Future of Whole Person Care

June 2019

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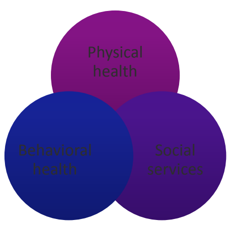
Whole Person Care Overview

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



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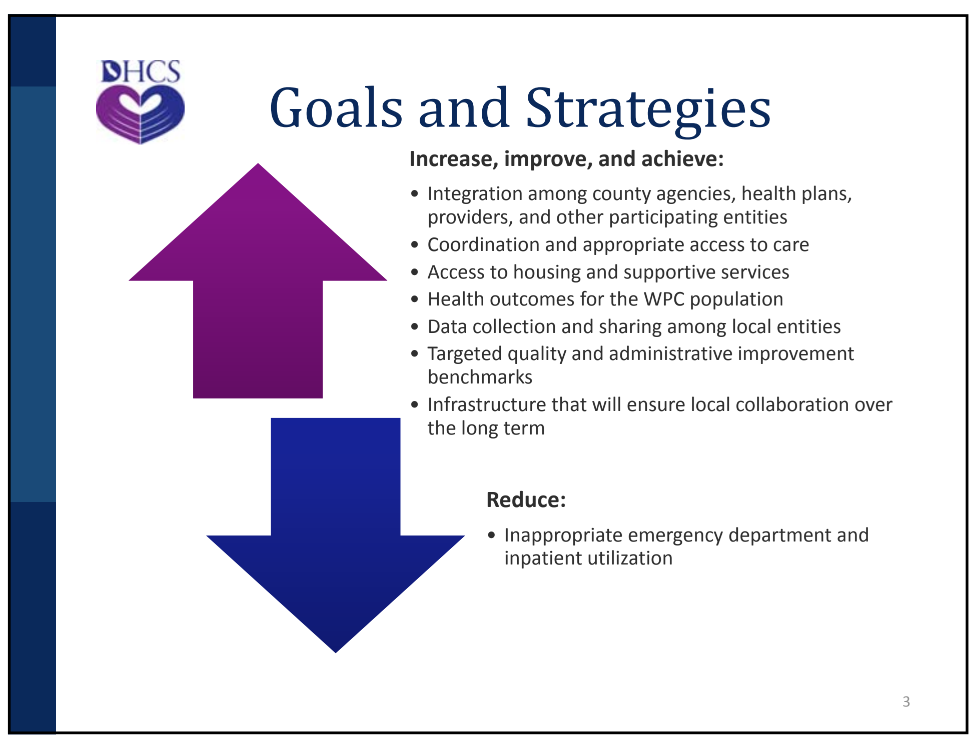
DHCS
Goals and Strategies
Increase, improve, and achieve:
• Integration among county agencies, health plans, providers, and other participating entities
• Coordination and appropriate access to care
• Access to housing and supportive services
• Health outcomes for the WPC population
• Data collection 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
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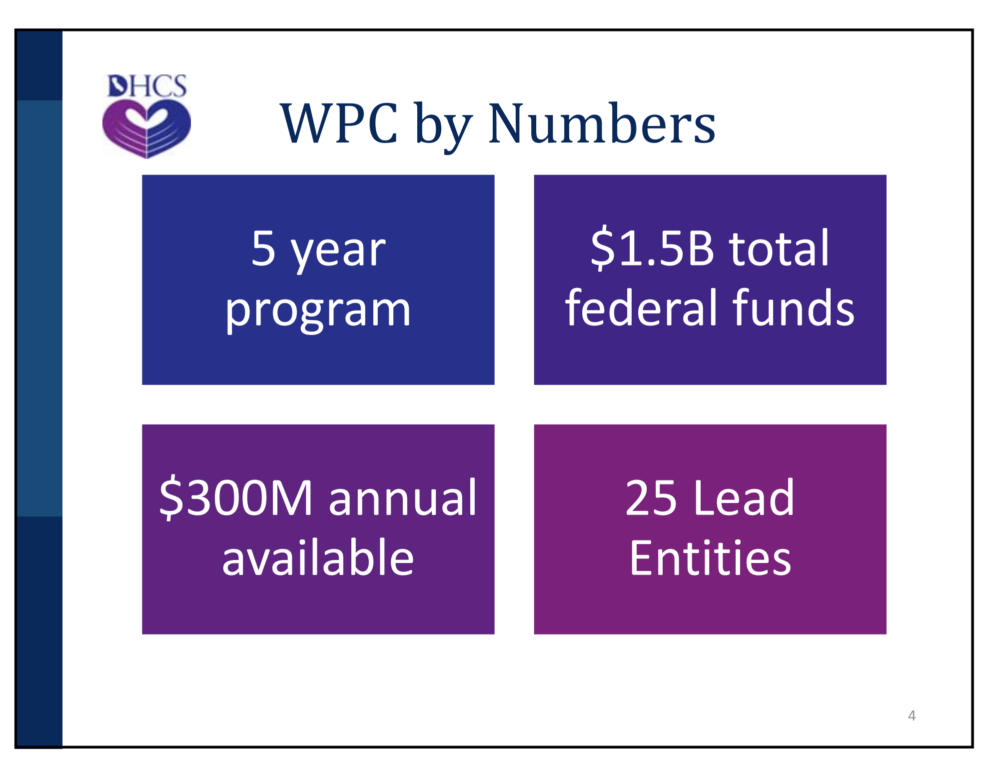
DHCS
WPC by Numbers
5 year program
$1.5B total federal funds
$300M annual available
25 Lead Entities
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Target Populations

