Medi-Cal 2020 Waiver – Whole Person Care (WPC) Pilots
Frequently Asked Questions and Answers
Revision 9.0 (7/11/18)

This document is a compilation of frequently asked questions (FAQs) and responses regarding the Medi-Cal 2020 Whole Person Care (WPC) pilots. This document will continue to be updated over time.

A. Overview, Timeline, and Contact Information

1. What are the Whole Person Care (WPC) pilots?

Answer: The WPC pilots are a 5-year program authorized under California's Medi-Cal 2020 waiver to test locally-based initiatives that will coordinate physical health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple health care systems and continue to have poor outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC pilots will identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population health progress. Up to $1.5 billion in federal funds is available over five years to match local public funds for the WPC pilots.

2. What are the key deadlines for launching the WPC Pilots?

Answer: The anticipated timeline is as follows:

First Round Deliverable/Activity	Date
1. DHCS releases draft WPC pilot Request for Applications (RFA) and selection criteria for public comment	April 11, 2016
2. Public comments on WPC pilot application and selection criteria due to DHCS	April 18, 2016
3. CMS approves the WPC pilot application	May 6, 2016
4. DHCS releases WPC pilot RFA, timeline, and selection criteria	May 16, 2016
5. DHCS conducts webinar for potential applicants/interested entities	May 19, 2016
6. WPC pilot applications due to DHCS	July 1, 2016
7. DHCS completes WPC application review; sends written questions to applicants	September 1, 2016
8. Applicants' written responses due to DHCS	September 8, 2016
9. DHCS notifies CMS of WPC pilot selection decisions	October 7, 2016
10. DHCS notifies applicants of WPC pilot selection final decisions	October 24, 2016
11. Lead entities provide formal acceptance to DHCS	November 3, 2016

Second Round Deliverable/Activity	Date
1. DHCS releases Second Round WPC pilot RFA, timeline, and selection criteria	January 13, 2017
2. DHCS conducts webinar for potential new applicants/interested entities	January 27, 2017
3. Second Round WPC pilot applications due to DHCS	March 1, 2017
4. DHCS reviews applications and sends written questions to applicants as necessary Applicant written response sent to DHCS and reviewed	March 1 – July 1
5. DHCS notifies applicants of WPC pilot selection final decisions	July 2, 2017
6. Lead entities provide formal acceptance to DHCS	July 12, 2017

Updated information about the first and second application round timelines and WPC applications are posted on the WPC webpage at http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx and released through the Medi-Cal 2020 waiver listserv. DHCS recommends checking the WPC website regularly for updates. To join the listserv, please go to http://apps.dhcs.ca.gov/listsubscribe/default.aspx?list=DhcsStakeHolders

3. Does DHCS have a specific email address for WPC questions and comments?

Answer: Yes – 1115wholepersoncare@dhcs.ca.gov.

4. Does DHCS have a specific stakeholder listserv for WPC?

Answer: No – DHCS is no longer supporting a separate listserv specific to WPC only. Please subscribe to the Medi-Cal 2020 waiver listserv for Whole Person Care and 2020 waiver updates. To join the DHCS listserv by visiting http://apps.dhcs.ca.gov/listsubscribe/default.aspx?list=DhcsStakeHolders

B. Lead and Participating Entities

1. What types of organizations can serve as the Lead Entity for a WPC Pilot?

Answer: The "lead entity" for a WPC pilot must either be a county, a city and county, a health or hospital authority, a designated public hospital, or a district/municipal public hospital, a federally recognized tribe, a tribal health program operated under a Public Law 93-638 contract with the federal Indian Health Services, or a consortium of any of the above entities.

2. What types of organizations should participate in the WPC pilots?

Answer: WPC participating entities must include a minimum of one Medi-Cal managed care health plan (MCP) operating in the geographic area of the WPC pilot to work in partnership with the lead entity for MCP members. Participating entities must also include both the health services and the specialty mental health agencies or departments, and at least one other public agency or department, which may include, but is not limited to, county alcohol and substance use disorder programs, human services agencies, public health departments, criminal justice/probation entities, or housing authorities (regardless of how many of these fall under the same agency within a county).

WPC pilots must also include at least two other key community partners that have significant experience serving the target population within the participating county or counties geographic area, such as physician groups, clinics, hospitals, and community-based organizations. The lead entity may not list itself as one of the two required WPC community partners. If a lead entity cannot reach agreement with a required participant, it may request an exception to the requirement to have agreements in place with all required participants.

3. Who decides which entities will participate in the WPC pilot?

Answer: Each lead entity will need to indicate who the participating entities will be for the WPC pilot. WPC pilot applicants must include letters of participation agreement from WPC participating entities as part of their application (STC 117(b)(xvi)).

