Advanced Policy Analysis

LOOKING AT THE WHOLE PICTURE

Analysis of the Whole Person Care Pilot and Medical-Behavioral Health Integration in Medi-Cal

A Study Conducted for
the California Senate Office of Research

By
Lillian Chen
Goldman School of Public Policy
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EXECUTIVE SUMMARY

The top five percent of high-cost Medi-Cal beneficiaries have significantly higher rates of behavioral health conditions (i.e., mental health and substance use disorders) compared to less costly beneficiaries.[1] At the same time, they also face a complex health care safety net with fragmented physical and behavioral health systems. These systems have different financing and administrative structures, face legal and technological barriers to sharing data, and practice care in distinct ways. Furthermore, in California, there are "carved out" systems for certain behavioral health conditions, separate from Medi-Cal managed care.

National and state policies, including the Mental Health Parity and Addiction Equity Act, the Affordable Care Act (ACA), and California's expansion of outpatient mental health benefits for those with "mild to moderate" impairment have sought to ensure sufficient Medi-Cal coverage for behavioral health services. These changes have set the stage for more systemic delivery reform. In California, this has translated into a number of different initiatives to expand and strengthen delivery of behavioral health services to especially vulnerable Medi-Cal populations.

This report describes three of these initiatives—**the Coordinated Care Initiative (CCI), the Health Homes Program (HHP), and the Whole Person Care (WPC) pilot**—with a focus on the latter due to its expansive scope and recent implementation of first-round projects. While none of these initiatives intend to integrate currently carved-out systems with Medi-Cal managed care, they all aim to make care more patient-centered, increase access to community-based services, coordinate services across different sectors, and ultimately achieve the "triple aim" of improved health outcomes, improved patient experience, and reduced health care costs for the system. As its name suggests, the WPC pilot most directly represents the state's effort to scale up whole-person care to address the areas of fragmentation described earlier. This project serves as a strategic guide for policymakers and legislative staff seeking to understand these initiatives and aims to accomplish the following:

- Describe the goals and activities of each initiative, as well as similarities and differences;
- Analyze the WPC pilot and how it seeks to advance whole-person care, especially with regard to behavioral health, and critical factors for its success; and
- Provide considerations for strategic planning as WPC implementation continues.

KEY FINDINGS

Despite their shared goals, the initiatives have different focal areas and strategic levers. CCI's centerpiece is Cal MediConnect (CMC), a demonstration program in which health plans administer both Medicare and Medi-Cal benefits as part of an organized delivery system. HHP is an optional care coordination benefit through the ACA for beneficiaries with multiple chronic conditions. The WPC pilot is one of several in California's Section 1115 waiver, Medi-Cal 2020, and allows a county, city and county, health or hospital authority, or consortium of entities to

establish infrastructure to deliver patient-centered, coordinated care to particular subgroups in Medi-Cal. Table 1 presents key findings from an analysis of the three initiatives.

Table 1: Key Findings from Initiative Analysis

Domain	Key Findings
Scope of services	▪ Of the three, CCI funds the most "direct" services. ▪ CCI and HHP provide care coordination of services, while WPC works to strengthen coordination of both services and systems. ▪ HHP and CCI largely still operate within the Medi-Cal space, while WPC explicitly targets services not funded by Medi-Cal. ▪ HHP and WPC can fund housing support services.
Target populations	▪ CCI and WPC serve populations with very specific characteristics; CCI serves dual eligible beneficiaries, while WPC targets high-risk, high-utilizing groups. ▪ HHP builds on CCI and serves the broadest population.
Lead implementation entities	▪ Medi-Cal managed care plans are the lead entities in CCI and HHP. ▪ Counties—most often the county health services department—are taking the lead on WPC.
Financing	▪ HHP and CCI use capitation, and HHP also has an enhanced matching rate. ▪ WPC is funded through intergovernmental transfer from counties to the state. ▪ CCI and WPC use quality-based incentives through withholds and incentive payments for "deliverables," respectively.
Quality metrics	▪ CCI has to report on the largest number of measures. ▪ WPC counties have more flexibility in metrics that must be reported. ▪ Final measures for HHP are still tentative.

What is new about the initiatives is the intensity of coordination that will be expected in participating counties. In CCI, CMC plans are responsible for coordination, while in HHP, Medi-Cal managed care plans certify entities to provide care coordination. WPC counties have varying coordination structures. Across these initiatives, participating entities are accountable for coordinating and delivering behavioral health services, as shown in quality metrics.

WPC is really about scaling up existing practices and/or funding activities that stakeholders have wanted to carry out for some time. An analysis of how the WPC pilot is advancing the framework of whole-person care highlights the following:

- **Collaborative leadership:** County health departments are working with a comprehensive set of partners that include other county entities, health plans, housing authorities, and community-based organizations.
- **Target population:** Among the 18 counties participating in Round 1, nearly all are focusing on high-utilizing groups that repeatedly go to expensive care settings and/or individuals experiencing or at risk of homelessness.
- **Patient-centered care and cross-sector coordination:** To provide more intensive, targeted coordination, counties are employing a range of strategies, including patient navigators, interdisciplinary care teams, field-based outreach and coordination, and comprehensive assessments. A number of counties are also using funds to expand and/or diversify behavioral health services, as well as build behavioral health workforce.

- **Financial flexibility:** In addition to funding for reporting and outcome achievement, counties requested funding to provide discrete and bundled services. They could also request funding for incentive payments to providers.
- **Shared data:** Data and information sharing is a core, required component of WPC. In addition to developing the technological infrastructure, navigating the legal, cultural, and practice implications is an additional layer of work.

WPC counties have a host of strengths and internal challenges in the face of several opportunities and threats that are critical to WPC's success. Review of existing literature and interviews with key informants revealed the following:

- ***Strengths*, or assets for implementation**, include relationships with partners, engagement of leadership and other stakeholders, existing infrastructure and previous work, and funding for historically non-reimbursable work.
- ***Challenges*, or internal limitations to the work**, include the legal, technological, cultural, and administrative aspects of data sharing; the substantial time and effort needed to transform delivery of care; bureaucratic constraints; and difficulty with achieving the optimal level of flexibility.
- ***Opportunities*, or other efforts that could be leveraged,** include other Medi-Cal initiatives and non-Medi-Cal initiatives related to public health.
- ***Threats*, or external policies or efforts that could hinder success,** include a lack of affordable housing, shortage in behavioral health provider workforce, and potential federal/state policy changes to Medicaid.

After investigating how these strengths and challenges interact with these opportunities and threats, this report presents the following **strategic considerations to maximize the cohesion and impact of the state's whole-person care efforts:**

- **Tighten intersections between initiatives** by aligning Medi-Cal initiatives and assessing readiness to braid or blend funding at the state level.
- **Alleviate pressure of threats** by intensifying efforts in workforce development and forging strategies that continue bridging Medi-Cal and housing.
- **Adapt and build on lessons learned** by sharing lessons learned from other initiatives and harnessing other non-Medi-Cal initiatives and examining departmental silos.
- **Position the state to confront difficult choices** by developing a common vision around integration and identifying non-negotiable components.

By taking into account these potential synergies and pain points, the state and counties can collectively ensure that they are able to anticipate, design, and implement any adjustments they may need to make to their approach to innovate and improve care for Medi-Cal beneficiaries.

ABOUT THIS REPORT

PREFACE

This report focuses on the Whole Person Care pilot (or "WPC"), the Health Homes Program (or "HHP"), and the Coordinated Care Initiative (or "CCI") in California. These three programs represent key efforts of the California Department of Health Care Services (DHCS) to reform service delivery for Medi-Cal adult beneficiaries. Currently, these beneficiaries face disjointed health care systems, which contributes to inconsistent, uncoordinated care and poor health outcomes. These initiatives aim to provide more seamless delivery of services that address their physical health, behavioral health, and social service needs. By doing so, the state hopes to produce better outcomes and bend the cost curve in the Medi-Cal population.

This study will examine the purpose of each initiative and the components designed to achieve those goals. Given the complex relationship between the medical and behavioral health care systems in Medi-Cal, this project will explore how the initiatives aim to align these systems. Informed by key informant interviews and a literature review, this study serves to deepen understanding of these initiatives among legislative staff and policymakers responsible for overseeing these initiatives. In particular, this study presents critical factors that have been identified in the very early stages of implementation and provides considerations for how these critical factors could be leveraged to form a more cohesive, impactful strategy for innovating care for the Medi-Cal population.

OBJECTIVES

- Describe the goals and activities of each initiative, as well as similarities and differences;
- Analyze the Whole Person Care pilot and how it seeks to advance whole-person care, especially with regard to behavioral health, and critical factors for its success; and
- Provide considerations for strategic planning as WPC implementation continues

METHODS

This report was informed by interviews with agency and department staff as well as other key partners and field experts in this work. Entities represented include:

- California Health and Human Services Agency
- California Department of Health Care Services
- California Association of Public Hospitals and Health Systems
- The Blue Shield of California Foundation
- The California Health Care Foundation
- The County Behavioral Health Directors' Association
- Harbage Consulting

Agencies and departments from a sample of counties implementing one or more initiatives were also interviewed. Counties targeted for interviews were selected to create a diverse sample

in terms of geographic region, type of Medi-Cal managed care model, and initiative(s) being selected for implementation. Due to the report's focus on WPC, attention was also given to the number of beneficiaries served in the WPC pilot and the type of entity leading the pilot (i.e., county health services, hospital authority, county-designed public hospital, county behavioral health department). A total of 11 counties were interviewed in the course of this study.

Finally, this report also draws from state and county documents and other secondary sources, including:

- WPC Round 1 county applications
- Slide decks/webinars from DHCS
- CCI evaluation materials from the SCAN Foundation and Health Research for Action at the University of California, Berkeley
- Other historical reports and briefs related to Medi-Cal managed care, the state's mental health service delivery system, and the medical-behavioral health care landscape in California and more broadly

Note: At the time of the writing of this report, DHCS had completed a second application round for WPC composed of both new counties and first-round counties wanting to expand their pilot. In this second round, DHCS received 15 applications, of which eight were Round 1 counties.[2] DHCS is not scheduled to announce second-round participants until July 2017. As a result, this report only includes responses from counties participating in Round 1.

For a full list of key informants, see **Appendix A**.

TERMINOLOGY

"Mental health" and "behavioral health" are distinct, but related concepts; the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) refer to **behavioral health** as including mental and emotional wellbeing as well as substance use disorders (SUDs), which describe occurrences when repeated use of alcohol and/or drugs impair a person's ability to work, learn, or fulfill daily living needs.[3]

In California, **the California Department of Health Care Services (DHCS),** referred to as **"the state"** in some contexts throughout this report, oversees behavioral health services for Medi-Cal beneficiaries and is responsible for overall Medi-Cal administration. However, individual counties are responsible for delivery of Medi-Cal programs at the local level through their health and human services departments, which vary in organizational structure at the county level. Within these larger departments, most counties have one behavioral health department, also referred to as **"counties"** in some cases in this report, that is responsible for both mental health and SUD benefits. Behavioral health departments are often distinct from those that oversee Medi-Cal benefits for physical health.[4]

For a full list of commonly used acronyms in this report, see **Appendix B.**

BACKGROUND

OVERVIEW OF MEDI-CAL

Medi-Cal is California's Medicaid program and is a critical piece of the safety net. It covers health services for low-income families, seniors, people with disabilities, current foster youth as well as former foster youth up to age 26, pregnant women, and as a result of California's Medicaid eligibility expansion under the Affordable Care Act, childless adults ages 18-64.[5] Currently, a third of all Californians are covered by Medi-Cal.[6]

Medi-Cal is largely administered as a managed care program, whereby the state contracts with health plans to deliver services within an organized network and pays plans per-member-per-month (PMPM) capitation payments, rather than reimburse providers for each service or visit, known as "fee-for-service" (FFS) payment.[7] The majority (80 percent) of Medi-Cal beneficiaries are covered under managed care plans.[8]

Figure 1: Medi-Cal Managed Care Models

- **County Organized Health System (COHS, n=22):** All enrollees are in the same plan, which is administered by the Board of Supervisors.
- **Regional Expansion (n=18):** Enrollees choose between two commercial plans.
- **Two-Plan (n=14):** Enrollees choose between a publicly-run ("Local Initiative") plan and a commercial plan.*
- **Geographic Managed Care (GMC, n=2):** Enrollees choose among several commercial and non-profit plans.
- **Imperial County** enrollees choose between two commercial plans.
- **Benito County** enrollees choose between fee-for-service and a commercial plan.

*Among Two-Plan counties, Tulare County is an exception; beneficiaries choose between two commercial plans.

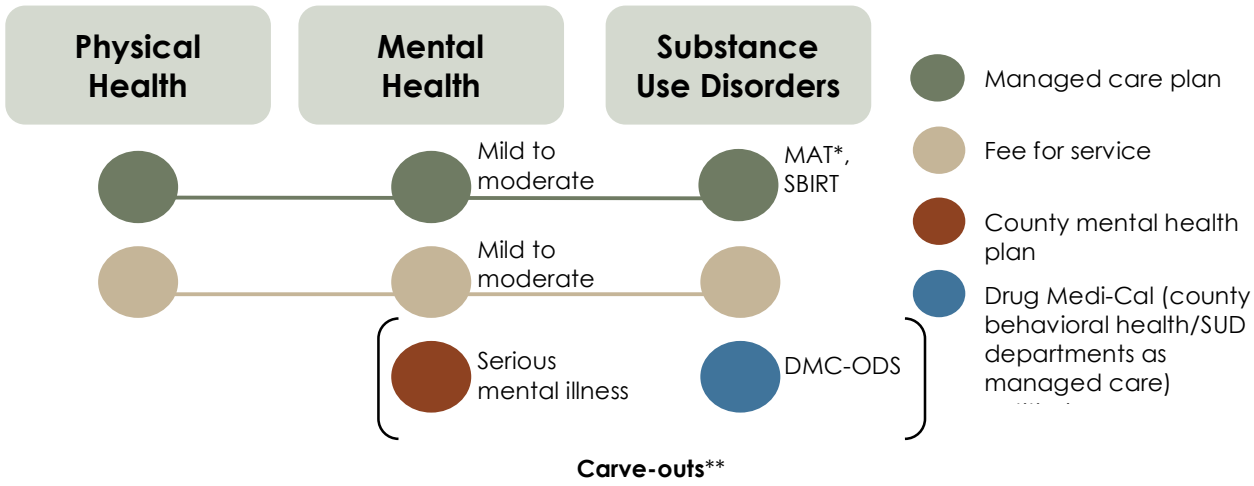
The Medi-Cal managed care system is complex. For one, it is county-driven; counties vary in the number and type of managed care plans available. As shown in Figure 1, there are four primary models: County Organized Health System (COHS), Regional Expansion, Two-Plan, and Geographic Managed Care (GMC). Imperial and San Benito have their own unique structures.[9] Thus, beneficiaries have different types of plan choices depending on their county of residence.

Secondly, specialty mental health services are "carved out" as a separate benefit. These specialty services are intended for individuals with serious or severe mental illness (SMI) and include inpatient services, rehabilitation, and targeted case management. Since 1995, through a Medicaid 1915(b)(1) waiver allowing participating states to consolidate Medicaid services under a managed care delivery system ("Specialty Mental Health Services (SMHS) waiver"), counties each operate a specialty mental health plan.[10] Beneficiaries who meet the state's diagnostic and impairment criteria to receive specialty mental services go to these county mental health plans, which are contracted by DHCS to provide these specialty services.[11]

Adding to this complexity is the separate system to address SUDs, which one senior foundation staff member referred to as a "trifurcation" of the health care system into physical health,

mental health, and SUDs.[12] Figure 2 presents these different pathways through which Medi-Cal beneficiaries can access services for different needs.[13] Through AB 106 (Committee on Budget, Chapter 32, Statutes of 2011), the state transferred responsibilities for Drug Medi-Cal (DMC) from the Department of Alcohol and Drug Programs to DHCS. DMC covers most SUD services for Medi-Cal beneficiaries, including narcotic treatment, residential treatment, outpatient drug free treatment, and intensive outpatient treatment, on a fee-for-service basis. Programs must be certified by DMC to be reimbursed for such services. Non-DMC benefits include medication-assisted treatment (MAT), medically necessary voluntary inpatient detoxification, and screening, brief intervention, and referral to treatment (SBIRT) services. These are provided through either Medi-Cal managed care or FFS, depending on the service and/or plan in which the beneficiary is enrolled.[14]

Figure 2: Delivery Systems Under Medi-Cal



*Coverage in Medi-Cal managed care depends on the specific medication. See: http://www.chcf.org/publications/2016/03/recovery-reach-medication-assisted-treatment.
**This is not a comprehensive list of carve-outs; other carved-out services in Medi-Cal include dental care, In-Home Supportive Services, home and community-based waiver services, and skilled nursing facility services. See: http://kff.org/report-section/medi-cal-managed-care-an-overview-and-key-issues-issue-brief/.

As Figure 2 shows, Medi-Cal is composed of a web of different delivery structures. Behavioral health in particular has received greater attention in recent years.

ELEVATING BEHAVIORAL HEALTH COVERAGE IN MEDI-CAL

Several national policies have sought to increase access to behavioral health care services in Medicaid. There is considerable evidence that failure to address both physical and mental health/SUD issues leads to worse patient outcomes and higher costs for the system. On average, adults with SMI have a life span 25 years shorter than the general population.[15] Care for patients with behavioral health conditions are more than two to three times as costly as for those lacking such conditions.[16]

As shown in Figure 3, the highest-cost Medicaid beneficiaries often have mental health and/or SUD conditions.[17] In California, 59 percent of the top five percent of high-cost Medi-Cal beneficiaries had a mental health condition of any kind.[18]

Figure 3: Prevalence of Behavioral Health Conditions Among High-Cost Medicaid Beneficiaries

Among the high-expenditure (i.e., top 5 percent) Medicaid beneficiaries:

- Just over half (51 percent) had a diagnosed mental health condition
- 20 percent had a SUD.
- Almost three-quarters (71 percent) had both a SUD and at least one mental health condition.

Among Medi-Cal beneficiaries:

- Over half (59 percent) had a mental health condition, with 45 percent diagnosed with SMI.
- It was estimated that anywhere from 8 to 16 percent of the Medi-Cal expansion population would need mental health services.

In 2008, the federal **Mental Health Parity and Addiction Equity Act** mandated that health plans offer benefits for mental health and SUD services that are consistent with medical and surgical benefits in terms of treatment restrictions and financial requirements. CMS issued regulations in 2016 that applied these requirements to Medicaid managed care.[19]

The **Affordable Care Act (ACA)** has been a catalyst for changes to the delivery of behavioral health services. For one, the ACA recognized behavioral health services as an essential benefit, therefore ensuring that all Medi-Cal plans cover behavioral health services. With the inclusion of mental health and SUD services as an essential benefit in Medi-Cal plans, more people are now covered for these types of services. Medi-Cal expansion also has been a policy lever to increase access to such services. In 2014, as a result of the ACA, California expanded eligibility for Medicaid to low-income, childless adults ages 19-64 and raised the eligible income level to 138 percent of the federal poverty level for both parents and childless adults. This has increased the number of beneficiaries, from 8.6 million in 2013 to currently over 13 million (children, youth, and adults), who are eligible to receive behavioral health services through Medi-Cal.[20] It was estimated that 8 to 16 percent (at least 124,5000 individuals) of the Medi-Cal expansion population would need mental health services.[21]

At the state level, SB X 1-1 (Hernandez, Chapter 4, Statutes of 2013) **expanded outpatient mental health benefits for Medi-Cal beneficiaries with "mild to moderate impairment of mental, behavioral, or emotional functioning."** Now, Medi-Cal managed care plans, as well as FFS mental health providers, are expected to cover individual and group mental health evaluation and treatment, psychological testing, medication management, psychiatric

consultation, and a number of different outpatient services. Furthermore, Medi-Cal managed care plans have had to establish new components in their Memorandums of Understanding (MOUs) with county mental health plans to facilitate coordination between plans and ensure access to services. These new components include oversight responsibilities and policies and procedures for screening, assessment, referral, care coordination, information exchange, reporting, and dispute resolution.[22]

The waiver to maintain the carve-out structure was most recently renewed in 2015 to last through 2020. In response to federal concerns about the lack of state oversight over county mental health, the waiver included more reporting and transparency requirements, as described further in Figure 4.[23]

Figure 4: Increasing Transparency and Reporting in Medi-Cal

Quality review is not new for Medicaid; CMS regulations in 2003 required Medicaid managed care plans to contract with an External Quality Review Organization (EQRO) to conduct annual reviews of managed care plan performances in the domains of access, quality and timeliness. In California, DHCS contracts with one EQRO to review Medi-Cal managed care plans, and contracts with another to review county mental health plans.

