THE HEALTH HOMES PROGRAM

WHOLE PERSON CARE INTEGRATION

2020

PRODUCED WITH SUPPORT FROM THE CALIFORNIA ENDOWMENT

INTRODUCTION

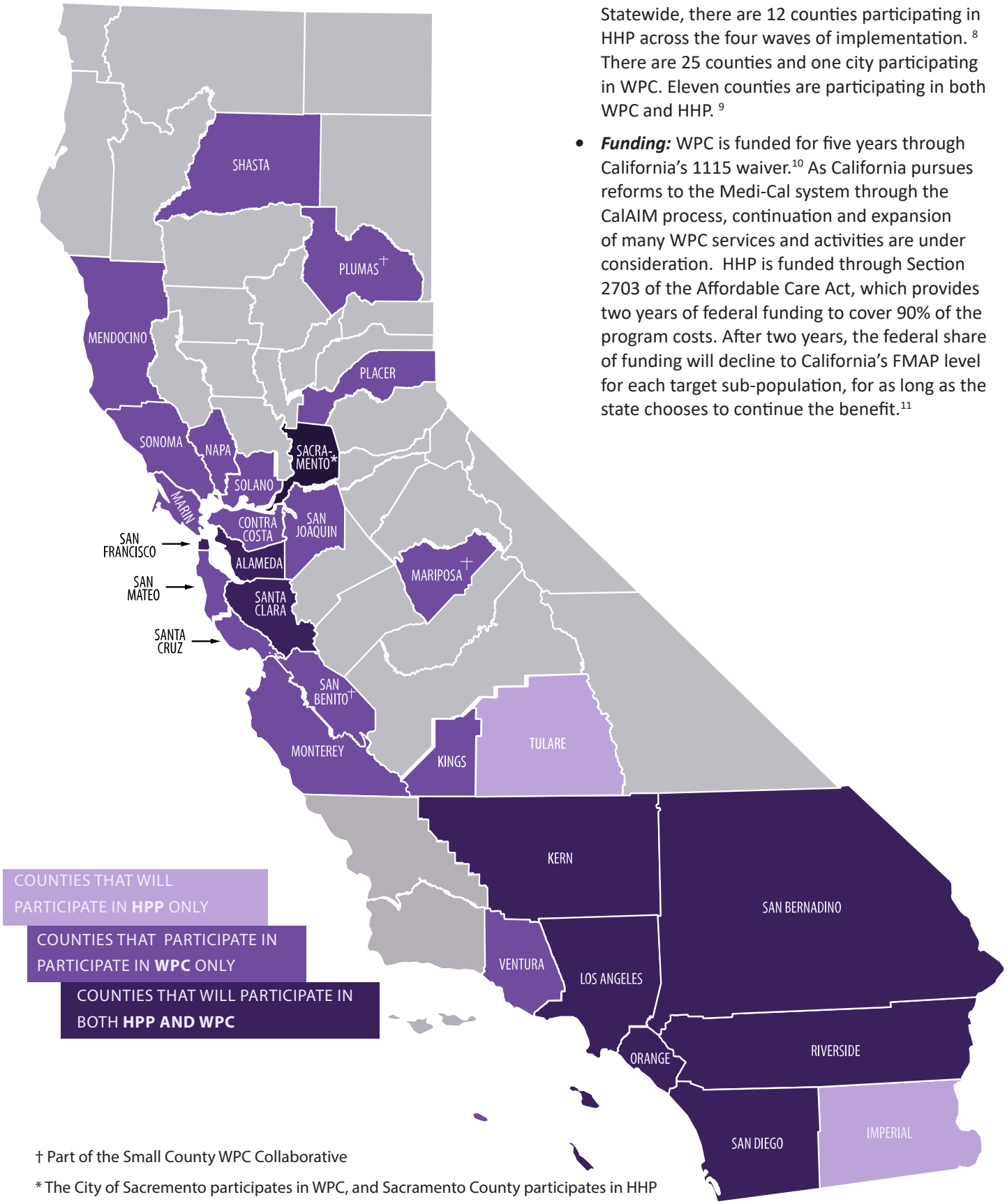
The landscape of health care delivery and housing supports for Medicaid members with complex needs is transforming dramatically in California as the result of two statewide efforts: the Health Homes Program (HHP) and Whole Person Care (WPC) demonstration under California's Medi-Cal 2020 1115 Waiver. To examine the challenges, synergies, and lessons learned in the implementation of these coinciding efforts, JSI Research and Training Institute, Inc. (JSI) conducted interviews with stakeholders across California, including representatives from Group 1 and 2 HHP counties, organizations that have implemented "HHP-like" care management programs, and WPC counties. California is now is considering how to best provide and finance enhanced care management and coordination services for Medi-Cal members going forward, and multiple counties are at the beginning stages of or are still planning to implement HHP. To inform both of these efforts, in this brief, we provide an overview comparison of the two efforts, key implementation challenges, and early lessons learned.

