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State/Territory Name: California

State Plan Amendment (SPA) #: 16-007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

December 19, 2017

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services (DHCS)
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

The Centers for Medicare & Medicaid Services (CMS) San Francisco Regional Office has completed its review of California State Plan Amendment (SPA) Transmittal Number 16-007. This SPA implements Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act. The state plan pages for this SPA were submitted and approved through the Medicaid Model Data Lab. To qualify for enrollment in a health home, Medicaid participants must have (a) two or more chronic conditions from the following list of conditions: substance abuse disorder, asthma, diabetes, heart disease, chronic liver disease, chronic obstructive pulmonary disease (COPD), chronic or congestive heart failure, chronic renal disease, dementia, HIBP, only combined with COPD, DM, CAD, chronic or CHF and traumatic brain injury or (b) one chronic condition of asthma and be at risk of developing either diabetes, SUD, depression or BMI over 25. This SPA delegates designated providers, as described in Section 1945(h)(6) of the Social Security Act, as the health home provider.

We are approving this SPA with an effective date of July 1, 2018, and have included the approved state plan pages with this letter. In accordance with the statutory provisions at Section 1945(c) (1) of the Social Security Act, for payments made to health home providers under this amendment, during the first eight fiscal quarters that the SPA is in effect, July 1, 2018 through June 30, 2020, the federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the state's published FMAP rate on July 1, 2020.

We want to remind DHCS that it must submit a claiming methodology to be approved by CMS *before* the state can claim any portion of the managed care payments at the enhanced matching rate. CMS recommends that DHCS submit this claiming methodology *no later than 60 calendar days* before the state begins claiming health home expenses incurred starting on July 1, 2018. CMS staff are available to provide technical assistance in this area upon request.

This approval is based on the state's agreement to collect and report information required for the evaluation of the health home model. CMS encourages DHCS to report on the CMS recommended core set of quality measures.

CMS is approving this SPA concurrently with a companion 1115 state demonstration waiver amendment to waive freedom of choice, which will allow the state to provide HHP services through the Medi-Cal managed care delivery system. The effective date of the 1115 state demonstration waiver amendment is July 1, 2018.

CMS understands with the approval of this SPA, along with the approval of the companion Section 1115 demonstration amendment, California plans to develop prospective risk-based rates for the health homes services provided under the managed care plans. CMS expects that the state will develop the overall capitation rates, including the HHP-related rates, on a timely basis, which will provide CMS an opportunity to review the rates prior to the rating period. In addition, CMS also expects the state to make progress on the reconciliation related to the medical loss ratio for the adult expansion group for the reporting periods of January 2014 through June 2015 and July 2015 through June 2016. This request is consistent with the information outlined in the November 17, 2017 letter from CMS.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Health Home State Plan Amendment, pages 1-53.

If you have any questions concerning this amendment, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Henrietta Sam-Louie
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Sarah Brooks, California Department of Health Care Services (DHCS)
Brian Hansen, DHCS
Alan Roush, DHCS
Nathaniel Emery, DHCS

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Transmittal Number: CA-16-007 Supersedes Transmittal Number: Proposed Effective Date: Jul 1, 2018 Approval Date: Attachment 3.1-H Page Number:

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

CA-16-007

Supersedes Transmittal Number:
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☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:

CA Health Home Program (HHP)

State Information

State/Territory name:	**California**
Medicaid agency:	Department of Health Care Services (DHCS)

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name:	Nathaniel Emery
Title:	SPA Coordinator
Telephone number:	(916) 445-8657
Email:	nathaniel.emery@dhcs.ca.gov

The primary contact for this submission package.

Name:	Gloria Petrul
Title:	Health Program Specialist

Telephone number:	(916) 552-9678
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The secondary contact for this submission package.

Name:	Bob Baxter
Title:	Chief Health Homes Section
Telephone number:	(916) 552-9375
Email:	bob.baxter@dhcs.ca.gov

The tertiary contact for this submission package.

Name:	Nathan Nau
Title:	Chief Managed Care Quality & Monitoring Division
Telephone number:	(916) 552-9373
Email:	nathan.nau@dhcs.ca.gov

Proposed Effective Date

07/01/2018 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
CA's 1st HHP SPA is for the 11 Group 1 counties & the population criterion of chronic physical conditions/SUD. Additional counties for Groups 2 and 3 for chronic conditions/SUD will be submitted as amendments to this SPA. A separate SPA will be submitted for specific counties & the population criteria of Serious Mental Illness or Serious Emotional Disturbance. The HHP will utilize the Medi-Cal Managed Care (MCMC) infrastructure. Managed care plans (MCPs) will be responsible for the overall administration of the HHP. The HHP will be structured as a HHP network including MCP, one or more Community Based Care Management Entities (CB-CMEs), linkages to Medi-Cal specialty mental health plans, community & social support services. The HHP benefit authorized herein, will operate in conjunction with, & is subject to the terms of, the state's approved section 1115 demonstration, including any approved waiver of freedom-of-choice that enables the state to limit the HHP benefit to the MCMC Delivery System. The goals for HHP are: improve care coordination; integrate palliative care; strengthen community linkages & team- based care; improve the health outcomes of HHP members; & wrap increased care coordination around existing care as close to the member's usual point of care delivery as possible in the community. DHCS Objectives include ensure sufficient provider infrastructure & capacity to implement HHP as an entitlement benefit; ensure HHP providers appropriately serve members experiencing homelessness; & increase integration of physical & behavioral health services. Group 1 Counties (Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, Shasta, Solano, Sonoma, Yolo) will implement 7/1/18. Group 2 Counties (Imperial, Lassen, Merced, Monterey, Orange, Riverside, San Bernardino, San Mateo, Santa Clara, Santa Cruz, Siskiyou) will implement on 1/1/19. Group 3 Counties (Alameda, Fresno, Kern, LA, Sacramento, San Diego, Tulare) will implement 7/1/19.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2018	$ 477535.50
Second Year	2019	$ 5490342.00

Federal Statute/Regulation Citation

Section 2703 of the Patient Protection & Affordable Care Act

Governor's Office Review

- ○ **No comment.**
- ○ **Comments received.**
  Describe:
- ○ **No response within 45 days.**
- ◉ **Other.**
  Describe:
  Governor office does not want to review.

Transmittal Number: CA-16-007 Supersedes Transmittal Number: Proposed Effective Date: Jul 1, 2018 Approval Date:

Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

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  Describe:
- ○ **No response within 45 days.**
- ◉ **Other.**
  Describe:
  Governor office does not want to review.

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Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- ○ **Public notice was not required and comment was not solicited**
- ○ **Public notice was not required, but comment was solicited**
- ◉ **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

- ☐ **Newspaper Announcement**

☑ **ublication in State's administrative record, in accordance with the administrativ**

Date of Publication:
05/29/2015 (mm/dd/yyyy)

☐ **Email to Electronic Mailing List or Similar Mechanism.**

Date of Email or other electronic notification:
(mm/dd/yyyy)

Description:

☐ **Website Notice**

Select the type of website:

☐ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:
(mm/dd/yyyy)

Website URL:

☐ Website for State Regulations

Date of Posting:
(mm/dd/yyyy)

Website URL:

☐ Other

☐ **Public Hearing or Meeting**

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: CA-16-007 Supersedes Transmittal Number: Proposed Effective Date: Jul 1, 2018 Approval Date:

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Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **e State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☐ **Indian Tribes**

☑ **ndian Health Program**

Indian Health Programs	
Name of Indian Health Programs:	
All IHPs	

Indian Health Programs	
Date of consultation: 05/29/2015 (mm/dd/yyyy) Method/Location of consultation: On 5/26/15 the tribal notice was sent to Indian health programs and Urban Indian Organizations. On 5/29/15 a tribal webinar was held with Indian health programs and Urban Indian Organizations on the SPA.	