In 2014, DHCS began publishing a quarterly Managed Care Performance Dashboard on its website. Notably, quality measurement of mental health services in Medi-Cal has relatively lagged. The Managed Care Performance Dashboard currently includes one mental health-related metric (mild to moderate mental health visits per 1,000 member months).

Furthermore, to improve accountability and performance of county mental health plans, CMS mandated in the Special Terms and Conditions of its approval of California's SMHS waiver mandated that the state publish an annual mental health plan dashboard, as well as plans of correction and quality improvement plans, on its website. In 2016, DHCS published its first dashboard for specialty mental health services on statewide trends dating back to 2011 on demographics, penetration rates, utilization, stage of service (arrival, exit, continuance), and time from inpatient discharge to step-down services. To date, county-level dashboards have not yet been posted.

MEDICAL AND BEHAVIORAL HEALTH INTEGRATION LANDSCAPE

While changes to Medi-Cal described above have set the stage for greater coverage of behavioral health services, there have also been efforts to reform service delivery. In particular, decision makers, practitioners, and experts have increasingly looked to system- and provider-level integration of physical and behavioral health care to provide services that address individuals' health needs outside of just physical health.

Features of Integration

In practice, integration can take many forms, such as through the engagement of behavioral health in medical settings, or vice versa; the relationship with mental health or behavioral health department; in service modality; inclusion of behavioral health performance metrics; or interdisciplinary learning. Integrated Behavioral Health Partners, a collaborative of California

behavioral health experts, describe several ways that integration could be implemented, as shown in Table 2.[24]

Table 2: Examples of Integration in Practice

Area of Integration	Feature
Presence of behavioral health professionals and their relationship with medical professionals	▪ Physical proximity/co-location ▪ Warm hand-offs ▪ Using psychiatrists as service providers or consultants ▪ Case conferencing ▪ Degree to which medical staff engage in treating behavioral health conditions (and vice versa) ▪ Medical staff supervision of behavioral health staff ▪ Social work/counseling students on site ▪ Offering substance abuse programming/services
Relationship with local mental health or behavioral health department	▪ Ease of referrals
Service modalities	▪ Length of therapy ▪ Therapeutic approach ▪ Patient self-management ▪ Degree of care/case management
Inclusion of behavioral health metrics	▪ Comprehensive screening tool ▪ Use of behavioral health-related outcome measures
Cross-disciplinary learning	▪ Cross-disciplinary training ▪ Participation in collaboratives

Other common frameworks include:

- The **Four Quadrant Clinical Integration Model** in which service delivery design and treatment responsibilities are based on whether the primary care and behavioral health needs of the target population(s) are high or low in complexity and risk.[25]
- The **Standard Framework for Levels of Integrated Healthcare,** a continuum created by SAMHSA's Center for Integrated Health Solutions, in which primary care and behavioral health, in their least integrated form, communicate with each other, followed by co-location/physical proximity of practice. In their most integrated configuration, primary care and behavioral health have undergone practice change to where they are working regularly as a team, are in consistent communication, and have created a culture and practice that understand their respective roles and utilize them to deliver seamless delivery of care.[26]

Thus, there is no single, universally accepted model of integration.[27] This is especially true given the state-specific nature of health care in the U.S., and especially in California, where health care is largely county-based. In terms of evidence, psychiatric consultations with primary care providers and interdisciplinary teams to treat both physical and mental health conditions have shown positive signs in quality of care and outcomes.[28] Within the Medicaid space, some promising strategies have emerged, including screening for both medical and behavioral health conditions, use of patient navigators, co-location of physical and behavioral health providers, providing "health home" services (i.e., patient-centered, team-based care coordination), and

system-level integration of both delivery of physical and behavioral health care services and the associated financial risk.[29]

Barriers to Integration

Delivery of medical and behavioral health care services has historically been fragmented in the U.S., thereby contributing to care that is inappropriate, inconsistent, and/or redundant for patients. In 2006, the Institute of Medicine (now the National Academy of Medicine) concluded that the separation of these systems led to poorer access to and quality of care.[30] This division stems from several factors, and while none of them are unique to California, its county-driven health system and various carve-outs suggest that at least some of them may pose a greater challenge for the state and/or be more pronounced in certain counties. These factors include:

- **Financing and administrative discrepancies:** Systems are set up differently in terms of funding streams, provider networks, billing and coding practices, metrics, and record-keeping requirements.[31] These create major administrative and structural obstacles. Furthermore, efforts to coordinate across systems have traditionally not been reimbursed under either system, thus providing little financial incentive to change. [32]
- **Legal and technological obstacles around data sharing:** There are differing legal frameworks around the sharing of data. SUD providers, in particular, face stricter restrictions in sharing data. However, even on the mental health side, the lack of clarity on confidentiality requirements has led to differing interpretations and thus inconsistent practices in information exchange. Beyond legal barriers, there are also technological barriers, with lack of interoperability between medical, mental health, and SUD electronic health record systems prohibiting any data exchange in the first place.[33]
- **Cultural differences:** Beyond the operational and administrative barriers, there continues to be a cultural divide between physical health and behavioral health. Behavioral health and its treatment still face stigma and its more psychosocial orientation is fundamentally different from the traditional disease-oriented medical model of training and practice. Furthermore, working across disciplines also requires a different orientation of skills, infrastructure, and practice change.

Integrated Care in California

In California, integration of physical and behavioral health services is common, particularly in community clinics and health centers (CCHCs), which predominantly serve Medicaid and uninsured individuals. Many of these organizations are Federally Qualified Health Centers (FQHCs), which are required to at least provide referrals to behavioral health services if they receive a grant under Section 330 of the Public Health Service Act.[34] However, most health centers exceed this minimum requirement and provide a broad swath of behavioral health services depending on their patient population, as their scope of services for mental health care does not differentiate between mild-moderate or serious mental illness.[35]

As shown in Figure 5, in a 2016 survey administered by the California Primary Care Association (CPCA), nearly all CCHCs reported providing any mental health (89 percent) and/or SUD services (80 percent), with 72 percent indicating they had fully integrated or co-located mental health services. Conversely, 26 percent said they had integrated or co-located SUD services.[36]

Figure 5: Select Findings from 2016 CPCA Behavioral Health Survey

This survey is conducted bi-annually and represents CCHC executive and behavioral health leadership. Among respondents:

- **89 percent said they provided mental health services, and 80 percent reported providing SUD services.** Almost half (47 percent) said mental health services were integrated* and 25 percent said they were co-located.
- **Most common mental health services offered** were individual counseling/therapy (95 percent), universal mental health screening for adults (81 percent), and family counseling/therapy (72 percent).
- **Most common SUD services offered** were SBIRT (83 percent), case management (53 percent), physician consultation (53 percent), and outpatient services (53 percent).
- **18 percent** said that over half of their **visits included a behavioral health component**.
- Almost all said they **integrated behavioral health operationally** in their electronic records (98 percent), practice management software (98 percent), and/or scheduling system (96 percent).

*In the survey, "integration" was defined as not only colocation but also regular communication and consultation, shared treatment plans and systems (e.g., scheduling), and at least a basic understanding other team members' roles, in accordance with levels four and five in the framework created by Doherty et al (1996): http://www.ibhpartners.org/background/levels-of-integrated-behavioral-health-care/.

Therefore, it is difficult to identify where California as a whole falls in any integration framework. Some informants argued that California could not have truly integrated care in its current carve-out structure. As one external expert simply put it, "integration combines funding streams." "It's a fundamentally non-integrated payment system and delivery structure," said a foundation senior staff member, who continued:

> *"**What California makes hard to integrate is not at a point of care level**, but really about the **money and legal structure and who bears responsibilities**. You can find many places in California's safety net…where they've built, one way or another, an integrated system…but I would say, **at a county and state level, we're not even on the chart [in those frameworks]** because of the way we pay for those things."*

There are a few examples where integration is happening at the payer level among Medi-Cal managed care health plans, as described further in Figure 6.

Figure 6: Examples of Integration Spearheaded by Health Plans

Inland Empire Health Plan (IEHP), which serves Riverside and San Bernardino Counties, is an oft-cited example due to its in-house behavioral health program. In addition to a directly contracted behavioral health network and clinical experts on staff, it hosts a data exchange portal that primary care providers and behavioral health providers can access electronic health records and treatment reports.[37] Last year, IEHP initiated the Behavioral Health Integration and Complex Initiative, a two-year pilot working with 13 provider organizations to create integrated health homes for individuals with complex needs. This approach focuses on social determinants of health and behavioral health as central to primary care.[38]

The sole Medi-Cal plan for 14 primarily rural counties in northern California, **Partnership HealthPlan** is working with the state to develop a regional Drug Medi-Cal benefit for ten counties in order to leverage the plan's capacity.[39]

Consequently, reconciling California's current structure and traditional integration frameworks is complex. In when it comes to informants' views of the current specialty mental health carve-out, perspectives are mixed about its effectiveness:

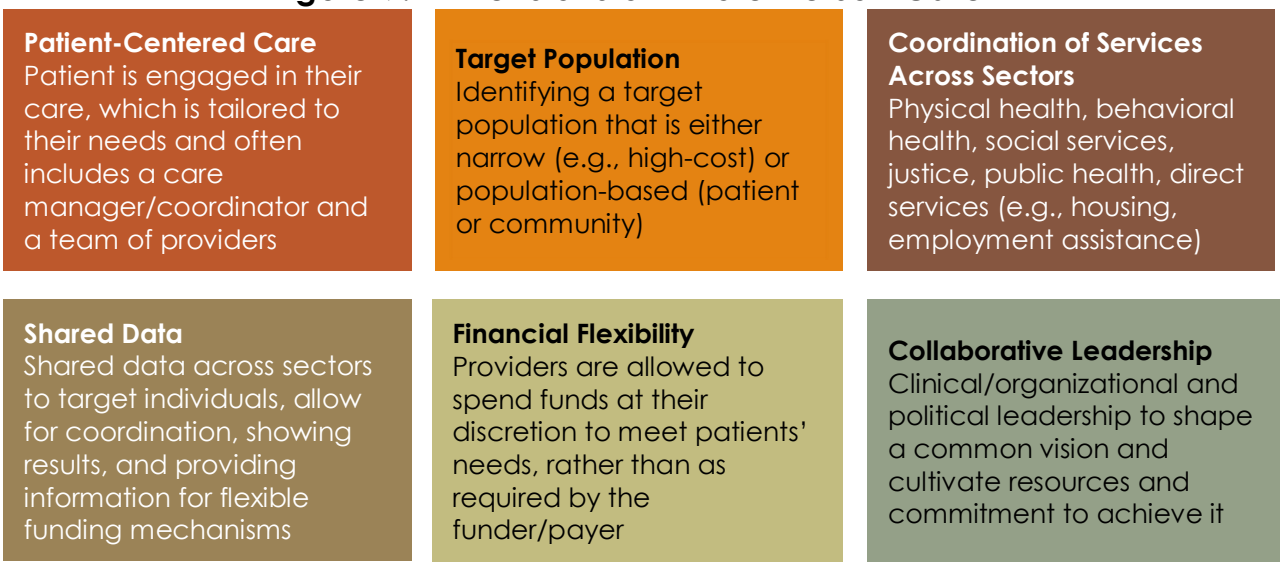
- *"Specialty mental health is very hard. I worry about quality of care when it's not carved out. Do managed care plans, who control the access and nature of services provided, have the ability to do this complex care better than what the carve-out does now? I don't know the answer." – External expert*
- *"With the carve-out, the closest thing we can do is get to coordination and we can't do that until we have accountability in the system."- Trade association staff member*

Indeed, research about the effectiveness of the specialty mental health carve-out is limited, though county anecdotes have suggested that a lack of a clear distinction between "moderate" and "severe" has presented additional complexity to integrating care in California.[40] (Furthermore, some informants also argued that, as another barrier, mental health and SUD systems are not necessarily integrated either.) Yet, achieving more cohesive care has not been a completely insurmountable goal. Counties and plans have worked together, not only to establish clearer definitions for mild-to-moderate and severe, but also build a foundation for system coordination in light of the carve-out by establishing clear protocols for moving patients across systems, creating data exchange structures, and bridging cultural and organizational divides between physical and mental health providers.[41]

A framework that encompasses these principles and could co-exist with California's structure, and the state has sought to scale up through these initiatives, is **whole-person care,** which focuses on the goals the individual wants to fulfill and may not be strictly limited to physical and behavioral health. "When you get a client/person-centered perspective, you see their problem is not compartmentalized in the same way or in the same domain [as your expertise],"

explained one external expert. In a white paper published in 2014, John Snow, Inc. presented the six dimensions of whole-person care, summarized in Figure 7.[42]

Figure 7: Dimensions of Whole-Person Care



Source: JSI/Blue Shield of California Foundation

The paper goes on to posit that integration is actually "too narrow" a lens to address the full range of an individual's needs, especially those in vulnerable populations.[43] A few informants echoed this sentiment:

- *"I don't think we'll be able to integrate all care like creating a superagency and I'm not sure that's the goal. For whole-person care, you need care coordination and not just integration [by co-locating services or having providers providing both physical and behavioral health care services]." – External expert*
- *"Something you may hear is that the easy target is that the mental health carve-out system prevents integration and if it went away, it'd be easier. I don't think that's necessarily the solution. I think that having projects to really focus on some of the highest need beneficiaries and having that be the starting place and really working through proper methods to create models of care coordination can be really successful." – Trade association staff member*

Thus, since Medi-Cal is currently characterized by fragmented payment and delivery systems for medical and behavioral health, it could be argued that the systems are not necessarily designed for integration. However, taking into consideration its county-driven system, the state is poised to advance whole-person care, of which integration—through coordination—of behavioral health services is one vehicle.

In 2015, CMS approved California's renewal of its Section 1115 waiver, known as "**Medi-Cal 2020**." As stated in its concept paper, DHCS seeks to use the Medi-Cal 2020 waiver authorities and funding to "facilitate the system transformation, including whole-person health care integration across the physical health, behavioral health, and long-term care spectrum in order to improve health outcomes and quality of life overall."[44] Medi-Cal 2020 is composed of four

programs, as well as an amendment, several of which directly relate to delivery of behavioral health services:

- **Public Hospital Redesign and Incentives in Medi-Cal (PRIME)** is a 5-year program that provides incentives to public hospitals to implement quality improvement projects in three domains: (1) outpatient delivery system transformation, (2) improving care for high-risk or high-cost populations, and (3) reducing wasteful use of services.[45] One project that entities may work on, and is required for Designated Public Hospitals (DPHs), is "Integration of Behavioral Health and Primary Care," in which systems can work on implementing assessment and screening tools, implementing or expanding programs, ensuring access to disease management, developing integrated treatment plans, installing data systems, or utilizing team-based care.[46] For the counties implementing this PRIME project, see **Appendix C, Table C1.**
- One of the main initiatives explored in this report, the **Whole Person Care** pilot is a voluntary program that funds counties to establish the infrastructure and systems to deliver medical and behavioral health care, as well as social services, in a data-driven, coordinated, and patient-centered fashion.
- As an amendment to the waiver, CMS approved the state's proposal to expand and reorganize its Drug Medi-Cal program, the first of its kind in the nation. Known as the **Drug Medi-Cal Organized Delivery System (DMC-ODS)**, this demonstration program will fund a larger array of SUD benefits such that Medi-Cal beneficiaries in counties that opt in have access to a continuum of care consistent with the American Society of Addiction Medicine's diagnostic criteria.[47] For the status of implementation plans submitted by opt-in counties, see **Appendix C, Table C1**.
- The waiver also includes (1) the Global Payment Program, which establishes a statewide funding pool and risk-based payments to DPHs to care for the remaining uninsured and (2) the Dental Transformation Initiative to incentivize preventive and disease management services for oral health among children covered under Medi-Cal.[48]

In sum, with its various carve-outs, the state's Medi-Cal program is generally not integrated in terms of payment or administration on a broad level. In light of this structure and its ultimate goals, the state has envisioned whole-person care as its overarching strategy. This paper focuses on medical and behavioral health care integration, but it is worth noting that this is only one arm of the statewide strategy embodied in Medi-Cal 2020. This waiver represents the flexible financing lever to not only align medical and behavioral health care service delivery but also incentivize counties to confront the cultural, legal, and technological barriers that inhibit whole-person care overall. As one county administrator put it:

> *"**We can do a lot with culture and leadership change.** Even just having regular team meetings, I think that gets us most of the way. I would love to have payment better integrated but it's not necessarily going to get us more integrated than we are right now. I think that's where things are going but **we don't have to wait too long to move the ball farther along**."*

THE INITIATIVES

OVERVIEW

The Coordinated Care Initiative, Health Homes Program, and Whole Person Care pilot are three programs through which the state aims to achieve more integrated care for the most vulnerable Medi-Cal beneficiaries. The programs share several overarching goals:[49]

- Make care more patient-centered
- Increase access to supports and services in the community
- Coordinate services across domains that span individuals' needs
- Achieve the "triple aim" – improved health outcomes, increased beneficiary satisfaction, reduction of total per capita costs

Table 3 presents the counties that are implementing any or all of these initiatives. All seven CCI counties are also implementing WPC and HHP (highlighted). For a more detailed crosswalk of counties implementing these initiatives, see **Appendix C, Table C1.**

Table 3: County Participation Crosswalk

	Initiative			
County	CCI	HHP*	WPC	Total
Alameda		x	x	**2**
Contra Costa			x	**1**
Kern		x	x	**2**
Los Angeles	x	x	x	**3**
Monterey		x	x	**2**
Napa		x	x	**2**
Orange	x	x	x	**3**
Placer			x	**1**
Riverside	x	x	x	**3**
San Bernardino	x	x	x	**3**
San Diego	x	x	x	**3**
San Francisco		x	x	**2**
San Joaquin			x	**1**
San Mateo	x	x	x	**3**
Santa Clara	x	x	x	**3**
Shasta		x	x	**2**
Solano		x	x	**2**
Ventura			x	**1**

*Counties scheduled for HHP implementation.

Currently underway in seven counties, **the Coordinated Care Initiative (CCI)** was enacted in 2012 through SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012) and SB 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), and updated in SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013). CCI has three components: (1) Cal MediConnect (CMC), mandatory enrollment of dual eligible beneficiaries (those eligible for both Medicaid and Medicare) into Medi-Cal managed care to receive their Medi-Cal benefits, and (3) inclusion of Long-Term Supports and Services (LTSS) in managed care.[50] A three-year demonstration program, CMC is the centerpiece of CCI; in CMC-participating counties, health plans are responsible for administering both Medicare and Medi-Cal benefits, as well as some additional benefits, as part of an organized delivery system. A central focus of CMC is increasing access to home- and community-based services and shifting away from institutional care, which is more expensive. This also acknowledges the interrelatedness between physical, behavioral, and social needs. In 2012, DHCS released a Request for Solutions to health plans to participate in the demonstration, after which Los

Angeles, Orange, San Diego, and San Mateo were announced as the first participating counties.[51] In this study, CMC will be the primary focus when discussing CCI.

The Health Homes Program (HHP), also known as Health Homes for Patients with Complex Needs, enhances care coordination to Medi-Cal beneficiaries with multiple chronic conditions.[52] Through the Medicaid Health Home State Plan Option (Section 2703) of the ACA, states can provide this "health home" benefit with federal authorization. By late 2016, almost half of all states were providing health home services under a Section 2703 state plan amendment.[53] AB 361 (Mitchell, Chapter 642, Statues of 2013), authorized California to submit an application to offer this new benefit. Managed care plans indicated their intent and readiness to offer this benefit by responding to DHCS' Request of Interest. DHCS then created a phased-in implementation schedule for 28 counties based on plans' readiness and to not overburden internal resources at any one time.[54] Per federal requirements, all managed care plans in the county had to be ready for implementation. In counties where this was not the case, implementation was not scheduled. Although the first wave of implementation was initially planned to begin in January 2017, it has since been postponed to July 2018.[55]

Whole Person Care (WPC), as mentioned previously, is part of California's Section 1115 waiver, Medi-Cal 2020, and provides up to $1.5 billion over the waiver's five years in federal matching dollars for county pilots. The program allows a county, city and county, health or hospital authority, or consortium of entities to better coordinate physical health care, behavioral health care, and social services and deliver patient-centered care for particularly vulnerable groups within its Medi-Cal population. The pilot has had two rounds of applications; the first round of participants represents 18 counties, with implementation starting earlier this year.[56]

CROSSWALKING THE INITIATIVES

This section explores the similarities and differences across the initiatives in the domains of covered services, delivery system structure, target populations, financing, and quality metrics. Table 4 summarizes some of these key features in each pilot.[57]

Table 4: Initiative Feature Crosswalk

Initiative	Scope of Services	Target Population(s)	Lead Entities	Financing
CCI	Medicare + Medi-Cal + additional benefits (Care Plan Options)	Dual eligibles (older, disabilities, low-income, chronic conditions)	Medi-Cal managed care plans (through CMC)	Capitation + quality withholds → cost-effective
HHP	Non-direct services, e.g., care coordination, referrals, transitional care, health promotion	Individuals with multiple chronic conditions, including mental illness	Medi-Cal managed care plans	Capitation + enhanced match → cost- savings
WPC	Can't be reimbursable under Medi-Cal; more focus on building infrastructure	High-utilizers, 2 or more chronic conditions, mental health and/or SUDs, homeless or at risk *(not duals)*	County health services department (generally)	IGT (using county dollars) → cost-neutral

Scope of Services

All initiatives provide funding for services that go beyond what is traditionally covered under Medi-Cal. Medi-Cal traditionally pays for physical health care services, so each initiative serves to provide funding for other types of services. However, there are several primary differences:

Scope of Services: Key Takeaways

- CCI funds the most "direct" services.
- CCI and HHP provide care coordination of services, while WPC works to strengthen coordination of both services and systems.
- HHP and CCI largely still operate within the Medi-Cal space, while WPC explicitly targets services not funded by Medi-Cal.
- HHP and WPC can fund housing support services.

