Policy Landscape in Medi-Cal: Health Homes and Practice Transformation in the Inland Empire

IHA Stakeholder Meeting
September 23, 2016

Jennifer N. Sayles, MD, MPH
CMO, Inland Empire Health Plan
Current State: Dizzying Array of Initiatives for Medi-Cal Population

- Behavioral Health Integration
- Whole Person Care
- Health Homes
- APM
- GPP
- Complex Care
- PRIME
- PCMH & Model Practice
- Landmark Home Program
IEHP Practice Transformation

- Model Practice
- BH & Complex Care Initiative
- Whole Person Care
- Health Homes
- PRIME
- Landmark Home Program

- PCMH Standards
- Office Efficiency Business Functions
- Improved Access
- Behavioral Health Integration
- EHR, HIE, Pop Mgmt Tools
- Complex Care

One Assessment
One Agreement
One Set of Tools
One Set of Metrics
IEHP Framework for Practice Transformation

HIGHEST RISK MEMBERS
(0-5%)

MODERATE/HIGH RISK MEMBERS
(25-30%)

LOWER RISK MEMBERS
(65-70%)

Whole Person Care
Complex Case Mgmt

Care Coordination
Disease Mgmt
BH Integration
Care Transition
Social Svc/Housing

Care Coordination
Team Based Care
Panel Management/Pop Health
Prevention & Wellness
Community Svc / Social Determinants
Whole Person Care

Practice Based Interventions/Services
(may be augmented by Plan)
IEHP Framework for Practice Transformation

**HIGHEST RISK MEMBERS (0-5%)**
- Landmark & HHP (WPC Pilot)
- Whole Person Care Complex Case Mgmt

**MODERATE/HIGH RISK MEMBERS (25-30%)**
- BHI-CCI (PRIME)
- Care Mgmt
- Disease Mgmt
- BH Integration
- Care Transition
- Social Svc/Housing

**LOWER RISK MEMBERS (65-70%)**
- Model Practice
- Care Coordination
- Team Based Care
- Panel Management/Pop Health
- Prevention & Wellness
- Community Svc / Social Determinants
- Whole Person Care

**Practice Based Interventions/Services (may be augmented by Plan)**
**Practice Transformation**

**Tier 2: Approach to Moderate/High Risk**

**MODERATE/HIGH RISK MEMBERS (25-30%)**

- **Care Coordination**
- **Medical Home**
- **Preventive Services**
- **Wellness Services**
- **Community Svc / Social Determinants**
- **Whole Person Care**

**BHI-CCI:** Behavioral Health Integration and Complex Care Initiative

**Practice Based Interventions/Services**

- Care Mgmt
- Disease Mgmt
- BH Integration
- Care Transition
- Social Svc/Housing

*(may be augmented by Plan)*
# BHI-CCI: Footprint for Health Homes

<table>
<thead>
<tr>
<th><strong>BHI-CCI - Behavioral Health Integration and Complex Care Initiative</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population</strong> – Complex members with chronic physical health condition as well as one mental health condition and/or a substance use disorder (SUD).</td>
</tr>
<tr>
<td><strong>Timeframe</strong> – January 2016 to July 2018</td>
</tr>
<tr>
<td><strong>Program</strong> – Multidisciplinary teams in 13 safety net health care organizations (e.g. clinics, Substance Use Tx Ctr, Adult Day Health Care) 29 sites in Riverside and San Bernardino Counties.</td>
</tr>
<tr>
<td><strong>Funding / Support</strong> – $23,000,000 budget. 10 quarters of funding for care teams, practice coaching, learning collaborative</td>
</tr>
</tbody>
</table>
Practice Transformation

Tier 3: Approach to Highest Risk

HIGHEST RISK MEMBERS (0-5%) → Landmark & HHP

Practice Based Interventions/Service
(may be augmented by Plan)

Whole Person Care
Complex Case Mgmt
Overview – Landmark is a Provider group that delivers in-home intensive management of an identified cohort of complex IEHP patients

Target Population – 7,500 Members qualify, 1000 have been engaged. Criteria is 5 or more chronic conditions; historical cost >$50,000

In-Home Clinical Model – Landmark partners with PCP to provide additional in home clinical and behavioral health support to stabilize high acuity members.

4 Pillars of Landmark Care Model – 1) Complexivist Care 2) Behavioral Health 3) Palliative Care 4) Clinical Partnership

Financing – Landmark at financial risk for patient population and incentivized to coordinate better management of patient with PCP, specialists, BH providers, plan, and community resources
Health Homes Program (HHP)

HHP – Health Homes for Patients with Complex Need (Health Homes Program or HHP)

History – Provision written into Affordable Care Act, 90% CMS funding with 10% State match for 10 quarters. California applied to CMS to participate and was approved.

