California's Health Homes Program: Lessons Learned and Promising Practices

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Made Possible with Support from The California Endowment
February 2020

Introduction

The Health Homes Program (HHP) is a Medi-Cal initiative that helps manage and coordinate care for enrollees with certain chronic health and/or mental health conditions who have high health care needs or who are experiencing chronic homelessness. The California Department of Health Care Services (DHCS) oversees the administration of the HHP; and 17 Medi-Cal managed care plans (MCPs) are operating the program in 12 counties. Implementation began in San Francisco County on July 1, 2018 and the program will be fully implemented in all participating counties and for all populations on July 1, 2020. As of September 2019, more than 14,000 individuals were enrolled in California's HHP. See Appendix A for an overview of the HHP.

Background

Over the last several years, DHCS and Harbage Consulting have convened a series of Learning Collaboratives (LCs) for participating MCPs to discuss HHP planning and implementation activities. MCPs and other stakeholders have shared lessons learned and promising practices regarding a number of aspects of the HHP.

Lessons from the HHP in providing intensive care management and care coordination services to members with high health care needs are particularly important to understand and translate as DHCS implements the California Advancing and Innovating Medi-Cal (CalAIM) initiative. This initiative seeks to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program, and payment reforms across the state. The major components of CalAIM are built upon the successful outcomes of the Whole Person Care Pilots, the Health Homes Program, and the Coordinated Care Initiative.

This paper summarizes many of the lessons learned and promising practices from California's Health Homes Program, gleaned from LC presentations and discussions to help inform MCPs and providers as they prepare to implement CalAIM.

Promising Practices and Lessons Learned

The LC sessions covered a wide range of HHP planning and implementation activities, including developing provider networks (referred to as Community-Based Care Management Entities (CB-CMEs)), conducting outreach and engagement to eligible members, serving members with serious mental illness as well as members experiencing homelessness, and sharing data to improve care coordination. The key lessons learned and promising practices are described below.

Preparing for Implementation

At the LC sessions, plans had significant lessons to share on how to develop a CB-CME provider network and otherwise prepare for HHP implementation.

Building the CB-CME Provider Network

In Phase 1 of implementation in San Francisco County, MCPs built CB-CME networks composed primarily of primary care providers. In most cases, a member's primary care provider was ideally positioned to help manage and coordinate medical care and connect the member to needed social supports.

For Phase 2, MCPs focused on building a network of CB-CMEs that had experience providing and coordinating care for individuals with serious mental illness (SMI). Many primary care providers have experience treating individuals with mild to moderate mental health conditions, but not those with SMI. To build their CB-CME networks, MCPs sought out providers and organizations with recent experience providing behavioral health services and care management to individuals with SMI. This group included providers contracted with the local mental health plan (operated by the county), clinics that specialize in mental health services, and other community-based organizations that work directly with the SMI population.

Recruiting network providers with experience providing behavioral health services and care management to members with serious mental illness was critical to success.

Preparing for Launch

Many MCPs emphasized the importance of hosting multiple in-person meetings with clinical and organization leaders at prospective CB-CMEs as early as possible in the planning process. During these meetings, MCPs provided an overview of their goals for HHP, defined and

discussed the services available through the HHP, explained the MCP's payment methodology, reviewed data sharing and reporting successes and challenges, and discussed the plan's contracting requirements and readiness review process.

Many MCPs reported that, through in-person meetings, they were able to secure buy-in from CB-CME leadership, which was critical to building successful ongoing partnerships with the organizations. Plans also found that CB-CMEs that were already providing some care management and coordination services to their members were excited to expand and be able to receive payment for such services. Following an initial in-person meeting, several plans found it valuable to send a formal letter of intent to the CB-CME outlining requirements and expectations for participation, as well as next steps in the readiness assessment and contracting process.

Securing buy-in from CB-CME leadership was critical to building successful ongoing partnerships.