☑ **an Organizati**

Urban Indian Organizations	
Name of Urban Indian Organization: All UIOs Date of consultation: 05/29/2015 (mm/dd/yyyy) Method/Location of consultation: On 5/26/15 the tribal notice was sent to Indian health programs and Urban Indian Organizations. On 5/29/15 a tribal webinar was held with Indian health programs and Urban Indian Organizations on the SPA.	

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☑ **Payment methodology**

Summarize Comments

The HHP tiered payment structure should include metrics that account for the social determinants of health. The payment methodology should support and strengthen services provided by Federally Qualified Health Centers/Urban Indian Health Organizations while ensuring that duplicative payment does not occur and that FQHCs/UIHs can participate in the HHP network.

Summarize Response

Homelessness and other social determinants of health will be considered in how DHCS calculates the funding for HHP services. Duplication of services or payment is not allowed under HHP. DHCS anticipates that the additional funding allocated for HHP services will support and strengthen care coordination activities in all HHP participating organizations and providers including FQHCs/UIH organizations.

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☑ **Other Issue**

Issues	
Issue Name: Definition **Summarize Comments** Definitional language needs to be added to include “Natural Helpers” and “Traditional Healers” to the multi-disciplinary HHP team. **Summarize Response** We will take this recommendation under consideration.	

Transmittal Number: CA-16-007 Supersedes Transmittal Number: Proposed Effective Date: Jul 1, 2018 Approval Date:

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Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation: 12/21/2015 (mm/dd/yyyy)	
Date of consultation: (mm/dd/yyyy)	
Date of consultation: (mm/dd/yyyy)	

Transmittal Number: CA-16-007 Supersedes Transmittal Number: Proposed Effective Date: Jul 1, 2018 Approval Date:

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Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☑ **Two or more chronic conditions**

Specify the conditions included:

☐ **Mental Health Condition**
☑ **Substance Abuse Disorder**
☑ **Asthma**
☑ **Diabetes**
☑ **Heart Disease**
☐ **BMI over 25**

Other Chronic Conditions	
chronic liver disease	
chronic obstructive pulmonary disease (COPD)	
chronic or congestive heart failure	
Chronic Renal Disease	
dementia	
HBP, only combined with one of the following: COPD, DM, CAD, chronic or CHF	
traumatic brain injury	

☑ **One chronic condition and the risk of developing another**

Specify the conditions included:

☐ **Mental Health Condition**
☐ **Substance Abuse Disorder**
☑ **Asthma**
☐ **Diabetes**
☐ **Heart Disease**
☐ **BMI over 25**

Other Chronic Conditions	
asthma with diabetes or SUD or depression or BMI over 25	

Specify the criteria for at risk of developing another chronic condition:
To be eligible for HHP, a member must meet the following eligibility criteria: A) two or more chronic conditions specified above; or one chronic condition and the risk of developing another defined as the one chronic condition of asthma and at risk of developing at least one of the following: diabetes, or SUD, or depression, or BMI over 25; and B) at least one of the following acuity/complexity criteria: chronic homelessness; or three, or more, of the HHP eligible chronic conditions; or at least one inpatient stay in the last year; or three or more Emergency Department (ED) visits in the last year. Citations for asthma include: Bhan N, Glymour M, Kawachii I, Subramanian V. Childhood adversity and asthma prevalence: Evidence from 10 US states (2009-2011); BMJ Open Respir Res 2014; 1(1):e000016;National Asthma Education and Prevention Program (NAEPP), Third Expert Panel on the Diagnosis and Management of Asthma. Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. Bethesda, MD: National Heart, Lung, and Blood Institute, 2007; Rastogi D, Fraser S, Oh J, Huber AM, Schulman Y, Bhagtani RH, Khan ZS, Tesfa L, Hall CB, Macian F. Inflammation, metabolic dysregulation, and pulmonary function among obese urban adolescents with asthma; Am J Respir Crit Care Med

2015; 191(2):149-60;Song Y, Klevak A, Mason J, Buring J, Liu S. Asthma, Chronic Obstructive Pulmonary Disease, and Type 2 Diabetes in the Women's Health Study; Diabetes Res Clin Pract 2010: 90(3): 365–371. Citations for hypertension include: Mozaffarian D, Benjamin EJ, Go AS, et. al. Heart disease and stroke statistics: 2016 update: a report from the American Heart Association. Circulation 2016; 133: e38–e360; Arauz-Pacheco C, Parrot MA, Raskin P; The Treatment of Hypertension in Adult Patients with Diabetes. Diabetes Care 2002; 25(1):134-147; Sin DD, Anthonisen NR, Soriano JB, Agusti AG. Mortality in COPD: Role of comorbidities. Eur Respir J 2006; 6:1245-57.

☐ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:

Geographic Limitations

☐ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

If no, specify the geographic limitations:

◉ **By county**

Specify which counties:
Group 1: Counties of Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, Shasta, Solano, Sonoma, and Yolo will implement chronic physical conditions and Substance Use Disorder on July 1, 2018.

○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

◉ **Opt-In to Health Homes provider**

Describe the process used:
MCPs will notify their members via a notice, no later than the start of HHP in the county, that HHP is enhanced care coordination for members with chronic conditions, is voluntary, members can choose a different CB-CME, and they can opt-out at any time. DHCS/MCPs will develop the Targeted Engagement List (TEL) based upon eligibility and utilization data multiple times each year. MCPs will use the TEL to conduct a progressive process (including letters, phone calls, in-person visits, texts, and emails) to engage the members. Members are advised that the HHP is voluntary, and that they can opt-out at any time. MCPs will inform members of their assigned CB-CME and the option to choose a different CB-CME. If the member's assigned primary care physician is affiliated with a CB-CME, the member will be assigned to that CB-CME, unless the member chooses another CB-CME.
The MCP and/or CB-CME will secure consent from the member to participate in HHP and to authorize release of information in accordance with legal requirements. The MCP/CB-CME will maintain records of these consents.
DHCS is providing significant resources for provider awareness and engagement to facilitate participation in the program. Providers will have the ability to refer potentially eligible members to their MCPs to evaluate their eligibility for HHP.

DHCS will use administrative data to identify and notify potentially eligible FFS members regarding the HHP. This notice will be provided no later than the start of HHP in the county, and will inform these members that HHP is enhanced care coordination for members with chronic conditions, is voluntary, that they have the option to enroll in managed care for all of their services, including HHP services, have the opportunity to choose a different CB-CME, and HHP members can opt-out at any time. Providers can refer potentially eligible FFS members to the program for eligibility determination.

○ **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:

☐ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**

Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**

☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**

☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**

☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

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Health Homes Providers

Types of Health Homes Providers

☑ **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☑ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☑ **Other (Specify)**

Provider	
Name: Community Based Care Management Entity (CB-CMEs) Provider Qualifications and Standards: 1. Organizations must be: behavioral health entities, community mental health center, community health center, FQHCs, rural health center, 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, substance use disorder treatment provider, providers serving those that experience homelessness, other entities who meet certification and qualifications of a CB-CME may serve in this capacity if selected and certified by the MCP. 2. Experience serving Medi-Cal members and, as appropriate for their assigned HHP member population, experience with high-risk members such as individuals who are homeless; 3. Comply with all program requirements; 4. Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls; 5. Provide appropriate and timely in-person care coordination activities, as needed. If in person communication is not possible, alternative communication methods in addition to in-person such as telehealth or telephonic contacts may also be utilized if culturally appropriate and accessible for the HHP member to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice; 6. Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals; 7. Agree to accept any eligible HHP members assigned by the MCP, according to their contract with the MCP; 8. Demonstrate engagement and cooperation of 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; 9. Use HIT/HIE to link HHP services and share relevant information with other providers involved in the HHP member's care, in accordance with the HIT/HIE goals.	
Name: Managed Care Plans (MCPs) Provider Qualifications and Standards: 1. Qualified through review of certification criteria and through a readiness review process. 2. Contracts directly with the state 3. Have experience operating broad-based regional provider network 4. Have an adequate network of CB-CMEs (including behavioral health professionals) in geographic target areas for HHP to serve eligible members, maintained through contracts, MOU or MOA with organizations that are part of the HHP provider network.	