- **Of the three, CCI funds the most "direct" services/benefits**. CMC plans are still responsible for Medi-Cal benefits but must also offer vision and non-emergency medical transportation services. They may also cover additional services, known as Care Plan Options (CPOs), that supplement LTSS and support beneficiaries with living independently and safely at home. Examples of CPOs include home modifications (e.g., grab bars and ramps), meal preparation, and caregiver respite.
- **CCI and HHP provides care coordination of services, while WPC works to strengthen coordination of both services and systems.** CMC plans provide care coordination as a new benefit that CMC beneficiaries can access. HHP funds only care coordination and management services, as well as other ancillary services like health promotion, transitional care, beneficiary and family support, and referrals to community and social supports. On the other hand, WPC not only supports activities and services that advance coordination and more efficient use of health care services, but it also involves making sure systems themselves are coordinated. In counties not scheduled for HHP implementation, WPC entities could elect to provide HHP-like services through their WPC program.
- **HHP and CCI largely still operate within the Medi-Cal space, while WPC explicitly targets services not funded by Medi-Cal.** Under the terms of the waiver, counties are prohibited from using WPC funds for services that are reimbursable under Medi-Cal. Thus, it is structured not to overlap with HHP, a new Medi-Cal benefit, but rather to strengthen it. WPC has a greater focus on developing the organizational infrastructure (e.g., information technology, staffing) that facilitates coordination, which is ordinarily not reimbursed by Medi-Cal.
- **HHP and WPC can fund housing support services.** HHP beneficiaries with housing needs are entitled to any necessary housing-related services. With WPC, certain housing support services, such as those that support housing transition and housing/tenancy sustainment, are eligible for matching federal funds. Expenses like room and board, rent or mortgage payments, food, utilities, and household items are not eligible for matching. WPC pilots can also set up a Flexible Housing Pool to pay for housing services that, depending on the type of service, may or may not be eligible for federal matching. This

pool can draw from several sources: WPC funds (if services are eligible for federal matching), partner contributions, or health care savings generated from WPC housing-related services. Conversely, CCI does not directly address housing issues. Figure 8 goes into further detail about the rationale behind addressing housing in these initiatives.

Figure 8: Addressing Housing as a Social Determinant of Health

Broadly speaking, there has been increasing recognition of the importance of addressing the social determinants of health—the social, economic, and environmental conditions that contribute to health outcomes—to rethink how health care is designed and delivered. **Homelessness** is one determinant that has received considerable attention. In addition to housing instability, the chronically homeless often also experience food insecurity and lack of social supports in addition to other conditions, including mental illness and/or SUDs. Consequently, they suffer considerably worse health outcomes than average Americans and are more likely to enter high-cost settings, such as emergency rooms, hospitals, and jails, because of the severity of their circumstances and/or delay in receiving services for unmet needs.[58] The most recent point-in-time count of unsheltered people nationwide found that the highest share was in California (44 percent).[59]

Supportive housing programs, in which individuals are placed in rental housing and simultaneously receive case management, is one intervention that has shown evidence of positive health outcomes for this population in many U.S. communities.[60] In a study funded by the Blue Shield of California Foundation, JSI Research and Training Institute profiled supportive housing initiatives in San Diego, Los Angeles, and Santa Clara from a whole-person lens. San Diego's pilot experienced savings of $33,000 per participant per year in emergency room and hospital stay utilization.[61]

More states are also looking at innovative ways to leverage Medicaid dollars to fund and scale up housing-related interventions such as supportive housing.[62] As the country continues its shift to value-based care continues, stakeholders expect these types of innovative service delivery reforms to continue to take hold.

Target Populations

All initiatives are serving specific Medi-Cal populations that are especially vulnerable. Nevertheless, they focus on somewhat different groups of beneficiaries:

Target Populations: Key Takeaways

- CCI and WPC serve populations with very specific characteristics; CCI serves dual eligible beneficiaries, while WPC targets high-risk, high-utilizing groups.
- HHP builds on CCI and serves the broadest population.

- **CCI and WPC serve very specific groups**. CCI was established specifically for the dual eligible population, who tend to be older adults (i.e., age 65 or older), have disabilities, be low-income and/or have several chronic conditions. WPC pilot counties have established their eligibility criteria and identified their target populations, which include an even broader set of groups: people who repeatedly use emergency room, inpatient, or nursing facility services; have two or more chronic conditions; have mental health conditions and/or SUDs; and/or are homeless or at risk of

being homeless. WPC and CCI are not intended to be duplicative and, as such, duals are not eligible to participate in WPC. Should they need any WPC-like services, they are expected to go to their CMC plans.

- **HHP serves the broadest population of the three.** HHP is meant to build on CCI efforts by providing more intensive care coordination for high-utilizing beneficiaries with multiple chronic conditions, including mental health conditions. Consequently, HHP serves the broadest population. Since HHP is an entitlement, any beneficiary who meets DHCS eligibility criteria must be offered services, though the state can select specific geographies or counties to offer services. Duals are required to receive HHP services as a Medi-Cal benefit. Enrollees can opt out of participating in CMC, which has an enrollment cap of 456,000 people. WPC counties can decide to set an enrollment cap; if they do, they are required to describe how they will manage the waiting list. For the numbers of beneficiaries being served in WPC pilots, see **Appendix C, Table C2.**

Lead Implementation Entities

Lead Entities: Key Takeaways

- Medi-Cal managed care plans are the lead entities in CCI and HHP.
- Counties—most often the county health services department—are taking the lead on WPC.

Each initiative is carried out through a network of different entities. However, they vary in governance structure in terms of the lead entity responsible for overseeing service delivery:

- **Medi-Cal managed care plans are the lead entities in CCI and HHP.** In CCI and HHP, health plans are the main entities overseeing coordination of services for both Medi-Cal managed care and CMC. Plans administer CMC programs through their existing Medicaid and Medicare networks.
- **Counties—most often the county health services department—are taking the lead on WPC.** In most counties (n=13) implementing WPC, the lead entity is the county health services department or health and human services agency. In four counties, county-designated public hospitals or hospital authorities are serving as the lead, while in one county, the lead entity is the county behavioral health department. For the types of lead entities in each WPC county, see **Appendix C, Table C2.**

The Medi-Cal managed care plan structure in each county may play a part in the initiatives' success, particularly in WPC since plans are not the lead entities, but are key partners, for WPC. Half (n=9) of the WPC counties are Two Plan counties while COHS counties make up the next largest share (n=7). Since there is only one plan for Medi-Cal beneficiaries, COHS counties may experience fewer barriers with coordinating care and thus implementing the pilots.

While the Regional managed care structure is the second most common managed care structure in the state, only one Regional county is participating in WPC. However, given that this is the newest model and represents mostly rural counties, who generally have fewer resources, it is not surprising to see relatively little representation of Regional counties participating in WPC.

Financing

The three initiatives utilize different financing structures. Since they are headed by plans, CCI and HHP employ capitation, while WPC is budget-driven. To explain further:

Financing: Key Takeaways

- HHP and CCI use capitation, and HHP also has an enhanced matching rate.
- WPC is funded through intergovernmental transfer from counties to the state.
- CCI and WPC use quality-based incentives through withholds and incentive payments for "deliverables," respectively.

- **Enhanced matching rate and capitated payments in HHP:** HHP reflects the enhanced matching rate from Medi-Cal expansion. In HHP, there is a 90% federal match for the pre-Medicaid expansion population in the first eight quarters, after which it falls to the usual 50%. For the post-expansion population, HHP services are 100% funded by the federal government until 2020, at which the match becomes 90%, per the Affordable Care Act. Plans will receive payment for HHP services through PMPM, risk-based add-ons to their existing capitated payments.
- **Capitation and quality withholds in CCI:** CCI represents California's participation in CMS' Financial Alignment Initiative to align Medicare and Medicaid financing and services for dual eligible beneficiaries.[63] This initiative is testing two models, a Managed Fee-For-Service Model and a Capitated Model; California is testing the latter. CMC plans receive risk-adjusted, capitated payments for enrolled duals in a three-way contract with the state and CMS (federal funding at 50% FFP) for Medicaid and Medicare services, respectively. CCI also includes quality withholds, whereby a percentage of the capitation rates are withheld but returned to the plans if they meet performance targets, described in more detail later.
- **Intergovernmental transfer and deliverable-based budgeting in WPC:** Counties are dedicating funds, through intergovernmental transfer, to draw down federal dollars (50% match) for WPC. In their applications, counties had to assemble a deliverable-based budget, a blend of a grant process and a cost-based reimbursement, in which counties requested a specific amount of money and tied that amount to a deliverable. Deliverables fell into categories of administrative infrastructure, delivery infrastructure, incentive payments for downstream providers, discrete/FFS services, and bundled/PMPM services. Furthermore, in their budgets, WPC counties must include at one least outcome metric for which they will receive payment if they achieve it, and may choose to include payment for reporting metrics.

The initiatives' funding structures also have different accountability mechanisms built into them. Since counties are provide the non-federal match for WPC, WPC is cost-neutral to the state. HHP and CCI have higher financial stakes; the permanency of HHP hinges on its ability to produce cost-savings, and therefore not produce any net costs to the state General Fund. The CCI legislation contained a provision that prompted the discontinuation of CCI if it did not show to be cost-effective. The Governor's recent budget proposal accounts for this provision,

calling for CCI's discontinuation beginning January 1, 2018. However, it included continuation of all three components of CCI, except for the inclusion of In-Home Supportive Services, one of the LTSS service types, in managed care.[64]

Part of the payment for CCI and WPC relies on fulfilling quality-based measures, which is described in more detail below.

Quality Metrics

Each initiative includes quality monitoring and reporting requirements to ensure that programs are making progress toward less fragmented care, improved quality of life and outcomes, greater beneficiary satisfaction with service delivery, and slowing/reduction of health care costs. The status and range of specific indicators that initiatives are tracking in their respective evaluations, vary:

Quality Metrics: Key Takeaways

- CCI has to report on the largest number of measures.
- WPC counties have more flexibility in metrics that must be reported.
- Final measures for HHP are still tentative.

- **CCI has to report on the largest number of measures.** Since CMC is a joint collaboration between CMS, DHCS, and plans, there are core (CMS-identified) and DHCS/state-identified measures that plans report to CMS and DHCS. In total, CMC plans must report on over 80 metrics, of which 18 unique measures are considered for quality withholds.[65]
- **As a county-driven pilot, WPC has more flexibility in metrics that must be reported.** Counties participating in WPC must report on seven core "universal" metrics but they also select at least five "variant" metrics based on what is feasible and applicable to their pilots. However, there is some limitation of choice; selection of certain variant metrics depends on whether counties are targeting individuals with mental illness and/or individuals experiencing or are at risk of homelessness.
- **The final measures for HHP are, as of yet, still tentative.** Similar to CCI, HHP also contains CMS- and state-identified measures that plans are responsible for reporting.[66] Currently, there is a proposed list of 14 measures, to which operational measures will also be added.

As the longest-running initiative of the three, only evaluation of CCI/CMC has been conducted to date. For a list of each initiative's evaluation activities, see **Appendix D.**[67]

Table 5 on page 24 presents a comparison of metrics that initiatives are expected to report.[68] This map reflects the similarities as well as the subtle differences in focus areas among the initiatives. The greatest similarities are in the areas of care coordination, outcomes, and utilization, which makes sense given the common goals of the initiatives. Using the metrics as a way to understand how coordination is being conceptualized, the initiatives envision "successful" coordination as having accurate and compliant encounter data, assignment of a care coordinator (and care team), documented discussion of care goals, having a comprehensive care

plan, having infrastructure (e.g., Memorandum of Understanding) around care coordination and information sharing, and sharing of health information.

The most variation in metrics appears in the procedural measures, with the exception of commonly used HEDIS and CMS measures (e.g., follow-up after hospitalization for mental illness), all of which are notably related to behavioral health. Other procedural measures are specific to the respective focus areas/target populations of the initiatives, for example, BMI and PQI 92 to reflect the chronic condition focus of HHP, suicide risk for WPC (for the SMI population), and risk of falling and Part D medication adherence for the older adult/Medicare population in CCI.

Table 5: Quality Metrics Crosswalk

Domain	Metric	CCI*	HHP	WPC**
Care Coordination	Encounter data	■		■
	Interaction with care team	■	■	■
	Documentation of care goals	■	■	■
	Comprehensive care plan	■	■	■
	Care coordination, case management, and referral infrastructure	■	■	■
	Data and information infrastructure	■		■
	Care transition record transmitted to health care professional	■	■	■
Outcomes	Plan all-cause readmissions	■	■	■
	Controlling blood pressure	■	■	■
	Overall beneficiary health	■		■
	Decrease jail recidivism			■
	Blood sugar control	■		■
	Housing-related metrics		■	■
	Depression Remission at 12 months (NQF 0710) metric			■
Procedural - Governance and Access	Consumer governance board	■		
	Customer service	■		
	Ensuring physical access to buildings, services, and equipment	■		
	Access to care	■		
Procedural - Clinical	Completion of risk assessments	■	■	■
	Follow-up after hospitalization for mental illness	■	■	■
	Screening for clinical depression and follow-up	■	■	■
	Part D medication adherence for oral diabetes medications	■		
	Reducing the risk of falling	■		
	Annual flu vaccine	■		
	Adult BMI assessment		■	
	Initiation and engagement of alcohol and other drug dependence treatment	■	■	■
	PQI 92 (chronic conditions composite)		■	
	Suicide Risk Assessment (NQF 0104) metric			■
Utilization	Ambulatory care – emergency department (ED) visits	■	■	■
	Inpatient utilization - general hospital/acute care		■	■
	Avoidable hospital readmissions that followed inpatient stays	■	■	
	Nursing facility utilization		■	

* Not all CCI-required metrics shown. Only those considered quality withholds as well as several others (overall beneficiary health, blood sugar control, ambulatory care, avoidable hospital readmissions) that map onto measures in other initiatives are listed.
**Depression Remission is only required if WPC pilots are using the PHQ-9 metric, Suicide Risk Assessment is only required if pilots are targeting individuals with SMI. Housing-related metrics (e.g., percent of homeless who are permanently housed for at least 6 months) are only required if pilots are targeting individuals experiencing or at risk of homelessness.

KEY

■ Plan/county required metric

■ Some WPC counties are reporting as an administrative metric

MEDICAL-BEHAVIORAL HEALTH INTEGRATION IN THE INITIATIVES

Given the historically siloed nature of the medical and behavioral health systems, this is a particular area that the initiatives work to address. Thus, integration by way of coordinating care across these systems is a central component of each initiative, as described in the legislative language shown in Figure 9.[69] This section more fully explores how these initiatives aim to achieve better coordination.

Figure 9: Legislative Language on Integration in the Initiatives*

Coordinated Care Initiative
"[DHCS] shall establish the demonstration project that enables dual eligible beneficiaries to receive a continuum of services that maximizes access to, and **coordination** of, benefits between the Medi-Cal and Medicare programs and access to the continuum of long-term services and supports **and behavioral health services, including mental health and substance use disorder treatment services.** The purpose of the demonstration project is to **integrate services** authorized under the federal Medicaid Program…and the federal Medicare Program."

Health Homes Program
"Subject to federal approval for receipt of the enhanced federal reimbursement, services provided under the Health Home Program established pursuant to this article shall include…**care coordination** and health promotion, including **connection to medical, mental health, and substance use disorder care."**

Whole Person Care
"As a component of the 'Medi-Cal 2020' demonstration project, the Whole Person Care pilot program creates an opportunity for counties, Medi-Cal managed care plans, and community providers to establish a **new model for integrated care delivery that incorporates health care needs, behavioral health, and social support for** the state's most vulnerable, high-user populations. The Whole Person Care pilot program **encourages coordination** among local partners to address the root causes of poor health outcomes, including immediate health needs and other factors, such as housing and recidivism, that impact a beneficiary's health status."

*Author bolded key phrases

It is worth noting how quality metrics, as described in the previous section in Table 5, focus on coordination at the delivery level, underscoring the initiatives' efforts to "integrate" care, as articulated in legislation, is largely through the vehicle of coordinating services.

Coordination Structure

The overall systemic structure as created by the specialty mental health and SUD carve-outs in Medi-Cal remains relatively intact under each of the initiatives. For example, under CCI, CMC plans must still cover behavioral health services that are covered by Medicare and Medi-Cal. For specialty mental health and Drug Medi-Cal services, there must be MOUs in place between CMC plans and with the county to ensure that processes are in place for eligible beneficiaries to receive such services.[70]

What is new, however, is the intensity of coordination that will be expected in participating counties. Across all of the initiatives, counties, health plans, and community-based agencies are expected to work together to deliver patient-centered care through care coordinators, interdisciplinary teams, and cross-system collaboration. Where the initiatives differ, however, is the locus of coordination and the supporting structure.

Care Coordination: Key Takeaways

- In CCI, CMC plans are primarily responsible for coordination
- In HHP, Medi-Cal managed care plans certify entities to provide care coordination services
- WPC counties have varying coordination structures

- **In CCI, CMC plans are primarily responsible for coordination.** Each beneficiary has access to a nurse or social worker through their CMC plan who coordinates their care, as well as a Health Risk Assessment, Interdisciplinary Care Team (ICT), and Individualized Care Plan (ICP) to tailor and organize their care. Health Risk Assessments serve to capture a comprehensive picture of the beneficiary and assess their medical, LTSS, behavioral health, and functional needs.
- **In HHP, Medi-Cal managed care plans certify entities to provide care coordination services.** Both managed care plans and Community-Based Care Management Entities (CB-CMEs), which are contracted by managed care plans to provide HHP services, must be certified as being able to carry out the responsibilities under HHP. Types of entities that may serve as CB-CMEs include hospitals, clinics, physicians, local health departments, community mental health centers, mental health plans, and SUD service providers/agencies.[71] Managed care plans, along with the CB-CMEs and other community and social support services, form the "health home." Similar to CCI, each HHP beneficiary has a dedicated care manager, who is either a CB-CME staff member or contracted by the CB-CME. This care manager works with a team of staff members that are from the CB-CME, plan, and/or contracted. Housing navigators are required to serve on the team for beneficiaries experiencing homelessness. In counties implementing both HHP and WPC, CB-CMEs may also participate in WPC.[72] In counties implementing both HHP and CCI, CMC plans must also be involved.
- **WPC counties have varying coordination structures.** While HHP and CCI have a specific structure, WPC have the flexibility to design their programs within the waiver guidelines. Though there is no minimum number of partners required, lead entities must partner with the Medi-Cal managed care plan(s), health services, public agencies, community partners, and housing authority (if providing housing services in the pilot) to deliver and coordinate services. However, WPC pilots generally have similar structural components as in CCI and HHP, including comprehensive assessments, interdisciplinary teams, and individualized care/case management. What is unique about WPC is the investment in the technological infrastructure to enable coordination (e.g., data sharing) and, in some counties, development of new behavioral health resources for beneficiaries. These features are explored in more detail in the subsequent section.

Accountability

As described in the earlier section on "Quality Metrics," participating entities are being held accountable for coordinating and delivering behavioral health services through a variety of metrics in each initiative. Initiatives share several coordination-related metrics and are also tracking behavioral health-specific metrics such as depression remission at 12 months, suicide risk assessment, and initiation and engagement of alcohol and other drug dependence treatment.

Figure 10: Behavioral Health Shared Accountability Measures in CMC

- *Year 1 (from Sept-Dec 2013)*: Policies and procedures attached to a **memorandum of understanding** with county behavioral health department(s) around assessments, referrals, coordinated care planning and information sharing.
- *Year 1 (from Jan-Dec 2014)*: Percent of demonstration enrollees receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services receiving a **coordinated care plan** as indicated by having an individual care plan that includes the signature of the primary behavioral health provider.
- *Years 2 and 3*: **Reduction in emergency room use** for seriously mentally ill and substance use disorder enrollees (greater reduction in Year 3).