DHCS will review and approve the WPC applications and confirm the selection of participating entities. We strongly encourage lead entities to engage in a collaborative process at the local level to identify participating entities based on the needs of the target population.

4. Are lead entities required to submit letters of participation or letters of support as part of the WPC application?

Answer: The lead entity should submit a Letter of Participation for each Participating Entity participating in the WPC pilot. The lead entity should also submit letters of support for participating providers and other relevant stakeholders in the geographic area where the WPC pilot will operate. Letters must:

- Confirm participation in (for letters of participation), or support of (for letters of support), the WPC pilot program
- Not be form letters
- Be on the appropriate letterhead
- Not be more than two pages long
- Be signed by an authorized representative of the participating entity, provider or stakeholder

- Be addressed to Sarah Brooks, Deputy Director, Health Care Delivery Systems, Department of Health Care Services

5. **In a WPC pilot county, are all Medi-Cal managed care plans required to participate in the pilot?**

   Answer: While only one managed care plan is required to participate in each pilot county, DHCS encourages applicants to include multiple participating plans.

6. **In a county with managed care plans that directly contract with DHCS and then subcontract with other plans, will the subcontracted plans also be encouraged to participate in WPC?**

   Answer: WPC pilot proposals are required to include at least one Medi-Cal managed care plan and are encouraged to include additional plans. Plan participation must include the plan's entire network (i.e., where delegation of full risk has occurred to an entity in the plan's network). However, the participating plan(s) may determine whether or not to include specific full-risk delegated entities in pilot participation. Also, specific pilot-requested exclusions may be considered by DHCS on a case-by-case basis.

7. **Can an organization be a lead entity for more than one WPC pilot?**

   Answer: Nothing precludes organizations from being a lead entity on more than one WPC pilot, as long as the applicant meets all requirements for each pilot application. However, it is unlikely that DHCS would approve multiple pilots for the same geographic area. DHCS is more interested in applications with a higher degree of complexity from one entity than multiple applications from the same entity and asks that entities in the same geographic area work to submit a single application.

8. **Which entities are required to participate in the development of the WPC application?**

   Answer: The lead entity is responsible for submitting the WPC application, including obtaining letters of participation agreements from participating entities, and should collaborate with participating entities as part of this process.

C. Target Population

1. **How will the target population for the WPC pilot be defined and assigned?**

   Answer: The waiver Special Terms and Condition[1] (STC) 111 describes the target populations for the WPC. WPC pilots shall identify high-risk, high-utilizing Medi-Cal beneficiaries in the geographic area

[1] http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx

that they serve and assess their unmet need. WPC pilots must define their target populations and interventions to provide integrated services to high users of multiple systems. The target population shall be identified through a collaborative data approach to identify common patients who frequently access urgent and emergent services, often times across multiple systems. Section 2.3 of the Application Selection Criteria notes that applications will be scored on the "quality of methodology used to define target population(s)." The application should include a description of the collaborative data approach(s), and the aggregate data result and findings that the applicant used to select the target population(s). (The aggregate data results and findings required for the application are separate from "Target Population Baseline Data," which will be required for approved pilots as a subsequent deliverable relating to Year 1 funding.)

Participants voluntarily enroll into the program and may be enrolled on a rolling basis throughout the year. The Med-Cal beneficiary must be enrolled into WPC; however, a separate application does not have to be completed if the member is being "transferred" to WPC from a prior existing county care coordination program. The new- to- WPC enrollee must be provided with a notice of the change.

Target populations may include, but are not limited to, individuals:

A. With repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement;
B. With two or more chronic conditions;
C. With mental health and/or substance use disorders;
D. Who are currently experiencing homelessness; and/or
E. Individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (hospital, subacute care facility, skilled nursing facility, rehabilitation facility, Institution for Mental Disease (IMD), county jail, state prisons, or other).

Individuals who are not Medi-Cal beneficiaries may participate in approved WPC pilots, but funding in support of services provided to such individuals is not eligible for federal financial participation. These individuals shall only be included in the pilot at the discretion of the WPC pilot and as approved during the application process. The non-Federal funds expended providing services to individuals who are not Medi-Cal beneficiaries may exceed the funding limits described in STCs 125 and 126.

2. Can individuals eligible for Medicaid and Medicare (dual eligibles) be included in the WPC Pilot target population?

Answer: WPC pilot target populations may include dually eligible beneficiaries. For counties where the Coordinated Care Initiative (CCI) is in place and a beneficiary is eligible for both programs, the WPC pilot would be expected to coordinate with the model already in place.