Provider	
5. Have the capacity to qualify and support organizations who meet the standards for CB-CMEs, including: • Identifying organizations; • Providing the infrastructure and tools necessary to support CB-CME in care coordination; • Gathering and sharing HHP member-level information regarding health care utilization, gaps in care and medications; • Providing outcome tools and measurement protocols to assess CB-CME effectiveness; and • Developing and offering learning activities that will support CB-CME. 6. Have authority to access Medi-Cal claims/encounter data for the population served;	

☐ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**

9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description:

1.Require MCPs to have an adequate network.
2.Providers will follow existing managed care contractual requirements and guidance including maintenance of a quality improvement program, and provider training on evidenced-based practice guidelines.
3.DHCS will provide guidelines/requirements, including readiness tools to determine if MCPs and their network are ready to implement the HHP. The readiness tools will be used to conduct assessments of provider organizations identified by MCPs and the State as potential CB-CMEs. The assessment tool addresses staff composition,data infrastructure, etc.
4.An instructional program for care coordinators is being developed to include a series of instructional sessions for a patient-centered, high touch model of care management including, but not limited to online instruction, peer sharing through webinars, and multiple sessions on advanced care coordination beginning prior to implementation and continuing after implementation. Each stage of the care coordinator-patient partnership will be addressed in the curriculum (outreach, engagement, assessment, care plan development, and coordination of all services).
5.Materials developed under #4 above will be used as a base with the addition of new materials to establish a learning collaborative to educate providers before and after implementation with the appropriate tools and materials for successful program operation and to guarantee participation in quality improvement activities designed to improve performance of the HHPs and outcomes for the HHP members. Best practices and lessons learned will be analyzed and shared during teleconferences to support their usage. Topics will include development and implementation of communication techniques, engagement strategies, and care coordinator training. This learning collaborative will consist of a combination of statewide and regional meetings, webinars, teleconferences, and a provider's section of the State's HHP webpage.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

HHP services and care team providers will be added to California's managed care plan (MCP) infrastructure (including all non-Cal Medi-Connect and non-specialty plans) to facilitate the expansion needed for enhanced HHP services to members enrolled in managed care. HHP is supported by the existing services provided in the managed care environment. The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including the assignment of each HHP member to a Primary Care Provider. The MCPs also have existing relationships with the Medi-Cal County Specialty Mental Health plans (MHP) in each county to facilitate care coordination.

The HHP will be structured as a HHP network to provide care coordination. This network includes MCP, one or more Community Based Care Management Entity (CB-CME), and community and social support services (taken together as the health home). The delivery of HHP services will be accomplished through the partnership between MCP and CB-CME either through direct provision of HHP services, or through contractual arrangements with appropriate providers who will be providing components of the HHP services and planning and coordination of other services. MCPs contract directly with the State and will be responsible for the overall administration of the HHP, maintain overall responsibility for the HHP network, and receive HHP payment from the State. CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. The vast majority of CB-CMEs will have contracts with the MCPs. In limited cases some duties may be provided under an MOU or MOA. In all cases there will be an agreement which will be either a contract, MOU or MOA between the MCPs and CB-CMEs. MCPs will certify and select organizations to serve as CB-CMEs. The CB-CMEs serve as the single community-based entities with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or

willing to provide for the full range of CB-CME duties, the MCP can perform duties of the CB-CME, or subcontract with other entities to perform these duties, with advance approval from DHCS. In addition, the MCP may provide, or subcontract with another community based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals.

DHCS will require the following team members on a multi-disciplinary care team:
• dedicated care manager,
• HHP director,
• clinical consultant,
• community health workers (in appropriate roles at the discretion of the MCP) and
• housing navigator for HHP members experiencing homelessness.

Required team members Qualifications:
• Dedicated Care Manager - Including but not limited to paraprofessional (with appropriate training) or licensed care manager, social worker, or nurse.
• HHP Director - Including but not limited to ability to manage multi-disciplinary care teams.
• Clinical Consultant - Including but not limited to 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.
• Community Health Workers - Including but not limited to paraprofessional or peer advocate.
• Housing Navigator - Including but not limited to paraprofessional or other qualification based on experience and knowledge of the population and processes.

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. The team will primarily be located at the CB-CME organization, except as noted above regarding organization flexibility. The MCP may organize its provider network for HHP services according to provider availability and capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's service providers for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's Health Action Plan. The MCP may make such payments directly to the providers or through their CB-CME.

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team, such as the involvement of a pharmacist for medication reconciliation for care transitions. It is the responsibility of the MCP to ensure their cooperation.

The agreement and/or All Plan Letter (APL) language will include all appropriate CB-CME required responsibilities that are delegated to CB-CMEs under the HHP. This language will include, but not be limited to, staffing requirements, HHP network adequacy, relationship to for SMI/SED services with county mental health plans, monitoring and reporting requirements, and standards for the six HHP services- Comprehensive Care Management, Care Coordination, Health Promotion, Transitional Care, Individual and Family Support, and Referrals to the Community; hospitals instructed to establish procedures for referring eligible to HHP providers; receive payment from DHCS and disperse funds to CB-CMEs; use of multi-disciplinary care teams, provision of cost effective culturally appropriate and person and family centered HHP services; coordinate access to high-quality health care services informed by evidence-based clinical practice guidelines, develop a person-centered care plan; use of health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate: establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

MCPs

1. Attribute assigned HHP members to CB-CMEs
2. Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;
3. Notify the CB-CME of inpatient admissions and emergency department visits/discharges;
4. Track and share data with CB-CMEs regarding each participant's health history;
5. Track CMS-required quality measures and state-specific measures;
6. Collect, analyze and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process;
7. Provide member resources (e.g. customer service, member grievances) relating to HHP;
8. Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and CB-CME;
9. Establish and maintain a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers;
10. Ensure access to timely services for HHP members, including seeing HHP members within established length of time from discharge from an acute care stay (The length of time will be established by DHCS as part of the MCP Request for Application and readiness process);
11. Ensure network compliance with 42 CFR 438.206, as applicable.
12. Ensure CB-CME care manager aggregate ratio for their enrolled population is 60 members per one care manager.
13. Ensure participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary HHP team but who are responsible for coordinating with the CB-CME care manager to conduct case conferences and to provide input to the Health Action Plan. These providers are separate and distinct from the roles outlined for the multi-disciplinary HHP team.
14. Develop CB-CME training tools and reporting capabilities.
15. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed.
16. Develop and implement a documented policy regarding the steps that will be taken by MCP or CB-CME staff to engage members. The steps may be different for different types of members. For example, the steps may start with in-person engagement for homeless members at a shelter. For others it may start with a letter, and then progress to multiple calls, contact with their PCP, or other means until the member is successfully contacted and either enrolls or declines enrollment. The full policy process will have to be completed within an amount of time specified in the policy, such as 90 days.

