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

<table>
<thead>
<tr>
<th>Lead Entities</th>
<th>Lead Entity Responsibilities</th>
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<tbody>
<tr>
<td>• County</td>
<td>• Submits Letter of Intent and application</td>
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<tr>
<td>• A city and county</td>
<td>• Serves as the contact point for DHCS</td>
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<tr>
<td>• A health or hospital authority</td>
<td>• Coordinates WPC pilot</td>
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<td>• A designated public hospital</td>
<td>• Collaborates with participating entities</td>
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<tr>
<td>• A district/municipal public hospital</td>
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<tr>
<td>• A federally recognized tribe</td>
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<td>• A tribal health program under a Public Law 93-638 contract with the federal Indian Health Services</td>
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<tr>
<td>• A consortium of any of the above entities</td>
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Participating Entities

- (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

Participating Entity Responsibilities

- 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**
- 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

**FFS Items**
- 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)
- Alameda
- Contra Costa
- Napa
- Orange
- San Francisco
- San Mateo
- Solano

Counties between 1,001 – 3,000 sq. mi. (4)
- Santa Clara
- San Joaquin
- Placer
- Ventura

Counties between 3,001 – 5,000 sq. mi. (4)
- Los Angeles
- Monterey
- San Diego
- Shasta

Counties with > 5,000 sq. mi. (3)
- Kern
- Riverside
Pilot Size

**Larger:**
- Over 100,000
  - Los Angeles

**Large:**
- Between 10,000 and 100,000
  - Alameda
  - Contra Costa
  - Riverside
  - Santa Clara
  - San Francisco

**Medium:**
- Between 1,000 and 5,000
  - Kern
  - Orange
  - San Diego
  - San Joaquin
  - San Mateo
  - Ventura

**Small:**
- Between 250 and 800
  - Monterey
  - Napa
  - Placer
  - Shasta
  - Solano
## Target Population Selection

<table>
<thead>
<tr>
<th>Target Population Criteria</th>
<th># of Pilots that Selected this Target Population</th>
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<tbody>
<tr>
<td>1. High utilizers with repeated incidents of avoidable ED use, hospital admissions or nursing facility placement</td>
<td>15 Pilots</td>
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<tr>
<td>2. High utilizers with two or more chronic conditions</td>
<td>3 Pilots</td>
</tr>
<tr>
<td>3. Individuals with mental health and/or substance use disorder conditions</td>
<td>8 Pilots</td>
</tr>
<tr>
<td>4. Individuals who are homeless/at-risk for homelessness</td>
<td>14 Pilots</td>
</tr>
<tr>
<td>5. Individuals recently released from institutions (i.e., hospital, county jail, IMD, skilled nursing facility, etc.)</td>
<td>7 Pilots</td>
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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/WholePersonCarePilot](http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilot)

Submit questions/sign up for the listserv:

- [1115WholePersonCare@dhcs.ca.gov](mailto:1115WholePersonCare@dhcs.ca.gov)