Some of these quality metrics, however, are also tied to payments, providing a greater financial incentive for achieving them. In CCI, all of the care coordination and clinical procedure metrics in Table 5 are subject to payment withholds. Some of the CCI care coordination metrics, known collectively as "behavioral health shared accountability measures," have a specific behavioral health process or outcome focus, as shown in Figure 10.[73]

In WPC, many counties have identified behavioral health-related metrics that they have chosen to tie to payment for either reporting and/or achieving. Examples of these payment-based metrics are shown in Table 6, with those most directly related to behavioral health and/or care coordination. Counties could also elect to include payments to providers for fulfilling operational and quality-related activities in their budgets, described further in the next section.

Table 6: Examples of WPC Payment-Based Metrics

County*	Pay for Reporting	Pay for Outcome Achievement
Alameda	▪ Depression remission (PHQ-9) ▪ Initiation and engagement of alcohol and other drug treatment ▪ Care coordination assignment and care plan	▪ Follow-up after hospitalization for mental illness
Monterey	▪ Medication list provided at discharge ▪ Timely documentation transition to clinics/primary care providers ▪ Depression remission at 12 months ▪ Mental health unit re-hospitalization within 30 days	▪ 80 percent or greater follow up mental health, medical, and SUD appointment within 30 days post-hospitalization ▪ Suicide risk assessment and alcohol drug misuse (SBIRT) ▪ 12 months of coordinated case management ▪ Comprehensive care plan

*These are not exhaustive lists of payment-based metrics for these counties.

Figure 11 provides more information on key findings specific to behavioral health thus far from the CCI evaluation.

Figure 11: A Closer Look at Behavioral Health Integration in CMC

In the first year of their evaluation of CMC, researchers at the Universities of California, San Francisco and Berkeley found that **beneficiaries were highly satisfied with CMC** (8 on a scale of 1 to 10). Focus group participants shared that increased access and understanding of services through the care coordination benefit, as well as better access to behavioral health services, contributed to their satisfaction with CMC. Interestingly, phone survey data revealed that the only characteristic distinguishing those who did and did not access the care coordination benefit was utilization of behavioral health services.[74]

Overall, the evaluation found a high degree of variance in the implementation of CMC. Plans worked on developing **relationships with county behavioral health departments**, with some struggling more than others. Data-sharing capabilities and ICT engagement of county behavioral health also differed, making CMC easier to implement in some regards for certain plans. **Availability of workforce** also differed between regions/plans, with behavioral health being one specialty that plans generally found challenging to meet network adequacy.[75]

CMC encouraged adoption of **care coordination strategies** between plans and county behavioral health, though implementation of care coordination, ICPs, and ICTs varied between regions/plans. Data sharing was a major challenge to overcome due to HIPAA restrictions, different systems, and different communication styles. Strategies that plans used to facilitate information sharing included training care coordination nurses to use the county behavioral health data system, creating a shared data platform, and utilizing financial incentives. Nonetheless, data sharing continues to be an ongoing challenge.[76] With regard to ICTs, most plans worked on integrating county behavioral health into these teams, with some also bringing on care coordinators with a behavioral health specialty and/or creating teams of care coordinators with a behavioral health (or other specialty) focus to consult care teams. However, regardless of how plans are implementing CMC in their counties, ICPs and ICTs, and new relationships with other types of providers/services more broadly, are considered significant changes for service delivery, especially on the behavioral health side.[77]

The evaluation team is currently in their second year of evaluation, and is working on case studies of CMC counties to investigate how they are integrating behavioral health.[78]

Thus, while all initiatives focus on enhancing care coordination, particularly of services beyond medical care, they have different focal areas and strategic levers. While behavioral health agencies and providers are expected to be involved in CMC, CCI does not necessarily change the coordination infrastructure within counties. Moreover, CCI is largely aimed at increasing access to community-based LTSS, not necessarily behavioral health services, and operates through the streamlining of Medicare and Medicaid benefits administration. HHP covers chronic conditions more broadly and focuses on scaling up the standardized model of CB-CMEs. WPC has more targeted populations and provides funding to build up the processes and tools needed for care coordination to happen. It also allows for significant variation in integration strategies because counties essentially design their own initiatives, thus harnessing the county-based nature of the health care system to allow flexibility in planning and implementation.

IN DEPTH: THE WHOLE PERSON CARE (WPC) PILOT

As the pilot that is most flexible and varied in strategy, the Whole Person Care pilot warrants deeper investigation to explore how participating counties are coordinating behavioral health and medical care. As alluded to earlier, counties throughout California have been engaged in coordination activities for a while, and this movement has gathered steam over the last several years under the ACA. Thus, **WPC is really about scaling up existing practices and/or funding activities that stakeholders have wanted to carry out for some time.** For the most part, county informants indicated that strategies or models that they were employing in their county to coordinate services were not necessarily new, but that this new source of funding allowed them to expand or mature these services. "Our program is designed to work with all of the services that exist and to provide connective tissue to enable different parts of the system and different providers to work together in a more coordinated way," one county administrator reported.

> "Our program is designed to work with all of the services that exist and to **provide connective tissue** to enable different parts of the system and different providers to **work together in a more coordinated way**."
>
> *- County Administrator*

Drawing from key informant interviews, this section explores how WPC advances whole-person care in practice, using the six dimensions from Figure 7 as an organizing framework and with particular attention to the incorporation of behavioral health.

COLLABORATIVE LEADERSHIP

As described in the previous section, county health departments, who are largely the lead entities for first-round WPC counties, are working with a comprehensive set of partners that include other county entities, health plans, housing authorities, and community-based organizations. Many informants noted the commitment from leaders and partners as critical factors to carrying out the work, described in more detail in "Critical Factors for Success."

While there still remain barriers to integration in financial and administrative terms, there is a significant collective energy and vision to move toward deeper system transformation. WPC represents an opportunity to stretch the system in terms of changing the way stakeholders think about different systems at play and how to more tightly weave traditionally siloed systems. As one trade association staff member put it, "It's not that we're ready to go toward full integration and upset the system we have, but how can we break down some of those barriers and work more closely within the structures we have?" A few informants framed this as an opportunity to build proof of concept:

"The hope is to build enough infrastructure and show enough benefits to the system that these programs continue [with other funding]…This is an opportunity to sell the idea of addressing social determinants of health and improving health outcomes on a more permanent basis." – Trade association staff member

"I've tasked WPC staff to treat this as a 4-year job audition to reduce [unnecessary or inappropriate] utilization—to substantiate these positions and help this department help with better compliance with medication management, behavioral health management, etc. to get better outcomes for members and develop structures for efficiency." – County administrator

TARGET POPULATION

Table 7 displays the high-risk, high-cost populations that counties are targeting in their pilots. Nearly all counties are focusing on high-utilizing groups that repeatedly go to expensive care settings (ED, hospitals, nursing facilities) (n=15) and/or individuals experiencing or at risk of homelessness (n=14).

Table 7: WPC Target Populations

County*	Repeated incidents of avoidable ER use, hospital admissions or nursing facility placement	Homeless/at risk for homelessness	Individuals with mental health condition and/or SUD	Recently released from institutions	2+ chronic conditions
Alameda	x	x			
Contra Costa	x				
Kern	x	x		x	
Los Angeles	x	x	x	x	
Monterey	x	x	x	x	x
Napa	x	x	x		
Orange		x	x		
Placer	x	x	x	x	x
Riverside		x		x	
San Bernardino	x				
San Diego	x	x	x		
San Francisco		x			
San Joaquin	x	x	x	x	
San Mateo	x	x	x	x	
Santa Clara	x				
Shasta	x	x			
Solano	x	x			x
Ventura	x				
TOTAL	**15**	**14**	**8**	**7**	**3**

*Taken from WPC applications.

The strong focus on populations experiencing or at risk of homelessness in WPC demonstrates the unique niche that this pilot occupies in relation to the others, which do not readily reach this population. This population is more likely to be disconnected from health care and have behavioral health conditions than the general public, so WPC is a direct response to provide care coordination and support services that are tailored to meet the intensive needs of this population.[79] This also comes at a time when there has been growing attention on homelessness in California. "The amount of activity occurring in homelessness is unprecedented," said a senior foundation staff member. "So many local jurisdictions want to have the political will and momentum to address it and are putting real money into it. That's been a really important leverage point for a lot of WPC pilots."

PATIENT-CENTERED CARE AND CROSS-SECTOR COORDINATION

Central to each county's approach is **organizing care around the patient.** As one county administrator described it, "Rather than having them to go a clinic that doesn't suit their personality or style, we're going to where they're at. It's a patient-centered model rather than having them come to us. It's not a one-size-fits-all approach, but what works for the patient and providing care in that context." "It's a change in philosophy and operating differently that is spearheaded by the agency—finding ways we can be inside out rather than having [patients] come from the outside in," echoed another county administrator.

In WPC, the overall philosophy that counties are using is "whatever it takes" and meeting patients where they are, both physically and in terms of ensuring that care addresses treatment goals. As a result, **care coordination** is inextricably linked to patient-centered care. Counties are also required to report on their care coordination infrastructure, though type and delivery of services can take many forms.[80] In order to sufficiently address patients' needs, especially with regard to behavioral health, counties are also using a host of strategies related to enhancement and expansion of behavioral health services and workforce development.

Notes: Tables 8-12 on the following pages are not comprehensive lists of strategies/services provided in the pilots, nor do they display the only counties employing those strategies. It is also worth noting that the strategies in these tables reflect what counties have proposed in their applications and may not necessarily reflect what has been or will be implemented or observed.

Care Coordination

Key informants noted that, while they were not necessarily providing new services, what is new is **more intensive, targeted coordination**. Common approaches for care coordination are use of patient navigators and interdisciplinary care teams (including mental health and/or SUD professionals), as well as field-based outreach and coordination. Many counties are also using comprehensive assessments that screen for physical, behavioral, and social needs. (Data sharing is also a mechanism that many counties are employing; this is explored in more detail below.)

Table 8 presents examples of specific care coordination strategies that counties are taking toward coordinating and managing care. These examples also present different ways to design care coordination. San Diego utilizes a tiered approach with varying levels of intensity, while San Joaquin and Ventura have various navigation teams. San Joaquin has two teams of navigators, one of which specializes in behavioral health, while Ventura has a braided structure with various care teams and the community health worker serving as the common thread.

Table 8: Examples of Care Coordination Strategies in WPC

County	Strategies*
San Diego	▪ Regionally based **Service Integration Teams** (1 social worker and 1 peer support specialist): Teams will be supported by 2 RN consultants, 4 housing navigators, and project manager/staff. Responsible for engaging clients, developing and monitoring individualized **Comprehensive Care Plans** and coordinating services across systems. ▪ There are five phases of care coordination, starting with **intensive outreach**, followed by **stabilization** and **maintenance** with housing services and development and monitoring of care plans, and then moderate- and lower-level care coordination in the **transition** and **after-care** phases starting in months 10 and 16, respectively, after enrollment.
San Joaquin	▪ **Behavioral Health Navigation Team (behavioral health professionals):** Team will seek out individuals and collaborate with existing behavioral health mobile crisis service teams. Will maintain engagement and support by providing weekly face-to-face contacts for first 3 months, and help address non-clinical barriers to care and provide on-going support to high-risk individuals. ▪ **Population Health Team (mostly nurses):** Team will coordinate with Behavioral Health Navigation Team to provide each client with an individualized care plan based on **a standardized assessment** of medical, behavioral, and social needs. They will assist patient with navigating systems. Each client will be assigned a **dedicated care coordinator** within the team. ▪ **Interpretive services and transportation** are available to enhance care coordination.
Ventura	▪ **Mobile outreach staff** (Engagement Teams and community health workers (CHWs)) will reach out to those who are identified. CHWs complete comprehensive assessment to develop integrated care plan and serve as PCMH lead and connect with centralized care coordination team. May also provide field-based care coordination. ▪ **Engagement teams** (Care Coordination Manager, Nurse Practitioner, and Clinic Assistant) will determine immediate needs, offer enrollment and assessment services, and connect clients to services. ▪ **Centralized care coordination team** (CHWs and Care Managers – at least one care manager will be a licensed mental health professional, and at least one will be a substance abuse specialist) will oversee identification, enrollment, and linkage to resources.

*Taken and adapted from WPC applications. These more intensive coordination services are not intended, nor are they allowed, to duplicate services provided under the Targeted Case Management benefit in Medi-Cal. See: http://www.dhcs.ca.gov/provgovpart/Pages/TCM.aspx.

Common care coordination services that WPC counties mentioned in their applications include:

- Completing assessments and developing care plans
- Enrolling individuals in WPC and other programs
- Assisting individuals navigate services and address any barriers to care (e.g., scheduling, transportation, language)
- Connecting individuals to primary care, mental health and/or SUD services, and social supports as necessary
- Managing care transitions and referrals
- Managing/reconciling medications
- Remote monitoring of clinical data
- Communicating/collaborating with other care coordination team members

Enhancement of Behavioral Health Services

A number of pilots are using funds to **expand and/or diversify behavioral health services.** This includes creation of new infrastructure that provides medical services for people with behavioral health issues (e.g., recuperative care, Sobering Centers), co-locating medical and behavioral health services, and building capacity to provide SUD services, particularly with the Drug Medi-Cal waiver. In many cases, counties are leveraging existing mental health and/or SUD services and strengthening connections or referrals to those services and/or employing data to target their services. Table 9 presents examples of such expansions or enhancements.

Table 9: Examples of Behavioral Health Care Enhancements in WPC

County	Strategies*
Alameda	▪ **Enhanced linkage** to SUD treatment: Sobering Center, SUD Diversion program, portals to SUD treatment, substance use residential helpline. ▪ **Integration of behavioral health into primary care settings**: psychiatric consultation program, care managers in FQHCs, primary care in behavioral health treatment centers.
Los Angeles	▪ **Sobering Centers** and **recuperative care** for homeless high-risk. ▪ **SUD engagement, navigation, and support** for SUD high-risk. ▪ For mental health high-risk population: **intensive service recipient (ISR) services** and **residential and bridging care (RBC) services**. ISR is a field-based, cross-agency team that provides 60 days of intensive therapeutic and case management services after hospitalization, after which it provides a warm handoff to a Full Service Partnership, an integrated mobile health team, or a community-based organization. RBC teams are county mental health staff who will work with providers, inpatient units, residential treatment facilities, and emergency response teams to develop after-care plans and facilitate linkage to other resources.
Riverside	▪ RN Complex Care Case Managers, clinical therapists, and care coordinators will be equally distributed at each FQHC, which **integrate behavioral health services**. Case Managers will facilitate care between primary care, behavioral health, and additional supportive services.
San Francisco	▪ Building capacity to **expand detoxification services** (that will become reimbursable under DMC-ODS). ▪ Extension of **residential SUD treatment** (i.e., beyond 90 days).

San Mateo	▪ Expand access to **Integrated Medication Assisted Treatment** (IMAT). ▪ Collaborative Care Team, which targets adults with SMI, co-occurring SUDs, and medical problems, will partner with Community Care Settings Pilot to provide **psychiatric expertise and linkage to county behavioral health and aging services** and transition members from institutions to community living. ▪ **Expand Bridges to Wellness Team** to include field-based outreach worker and Health Resiliency Specialist and work with Homeless Outreach Team to **restore engagement with primary care and behavioral health homes.**
Santa Clara	▪ **Integrated Medical-Psychiatric Skilled Nursing Facility:** Bridges medical and psychiatric services for individuals with concurrent need
Shasta	▪ Development of a **Mental Health Resource Center** to serve as a hub for behavioral health services for those experiencing less severe mental health crises. Center will be hub for coordinating other non-medical services and operate Assisted Outpatient Treatment program. ▪ **Mobile Crisis Team** provides field-based professional intervention for those experiencing acute mental health crises. ▪ **Sobering Center** as an alternative to the ED and/or incarceration for intoxicated individuals. ▪ Enhanced **referrals** to residential and outpatient SUD services (e.g., use of motivational interviewing).

*Taken and adapted from WPC applications.

Behavioral Health Workforce Development

Finally, several counties are utilizing strategies to **build behavioral health workforce** through involvement of peer mentors and trainings, as shown in Table 10.

Table 10: Examples of Behavioral Health Workforce Development in WPC

County	Strategies*
Alameda	▪ Provide **clinical education and placements** for a UCSF Psychiatric Fellow. ▪ Sponsor a UC Davis Collaborative Fellowship Program for primary care providers to receive training in primary care-based psychiatry.
Contra Costa	▪ NAMI will provide **peer support** to patients being discharged from mental health inpatient or emergency services.
Kern	▪ Mobile team members will receive **trainings** led by public health nurses to expand their beneficiary assessment skills**.**
Los Angeles	▪ Pilot will build a new **Training Institute** to train and integrate community health workers and provide countywide training on WPC teams and providers on motivational interviewing, harm reduction, recovery, and trauma-informed care principles. ▪ **Peer mentors** serve as community health workers on both the ISR and RBC teams.
Shasta	▪ Mental Health Resource Center behavioral health clinicians will convene **monthly multi-disciplinary clinician and case manager trainings** on coordination and integration of evidence-based strategies.

*Taken and adapted from WPC applications.

Other Services

Housing services and other social supports are also high priority in WPC and complementary to addressing physical and behavioral health, described further in Figure 12.[81]

Figure 12: Addressing Social Determinants of Health in WPC

Virtually all counties (n=17) are using a flexible housing pool to help pay for **housing services** and supports. Most counties are also providing housing transition and tenancy sustaining services (n=11) through housing navigators/specialists. Such services include assessing housing-specific needs, assisting with applications and moving, developing housing support crisis plans, and providing tenant education/coaching.

Counties that are providing housing services are required to partner with their local Housing Authority and must report at least one of the following housing-related metrics:

- Percent who are permanently housed for 6+ months
- Percent receiving housing services in PY that were referred for housing
- Percent referred for supportive housing who receive supportive housing services

Counties are also providing other **social services** that support patients' overall wellness and recovery such as child care, job search and training, eligibility services, legal support, life skills, personal financial management, and food and clothing assistance.

*Counts come from DHCS' analysis

.

FINANCIAL FLEXIBILITY

WPC presents an opportunity to align financing with structuring and delivery of services. Counties were given latitude to design care coordination services/programs, and additional services, as appropriate for their target populations. These services could be provided to beneficiaries on either a discrete/FFS or bundled/PMPM basis; discrete services are those that occur on an encounter basis, while PMPM services are a "bundle" or set of services provided to beneficiaries.

For a table that outlines what Round 1 counties specified as discrete and bundled/PMPM services in their WPC pilots, see **Appendix E.**

Counties were also given the flexibility to identify outcomes for which they would receive payment for achieving them, aligning with the current movement on paying for care on the basis of value, rather than volume.[82] In addition to identifying at least one outcome achievement to tie to payment, counties were also allowed to include payments to incentivize providers to produce "timely achievement of deliverables."[83] Deliverables that counties included in their budgets ranged from capacity/infrastructure development, data utilization and quality improvement, behavioral health service utilization and outcomes, and care coordination, as shown in Table 11.

Table 11: Examples of Provider Deliverables in WPC

County	Type of Deliverable	Deliverables*
Alameda	Behavioral health service utilization	▪ Address opioid disorder
	Care coordination	▪ Identify and link people with chronic hepatitis C to treatment
	Data utilization and quality improvement	▪ Adopt and apply Healthcare Effectiveness Data and Information Set (HEDIS) measures ▪ Ensure cleanliness and integrity of data
	Access to care	▪ Change workflow to increase access to appointments
Contra Costa	Data utilization and quality improvement	▪ Complete data sharing projects (e.g., enable e-prescribing for behavioral health providers)
Monterey	Behavioral health outcome	▪ Reduce in mental health unit readmission within 30 days
San Francisco	Capacity/infrastructure	▪ Open Navigation Centers ▪ Certify detox programs for DMC
	Data utilization and quality improvement	▪ Increase data usage
Shasta	Behavioral health service utilization	▪ WPC participant enters and stays at least 72 hours in sobering center
Ventura	Care coordination	▪ At least 60% of patients have a care plan within 30 days ▪ At least 50% follow up after mental health emergency department visit

*Taken and adapted from WPC applications.