CB-CMEs

1. Responsible for care team staffing, according to HHP required staffing ratios to be determined by DHCS, and oversight of direct delivery of the core HHP services;
2. Implement systematic processes and protocols to ensure member access to the multi-disciplinary HHP team and overall care coordination;
3. Ensure person-centered and integrated health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical health care related needs and services and social services needs and services;
4. Collaborate with and engage HHP members in developing a HAP and reinforcing/maintaining/reassessing it in order to accomplish stated goals;
5. Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure HHP member care is integrated among providers;
6. Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and improve health;
7. Provide evidence-based care;
8. Manage referrals, coordination and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow up;
9. Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
10. Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);

11. Provide service in the community in which the HHP member lives so services can be provided in-person, if needed;
12. Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven days a week availability of information and emergency consultation services to HHP members;
13. Provide quality-driven, cost-effective HHP services in a culturally competent and trauma informed manner that addresses health disparities and improves health literacy.

Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

☐ **Fee for Service**
☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☑ **Risk Based Managed Care**

○ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

☐ **Other**

Describe:

◉ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

MCP agreement and/or APL language will include but not be limited to staffing requirements, HHP network adequacy, relationship for SMI/SED services with county mental health plans, monitoring and reporting requirements, and standards for the six HHP services, hospitals instructed to establish procedures for referring eligible to HHP providers; receive payment from DHCS and disperse funds to CB-CMEs; use of multi-disciplinary care teams, provide cost effective, culturally appropriate, and person and family centered HHP services, coordinate access to high-quality health care services informed by evidence-based clinical practice guidelines, develop a person-centered care plan; use of health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate: establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

☑ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

◉ **Yes**

☑ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☑ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☑ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

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Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☐ **Fee for Service**

☐ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☐ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (description included in Service Delivery section)**

☑ **Risk Based Managed Care (description included in Service Delivery section)**

☐ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
DHCS will ensure non duplication of services through several mechanisms. First, through policies and guidance letters to the health plans. Second, because there are similar comprehensive case management components within the targeted case management and 1915 (c) community based services waiver programs, eligible members must choose between HHP and the other programs with similar comprehensive case management components. Lastly, agreement and/or APL language, and policies will be developed to assure that there is no duplication of payment for HHP services including, but not limited to the requirement that providers may not designate as a HHP service any activity that has already been billed to or counted towards a service requirement for another Medicaid program.

Payment Methodology
The MCPs will be responsible for negotiating contracts and payments to qualified CB-CMEs or other providers to ensure the delivery of HHP services.
MCPs will receive a payment for HHP services through the capitation rates based on a prospective, risk-based methodology that uses a hybrid approach of payment through the existing capitation rate structure for all MCP members and a new monthly add-on risk based PMPM payment for HHP enrolled members during the ongoing service delivery period.

DHCS Payments to MCPs – The rates will be developed with the assistance of DHCS' actuaries. DHCS will develop assumptions about member acuity and intensity of service needs to facilitate the development of capitation rates.

Within the existing capitation rate structure, DHCS will identify the amounts currently included in capitation payments that reflect DHCS' assessment of the overlap between HHP requirements and requirements currently in the MCP contracts. This amount will be counted as HHP services to be claimed at 90% FFP match (for traditional populations; expansion populations will align to the applicable FFP match). Certain components of health home services are currently being performed as part of the utilization management functions of the MCPs and these expenditures are included within the existing capitation rate structure and combined with other services. For these expenditures, DHCS will utilize MCP reporting and work with DHCS actuaries to estimate the portion of the capitation payment attributable to health home services. Any of the health home services may be currently performed as part of the MCPs' functions and this may likely vary by MCP. An analysis of the detailed services being provided today will be undertaken to determine an appropriate factor for calculating the current amount being provided within the rates today. This analysis will be similar in nature to the structure currently utilized for family planning services.

The new add-on PMPM monthly payment will reflect the additional amounts necessary to account for the full package of HHP services and the projected costs to successfully engage and manage HHP members. The methodology for determining the add-on PMPM rate is as follows: DHCS will develop assumptions about acuity and intensity of service needs in order to estimate the cost associated with health homes and to determine the appropriate supplemental capitation payment for verified health home members. Since some health homes services are currently

performed as part of existing MCPs functions, DHCS will utilize available information including plan reported data to inform the assumptions underlying the supplemental capitation payment. An analysis of the services being provided today will be undertaken to determine an appropriate factor for calculating the current amount being provided within the rates and DHCS will exclude these costs from the development of the supplemental capitation payment to avoid duplication. Therefore, the final add-on PMPM monthly payment will reflect the additional amounts necessary to account for the full package of health homes services. For the new services and costs associated with health homes, DHCS will make the supplemental capitation payment for verified health home members. This add-on PMPM monthly payment will be claimed at 90% or expansion level FFP match. The add-on PMPM payments are turned on/off based upon each member's enrollment/disenrollment from the HHP.

HHP will utilize the MCPs' existing communication and reporting capabilities to perform encounter reporting for Health Home Services.

HHP services when provided by an FQHC or RHC, shall be compensated separately from, and in addition to, the prospective payment rate received by an FQHC or RHC. This additional rate shall be deemed a supplemental rate for services not already included in the PPS rate calculation and shall therefore not be subject to a reconciliation or other reductions.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition:
Comprehensive care management involves activities related to engaging and collaborating with members and their family/support persons to develop their HAP. The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS,

palliative care, trauma-informed care needs, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and is reassessed based on the member's progress or changes in their needs. It tracks referrals.
Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers. The member will be engaged through various electronic means, letters, community outreach, and in-person meetings where the member lives, seeks care, or is accessible. Communication/information will meet health literacy standards, trauma-informed care standards and be culturally appropriate.
Comprehensive care management services include, but are not limited to
• Engaging the member in HHP and in their own care
• Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
• Promoting the member's self-management skills to increase their ability to engage with providers
• Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
• Completing a comprehensive health risk assessment to identify the member's physical, mental health, substance use, and social service needs
• Developing a member's HAP and revising it as appropriate
• Reassessing a member's health status, needs and goals
• Coordinating and collaborating with all involved parties to promote continuity and consistency of care
• Clarifying roles and responsibilities of the multidisciplinary team, providers, member and family/support persons

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Comprehensive care management will be supported through varying methods throughout the state. Parts of the state are very connected via health information exchange that includes providers, facilities, public health and other entities to exchange structured electronic data. Other parts of the state have minimal health information exchange infrastructure. The state and federal government have made significant investments for providers to adopt electronic health records through the EHR Incentive Programs, the Mental Health Services Act support for Specialty Mental Health, and the other HITECH programs. This will be built upon by the MCPs, CB-CMEs and external providers to support electronic health information exchange for HHP.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Provide clinical consultant services at the MCP or CB-CME. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Provide clinical consultant services at the MCP or CB-CME. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Medical Specialists**

Description
Provide clinical consultant services at the MCP or CB-CME. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Physicians**

Description
Provide clinical consultant services at the MCP or CB-CME. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Physicians' Assistants**

Description

☑ **Pharmacists**

Description
Provide clinical consultant services at the MCP or CB-CME. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Social Workers**

Description
Provide dedicated care manager or clinical consultant services at the MCP or CB-CME. These services include but are not limited to oversee provision of HHP services and implementation of HAP; offer services where the HHP member lives, seek care, or finds most easily accessible and within MCP guidelines; connect HHP member to other social services 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; assist with linkage to social supports; have overall responsibility for management and operation of the team; have responsibility for quality measures and reporting for the team; call HHP member to facilitate HHP visit with care manager; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☑ **Nutritionists**

Description
Provide clinical consultant services at the MCP or CB-CME. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Other (specify):**

Name
Dedicated care managers, Community health worker, HHP director, Housing navigator a

