Whole Person Care Program

Medi-Cal 2020 Waiver Initiative

California Department of Health Care Services

November 2016

Program Overview

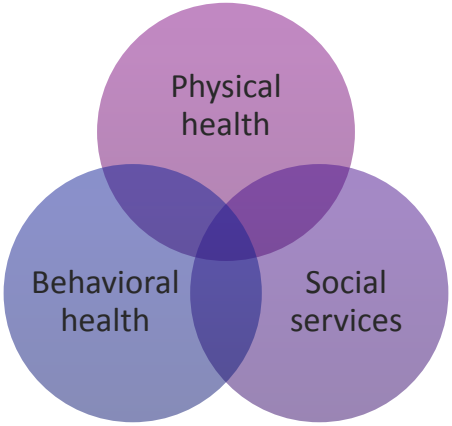
Whole Person Care Overview

Overarching goal for Whole Person Care (WPC)

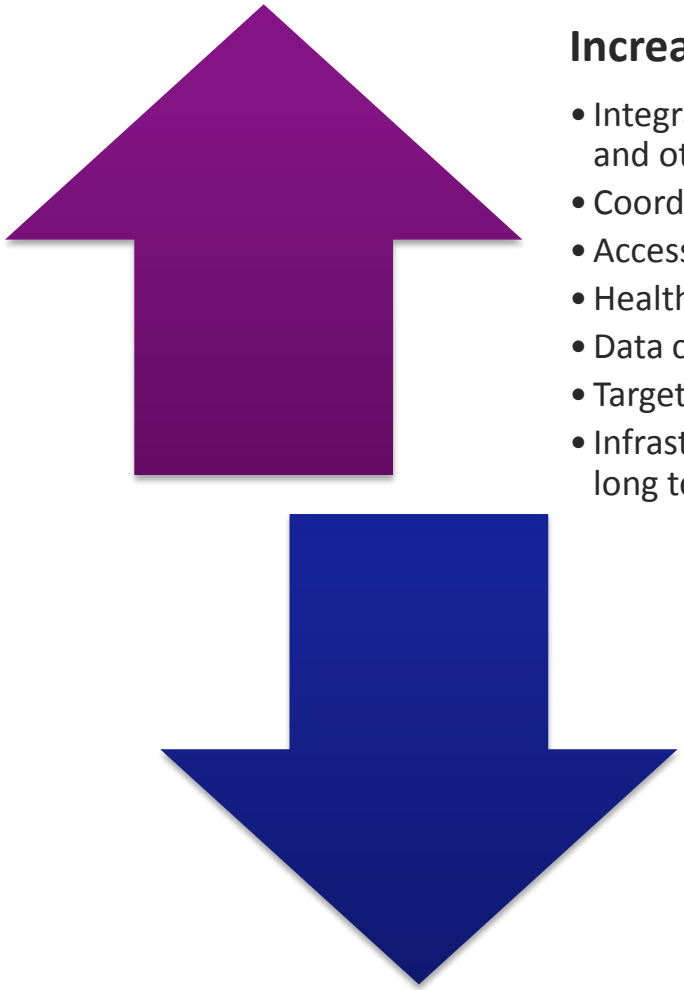
- Coordination of health, behavioral health, and social services
- Comprehensive coordinated care for the beneficiary resulting in better health outcomes

WPC Pilot entities collaboratively to:

- Identify target populations
- Share data between systems
- Coordinate care real time
- Evaluate individual and population progress



Goals and Strategies



Increase, improve, and achieve:

- Integration among county agencies, health plans, providers, and other participating entities
- Coordination and appropriate access to care
- Access to housing and supportive services
- Health outcomes for the WPC population
- Data collection and sharing among local entities
- Targeted quality and administrative improvement benchmarks
- Infrastructure that will ensure local collaboration over the long term

Reduce:

- Inappropriate emergency department and inpatient utilization

WPC by Numbers

5 year program

$1.5B total federal funds

$300M annual available

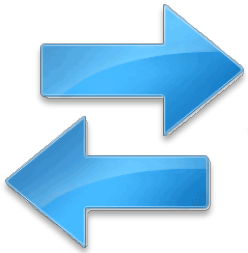
2 application rounds

18 applicants for Round 1

Funding

No single WPC pilot will be awarded more than 30% of total available funding unless additional funds are available after all initial awards are made

Funding is based on semi-annual reporting of activities/interventions



Non-federal share provided via intergovernmental transfer (IGT), matched with federal Medicaid funding

Lead Entities

Lead Entities

- County
- A city and county
- A health or hospital authority
- A designated public hospital
- A district/municipal public hospital
- A federally recognized tribe
- A tribal health program under a Public Law 93-638 contract with the federal Indian Health Services
- A consortium of any of the above entities

Lead Entity Responsibilities

- Submits Letter of Intent and application
- Serves as the contact point for DHCS
- Coordinates WPC pilot
- Collaborates with participating entities

Participating Entities

Participating Entities	Participating Entity Responsibilities
• (1) Medi-Cal managed care health plan • (1) Health services agency/department • (1) Specialty mental health agency/department • (1) Public agency/department • (2) Community partners	• Collaborates with the lead entity to design and implement the WPC pilot • Provides letters of participation • Contributes to data sharing/reporting

Relationships Between Entities

WPC Goals for Participating Entities

- Increase integration among county agencies, health plans, providers, and other entities within the county that serve high-risk, high-utilizing beneficiaries
- Develop infrastructure to ensure collaboration among the participating entities over the long term

Requirements

- Lead entities indicate in the application who the participating entities will be.
- DHCS encourages a collaborative approach.
- Only one Medi-Cal managed care plan is required to participate, but DHCS encourages including multiple plans.
- Medi-Cal managed care plan participation must include the plan's entire network (i.e., where delegation of risk has occurred to an entity in the plan's network).
  - Specific exclusions and exceptions may be considered on a case-by-case basis.
- Lead Entities cannot also be one of the two required community partners.