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

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Payment Mechanisms

Admin	Delivery Infrastructure	PMPM Bundle	FFS Items
• Core program development and support • Staffing • IT infrastructure • Program governance • Training • Ongoing data collection • Marketing materials	• Advanced medical home • Mobile street team infrastructure • Community paramedicine team • Community resource database • IT workgroup • Care management tracking and reporting portal	• 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, sobering center

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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)

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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

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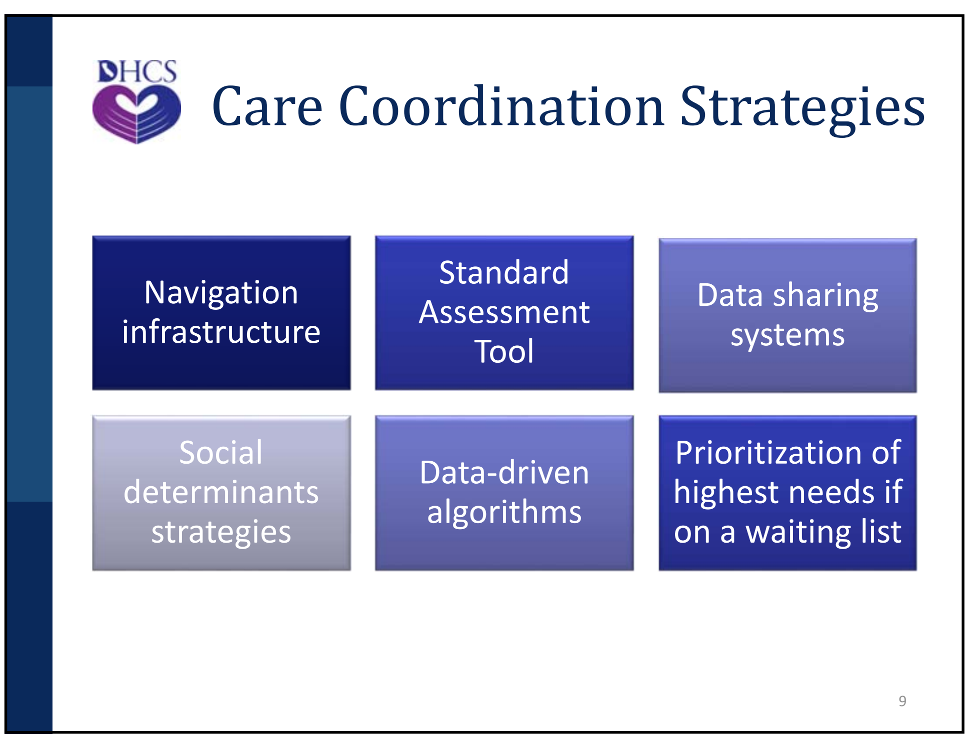
DHCS
Care Coordination Strategies
Navigation infrastructure
Standard Assessment Tool
Data sharing systems
Social determinants strategies
Data-driven algorithms
Prioritization of highest needs if on a waiting list
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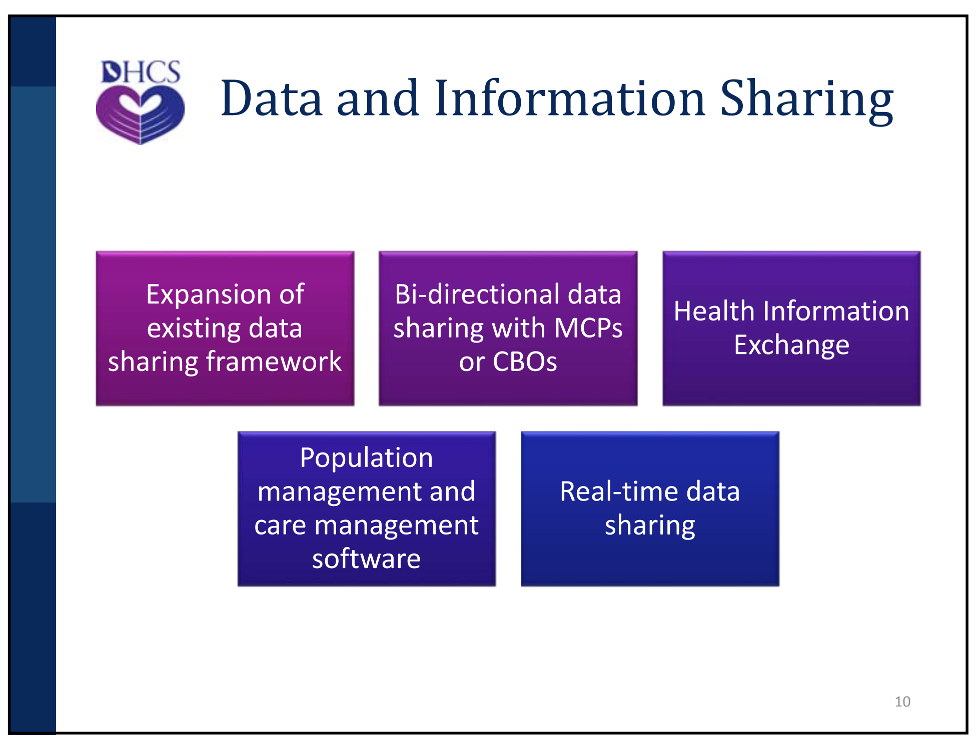
DHCS
Data and Information Sharing
Expansion of existing data sharing framework
Bi-directional data sharing with MCPs or CBOs