SHARED DATA

Having seamless access to comprehensive patient data is critical to providing the types of patient-centered, and often field-based, services that WPC counties have designed. In order to bridge different systems, reduce duplication, inaccuracy, and gaps in information, and better coordinate care overall, data and information sharing is a core component of WPC. Counties must provide documentation for data sharing infrastructure as one of the other required administrative metrics.[84]

Virtually all informants identified data sharing as a challenge to whole-person care and that the ability to use funds to develop infrastructure was a prime opportunity to address this. As one county administrator put it, "A practical challenge we're hoping to alleviate with WPC is the IT infrastructure that allows us to share data across different platforms through a health information exchange that also allows for real-time alerts and real-time information sharing…so that it's very coordinated and people aren't calling around the county to find information on this specific client." Table 12 provides more detail on strategies that some counties are utilizing to strengthen their data infrastructure, particularly with regard to behavioral health.

Table 12: Examples of Data Infrastructure Strategies in WPC

County	Strategies*
Contra Costa	▪ Implement behavioral health **documentation** with Epic. ▪ **Schedule** for behavioral health population in Epic. ▪ Allow behavioral health providers to **e-prescribe** through Epic.
Napa	▪ Implement **new, web-based eBHS platform** to integrate and allow upload and real-time analysis of Homeless Management Information System, behavioral, and physical health data.
Orange	▪ Patient-specific behavioral health data will be shared with Safety Net Connect to **notify behavioral health staff** that a known beneficiary went to the emergency room for services and will also **alert** CalOptima so that medical and mental health needs of beneficiaries can be managed.
San Francisco	▪ Data infrastructure will **integrate multiple information systems and data sources** (Coordinated Care Management System, Homeless Management Information System, electronic health records, Human Services Agency information systems, emergency department information exchange). ▪ Employ **cloud-based technology** to allow for mobile viewing of client data as a real-time care management tool and integrated data system
Ventura	▪ Develop **web-based Integrated Care Plan and WPC Care Coordination platform** that will maintain the participant repository, care coordination system, data repository, and the project eReferral system. ▪ A WPC **Community Partner platform** will link outside providers with care coordination while protecting personal health information. ▪ **Web-based telemedicine consultation system** will allow primary care, care team, community health workers, mobile outreach staff, and other providers to securely share health information and discuss patient care. ▪ A **data warehouse** will be used to consolidate electronic health record, behavioral health, social services, and health registry data. ▪ **Population health management tool** will enable providers to use data-driven clinical decision making. Dashboards will allow providers, care team, and CHWs to track participant's needs.

*Taken and adapted from WPC applications.

All participating counties plan to expand their existing data sharing framework (e.g., establishing appropriate policies and procedures and necessary consent forms) in order to facilitate communication and care planning among partners and across different systems. County lead entities are also planning to engage in bidirectional data sharing with Medi-Cal managed care plans, whereby plans provide client information to the lead entity to identify who is eligible for WPC and conduct any necessary outreach and engagement activities. Plans then receive regular service reports from the entity and/or they can query the data sharing system and request reports.

In summarizing the data and information sharing strategies across all participating counties, DHCS reported that the most common tools were Health Information Exchanges (HIEs, n=12), patient population software (n=11), and data warehouse (n=9). Furthermore, three counties were implementing entirely new data sharing systems.[85]

A number of informants also noted that changing cultures and practices would have to move in lockstep with data infrastructure development in order to create more coordinated systems beyond the point of care. "You can't just slap down a piece of technology and expect people to make use of it," explained a county administrator. "We put a lot into what we call 'human infrastructure'—all of the training and coaching that goes into changing the way people work…across systems. We're going to be asking people to take the time and learn about different parts of the system."

> "You can't just slap down a piece of technology and expect people to make use of it. We put a lot into what we call '**human infrastructure**'…We're going to be asking people **to take the time and learn about different parts of the system.**"
>
> *- County Administrator*

CRITICAL FACTORS FOR SUCCESS

In order to realize the promise of the WPC pilot, it is key to align the activities and strategies of participating counties with program goals. Similar to an organizational SWOT analysis, this section investigates the strengths, weaknesses (reframed as "challenges" in this context), opportunities, and threats of the WPC pilot to better understand ways in which counties, and the state, could maximize their impact. Figure 13 summarizes these aspects of WPC, which are drawn from interviews with 11 counties, followed by a description of these aspects. In this context, this analysis is not looking at a specific county, but rather the counties as a collective.

Figure 13: WPC Pilot Strengths, Challenges, Opportunities, and Threats

Internal	**Strengths** **Competencies and capabilities that facilitate implementation** ▪ Relationships with partners ▪ Engagement of leadership and other stakeholders to change the system ▪ Existing infrastructure and previous work ▪ Funding for historically non-reimbursable work	**Challenges** **Counties' Internal limitations** ▪ Overcoming legal, technological, cultural, and administrative obstacles to data sharing ▪ Substantial time and effort needed to transform delivery of care ▪ Bureaucratic constraints ▪ Difficulty with achieving the optimal level of flexibility
External	**Opportunities** **Other initiatives that could be leveraged to bolster success** ▪ Other Medi-Cal programs ▪ Non Medi-Cal initiatives related to public health and social determinants of health	**Threats** **External policies or efforts that could hinder success** ▪ Lack of affordable housing ▪ Behavioral health workforce shortage ▪ Federal/state policy changes to Medicaid

Strengths: Assets that Facilitate the Work

> "I don't think we've worked with [the health plan] in this way to **share data and learn from data** and **communicating back with them** about 'this is what we're learning about with populations' and **working with them to figure out how it changes what we do and what they do**."
>
> *- County Administrator*

Most counties (n=7) noted their **relationships with their partners** as being key assets for the work. In general, informants indicated that they were not necessarily working with new partners but working with them in new ways. For example, as one county described their relationship with their Medi-Cal managed care plan, "I don't think we've worked with [the plan] in this way to share data and learn from data and communicating back with them about 'this is what we're learning about with populations' and working with them to figure out how it changes what we do and what they do." Many also noted the pilot to help them weave together partners to begin creating a more cohesive, comprehensive network. As one county administrator put it: "What's new is convening and bringing together new partners – for example, homeless shelters talking with the hospital system—and that's what WPC has done for us in a very short period of time." Some informants also noted the pilot as providing a platform for them to deepen practice change. "This pilot gives us the ability to communicate with providers about what we're doing and how to change practices," described a county administrator.

Finally, a few informants (n=3) also discussed the support from DHCS, its implementation partners, and other participating counties as a valuable asset to collect and build on lessons learned. Part of this is built into the learning collaboratives that DHCS has developed, as well as the Plan-Do-Study-Act (PDSA) continuous learning and improvement process that the state requires counties to utilize in their pilots.[86] However, cross-county learning is already beginning to take place through exchange of resources (e.g., language around data sharing). One informant also mentioned beginning conversations with another participating county to explore potential cross-county, regional strategies around service delivery.

> "We're using this as an opportunity to **rethink certain things** and always **ask questions of how we can do things differently** with the **mindset of tearing down walls** that affect how we deliver services."
>
> *- County Administrator*

Many noted **the will from leadership and other stakeholders to change the current system** as crucial for maintaining momentum and investment in the work (n=6). "One of the things working in our favor to make this successful is commitment of county leaders, our CEO, and board members," said a county administrator. "We've had a lot of support from our board of supervisors…Across the political spectrum, we've had a lot of support," stated another county administrator. Key to this support is genuine interest in trying new approaches to service delivery. As one county administrator noted: "We're using this as an opportunity to rethink certain things and always ask questions of how we can do things differently with the mindset of tearing down walls that affect how we deliver

services." A number of key informants (n=3) identified initial stakeholder engagement in developing the pilot application as critical to generating buy-in around goals for the pilot and issues to address.

At the same time, several informants also noted that fostering these relationships and navigating its dynamics effectively will be an ongoing process. "All of those relationships have to be understood and navigated and supported and documented because the pilot makes you break out care coordination policies and procedures as a key deliverable," explained a county administrator. Another county administrator described the complexity of maneuvering within a collaborative leadership structure: "How do you have equal participation when the county holds the contracts and has all the deliverables and has to make financial decisions? You can't have a conflict of interest, which can be confusing for people in terms of which table you're sitting at and which decisions are being made."

Several counties also identified **existing data projects and/or previous work in this area** as a helpful foundation for advancing WPC-related work (n=3). For example, a few counties already have fairly sophisticated infrastructure, such as data systems that pull in information from multiple sources and/or have analytic capability (and as noted before, only three counties are creating new data sharing systems). Beyond technology, counties are also generally well-versed in this type of work. "We're not starting from scratch. This is giving us an opportunity to go further and innovate than we have in the past," stated a county administrator. Another explained that their pilot is modeling the WPC team structure from its work on another initiative.

Finally, a few informants highlighted the importance of the **funding**, not just in the dollars themselves but also its performance-based structure to allow flexibility in delivery while incentivizing counties to achieve quality outcomes (n=3). "I think that the structure of incentives and having performance-based funding is important. It makes people really sharpen up – if they don't succeed, they won't get funds," said a county administrator. As another described further, "The savings can be retained and used. It creates an incentive for lead entities to address this in creative ways. Counties aren't used to having this much flexibility; it's a real opportunity."[87]

Challenges: Internal Limitations to Overcome

> "We're constantly challenged with the **balance between privacy** and dealing with federal regulations on privacy as well as **sharing data and coordinating care** for folks."
>
> *- County Administrator*

Key informants most commonly indicated **data sharing** as a primary challenge with implementing WPC, especially given the central goals of creating and behaving like one coordinated system (n=8). This challenge has multiple dimensions:

- On the ***legal*** side, dealing with patient privacy, especially with SUD records, is a barrier to providing the kind of coordinated care that counties envision, for example with

mobile staff/navigators who have to locate people using limited information. "Folks will need to understand how to work in the care coordination team and how to understand HIPAA and privacy when they're out in the field working," said a county administrator. As another informant stated, "We're constantly challenged with the balance between privacy and dealing with federal regulations on privacy as well as sharing data and coordinating care for folks." Non-COHS counties also have to contend with dealing with multiple legal departments and reconciling language for data sharing and consent.

- ***Technologically***, constructing the system that can meet all of the pilot's needs is a challenge. Part of this involves communicating with different vendors and figuring out what works best for the county, especially when there is no one-size-fits-all solution. "There are many vendors that provide data sharing but since each WPC pilot is unique on its own, there's no good off-the-shelf solution for us," said a county administrator.
- There is also a ***cultural*** aspect with sharing information across different systems that mirrors silos at the service delivery level. As one county administrator put it, "Another challenge is getting people on the same page and getting the partners to let go of the mentality of 'this is mine' and trying to figure out more politically appropriate ways [to get around it]. People are used to staying in their own lanes, so when it comes to sharing, organizations struggle with that." Another discussed the nuance of differentiating between legal and cultural barriers: "A lot of the time, it's not legal. People cite HIPAA…but it allows for sharing of information if it's about treatment or payment or other reasons, so pushing back on some of these issues and recognizing it's about culture and concerns like 'I'm not used to sharing' or 'I'm not sure what will happen to the data' [can make a difference]."
- Finally, on the ***administrative*** side, key informants hope to avoid placing additional administrative burden for providers/staff in terms of entering information, as well as patients with having to sign multiple consent forms.

A few key informants also described the difficulty of **working nimbly in a bureaucratic structure** (n=4). From contracting and hiring, to obtaining new infrastructure and resources (e.g., vehicles), to creating new policies and procedures, a number of individuals spoke to the time needed to secure and organize the components needed for an ambitious, yet time-limited pilot. "It's challenging maneuvering through the bureaucratic system of county government to get county approval to move anything," stated a county administrator. "The bureaucracy of trying to do something innovative [is challenging]. Multi-agency work takes three times as long; it has three times the impact but very time-consuming. It takes time to get people to the table who you don't supervise," echoed another administrator. Finally, one county administrator described the effort needed to shift the cultural inertia: "What we're looking at with WPC and connecting social services with behavioral health and housing is something others might consider prioritization

"The bureaucracy involved in trying to do something innovative [is challenging]. **Multi-agency work takes three times as long; it has three times the impact but it's very time-consuming**. It takes time to get people to the table who you don't supervise."

- County Administrator

[of populations] because there are different service models for different populations. Shifting that thinking and having people open to that is a big change for the bureaucracy."

> "Engagement is always a challenge and **WPC is really a community engagement program as much as service delivery**. It's getting people to change how they do the work to communicate and collaborate more."
>
> *- County Administrator*

On a related note, several informants described the **inherent difficulty of transforming care** and, more simply, shifting away from the status quo (n=3). Changing the usual way of thinking and delivering service is not insignificant. Part of this involves working on interdisciplinary teams and bringing different skills and perspectives together under common goals and language. As one county administrator noted, "Engagement is always a challenge and WPC is really a community engagement program as much as service delivery. It's getting people to change how they do the work to communicate and collaborate more, and not to look at each other as competition," reflected another administrator. Moreover, the intricacies and emotional strain of coordinating care are augmented when delivering person-centered care for the types of complex populations that WPC counties are targeting. "How do you train people who haven't worked in those populations to build those relationships and dynamics to help people achieve their goals and help us achieve our goals?" said a county administrator. "Providing services differently instead of asking clients who have a lot of challenges to come and find care when it's not always easy for them—they don't have phones, they need to take a bus—going to them instead of asking them to seek care [is difficult]," explained another administrator.

Finally, while the pilot structure aims to maximize flexibility for counties, a few informants stated the difficulty of **striking the optimal level of flexibility in the pilot** (n=3). On one hand, a county administrator spoke about the initial lack of focus in federal and state expectations: "We're sort of building the ship as we're leaving the port. One of the biggest challenges is lack of clarity and specificity of what was required of us in terms of reporting." However, as counties begin implementation, others discussed the need to preserve flexibility. "There have been counties…who [originally] said, 'We want to hire more staff,' but realized it would be more bang for their buck to dedicate those funds to their data system but the state said, 'You have to go with what we approved in your budget,'" described another administrator. Thus, while counties generally acknowledged the pilot structure as being flexible, the ability to pivot and adjust original strategies as needed is also bounded by administrative structures. As one administrator described, "The opportunity of WPC was to innovate and test changes...There's also a challenge there because we have to fit within the budgetary guidelines the state is putting on us. We understand they have to report back to CMS so we're trying to work within our boundaries but still have flexibility."

Opportunities: Other Avenues for Advancing the Work

A number of informants discussed the role of **other Medi-Cal programs** to complement WPC activities. As part of Medi-Cal 2020, PRIME and the Drug Medi-Cal Organized Delivery System

waiver have the most explicit overlap with WPC and behavioral health integration efforts. As Table 9 showed, many counties have intentionally bridged their DMC and WPC projects. One county administrator described active efforts to coordinate PRIME and WPC activities: "We realized in looking at our care coordination effort that there was some outreach to PRIME clients and we could've duplicated some calls. We realized this would be the time to streamline and share information from the call."

The shared, overarching goals of CCI, and information gathered from its implementation thus far, also suggests that there could be opportunities to use lessons learned to inform WPC, as discussed in more detail in the next section.

Several people also spoke of the potential of **non-Medi-Cal initiatives**, particularly those related to public health and social determinants of health, to create environments that promote wellness and prevention. "WPC is bigger than these very narrowly defined populations," a county administrator commented. "Even if people do their hard work for those populations, how do we think about addressing prevention and social determinants of health that might be holding back all those communities and others as well?" California's Accountable Communities for Health Initiative is one potentially reinforcing effort with a similar approach of using cross-sector collaboration and flexible funding (through a Wellness Fund) to reduce costs and improve health outcomes. Three of the six grantee sites are in WPC counties.[88] Another administrator noted that nonprofit hospitals' community benefits programs, which are required for maintaining tax-exempt status, could be leveraged for WPC. Before the ACA, hospitals often provided charity care to meet this requirement. More recently, there have been greater efforts to shift community benefit dollars toward bolstering community health initiatives, including accountable health communities.[89]

> "WPC is bigger than these very narrowly defined populations. Even if people do their hard work for those populations, how do we think about **addressing prevention and social determinants of health** that might be holding back all those communities and others as well?
>
> *- County Administrator*

Threats – External Challenges to Successful Implementation

Although WPC funds are available to provide housing services, they do not necessarily address supply of housing. The **shortage and unaffordability of housing** in California is a formidable issue; the bottom quarter of low-income families in California spend two-thirds of their income on housing, compared to 55 percent for Americans in general. In addition, the pace of current housing construction as compared to population growth is less than half of what it used to be in 1970 to 1980.[90] A few key informants explicitly mentioned this as presenting a major challenge to their work (n=3). "The lack of housing is probably the most critical challenge we have," mentioned one county administrator. "A lot of our success is based on the assumption that we'll able to build more housing and encourage more existing housing to be used for affordable and supportive housing." While delving deeper into housing policy is beyond the scope of this study, California's current housing crisis, coupled with the emphasis in WPC on populations

experiencing homelessness, makes the shortage of affordable housing an issue that cannot be disregarded in the course of implementation.

2016 CPCA survey results: Insufficient workforce was the most commonly cited barrier to access of mental health (92 percent) and SUD services (44 percent).

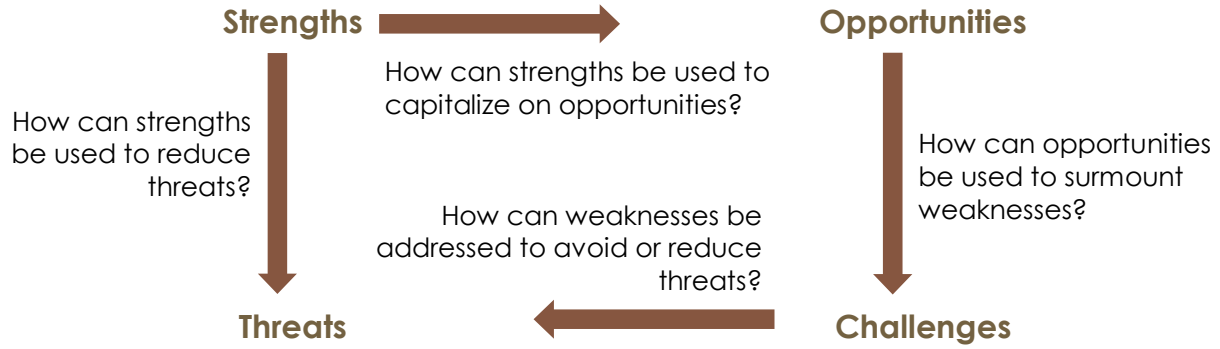
Another challenge is the **shortage of behavioral health provider workforce**. While many WPC pilots are using funds to address this, as shown in Table 10, there are some indications that this may prove to be a limiting factor to success. In the 2016 CPCA survey, insufficient workforce was the most commonly cited barrier to access of behavioral health services for both mental health (92 percent) and SUDs (44 percent). Almost a third (29 percent) cited shortages in workforce, including providers that were bilingual and/or culturally competent, as a challenge to deepening integration.[91] There are also several policy barriers that constrain health centers' ability to finance behavioral health service delivery. A longstanding issue is that Medi-Cal gives FQHCs only one payment even if a patient has medical and behavioral health visits on the same day.[92] Reimbursement for field-based services and/or services provided by non-professionals, a key strategy in WPC pilots, has also been a challenge since services generally need to be provided on-site and billable to providers in order to be reimbursed. A recently introduced bill, SB 456 (Pan) aims to address this by amending the Welfare and Institutions Code to ensure that FQHCs and Rural Health Clinics can be contracted to provide and be reimbursed for "services that follow a patient."[93]

Finally, **potential changes to Medicaid at the federal level** poses a potential threat to the Medi-Cal program. Though the Trump administration has not yet indicated its strategy with state waivers, changes to other provisions, such as Medicaid expansion, would have a major impact on Medi-Cal beneficiaries and Medi-Cal as a whole. The UC Berkeley Center for Labor Research and Education projected that, under the American Health Care Act (AHCA) as presented in Congress in March 2017, almost four million Californians would lose Medi-Cal coverage and the state would lose $130 billion in Medi-Cal funding from 2020 to 2027 if it could not cover the federal cuts.[94] While the AHCA has since been withdrawn, uncertainty surrounding the status of Medicaid has still put pressure on the safety net. "Local players may be dragged into more immediate, pressing things…for instance, if people become uninsured again or if public hospitals are facing possibility of failing because of insufficient funding," said a senior foundation staff member. "It was a heavy lift even in the environment when [Medi-Cal 2020] was approved. It's harder now."

STRATEGIC CONSIDERATIONS FOR WPC

It is important to recognize that these three initiatives are still relatively nascent. Though it is the most established of the three, CCI is still only several years old and it will take time to see substantial changes. WPC has only recently gotten off the ground (with a second round of applications still under review), and HHP implementation has been delayed until 2018. Nevertheless, it is worthwhile to investigate how strengths and challenges in WPC, as identified in the previous section, could interact with opportunities and threats to anticipate major decision points as the initiatives progress. Figure 14 presents the strategic questions that arise when crosswalking these features.

