Health Homes Program: Santa Clara County

What is the HHP?

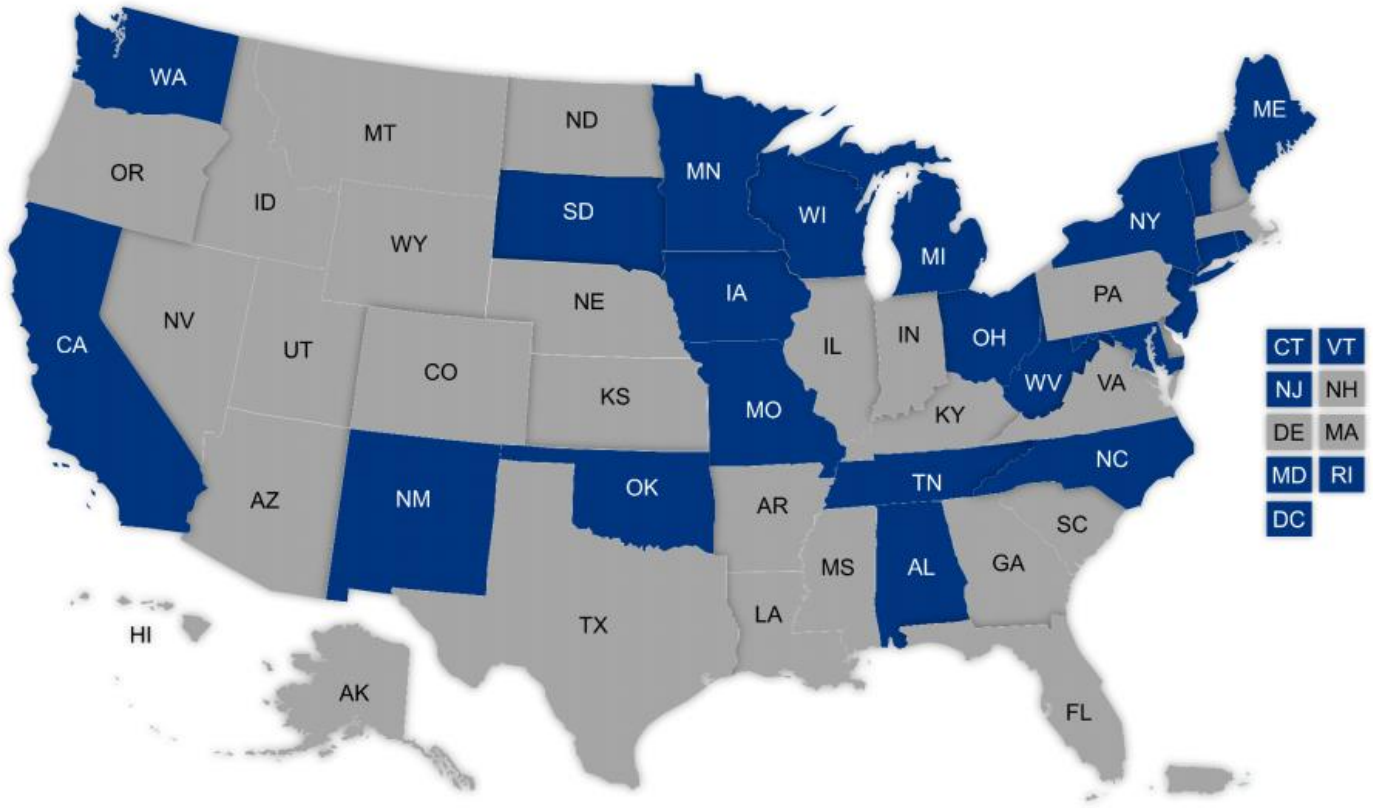
The HHP is:

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

HHP Background

- The Medicaid Health Home State Plan Option is authorized under the *Affordable Care Act*, Section 2703.
- There is a California State Plan Amendment for target populations with:
  - Chronic physical health conditions- Launch July 1, 2019
  - Serious mental illness (SMI)-Launch January 1, 2020

HHP background (cont.)



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

Counties Participating

Group	Counties	
Group 1	❖ San Francisco	
Group 2	❖ Riverside ❖ San Bernardino	
Group 3.1	❖ Imperial ❖ Santa Clara	
Group 3.2	❖ Alameda ❖ Fresno ❖ Kern ❖ Los Angeles	❖ Sacramento ❖ San Diego ❖ Tulare
Group 4	❖ Orange	

Who is Eligible?