Target Populations

Identifying target population(s)

- WPC pilots identify high-risk, high-utilizing Medi-Cal beneficiaries in their geographic area.
- Pilots work with participating entities to determine the best target population(s) and areas of need.

Target population(s) may include, but are not limited to, individuals:

- with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement;
- with two or more chronic conditions;
- with mental health and/or substance use disorders;
- who are currently experiencing homelessness; and/or
- who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (e.g., hospital, skilled nursing facility, rehabilitation facility, jail/prison, etc.)

May also include the following populations with certain caveats:

- Individuals not enrolled in Medi-Cal, but federal funding is not available for them
- Dual-eligible beneficiaries, but must coordinate with the Coordinated Care Initiative where applicable

Program Structure

Administrative Infrastructure

Description

- Builds the programmatic supports necessary to plan, build and run the pilot

Examples

- Core program development and support
- Staffing
- IT infrastructure
- Program governance
- Training
- Ongoing data collection
- Marketing materials

Delivery Infrastructure

Description

- Supports the non-administrative infrastructure needed to implement the pilot

Examples

- Advanced medical home
- Mobile street team infrastructure
- Community paramedicine team
- Community resource database
- IT workgroup
- Care management tracking and reporting portal

Payment Mechanisms

PMPM Bundle	FFS Items
• One or more services and/or activities that would be delivered as a set value to a defined population • Examples: Comprehensive complex care management, housing support services, mobile outreach and engagement bundle, long-term care diversion bundle	• Single per-encounter payments for a discrete service • Examples: Mobile clinic visit, housing transition services, medical respite, transportation, sobering center, care coordination

Performance Measures

Objective

- To assess the success of the Pilot in achieving the WPC goals and strategies

Reporting requirements

- All WPC Pilots must report initial baseline and subsequent year data on universal and variant metrics as outlined in Attachment MM of the Special Terms & Conditions (STCs)

Performance Measures

Health Outcomes Universal Metrics

- Ambulatory Care - Emergency Department Visits
- Inpatient Utilization - General Hospital/Acute Care
- Follow-up After Hospitalization for Mental Illness
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Health Outcomes Variant Metrics, as applicable

- 30 day All Cause Readmissions
- Decrease Jail Recidivism
- Overall Beneficiary Health
- Controlling Blood Pressure
- HbA1c Poor Control <8%
- Depression Remission at Twelve Months
- Adult Major Depression Disorder (MDD): Suicide Risk Assessment

Housing Variant Metrics, as applicable

- Percent of homeless who are permanently housed for greater than 6 months
- Percent of homeless receiving housing services in PY that were referred for housing services
- Percent of homeless referred for supportive housing who receive supportive housing

Pilot-identified Pay for Outcome metrics, other than required universal and variant metrics

Summary of First Round Applications

First Round Applications

Counties with < 1,000 sq. mi. (7)	Counties between 1,001 – 3,000 sq. mi. (4)	Counties between 3,001 – 5,000 sq. mi. (4)	Counties with > 5,000 sq. mi. (3)
Alameda	Santa Clara	Los Angeles	Kern
Contra Costa	San Joaquin	Monterey	Riverside
Napa	Placer	San Diego	
Orange	Ventura	Shasta	
San Francisco			
San Mateo			
Solano			

Pilot Size

Larger: Over 100,000	Large: Between 10,000 and 100,000	Medium: Between 1,000 and 5,000	Small: Between 250 and 800
Los Angeles	Alameda	Kern	Monterey
	Contra Costa	Orange	Napa
	Riverside	San Diego	Placer
	Santa Clara	San Joaquin	Shasta
	San Francisco	San Mateo	Solano
		Ventura	

Target Population Selection

Target Population Criteria	# of Pilots that Selected this Target Population
1. High utilizers with repeated incidents of avoidable ED use, hospital admissions or nursing facility placement	15 Pilots
2. High utilizers with two or more chronic conditions	3 Pilots
3. Individuals with mental health and/or substance use disorder conditions	8 Pilots
4. Individuals who are homeless/at-risk for homelessness	14 Pilots
5. Individuals recently released from institutions (i.e., hospital, county jail, IMD, skilled nursing facility, etc.)	7 Pilots

Care Coordination Strategies

- Navigation infrastructure (13 Pilots)
- Standard Assessment Tool (9 Pilots)
- Data sharing systems (9 Pilots)
- Social determinants strategies (7 Pilots)
- Data-driven algorithms (4 Pilots)
- Prioritization of highest needs if on a waiting list (3 Pilots)

Data and Information Sharing

Expansion of existing data sharing framework (18 Pilots)	Bi-directional data sharing with MCPs (18 Pilots)	Health Information Exchange (12 Pilots)
Patient population software (11 Pilots)	Data warehouse (9 Pilots)	Query-based real-time data (7 Pilots)
Case management software (7 Pilots)	Real-time data sharing (6 Pilots)	New data sharing systems (3 Pilots)

Services and Interventions

Care Management (15 Pilots)	Wellness and Education (9 Pilots)	Housing Services (11 Pilots)
Flexible Housing Pool (17 Pilots)	Post-Incarceration Services (4 Pilots)	Mental Health (6 Pilots)
Mobile Services (4 Pilots)	Respite Services (4 Pilots)	Sobering Centers (4 Pilots)

Resources

Visit the Whole Person Care webpage:

- http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilo

Submit questions/sign up for the listserv:

- 1115WholePersonCare@dhcs.ca.gov