Figure 14: Strategic Questions



Using the lens of WPC, this section serves to analyze the questions posed in Figure 14 and present several considerations for policymakers and administrators, as summarized in Table 13 and followed by further description of each. These strategic choices would *tighten* intersections between initiatives, *alleviate* pressures of threats, *adapt* and build on lessons learned, and *position* the state to confront difficult choices. These are not mutually exclusive and are intended to work in concert with each other.

Table 13: Strategic Considerations for Medi-Cal

Domain*	Strategic Lever	Considerations
SO	Tightening	▪ Aligning Medi-Cal initiatives ▪ Assessing readiness to braid or blend funding at the state level
ST	Alleviating	▪ Intensifying efforts in workforce development ▪ Forging strategies that continue bridging Medi-Cal and housing
CO	Adapting	▪ Sharing lessons learned from other initiatives ▪ Harnessing non-Medi-Cal initiatives and examining departmental silos
CT	Positioning	▪ Developing a common vision of integration ▪ Identifying non-negotiable components

*S = Strengths, C = Challenges, O = Opportunities, T c= Threats

DISCUSSION

Strengths-Opportunities (SO): Tightening Intersections between Initiatives

Tightening:

- Aligning Medi-Cal initiatives
- Assessing readiness to braid or blend funding at the state level

- **Aligning Medi-Cal initiatives**. There is a significant amount of momentum behind all three initiatives, and WPC in particular. As implementation of WPC rolls out, many informants noted the importance of teasing out the different eligibility criteria of the initiatives to reduce the risk of duplicating services. At the same time, there appears to be room to better understand how these initiatives are aligned in terms of common goals and measures. In interviews, informants generally spoke of limited crossover between CCI, HHP, and WPC, as described further in Figure 15.

Figure 15: Limited Crossover Between Medi-Cal Initiatives

Among those originally scheduled to implement **HHP**, few informants discussed synergies with WPC, though this was largely due to uncertainty surrounding the implementation timeline of HHP implementation. However, a few noted the direct leveraging of the two in their strategy. "Though patient-centered medical homes (PCMH) can't duplicate WPC services, we're using WPC to further extend services available at our PCMH because…PCMH is there for clinical purposes and can't pay for social services, whereas WPC can assist there," described one informant. Another talked about HHP playing a key role in their plans' participation in WPC: "[Plans] know what's happening [in WPC] and they're keeping us in mind and vice versa. This was key to [their] participation in WPC because they're looking ahead to HHP and said, 'We want to work with you on WPC because it sets up the future of HHP.'"

Due to the different target populations in **CCI** and/or being addressed by a different agency/department, informants generally noted this was a predominantly separate effort from WPC. Engagement with CCI varied from not being aware of CCI at all to being involved with initial discussions but not with actual implementation. A few, however, indicated that CCI was on their radar in the course of implementing WPC and other integration work. "We're trying to make sure we keep all of those stakeholders in good touch with us so we don't create redundant work," said one informant.

Yet, as discussed in this study, the initiatives share overarching goals, have similar activities, and involve many of the same entities, which has operational and strategic implications for the state and counties. *Operationally*, aligning initiatives would help implementing entities piece together different services to ensure that beneficiaries are neither "over-managed" nor do they fall through the cracks. This would also help key players use resources more efficiently when trying to comply with different programs. As a senior foundation staff member put it, "It's really important for local communities to think about how these things fit together and how they can be mutually reinforcing…Is there potential for overlap, or ways to use resources for an initiative when you don't have use for it in another?" This may also help to clarify the roles of

different stakeholders across the initiatives and identify opportunities to reduce administrative burden, such as in data collection.

Understanding how the initiatives interlock can also add clarity to *strategic* focus. Using quality metrics as indicators of each initiative's vision of change, there seems to be considerable commonality in the initiatives' desired outcomes, as shown in Table 5. Thus, while the initiatives have different focus areas and target populations, keeping the initiatives entirely separate in strategy put the state and counties at risk of preserving or deepening silos and missing key opportunities to reinforce and amplify reforms that contribute to whole-person care more broadly. This risk becomes elevated without a common vision of care coordination and patient-centered care (see "Challenges-Threats"). The state should capitalize on the collective energy across different counties and initiatives to develop a comprehensive theory of change or logic model to (1) visualize the various programs, which include the three mentioned in this report as well as others (e.g., PRIME, DMC), and (2) articulate a "master" strategy for achieving the Medi-Cal vision of more coordinated systems.

- **Assess readiness to braid or blend funding at the state level.** In general, county informants extolled the ability to use WPC funds for traditionally non-reimbursable elements like infrastructure development and service delivery innovation. As a result of the ACA, states have had more flexibility to test out innovative payment and delivery models, including braided and blending funding. Braided funding involves coordinating different funding streams that maintain their original administrative requirements, while blended funding pools different funds together. In WPC, flexible housing pools represent a "braided" funding approach that nearly all participating counties are employing to address housing instability. This is not a novel approach for California or WPC; prior to WPC, several counties had already implemented braided funding structures for safety net populations, and CMC is a blended (Medicare and Medi-Cal) approach.[95] This suggests that the state should assess its readiness to use braided or blended funding across multiple departments beyond Medi-Cal (e.g., community development, food security, social services) to fund services that span beneficiaries' range of needs.[96] Especially as proposals to change Medicaid continue to roll out, the state will need to think creatively about how it will fund services for Medi-Cal beneficiaries and avoid losing the ground it has gained on addressing housing and other social determinants of health.

Strengths-Threats (ST): Alleviating the Pressure of Threats

- **Intensifying efforts in workforce development.** The lack of behavioral health workforce is a widely recognized issue; a 2012 needs assessment of California's behavioral health system found, among other things, a dearth of certified Addiction Psychiatrists in the state and disparities in the availability of psychiatrists between rural and

Alleviating:

- Intensifying efforts in workforce development
- Forging strategies that continue bridging Medi-Cal and housing

urban counties.[97] WPC, in part, is a response to these issues, with many pilots using WPC funds to provide training and incorporate non-professionals in service delivery (e.g., peers) to address workforce shortages and increase cultural sensitivity. Especially with ongoing DMC implementation, it is worth considering how funding and other resources could be leveraged to continue building mental health and SUD workforce. On the reimbursement side, bills that establish financing mechanisms that are both adequate and appropriate for WPC's new service delivery models may merit particular attention. In addition, there could be efforts to investigate strategies that strengthen the provider pipeline, such as partnerships with schools and workforce development programs, especially for more rural and/or underserved areas.

An important, related issue is the diversity of behavioral health workforce. The needs assessment found an underrepresentation of Hispanic/Latinos and African Americans in the behavioral health workforce, which is largely Caucasian and English-speaking only.[98] Currently, almost half (46 percent) of Medi-Cal managed care beneficiaries are Hispanic/Latino.[99] Since this is not explicitly reflected in required metrics for WPC, the state may want to consider how it is addressing and/or tracking workforce diversity and representation in WPC (and other initiatives).

- **Forging strategies that continue bridging Medi-Cal and housing.** The central role of housing in a person's health is reflected in the strategies and aim of WPC and participating counties. However, California's lack of affordable housing suggests this may pose a limiting effect on the impact of WPC and whether individuals can reach their goals. It will be important for counties to solidify and capitalize on the relationships developed through WPC with housing authorities and organizations to advance mutual goals in health and housing. Recently, there has been significant momentum at the state level to address homelessness and the shortage of affordable housing. Signed into law in July 2016, No Place Like Home is a program that will provide $2 billion in competitive and non-competitive loans to counties to develop permanent supportive housing units.[100] In December 2016, AB 74 (Chiu) was introduced, proposing to create the Housing for a Healthy California Program and dedicate $90 million in state housing funds toward rent subsidies for homeless Medi-Cal beneficiaries, thereby directly complementing WPC.[101] The extent to which these types of programs will mitigate housing issues remains to be seen. What is clear, however, is that the state will need to consider more strategies that address Medi-Cal/the health care safety net in conjunction with homelessness/housing given the inextricable link between health and housing and as Medicaid becomes an increasingly prominent partner in supportive housing initiatives.

  The state may also need to design and/or consider more ambitious proposals, such as using health care dollars or savings to build housing. For example, New York recently launched a Medicaid Redesign Team project to use some of its Medicaid savings toward constructing new supportive housing units.[102] However, this may necessitate more

substantive payment reform as well as a deeper paradigm shift in terms of how health care/Medicaid dollars are used.

Challenges-Opportunities (CO): Adapting and Building on Lessons Learned

Adapting:

- Sharing lessons learned from other initiatives
- Harnessing non-Medi-Cal initiatives and examining departmental silos

- **Sharing lessons learned from other initiatives.** As counties continue to confront the challenges with implementing WPC, there are likely valuable lessons learned from other initiative. Experiences from CCI/CMC in particular may help entities implementing WPC avoid similar pitfalls and inform strategies that address common themes such as care coordination and data sharing. In fact, many of the challenges that CMC has faced are those that are likely to arise (or have arisen) in the course of carrying out WPC. For example, challenging areas of implementation that CMC's first phase of evaluation uncovered, and may be relevant for WPC, included having a sufficient range of provider options, ensuring access to specialty care, executing team-based care, and ensuring beneficiaries were aware of available services and able to communicate their needs. In their report on the health system's response to implementing CMC, the evaluation team recommended that CMC plans share promising practices in serving challenging populations, such as those experiencing homelessness and/or behavioral health issues.[103] The relatively short timeline of WPC/Medi-Cal 2020 further underscores the need to gather and build on knowledge as efficiently as possible. Thus, the state and counties should think about how they are facilitating cross-initiative learning (e.g., in-person convenings, peer collaboratives, webinars). This can also help cultivate a strong foundation for when HHP implementation is underway.

- **Harnessing non-Medi-Cal initiatives and examining departmental silos.** Though this report focuses on integration of medical and behavioral health care, it is important to reiterate that the ultimate goal is advancing whole-person care. Thus, a key component of transforming care delivery is coordination of services that address social determinants of health. In addition to the California Accountable Communities for Health Initiative, Let's Get Healthy California, an initiative spearheaded by the California Department of Public Health, also has delivery system reform goals.[104] Yet it is not clear how these initiatives are intended to work alongside the Medi-Cal initiatives operationally. Identifying and articulating these relationships may help with strengthening collaboration, aligning strategic visions, and understanding mutually reinforcing capabilities of different entities.

  Transforming service delivery may also require examining any bureaucratic silos in which state health departments operate. While public health and Medi-Cal represents one possible silo, there may also be room for greater alignment of programs within DHCS itself. The Mental Health Services Act (MHSA, or Proposition 63), for example, has generated about $12 billion since 2004 for counties to deliver community-

based mental health services.[105] Some counties have used MHSA funds to support pilots that integrate mental health with primary care. Furthermore, a number of WPC counties noted in their applications that they were using MHSA funds as a local funding source to draw down the federal match. Yet, most of the money has traditionally gone to county mental health to draw down federal funds for specialty mental health services and, thus, has been funneled into a system largely separate from Medi-Cal. One senior foundation staff member noted that, with growing integration efforts, it would be useful to "really understand the role of MHSA in a post-ACA environment and post-waiver environment." How this translates into financing is also a key, related issue to examine.

Challenges-Threats (CT): Positioning the State to Confront Difficult Choices

Positioning:

- Developing a common vision around integration
- Identifying non-negotiable components

- **Developing a common vision around integration.** Similar to the issue of having multiple initiatives, it is unclear whether there is a common vision of the level or type of integration that the state hopes to achieve. Even within one initiative, there may be significant differences; the first phase of CMC evaluation found potential variation in how care coordination was defined among different CMC plans (e.g., utilization review versus completion of a Health Risk Assessment) and the degree to which Health Risk Assessments contributed to patient-centered care.[106] Taking into account additional initiatives, without a common vision or definitions, only compounds this variation. As one external expert noted, "Integration means different things to different entities. We don't yet have a vision around medical and behavioral health integration in terms of why it's needed…and who does it benefit—providers, payers, or beneficiaries?" Lack of consensus on the definition of integration is also true at the national level.[107]

  As a result, the state should play a role here in aligning the different understandings of integration and generating a shared vision for what a more "integrated" system will look like upon completion of the pilot (and integrated for whom). While the state wants to allow counties flexibility to implement care coordination as appropriate for their local context, it will need to think about whether there is latitude with the vision of service delivery reform it intends to achieve by 2020 and beyond. This may also require developing a better understanding of the impact of the carve-outs in Medi-Cal and how these may or may not align with the state's goals around integration and, more broadly, whole-person care.

- **Identifying non-negotiable components**. The WPC pilot has ambitious goals amidst a time-limited waiver and an uncertain Medicaid landscape. One strategic question that the state will have to ask, pending changes, is, "What would have to be true to ensure we deliver high-quality whole-person care to Medi-Cal beneficiaries?" One way to answer this is to identify non-negotiable components of its, and counties', strategies, or in other words, what would have to remain/be in place despite any changes to Medicaid. This aligns with the need to construct a common vision of integration.

Even at this very early stage of implementation, county informants identified several non-negotiables:

- Data sharing and IT infrastructure
- Continued commitment to WPC and overall system transformation
- Relationships with partners and patients
- The role of navigators and physically going out into the community to engage patients
- Patient population stratification/targeting those most in need of services

These may certainly change over the course of implementation, but this type of thinking could contribute to visual/strategic tools such as backward maps to forecast potential scenarios under a different Medicaid structure. Similarly, key informants also identified planning for sustainability as a non-negotiable component. This involves both a commitment in strategy and funding from the state. "The state needs to demonstrate real, long-term commitment especially since WPC takes a long time to get off the ground…and [the payoff] doesn't happen as fast as policymakers would like," explained an external expert. Thus, while counties are contributing the non-federal match for the waiver period for WPC in the immediate term, the state will need to decide where it will set its stake in the ground both in terms of the level of funds it will dedicate and the course it will chart with transforming care in Medi-Cal.

CONCLUSION

The Medi-Cal program is at a major crossroads. State spending on Medi-Cal spending has continued to grow, and the flow of federal funding remains a top concern. With the concurrence of a new administration and implementation of WPC and the Medi-Cal 2020 waiver, it is a pivotal time to examine how the state and counties will plan and position themselves for the greatest chance of success in transforming service delivery and fulfilling the promise of whole-person care. In order to do this, three overarching questions the state and counties must ask are:

(1) **What must we do?** How should we respond to the external environment, i.e., opportunities and threats?
(2) **What do we want to do?** What are our goals?
(3) **What can we do?** What are our strengths and internal challenges?

Using WPC as the central point for discussion, this report has sought to answer the first and third questions, in efforts to inform the state and counties' thinking on the second. While many discussions about the next stage of evolution for Medi-Cal still remain, this study has ideally presented a range of strategic options for policymakers and administrators as they continue to strengthen the health care safety net and enhance the health, wellness, and recovery of vulnerable communities throughout California.

APPENDIX A: LIST OF KEY INFORMANTS

State Agencies/Departments
Robert Ducay – California Health and Human Services Agency
Brian Hansen – California Department of Health Care Services

Trade Associations
Allie Budenz – California Primary Care Association
Allison Homewood – California Association of Public Hospitals and Health Systems
Linnea Koopmans – County Behavioral Health Directors Association
Meaghan McCamman – California Primary Care Association
Liz Oseguera – California Primary Care Association

Technical Assistance Providers/Consultants/Evaluators
Molly Brassil – Harbage Consulting
Jennifer Clancy – Jen Clancy Consulting
Carrie Graham – Health Research for Action, UC Berkeley
Hilary Haycock – Harbage Consulting
Michelle Herman Soper – Center for Health Care Strategies
Karin Kalk – California Institute of Behavioral Health Solutions/Independent Consultant
Marian Liu – Health Research for Action, UC Berkeley
Lucy Pagel – Harbage Consulting
Will Rhett-Mariscal – California Institute of Behavioral Health Solutions
Julie Stone – Mathematica Policy Research

Foundations
Catherine Teare – California Health Care Foundation
Rachel Wick – Blue Shield of California Foundation

Counties and Health Plans
Ernie Barrio and Ron Boatman – San Bernardino County
Susan Bower – San Diego County
Amy Carta and Emily Chung – Santa Clara County
Nancy Halloran – Alameda County
Deanna Handel – Ventura County
Ed Hill – Kern County
Maria Martinez – San Francisco County
Robert Moore – Partnership HealthPlan
Judi Nightingale – Riverside County
Robert Oldham – Placer County
Peter Shih – San Mateo County
Melissa Tober – Orange County
Amy Turnipseed – Partnership HealthPlan

APPENDIX B: FREQUENTLY USED ACRONYMS

Acronym	Full Name	Definition
CCI	Coordinated Care Initiative	One of the three Medi-Cal initiatives explored in this study. It includes (1) the Cal MediConnect (CMC) demonstration, (2) mandatory enrollment of dual eligible beneficiaries into Medi-Cal managed care, and (3) inclusion of Long-Term Supports and Services (LTSS) in managed care.
CMC	Cal MediConnect	One of the three components of CCI; also known as California's duals demonstration in which managed care plans enter a three-way contract with CMS and DHCS to provider both Medicare and Medi-Cal benefits to dual eligible beneficiaries.
CMS	Centers for Medicare and Medicaid Services	The federal agency responsible for oversight of Medicaid as well as reviewing, approving, and monitoring state waiver programs.
DHCS	(California) Department of Health Care Services	The state department responsible for administering Medicaid programs, including Drug Medi-Cal.
DMC	Drug Medi-Cal	Substance use disorder services for Medi-Cal beneficiaries. The Drug Medi-Cal Organized Delivery System, authorized under Medi-Cal 2020, is the expanded DMC waiver program in opt-in counties.
FFS	Fee for service	A payment model in which providers are reimbursed for each service or visit (as opposed to PMPM, where payment is based on enrollment).
FQHC	Federally Qualified Health Center	Community clinics that must meet federal requirements to receive certification as a FQHC. They provide comprehensive primary care services and primarily serve Medicaid and uninsured patients.
HHP	Health Homes Program	One of the three Medi-Cal initiatives explored in this study. Under Section 2703 of the ACA, the program allows California to provide enhanced care coordination to Medi-Cal beneficiaries with multiple chronic conditions.
LTSS	Long-Term Supports and Services	Assistance services and supports provided in homes, community-based settings, or facilities to individuals experiencing aging, chronic illness, and/or disability and have challenges with daily living activities.
PMPM	Per member per month	A payment model in which providers receive a fixed amount based on the number of enrolled members each month rather than volume (i.e., FFS). Also known as capitation.
SAMHSA	Substance Abuse and Mental Health Services Administration	The federal agency that supports public programs and provides resources related to behavioral health (substance use disorders and mental health).
SMI	Serious or Severe Mental Illness	Categorization defined in state law for any mental illness that results in substantial impairment in daily living activities for adults (18 years and older). Services for these individuals are "carved" out of Medi-Cal managed care benefits for physical health and mild-to-moderate diagnoses and are covered by county mental health plans under the Specialty Mental Health Services waiver.
WPC	Whole Person Care (pilot)	The primary Medi-Cal initiative, and one of three, explored in this study. Part of the Medi-Cal 2020 waiver, this program provides $1.5 billion in federal matching dollars for local entities to improve coordination of physical health, behavioral health, and social services and delivery of patient-centered care.
SUD	Substance use disorder	Defined by SAMHSA as "recurrent use of alcohol and/or drugs [that] causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home."