Overview – HHP providers will integrate and coordinate all primary, acute, behavioral health and long term services and supports to treat the “whole-person”

Provider Sites – Identified as Community Based Care Management Entities (CB-CMEs) to provide comprehensive and integrated care to highest risk patients. Expands BHI-CCI footprint in the Inland Empire.

Funding – DHCS is still negotiating, IEHP will start January 1, 2018
## Target Population

<table>
<thead>
<tr>
<th>Phase</th>
<th>Date</th>
<th>Eligible Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>January 1(^{st}), 2018</td>
<td>Members with chronic physical conditions and substance use disorders (SUD)</td>
</tr>
<tr>
<td>Phase 2</td>
<td>July 1(^{st}), 2018</td>
<td>Members with severe mental illness</td>
</tr>
</tbody>
</table>

## IEHP Membership Data

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Estimated HHP Eligible Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Meets Chronic Condition Criteria</td>
<td>80,304</td>
</tr>
<tr>
<td>Member Meets Acuity Criteria</td>
<td>28,321</td>
</tr>
<tr>
<td>Role</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HHP Director</td>
<td>Ability to manage multi-disciplinary care teams</td>
</tr>
<tr>
<td>Care Manager</td>
<td>Paraprofessional or licensed care manager, social worker, or nurse</td>
</tr>
<tr>
<td>Provider</td>
<td>PCP, specialist, psychiatrist, psychologist, pharmacist, RN, nutritionist, or LCSW</td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>Paraprofessional or peer advocate who gives administrative support to care manager</td>
</tr>
<tr>
<td>Housing Navigator</td>
<td>Paraprofessional who assists in identifying housing resources</td>
</tr>
<tr>
<td>Model 1</td>
<td>Model 2</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>BHI-CCI Sites</td>
<td>&gt;100 eligible HHP Members and/or interested in being a CB-CME</td>
</tr>
</tbody>
</table>

**Diagram:**
- **Model 1:** IEHP \(\rightarrow\) BHI-CCI Sites \(\rightarrow\) CB-CME \(\rightarrow\) Practice/Clinic
- **Model 2:** IEHP \(\rightarrow\) CB-CME \(\rightarrow\) Practice/Clinic
- **Model 3:** IEHP \(\rightarrow\) CB-CME \(\rightarrow\) Practice/Clinic
# HHP Target Population

<table>
<thead>
<tr>
<th>IEHP Membership</th>
<th># of PCPs</th>
<th># of Addresses</th>
<th>HHP Eligible Members</th>
<th>BHICCI Eligible Members*</th>
<th>Landmark Eligible Members*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Sites &gt; 100</td>
<td>268</td>
<td>110</td>
<td>11,211</td>
<td>3,184</td>
<td>1,876</td>
</tr>
<tr>
<td>eligible HHP Members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Sites &lt; 100</td>
<td>717</td>
<td>587</td>
<td>12,307</td>
<td>367</td>
<td>1,302</td>
</tr>
<tr>
<td>eligible HHP Members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>985</td>
<td>697</td>
<td>23,518</td>
<td>3,551</td>
<td>3,178</td>
</tr>
</tbody>
</table>

*of the 23,518 HHP eligible Members
# DHCS and CMS Core/Utilization Measures for HHP

<table>
<thead>
<tr>
<th>#</th>
<th>Measures</th>
<th>Source-Steward</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adult Body Mass Index (BMI) Assessment</td>
<td>CMS-HEDIS</td>
</tr>
<tr>
<td>2</td>
<td>Screening for Clinical Depression and Follow-up Plan</td>
<td>CMS</td>
</tr>
<tr>
<td>3</td>
<td>Plan All-Cause Readmission Rate</td>
<td>CMS-HEDIS</td>
</tr>
<tr>
<td>4</td>
<td>Follow-up After Hospitalization for Mental Illness</td>
<td>CMS-HEDIS</td>
</tr>
<tr>
<td>5</td>
<td>Controlling High Blood Pressure</td>
<td>CMS-HEDIS</td>
</tr>
<tr>
<td>6</td>
<td>Care Transition – Timely Transmission of Transition Record</td>
<td>CMS-AMA/PCPI</td>
</tr>
<tr>
<td>7</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
<td>CMS-HEDIS</td>
</tr>
<tr>
<td>8</td>
<td>Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite</td>
<td>CMS-AHRQ</td>
</tr>
<tr>
<td>9</td>
<td>Avoidable hospital readmissions that followed inpatient stays</td>
<td>DHCS</td>
</tr>
<tr>
<td>10</td>
<td>Engagement rate</td>
<td>DHCS</td>
</tr>
<tr>
<td>11</td>
<td>Cost savings that result from improved chronic care</td>
<td>DHCS</td>
</tr>
<tr>
<td>12</td>
<td>Ambulatory Care – Emergency Department Visits</td>
<td>CMS-HEDIS</td>
</tr>
<tr>
<td>13</td>
<td>Inpatient Utilization</td>
<td>CMS</td>
</tr>
<tr>
<td>14</td>
<td>Nursing Facility Utilization</td>
<td>CMS</td>
</tr>
</tbody>
</table>
Next Steps