D. Services

1. **The STCs state that: *"Individuals who are not Medi-Cal beneficiaries may participate in approved WPC pilots, but funding in support of services provided to such individuals is not eligible for federal Financial Participation.*" How will this requirement be applied in the context of WPC pilots?**

   Answer: WPC pilot payments for infrastructure and other non-service deliverables may benefit individuals who are not Medi-Cal beneficiaries. Generally, WPC pilot payments may support activities, such as 1) building infrastructure to integrate services among local entities that serve the target population; 2) providing services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population, such as housing components; and 3) implementing strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes. Thus, federal WPC payments are not available for items in category 2 for patients who are not Medi-Cal beneficiaries. The Pilot may provide WPC-funded services for limited scope Medi-Cal beneficiaries, but the Pilot may only provide services that would not be covered by Medi-Cal for a full-scope Medi-Cal beneficiary.

2. **How can WPC pilots support Medi-Cal beneficiaries' housing needs?**

   Answer: WPC pilots may target individuals who are experiencing, or are at risk of, homelessness who have a demonstrated a medical need for housing or supportive services. In the event that this population is included in the WPC pilot proposal, participating entities would include local housing authorities, local Continuum of Care (CoC) programs, and community-based organizations serving homeless individuals.

   Federal Funding for Housing Supports
   The types of housing services that may be offered as part of the pilot that are eligible for federal financial participation (FFP) may include the services described below, which are quoted from the June 26, 2015 CMCS Informational Bulletin, *"Coverage of Housing-Related Activities and Services for Individuals with Disabilities*."[1] Housing-related services described in the Informational Bulletin include:

   a. Individual Housing Transition Services: Housing transition services are meant to assist beneficiaries with obtaining housing and include:
      i. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy.

[1] CMCS Informational Bulletin. June 26, 2015. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

ii. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
iii. Assisting with the housing application and/or search process, including identifying and securing available resources to assist with subsidizing rent (such as Section 8 or Section 202, etc.).
iv. Identifying and securing resources to cover expenses, such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs, and other one-time expenses.
v. Ensuring that the living environment is safe and ready for move-in.
vi. Assisting in arranging for and supporting the details of the move.
vii. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

b. Individual Housing & Tenancy Sustaining Services: This service is made available to support individuals in maintaining tenancy once housing is secured. The availability of ongoing housing-related services, in addition to other long-term services and supports, promotes housing success, fosters community integration and inclusion, and develops natural support networks. These tenancy support services are:
    i. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
    ii. Educating and training on the role, rights, and responsibilities of the tenant and landlord.
    iii. Coaching on developing and maintaining key relationships with landlords/property managers, with a goal of fostering successful tenancy.
    iv. Assisting in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
    v. Advocating and linking individuals to community resources to prevent eviction when housing is or may potentially become jeopardized.
    vi. Assisting with the housing recertification process.
    vii. Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
    viii. Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

c. Additional examples of transition services: The bulletin includes these additional examples of services that can be covered:

i. Assessing the participant's housing needs and presenting options
ii. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history)
iii. Searching for housing
iv. Communicating with landlords
v. Coordinating the move
vi. Establishing procedures and contacts to retain housing
vii. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
viii. Identifying, coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility.
ix. Identifying, coordinating, securing, or funding services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access, first month coverage of utilities, including telephone, electricity, heating, and water; essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; first month's rent; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically necessary services, such as hospital beds, hoyer lifts, etc. to ensure access and reasonable accommodations.

These services may also include outreach to people experiencing homelessness where they live to form trusting relationships with service providers.

In addition, federal funding may be used for housing-related collaborative activities between public agencies and the private sector that assist WPC entities in identifying and securing housing for the target population.

It is important to note that federal Medicaid funds may **not** be used to cover the cost of room and board, monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. State or local government and community entity contributions are separate from federal matching funds, and may be allocated to fund support for long-term housing, including rental housing subsidies.

Financial Structures for Housing
The county-wide Flexible Housing Pool is one suggested way to structure funding to pay for housing services and supports.

WPC pilots may utilize a county-wide Flexible Housing Pool to structure funding to pay for housing services and supports. The Flexible Housing Pool may include WPC pilot payments for housing-related deliverables for which federal financial participation is available. In addition, the Flexible Housing Pool may include funds that will be used for long-term housing costs, including rental subsidies that are not eligible for federal matching funds through the WPC pilots. WPC pilot entities may provide or collect contributions to the Flexible Housing Pool from partner agencies or from community entities, subject to the applicable provisions of Section 1903(w) of the Social Security Act and 42 C.F.R. Part 433, subpart B.