APPENDIX C: COUNTY CROSSWALKS

Table C1: County Initiative Participation and Geographic Characteristics

	Initiatives				Other Pilots		Geography	
County	CCI	HHP	WPC	Total	DMC-ODS Plan Status	PRIME Project 1.1 *(DPHs only)*	Region	County Size (sq. miles)
Alameda		Group 3	x	2	Drafted	x	Bay Area	Small (<1000)
Contra Costa			x	1	Approved	x	Bay Area	Small (<1000)
Kern		Group 3	x	2	Drafted	x	South Valley/Sierra	Large (>5000)
Los Angeles	x	Group 3	x	3	Approved	x	Los Angeles	Med-large (3001-5000)
Monterey		Group 2	x	2	Approved	x	Central Coast	Med-large (3001-5000)
Napa		Group 1	x	2	Drafted		Bay Area	Small (<1000)
Orange	x	Group 2	x	3	Drafted		Orange	Small (<1000)
Placer			x	1			North Valley/Sierra	Medium (1001-3000)
Riverside	x	Group 2	x	3	Approved	x	Inland Empire	Large (>5000)
San Bernardino	x	Group 2	x	3	Drafted	x	Inland Empire	Large (>5000)
San Diego	x	Group 3	x	3		x	San Diego	Med-large (3001-5000)
San Francisco		Group 1	x	2	Approved	x	Bay Area	Small (<1000)
San Joaquin			x	1		x	Central Valley/Sierra	Medium (1001-3000)
San Mateo	x	Group 2	x	3	Approved	x	Bay Area	Small (<1000)
Santa Clara	x	Group 2	x	3	Approved	x	Bay Area	Medium (1001-3000)
Shasta		Group 1	x	2			North Counties	Med-large (3001-5000)
Solano		Group 1	x	2			Bay Area	Small (<1000)
Ventura			x	1	Approved	x	Central Coast	Medium (1001-3000)

Notes:
- *Total (Count of Initiatives):* This is the total number of initiatives that counties are implementing of the three examined in this report and is not a comprehensive list of all initiatives that counties may be implementing.
- Drug Medi-Cal Organized Delivery System (DMC-ODS) implementation plans can be found on DHCS website: http://www.dhcs.ca.gov/provgovpart/Pages/County-Implementation-Plans-.aspx
- Full list of PRIME projects can be found here: http://www.dhcs.ca.gov/provgovpart/Documents/PRIME/PRIMEProjectSelections-ADA.pdf
- Regions based on Department of Consumer Affairs
- County size categories from DHCS summary: http://www.dhcs.ca.gov/provgovpart/Documents/WPCProgramOverview.pdf

Table B2: WPC Pilot and Medi-Cal Data

County	WPC Pilot			Medi-Cal Managed Care (MMC)		County Mental Health Plan		
	Number of Beneficiaries	Funding Amount	Type of Lead Entity*	Model	Percent of Population Enrolled in MMC	Annual Count of Beneficiaries Served	Penetration Rate	Percent Served that are High-Cost
Alameda	20,000	$283 m	County	Two Plan	20%	22,254	7.1%	4.5%
Contra Costa	52,500	$204 m	County	Two Plan	18%	13,786	7.2%	4.8%
Kern	2,000	$157 m	Hospital Authority	Two Plan	34%	13,134	4.4%	1.4%
Los Angeles	137,700	$900 m	County	Two Plan	28%	161,888	5.6%	2.3%
Monterey	500	$27 m	County	COHS	34%	5,096	3.8%	5.3%
Napa	800	$23 m	County	COHS	20%	1,284	5.3%	2.2%
Orange	8,098	$24 m	County	COHS	24%	21,342	3.4%	0.5%
Placer	450	$20 m	County	Regional	13%	2,035**	4.6%	1.8%
Riverside	38,000	$35 m	BH Department	Two Plan	27%	23,607	4.1%	1.1%
San Bernardino	2,000	$25 m	DPH	Two Plan	30%	30,057	4.7%	0.9%
San Diego	1,049	$44 m	County	GMC	20%	34,712	5.8%	1.5%
San Francisco	10,720	$118 m	DPH	Two Plan	18%	15,070	9.4%	8.7%
San Joaquin	2,130	$18 m	County	Two Plan	32%	10,615	4.8%	1.4%
San Mateo	5,000	$165 m	County	COHS	15%	5,836	5.3%	4.7%
Santa Clara	10,000	$226 m	DPH	Two Plan	17%	17,444	5.4%	6.6%
Shasta	600	$19 m	County	COHS	35%	3,353	6.9%	1.9%
Solano	250	$5 m	County	COHS	27%	3,002	3.4%	4.8%
Ventura	2,000	$98 m	DPH	COHS	24%	7,506	4.5%	2.7%

*BH = Behavioral Health, DPH = Designated Public Hospital

**Placer's county mental health plan data reflects an aggregate of Placer and Sierra Counties' data.

Notes:

- WPC pilot information from DHCS summary: http://www.dhcs.ca.gov/provgovpart/Documents/WPCProgramOverview.pdf. Funding amounts have been rounded to the nearest million.
- Percent of Population in Enrolled in Medi-Cal Managed Care: Numerator from DHCS monthly enrollment data from Jan 2016. Denominator from January 2016 population estimates from the California Department of Finance. Percentages include all age groups.
- County mental health plan data from Behavioral Health Concepts (EQRO) FY 2015-2016 reports: http://bhceqro.com/#!reports_and_presentations. "High-cost" indicates that the beneficiary had at least $30,000 in claims in a year.

APPENDIX D: INITIATIVE EVALUATION ACTIVITIES

Figure D1: Initiative Evaluation Activities and Goals

Initiative	Activities	Goals
CCI (CMC)*	Annual federal evaluation	Monitor and evaluate impact of demonstrations in Financial Alignment Initiative on beneficiary experience, quality of care, access and utilization, and costs.
	Dual Eligible Plan Choice Report	Understand beneficiary experience with health plans, communications (notices, guidebook, and enrollment forms), and passive enrollment. First study in 2014 with Los Angeles and Long Beach Counties, with a similar one conducted in 2015 with those who opted out of CMC.
	Rapid Cycle Polling Project**	Phone surveys across 5 CMC counties and 2 non-CMC counties to compare beneficiaries' confidence and satisfaction with health care service delivery. Three waves completed to date.
	Three-year CMC evaluation**	Conduct focus groups with beneficiaries and interviews with health plans to examine coordination of medical care, behavioral health care, and LTSS. Two rounds completed.
HHP***	Evaluation within 2 years after implementation	Assess fiscal sustainability of program design and impact on Triple Aim goals, in addition to reporting on a core set of health care quality and utilization indicators.
WPC	Mid-point and final evaluation	Assess improvement of care coordination, improvement in beneficiary health outcomes, reduction of avoidable utilization of emergency and inpatient services, increased access to social services, and improvement in housing stability (if applicable).
	Mid-year and annual progress reports from lead entities	Collect participant data, type and volume of service utilization (medical, non-medical, ED, inpatient services), and total amount spent, as well as data to measure the outcomes for the statewide evaluation.

*Managed care plans are also required to submit data to the National Opinion Research Center for compliance with federal and state requirements.
**Funded by the SCAN Foundation.
***Based on DHCS concept paper

APPENDIX E: WPC SERVICES SUMMARY

The content in the following table is taken and adapted from counties' full WPC applications, which can be found on DHCS' website: http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilotApplications.aspx. "n/a" in the "Discrete Services" column indicates that the pilot did not list any services for that service type in its application.

Table E1: Discrete and Bundled/PMPM Services in Round 1 WPC Counties

County	Discrete Services	Bundled/PMPM Services
Alameda	▪ Housing education and legal assistance ▪ Client move-in and landlord funds ▪ Expanded linkage to SUD treatment: Sobering Center, SUD Diversion Program, portals to SUD treatment, residential helpline ▪ Behavioral health care coordinators at FQHCs ▪ Nurse care coordination and patient navigators in behavioral health treatment centers ▪ Expanded street outreach services to homeless	▪ Care management service bundles: 2 tiers (homeless, not homeless) ▪ Enhanced housing transition service bundle ▪ Housing and tenancy sustaining supportive service bundle ▪ Skilled nursing facility housing transition bundle
Contra Costa	▪ Sobering Center	▪ Complex care management: 2 tiers (intensive teams led by public health nurses, social teams led by social workers)
Kern	▪ Child care support services ▪ Beneficiary assessment training	▪ Housing navigation ▪ Employment services ▪ WPC care coordination, including mobile outreach/engagement ▪ 90-day post-incarceration coordination
Los Angeles	▪ Sobering Center	▪ *For homeless high-risk*: homeless care support services, benefits advocacy, recuperative care services, tenancy support services ▪ *For justice-involved high-risk*: re-entry services ▪ *For mental health high-risk*: Residential and Bridging Care Transitions, Intensive Service Recipient Services ▪ *For SUD high-risk*: engagement, navigation, and support ▪ *For medically complex*: transitions of care
Monterey	▪ Mobile Outreach Team	▪ Community-based case management services (housing supports): screening and assessment, individualized support plan, case management, placement referral to Coalition of Service Providers ▪ Complex care management team: public health community health workers/case managers, integrated with specialties in physical health, behavioral health, social services, housing, and life skills

County	Discrete Services	Bundled/PMPM Services
Napa	▪ Sobering Center ▪ Respite care ▪ Mental health support services ▪ Alcohol and drug services ▪ Multidisciplinary care access unit ▪ OLE Health coordinated clinic services ▪ Housing-related legal assistance	▪ Engagement team: clinical supervisor, care coordinator, nurse case management, peer support ▪ Coordinated Entry: consolidated assessment and screening, diversion, problem solving resources ▪ Tenancy care coordination services
Orange	▪ Recuperative and respite care	▪ Engagement, resource management, and information (Note: these are not "bundles," but rather services that hospitals/clinics will provide)
Placer	n/a	▪ Engagement: nurse, peer advocates, clinician specializing in co-occurring disorders, probation officer ▪ Comprehensive Complex Care Coordination (CCCC) Team: nurse, case manager(s), clinician with expertise in co-occurring disorders, 2 peer advocates, coordination support from probation officers and social work practitioners and contracted pharmacist ▪ Housing services ▪ Medical respite care: CCCC nurses, 1 licensed vocational nurse, respite staff
Riverside	▪ Screening and outreach services	▪ Care management services: Complex Care Case Managers, clinical therapists, and care coordinators will be equally distributed at each FQHC. Case Managers will facilitate care between primary care, behavioral health, and additional supportive services. After presenting at the FQHC, probationers will receive a customized Wellness Map that integrates with their electronic health record. ▪ Housing navigation and support services
San Bernardino	▪ Field-based outreach activity (patient navigators, clinical therapist, social worker)	▪ Case coordination: patient navigators, clinical therapist, social worker, registered nurse care manager, utilization review tech, alcohol and drug counselor, and enhanced care coordination
San Diego	▪ Phase 1 of Service Integration Team services: outreach/engagement and enrollment ▪ Post-enrollment care coordination, monitoring, and follow-up phases	Phases 2-5 of Service Integration Team services: ▪ (2) Stabilization: intensive housing navigation, care coordination, and development of care plan; ▪ (3) Maintenance: continued care coordination, monitoring of care plan, housing supports, and tenancy sustaining services; ▪ (4) Transition: moderate care coordination; ▪ (5) Aftercare: lower level care coordination and follow-up
San Francisco	▪ Dual diagnosis residential treatment ▪ Medical Respite expansion	▪ Engagement service bundles (Navigation Centers, shelters) ▪ Enhanced Care Coordination support: Coordinated Entry Lead, Clinical Services Lead, engagement specialist, and additional care coordinator

County	Discrete Services	Bundled/PMPM Services
San Joaquin	▪ Respite care ▪ Care coordination (mental health specialist) ▪ Behavioral Health Navigation Team	▪ Population Health Team: Coordinate with Behavioral Health Navigation Team to provide each client with individualized care plan and assist patient with navigating systems. Each client will be assigned a dedicated care coordinator within the team. Enhanced care coordination services (interpretation, transportation) will be available.
San Mateo	n/a	▪ Bridges to Wellness Team (care coordination, clinical management and supervision, driver and outreach worker, nurse, patient/medical assistants, pharmacist, social worker, enhanced care coordination) ▪ Behavioral Health and Recovery Services (case manager, peer supports, clinical management and supervision, data support, financial management, medical supervision, nurse, patient services assistant, physician, psych social work, public guardian support)
Santa Clara	▪ Peer respite services ▪ Medical respite services	▪ Rehabilitation and peer support teams ▪ Short-term care coordination (intensive care coordination) ▪ Mid-term care coordination (extended assessment period) ▪ Long-term care coordination (high of need)
Shasta	▪ Sobering Center ▪ Mobile Crisis Team	▪ Intensive medical case management ▪ Housing case management
Solano	n/a	▪ Complex Care Coordinator (CCC): mobilize relevant care systems ▪ Community Health Outreach Worker (CHOW): engage participants and address basic social service needs ▪ Other services (some may be non-PMPM): complex care coordination, tenancy advocacy, outreach/engagement, medical care
Ventura	▪ Mobile outreach services	▪ Field-based Care Coordination bundle: community health worker completes comprehensive assessment to develop integrated care plan and serve as lead for PCMH and connect with Care Coordination Team. ▪ Care coordination bundle: community health workers and care managers – at least one care manager will be a licensed mental health professional, and at least one will be a substance abuse specialist) will oversee identification, enrollment, and linkage to resources ▪ Engagement bundle: care coordination manager, nurse practitioner, and clinic assistant

ENDNOTES

1. Watkins, J. (2015, June 9). *Symposium Slides - Understanding Medi-Cal's High-Cost Populations.* Retrieved from the California Health Care Foundation - Data Symposium and Webinar on High Utilizers of Medi-Cal Services: http://www.chcf.org/events/2015/medical-data-symposium.

2. April 2017 DHCS Stakeholder Communication Update email.

3. Substance Abuse and Mental Health Services Administration (SAMHSA). (2014, October 30). *National Behavioral Health Quality Framework.* Retrieved from National Behavioral Health Quality Framework | SAMHSA: https://www.samhsa.gov/data/national-behavioral-health-quality-framework.

4. Kelch, D. (2015, October). *Locally Sourced: The Crucial Role of Counties in the Health of Californians.* Retrieved from the California Health Care Foundation: http://www.chcf.org/publications/2015/10/locally-sourced-crucial-role-counties.

5. Covered California. (n.d.). *Medi-Cal.* Retrieved from Medi-Cal Program Overview: http://www.coveredca.com/medi-cal/.

6. California Department of Health Care Services. (2017). *Medi-Cal Certified Eligibles - Recent Trends*. Retrieved from Medi-Cal Certified Eligibles - Recent Trends: http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx.

7. Tatar, M., Paradise, J., & Garfield, R. (2016, March 2). *Medi-Cal Managed Care: An Overview and Key Issues*. Retrieved from the Kaiser Family Foundation: http://kff.org/report-section/medi-cal-managed-care-an-overview-and-key-issues-issue-brief/.

8. California Department of Health Care Services. (2017, March 16). *Medi-Cal Managed Care Performance Dashboard – March 16, 2017 Release.* Retrieved from Medi-Cal Managed Care Performance Dashboard: http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx.

In April 2016, CMS issued a final rule on Medicaid managed care, otherwise known as the "Mega Reg," to revise existing managed care regulations to align standards across entities and with other insurance providers, add consumer supports and protections, strengthen network adequacy and access, and improve state accountabilty and transparency around quality of care. Implementation of individual provisions are phased in from 2016 to 2019. One provision clarifies what states are allowed to execute with regard to delivery and payment reform initiatives starting with the July 1, 2017 contract rating period. The Kaiser Family Foundation provides a more detailed overview of the provisions in the rule: http://kff.org/report-section/cmss-final-rule-on-medicaid-managed-care-issue-brief/.

9. Tatar, M., Paradise, J., & Garfield, R. (2016, March 2). *Medi-Cal Managed Care: An Overview and Key Issues*. Retrieved from the Kaiser Family Foundation: http://kff.org/report-section/medi-cal-managed-care-an-overview-and-key-issues-issue-brief/. More information about the publicly-run health plans specifically can be found through their trade association: http://www.lhpc.org/medi-cal.

10. Kelch, D. (2015, October). *Locally Sourced: The Crucial Role of Counties in the Health of Californians*. Retrieved from the California Health Care Foundation: http://www.chcf.org/publications/2015/10/locally-sourced-crucial-role-counties.

11. Kingdon, D., Brassil, M., & Jones, E. (2016, August). *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions*. Retrieved from the California Health Care Foundation: http://www.chcf.org/publications/2016/08/circle-expands-medical-mental.

12. While a pertinent topic, deeper exploration of the Drug Medi-Cal system and the Drug Medi-Cal Organized Delivery System waiver is outside of the scope of this report. For more information, see *DMC-ODS at the Starting Blocks: Insights from Phase I Counties*, by Paula Wilhelm for the Senate Office of Research at http://sor.senate.ca.gov/sites/sor.senate.ca.gov/files/DMC-ODS%20Final%20Report%20Wilhelm%20Hyperlinked.pdf.

13. In their issue brief, *Mental Health Services in Medi-Cal,* Lewis and Coursolle (2017) from the National Health Law Program created a table of which behavioral health services are delivered through which Medi-Cal system: http://www.healthlaw.org/publications/search-publications/Mental-Health-Services-in-Medi-Cal#.WP2heY61vBI.

14. Joint Informational Hearing of the Senate Committees on Budget and Fiscal Review and Health – The Administration's Drug Medi-Cal Organized Delivery System Proposed Waiver. (2014, October 21). *Background Paper.* Retrieved from 2013-14 Oversight and Informational Hearings: http://shea.senate.ca.gov/content/2013-14-oversight-and-informational-hearings.

15. Nardone, M., Snyder, S., & Paradise, J. (2014, February 12). *Integrating Physical and Behavioral Health Care: Promising Medicaid Models*. Retrieved from the Kaiser Family Foundation: http://kff.org/report-section/integrating-physical-and-behavioral-health-care-promising-medicaid-models-issue-brief/.

16. Klein, S., & Hostetter, M. (2014, August/September). *In Focus: Integrating Behavioral Health and Primary Care*. Retrieved from The Commonwealth Fund - Quality Matters: http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus.

17. United States Government Accountability Office. (2015, May). *Medicaid: A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures.* Retrieved from GAO.gov: http://www.gao.gov/assets/680/670112.pdf.

18. Watkins, J. (2015, June 9). *Symposium Slides - Understanding Medi-Cal's High-Cost Populations.* Retrieved from the California Health Care Foundation - Data Symposium and Webinar on High Utilizers of Medi-Cal Services: http://www.chcf.org/events/2015/medical-data-symposium.

19. Kingdon, D., Brassil, M., & Jones, E. (2016, August). *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions*. Retrieved from the California Health Care Foundation: http://www.chcf.org/publications/2016/08/circle-expands-medical-mental.

20. California Department of Health Care Services. (2016, November). *Medi-Cal Monthly Enrollment Fast Facts – November 2016*. Retrieved from Medi-Cal Certified Eligibles - Recent Trends: http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx.

21. California Health Care Foundation. (2013, July). *Mental Health Care in California: Painting a Picture.* Retrieved from the California Health Care Foundation: http://www.chcf.org/publications/2013/07/mental-health-california.

22. Kingdon, D., Brassil, M., & Jones, E. (2016, August). *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions*. Retrieved from the California Health Care Foundation: http://www.chcf.org/publications/2016/08/circle-expands-medical-mental.

23. California Department of Health Care Services. (n.d.). *June 24, 2015 CMS Approval Letter an STCs.* Retrieved from 1915(b) Medi-Cal Specialty Mental Health Services Waiver: http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx.

24. Integrated Behavioral Health Partners. *Models.* Retrieved from Background/Models: http://www.ibhpartners.org/background/models/. More information about clinical approaches can be found here: http://www.ibhpartners.org/background/clinical-approaches/.

Furthermore, the structure of primary care-based behavioral health services also differs from that of specialty mental health services: http://www.ibhpartners.org/background/primary-care-and-specialty-mental-health/.

25. Mauer, B. (2009, April). *Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home.* Retrieved from SAMHSA-HRSA Center for Integrated Health Solutions: http://www.integration.samhsa.gov/resource/four-quadrant-model. The Four Quadrant Model was first developed in 2006 by the National Council for Behavioral Health, then updated in 2009.

26. Heath, B., Wise Romero, P., & Reynolds, K. (2013, March). *A Review and Proposed Standard Framework for Levels of Integrated Healthcare.* Retrieved from SAMHSA-HRSA Center for Integrated Health Solutions: http://www.integration.samhsa.gov/resource/standard-framework-for-levels-of-integrated-healthcare.

27. The SAMHSA-HRSA Center for Integrated Health Solutions includes a list of other integrated care models: http://www.integration.samhsa.gov/integrated-care-models/list.

28. Klein, S., & Hostetter, M. (2014, August/September). *In Focus: Integrating Behavioral Health and Primary Care*. Retrieved from The Commonwealth Fund - Quality Matters: http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus.

29. Nardone, M., Snyder, S., & Paradise, J. (2014, February 12). *Integrating Physical and Behavioral Health Care: Promising Medicaid Models*. Retrieved from the Kaiser Family Foundation: http://kff.org/report-section/integrating-physical-and-behavioral-health-care-promising-medicaid-models-issue-brief/.

30. Scharf, D., Eberhart, N., Hackbarth, N., Horvitz-Lennon, M., Beckman, R., Han, B., Lovejoy, S., Pincus, H., & Burnam, M. (2013, December 1). *Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program: Final Report.* Retrieved from Office of the Assistant Secretary for Planning and Evaluation, U.S., Department of Health and Human Services: https://aspe.hhs.gov/basic-report/evaluation-samhsa-primary-and-behavioral-health-care-integration-pbhci-grant-program-final-report.

31. Klein, S., & Hostetter, M. (2014, August/September). *In Focus: Integrating Behavioral Health and Primary Care*. Retrieved from The Commonwealth Fund - Quality Matters: http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus.

32. McGraw, D. (2015, July). *Fine Print: Rules for Exchanging Behavioral Health Information in California.* Retrieved from the California Health Care Foundation: http://www.chcf.org/publications/2015/07/fine-print-exchanging-behavioral.

