ITUP
Insure the Uninsured Project

# Care Coordination Discussion Guide

JUNE 2019

# Framing a Conversation on Improving Services for Medi-Cal Patients

## 2019 ITUP Regional Workgroups Discuss Care Coordination

## PURPOSE OF THIS GUIDE

Over the next six months, ITUP will hold its annual regional workgroups across ten regions in the state, including densely populated urban centers and remote rural areas, North and South, well-resourced and underserved communities. ITUP workgroups bring together a diverse range of local health care leaders, including county staff, clinics, hospitals, medical providers, health plans, community-based organizations and advocates.

In 2019, ITUP workgroups will take stock of the progress and remaining challenges to achieving universal coverage. In addition, this year ITUP will focus on improving access and services for Medi-Cal recipients through care coordination, case management and care management across delivery systems.

This discussion guide provides general background to support the 2019 regional workgroup conversations around care coordination challenges, best practices, and policy recommendations.

***Workgroup Discussion Questions***

1. *What are the barriers and challenges to effectively coordinating health care and related services for Medi-Cal recipients in the region? What are some of the largest failures of care coordination in Medi-Cal? How do the challenges differ by client population?*
2. *What strategies, work arounds and other efforts are local agencies, providers and community organizations employing to help address care coordination challenges? What innovations and best practices are happening locally?*
3. *What policy change or flexibility would make the most difference in effectively meeting the needs of Medi-Cal recipients?*
4. *What are some successes of care coordination? What does good care coordination look like? What does success look like and how should it be measured? What can and should care coordination accomplish for the recipients served? For the system overall?*
5. *What is the status of local care coordination initiatives such as Whole Person Care, Whole Child Model, Health Homes, Cal Medi-Connect, and others?*

## BACKGROUND

The Medi-Cal program is at a crossroads. Multiple deadlines, changes in federal law and system challenges will be converging over the next few years, requiring thoughtful and comprehensive review of the current program. (See the recent ITUP publication *Mapping the Future of Medi-Cal* for more on the issues affecting Medi-Cal in the next several years.)

While 82 percent of Medi-Cal recipients are enrolled in Medi-Cal managed care (MCMC) plans, and just 18 percent remain in the fee-for-service (FFS) program, the Medi-Cal delivery system continues to be complex and often fragmented. MCMC plans deliver and pay for covered services and are required to coordinate services for enrolled members (enrollees) through contracts with the state Department of Health Care Services (DHCS).

However, certain services and populations are excluded, or "carved out," from MCMC. For example, specialty mental health services (for individuals with severe mental illness) and most substance use disorder (SUD) treatment services are carved-out of MCMC contracts and administered by counties. Medi-Cal recipients must access major organ transplants, most psychotherapeutic drugs, and most HIV/AIDS drugs through the FFS program. Most individuals "dually-eligible" for Medicare and Medi-Cal are not required to enroll in MCMC but may do so voluntarily.

Under the current system, many Medi-Cal recipients, such as those with complex chronic conditions or co-occurring physical and mental health conditions, must secure the care and services they need through multiple health plans and programs operating under different state laws, regulations, funding streams and contracts. In addition, low-income individuals with significant health issues or disabilities often also require social support services, necessitating interaction with additional agencies and community providers.

To address the challenges of a fragmented system, the state currently administers multiple programs and demonstration projects -- including several federal Medicaid waivers soon up for renewal -- to assess, track and coordinate health and health-related services for Medi-Cal recipients. (See Appendix A.)

### Defining Care Coordination

The term "care coordination" can have many meanings. Sometimes care management, case management and care coordination are used interchangeably but can also describe different activities and functions.

While there is no consensus definition of care coordination, most descriptions generally share the same core goal. The federal Agency for Healthcare Quality and Research states that, "*care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and this information is used to provide safe, appropriate, and effective care to the patient.*"[1] Thus, care coordination works to meet the patient's needs in a patient-centered, safe, and efficient way.

Approaches to care coordination can also vary in response to patient needs, delivery system context, and other factors. For example, care coordination activities can include medication management, assessing patient needs and goals, linking to community resources, supporting transitions of care, and establishing clear roles and responsibility among providers and agencies involved in a client's care. Care coordination can include coordinating services through a single provider, such as the primary care provider, sometimes referred to as a medical home.

Care coordination is an important factor in ensuring safe, high-value, quality care. The need for care coordination depends on a patient's clinical complexity, the extent of delivery system fragmentation, and a patient's capacity to coordinate care on their own. When there are gaps in needed care coordination—such as during transitions between services and providers—it can be harmful to the patient and expensive for the health care system.