WPC pilot entities should track funding through the Flexible Housing Pool to demonstrate that federal financial participation funds are not applied for services for which federal financial participation is prohibited. The Flexible Housing Pool may incorporate a financing component that makes funds available to the WPC pilot based on a portion of the reduced utilization of health care services associated with the operation of the WPC pilot housing-related services.

3. What are some examples of specific services that stakeholders have asked about that can be included in a WPC pilot?

Answer:

- Services currently provided by a local government entity: In addition to the exclusion for Medi-Cal funded services, WPC cannot be used to fund local responsibilities for health care or social services that are mandated by state or federal laws, or to fund services for which state or federal funding is already provided.

- Recuperative care/medical respite: Medical respite care, also referred to as recuperative care, is acute and post-acute medical care for individuals, primarily those who are homeless or those with unstable living situations, who are too ill or frail to recover from a physical illness or injury in their usual living environment but are not ill enough to be in a hospital. Unlike "respite" for caregivers, "medical respite" is short-term residential care that allows individuals with unstable living situations the opportunity to rest in a safe environment while accessing medical care and other supportive services. In addition to providing post-acute care and clinical oversight, medical respite programs seek to improve transitional care for this population and end the cycle of homelessness by supporting patients in accessing benefits and housing while also gaining stability with case management relationships and programs. Recuperative care/medical respite is an allowable WPC service if it is 1) necessary to achieve or maintain medical stability, which may require behavioral

health interventions, 2) directly linked to the overarching strategies and goals for the target population, 3) not more than 90 days in continuous duration, 4) does not include funding for building modification or building rehabilitation, and 5) not covered by Medi-Cal.

- Sobering centers: Sobering centers provide a safe, supportive, environment for individuals found to be publicly intoxicated, primarily those who are homeless or those with unstable living situations, to become sober. A sobering center is an allowable WPC service if it is 1) necessary to achieve or maintain medical stability, which may require behavioral health interventions, 2) directly linked to the overarching strategies and goals for the target population, 3) not more than 24 hours in continuous duration, 4) does not include funding for building modification or building rehabilitation, and 5) not covered by Medi-Cal. For alcohol or other drug-dependent persons, primarily those who are homeless or those with unstable living situations, the goals of a sobering center are to:
    - Provide better care and improve health outcomes
    - Decrease the number of inappropriate ambulance trips to the emergency department (ED)
    - Decrease the number of inappropriate ED visits

- Transportation: Transportation is an allowable WPC service if it is 1) necessary to achieve or maintain medical and/or behavioral health stability, 2) directly linked to the overarching strategies and goals for the target population, and 3) not covered by Medi-Cal.

- Field-based care (examples include, but are not limited to, nurses, case managers, therapists delivering services on the street or in the home): Field-based care is an allowable WPC service if it is 1) necessary to achieve or maintain medical and/or behavioral health stability, 2) directly linked to the overarching strategies and goals for the target population, and 3) not covered by Medi-Cal.

- Information Technology (IT) Infrastructure: The WPC pilot may fund new IT infrastructure development, or existing infrastructure operations, that are: 1) necessary to achieve or maintain medical and/or behavioral health stability, 2) directly linked to the overarching strategies and goals for the target population, 3) not otherwise covered by Medi-Cal, and 4) not a local responsibility for health care or social services that is mandated by state or federal laws, or already funded with state or federal funds. The WPC pilot IT infrastructure project funding must be adjusted proportionally to: reflect a target population cap approved in the WPC pilot application as a percent of the total possible target population, and/or adjust for utilization of the IT infrastructure project to serve individuals outside of the target population; across the lead and participating entities.

E. Funding

1. **How much funding can one WPC pilot receive? If the total proposed funding in all WPC applications exceeds the total allocated program funding, how will DHCS decide what to approve/fund?**

   Answer: DHCS has developed application selection criteria, which are included in the application documents.

   A single WPC pilot may not receive more than 30 percent of the total statewide funding available in a given year, unless additional funds are available after all initial awards are made and the WPC pilot receives approval through an application process. In the event that an approved WPC pilot application is approved for less than 90 percent of its requested funding, DHCS will allow the lead entity to withdraw its application.

2. **How will the WPC pilot funding flow?**

   Answer: As part of the WPC application submission, Lead Entities will need to include a total requested annual dollar amount that specifies budgeted payments for each element for which funding is proposed, including infrastructure, data collection, interventions, and outcomes, such that a specific dollar amount is linked in each year to specific deliverables, e.g., performance of specific activities, interventions, supports and services, and/or outcomes. Lead entities will also be required to outline how they plan to distribute funds among the participating entities.