Description
Care manager services include but are not limited to oversee provision of HHP services and implementation of HAP; offer services where the HHP member lives, seek care, or finds most easily accessible and within MCP guidelines; connect HHP member to other social services 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 self-management training; arrange transportation; assist with linkage to social supports; have overall responsibility for management and operation of the team; have responsibility for quality measures and reporting for the team; call HHP member to facilitate HHP visit with care manager. CHW services include but not limited to, engage eligible HHP members; accompany member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines; self-management training; arrange transportation; assist with linkage to social supports; call member to facilitate visit with care manager. Director services include but not limited to, oversight of team; direct provision of services, case conferences; information sharing, reporting and design/implement HHP. Housing navigator services include but not limited to, form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers; partner with housing agencies and providers to

offer the member permanent, independent housing options, including supportive housing; connect and assist the member to get available permanent housing; coordinate with member in the most easily accessible setting, within MCP guidelines.
Other- other provider types will be included by MCPs to provide services as needed based on member's health needs.
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Care Coordination

Definition:
Care coordination includes services to implement the member's HAP. Care coordination services begin once a HAP is completed. For members, these care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous & integrated among all providers. Care coordination may include engagement activities notifying the individual of linkage to a CB-BME and supporting the participation process. HHP services will be provided through various electronic means, letters, & in-person meetings where the member lives, seeks care, or is accessible. These services will meet health literacy standards, trauma informed care standards, & be culturally appropriate. Care coordination services address the implementation of the HAP & ongoing care coordination and include, but are not limited to
• Working with the member to implement, update, & maintain their HAP
• Assisting the member in navigating health, behavioral health, long term services & support; and social services systems, including housing.
• Sharing options with the member for accessing care, providing information to the member regarding care planning, facilitating communication & understanding
• Monitoring/supporting treatment adherence (including medication management & reconciliation)
• Managing referrals, coordination, and follow-up to needed services/supports to ensure needed services/supports are offered & accessed
• Sharing information with all involved parties to monitor the member's conditions, health status, & medications and side effects
• Assisting in attainment of the member's goals
• Identifying & addressing barriers to treatment adherence
• Encouraging the member's decision making & continued participation
• Creating and promoting linkages to other services/supports
• Accompanying members to appointments

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
HHP providers will work with MCPs or a qualified entity to securely access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals). HHP providers will utilize HIT to create, document, execute and update a plan of care for every patient that is accessible to the interdisciplinary team of providers. HHP providers will also be encouraged to utilize HIT to monitor patient outcomes, initiate changes in care and follow up on patient testing, treatments, services and referrals.
The HHP will promote the use of web-based health information technology registries and referral tracking systems that leverage electronic health information exchange and technology in the community.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Provide clinical consultant services at the MCP or CB-CME. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as

needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Provide clinical consultant services at the MCP or CB-CME. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Medical Specialists**

Description
Provide clinical consultant services at the MCP or CB-CME. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Physicians**

Description
Provide clinical consultant services at the MCP or CB-CME. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Physicians' Assistants**

Description

☑ **Pharmacists**

Description
Provide clinical consultant services at the MCP or CB-CME. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Social Workers**

Description
Provide dedicated care manager or clinical consultant services at the MCP or CB-CME. These services include but are not limited to oversee provision of HHP services and

implementation of HAP; offer services where the HHP member lives, seek care, or finds most easily accessible and within MCP guidelines; connect HHP member to other social services 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; assist with linkage to social supports; have overall responsibility for management and operation of the team; have responsibility for quality measures and reporting for the team; call HHP member to facilitate HHP visit with care manager; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☑ **Nutritionists**

Description
Provide clinical consultant services at the MCP or CB-CME. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Other (specify):**

Name
Dedicated care managers, Community health worker, HHP director, Housing navigator a

Description
Care manager services include but are not limited to oversee provision of HHP services and implementation of HAP; offer services where the HHP member lives, seek care, or finds most easily accessible and within MCP guidelines; connect HHP member to other

social services 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 self-management training; arrange transportation; assist with linkage to social supports; have overall responsibility for management and operation of the team; have responsibility for quality measures and reporting for the team; call HHP member to facilitate HHP visit with care manager. CHW services include but not limited to, engage eligible HHP members; accompany member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines; self-management training; arrange transportation; assist with linkage to social supports; call member to facilitate visit with care manager. Director services include but not limited to, oversight of team; direct provision of services, case conferences; information sharing, reporting and design/implement HHP. Housing navigator services include but not limited to, form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers; partner with housing agencies and providers to offer the member permanent, independent housing options, including supportive housing; connect and assist the member to get available permanent housing; coordinate with member in the most easily accessible setting, within MCP guidelines.
Other- other provider types will be included by MCPs to provide services as needed based on member's health needs.

Health Promotion

Definition:
Health promotion includes services to encourage and support members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions. HHP services will
be provided through various electronic means, letters, mailings, community outreach, and in-person meetings where the member lives, seeks care, or is accessible. Communication and information will meet health literacy standards, trauma informed care standards, and be culturally appropriate.
Health promotion services include, but are not limited to
• Encouraging and supporting health education for the member/family/support persons
• Coaching members/family/support persons about chronic conditions and ways to manage health conditions based on the member’s preferences
• Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
• Promoting engagement of the member and family/support persons in self-management and decision making
• Encouraging and facilitating routine preventive care such as flu shots and cancer screenings
• Linking the member to resources for smoking cessation management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
• Assessing the member’s and family/support persons’ understanding of the member’s health condition and motivation to engage in self-management
• Using evidence-based practices, such as motivational interviewing, to engage and help member participate in and manage their care

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
HHP providers will work with MCPs or a qualified entity to securely access patient data and to develop partnerships that maximize the use of HIT across providers. HHP providers will utilize HIT to promote, link, manage and follow up on member health promotion activities. The HHP will leverage electronic health information exchange and technology in the community, including reporting regarding health promotion activities that is required as part of the EHR Incentive Program Meaningful Use and Quality Measures.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Provide clinical consultant services at the MCP or CB-CME to encourage and support health education for the member/family/support persons. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager to encourage and support health education for the member/family/support persons.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Provide clinical consultant services at the MCP or CB-CME to encourage and support health education for the member/family/support persons. These services include but are not limited to coach members about chronic conditions and ways to manage health conditions, connect the member to self-care programs, promote engagement, encourage/facilitate routine preventive care; assess understanding of member's health condition and motivation to engage in self management; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager to encourage and support health education for the member/family/support persons.

☑ **Medical Specialists**

Description
Provide clinical consultant services at the MCP or CB-CME to encourage and support health education for the member/family/support persons. These services include but are not limited to limited to coach members about chronic conditions and ways to manage health conditions, connect the member to self-care programs, promote engagement, encourage/facilitate routine preventive care; assess understanding of member's health condition and motivation to engage in self management;review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager to encourage and support health education for the member/family/support persons.

☑ **Physicians**

Description
Provide clinical consultant services at the MCP or CB-CME to encourage and support health education for the member/family/support persons. These services include but are not limited to limited to coach members about chronic conditions and ways to manage health conditions, connect the member to self-care programs, promote engagement, encourage/facilitate routine preventive care; assess understanding of member's health condition and motivation to engage in self management; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager to encourage and support health education for the member/family/support persons.

☐ **Physicians' Assistants**

Description

☑ **Pharmacists**

Description
Provide clinical consultant services at the MCP or CB-CME to encourage and support health education for the member/family/support persons. These services include but are not limited to limited to coach members about chronic conditions and ways to manage health conditions, connect the member to self-care programs, promote engagement, encourage/facilitate routine preventive care; assess understanding of member's health condition and motivation to engage in self management; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager to encourage and support health education for the member/family/support persons.

