sacramento County
- Explicit state funding for care management activities
- Improve beneficiary ability to navigate care
- Build safety net connections

Challenges and risks

- Rate sufficiency to meet program requirements
- Reaching cost neutrality quickly (two years)
- Potential overlap and confusion with existing services and programs
- Workforce availability to meet multidisciplinary team requirements across MCPs and CB-CMEs
- Variability among MCPs, given that MCPs are given discretion to customize their HHP model design
- Functionality of health information exchange between health plans and CB-CMEs in order to track and share data regarding member health history

Next steps

These steps are high-level and tentative:

1. Complete *Interest Questionnaire*
2. November/December 2018 — Initial *CB-CME Readiness Surveys* and *Letters of Intent* submitted
3. December 2018 — Initial on-site visits
4. January 2019 — Begin readiness review activities
5. March 2019 — On-site readiness visits
6. April/May 2019 — Readiness review wrap-up and contracting
7. May/June 2019 — Completion of provider training
8. July 2019 — Program launch

Resources

- California DHCS Health Homes: <https://www.dhcs.ca.gov> > Services > Pages > Health Homes Program
- *HHP Program Guide*

Contact information

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Thank you