   For each payment that will be made from DHCS to the lead entity over the duration of the five-year pilots, once DHCS has determined a payment amount for what has been earned by the pilot, DHCS will notify the lead entity of the IGT amount and the lead entity, or participating entity, will transfer the required IGT funding amount to DHCS. (The Application should indicate which entity will be transferring the IGT funding to DHCS.) The IGT funds are then matched by the federal government and the combined gross amount is paid to the lead entity. The lead entity is responsible for disbursing those funds in accordance with the terms of the approved pilot.

   In this context, IGT refers to an intergovernmental transfer of public funds from a governmental entity (e.g. county, city, Indian Tribe) to the State Medicaid agency (DHCS). The transferring governmental entity must certify that the transferred funds are public funds that qualify for federal financial participation under relevant federal Medicaid law, including that the funds are not derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as state match, impermissible taxes, and non-bona fide provider donations. For transferring governmental entities that are also providers, the above exclusions will not preclude use of patient care revenue received as payment for services by the transferring entity under programs such as Medicaid, Medicare, or Designated State Health Programs, or PRIME payments.

DHCS' determination of the LE's entitlement to WPC Payment is based on the LE's completion of deliverables as set forth in the approved WPC Application. DHCS and/or CMS have the right to audit supporting documentation to confirm that the agreed upon deliverables were completed. DHCS is not responsible for tracking or verifying the LE's use of funds once the WPC Payment is earned and made to the LE.

For more information on WPC financing, review STCs 126 and 188. The application will also include additional details.

3. Are per-member-per-month/bundled pilot payments permissible?

Answer: WPC pilots may include in their budget request one or more per-member-per-month (PMPM)/bundled payments. These PMPM/bundled payments, if approved by DHCS in the WPC pilot application/agreement, may be used solely or in conjunction with non-PMPM/bundled payment funding structures to complete the total proposed budget request for the pilot. Any PMPM/bundled payment must be based on an identified set of services that will be made available for a specific target population; supporting documentation must be included as a part of the WPC pilot application.

4. For per-member-per-month bundles, what are the requirements LEs must satisfy to receive full payment?

Answer: For purposes of payment, Lead Entities must attest that they have completed each PMPM deliverable before they can claim for payment. Audits are not anticipated as part of the WPC pilot, but records relating to service provision and resources expended are auditable and the LE must maintain these records. LEs may *not* claim PMPM deliverable completion and payment for providing a level of service that is less than what is assumed and required in the approved application. LEs must attest that they are meeting the requirements listed in numbers 1 and 2 below:

1. PMPM cost development assumptions: In the aggregate, the LE needs to be delivering services at a level that roughly equals the assumptions that the LE used to build the PMPM cost in the approved application. Service levels could vary for an *individual* across the projected number of months of the duration of the PMPM delivery. Generally, this would occur for people who need more services at the beginning of their enrollment in the PMPM, and this dynamic would have been projected in the assumptions upon which the PMPM cost was built. For example, if the PMPM is $300 and the average duration is seven months, this amount might assume that there is a high need for service in the first month or two, say $500 in service cost, but that in the last month or two the need is lower, say $100 in service cost. But, in the aggregate for the whole population, over the average seven-month duration, the average amount of service per person that is assumed must be provided.

2. PMPM service bundle description in approved application: The LEs must also comply with any specific requirements that are written into the approved application description of the service bundle for each enrolled individual. For example, if the application description said each member would be contacted each month as part of the PMPM bundle, then that activity must occur. If the bundle is designed to provide care coordination, then that care coordination must be happening for each individual on a regular basis as specified in the application. Otherwise the pilot may not claim the deliverable for the individual.

Engagement PMPM Example: If the LE designed an engagement PMPM's assumptions to allow one or two months to find and enroll the individual, then the activity of attempting to find the member is sufficient. In this case, services need not be provided to the individual each month for the LE to claim the monthly PMPM deliverable. The PMPM assumptions would govern how many months of "find/engage" time are allowed in the aggregate for the engagement PMPM population. However, the LE may have designed the engagement PMPM assumptions to be a one-month engagement bundle that covers finding, enrolling, and providing services, assessment, etc. In this case, the LE would not be able to claim the months while they were attempting to find and engage the member. They could only claim the last month where the member was successfully engaged and services were provided.

Should the pilot or a participating entity experience savings for a PMPM/bundled payment due to administrative implementation efficiencies, the pilot may utilize these savings to pay for services under in its WPC pilot flexible housing pool (Pool). The WPC lead entity and each WPC participating entity may individually determine if their savings under this construct would be utilized in the Pool, as approved in the WPC pilot application/agreement. Savings may also be utilized under the pilot for other purposes, as approved by DHCS. The use of funds in this manner is not permissible if the budget is not in a PMPM or bundled payment amount.