MCPs were required to conduct a readiness assessment to ensure their CB-CMEs were prepared to participate in the HHP. When conducting the readiness assessment, MCPs stressed that it was important to perform both document reviews and on-site reviews. The document reviews were critical to ensuring that the CB-CMEs' policies and procedures, and other documents submitted as part of the application process, complied with HHP and MCP requirements. At the on-site reviews, MCPs were able to meet the CB-CME staff who would provide HHP services, review the CB-CME's technology platforms to ensure all needed IT systems were up and running, and more generally, conceptualize the CB-CME's actual readiness to participate in the HHP. MCPs found it helpful to specifically probe CB-CME readiness to provide housing and tenancy support services, as this work was new to many CB-CMEs.

Readiness assessments that included both on-site and document reviews were helpful in ensuring that CB-CMEs were adequately prepared to participate in the HHP.

In developing their CB-CME application and contracting requirements, MCPs found it useful to align their requirements with those of other plans in the county, to the extent possible. Aligning with other MCPs on these requirements reduced the administrative burden on shared CB-CMEs, which allowed for faster and more seamless contracting. MCPs also found that it was possible to align on

Aligning requirements with other plans in the county reduced administrative burden on shared CB-CMEs and allowed for faster and more seamless contracting.

many application and contracting requirements, specifically those that track HHP requirements, and still preserve substantial discretion to tailor the CB-CME application and contracting process to meet the MCPs' unique needs and preferences.

While conducting the readiness review and contracting process, MCPs found it helpful to simultaneously develop a work plan with CB-CMEs that set forth specific milestones, tasks, and timelines related to HHP implementation. The work plans included items related to hiring and training staff to perform HHP services, outreach and enrollment of eligible members, roles and responsibilities, and developing and testing required data-sharing and IT functions, among other operations. MCPs also stressed the importance of engaging the right staff at the CB-CME, including a leadership champion to help ensure broad buy-in and excitement around HHP activities, a clinical lead to oversee the care coordination work, and an IT and billing lead to ensure the CB-CME developed the data reporting and billing infrastructure necessary to meet the specifications of the MCP.

It is important to have a CB-CME leadership champion, a clinical lead, an IT lead, and a billing lead.

MCPs recommended launching a robust CB-CME training program as early as possible (ideally, months prior to launch) and continuing training on an ongoing basis after implementation. DHCS and Harbage Consulting developed trainings on a variety of HHP topics for MCPs to use and tailor for their CB-CMEs. Some plans conducted monthly calls prior to and after implementation to provide education and updates to CB-CME staff. Others hosted weekly webinars on topics including outreach and education and the provision of housing support services. Many plans made their trainings, webinars, and other educational materials available on a learning management system, so that their CB-CMEs could access the materials on an as-needed basis.

Training and regular communication with CB-CMEs was critical.

In addition to robust training, plans stressed the importance of frequent communication with CB-CMEs both before and after implementation. Regular communication gave plans and CB-CMEs an opportunity to work through challenges and recognize and learn from HHP successes. Plans also emphasized that in-person communication with CB-CMEs was key to strengthening their partnership, particularly prior to and in the period immediately following implementation. In addition to in-person meetings, plans also recommended communicating with CB-CMEs regularly by phone and email.

Assigning Members to CB-CMEs

HHP enrollees are assigned a CB-CME by the MCP that serves as their frontline service provider – but members can choose a different CB-CME if they prefer. When assigning potential members to CB-CMEs, plans recommended considering first and foremost a member's claims history. To the extent possible, members were assigned to a CB-CME where they were already receiving significant healthcare services or care management. Doing so promoted continuity of care, and familiarity with the location, providers, and staff and increased the likelihood of HHP engagement and success. This policy reflects "meeting the member where they are," which is an important principle of the program. If assignment to a provider with which the member has an established relationship was not possible, the best alternative was assignment to a CB-CME that was in close geographic proximity to the member.

Meeting members where they are is an important principle of the Health Homes Program.

MCPs recommended ensuring that each CB-CME has at least a minimum number of attributed members (or potential members) to make investment in HHP services financially viable, but not so many as to exceed their capacity to effectively provide services. MCPs found it useful to specifically ask CB-CMEs during the readiness process how many of the MCP's HHP members the CB-CME could serve.