☑ **Social Workers**

Description
Provide dedicated care manager or clinical consultant services at the MCP or CB-CME to encourage and support health education for the member/family/support persons. These services include but are not limited to limited to coach members about chronic conditions and ways to manage health conditions, connect the member to self-care programs, promote engagement, encourage/facilitate routine preventive care; assess understanding of member's health condition and motivation to engage in self management; oversee provision of HHP services and implementation of HAP; offer services where the HHP member lives, seek care, or finds most easily accessible and within MCP guidelines; connect HHP member to other social services 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; assist with linkage to social supports; have overall responsibility for management and operation of the team; have responsibility for quality measures and reporting for the team; call HHP member to facilitate HHP visit with care manager; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager to encourage and support health education for the member/family/support persons.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☑ **Nutritionists**

Description
Provide clinical consultant services at the MCP or CB-CME to encourage and support health education for the member/family/support persons. These services include but are not limited to review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager to encourage and support health education for the member/family/support persons.

☑ **Other (specify):**

Name
Dedicated care managers, HHP Director, Community health worker (CHW) and other

Description
Dedicated care manager, Community health worker, HHP director, Housing navigator. Care manager services include but are not limited to oversee provision of HHP services and implementation of HAP; offer services where the HHP member lives, seek care, or finds most easily accessible and within MCP guidelines; connect HHP member to other social services 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; assist with linkage to social supports; have overall responsibility for management and operation of the team; have responsibility for quality measures and reporting for the team; call HHP member to facilitate HHP visit with care manager. Health work services include but not limited to, engage eligible HHP members; accompany 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 member to facilitate visit with care manager. Director services may include but not limited to, oversight of team; direct provision of health promotion services, case conferences; information sharing' reporting and design/implement HHP.
Other- other provider types will be included by MCPs to provide services as needed based on member's health needs.

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:
Comprehensive transitional care includes services to facilitate HHP members' transitions among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an emergency department, hospital inpatient facility, residential/treatment facility are required. Methods to promote sharing of information on transitions to/from transitional and/or permanent supportive housing, incarceration facility, or other treatment center are encouraged as appropriate. The member and family/support persons will be assisted through emails, texts, phone calls, letters, and in-person meetings. Communication and information will meet health literacy standards, trauma informed care standards, and be culturally appropriate.

Comprehensive transitional care services include, but are not limited to:

• Transmitting a summary care record or discharge summary to all involved parties
• Providing medication information and reconciliation
• Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
• Collaborating, communicating, and coordinating with all involved parties
• Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
• Planning appropriate care/place to stay post-discharge, including temporary housing or stable housing and social services
• Arranging transportation for transitional care, including medical appointments
• Developing and facilitating the member's transition plan
• Preventing and tracking avoidable admissions and readmissions
• Evaluating the need to revise the member's HAP
• Providing transition support to permanent housing

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
HHP providers will work with MCPs or a qualified entity to securely access patient data and to develop partnerships that maximize the use of HIT across providers. HHP providers will utilize HIT to communicate with health facilities and to facilitate interdisciplinary collaboration among all providers, the patient, family, caregivers and local supports. The HHP will leverage electronic health information exchange and technology in the community, including reporting regarding transition of care activities that is required as part of the EHR Incentive Program Meaningful Use and Quality Measures.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Provide clinical consultant services at the MCP or CB-CME to facilitate HHP members' transitions among treatment facilities, including admission and discharges. These services include but are not limited to provide medication information, plan timely scheduling of follow-up appointments, plan appropriate care, develop and facilitate member's transition plan; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Provide clinical consultant services at the MCP or CB-CME to facilitate HHP members' transitions among treatment facilities, including admission and discharges. These services include but are not limited to provide medication information, plan timely scheduling of follow-up appointments, plan appropriate care, develop and facilitate member's transition plan; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Medical Specialists**

Description
Provide clinical consultant services at the MCP or CB-CME to facilitate HHP members' transitions among treatment facilities, including admission and discharges. These services include but are not limited to provide medication information, plan timely scheduling of follow-up appointments, plan appropriate care, develop and facilitate member's transition plan; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Physicians**

Description
Provide clinical consultant services at the MCP or CB-CME to facilitate HHP members' transitions among treatment facilities, including admission and discharges. These services include but are not limited to provide medication information, plan timely scheduling of follow-up appointments, plan appropriate care, develop and facilitate member's transition plan; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Physicians' Assistants**

Description

☑ **Pharmacists**

Description
Provide clinical consultant services at the MCP or CB-CME to facilitate HHP members' transitions among treatment facilities, including admission and discharges. These services include but are not limited to provide medication information, plan timely scheduling of follow-up appointments, plan appropriate care, develop and facilitate member's transition plan; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Social Workers**

Description
Provide dedicated care manager or clinical consultant services at the MCP or CB-CME to facilitate HHP members' transitions among treatment facilities, including admission and discharges. These services include but are not limited to oversee provision of HHP services and implementation of HAP; offer services where the HHP member lives, seek care, or finds most easily accessible and within MCP guidelines; connect HHP member to other social services 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; assist with linkage to social supports; have overall responsibility for management and operation of the team; have responsibility for quality measures and reporting for the team; call HHP member to facilitate HHP visit with care manager; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☑ **Nutritionists**

Description
Provide clinical consultant services at the MCP or CB-CME to facilitate HHP members' transitions among treatment facilities, including admission and discharges. These services include but are not limited to provide medication information, plan timely scheduling of follow-up appointments, plan appropriate care, develop and facilitate member's transition plan; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Other (specify):**

Name
Dedicated care managers, Community health worker, HHP Director, Housing navigator a

Description
Care manager services include but are not limited to oversee provision of HHP services & implementation of HAP; offer services where the HHP member lives, seek care, or finds most easily accessible & within MCP guidelines; connect HHP member to other social services he/she may need; advocate on behalf of members with health care professionals; use motivational interviewing & trauma-informed care practices; work with hospital staff on discharge plan; engage eligible HHP members; accompany HHP member to office visits, as needed & according to MCP guidelines; monitor treatment adherence (including medication); provide self-management training; arrange transportation; assist with linkage to social supports; have overall responsibility for management & operation of the team; have responsibility for quality measures & reporting for the team; call HHP member to facilitate HHP visit with care manager. CHW services include but not limited to, engage eligible HHP members; accompany member to office visits, as needed, & in the most easily accessible setting, within MCP guidelines; self-management training; arrange transportation; assist with linkage to social supports; call member to facilitate visit with care manager. Director services may include but not limited to, oversight of team; direct provision of comprehensive transitional care services, case conferences; reporting & HHP implementation. Housing navigator services include but not limited to, form & foster relationships with housing agencies & permanent housing providers, including supportive housing providers; partner with housing agencies & providers to offer the member permanent, independent housing options, including supportive housing; connect & assist the member to get available permanent housing; coordinate with member in the most easily accessible setting, within MCP guidelines.
Other- other provider types will be included by MCPs to provide services as needed based on member's health needs.

Individual and family support, which includes authorized representatives

Definition:
Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services. The member and family/support persons will be assisted through e-mails, texts, phone calls, letters, and in-person

meetings where the member lives, seeks care, or is accessible. Communication and information will meet health literacy standards, trauma informed care standards, and be culturally appropriate.