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

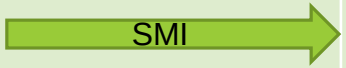
- Three or more eligible chronic conditions *or*
- At least one inpatient stay within one year *or*
- Three or more emergency department visits within one year *or*
- Chronic homelessness

Identification:

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

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

Eligible Chronic Conditions

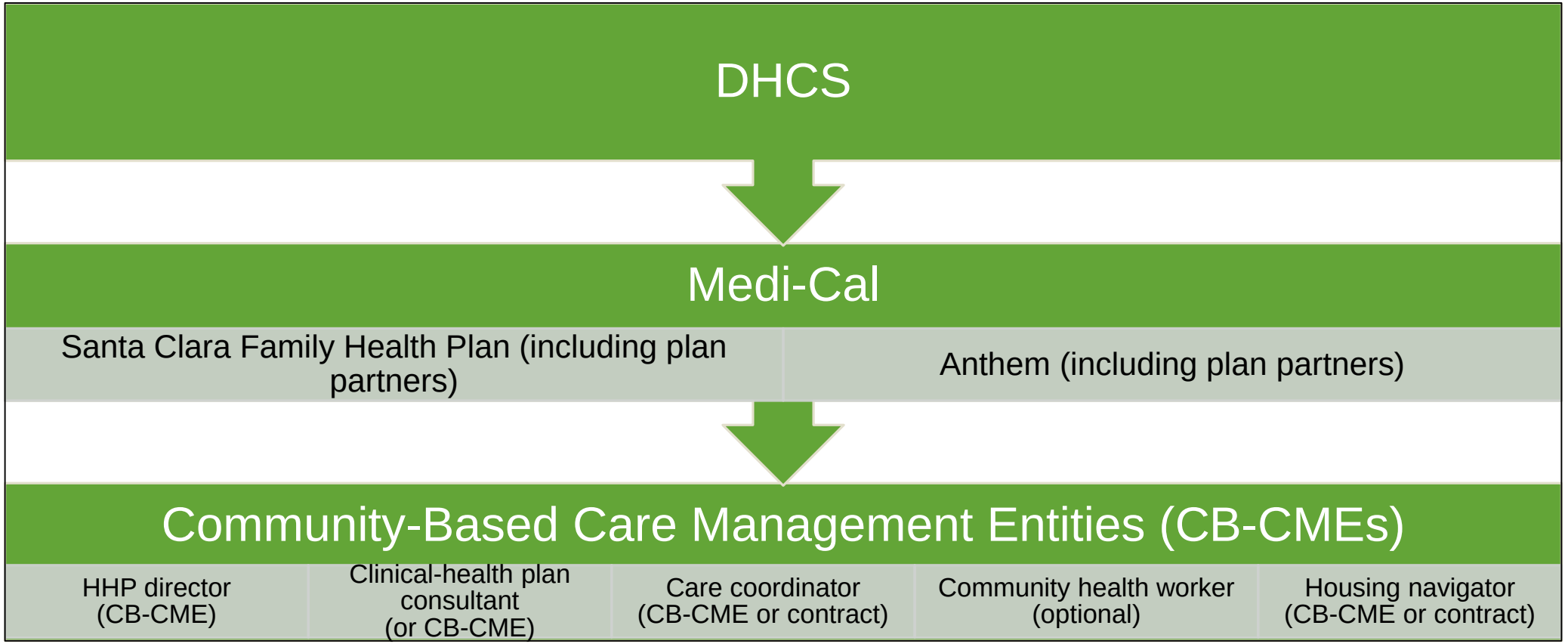
Eligibility requirement	Criteria details
1. Chronic condition criteria 	Has a chronic condition in <u>at least one</u> of the following categories: • At least two of the following: chronic obstructive pulmonary disease (COPD), diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, SUD • Hypertension and one of the following: COPD, diabetes, coronary artery disease, chronic or congestive heart failure • One of the following: major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia) • Asthma
2. Meets at least one acuity/complexity criteria	• Has at least three or more of the HHP eligible chronic conditions • At least one inpatient hospital stay in the last year • Three or more emergency department visits in the last year • Chronic homelessness

Required HHP Services

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support services
- Referral to community and social supports
- Housing navigation and tenancy support (for enrollees experiencing homelessness)

Note: Details available in *DHCS Program Guide*

HHP Structure



What is a CB-CME?

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

Value of Health Homes

Local goals:

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

Statewide goals:

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

Contact information

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