Community Health Workers in the Medi-Cal Health Home Program

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10-27-16
Health Homes Program - Background

• ACA Section 2703
  – Created the new state-optional health homes Medicaid benefit for intensive care coordination for people with chronic conditions
  – 90% federal funding for the first eight quarters, 50% thereafter

• Assembly Bill 361 – enacted in 2013
  – Requires inclusion of specific target populations of frequent utilizers and those experiencing homelessness
  – Requires that DHCS implement only if no additional State General Funds will be used
HHP Services

• The HHP includes six core services, delivered through the managed care system:
  – Comprehensive care management
  – Care coordination
  – Health promotion
  – Comprehensive transitional care
  – Individual and family support
  – Referral to community and social support services

• HHP includes the use of health information technology and exchanges (HIT/HIE), as feasible and appropriate
<table>
<thead>
<tr>
<th>Counties</th>
<th>Implementation Date for Members with Eligible Chronic Physical Conditions</th>
<th>Implementation Date for Members with Serious Mental Illness</th>
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</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td></td>
<td></td>
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<tr>
<td>Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, Shasta, Solano, Sonoma, Yolo</td>
<td>July 1, 2017</td>
<td>January 1, 2018</td>
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<td><strong>Group 2</strong></td>
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<td>Imperial, Lassen, Merced, Monterey, Orange, Riverside, San Bernardino, San Mateo, Santa Clara, Santa Cruz, Siskiyou</td>
<td>January 1, 2018</td>
<td>July 1, 2018</td>
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<td><strong>Group 3</strong></td>
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<tr>
<td>Alameda, Fresno, Kern, Los Angeles, Sacramento, San Diego, Tulare</td>
<td>July 1, 2018</td>
<td>January 1, 2019</td>
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</tbody>
</table>
HHP Eligibility: Highest Risk 3%

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<thead>
<tr>
<th>Two or more of these:</th>
<th>HTN and one of these:</th>
<th>SMI:</th>
<th>Asthma and risk of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>COPD</td>
<td>Major depression</td>
<td>Diabetes</td>
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<tr>
<td>COPD</td>
<td>Diabetes</td>
<td>Bipolar disorder</td>
<td>Substance use disorder</td>
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<tr>
<td>Diabetes</td>
<td>CAD</td>
<td>Psychotic disorder</td>
<td>Depression</td>
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<td>Traumatic brain injury</td>
<td>CHF</td>
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<td>Obesity</td>
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<td>CHF</td>
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<td>CAD</td>
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<td>Chronic liver disease</td>
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<td></td>
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<td>Dementia</td>
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<tr>
<td>Substance use disorder</td>
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</tbody>
</table>

AND:
1. Three of the eligible conditions, or
2. One inpatient stay in last 12 months, or
3. Three ED visits in last 12 months, or
4. Chronic homelessness
**Health Home Network**

**MANAGED CARE PLANS (MCPs)**
- **Mandatory:** MCP and Medicare-Medicaid plans in target HHP counties
- **Optional:** MHP and county integrated Mental Health/Substance Use Disorder plans in target HHP counties

**COMMUNITY BASED CARE MANAGEMENT ENTITIES (CB-CMEs)**
Qualifying organizations include: Community health centers, community mental health centers, hospitals, local health departments, primary care or specialist physicians or groups, SUD treatment providers, providers serving individuals experiencing homelessness, or other organizations who meet CB-CME requirements and are selected by the MCP

**COMMUNITY AND SOCIAL SUPPORT SERVICES**
Sample organizations could include supportive housing providers, food banks, employment assistance, social services
1. DHCS will develop a capitated, risk-based add-on payment for each enrolled HHP member, which will be paid to the MCP.

2. The MCP will develop a contracted network of HHP community providers.

3. CB-CMEs serve as primary frontline, community providers of HHP services, delegated by the MCP.

4. MCPs have the flexibility to:
   1. Contract for services and rates; and
   2. Determine how CB-CMEs are organized to best provide services to members (within DHCS guidelines)
CB-CME Duties

• CB-CMEs are responsible for overall care management, including:
  – Care team staffing/training
  – Reporting to MCP
  – Driving all activities relating to the HAP
  – Coordinating with other entities, conducting case conferences as needed to ensure care is integrated among providers
  – Managing and following up on referrals and including family in care planning and transitions

• See the Health Homes Program Concept Paper for a detailed list of duties
Multi-Disciplinary Team

• CB-CME will employ a multi-disciplinary team to provide HHP services, including:
  – Dedicated care manager
  – HHP director
  – Clinical consultant(s)
  – Community health workers
  – Housing navigator (for members experiencing chronic homelessness)

• Additional team members may be included in order to meet an individual member’s care coordination needs
Another Opportunity: WPC Pilots

1115 Demonstration Waiver:

Whole Person Care (WPC) Pilots

1. Similar goals as HHP regarding whole person care coordination and services, but operated by counties

2. Additional focus of developing strategies and data systems to bring the silos together:
   – Physical health; Behavioral health; Substance use disorder; Stable housing; Corrections; and others

3. Flexibility in the staffing model – each pilot can do it their own way (within broad DHCS guidance).

4. 18 current county pilot applicants
GOOGLE “DHCS Whole Person Care Pilots” for:
1. Additional Whole Person Care Pilot program information
2. Email address for questions or requests to be included on future 1115 Waiver Whole Person Care Pilot stakeholder communications from DHCS

GOOGLE “DHCS Health Homes Program” for:
1. Update rollout schedule
2. Health Homes Program Concept Paper
3. Email address for questions or requests to be included on future HHP stakeholder communications from DHCS