5. What are the timing and deliverables requirements for Program Year 1 funding?

Answer: Funding for the WPC pilot in Program Year 1 (2016 for first-round applicants; Jan-June 2017 for second-round applicants) will be based on the submission of the WPC application and target population baseline data. The allocation will be 75% for the submission of the application and 25% for the submission of baseline data. **Second-round Program Year 1 funding is only available for new lead entities with approved pilots. There is no second-round Program Year 1 funding for expansion lead entities with new approved pilots.**

Once DHCS has approved the pilot application, and the lead entity provides formal acceptance, DHCS will make a request to the pilot for the IGT representing the 75% for application submission no later than January 2017, for first-round pilots. For second-round pilots, DHCS will make the request to the pilots no later than August 2017. The pilot may then submit the appropriate IGT funding for the non-federal share for 75% of the total approved amount of Program Year 1 funding and DHCS will make the

corresponding payment to the lead entity according to the timelines and process specified in Attachment GG.

The baseline data will be considered to be the Annual Report (as required in Attachment GG) for Program Year 1. For first-round pilots, the baseline data will be due to DHCS March 1, 2018. DHCS will release guidance in the first quarter of 2017 regarding the specific baseline data pilot reporting requirements. For second-round pilots, the baseline data will be due to DHCS on a date designated by DHCS. Once the pilot has submitted complete and timely baseline data, and DHCS has reviewed and approved the deliverable, DHCS will make an IGT request to the pilot for the remaining 25%. The pilot may then submit the appropriate IGT funding for the non-federal share for 25% of the total approved amount of Program Year 1 funding and DHCS will make the corresponding payment to the lead entity according to the timelines and process specified in Attachment GG.

6. **Can WPC collaboratives estimate funding used by undocumented individuals in the program on the back end / after spending or does it have to be tracked up front on the individual level based on the services that specific person receives?**

   Answer: The WPC budget and WPC funding apply to MC beneficiaries only. DHCS will only provide Pilot funding to Pilots for completed deliverables that are for Medi-Cal beneficiaries. There would be no computation in the budget request by the pilot or the payment made by DHCS regarding non Medi-Cal individuals. Individuals who are not Medi-Cal beneficiaries may participate in approved WPC pilots, but funding in support of services provided to such individuals is not eligible for federal financial participation. These individuals shall only be included in the pilot at the discretion of the WPC pilot and as approved during the application process. The non-Federal funds expended providing services to individuals who are not Medi-Cal beneficiaries may exceed the funding limits described in STCs 125 and 126.

7. **Is a year-by-year funding plan required in the application?**

   Answer: Yes. Please see WPC Pilot Applications for addition information. The applications for both first and second rounds are available on the Whole Person Care Pilot webpage at www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.

8. **How do pilot metrics relate to payment for completed deliverables?**

   Answer: Most of the following information is from the WPC Pilot Budget Instructions document. Please see that document for additional detail.

   Applicants should develop a deliverables-based budget that includes detailed information regarding infrastructure, interventions, bundled services, pay-for-reporting/outcomes, and incentives for

providers. For first-round applicants, the budget submitted should include a total detailed annual proposed budget which should be the same total for each of the five pilot years. For second-round applicants, the budget submitted will include total detailed annual proposed budgets which should be the same total for each of Program Years 3-5. For new applicants, the total budgets for Program Year 1 and for Program Year 2 will each be 50% of the total annual budgets for Program Years 3-5. For expansion applicants, there will be no funding for Program Year 1 and the budget for Program Year 2 will be 50% of the annual budget for Program Years 3-5. Budgets will also include a justification of estimated costs or value associated with each deliverable. Pilot applications must include sufficient details regarding all components of the requested budget to ensure proposed funding amounts adhere to state guidelines and requirements. A budget helps the State decide whether a pilot merits funding and should reinforce the framework in the pilot.

The budget will provide the associated payment amounts requested for each individual item (deliverable – e.g. service/metric) for which funding is proposed. The selected pilots will only invoice and the State will only pay based on completed deliverables, e.g. services actually provided, metric reported, or metric outcome achieved. The payment for any deliverable will not exceed the DHCS approved budget amount for that item, for that budget year. However, pilots will have an opportunity to request approval for a budget adjustment for Program Year 3 - 5.

A pilot has the flexibility to propose its own payment structure. For example:

- Deliverables and payment for infrastructure that supports interventions;
- Deliverables and payment for services that are facilitated by the supporting infrastructure;
- Deliverables and payment for reporting of metrics that measure the outcomes of the combined intervention of the infrastructure and services; and
- Deliverables and payment for achievement of specified goal metric outcomes that demonstrate the success of the interventions. (The pilot application must propose at least one of these.)