Incentive Payments to CB-CMEs

The LC sessions did not focus on MCP payments to CB-CMEs since each plan could determine its own approach, but there was a brief discussion of the topic. Some MCPs recommended providing ramp-up funding to CB-CMEs to support the employment of additional care coordination and outreach staff for HHP purposes. This ramp-up funding was for a limited amount of time only (six months for one plan), after which they switched to their regular payment methodology. Another plan reported providing payments to primary care providers who were not CB-CMEs for the time they spent on care management, as well as the time their staff spent interacting with HHP enrollees and their CB-CME care teams.

Some plans provided ramp-up funding to CB-CMEs so they could hire care coordination staff. Others provided payment to PCPs for time spent on care management.

Successful Outreach and Engagement

The LCs discussed strategies for identifying potential members for outreach, conducting outreach, and reaching target populations such as members experiencing serious mental illness and members experiencing homelessness.

Identifying Potential Members for Outreach

The starting point for each MCP's outreach was the Targeted Engagement List (TEL), which is a running list of members DHCS has identified through claims data as potentially eligible for the HHP. DHCS refreshes the TEL every six months and sends updated versions to the MCPs. Using the TEL as a base, plans reviewed their own member data, including diagnoses and claims history, to confirm that individuals listed on the TEL were still enrolled in Medi-Cal and the MCP, and likely eligible for HHP services. MCPs also combed their data to flag other members who, based on their diagnoses and claims history, were likely to be eligible. Many plans created an HHP keyword in their medical management systems so that case management staff, who were trained on HHP eligibility, could flag plan members as potentially eligible for the program. MCPs also added HHP-specific details/indicators to the medical management profiles of HHP members and potential members, such as homelessness, enrollment in other state health care programs, and potential HHP implementation phase (1 or 2).

MCPs established policies to prioritize outreach and enrollment of certain high-need populations.

One plan reported using the HHP eligibility criteria as a guide to create tiers for prioritizing member outreach. This plan distributed its tier 1 list to its CB-CMEs first, as the initial group of members to contact and engage, then its tier 2 list, and later, tier 3. MCPs established policies to prioritize outreach and enrollment of certain high-need populations. A number of MCPs emphasized the importance of discussing the HHP eligibility criteria and the MCP's specific member prioritization strategy with its contracted CB-CMEs to ensure plan and CB-CME alignment on the members and populations to target for HHP outreach and enrollment.

Outreach Strategies

Plans recommended having CB-CMEs take the lead on HHP outreach, education, and enrollment, to the extent possible, since it gave CB-CMEs an opportunity to build and strengthen their relationships with their future HHP members. In addition, CB-CMEs often had existing relationships with members and were potentially trusted sources of information. MCPs noted that this work can sometimes require more staff resources than many CB-CMEs have,

which is why some MCPs provided CB-CMEs with ramp-up funding to hire additional outreach and care team members.

MCPs also found that it was important for CB-CME staff to conduct outreach because many of them know how to approach and engage hard-to-reach members. There was widespread agreement that for the HHP-eligible population, telephonic outreach was much less successful than in-person communication and engagement. More generally, MCPs found persistent outreach to be critical. MCPs reported that very few members self-referred to the HHP.

Telephonic outreach was much less successful than in-person communication and engagement.

As described in more detail below, many MCPs found it particularly difficult to connect with potential HHP members experiencing homelessness. To better engage with these members, some plans worked with housing organizations and other community organizations with experience engaging the homeless population to find creative ways to locate and engage them. Plans found that locating members experiencing homelessness could take up to or more than 90 days, and that once located, it was essential to develop a clear follow-up plan, as this significantly increased the likelihood of further contact and successful engagement with the member.

Locating members experiencing homelessness could take up to or more than 90 days, and once they were located, a clear follow-up plan was needed.

Reaching Special Populations

The success of the HHP hinges on each MCP's ability to effectively engage the populations with the greatest need, who are also often the hardest to reach.