Individual and family support services include, but are not limited to
• Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
• Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
• Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
• Accompanying the member to clinical appointments, when necessary
• Assessing the strengths and needs of the member and family/support persons
• Identifying barriers to improving their adherence to treatment and medication management
• Evaluating family/support persons' needs for services.
• Providing individual housing transition services, including services that support an individual's ability to prepare for and transition to housing.
• Providing individual housing and tenancy sustaining services, including services that support the individual in being a successful tenant in his/her housing arrangement and thus able to sustain tenancy.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
HHP providers will work with MCPs or a qualified entity to securely access patient data and to develop partnerships that maximize the use of HIT across providers. HHP providers will utilize HIT to provide the patient access to care plans and options for accessing clinical information. The HHP will leverage electronic health information exchange and technology in the community, including reporting and patient services that are required as part of the EHR Incentive Program Meaningful Use and Quality Measures.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Provide clinical consultant services at the MCP or CB-CME that ensure the member is knowledgeable about their conditions with goal to improve adherence to treatment and medication management. These services include but are not limited to link to support groups, assist with informed choices, advocate for the member, identify barriers to treatment and medication management; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Provide clinical consultant services at the MCP or CB-CME that ensure the member is knowledgeable about their conditions with goal to improve adherence to treatment and medication management. These services include but are not limited to link to support

groups, assist with informed choices, advocate for the member, identify barriers to treatment and medication management; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Medical Specialists**

Description
Provide clinical consultant services at the MCP or CB-CME that ensure the member is knowledgeable about their conditions with goal to improve adherence to treatment and medication management. These services include but are not limited to link to support groups, assist with informed choices, advocate for the member, identify barriers to treatment and medication management; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Physicians**

Description
Provide clinical consultant services at the MCP or CB-CME that ensure the member is knowledgeable about their conditions with goal to improve adherence to treatment and medication management. These services include but are not limited to link to support groups, assist with informed choices, advocate for the member, identify barriers to treatment and medication management; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Physicians' Assistants**

Description

☑ **Pharmacists**

Description
Provide clinical consultant services at the MCP or CB-CME that ensure the member is knowledgeable about their conditions with goal to improve adherence to treatment and medication management. These services include but are not limited to link to support groups, assist with informed choices, advocate for the member, identify barriers to treatment and medication management; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Social Workers**

Description
Provide dedicated care manager or clinical consultant services at the MCP or CB-CME that ensure the member is knowledgeable about their conditions with goal to improve adherence to treatment and medication management. These services include but are not limited to oversee provision of HHP services and implementation of HAP; offer services where the HHP member lives, seek care, or finds most easily accessible and within MCP guidelines; connect HHP member to other social services 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; assist with linkage to social supports; have overall responsibility for management and operation of the team; have responsibility for quality measures and reporting for the team; call HHP member to facilitate HHP visit with care manager; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☑ **Nutritionists**

Description
Provide clinical consultant services at the MCP or CB-CME that ensure the member is knowledgeable about their conditions with goal to improve adherence to treatment and medication management. These services include but are not limited to link to support groups, assist with informed choices, advocate for the member, identify barriers to treatment and medication management; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Other (specify):**

Name
Dedicated care managers, Community health worker, HHP Director, Housing navigator a

Description
Care manager services include but are not limited to oversee provision of HHP services & implementation of HAP; offer services where the HHP member lives, seek care, or finds most easily accessible & within MCP guidelines; connect HHP member to other social services he/she may need; advocate on behalf of members with health care professionals; use motivational interviewing & trauma-informed care practices; work with hospital staff on discharge plan; engage eligible HHP members; accompany HHP member to office

visits, as needed & according to MCP guidelines; monitor treatment adherence (including medication); provide self-management training; arrange transportation; assist with linkage to social supports; have overall responsibility for management & operation of the team; have responsibility for quality measures and reporting for the team; call HHP member to facilitate HHP visit with care manager. CHW services include but not limited to, engage eligible HHP members; accompany member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines; self-management training; arrange transportation; assist with linkage to social supports; call member to facilitate visit with care manager. Director services may include but not limited to, oversight of team; direct provision of individual and family support services, case conferences; reporting & HHP implementation. Housing navigator services include but not limited to, form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers; partner with housing agencies and providers to offer the member permanent, independent housing options, including supportive housing; connect and assist the member to get available permanent housing; coordinate with member in the most easily accessible setting, within MCP guidelines.
Other- other provider types will be included by MCPs to provide services as needed based on member's health needs.

Referral to community and social support services, if relevant

Definition:
Referral to community and social support services involves determining appropriate services to meet the needs of members, identifying and referring members to available community resources, and following up with members. HHP services will be provided through emails, texts, phone calls, letters, and in-person meetings where the member lives, seeks care, or is accessible. Communication and information will meet health literacy standards, trauma informed care standards, and be culturally appropriate.
Community and social support services may include, but are not limited to:
• Identifying the member's community and social support needs.
• Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
• Identifying or developing a comprehensive resource guide for the member
• Actively managing appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
• Following up with the member to ensure needed services are obtained
• Coordinating services and follow-up post engagement
• Checking with member routinely through in-person or telephonic contacts to ensure they are accessing the social services they require

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
HHP providers will work with MCPs or a qualified entity to securely access patient data and to develop partnerships that maximize the use of HIT across providers. HHP providers will utilize HIT to initiate, manage and follow up on community based and other social service referrals. The HHP will leverage electronic health information exchange and technology in the community, including reporting and patient services that are required as part of the EHR Incentive Program Meaningful Use and Quality Measures. The HHP will work with entities supporting the use of HIT to include information and links to community and social support resources. This will be synergistic to existing websites and secure email supported by the HHP network to share information with members.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Provide clinical consultant services at the MCP or CB-CME to meet the needs of members and refer to available community resources. These services include but are not limited to identify member needs, manage appropriate referrals, coordinate services and follow-up post to ensure needed services are obtained; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Provide clinical consultant services at the MCP or CB-CME to meet the needs of members and refer to available community resources. These services include but are not limited to identify member needs, manage appropriate referrals, coordinate services and follow-up post to ensure needed services are obtained; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Medical Specialists**

Description
Provide clinical consultant services at the MCP or CB-CME to meet the needs of members and refer to available community resources. These services include but are not limited to identify member needs, manage appropriate referrals, coordinate services and follow-up post to ensure needed services are obtained; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Physicians**

Description
Provide clinical consultant services at the MCP or CB-CME to meet the needs of members and refer to available community resources. These services include but are not limited to identify member needs, manage appropriate referrals, coordinate services and follow-up post to ensure needed services are obtained; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Physicians' Assistants**

Description

☑ **Pharmacists**

Description
Provide clinical consultant services at the MCP or CB-CME to meet the needs of members and refer to available community resources. These services include but are not limited to identify member needs, manage appropriate referrals, coordinate services and follow-up post to ensure needed services are obtained; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Social Workers**

Description
Provide dedicated care manager or clinical consultant services at the MCP or CB-CME to meet the needs of members and refer to available community resources. These services include but are not limited to identify member needs, manage appropriate referrals, coordinate services and follow-up post to ensure needed services are obtained; oversee provision of HHP services and implementation of HAP; offer services where the HHP member lives, seek care, or finds most easily accessible and within MCP guidelines; connect HHP member to other social services 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; assist with linkage to social supports; have overall responsibility for management and operation of the team; have responsibility for quality measures and reporting for the team; call HHP member to facilitate HHP visit with care manager; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☑ **Nutritionists**

Description
Provide clinical consultant services at the MCP or CB-CME to meet the needs of members and refer to available community resources. These services include but are not limited to identify member needs, manage appropriate referrals, coordinate services and follow-up post to ensure needed services are obtained; review and inform HAP; act as clinical resource for care manager, as needed; and facilitate access to primary care and behavioral health providers, as needed to assist care manager.

☑ **Other (specify):**

Name
Dedicated care managers, Community health worker, HHP Director, Housing navigator a

Description
Care manager services include but are not limited to oversee provision of HHP services & implementation of HAP; offer services where the HHP member lives, seek care, or finds most easily accessible & within MCP guidelines; connect HHP member to other social services he/she may need; advocate on behalf of members with health care professionals; use motivational interviewing & trauma-informed care practices; work with hospital staff on discharge plan; engage eligible HHP members; accompany HHP member to office visits, as needed & according to MCP guidelines; monitor treatment adherence (including medication); provide self-management training; arrange transportation; assist with linkage to social supports; have overall responsibility for management & operation of the team; have responsibility for quality measures & reporting for the team; call HHP member to facilitate HHP visit with care manager. Health work services include but not limited to, engage eligible HHP members; accompany member to office visits, as needed, & in the most easily accessible setting, within MCP guidelines; self-management training; arrange transportation; assist with linkage to social supports; call member to facilitate visit with care manager. Director services may include but not limited to, oversight of team; direct provision of referral to community & social support services, case conferences; reporting & HHP implementation. Housing navigator services include but not limited to, form & foster relationships with housing agencies & permanent housing providers, including supportive housing providers; partner with housing agencies & providers to offer the member permanent, independent housing options, including supportive housing; connect & assist the member to get available permanent housing; coordinate with member in the most easily accessible setting, within MCP guidelines.
Other- other provider types will be included by MCPs to provide services as needed based on member's health needs.

