Planning for Health Homes Implementation in California: Key Steps

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The Health Homes Program (HHP) is geared toward high-risk Medi-Cal enrollees whose care could be improved by additional coordination services. Currently, the California Department of Health Care Services (DHCS), Medi-Cal managed care plans (MCPs) and Community-Based Care Management Entities (CB-CMEs) across the state are implementing HHP. California stakeholders are also preparing for how an Enhanced Care Management (ECM) benefit will sustain HHP services. HHP implementation is rolling out in four groups comprised of the 12 participating counties.[1] Each group is implement the program in 2 phases: Phase 1 for members with eligible chronic physical conditions and substance use disorders and Phase 2 for members with eligible serious mental illness conditions.[2] Based on interviews with early implementers of the program, this document lays out some of the key considerations for Health Homes implementation planning in four areas: partnerships and contracts, hiring and training, data sharing, and integration with Whole Person Care. These insights will be relevant for both the HHP and the future ECM in California.

PARTNERSHIPS AND CONTRACTS

Selecting a good fit for partnerships requires that partners (namely, MCPs and CB-CMEs) have shared expectations and contractual agreements in place about key aspects of program administration. During contract negotiations and at the beginning of the partnership, CB-CMEs and MCPs should:

- **Sign a contractual agreement for payment of services.** DHCS pays the MCP, which in turn, disperses payment to the CB-CMEs based on claims and/or encounter data for HHP enrollees.
- **Identify and agree upon a service delivery model including caseloads and a care coordinator to patient ratio.** It is key to clarify the percentage of HHP-eligible patients for whom a MCP expects a CB-CME to provide care.
- **Establish agreements for how MCPs and CB-CMEs will integrate other services**, including community social supports, substance use disorder services, long term support services, and housing services into a member's Health Action Plan.[3]

Additionally, CB-CMEs should consider whether they will subcontract with other community-based organizations or individuals to provide some HHP services to their eligible members, even though CB-CMEs will be responsible for ensuring all required duties are being met.[4]

HIRING AND TRAINING

Key considerations for assembling an HHP team include the care team composition, hiring process, and training requirements. MCPs and CB-CMEs can:

- **Take advantage of staffing flexibility.** DHCS requires that each HHP multi-disciplinary care team include a care coordinator, HHP director, and clinical consultant (which can be fulfilled via several qualifications). Beyond this, the MCP has discretion to create an HHP provider network that meets the needs of its patient population.
- **Factor in hiring challenges.** CB-CMEs need to be realistic about timelines for hiring new staff given the existing workforce shortages, need for market competitive salaries (HHP rates that DHCS pays to plans decline as the program continues), and potential delays in hiring processes.
- **Ensure that key training messages are aligned.** If both CB-CMEs and MCPs are offering training to HHP teams based at CB-CME sites, confusion can arise. Strong training requirements are especially helpful for community-facing roles, such as community health workers, regarding working safely in the community and documenting care sufficiently.

1. At the time of publication, Group 1 includes San Francisco County, Group 2 includes Riverside and San Bernardino Counties, Group 3 includes Alameda, Imperial, Kern, Los Angeles, Sacramento, San Diego, Santa Clara and Tulare Counties, and Group 4 includes Orange County.
2. Medi-Cal Health Homes Program: Program Guide. California Department of Health Care Services; https://www.dhcs.ca.gov/services/Documents/MCQMD/HHP%20Documents/HHP_Program_Guide_11.01.19.pdf. Published November 1, 2019. Accessed November 7, 2019.
3. Ibid.
4. Ibid.

DATA SHARING

Data sharing is a critical aspect of HHP implementation for MCPs, CB-CMEs and other partners. Data sharing is needed for identifying HHP-eligible members and for managing their care. It is both technically complex in terms of the infrastructure required, and also in terms of creating agreements and protecting patient privacy. MCP and CB-CME leadership and partners should:

- **Plan for alignment between systems.** Data sharing requires that systems be able to "talk to one another" in multiple settings, including between CB-CMEs, MCPs and other CBO partners.
- **Detail reporting and data sharing requirements,** including MCP auditing of care management requirements and notification to CB-CMEs of members' inpatient admissions and ED visits.
- **Keep track of current eligibility and enrollment.** Every six months, DHCS creates a Targeted Engagement List (TEL); the MCP uses this information to engage HHP-eligible members. The TEL notes which members meet criteria for eligible chronic conditions and acuity. With approval from DHCS, MCPs may implement policies to prioritize outreach to certain members.[5]
- **Ensure MCPs assist CB-CMEs with data related to care coordination and identifying gaps in care**. Per program guidance, MCPs are required to work in partnership with CB-CMEs to assist with data on inpatient admissions and discharges, ED visits, gaps in care, and other relevant data for members with complex health needs.[6] MCPs and CB-CMEs may do this by monitoring documented care gaps in the member's case file or health action plan, assessment of the member's perception of gaps in care or through other means specified in program guidance.[7]

WHOLE PERSON CARE AND HHP INTEGRATION

Whole Person Care (WPC) is being implemented in many Health Homes counties. MCPs, CB-CMEs, and county leads of WPC should consider several factors regarding integration of the two programs. HHP and WPC leadership can:

- **Prevent duplication of services.** Eligible members may receive services from both WPC and HHP if such services do not overlap. Members are not to receive duplicative care coordination services from the two programs, and they may select one program through which to receive their care coordination services. WPC lead entities are required to ensure the non-duplication of services and may do so by communicating with the MCP and periodically checking member participation in other programs.[8]
- **Share information and maintain communication.** Strengthening these relationships early on and attending key meetings for each program is one strategy to remain aligned and up-to-date. Some WPC and HHP leadership may decide to set regular planning meetings for both programs together. This can facilitate alignment in key areas such as data sharing.
- **Strive to collaborate for financial sustainability.** Organizations involved in WPC and HHP can design WPC care management services in alignment with HHP requirements. This supports one care management model across the two programs and sets the stage for an ECM implementation in the future. Additionally, WPC and HHP organizations should share plans for staffing to align care teams within clinics that participate in both WPC and as CB-CMEs.
- **Sequence funding for infrastructure**. Counties and entities participating in both WPC and HHP should utilize WPC infrastructure investments in information exchanges and other needed infrastructure for use in HHP.

5. Medi-Cal Health Homes Program: Program Guide. California Department of Health Care Services; https://www.dhcs.ca.gov/services/Documents/MCQMD/HHP%20Documents/HHP_Program_Guide_11.01.19.pdf. Published November 1, 2019. Accessed November 7, 2019.
6. Ibid.
7. Ibid.
8. Ibid.