OVERVIEW OF HHP AND WPC

Key points of comparison and distinctions between the two efforts include:

- ***Lead Entity:*** HHP is managed by Medi-Cal Managed Care Plans (MCPs), while WPC-participating counties identified their own lead entities (often county Health Services Agencies).[1] MCPs have been involved in WPC demonstrations to varying degrees, ranging from being a partner in data sharing to being considered a core member of the WPC planning and implementation team.
- ***Services provided:*** HHP services are outlined in a State Plan Amendment and are thus the same across counties.[2] By contrast, WPC services vary by county as described in their proposals to the State. WPC programs tend to offer the services provided under HHP (care coordination, care management, and housing supports) and additional activities and services (more comprehensive housing supports, data sharing, innovative behavioral health services). WPC also provides funding for infrastructure, including development of data platforms, quality improvement activities, training, and skills development for providers.[3] Under WPC, services are delivered by a range of providers and organizations, whereas under HHP, for any given individual, a single community-based care management entity (CB-CME) is responsible for ensuring the person receives the services they need through partnerships and referrals to a host of other organizations.
- ***Target population:*** The target population for HHP is specifically defined by the Department of Health Care Services (DHCS) as Medi-Cal enrollees with a particular set of chronic physical and behavioral health conditions and a high level of acuity or complexity. Using administrative data, DHCS creates a Targeted Engagement List (TEL) that indicates which plan members are eligible for HHP, which MCPs and CB-CMEs may further refine.[4] Under WPC, counties define their own target population within a set of criteria; this population may overlap with the HHP-eligible population, but in most cases there is not complete overlap (some individuals may be eligible for WPC but not HHP).[5] While an individual may be eligible for both programs, a person cannot receive duplicative care management and coordination services.[6]
- ***Timeline:*** WPC was initiated in 2016, and is scheduled to end in December 2020. HHP is being rolled out in four waves, with participating counties spread across the four start dates and each wave lasting two years.[7] Group 1 (San Francisco County) began in July 2018, and Group 4 is set to begin in January 2020. Additionally, under HHP, each county has a phased implementation; the initial roll out includes members with eligible physical conditions and substance use disorders, followed six months later by roll out for members with serious mental illness.[I] This means that WPC and HHP will overlap at least partially in all counties, and completely in three counties (Group 1, San Francisco, and 2, Riverside and San Bernardino).

FIGURE 1. CALIFORNIA COUNTIES PARTICIPATING IN WPC AND HPP



† Part of the Small County WPC Collaborative

* The City of Sacremento participates in WPC, and Sacramento County participates in HHP

- ***Participating counties:*** Both efforts are being implemented in distinct subsets of California's 58 counties for defined patient populations. Statewide, there are 12 counties participating in HHP across the four waves of implementation. [8] There are 25 counties and one city participating in WPC. Eleven counties are participating in both WPC and HHP. [9]
- ***Funding:*** WPC is funded for five years through California's 1115 waiver.[10] As California pursues reforms to the Medi-Cal system through the CalAIM process, continuation and expansion of many WPC services and activities are under consideration. HHP is funded through Section 2703 of the Affordable Care Act, which provides two years of federal funding to cover 90% of the program costs. After two years, the federal share of funding will decline to California's FMAP level for each target sub-population, for as long as the state chooses to continue the benefit.[11]

IMPLEMENTATION CHALLANGES

LEADERSHIP LEVEL

Separate leadership and systems of accountability make collaboration and accountability across programs difficult.

WPC and HHP have separate eligibility guidelines and reporting requirements, and tracking each requires significant effort. Providers are often required to use two distinct platforms to report data for WPC and HHP, in addition to electronic medical records, and data entry and tracking for the two programs can be redundant and time consuming for busy providers. On top of state reporting requirements, individual Medi-Cal members may be eligible for both programs but are not allowed to receive duplicate services, and providers are not always clear about the distinctions. Data sharing between counties, health plans, and providers is necessary in order for WPC and HHP entities to communicate around the services a patient is receiving and where they are enrolled. Such data sharing can be complicated by both organizational policies and technical limitations. These legal and operational challenges take time and significant effort to work though. In the worst-case scenarios, delays in reporting or data sharing can result in counties being required to return funding to the state for duplicated care management and coordination services. This occurs when HHP data, which is reported directly to DHCS, is reviewed and compared to WPC data by the state; the WPC program, which is responsible for ensuring there is no duplication but does not always have access to HHP data, is required by the state to return funding they received for patients who are found to have also received services through HHP.

PROVIDER LEVEL

Data tracking and reporting for two separate programs is burdensome.