Members Experiencing Serious Mental Illness

MCPs in each HHP implementation group began by conducting outreach and providing HHP services to members with chronic health conditions. Six months after the initial launch, MCPs began providing services to members experiencing SMI (Appendix A). Because this effort is still in its infancy, limited learnings have been shared at the LC sessions conducted to date. As previously noted, MCPs have contracted with a number of different types of organizations to serve as CB-CMEs, including the county mental health plans, behavioral health providers, and community-based organizations. MCPs shared that formalizing

Building relationships with the county was critical to ensuring physical and mental health services are coordinated.

relationships with their local county took an enormous amount of effort and time, but was worth it to have the provision of physical and mental health services work in a collaborative way.

Additionally, DHCS has flagged for plans that there are a number of HHP requirements specific to providing HHP services to members with serious mental illness. For example, plans are required to update their Memorandums of Understanding (MOUs) with MHPs to address HHP-specific information, as set forth in All Plan Letter (APL) 18-015, regardless of whether they have or intend to contract with MHPs to serve as CB-CMEs.

Additionally, DHCS emphasized that, although members can be enrolled in both HHP and Specialty Mental Health Targeted Case Management (SMH TCM), HHP CB-CMEs must ensure that they coordinate with SMH TCM providers and do not duplicate any SMH TCM activities. DHCS also noted that, once enrolled and assigned to an HHP implementation phase (1 or 2), a member's phase assignment may not change. However, HHP members who are enrolled under Phase 1 but would be more effectively supported by a CB-CME contracted for Phase 2 may change CB-CME assignments (even though their phase assignment itself will not change).

Members Experiencing Homelessness

One of the most significant and innovative aspects of the HHP model is its emphasis on helping members who are experiencing chronic homelessness obtain and maintain housing. Although some providers and MCPs have experience connecting members to housing agencies, experience delivering intensive housing navigation support services, as envisioned under the HHP, is less common. For many providers and MCPs, the HHP provides an opportunity to take a more active role in helping members find temporary and permanent housing.

Create an internal MCP culture in which addressing members' housing status is part of regular business.

To take advantage of this opportunity and fulfill HHP requirements, plans reported that it was important to create an internal culture in which addressing members' homelessness was considered part of the plan's regular business, and not outside of the MCP's standard scope. Because many CB-CME health care providers, like plans, have not historically provided housing support services or focused on homelessness, CB-CME and MCP staff alike benefited from training on housing services basics and terminology. Some MCPs recommended contracting with a housing organization.

MCPs found it useful to conduct trainings for CB-CME staff specifically focused on HHP housing support services, including topics such as the role of the housing navigator in the care team and helping members prepare to be housed (e.g., by completing necessary paperwork and applications). MCPs also noted that because the housing support system differs substantially by county, it was critical for plans and CB-CME staff to develop an understanding of the local housing landscape. Having only a general understanding of the homelessness support system in California was insufficient to enable MCPs and CB-CMEs to effectively connect members experiencing homelessness to needed services.

Conduct specific trainings for CB-CME staff on housing services. Develop an understanding of the local housing landscape and build strong relationships with local housing organizations. Obtain real-time access to local housing management information system (HMIS) and/or leverage housing organization partnerships.

MCPs emphasized the importance of developing strong relationships with local housing organizations. They found it useful to invest in a relationship with the local planning body that coordinates housing and services funding for homeless individuals (known as the Continuum of Care or COC) and design a clear process for placing members into the local coordinated entry system (CES), which aims to rapidly connect individuals experiencing homelessness or a housing crisis to needed interventions. Plans noted that some HHP members experiencing homelessness had longstanding relationships with local housing organizations, not all of which were positive and functional. That meant that sometimes HHP housing navigators were not spending time introducing members to local housing organizations but instead helping repair relationships and restore trust between the member and the housing entity.

Although MCPs do not typically have access to the local housing management information system (HMIS), some plans were able to execute agreements necessary to gain real-time access to their local HMIS. When MCPs could not access HMIS directly, they leveraged their relationships with housing organizations to obtain information contained in the HMIS. Plans were in widespread agreement that accessing this information was critical to helping members experiencing homelessness.

Data Sharing, Tracking, and Reporting

MCPs discussed the importance of bi-directional data sharing with CB-CMEs, tracking member health status and services, and developing dashboards and reports to monitor implementation.