Health Information Exchange
Population management and care management software
Real-time data sharing
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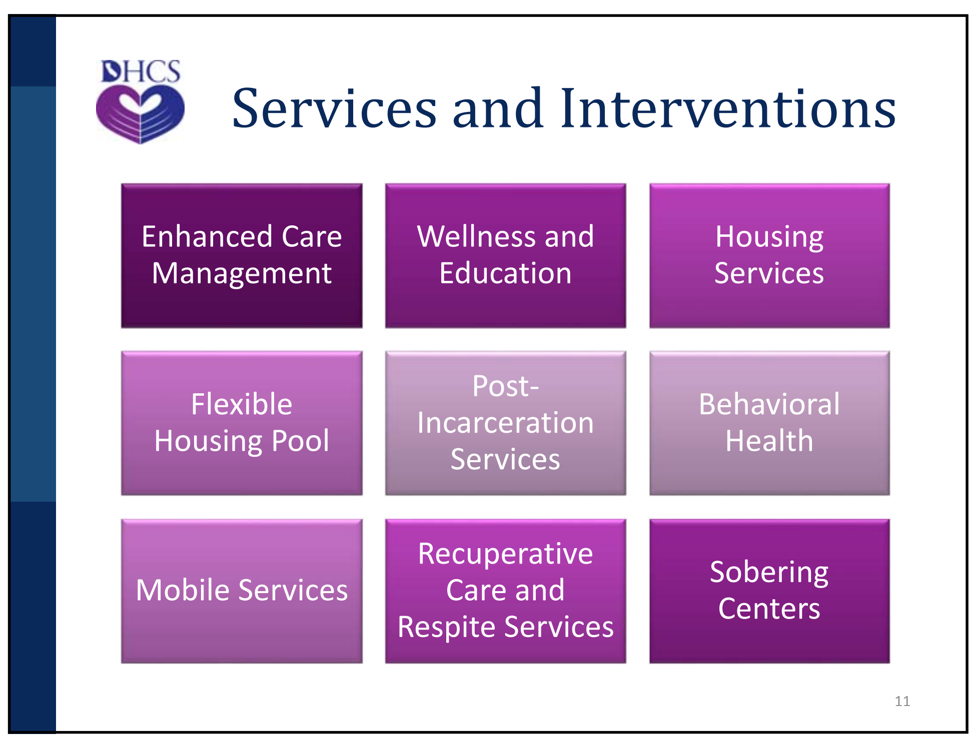
DHCS
Services and Interventions
Enhanced Care Management
Wellness and Education
Housing Services
Flexible Housing Pool
Post-Incarceration Services
Behavioral Health
Mobile Services
Recuperative Care and Respite Services
Sobering Centers
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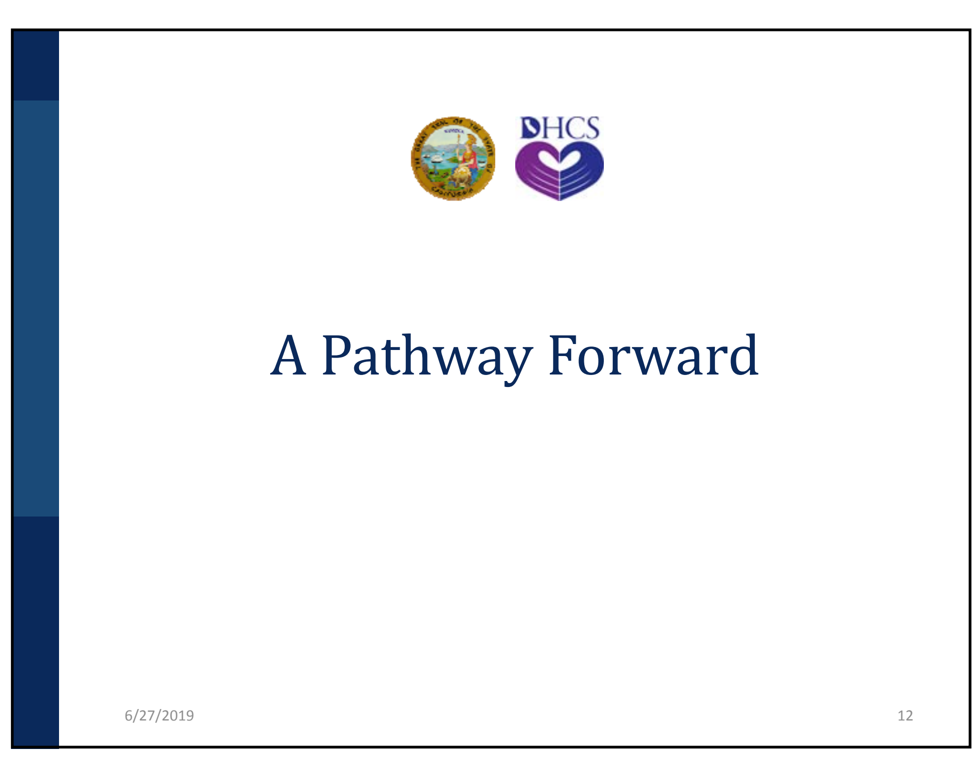
DHCS
A Pathway Forward
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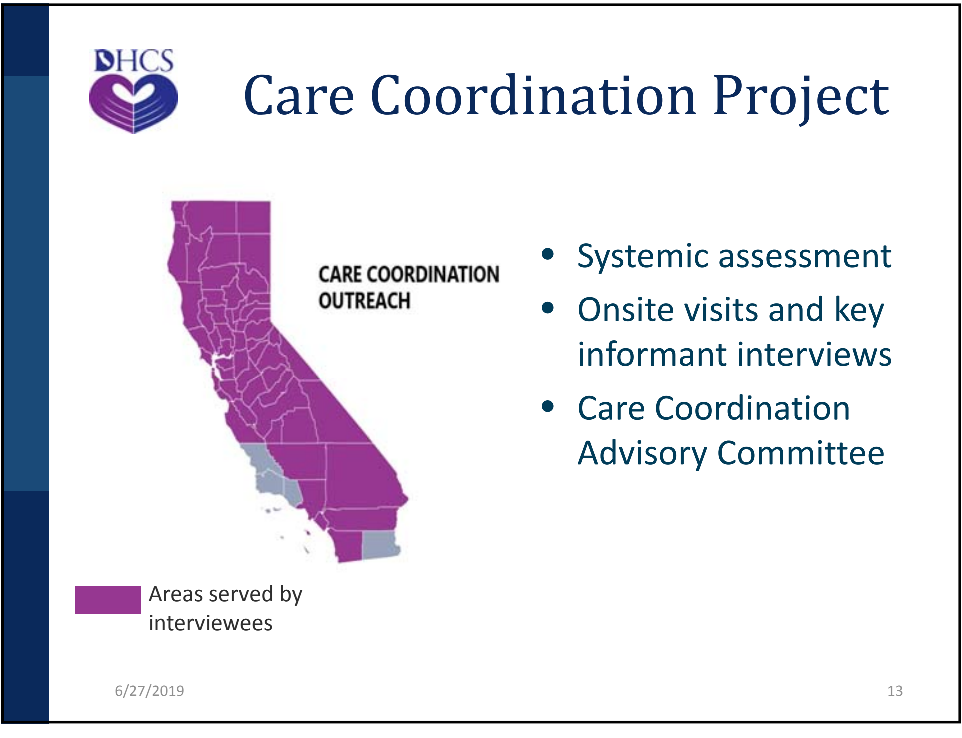