33. McGraw, D. (2015, July). *Fine Print: Rules for Exchanging Behavioral Health Information in California.* Retrieved from the California Health Care Foundation: http://www.chcf.org/publications/2015/07/fine-print-exchanging-behavioral.

34. Burke, B. T., Miller, B. F., Proser, M., Petterson, S. M., Bazemore, A. W., Goplerud, E., & Phillips, R. L. (2013, July 2). A needs-based method for estimating the behavioral health staff needs of community health centers. *BMC Health Services Research*, *13*, 245. http://doi.org/10.1186/1472-6963-13-245.

35. Follow-up email exchange with Allie Budenz, California Primary Care Association, in April 2017.

36. Final CPCA survey results from California Primary Care Association (CPCA), by email in March 2017. For more information and resources from CPCA on behavioral health in community clinics and health centers, see: http://www.cpca.org/index.cfm/policy-advocacy/policy/behavioral-health/.

37. Currie, P. (2015, June 23). *Integrating Behavioral & Physical Health: "Whole Person" Care Coordination* [PDF document/PowerPoint slides]. Retrieved from: http://www.calduals.org/wp-content/uploads/2015/06/IE-Summit-Session-1_Best-Practices-for-Care-Coordination.pdf. Inland Empire Health Plan was also referenced in interviews with Health Research for Action staff.

38. Interview with Jennifer Clancy, Jen Clancy Consulting, by phone, April 2017. More information can be found on IEHP's Behavioral Health Integration and Complex Care Initiative website: http://bhintegration.com/.

39. Partnership HealthPlan. (n.d.). *Drug Medi-Cal County Option.* Retrieved from: http://partnershiphp.org/Providers/HealthServices/Pages/Drug%20Medi-Cal/Drug-Medi-Cal-County-Option.aspx.

40. Hamblin, A., Wick, R., Smith, L., Sumek, C., & Krelstein, M. (2016, December 15). *Mild-to-Moderate Mental Health Coverage in Medi-Cal: The Challenge and Promise of Coordination between Counties and Health Plans* [PDF document/PowerPoint slides]. Retrieved from: http://www.chcs.org/media/12.15.16WebinarSlides.pdf.

41. Hamblin, A., Herman Soper, M., & Kuruna, T. (2016, June). *Promising Practices to Integrate Physical and Mental Health Care for Medi-Cal Members.* Retrieved from the Center for Health Care Strategies: http://www.chcs.org/resource/promising-practices-integrate-physical-mental-health-care-medi-cal-members/.

42. Maxwell, J., Tobey, R., Barron, C., Bateman, C., & Ward, M. (2014, March). *National Approaches to Whole-Person Care in the Safety Net.* Retrieved from the Blue Shield of California Foundation: http://www.blueshieldcafoundation.org/publications/national-approaches-to-whole-person-care-safety-net.

43. Maxwell, J., Tobey, R., Barron, C., Bateman, C., & Ward, M. (2014, March). *National Approaches to Whole-Person Care in the Safety Net.* Retrieved from the Blue Shield of California Foundation: http://www.blueshieldcafoundation.org/publications/national-approaches-to-whole-person-care-safety-net.

44. California Department of Health Care Services. (2015, March 27). *Medi-Cal 2020: Key Concepts for Renewal.* Retrieved from California Department of Health Care Services: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MC2020KCFR_032715.pdf

45. California Department of Health Care Services. (n.d.). *Public Hospital Redesign & Incentives in Medi-Cal Program.* Retrieved from California Department of Health Care Services: http://www.dhcs.ca.gov/provgovpart/Pages/PRIME.aspx.

46. California Department of Health Care Services. *Attachment Q – PRIME Projects and Metrics Protocol.* Retrieved from: http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_AttachmentQ_PRIMEProjectsMetrics.pdf.

47. California Department of Health Care Services. (n.d.). *Drug Medi-Cal Organized Delivery System.* Retrieved from California Department of Health Care Services: http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx.

48. California Department of Health Care Services. (n.d.). *Medi-Cal 2020 Demonstration.* Retrieved from California Department of Health Care Services: http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx.

49. *Coordinated Care Initiative:* California Senate Bill No. 1008, Public social services, Medi-Cal (2011-12), CA Welf & Inst. Code § 14132, 14182, 14183, 1414301, 14186 (2012). Available at http://leginfo.legislature.ca.gov/faces/billVersionsCompareClient.xhtml?bill_id=201120120SB1008.

Whole Person Care: California Department of Health Care Services, California Medi-Cal 2020 Demonstration (Waiver Special Terms and Conditions, No. 11-W-00193/9, Centers for Medicare and Medicaid Services, 2015). Retrieved from http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx.

Health Homes Program: California Assembly Bill No. 361, Medi-Cal: Health Homes for Medi-Cal Enrollees and Section 1115 Waiver Demonstration Populations with Chronic and Complex Conditions (2013-14), CA Welf. & Inst. Code § 14127 (2013). Available at: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201320140AB361.

50. Long-Term Services and Supports (LTSS) are assistance services and supports provided in homes, community-based settings, or facilities to individuals experiencing aging, chronic illness, and/or disability and have challenges with daily living activities. Medicaid is the primary payer for LTSS; Medicare offers limited coverage. See: https://www.medicaid.gov/medicaid/ltss/.

51. All information related to CCI/Cal MediConnect in the "Initiatives" section of this report retrieved from DHCS' dedicated webpage: http://www.dhcs.ca.gov/Pages/DualsDemonstration.aspx. DHCS also created a separate beneficiary- and provider-facing website regarding the demonstration: http://www.calduals.org/

52. It is worth clarifying the distinction between health homes in Medicaid and the similarly-named Patient-Centered Medical Homes (PCMHs), the model recognized by the National Committee for Quality Assurance (NCQA). While both promote patient-centered, coordinated care, health homes have a greater focus on individuals with chronic conditions. PCMHs also typically involve medical/primary care-based providers, though NCQA updated its standards in 2014 to include behavioral health integration. Therefore, a PCMH may or may not also be a Medicaid health home. SAMHSA-HRSA Center for Integrated Health Solutions provides more resources: http://www.integration.samhsa.gov/integrated-care-models/health-homes.

53. Centers for Medicare and Medicaid Services. (2016, November). *Health Home Information Resource Center - Map of State Health Home Activity.* Retrieved from Medicaid.gov: https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html.

54. Interview with Brian Hansen, California Department of Health Care Services, by phone, February 2017.

55. All information related to the Health Homes Program in the "Initiatives" section of this report retrieved from DHCS' dedicated webpage: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx.

56. All information related to Whole Person Care in the "Initiatives" section of this report retrieved from DHCS' dedicated webpage: http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.

57. DHCS also put together a crosswalk of the three programs, in addition to PRIME: http://www.dhcs.ca.gov/provgovpart/Documents/DHCSStateInitiativesCrosswalk3-16-16.pdf. This report serves to provide more explicit narrative on these similarities and differences between these programs and how they reinforce each other.

58. Cantor, J., Tobey, R., & Greenberg, E. (2015, June). *Integrating Housing Strategies with Health: An Opportunity to Advance Whole-Person Care in California.* Retrieved from the Blue Shield of California Foundation: http://www.blueshieldcafoundation.org/publications/integrating-housing-strategies-health-opportunity-to-advance-whole-person-care.

59. Henry, M., Watt, R., Rosenthal, L., & Shivji, A. (2016, November). *The 2016 Annual Homeless Assessment Report (AHAR) to Congress. Part 1: Point-in-Time Estimates of Homelessness.* Retrieved from the U.S. Department of Housing and Urban Development: https://www.hudexchange.info/resource/5178/2016-ahar-part-1-pit-estimates-of-homelessness/.

60. Klein, S., & Hostetter, M. (2014, August/September). *In Focus: Integrating Behavioral Health and Primary Care*. Retrieved from The Commonwealth Fund - Quality Matters: http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus.

61. Cantor, J., Tobey, R., & Greenberg, E. (2015, June). *Integrating Housing Strategies with Health: An Opportunity to Advance Whole-Person Care in California.* Retrieved from the Blue Shield of California Foundation: http://www.blueshieldcafoundation.org/publications/integrating-housing-strategies-health-opportunity-to-advance-whole-person-care.

62. Arabo, F., Wilkniss, S., Malone, S., & Isasi, F. (2016, September). *Housing as Health Care: A Road Map for States.* Retrieved from National Governors Association Center for Best Practices: http://ngahousingroadmap.cwsit.org/.

63. More information about the Financial Alignment Initiative can be found on CMS' website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

64. The California Legislative Analyst's Office published a report assessing the fiscal implications of the discontinuation of CCI, which is largely driven by costs from counties' maintenance of effort (MOE) for In-Home Supportive Services (IHSS) and effectively discontinuing this MOE. It proposes some ways the Legislature could build upon CCI, including providing funding for care coordination and piloting greater administrative responsibilities for IHSS under managed care plans: http://www.lao.ca.gov/Publications/Report/3585.

65. Count of unique measures is the author's own. There is a "behavioral health shared accountability measure" that has two definitions in the first year—one for September-December 2013, and another for January-December 2014, and then a new definition for years two and three. These were counted as three separate measures, even though they are grouped under the same measure name.

66. State-identified measures are "proposed" since these metrics are outlined in DHCS' concept paper and are not yet finalized.

67. SCAN-funded evaluations of CMC can be found on the SCAN Foundation's website: http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration.

In 2016, DHCS released the first CMC Performance Dashboard reflecting data from managed care plans: http://www.calduals.org/wp-content/uploads/2016/03/CMC-Performance-Dashboard-March-2016-Release.pdf.

DHCS released its most recent CCI evaluation summary report in January 2017: http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CCI-Evaluation_Outcome_Report_Jan_2017.pdf

68. In some cases, metrics are not identical but have been grouped together based on author's interpretation of their similarity.

69. *Coordinated Care Initiative:* California Senate Bill No. 1008, Public social services, Medi-Cal (2011-12), CA Welf & Inst. Code § 14132, 14182, 14183, 1414301, 14186 (2012). Available at http://leginfo.legislature.ca.gov/faces/billVersionsCompareClient.xhtml?bill_id=201120120SB1008.

Whole Person Care: California Senate Bill No. 815, Medi-Cal: demonstration project (2015-16), CA Welf. & Inst. Code § 14184 (2016). Available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB815.

Health Homes Program: California Assembly Bill No. 361, Medi-Cal: Health Homes for Medi-Cal Enrollees and Section 1115 Waiver Demonstration Populations with Chronic and Complex Conditions (2013-14), CA Welf. & Inst. Code § 14127 (2013). Available at: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201320140AB361.

70. The Department of Health Care Services lists which behavioral health services are not offered through CMC plans: http://www.calduals.org/wp-content/uploads/2013/08/FAQ-BH-8.20.13.pdf.

71. DHCS' concept paper contains more details on CB-CME qualifications and duties: http://www.dhcs.ca.gov/services/Documents/HealthHomesForPatients_Final.pdf.

72. This was explicitly referenced by San Joaquin in their WPC application.

73. DHCS includes more detail about required metrics in their Health Plan Quality and Compliance Report (January 2016): http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CCI_Healthplan-Quality-Compliance_Report.pdf.

74. Graham, C., Kurtovich, E., Stewart, H., Liu, M., Tlatelpa, K., & Wong, A. (2016, March). *Evaluation of Cal MediConnect: Results of Focus Groups with Beneficiaries.* Retrieved from the SCAN Foundation – Evaluating Medicare-Medicaid Integration: http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration.

75. Hollister, B., Graham, C., Harrington, C., Wong, A., O'Shea, L., Kurtovich, E., Nussey, B., & Liu, P. (2016, July). *Cal Medi-Connect: How Have Health Systems Responded?* Retrieved from the SCAN Foundation – Evaluating Medicare-Medicaid Integration: http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration.

76. Interviews with Carrie Graham and Marian Liu, UC Berkeley Health Research for Action, in person, March 6-7, 2017.

77. Interviews with Carrie Graham and Marian Liu, UC Berkeley Health Research for Action, in person, March 6-7, 2017.

78. It is worth noting that in the context of their research of the health system's response to CMC, the evaluation team used the term "coordination" in place of "integration" to characterize behavioral health practices, echoing the earlier discussion on the distinction between coordination and integration. In the report, a number of plans spoke about the need to integrate behavioral health at the payer level as part of their decision of whether or not to delegate services. One informant in the report said, "'If health plans haven't integrated, how are they going to really create that integration at the point of delivery?" See: http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_health_system_full_report.pdf.

79. Karaca Z, Wong HS, Mutter RL. (2013, March). *Characteristics of Homeless and Non-Homeless Individuals Using Inpatient and Emergency Department Services, 2008: Statistical Brief #152.* In: Healthcare Cost and Utilization Project (HCUP) Statistical Briefs [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2006 Feb-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK137747/.

80. Counties must submit documentation of their policies and procedures related to care coordination, case management, and referrals in their pilots, as well as documentation how they will conduct oversight and gather and analyze findings from oversight procedures. See: http://www.dhcs.ca.gov/provgovpart/Documents/WPCAttMMProtocol10-21-16.pdf.

81. California Department of Health Care Services. (2016, November). *Whole Person Care Program* [PDF document/PowerPoint slides]. Retrieved from: http://www.dhcs.ca.gov/provgovpart/Documents/WPCProgramOverview.pdf.

82. In efforts to make health care delivery more efficient, increase patient satisfaction, and improve health outcomes, the Affordable Care Act spurred a number of reform efforts to test our new payment and delivery models that would reward quality, rather than quantity, of services provided. For more information on how the ACA has catalyzed this movement, see: http://www.commonwealthfund.org/publications/issue-briefs/2015/may/aca-payment-and-delivery-system-reforms-at-5-years.

83. California Department of Health Care Services. *Whole Person Care Pilot – Budget Instructions.* Retrieved from: http://www.dhcs.ca.gov/services/Documents/WPCBudgetInstructions.pdf.

84. Similar to the requirements for care coordination, counties must submit documentation on their policies and procedures, oversight procedures, and information gathering and analysis around data sharing. See: http://www.dhcs.ca.gov/provgovpart/Documents/WPCAttMMProtocol10-21-16.pdf.

85. California Department of Health Care Services. (2016, November). *Whole Person Care Program* [PDF document/PowerPoint slides]. Retrieved from: http://www.dhcs.ca.gov/provgovpart/Documents/WPCProgramOverview.pdf.

86. California Department of Health Care Services. *Attachment MM: Whole Person Care Pilot Requirement and Metrics.* Retrieved from: http://www.dhcs.ca.gov/provgovpart/Documents/WPCAttMMProtocol10-21-16.pdf.

Plan-Do-Study-Act (PDSA) is a model commonly utilized in health care to plan and execute changes, develop knowledge from carrying out those changes, and take action based on lessons learned. This occurs in cycles in order to reduce risk and continuously improve based on more tests and knowledge. For more information, see: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx.

87. Savings from bundled/PMPM services can be used to pay for services allowed under pilots' flexible housing pools or, if approved by DHCS, for other services. See: http://www.dhcs.ca.gov/services/Documents/RevisedDHCSWPCFAQ6-2-16.pdf (question #3 under "Funding" (part E).

88. Community Partners. (n.d.). *California Accountable Communities for Health Initiative.* Retrieved from: http://www.communitypartners.org/cachi. Community Partners created an initiative matrix for grantees to identify how they might weave together different funding streams; the document includes a graphic in how different public health and Medi-Cal initiatives differ in target populations and focus areas: http://www.communitypartners.org/sites/default/files/documents/cachi/resources/Initiative%20Matrix.docx.

89. Corrigan, J., Fisher, E., & Heiser, S. (2015, March 24/31). Hospital community benefit programs: Increasing benefits to communities. *Jama*, *313*(12), 1211-1212. http://doi:10.1001/jama.2015.0609.

90. Southern California Association of Governments. (2016, October 11). Mission Impossible? Meeting California's Housing Challenge. Retrieved from California Housing Summit: http://www.scag.ca.gov/SiteAssets/HousingSummit/index.html.

91. Final CPCA survey results from California Primary Care Association (CPCA), by email in March 2017.

92. Felland, L., (2016, October). *Stepping Up to the Plate: Federally Qualified Health Centers Address Growing Demand for Care.* Retrieved from the California Health Care Foundation: http://www.chcf.org/publications/2016/10/stepping-up-plate-fqhcs.

93. California Senate Bill No. 456, Medi-Cal managed care: federally qualified health centers and rural health clinics: services that follow the patient (2017-18). Available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB456.

94. Lucia, L., Jacobs, K., & Bindman, A. (2017, March). *Medi-Cal Expansion under AHCA: Severe Coverage and Funding Loss unless State Backfills Billions in Federal Cuts.* Retrieved from the UC Berkeley Center for Labor Research and Education: http://laborcenter.berkeley.edu/medi-cal-expansion-under-ahca/.

95. Tobey, R., Maxwell, J., Bateman, C., & Barron, C. (2014, September). *Opportunities for Whole-Person Care in California.* Retrieved from the Blue Shield of California Foundation: http://www.blueshieldcafoundation.org/publications/opportunities-for-whole-person-care-california.

96. In their brief, *Braiding and Blending Funding Streams to Meet the Health-Related Social Needs of Low-Income Persons: Considerations for State Policymakers*, Clary and Riley (2016) from the National Academy for State Health Policy present a list of potential funding sources/partners that state Medicaid programs could leverage. See: http://www.nashp.org/braiding-and-blending-funding-streams-to-meet-the-health-related-social-needs-of-low-income-persons-considerations-for-state-health-policymakers/.

97. Technical Assistance Collaborative and Human Services Research Institute. (2012, February). *California Mental Health and Substance Use System Needs Assessment.* Retrieved from: http://www.dhcs.ca.gov/provgovpart/Pages/BehavioralHealthServicesAssessmentPlan.aspx.

98. Technical Assistance Collaborative and Human Services Research Institute. (2012, February). *California Mental Health and Substance Use System Needs Assessment.* Retrieved from: http://www.dhcs.ca.gov/provgovpart/Pages/BehavioralHealthServicesAssessmentPlan.aspx.

99. California Department of Health Care Services. (2017, March 16). *Medi-Cal Managed Care Performance Dashboard – March 16, 2017 Release.* Retrieved from Medi-Cal Managed Care Performance Dashboard: http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx.

100. For more information on No Place Like Home, see: http://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml.

101. California Assembly Bill No. 74, Housing (2017-18). Available at: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB74.

102. Viveiros, J. (2015, June). *Affordable Housing's Place in Health Care: Opportunities Created by the Affordable Care Act and Medicaid Reform.* Retrieved from the National Housing Conference: http://www.nhc.org/2015-affordable-housing-medicaid.

103. Hollister, B., Graham, C., Harrington, C., Wong, A., O'Shea, L., Kurtovich, E., Nussey, B., & Liu, P. (2016, July). *Cal Medi-Connect: How Have Health Systems Responded?* Retrieved from the SCAN Foundation – Evaluating Medicare-Medicaid Integration: http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration.

104. Let's Get Healthy California has goals across six domain areas: healthy beginnings, living well, end of life, redesigning the health system, creating healthy communities, and lowering the cost of care. Key metrics that align with WPC (and the other Medi-Cal initiatives) include percentage of adults who receive coordinated outpatient care (in the "redesigning the health system" domain) and percentage of Californians who receive care in an integrated system (in the "lowering the cost of care" domain). See: https://letsgethealthy.ca.gov/goals/.

105. National Alliance on Mental Illness (NAMI) California. (2016). *2016 MHSA County Programs: Services that Change Lives.* Retrieved from NAMI California: http://namica.org/wp-content/uploads/2016/06/NAMI-MHSA-Report-2016.pdf.

MHSA funds are derived from a 1% income tax on California taxpayers with more than $1 million in personal income and are required to support programs in five areas: (1) community services and support, (2) prevention and early intervention, (3) innovation, (4) capital facilities and technological needs, and (5) workforce education and training.

106. It is worth noting that in the context of their research of the health system's response to CMC, the evaluation team used the term "coordination" in place of "integration" to characterize behavioral health practices, echoing the earlier discussion on the distinction between coordination and integration. In the report, a number of plans spoke about the need to integrate behavioral health at the payer level as part of their decision of whether or not to delegate services. One informant in the report said, "'If health plans haven't integrated, how are they going to really create that integration at the point of delivery?" See: http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_health_system_full_report.pdf.

107. Hornberger, J., Franko, B., Freeman, D., & Vance Gopalan, S. (2016, October). *The Impact of State Health Policies on Integrated Care at Health Centers.* Retrieved from the National Association of Community Health Centers: http://www.nachc.org/wp-content/uploads/2016/11/NACHC-BHI-Impact-of-State-Health-Policies-on-Integrated-Care-at-Health-Ctrs-FINAL-102816.pdf.