Data Sharing and Reporting

Under the HHP, health plans must establish data-sharing agreements with CB-CMEs, and other providers as needed, to facilitate the tracking and sharing of member information regarding the provision of HHP services. When an HHP member is admitted to the hospital or is discharged from the emergency room, the MCP must notify the member's CB-CME. In addition, MCPs developed their own data management and analysis systems to ensure their compliance with DHCS's HHP reporting requirements.

It is critical to establish and execute data-sharing agreements with CB-CMEs prior to launch.

Effective data sharing between MCPs and CB-CMEs is a cornerstone of the HHP model. MCPs had significant learnings on how to prepare CB-CMEs to share HHP data. Specifically, plans emphasized the importance of:

- Executing data-sharing agreements with CB-CMEs prior to launch;
- Ensuring that prior to launch, CB-CMEs have all IT and data systems needed for HHP operation;
- Training CB-CME staff on all relevant data sharing and IT systems;
- Providing CB-CMEs with data specifications and a data dictionary if possible and being clear about what exact information must be recorded and shared;
- Being flexible (to the extent possible) as to how data is submitted since CB-CMEs vary in their IT systems and capacity; and
- Offering technical assistance to CB-CMEs after implementation to support effective data tracking and exchange.

Plans and CB-CMEs reported using a variety of systems for HHP data tracking and reporting. Many plans had success using care management programs to track member health status, the provision of services, and other aspects of HHP operation. Plans identified the following features of their care management programs as beneficial to HHP operations:

- Flags to identify HHP enrollees and members included on the TEL;
- Easy access to member health information including diagnoses and prescriptions;
- Inclusion of all state-approved templates and the Health Action Plan (HAP);
- Member assessment tools that create a customized path through the assessment, which varies based on the member's answers (referred to as "branch logic");

- Algorithms to tag documented care management activities (such as care coordination) with the appropriate codes and modifiers to make it easy and seamless for CB-CMEs to submit encounters to the MCP;
- The ability to generate letters to members; and
- The ability to set reminders and follow-up tasks.

Plans also reported that a comprehensive care management system makes it easier to audit HHP operations, since all necessary case documentation can be pulled directly from the system. More generally, plans agreed that whatever system was employed had to be able to provide CB-CMEs with the information they need to effectively serve members, including information on member prescriptions and medical (physical and mental health) history, demographic and contact information for members, inpatient and emergency department utilization dates, and health risk assessments on members conducted by the MCP.

A comprehensive care management system helps provide MCPs and CB-CMEs with the information they need to effectively serve members.

MCPs are required under HHP rules to notify CB-CMEs when members are admitted or discharged from an inpatient setting or visit the emergency department. In an exciting development, some MCPs are working on building the capacity to automatically notify CB-CMEs of inpatient admissions and discharges and emergency department visits as soon as the plan learns of the event.

The Health Action Plan (HAP), which is a comprehensive, individualized, person-centered care plan required for all HHP members, was identified by many MCPs as a critical document to keep track of and share with care team members and other providers. Some plans have required CB-CMEs to upload each HAP they create to a secure file transfer protocol site. Others have focused on ensuring that the HAP is shared with providers outside the CB-CME who are also serving the HHP member to promote care coordination.

The Health Action Plan is critical in tracking progress and sharing information across the care team. Some MCPs required CB-CMEs to upload each HAP to a secure file transfer protocol site. Some MCPs ensured the HAP is shared with providers outside the CB-CME who serve the member.

Plan Dashboards and Reports

Plans reported using dashboards and reports to track multiple metrics and data points related to HHP operation. Metrics/data points tracked by MCPs include, but are not limited to:

- Outreach activities, including percent of HHP-eligible members contacted;
- Number of members enrolled in the HHP;
- Number of members who declined enrollment and reasons for not enrolling;
- Data on how quickly a HAP is completed after enrollment (by category: not completed, within 90 days, after 90 days);
- The retention rate or how quickly members disenroll from the program;
- Real-time data on where members and CB-CMEs are located, which helps plans assign members to CB-CMEs and identify areas to target for CB-CME recruitment; and
- The number of members assigned to each CB-CME and a comparison of CB-CME enrollment numbers to capacity.