## The California Story

In the mid-1970s, California led the development of managed care in Medicaid and gradually expanded managed care in geographic reach, populations served, and covered benefits over the next 40 years.

California did so with the stated intent to achieve broad program goals such as cost efficiency, improved access, higher quality, and better coordinated care. Today, MCMC is offered statewide and covers about 82 percent of the 13 million Medi-Cal program recipients.

Some of the most recent managed care expansion milestones are outlined in Figure 1.

**Figure 1. Recent Medi-Cal Managed Care Milestones**

**2011**
- Transition of approximately 300,000 seniors and persons with disabilities

**2012**
- Carve-in of community-based adult services
- Carve-in of certain dual-eligible recipients and long-term care services and supports under the Coordinated Care Initiative

**2013**
- Expansion geographically to 28 additional rural counties
- Transfer of the Healthy Families Program to DHCS, moving more than 750,000 into Medi-Cal, primarily in Medi-Cal managed care

**2014**
- ACA expansion of eligibility to several million previously ineligible, childless adults who enroll in managed care on a mandatory basis
- Expansion of mental health coverage under ACA, with Medi-Cal health plans responsible for services to treat mild-to-moderate mental health conditions
- Carve-in of behavioral health treatment services for children with autism

**2017**
- Requirement for managed care plans to provide and coordinate specific transportation services for covered and non-covered services

**2018**
- Carve-in of previously county provided specialty and case management services for children with special health care needs through Whole Child Model demonstration program in select counties

Source: Insure the Uninsured Project

***County-Based Structure.*** The Medi-Cal program relies heavily on counties in the administration of the program and this means that Medi-Cal recipients can have very different experiences depending on the county where they live. County social services agencies determine Medi-Cal eligibility for all but aged, blind, and disabled recipients of Supplemental Security Income/State Supplemental Payment funds, who are automatically enrolled in Medi-Cal by the Social Security Administration. In addition, counties oversee the Medi-Cal enrollment and recertification process. In many counties, county clinics, hospitals, county-based health plans and other county programs organize and deliver Medi-Cal services. Counties and local entities also contribute to the financing of health care services for Medi-Cal recipients, including for services related to managed care, as well as case management, specialty services, and care coordination programs.

***Multiple Managed Care Models.*** As California expanded the reach of MCMC, the timing and approach varied by region, resulting in six different managed care models providing care in 58 counties. Recipients may have different care experiences and access depending on their resident county because of these differences. Most Medi-Cal recipients are automatically enrolled in a managed care plan offered in their county. MCMC plans include a mix of local public health plans generally organized by counties and private health plans voluntarily participating in Medi-Cal. See Figure 2 for key characteristics and counties served by the six MCMC models.

California's local public health plans serve a majority of the Medi-Cal recipients enrolled in MCMC (55.5 percent). County-organized health system (COHS) plans enroll all MCMC enrollees in the counties served. As of December 2018, 2.1 million Medi-Cal enrollees are enrolled in six COHS plans in 22 counties (16 percent of Medi-Cal beneficiaries). Local Initiative (LI) health plans participate in the "Two-Plan model" of MCMC, where they serve as the public plan choice in a county alongside a commercial, non-governmental health plan. There are five million Medi-Cal enrollees in nine LIs in 13 counties (39 percent of Medi-Cal beneficiaries). Statewide, 74 percent of MCMC enrollees in Two-Plan counties are enrolled in the LI.

**Figure 2. Medi-Cal Managed Care Models**

| MODEL TYPE | | COUNTIES SERVED |
|---|---|---|
| **Two-Plan Model** | ▪ One county-organized local initiative public health plan and a commercial health plan<br>▪ Statewide December 2018 enrollment: 6.8 million | ▪ Operates in 14 counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare |
| **COHS** | ▪ One county-wide, public health plan originally organized by the county serves all Medi-Cal beneficiaries in the county<br>▪ Three of the six COHS plans currently serve multiple counties<br>▪ Statewide December 2018 enrollment: 2.1 million | ▪ Operates in 22 counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura and Yolo |
| **GMC** | ▪ Multiple commercial health plans are chosen by the state<br>▪ Statewide December 2018 enrollment: 1.1 million | ▪ Operates in San Diego and Sacramento |
| **Regional Model and County-specific Models** | ▪ One or two commercial health plans in 20 primarily rural counties<br>▪ Statewide December 2018 enrollment: 378,000 | ▪ Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba<br>▪ In Imperial County, beneficiaries choose from among two commercial plans. DHCS separately refers to this as the "Imperial Model"<br>▪ In San Benito County, beneficiaries choose between one commercial plan and FFS. DHCS refers to this as the "San Benito" model |