Each of the deliverables noted above, and the associated payments, are separate and distinct. The pilot will receive payment for each deliverable it completes. Payment will not be withheld for any given deliverable because another deliverable is not completed, including metric reporting deliverables and metric achievement deliverables. For example, in the bullets above, if the pilot completed the deliverables associated with the first three bullets, but did not meet its metric outcome goal (fourth bullet), the pilot would receive payment for the deliverables in the first three bullets. It would not receive payment for the metric outcome goal.

Also, the WPC application requires that pilots propose goals for each pilot metric. But the pilot is only required to include one “pay for metric achievement” goal annually, which would be a pilot deliverable with an associated payment for achievement. For Program Year 2, the “pay for metric achievement”

goal can be maintenance of the baseline performance. In addition, the pilot may choose to propose that more of its required metric goals are "pay for metric achievement" goals, but this is not required.

The pilot may also propose to structure its pay for metric achievement goals so that the pilot completes one deliverable by reaching a certain metric outcome, and achieves a separate, subsequent deliverable by achieving a higher specified outcome for the same metric within the same deliverable/funding period. Finally, the "pay for metric achievement" goal may vary between program years if approved in the pilot's application.

9. Is there flexibility in the budget to reflect that pilots may not know exactly which mix of staff members they will hire to support service delivery?

Answer: In its budget request, the pilot may provide a budget amount for a staffing team deliverable for administration, infrastructure, or service delivery. The pilot should provide the back-up assumptions for the 1) various staff levels included, 2) the cost of each level of position, and 3) the number of each level of position that make up the team. This information will allow DHCS to review the appropriateness of the total team deliverable cost. The actual number of each level of staff that the pilot hires for the team may change, as compared to the budget assumption back-up information, for whatever reason. This is allowable. The pilot will receive funding for the staffing team deliverable based on the actual cost of the team, up to the total amount DHCS approved in the application budget (or a Program Year 3, 4, or 5 budget revision).

For example, the pilot could hire one care team consisting of doctors, nurses, social workers, analysts, and office technicians. The number of each type of position would only be specified in the budget request as an assumption for the back-up documents for each team. For example, the one doctor FTE ($200,000), two nurse FTEs ($125,000 each), one social worker FTE ($100,000), one analyst FTE ($75,000), and one office technician FTE ($50,000). The total dollar amount for the total FTEs for each team would be identified in the budget as an annual deliverable of $675,000. The pilot can then hire the appropriate mix of staff for the care team as better information is developed in the coming months/years about what staff are required, or available, to serve the target population and meet the pilot goals. This mix of staff or the actual cost of securing their services during a year may differ from what was initially included in the budget assumption but cannot exceed the maximum amount approved in the budget. For example, the actual team could include one doctor FTE ($250,000), two nurses at half time each ($125,000), two social worker FTEs ($200,000), one contract for analyst services ($75,000), and no office technician ($0). The same categories of staff are used to make up the team, but the nurse, social worker, and office technician mix is different from the initial budget assumption, the actual salary costs differ, and in one case the county contracted for a service instead of hiring the individual directly. The pilot would receive payment for actual staffing costs, including contracted functions, up to the amount approved in the budget. If the staffing mix resulted in an

actual cost that was more than the DHCS-approved budget for the staffing team deliverable, the pilot would only receive the amount that was approved in the budget.

F. Other

1. **Is there an opportunity to submit comments on the STCs, or have they already been finalized and approved?**

   Answer: The Medi-Cal 2020 waiver has been approved by the Centers for Medicare & Medicaid Services, and the STCs are final. The selection criteria and Request for Applications (RFA) was released for public comment prior to finalization.

2. **What data and information sharing requirements should the WPC lead entity follow?**

   Answer: Applicable state and federal laws regarding data sharing apply, but may vary depending on the target population.

3. **How do Distinct Part Skilled Nursing Facilities (DP-SNFs) fit into the 2020 demonstration waiver program?**

   Answer: A DP-SNF may serve as a participating entity in a WPC pilot. To the extent DP-SNF services are already covered under Medi-Cal, they are not eligible for support through the WPC pilot. In general, pilots should work to include all providers of care to a beneficiary in the beneficiary's care team and care planning.