MCPs reported that using dashboards and reports has allowed them to monitor their HHP activities and performance and comply with DHCS's reporting requirements.

Conclusion

Lessons from HHP implementation to date include:

- The importance of regular communication between MCPs and CB-CMEs, both during the program planning period and after program launch;
- A strong focus on outreach and engagement of members and supporting CB-CMEs in their outreach efforts;
- Investment in MCP and CB-CME staff training, particularly around housing issues is critical;
- The importance of building relationships with local housing organizations and coordinating with the county mental health system to support members with serious mental illness; and
- Attention to bi-directional data-sharing between MCPs and CB-CMEs, monitoring, and reporting.

These lessons and promising practices from MCPs in providing effective intensive care management and care coordination service and connecting members to social supports including housing can inform and streamline the implementation of the CalAIM initiative.

Appendix A. Health Homes Program Background

This Appendix provides background on the Health Homes Program. For additional information, visit the DHCS Health Homes Program website.

Section 2703 of the Affordable Care Act (ACA) granted states a new opportunity to provide Medicaid health home services to coordinate the full range of physical health and behavioral health services, and community-based long-term services and supports (LTSS) for members with chronic conditions. In 2013, California enacted AB 361 (codified at California Welfare & Institutions Code Sec. 14127-28) which authorized DHCS to create a Health Homes Program, subject to federal approval. DHCS submitted State Plan Amendments to the Centers for Medicare & Medicaid Services to add health home services as a covered Medi-Cal benefit.

HHP Overview

The Health Homes Program (HHP) is designed to serve eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by eligible beneficiaries.

As of September 30, 2019, there were 14,300 individuals enrolled in the HHP. Implementation of the HHP began in San Francisco County on July 1, 2018 and will be complete for all 12 participating counties and populations by July 1, 2020. See below for enrollment information and the HHP implementation schedule by group.

Delivery System

Medi-Cal Managed Care Plans (MCPs), which administer health services to approximately 85 percent of full scope Medi-Cal members, serve as the foundation of the HHP infrastructure. MCPs are responsible for developing a network of healthcare and social service providers that work as a team to provide HHP services. Key to that network are community health care providers, referred to as Community-Based Care Management Entities (CB-CMEs), which contract with plans to perform various HHP services including:

- Reaching out to and engaging plan members eligible for HHP enrollment;
- Enrolling plan members into the HHP;
- Providing care management and coordination to HHP members; and
- Connecting HHP members to other healthcare and social supports as needed.

HHP payments are made directly from DHCS to MCPs through monthly capitation rates (i.e., a set amount per member per month). MCPs have discretion to determine how they compensate CB-CMEs and potentially other providers for the provision of HHP services.

HHP Eligibility

To be eligible for HHP services, an individual must:

(1) Be enrolled in an MCP;
(2) Have certain chronic health or mental health conditions, such as diabetes, asthma, substance use disorder, or serious mental illness, among others; and
(3) Meet certain acuity/complexity criteria, one of which is chronic homelessness.

The detailed eligibility criteria is in the HHP Program Guide (found on the DHCS HHP website).

HHP Services

Each enrolled HHP member is given a care coordinator and a multidisciplinary care team that works together to address their health care needs and goals. There are six core HHP services:

- Comprehensive Care Management;
- Care Coordination;
- Health Promotion;
- Comprehensive Transitional Care;
- Individual and Family Support Services; and
- Referral to Community and Social Supports

HHP Enrollment and Implementation Timeline

Group	Counties	Enrollment (September 2019)	Phase 1 Implementation date for members with eligible chronic physical conditions and substance use disorders	Phase 2 Implementation date for members with eligible serious mental illness conditions
Group 1	San Francisco	539	July 1, 2018	January 1, 2019
Group 2	Riverside; San Bernardino	7,436	January 1, 2019	July 1, 2019
Group 3	Alameda; Imperial; Kern; Los Angeles; Sacramento; San Diego; Santa Clara; Tulare	6,325	July 1, 2019	January 1, 2020
Group 4	Orange	Enrollment recently began	January 1, 2020	July 1, 2020