Source: Insure the Uninsured Project

***Carve-outs and Specialty Managed Care Systems.*** While most physical health services and Medi-Cal recipients are covered by the MCMC plans, certain services and populations are carved-out or excluded as highlighted above. As a result, MCMC plans must coordinate with several specialty Medi-Cal delivery systems and programs. Recipients may access carve-out services through specialized managed care plans, such as county mental health plans, or through Medi-Cal FFS. MCMC carve-outs include dental services, substance use services and specialty mental health services. *See Figure 3 for a more comprehensive listing of MCMC carved-out services.*

***Care Coordination Requirements.*** There are several care coordination requirements for MCMC plans and for some of the programs and services that are carved out of MCMC. MCMCs are contractually required by DHCS to coordinate care for their enrollees, for both covered and non-covered benefits.[2] This may include establishing memorandums of understanding (MOUs) between health plans and other delivery systems or programs. For example, MCMC plans must have MOUs with regional centers that help coordinate care for developmentally disabled persons. Regional centers are nonprofit private corporations that contract with the state Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities. They have offices throughout California that serve as a local resource to help find and access the many services available to individuals and their families. MCMC plans must also have MOUs with counties related to mental health and SUD services.

**Figure 3. Select Medi-Cal Services***
**Covered by MCMC Plans and Carved Out of MCMC Contracts (As of June 2019)**

| COVERED BY MCMC PLANS | SERVICES CARVED OUT |
|---|---|
| ▪ Physician Services | ▪ Specialty Mental Health |
| ▪ Outpatient (Ambulatory) Services | ▪ Alcohol/SUD Treatment |
| ▪ Emergency Services | ▪ Institutional Long-term Care (Except for County Organized Health Systems or COHS) |
| ▪ Hospice and Palliative Care | ▪ Home and Community Based Waiver Services |
| ▪ Hospitalization | ▪ In-Home Supportive Services |
| ▪ Outpatient Surgery | ▪ Non-Medical Dental |
| ▪ Maternity and Newborn Care | ▪ Major Organ Transplants |
| ▪ Pediatric Services | ▪ Most Psychotherapeutic and SUD Drugs, Blood Factor, Antiviral |
| ▪ Prescription Drugs | ▪ Most HIV/AIDS Drugs |
| ▪ Rehabilitative and Habilitative Services and Devices | ▪ CCS Services (Except for the plans administering the Whole Child pilot) |
| ▪ Laboratory Services | ▪ Certain Lab Tests and Certain Management and Tuberculosis Services |
| ▪ Preventive and Wellness Services and Chronic Disease Management | ▪ Special Care Services for Adults with Genetic Diseases |
| ▪ Chiropractic | |
| ▪ Podiatry | |
| ▪ Vision | |
| ▪ Acupuncture | |
| ▪ Outpatient Mental Health Services for Mild to Moderate Conditions | |

Source: Insure the Uninsured Project
*Note: This list, prepared by ITUP using multiple sources, is not an exhaustive list of Medi-Cal covered services. Some services covered by MCMC plans are only available through a Federally Qualified Health Center. Medi-Cal services must be medically necessary and may be subject to limitations, including prior authorization or other service limits as allowed by law.

***Care Coordination Waivers and Specialty Programs.*** The state administers multiple specialty programs aimed at improving the delivery of care to bridge gaps, integrate services, and strengthen care coordination. These programs use a variety of care management, delivery system restructuring, service navigation, care plan development, and assessment and monitoring activities to achieve their stated goals. Generally, these special programs target specific, high need and vulnerable populations, including those who are homeless or have acute health care needs. Existing "care coordination" programs are generally limited in the number of individuals enrolled or served in the programs and are at various stages of implementation. Most waiver and specialty care management programs are not available statewide. A summary of selected care coordination programs, their target populations, and implementing organizations is provided in Appendix A.

***Coordination Challenges.*** The Medi-Cal program remains a fragmented system with numerous carve-outs from participating health plan contracts and multiple systems and programs providing services to recipients. Despite significant efforts to improve the coordination of care for recipients via managed care delivery systems, and specific specialty and pilot programs, significant challenges persist. These challenges to care coordination and integration can be categorized in four broad domains: (1) policy, (2) structural, (3) financial, and (4) individual or population characteristics. To facilitate the discussion, Figure 2 illustrates the domains affecting care coordination and lists some of the barriers to success within each domain.