4. **As a program to assist with establishing infrastructure, to what extent can a WPC pilot be used to fund the implementation of Coordinated Entry for Local Continuums of Care (CoC)? We anticipate staffing, technology, and infrastructure costs, tying together multiple community providers, medical providers, and county departments as well as trying to identify solutions to share data between health exchange and Homeless Management Information Systems. Building out a sophisticated system that allow for maximum coordination of care is the goal. How can WPC be utilized toward this end?**

   Answer: While WPC pilots are not specifically designed to provide supporting infrastructure of implementation of the CoC, several provisions of the STCs allow pilot entities to perform these activities. Pilot entities may apply for WPC funds to coordinate existing resources available to provide housing and services to people in the WPC pilot target population experiencing homelessness, and to enhance data sharing between partner agencies. Additionally, housing-related activities available through WPC pilots may include assessing the housing needs of the target population. These services

and activities may be included in WPC pilots to the extent they do not duplicate services and activities for which federal funding is available through other sources.

For example, to the extent that WPC funds are not duplicating any federal funding for the creation, strengthening, or implementation of coordinated entry and assessment or data matching systems, pilot entities may use WPC funds to fund many of the specific activities of a coordinated assessment and entry system in support of the WPC pilot target population. In addition, WPC pilot activities may include matching Homeless Management Information Systems with health plan data to identify a health plan's homeless members to coordinate housing, CoC, and health partners and partner resources, and to assess the housing needs of the target population.

If proposals are put forward to leverage dollars on building coordinated entry infrastructures, the coordinated entry systems must have one consolidated assessment tool that measures housing and health care, behavioral health and LTSS needs across the entities included in the pilot. In addition, the coordinated entry must weigh the member's vulnerability, ensuring members with the highest utilization, who obtain high-cost services from multiple systems with the highest care needs, are having their services coordinated and accessing available housing first.

5. How are the WPC pilots and the Affordable Care Act Section 2703 Health Homes Program (HHP) similar and different?

Answer: Please see the comparison table in the Appendix for a detailed description of the similarities and differences between the two programs.
Both the WPC and HHP will serve beneficiaries with complex, chronic conditions who are frequent users of health services, but specific eligibility requirements for each program may differ. Medi-Cal Managed Care Health Plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE).

The WPC pilots will have the flexibility to establish their own eligibility criteria within the guidelines of the waiver STCs, whereas DHCS has defined the beneficiary eligibility criteria[4] for HHP across the state. Thus, a beneficiary enrolled in a WPC pilot may also be in a HHP, or a beneficiary might be eligible for one program and not the other. Nothing prohibits a beneficiary from being in both programs. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services they want to receive.

The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

In most cases, WPC pilots also provide other services that are not duplicative or similar to HHP care coordination services. Please refer to the Crosswalk document entitled *Comparing Health Homes Program and Whole Person Care Pilot Program Services*. This document provides a template for LEs to use to compare the services that will be provided to Medi-Cal beneficiaries under the HHP with the services provided under the WPC pilot program. The participating LEs determine which of their DHCS-approved services are provided to each pilot target population. The WPC program is designed to provide Medi-Cal reimbursement for services that are not otherwise covered by Medi-Cal. Some of the care management and care coordination services the pilots provide may be duplicative of the services provided under the HHP and therefore are not eligible for Medi-Cal reimbursement; however, there are other services that may qualify. For example, medical respite, recuperative care, sobering center services, outreach and engagement, and other mobile services are a few examples of WPC services that are likely to not be duplicative of HHP services. Finally, the HHP is an entitlement, such that any beneficiary who meets the eligibility criteria must be offered services, while WPC pilot eligibility is at the discretion of the county.

6. How should a WPC application address the relationship between the WPC pilot and a concurrent Affordable Care Act (ACA) Section 2703 Health Homes Program that is operating in the county?

Answer: If a Health Homes Program is scheduled to operate in a county that is also applying for the WPC pilot, the WPC application should describe the interaction of the Health Home and WPC pilot programs, demonstrating at a minimum how the programs complement each other and are not duplicative.

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4 http://www.dhcs.ca.gov/services/Documents/Health%20Homes%20for%20Patients%20with%20Complex%20Needs%20California%20Concept%20Paper%20Version%203.0%20(Draft-Final)%2012-14-15.pdf

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.

- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.

- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.

- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.

7. What assistance can DHCS provide with Information and Data Sharing?

Answer: To assist with the WPC goals of care integration and coordination across systems through the sharing of beneficiary assessment and treatment information, please review the documentation posted on the California Health and Human Services Agency's State of California Office of Health Information Integrity (CalOHII) Resources webpage, in the *Patient Authorization Guidance Tool* section. Links are provided to Patient Authorization Guidance tools for Substance Abuse Treatment Records, for Mental Health Treatment Records, and for treatment of records involving the Lanterman, Petris, Short Act. DHCS expects WPC pilot entities to comply with State and federal law and, as part of the application, describe methods to address information and data sharing issues through the pilot interventions.

APPENDIX A

Crosswalk of California Health Care Integration Programs