- Outreach for readiness assessment
- Engagement to become a CB-CME
- State rate confirmation
- Recruitment of teams
- Staff training
- Practice coaching
- Learning collaboratives
Questions?

Questions
Alameda County’s Whole Person Care Pilot

Scott Coffin, CEO
Alameda Alliance for Health

IHA Conference, Los Angeles, CA
September 23rd, 2016
Agenda

- Introduction to the Alliance
- Whole Person Care Pilot
- Performance Measurements
- Next Steps
Introduction

- Alameda Alliance is a local public health plan serving residents in Alameda County.
- Formed in 1996, 20 years as a safety-net partner in the Alameda community, serving the underserved.
- NCQA-accredited.
- Employ 250 people from the local and surrounding communities.
- Transforming the managed care operations into a “culture of care”.
Our Members & Providers

- 270,000 members
- 98% Medi-Cal, 2% IHSS
- Member mix of 47% Adults, 38% Children, 10% Seniors & Persons with Disabilities, and 5% are Dual Eligible
- Provider Network comprised of 13 hospitals, 43 health centers, 200+ pharmacies, 46 nursing facilities, 500 PCPs, and 4000+ Specialists
- 60% delegated, 40% in direct network

91% of the Alliance’s members live in 9 communities.
Alameda County Health Care Services Agency is leading the planning and coordination with community partners.

Target Medi-Cal population consists 20,000 people, 30% are high-utilizers and 50% homeless.

Serve people with complex conditions and linking together systems of care for better health outcomes.

Whole Person Care Pilot is structured into two service bundles. Homeless (County) and Care Management Service Bundles (Health Plans).
Whole Person Care Pilot

Alliance’s Strategic Objectives:

- Build a sustainable “culture of care” model for Alameda County.
- Align the program to our vision and mission.
- Better access of our primary care and specialty networks.
- Creation of a county-wide data exchange for purposes of care coordination.
- Combination of patient-facing and telephonic interventions.
- Integrating mental health and substance use programs with Medi-Cal managed care.
- Improve health outcomes, timely access, and satisfaction.
- We care about the people we serve.
Whole Person Care Pilot

- WPC supported by local governance, implementation of a data sharing infrastructure, supported by connecting navigators with community resources, and establish care coordination linkages across agencies.

- Top priority is quality improvement, better experience and health outcomes, and to validate the effectiveness of integrated services.

- Health plans to oversee the care management service bundle, and work closely with community-based entities and county partners on homeless service bundle.
Performance Measurements

- Specific mental health and substance use interventions.
- Effective use of data and information sharing for care coordination.
- New housing placements and more housing options.
- Improvement of HEDIS measures.
- Community linkages to help people navigate the system in Alameda County
Next Steps

- DHCS intends to award the 5-year grant by November 2016.
- Alameda County HCSA and Alliance exploring data exchange, preparing baseline data, and continuing operational readiness.
- The Alliance is self-funding a health home pilot to start in Q1-2017; RFP process to initiate in Q4-2016.
- Development of a performance dashboard, workflows, policies & procedures, and technology roadmaps.
Understanding the Initiative Landscape in Medi-Cal

IHA Stakeholder Meeting
September 23, 2016
Sarah Lally, Project Manager
Agenda

- Welcome / Introduction
  Sarah Lally, Project Manager

- Inland Empire Health Plan: Health Homes Initiative
  Jennifer Sayles, MD, MPH, Chief Medical Officer

- Alameda Alliance for Health: Whole Person Care Pilot
  Scott Coffin, MBA, Chief Executive Officer

- Q & A
Medi-Cal Landscape

- Heath care landscape has changed rapidly with the ACA implementation
- Dramatic growth in Medi-Cal, Medi-Cal managed care
- Wide array of initiatives underway and under development
- Growing need for – and interest in – greater alignment across the policy landscape
Medi-Cal P4P Core Measure Set