**Figure 4. Challenges to Coordinated And Integrated Care**
**Discussion Draft**

**POLICY**

- Lack of clear policy goal setting at the state level **What problem(s) are we trying to solve?**
- Different legal frameworks (federal and state) by discipline, service, or program
- Medi-Cal Managed Care as the preferred delivery system but different models and health plan structures by region and county
- Primary responsibility for health and social services at the individual county level
- Competing and conflicting statutory and regulatory standards across programs

**FINANCING**

- Federal funding silos
  - Restrictions and limitations on available funding
  - Limited or no funding for key elements
  - Waivers – Requirements, special terms and conditions, restrictions
- State funding silos
  - Restrictions and limitations of available funding
  - Limited or no funding for key elements
  - Misaligned financial incentives
- Complex, legacy financing and payment arrangements

**STRUCTURAL**

- Multiple delivery systems and program silos within health care and across other key services recipients may need such as social supports, housing, etc.
- Multiple state and local agencies responsible for different services and programs
- Service and program "carve outs"
- Variation across counties and regions
- Communication and data/information sharing challenges
- Workforce shortages

**INDIVIDUAL AND POPULATION CHARACTERISTICS**

- Complex and chronic health and behavioral health conditions
- Lack of social supports and available caregivers
- Episodic health care seeking habits
- Language, cultural or literacy barriers (including health literacy) creating navigation challenges
- Unmet social and environmental needs (social determinants)
  - Poverty
  - Housing
  - Transportation

Source: Insure the Uninsured Project

## What's Next for California?

The Medi-Cal program is at a critical juncture as the state faces expiration of important federal Medicaid waivers and existing specialty programs are due for evaluation or review. As a result, several potential policy and Medi-Cal program change opportunities are on the horizon. These opportunities come alongside increased demands and requirements by various stakeholders for better program performance on outcomes and value. (For more details about Medi-Cal basics, delivery systems, and upcoming waiver and program renewals, see the ITUP issue brief entitled *Mapping the Future of Medi-Cal).*

In 2108, DHCS held a series of stakeholder convenings focused on care coordination and the overall future of the Medi-Cal program, referred to as the Care Coordination Assessment Project (CCAP). (See text box below for more detail.) DHCS recently announced that it will begin more robust stakeholder discussions following up on the CCAP in the Fall of 2019.

The 2019 ITUP regional workgroups are well-timed to engage stakeholders in communities around the state on care coordination topics. The discussion is important for the future of the Medi-Cal program and its ability to ensure recipients receive the health and health-related services they need to improve and preserve health. Through the regional workgroups, ITUP will collect key findings and best practices culminating in a *Notes from the Field* summary publication and panel discussions at the 24th Annual ITUP Conference in February 2020.

## DHCS Care Coordination Assessment Project

In 2018, DHCS initiated the Care Coordination Assessment Project (CCAP) to review care coordination across the Medi-Cal delivery system from a managed care lens. As part of this project, DHCS convened an Advisory Committee comprised of selected stakeholders that met six times in 2018 to discuss care coordination issues and potential policy recommendations. DHCS set a series of goals for the project including determining "whether a set of standards and expectations regarding appropriate care coordination activities and requirements can be developed within and among all the Medi-Cal delivery systems." The project included an internal review of various rules and regulations as well as site visits with key stakeholders across California. The convenings explored elements of care coordination including screenings, health assessments, data, transitions in care, and governance. Learn more about the CCAP at the DHCS web site.

DHCS recently summarized the findings from the CCAP as outlined below.

**Recap of DHCS Care Coordination Assessment Project**

| Reduce Variation And Complexity Across The System | Identifying And Managing Member Risk And Need Through Population Health Management Strategies | Improve Quality Outcomes And Drive System Transformation Through Value Based Payments, Incentives And Shared Savings |
|---|---|---|
| ▪ Plan Accreditation<br>▪ Mandatory enrollment in managed care vs. FFS<br>▪ Annual Medi-Cal Health Plan Open Enrollment<br>▪ Standardizing the benefit statewide<br>▪ Exploring opportunities for integration and breaking down historical delivery system silos<br>▪ Standardize/consolidate state required assessments | ▪ Risk Stratification/Assess Members for Risk and Need<br>▪ Wellness and Prevention<br>▪ Transitions in Care<br>▪ Point of Care and Community Based Enhanced Care Management<br>▪ Addressing Social Determinants of Health<br>▪ Explore In-Lieu of Services | ▪ Funding Flexibility<br>▪ Value Based Payments<br>▪ Shared Savings Models<br>▪ Incentives to drive delivery system transformation<br>▪ Behavioral Health quality and performance metrics<br>▪ Behavioral Health payment reform |

Source: Department of Health Care Services, presentation to Medi-Cal Stakeholder Advisory Committee, May 2019

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## Notes

1. Agency for Healthcare Research and Quality. Care Coordination, obtained online June 2019.
2. MCMC plan requirements are included in contracts with the state and various guidance or "All Plan Letters." For example, Exhibit A, Attachment 11 describes requirements for case management and care coordination and also outlines responsibilities for case management across systems of care.