Framing the Issue

- Evaluate existing statute, regulations, contract language, policy letters, and health assessments regarding Care Coordination through a systemic assessment
- National perspective and best practices, etc.
- Evaluate current care coordination practices through onsite visits and key informant interviews – plans, counties, providers, consumer advocates, etc.
- Create an internal DHCS workgroup
- Document key coordination and transition points, factors that influence better care coordination and factors that have a negative impact on care coordination

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Guiding Principles

- Improve the member experience.
- Meet the behavioral, developmental, physical, and oral health needs of all members.
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Focus on assessing and addressing social determinants of health and reducing disparities or inequities.
- Focus more on value and outcomes.
- Look to eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

Recap Committee Discussion

Reduce Variation and Complexity across the System

- Plan Accreditation
- Mandatory enrollment in managed care vs. FFS
- Annual Medi-Cal Health Plan Open Enrollment
- Standardizing the benefit statewide
- Exploring opportunities for integration and breaking down historical delivery system silos
- Standardize/consolidate state required assessments

Recap Committee Discussion

Identifying and Managing Member Risk and Need through Population Health Management Strategies

- Risk Stratification/Assess Members for Risk and Need
- Wellness and Prevention
- Transitions in Care
- Point of Care and Community Based Enhanced Care Management
- Addressing Social Determinants of Health
- Explore In-Lieu of Services

Recap Committee Discussion

Improve Quality Outcomes and Drive System Transformation through Value Based Payments, Incentives and Shared Savings

- Funding Flexibility
  - Value Based Payments
  - Shared Savings Models
- Incentives to drive delivery system transformation
- Behavioral Health quality and performance metrics
- Behavioral Health payment reform

Next Steps

- Internally vetting policy recommendations
- Stakeholder Engagement starting in fall 2019
- 1115 and 1915b Waiver Planning
- Roadmap for multi-year changes

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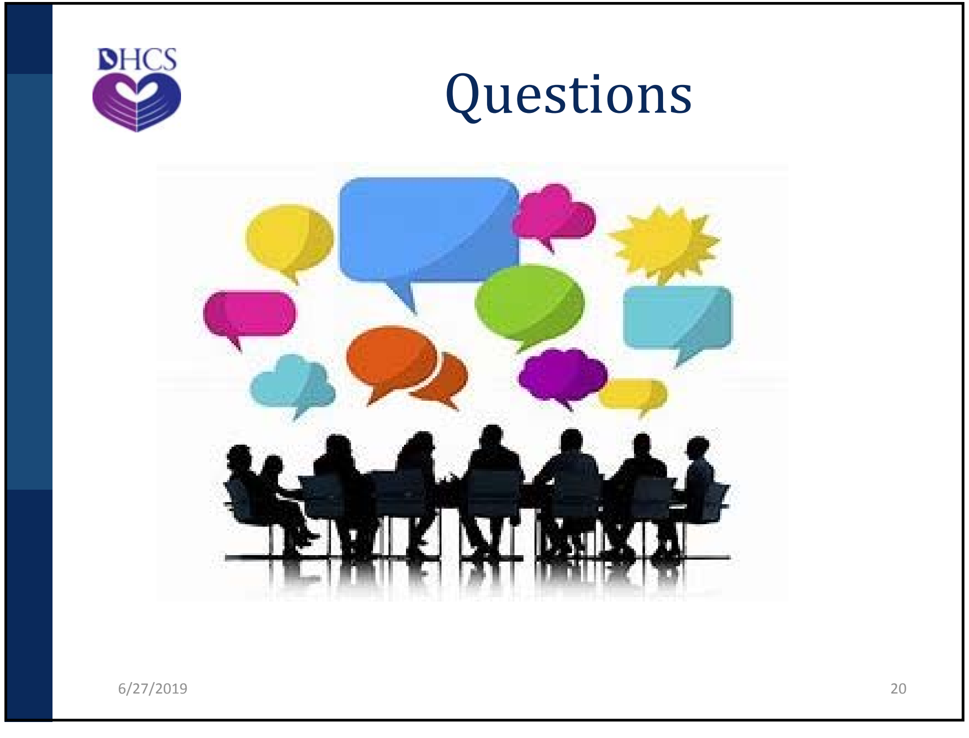
Questions



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