# Comparison of California's Health Home Program, Whole Person Care Pilot, Public Hospital Redesign and Incentives in Medi-Cal Program, and Coordinated Care Initiative

March 16, 2016

This document summarizes and compares four major California initiatives: 1) the Health Homes for Patients with Complex Needs Program;[1] 2) the Medi-Cal 2020 Whole Person Care Pilots;[2] 3) the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program; and 4) the Coordinated Care Initiative (CCI) for dual eligibles.[3]

These initiatives focus, individually and collectively, on care coordination and care management for high-need Medi-Cal beneficiaries. They recognize the importance of a whole-person approach to care that addresses the clinical and nonclinical needs of each individual. Given the similarities in target populations, beneficiaries are likely to be eligible for multiple programs, depending on the initiatives that are underway in their county of residence. It is the state's intention to implement these initiatives in a complementary, rather than duplicative, manner at the local level.

| Topics | Whole Person Care Pilots (WPC) | Health Home Program (HHP) | Coordinated Care Initiative (CCI) | Public Hospital Redesign and Incentives in Medi-Cal (PRIME) |
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| **Summary** | A 5-year, up to $1.5 billion federally funded pilot program to test county-based initiatives that coordinate health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who arehigh users of multiple systems and have poor outcomes. | An ongoing initiative to develop a network of providers that will integrate and coordinate primary, acute, andbehavioral health services for the highest risk Medi- Cal enrollees. | An ongoing demonstration to promote coordinated care to seniors and persons with disabilities who are eligible for both Medi-Cal and Medicare in seven California counties through Cal MediConnect managed care plans. | A 5-year, $3.7 billion federally funded program that continues and expands the California delivery system reform initiative that provides incentives for improving the way care is delivered in California's public safety net in order to maximize health care value. |
| **Authority** | The Medi-Cal 2020 Section 1115 waiver authorized the creation of WPC pilots. | Section 2703 of the Affordable Care Act established a new optional Medicaid state plan benefit covering health home services for beneficiaries with chronic conditions.<br>California Assembly Bill (AB) 361 (2013)<br>authorized DHCS to submit a State Plan Amendment to establish a HHP. | CCI was originally authorized in the Medi-Cal Bridge to Reform Section 1115 waiver and was enacted through State Bill (SB) 1008 and SB 1036 in July 2012. CCI has been carried forward through the Medi-Cal 2020 Section 1115 waiver. | The Medi-Cal 2020 Section 1115 waiver authorized the funding for and structure of PRIME. |

[1] It should be noted that the HHP is still in the planning changes and has not yet received federal approval. For more information about California's plans for a Health Home Program, see http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

[2] For more information on the Whole Person Care Pilots and for PRIME, see http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx

[3] For more information about CCI, please visit http://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareInitiative.aspx

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| **Implementation Timeframes** | Anticipated timeline:<br><br>Attachments to Special Terms and Conditions finalized in March 2016.<br><br>Application, selection criteria, and timelines released: May 16, 2016.<br><br>WPC pilot applications due: July 1, 2016 (45 days after application release). | Phased-in implementation, pending CMS approval of the HHP State Plan Amendment:<br>• Group 1: January 2017<br>• Group 2: July 2017<br>• Group 3: January 2018<br><br>Some counties are not scheduled for implementation at this time (See appendix for phase-in plan).<br><br>Program is permanent subject to demonstrating no net impact to the state General Fund. | Phased-in enrollment into Cal MediConnect plans on a county-by-county basis began in April 2014. | Attachments to Special Terms and Conditions finalized on March 2, 2016.<br><br>PRIME Application released: March 4, 2016.<br><br>PRIME Applications due: April 4, 2016. |
| **Program Duration** | 5-year program<br><br>Program Years: January 1, 2016 – December 31, 2020 | Ongoing | Three-year program that began in April 2014. Budgeted to continue through the end of 2017, with potential for extension through 2019. | 5-year program<br><br>Program Years: January 1, 2016 – June 30, 2020 |
| **Lead Entities** | Each WPC pilot will have a lead entity that will be a:<br>• county agency;<br>• city and county;<br>• health or hospital authority;<br>• designated public hospital;<br>• district municipal public hospital;<br>• a consortium of any of the above entities | Medi-Cal managed care plans (MCPs) will organize the payment and delivery of services.<br><br>In counties thatimplement HHP, Medi-Cal plan and Cal MediConnect plan participation will be mandatory. | Dual eligible beneficiaries voluntarily enroll in a Cal MediConnect plan (CMC) in the seven CCI counties.<br>Beneficiaries who choose not to enroll in a CMC plan must enroll in a Medi-Cal managed care plan. | Participation in PRIME is limited to:<br>• Designated Public hospitals (DPHs)<br>• District Municipal Public hospitals (DMPHs) |