HHP and WPC are led by different entities, and both involve multiple stakeholders and systems, including Medi-Cal MCPs, county health service agencies and public health departments, other county agencies, community health centers, other Medi-Cal providers, and state-level agencies and associations. Having HHP and WPC administered by different lead entities is a challenge, particularly when these entities do not have a history of collaboration. In many counties, the MCP has not been substantively involved in WPC, and in the first county to implement HHP, the county-led health clinics were not contracted by the MCP to be CB-CMEs. This lack of active collaboration between lead entities around the enrollment of eligible Medi-Cal members and delivery of services leads to a host of missed opportunities, including: identifying overlap in enrollment lists; coordinating care for individuals; and preventing duplication of services as required by both programs.

INDIVIDUAL LEVEL

Eligibility for duplicative programs is confusing.

The separation of these programs is a “disservice to patients,” according to a health plan Care Management Director. In most counties, WPC offers a broader range of resources than HHP, including outreach, engagement, and a more expansive set of housing-related services. Patients cannot receive duplicative services, but they can access WPC resources that are not offered through HHP, even if they are enrolled in HHP. This distinction can be unclear for providers, confusing and frustrating for patients, and can result in patients not receiving the full scope of services for which they are eligible. Being inundated with information about the programs can lead to disengagement among patients. Separating these programs and the resources they provide is seen by some as an impediment to providing patients with the well-coordinated, comprehensive services that they need.

LESSONS LEARNED

1

EARLY, FREQUENT COMMUNICATION AND COLLABORATIVE RELATIONSHIPS ACROSS THE TWO PROGRAMS ARE ESSENTIAL TO EFFECTIVE COORDINATION.

Because of the overlap in program timing, services, and populations, open and frequent communication between the entities involved in each program is essential. Interviewees found value in developing and deepening relationships early on, and prior to the implementation of HHP. This facilitated information sharing and laid the groundwork for collaboration around data tracking and sharing. Interviewees described having members of each program attend the other's meetings as a way of staying connected and up-to-date on each of the program's developments.

2

IDENTIFYING OVERLAP IN CAPACITY BUILDING AND SERVICE DELIVERY CAN LEAD TO EFFICIENCIES IN IMPLEMENTATION.

For example, interviewees reported MCPs coming together to co-host regular learning collaboratives for CB-CMEs; in addition to being an efficient use of resources, this created greater coordination and support amongst providers. Another type of collaboration taking place is around housing resources. Many CB-CMEs do not have expertise in housing navigation; by having their HHP housing coordinator work closely with WPC housing coordinators, they are able to build on existing expertise, increase coordination between programs, and build capacity internally.

3

EARLY, DELIBERATE FINANCIAL PLANNING ACROSS PROGRAMS CAN MAXIMIZE AVAILABLE FUNDING AND INFRASTRUCTURE INVESTMENTS.

Sharing staffing plans and designing WPC services to match HHP requirements meant that counties were prepared to implement HHP more quickly, and could take advantage of the higher rates offered in the first year of the HHP program by being equipped to start providing services immediately upon HHP start date. Aligning the services of the two programs has also allowed counties to use WPC funding as a way to expand the population receiving services by covering individuals who are not HHP-eligible. Interviewees also recommended using WPC data infrastructure investments to establish information exchanges and data sharing agreements that could be utilized by HHP.

4

IF EITHER PROGRAM IS CARRIED FORWARD BY THE STATE, THE PROGRAMS COULD BE COMBINED INTO ONE MODEL OF CARE.

Though federal match for HHP will decline to California's FMAP level for each target sub-population two years after implementation in a given county, the state can choose to continue the program indefinitely. Similarly, DHCS is exploring how to incorporate aspects of WPC into Medi-Cal managed care contracts after the end of the Medi-Cal 2020 waiver. Because of the overlap in select services, continuation of funding through MCPs could provide sustainable support for care management, care coordination, and housing navigation and stabilization services that are currently offered under the two programs. Some counties reported specifically designing WPC care management services to match the requirements of HHP for this reason; having one model of care regardless of whether the funding source is HHP or WPC allows services to potentially continue seamlessly in the absence of WPC funding.

CONCLUSION

Though implementing HHP and WPC simultaneously is challenging, the overlap also presents opportunities for leveraging resources and maximizing the impact of both programs. The State has a distinct opportunity, as WPC ends in 2020, to incorporate as many of the WPC services as possible that are resulting in the desired goals of better care, better outcomes and reduced total costs into an ongoing HHP managed care benefit. The HHP and WPC experience highlights the importance of considering how future waivers and care delivery transformation efforts could align with or complicate existing programs.

NOTES

I. New guidance released by the Center for Medicaid and CHIP Services in May 2019 allows states to request a two-quarter extension of the enhanced federal match for substance use disorder-focused health home programs.

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