Heritage Provider Network & Affiliated Medical Groups	Program: **UTILIZATION MANAGEMENT**	
	Policy No. **HH-008**	Effective Date: 1/1/2019
	Authored by: **HPNCS _UM**	Dated Authored: 12/17/2018
	Approved by: **UMC/QIC**	Date Approved: 2/12/2019
	Revised by: **HPN CS UM**	Date of Latest Revision:
Title of Policy: **OPT IN ACTIVITIES**		

PURPOSE:

This policy and procedure is established to define member identification, outreach protocol and process for opting-in members into the Medi-Cal Health Homes Program.

POLICY:

In accordance with DHCS contractual requirements and regulatory guidance, Molina Healthcare of CA (MHC) provides Health Homes Program (HHP) services to eligible members as defined by the DHCS Health Homes Program Guide. MHC has delegates and contracted with Heritage Provider Network and its affiliated medical groups (HPN) to facilitate these services.

The Health Homes program is designed to coordinate the full range of physical health, behavioral health, and community‐based long-term services and supports (LTSS) needed by members with chronic conditions and severe mental illness diagnoses. HHP is structured as a health home network, working together as a team to provide comprehensive care coordination services. The HHP network consists of MHC, Community-Based Care Management Entities (CB-CMEs - Heritage Provider Network and its affiliated Medical Groups – Regal Medical Groups and Desert Oasis Healthcare (HPN)) and other community based organizations that provide linkage to community and social support services as needed. As an opt-in program, outreach will be conducted to eligible members identified by either the state or health plan data in accordance with HHP requirements. Members will be assigned to Heritage Provider Network and its affiliated Medical Groups – Regal Medical Groups and Desert Oasis Healthcare, who will be responsible for provided the six core HHP services as follows: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services and Referral to Community and Social Supports. During the opt-in activities, eligible members.

PROCEDURE:

1. Molina will generate an Opt-In List that will be used to conduct outreach to eligible members for enrollment into HHP. The Opt-In List is derived from the DHCS Target Engagement List (TEL) and the Molina TEL (generated based on HHP eligibility requirements per the HH Program Guide and claims/utilization data from Molina's core system). The DHCS TEL membership will be matched against available claims/utilization data in the health plans system. The two TEL lists will be combined to create the Opt-In List for outreach and engagement, and will be provided to HPN
    a. Non-duplication logic is applied based on available state and health plan data to identify members who are enrolled in other programs as listed in the HH Program Guide and exclude them from the Opt-in List. Non-duplication is again assessed upon contact and discussion with the member during the outreach process.

b. If available health plan data indicates that the member is well managed, meaning that there was no substantial avoidable utilization or the member is enrolled in another care management program that will meet their care coordination needs, then the member is excluded from outreach. However if this is not clear from the data, the member remains on the list and this information is discussed during the outreach process.
c. Homeless members are identified as follows:
    i. Members meeting the following criteria are determined to be homeless:
        1. Claims containing diagnosis code Z59.0 for Homelessness
        2. Claims containing condition code 17
        3. Invalid physical addresses per the membership record based on key words, such as General Delivery, Homeless, Transient, etc.
d. Members identified as Homeless by the Whole Person Care (WPC) program.
    i. Analysis is conducted on all physical addresses of active members to determine the total number of distinct "households" per address. For purposes of identifying homelessness, a distinct household is defined as the number of unique household IDs (as provided by the state 834 eligibility file) and number of unique family names. Further analysis was conducted to determine if the address is indicative of homelessness, as follows:
        1. P.O. Boxes shared by five or more households are considered homeless addresses.
        2. Residential addresses shared by 21 or more households are researched to verify if the addresses are related to housing organizations or programs that offer housing services.
        3. Non-residential addresses shared by five or more households are researched to verify if the addresses are related to housing organizations or programs that offer housing services.
    ii. Homeless status in accordance with the federal definition will be confirmed upon successful contact and discussion with the member.