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| **Participating Entities** | The WPC pilot applications identify other entities [in addition to the lead entity] that will participate in the WPC pilot. Participating entities must include a minimum of:<br>• One Medi-Cal managed care health plan (MCP) operating in thegeographic area of the WPC pilot;<br>• Both the health services and specialty mental health agencies or department; At least one other public agency or department, which may include county alcohol andsubstance use disorder programs, human services agencies, public health departments, criminal justice/probation entities, and housing authorities (regardless of how many of these fall under the same agency head within a county); and<br>• 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.<br><br>• If a lead entity cannot reach agreement with a required participant, it may request an exception to the requirement. | Plans certify and contract with Community-Based Care Management Entities (CB-CMEs), which may include hospitals, clinics, physicians, local health departments, community mental health centers, and/or substance use disorder treatment providers.<br><br>County mental health plans and county substance use disorder agencies that participate in the Drug Medi-Cal waiver have the option to serve in the MCP and/or CB-CME role for HHP beneficiaries withconditions that are appropriate for specialty behavioral health treatment. | CMC plans and their contracted providers, as well as MCPs in the seven CCI counties.<br><br>CMC plans must sign an agreement with county mental health agencies agreeing to coordinate services, though the services are carved out and not included in the capitation rate. | DPHs and DMPHs are the participating entities. |

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| **Target Population** | WPC pilots identify Medi-Cal beneficiaries who are high-risk high users of multiple health care systems in the geographic area they serve. By sharing data among participating entities, WPC pilots identify common beneficiaries anddefine the target population(s), which may include, but are not limited to individuals:<br>• with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement;<br>• with two or more chronic conditions;<br>• with mental health and/or substance use disorders;<br>• who are currently experiencing homelessness; and/or<br>individuals who are at risk of homelessness, including individuals who will be experiencing homelessness upon release from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, Institution for Mental Disease, county jail, state prisons, or other)<br><br>The number of individuals served may be limited at the discretion of the pilot and upon approval by DHCS. | California's HHP targets the top 3-5% highest risk Medi-Cal beneficiaries with the best opportunity for improved health outcomes through HHP services.<br><br>HHP chronic condition eligibility criteria include:<br>• At least two of the following: asthma, chronic obstructive pulmonary disease (COPD), diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, dementia, substance use disorder **OR**<br>• Hypertension and one of the following: COPD, diabetes, coronary artery disease, chronic orcongestive heart failure **OR**<br>• One of the following: major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia)<br>In addition, criteria will specify that the member must also have:<br>• A chronic condition predictive risk score above three based on a specific risk-scoring tool selected by DHCS **OR**<br>• At least one inpatient stay in the last year **OR**<br>• Three or more emergency department (ED) visits in the last year<br><br>The following additional criteria are applicable:<br>• At least two separate claims for the eligible condition<br>Enrollment cannot be capped. However, states can operate the program only in certain geographic regions and define the eligible target populations. | Targets individuals who are dually eligible for Medi-Cal and Medicare and live in one of the seven participating counties. A majority of thispopulation (70%) are age 65 and older. Approximately 30% are younger people living with disabilities. In Los Angeles County, the maximum enrollment into the CMC plan is capped at 200,000. About 456,000 Californian's living in the seven CCI counties are eligible for enrollment in CMC plans (accounting for the Los Angeles cap). | For DPHs the target population includes both:<br>(a) All Medi-Cal managed care primary care lives assigned to the DPH as listed by DHCS at the end of each measurement period; and<br>(b) Individuals with at least two encounters by DPH for an eligible primary care service during the measurement period.<br><br>For DMPHs, the target population includes Medi-Cal beneficiaries with at least two encounters by the participating entity. |

