HEALTHY SAN DIEGO

HEALTH HOMES PROGRAM – FAQ FEBRUARY 2019

SUBMITTED BY THE HEALTH HOMES WORK GROUP COLLABORATIVE

TOPIC AREA	QUESTION	ANSWER
1. Payment for Outreach Efforts	Substantial effort will go into initial engagement and enrollment of individuals into Health Homes. We believe that providers are best positioned to be responsible for this process, but that there should be financial support from Health Plans to support these efforts, regardless of whether an individual ends up enrolling in Health Homes. Otherwise, providers may focus on the individuals that may be "easiest" to engage, which will limit the impact of the program. **We recommend referencing the payment model for Whole Person Wellness which reimburses the two county providers for outreach attempts.**	**This cannot be discussed collaboratively. See attachment provided by DHCS.**
2. Single Payment Structure	We support the stated effort by the Health Plans to develop a single boilerplate contract for Health Homes providers. A single payment structure (whether capitated or encounter-based) across all Health Plans would be ideal in this contract, even if details like the amount each Health Plan pays is different. A single payment structure would mean less administrative overhead for providers, thus allowing providers to spend more time on outreach and providing care to enrolled individuals. We believe that a capitated model of payment would best allow this program to move toward a more value-	**This cannot be discussed collaboratively. See attachment provided by DHCS.**

	based care model, and away from the traditional fee-for-service model. **We also believe that a tiered payment structure, based on the risk or complexity of the enrolled individual, will best enable providers to deliver necessary and timely services.**	
3. Staff Requirements	**We ask that staffing requirements be uniform across all Health Plans.** We also ask that staffing requirements be as clearly specified as possible, including which specific outreach, care coordination, health promotion, care transition, and support services will and will not be required of the CB-CMEs. Consistent requirements will ensure that a single Health Homes team is able to provide services for individuals enrolled with any Health Plan.	**Health plans are expecting for these requirements to be the same. Providers are encouraged to leverage existing resources.**
4. Sub-Contracting	Not all providers will have in-house capacity to address all enrolled individuals' needs. Some providers will have to leverage relationships with other community-based organizations (CBOs) to deliver needed services. Examples might include housing navigation (for providers with a small homeless population) or substance use disorder services. **We ask that contracts allow for providers to sub-contract with outside CBOs to ensure enrolled individuals get needed services.**	**Health Plans agree to allow for sub-contracts.**
5. Single Certification Process	**We support the Health Plans' stated effort to create a single certification process that would be recognized by all other Health Plans in San Diego County.** Such a process would decrease unnecessary overhead costs for both Health Plans and potential CB-CMEs.	**Health Plans agree to have a similar certification process.**

6. Single Set of Reporting Requirements	**To ensure reporting does not unnecessarily pull providers away from providing services, we think that all Health Plans should agree on a single set of reporting metrics, single method of transmitting data from providers to Health Plans, and single means of posting data (e.g. enrollment information) to tools like the Community Information Exchange (CIE).** As potential providers, we recognize that the CIE and Health Information Exchange (HIE) will be vitally important. By using these tools in a consistent manner, both providers and Health Plans will be best able to impact enrolled individuals' lives. Providers, like Health Plans, will also seek to use CIE and HIE in a consistent manner.	**The health plans have agreed to have the same reporting template which is currently in development.**
7. Total Costs of Care	Part of the evaluation of Health Homes will be whether costs of care for enrolled individuals go down. As potential providers, we believe that timely access to costs of care data (i.e. claims data) will enable us to know if our efforts are making a difference. Without such data, it is less likely that we will be able to ensure success of Health Homes within a two-year timeframe. **We request that, at a minimum, aggregate claims data for enrolled individuals are given to providers. Ideally, individual-level claims data would be made available at least quarterly.**	**The health plans are not clear about this question "what is the ask".**