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
DHCS uses administrative data to identify eligible members for HHP and notifies the MCPs of members targeted for engagement. Full Scope with zero SOC FFS members receive a notice regarding HHP and may enroll in managed care through Health Care Options or a local managed care plan. Once a Full Scope with zero SOC FFS member is enrolled in managed care, they will be included, if appropriate, on the Targeted Engagement List (TEL). MCPs assess members on the TEL to confirm eligibility to ensure they are not already well-managed or participating in another duplicative program. The engagement process including letters are sent to eligible members once eligibility is confirmed. The MCP/CB-CME continues the progressive engagement activities until a member consents to receive HHP services, declines to participate, or unsuccessful engagement occurs.

As part of the enrollment process, a comprehensive needs assessment and health action plan (HAP) is developed that includes the member goals. The care manager/clinical consultant help the enrollee select a PCP and schedule any needed appointments. HHP staff arranges transportation and attends appointments with them as applicable. HHP staff conveys updates to the PCP as well as other

providers as necessary. The community health worker assists with care management and coordination according to the HAP and member's goals. Additionally, the social worker helps coordinate needed social services.

For homeless members, the housing navigator assists with housing, transition and tenancy issues.

☐ **Medically Needy eligibility groups**

○ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
DHCS will work with the external evaluator to track the number of avoidable hospital readmissions using HHP claims/encounter data during the year that followed inpatient stays. The Agency for Healthcare Research Quality (AHRQ) Prevention Quality Indicators may be used for defining potential preventable hospitalizations.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
The DHCS/evaluator will calculate regional, risk adjusted, per member per month expenses in the target population in the baseline, either by applying trend factors and estimating a projected per member per month figure or by measuring expenses against a matched control group. Cost avoidance will be calculated as the difference between actual and projected risk adjusted per member per month expenditures.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
MCPs and CB-CMEs will establish and maintain data-sharing agreements compliant with all federal & state laws/regulations. The MCP is responsible for sharing health utilization & claims/encounter data with the HHP network to facilitate care coordination and prescription monitoring for HHP members. Each MCP will have a member website available to HHP members, their families & supports. MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow up care. CB-CMEs must demonstrate a capacity to use HIT to link services, facilitate communication and provide feedback to the team members. Services will be enhanced by the use of EHR systems and HIE. DHCS has established

the following goals for HHP: Provide a HHP Member Portal, Utilize EHR/HIT/HIE to register HHP members, Utilize EHR/HIT/HIE to perform Point of Care Charting, and Utilize EHR/HIT/HIE to prepare/send/receive/consume a summary of care record for care transitions. DHCS expects organizations receiving EHR Incentive Program payments to use EHR in combination with community and enterprise HIE to meet these goals. DHCS has also funded, in partnership with CMS, a California Technical Assistance Program that is assisting providers in advancing the use of EHRs and in connecting to HIE. Specific milestones include connecting to HIE that uses CalDURSA and CTEN Organizations that do not have support through the EHR Incentive Programs may need support from MCPs to support the achievement of these goals. In some areas relatively few providers have EHRs, there is limited interoperability between the systems, and HIE services may not be designed for the HHP requirements. If the technology environment does not fully support the HHP goals and requirements, the MCP will demonstrate that they, and their HHP network, are maximizing EHR/HIT/HIE to the extent possible, and relate their plan to make any possible improvements in the near future.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure: Inpatient Utilization- acute inpatient care. Measure Specification, including a description of the numerator and denominator. The rate of all acute inpatient care and services per 1,000 member months among HHP members. Admissions/1,000 member months. Data Sources: Administrative Frequency of Data Collection: ○ **Monthly** ○ **Quarterly** ○ **Annually** ◉ **Continuously** ○ **Other**	

Emergency Room Visits

Measure: Ambulatory care-emergency department visits Measure Specification, including a description of the numerator and denominator. The rate of emergency department visits per 1,000 member months among HHP members. Visits/1,000 member months Data Sources: Administrative Frequency of Data Collection: ○ **Monthly** ○ **Quarterly** ○ **Annually** ◉ **Continuously** ○ **Other**	

Skilled Nursing Facility Admissions

Measure: Nursing facility utilization Measure Specification, including a description of the numerator and denominator. The number of admissions to a nursing facility from the community that result in a short-term or long-term stay per 1,000 member months. Admissions/1,000 member months. Data Sources: Administrative Frequency of Data Collection: ○ **Monthly** ○ **Quarterly** ○ **Annually** ◉ **Continuously** ○ **Other**	

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
Claims and encounter data for HHP enrollees will be used to determine hospital admission rates for HHP.

Chronic Disease Management
DHCS will monitor chronic disease management through measures identified in this SPA:
Adult BMI assessment;
Screening for clinical depression and follow-up plan
Controlling high blood pressure;
All-cause readmission rate;
Follow-up after inpatient hospitalization for mental illness; Initiation and engagement of alcohol and other drug dependence treatment;
Prevention quality indicator chronic condition composite.

Coordination of Care for Individuals with Chronic Conditions
In addition to the evaluation of service utilization and assessment of identified metrics for operational outcomes for HHP members, DHCS will assess and measure provision of care coordination services for individuals with chronic conditions utilizing the health homes quality measures identified in this SPA as follows:
Timely transmission of transition record to facility, HHP provider, primary physician or other health care professional designated for follow-up care when discharged from inpatient facilities to home or any other site of care;

Follow-up after inpatient hospitalization for mental illness;
Initiation and engagement of alcohol and other drug dependence treatment.

Assessment of Program Implementation
DHCS will monitor implementation using operational measures developed with the external evaluator including, but not limited to, enrollment numbers, number engaged, care plan completion, service utilization, in person contact, current housing status for those members experiencing homelessness. Additionally, DHCS will obtain HHP provider and stakeholder feedback through a learning collaborative and webinars. The evaluation plan will include these findings as well as a review of the implementation. It is anticipated that a rapid cycle assessment will be conducted within a short time period after implementation that assesses the enrollment process, the rate of enrollment, reasons for high or low enrollment rates, challenges in outreach to potential members, and best practices.

Processes and Lessons Learned
The evaluation might include key informant surveys and interviews, provider surveys and member input from satisfaction surveys or measures on HHP will inform DHCS on ways to improve the process. As implementation progresses, guidelines and lessons learned will be documented and used for training additional HHP to further promote success statewide. DHCS anticipates at least quarterly meetings with participating HHPs, and other stakeholders as needed, to gather input on the program's success and challenges. A learning collaborative will be convened and will be utilized as necessary to glean feedback and lessons learned from a broad array of interested parties.

Assessment of Quality Improvements and Clinical Outcomes
To assess quality improvements and clinical outcomes, DHCS will collect clinical and quality of care data for the CMS core set of measures and state-specific quality goals. This assessment may include a combination of claims/encounter, administrative, and qualitative data. Where possible, DHCS will utilize metrics where benchmark data is available, such as Healthcare Effectiveness Data and Information Set (HEDIS). Data are to be compared to state and regional benchmarks and collected through defined quality processes as applicable.

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.