2. Members on the Opt-In List are flagged by Priority Engagement Groups (see Attachment 1 – Priority Engagement Groups) to delineate the order in which outreach will conducted. The prioritization methodology was determined in consideration of which subset of the TEL population had the highest, most immediate utilization, along with greatest opportunity for successful outreach and engagement, given the homelessness indicators. Furthermore, estimated membership volume in each priority engagement group was considered to ensure that appropriate resources are allocated to maximize outreach efforts and member enrollment:
    a. Outreach will start with those members with a chronic condition who have confirmed utilization through claims/encounters data that do not have the homeless indicator, as the probability of successful contact and subsequent program enrollment is higher for these members. Furthermore, the evidence of emergency and inpatient admissions indicates that enrollment in the program would be the greatest opportunity to facilitate care management to reduce avoidable utilization.
    b. The next set of priority engagement groups accounts for both utilization and homeless members who have a phone number on file. The health plan has determined that these members have a more immediate need for outreach given the utilization data, and higher probability for successful contact with an available phone number on file.
    c. The subsequent group consists of members who have utilization data and are homeless without a phone number.
    d. The final group will be those members who qualify for the program based on chronic condition and homelessness, with no utilization data.

3. Member Communication and Outreach Strategy: Member outreach will consist of a combination of member mailings, telephonic and face-to-face interactions to leverage all available opportunities to engage the member and opt them into the program.
    a. All members will be notified of the Health Homes Program through the member Evidence of Coverage.
    b. Members who are identified on the Opt-In List will receive a separate, targeted pre-engagement letter that provides a brief overview of the program benefits, and advises the member that they will be contacted by a member of the Health Homes team to discuss the program in further detail.
    c. Following the pre-engagement letter, outreach will be conducted to opt member into the program. HPN will conduct outreach activities to demonstrate capacity and ability to effectively conduct and document outreach attempts.
    d. Outreach will consist of five (5) attempts within the 90 days following mailing of the pre-engagement letter.
        i. The initial contact method is telephonic outreach for all members that have a phone number available.
            1. If the phone number listed is incorrect or invalid, or there is no phone number on file, outreach teams will follow the process outlined in policy and procedure *HH-001- Unable to Contact Member Policy*, where additional sources (Pharmacy, PCP office, additional data systems, etc.) are researched to obtain member contact information.
        ii. Members who are unable to contact following five (5) attempts will receive an "Unable to Contact" letter.
        iii. Additionally, whenever appropriate, as stipulated in policy and procedure *HH-001 Unable to Contact Member Policy*, a Community Health Worker (referred to as a Community Connector) will be deployed to locate and engage both homeless members, as well as members who become unable to contact (UTC). This may occur anytime during the outreach process as one of the five (5) contact attempts.
        iv. The health plan may also engage housing agencies or other vendors who have the experience and capacity to conduct outreach for targeted outreach to the homeless population. This outreach will also include a combination of telephonic and face-to-face outreach, as determined by the vendor and depending on member needs.
        v. If a HPN or vendor conducts outreach and the member becomes UTC after five (5) attempts, those members will be referred back to the health plan for additional research, following the steps outlined above to locate other valid contact information and/or deploy Community Health Workers as needed.
    e. All outreach attempts will be documented directly in the member electronic health record in the care management platform.
    i. If outreach is conducted by HPN or vendors who are unable to support direct documentation in the health plan's system, the documentation of outreach activities will be exchanged in a mutually agreed upon format and manner and will be stored in the member's record.
    f. When the member decides to opt-in to the program the member will be provided with the Health Homes Member Toolkit which provides more details and FAQs on the program. This may be either mailed to the member or provided to the assigned HPN to distribute to the member during the initial assessment visit.
    g. The assigned HPN is notified of the member's enrollment into HHP and will initiate next steps to meet with and assess the member and build the Health Action Plan (HAP), in accordance with policy and procedure *HH-009 Member Assessment and Health Action Plan (HAP).*

ATTACHMENTS:

Attachment 1, Priority Engagement Groups

Priority Group	Criteria
1	**Members with 1 Chronic Condition + 1 ER or IP Admission in the last 0 – 3 months (exclude Homeless)**
2	**Members with 1 Chronic Condition + 1 ER or IP Admission in the last 3 – 6 months (exclude Homeless)**
3	**Members with 1 Chronic Condition + AND 1 ER or IP Admission 6 – 12 months (exclude Homeless)**
4	**Members with 1 Chronic Condition + 1 ER or IP Admission in the last 0 – 3 months AND Homeless indicator with Phone Number**
5	**Members with 1 Chronic Condition + 1 ER or IP Admission in the last 3 – 6 months AND Homeless indicator with Phone Number**
6	**Members with 1 Chronic Condition + 1 ER or IP Admission in the last 6 – 12 months AND Homeless indicator with Phone Number**
7	**Members with 1 Chronic Condition + 1 ER or IP Admission in the last 0 – 12 months AND Homeless indicator without Phone Number**
8	**Members with 1 Chronic Condition AND Homeless indicator without utilization**