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| **Strategies/Services** | WPC pilots will design and implement specific strategies to:<br>• Increase integration among county agencies, health plans, and providers, and other entitieswithin theparticipating county or counties that serve high- risk, high-utilizing beneficiaries, anddevelop an infrastructure that will ensure localcollaboration among the entities participating in the WPC pilots over the long term;<br>• Increase coordination and Appropriate access to care for the most vulnerable Medi- Cal beneficiaries; Reduce inappropriate emergency and inpatient utilization; Improve data collection and sharing among local entities to support ongoing case management, monitoring, and strategic program improvements in a sustainable fashion;<br>• Achieve targeted quality and administrative improvement benchmarks;<br>• Increase access to housing and supportive services (optional); and<br>• Improve health outcomes for the WPC population.<br><br>WPC pilots determine the specific services that will be provided and the interventions and strategies that will be implemented to meet the goals outlined above. | HHP will provide reimbursement for care coordination services/benefits. There are six categories of required services:<br>• comprehensive care management;<br>• care coordination and health promotion;<br>• comprehensive transitional care;<br>• patient and family support;<br>• referral to community and social support services; and<br>• the use of health information technology to link services, as feasible and appropriate.<br><br>The most recent HHP concept paper released by DHCS in December 2015 (link on page 1) further defines these services and delineates the specific responsibilities of the MCPs and CB-CMEs.<br><br>HHP enrollees will have an individualized care plan and a care manager that ensures access to all needed services across the spectrum of care and support.<br><br>The HHP only funds the care coordination services. HHP does not fund any direct medical or social services. | The CCI provide a PMPM for the beneficiary's Medicare and Medicaid services. CMC plans coordinate all of a beneficiary's benefits, including medical, behavioral health (other than the county carve-out), and long-term services and supports (including institutional and home- and community-based services). CMC plans offer:<br>• All of a patient's Medi-Cal and Medicare benefits, including prescription drugs;<br>• A health risk assessment;<br>• Care coordination through a care coordinator, an interdisciplinary care team, and an individualized care plan;<br>• Additional transportation and vision benefits;<br>• Care plan option services not traditionally reimbursed for under Medicare and Medi-Cal, including ramps, grab bars, etc., to keep people safe in their homes. | PRIME provides incentive payments for quality improvement. Hospitals select projects to implement across three domains:<br>Domain 1: Outpatient Delivery System Transformation, including a major focus on prevention<br>• Domain 2: Improving care for targeted high-risk or high cost populations<br>• Domain 3: Reducing overuse and misuse of identifiedhigh-cost services, eliminate use of ineffective or harmful services, and address inappropriate underuse of effective services.<br><br>DPHs must implement at least nine projects, including a specified number from each domain. DMPHs must implement at least one project across the three domains.<br><br>The PRIME projects and related metrics are described in Attachment Q: http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_AttachmentQ_PRIMEProjectsMetrics.pdf |

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| **Continuation of Strategies/Services** | WPC pilots cannot duplicate services for the same beneficiaries as the HHP. However, the same services could be provided through both the WPC pilot and HHP if the programs target different populations. Lead entities will provide this information in the application.<br><br>WPC pilots may offer HHP services if no HHP is operating in the pilot county, or for people who are not eligible for HHP services. In either case, WPC pilots may also offer care coordination services that go beyond what is offered in the HHP. | | | |
| **Housing Supports and Services** | WPC pilots may target individuals experiencing or at risk of homelessness who have a demonstrated medical need for housing and/or supportive services.<br><br>Housing interventions may include:<br>• *Tenancy-based care management supports* to assist the target population in locating andmaintaining medically necessary housing.<br>• *County Housing Pools*. WPC pilot entities may include contributions to a county-wide housing pool that will directly provide support for medically necessary housing services, with the goal of improving access to housing and reducing churn in the Medicaid population. | The HHP includes assessing the patient'shousing needs and providing support in this area, as needed.<br><br>For HHP members experiencing homelessness, a "Housing Navigator" is a required member of the HHP care team. Their role is to:<br>• Form and foster relationships with and communication between team members, housing providers, and member advocates:<br>• Connect and assist the HHP member to get recuperative care or bridge housing<br>• Connect and assist the HHP member to get available permanent housing<br>Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g., could be a mobile unit that engages members on the street) | Does not include housing benefits, although some CMCs are working to support and coordinate transitions into the community. | Not applicable. |

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| **Continuation of Housing Supports and Services** | WPC investments in housing units or housing subsidies, including any payment for room and board, are NOT eligible for federal financial participation.<br><br>The housing pool may be funded through WPC pilot funds or direct contributions from community entities. These services may include those identified in the June 26, 2015 CMCS Informational Bulletin, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities". State or local government and community entity contributions to the housing pool are separate from federal financial participation funds, and may be allocated to fund support for long-term housing, including rental housing subsidies.<br><br>The housing pool may leverage local resources to increase access to subsidized housing units. The housing pool may also incorporate a financing component to reallocate or reinvest a portion of the savings from the reduced utilization of health care services into the housing pool. | | | |

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| **Federal Financing** | Up to $1.5 billion in federal funding is available for WPC pilots through the Medi-Cal 2020 waiver. Up to $300 million may be distributed in the first year. Individual pilots are limited to receiving a maximum of 30% of the total allowable funding. | 90 percent federal matching funds are available for the first eight quarters of the HHP, and are subsequently reduced to 50% federal match for the population that was eligible for Medicaid benefits pre-2014. Individuals eligible through the Medicaid optional expansion will continue to receive 100% FMAP for health home services, with the match gradually decreasing to 90% in 2020. | Federal funding for CCI is available through California's renewed Section 1115 Medicaid waiver at California's traditional 50% FFP. | Collectively, DPHs may qualify for up to $700 million in annual federal funding for the first 3 years, reducing to $630 million and $535.5 million in the following two years.<br>DMPHs may qualify for up to $100 million in annual federal funding per year for the first 3 years, reducing to $90 million and $76.5 million in the following two years. |
| **Non-Federal Share of Financing** | WPC pilots provide local match through permissible sources of intergovernmental transfers (IGTs). | California legislation AB 361 specifies that there should be no net cost to the state General Fund. The California Endowment has offered to provide up to $25 million per year for two years to finance the 10% non-federal share, ensuring the proposal would incur no state General Fund costs. DHCS is designing the program to maximize the opportunity for cost avoidance through reduced negative health outcomes. The state would be permitted to finance the non-federal share to the extent they claimed savings from the program. | The non-federal share is funded through California's Medi-Cal program. | Participating DPHs and DMPHs provide the non-federal share through intergovernmental transfers. |