- Create greater measure set alignment across the policy landscape
- Support the implementation of the core measure set across all Medi-Cal P4P programs
- Spread the adoption of the core measure set to plans not participating on the Advisory Committee
- Funding – CMMI (included in Transforming Clinical Practices Initiative grant awarded to PBGH/CQC)
- March 2016 – February 2018
Medi-Cal Initiatives Landscape

Objective:

- Identify opportunities for greater measure set alignment across the policy environment

Planned Activities:

- Identify initiatives impacting Medi-Cal & the safety net
- Develop crosswalk of key initiatives
- Summarize findings in an issue brief

Timeline:

- March 2016 – Fall 2016
# Multiple Related Initiatives Underway

<table>
<thead>
<tr>
<th>Policies/Initiatives</th>
</tr>
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<tbody>
<tr>
<td>Coordinated Care Initiative</td>
</tr>
<tr>
<td>Public Hospital Redesign and Incentives in Medi-Cal (PRIME)</td>
</tr>
<tr>
<td>Whole Person Care Pilots (WPC)</td>
</tr>
<tr>
<td>Alternative Payment Methodology (APM) Pilot</td>
</tr>
<tr>
<td>Health Homes for Patients with Complex Needs (Section 2703)</td>
</tr>
<tr>
<td>California Children’s Services (CCS) “Whole Child Model” Redesign</td>
</tr>
<tr>
<td>Global Payment Program (GPP)</td>
</tr>
<tr>
<td>Drug Medi-Cal Organized Delivery System (Drug Medi-Cal Waiver)</td>
</tr>
</tbody>
</table>
## Cross Initiative Themes / Objectives

### Value Based Payment Reform

<table>
<thead>
<tr>
<th>Payment for Services</th>
<th>Bonus / Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>FQHC Alternative Payment Methodology (APM) Demonstration</td>
<td>Global Payment Program (GPP)</td>
</tr>
</tbody>
</table>

### Practice Transformation: Care Coordination & Integration

<table>
<thead>
<tr>
<th>SMI / Chronic Conditions</th>
<th>Substance Abuse</th>
<th>Children</th>
<th>Duals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Person Care Pilot</td>
<td>Health Homes for Patients with Complex Needs</td>
<td>Drug Medi-Cal Organized Delivery System</td>
<td>California Children’s Services (CCS) “Whole Child Model” Redesign</td>
</tr>
</tbody>
</table>
## Whole Person Care Pilot

| Overview                                      | Included under Medi-Cal 2020 waiver renewal  
|                                              | County-based pilots to coordinate health, behavioral health and social services to improve health and well-being for high users of multiple systems |
| Timeline                                     | 5-year program  
|                                              | January 1, 2016 – December 31, 2020 |
| Funding                                      | $300 million/year in Federal Funding for 5 years ($1.5 billion total) |
| Lead Entity                                  | Counties |
| Implementing Entities                        | Pilots will vary; collaboration among public and private entities (county MH agencies, managed care plans, providers, housing, criminal justice, etc.) |
| Target Population                            | Medi-Cal beneficiaries who are high-risk high users of multiple health care systems |
| Measure Set Status                           | Under Development |
| Current Status                               | Applications released May 2016 and applications submitted to DHCS in July. Announcement of winner expected in November. |
# Health Homes for Patients with Complex Needs

<table>
<thead>
<tr>
<th>Overview</th>
<th>Authorized under ACA Section 2703, allows California to create a new health home optional Medicaid benefit for intensive care coordination for people with chronic conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeline</td>
<td>Ongoing; 1st implementation Jan 2017 pending CMS approval</td>
</tr>
<tr>
<td>Funding</td>
<td>Enhanced federal match (90% vs. 50%) available for first two years</td>
</tr>
<tr>
<td>Lead Entity</td>
<td>Managed Care Plans</td>
</tr>
<tr>
<td>Implementing Entities</td>
<td>Managed care plans certify and contract with Community Based Care Management Entities</td>
</tr>
<tr>
<td>Target Population</td>
<td>Medi-Cal beneficiaries with serious mental illness, and those with chronic conditions; top 3-5% risk</td>
</tr>
<tr>
<td>Measure Set Status</td>
<td>Under Development; CMS has developed a core set but DHCS can propose additional measures</td>
</tr>
<tr>
<td>Current Status</td>
<td>Waiting for CMS approval</td>
</tr>
</tbody>
</table>
Both initiatives serve beneficiaries with complex, chronic conditions who are frequent utilizers of health services.

Whole Person Care pilot is focused on infrastructure development and cross-system coordination.

Health Homes initiatives is a new Medi-Cal benefit and pays for specific care coordination services.

Coordination of initiatives challenging but essential.