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| **Payment Flow** | WPC payments will be made to the leadentity upon demonstration of fulfilling pilot requirements based on the amount of funding approved in the WPCapplication. Payments will be made once in the first year and twice per year thereafter: an interim payment after submission of the mid- year report, and a final payment after submission of the annual report.<br><br>WPC pilot payments support 1) infrastructure to integrate services among local entities that serve the target population; 2) services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population, such as housing components; and 3) other strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.<br><br>WPC pilot payments are not direct reimbursement for expenditures or payments for services.<br><br>Pilot applications will include a total requested annual dollar amount, which specifies budgeted pre- set payment amounts for each element for which funding is proposed, including: infrastructure, baseline 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. | Risk-based HHP payments will be made to MCPs, as a supplemental per member per month (PMPM)/add- on to what they would have received for these beneficiaries prior to the program's existence. The MCPs will be responsible for negotiating contracts and payment terms with qualified CB-CMEs or other providers to ensure the delivery of HHP services and will flow HHP payments to CB-CMEs or other providers.<br><br>There are two distinct periods of DHCS payments to the MCPs for HHP - the engagement period and the ongoing service delivery period. The rates for these periods will be developed with the assistance of DHCS'actuaries. DHCS willdevelop assumptions about member acuity and intensity of service needs to facilitate the development of the capitation rates.<br><br>HHP payments are considered payments for services. | Plans receive a monthly capitated payment to provide covered services. These capitated payments create strong financial incentives for health plans to ensure beneficiaries receive preventive care and home- and community-based care to avoid unnecessary hospital admissions and nursing home care. | PRIME payments are contingent upon DPHs and DMPHs achieving certain outcomes. DPHs and DMPHs are eligible to receive incentive payments from the PRIME funding pool to support their efforts to change care delivery and strengthen their systems.<br><br>The waiver requires that, by January 2018, 50% of the state's Medi-Cal managed care beneficiaries who are assigned to a DPH will receive all or a portion of their care under a contracted Alternative Payment Model (APM). By January 2019, the goal will increase to 55%, and by the end of the waiver renewalperiod in 2020, it will increase to 60%. In both years four and five of the waiver, 5% of the statewide yearly allocated pool amount for all DPHs will depend on meeting these goals.<br>Four tiers of capitated or APMs will exist in PRIME:<br>1) partial (primary care only);<br>2) partial-plus (primary care and some specialty);<br>3) global (primary care, specialty, ancillary and/or hospital; and<br>4) other methodologies approved by the state and CMS<br><br>PRIME payments are not direct reimbursement for expenditures or payment for services. |

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| **Continuation of Payment Flow** | Payments for WPC pilots will be based on the approved WPC pilot budgets. WPC pilot lead entities will be accountable to DHCS and CMS to demonstrate that WPC pilot funds were received for the interventions and in the manner agreed upon. If the lead entity cannot demonstrate completion of a deliverable or outcome as described in the application, DHCS may withhold or recoup the WPC funds linked to that deliverable. | | | |

**Appendix: Health Homes Program Roll-Out schedule**

| Counties | Implementation Date for Members with Serious Mental Illness | Implementation Date for Other Eligible Members |
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| **Group 1**<br>Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, Shasta, Solano, Sonoma, Yolo | January 1, 2017 | July 1, 2017 |
| **Group 2**<br>Imperial, Lassen, Merced, Monterey, Orange,Riverside, San Bernardino, San Clara, Santa Cruz, Siskiyou | July 1, 2017 | January 1, 2018 |
| **Group 3**<br>Alameda, Fresno, Kern, Los Angeles, Sacramento, San Diego, Tulare | January 1, 2018 | July 1, 2018 |

**Note:** HHP implementation in the following counties is not currently scheduled: Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Glenn, Inyo, Kings, Madera, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, San Benito, San Joaquin, San Luis Obispo, Santa Barbara, Sierra, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Ventura, and Yuba

**Source:** Based on February 2016 DHCS Stakeholder Advisory Committee Meeting and the December 2015 DHCS HHP Concept Paper.