# APPENDIX A

| Appendix A: Selected Care Coordination Programs Serving Medi-Cal Recipients, June 2019 | | | | |
|---|---|---|---|---|
| **PROGRAM** | **TARGET POPULATION** | **COORDINATING ENTITY** | **FEDERAL AUTHORITY** | **FUNDING SOURCE** |
| **Assisted Living Waiver (ALW)** aims to facilitate skilled nursing transitions into the community and prevent skilled nursing facility placements by providing beneficiaries with a choice to live in an assisted living setting. The program provides personal care, home health aide, care coordination, homemaker, residential habilitation, augmented plan of care development, and nursing facility transition services. | Seniors and persons with disabilities who need the level of care provided in a nursing facility who are age 21 or older, as specified | Provider types include care coordination agencies, home health agencies, and residential care facilities | Medicaid waiver §1915(c) Home and Community-Based Services[1]<br><br>Program is effective through February 29, 2024 | State General Funds and federal Medicaid funds |
| **California Community Transitions (CCT)** seeks to safely transition eligible Medi-Cal beneficiaries residing in health care facilities, such as long-term nursing facilities, to a community setting. Transition coordinators work with the participants, their support networks, and providers. Services include transitional case management, personal care, family and informal caregiver training, and pre-transition coordination. | Seniors and persons with developmental disabilities, physical disabilities, and/or mental health conditions living in skilled nursing care for 90 days or more | Designated lead organizations providing home and community-based services authorized by DHCS | Money Follows the Person demonstration as authorized by several authorities including the Deficit Reduction Act of 2005 (Section 6071) and the Affordable Care Act (ACA) of 2010<br><br>Effective through September 30, 2020 | State General Funds and federal grant funds<br><br>Grant funds support an enhanced match for services |
| **Community-Based Adult Services (CBAS)** offers facility-based services to frail older adults and adults with disabilities to restore or maintain their optimal capacity for self-care to delay or prevent institutionalization. A multidisciplinary team of health professionals conducts a comprehensive assessment of each potential participant to determine the services needed such as social services, care coordination, speech therapy, nutritional counseling, and personal care. | Older adults and individuals with disabilities, with chronic mental, health, or cognitive conditions at risk of needing institutional care | About 250 licensed CBAS centers provide services as a covered Medi-Cal benefit, primarily administered by Medi-Cal Managed Care (MCMC) plans | Medicaid waiver §1115 Demonstration Waiver[2] | State General Funds and federal Medicaid matching funds<br><br>CBAS services are included in the capitated rate the State pays to Medi-Cal managed care plans |

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| **PROGRAM** | **TARGET POPULATION** | **COORDINATING ENTITY** | **FEDERAL AUTHORITY** | **FUNDING SOURCE** |
| **Coordinated Care Initiative (CCI)/ Cal MediConnect** seeks to generally improve care eligible to beneficiaries by coordinating medical, long-term institutional, and home-and community-based services through MCMC plans; requires mandatory enrollment for certain beneficiaries.<br><br>Cal MediConnect is a component of the CCI that specifically integrates services —including long term services and supports—within a single health plan for those who are dually eligible for Medi-Cal and Medicare. | Dual-eligible and Medi-Cal only beneficiaries, including some seniors and persons with disabilities previously excluded from MCMC | MCMC plans in seven California counties[3] | §1115 Demonstration Waiver<br><br>Effective through December 31, 2022 | State General Funds and federal Medicaid matching funds |
| **Drug Medi-Cal Organized Delivery System (DMC-ODS)** is a pilot to expand substance use disorder (SUD) benefits by offering a full continuum of care through a managed care system that ensures needed, evidenced based services are provided including case management, coordination, medication assisted treatment, and recovery services. Participating entities must meet federal managed care requirements. | Beneficiaries needing SUD treatment and services | County governments that voluntarily participate | §1115 Demonstration Waiver | Local funds and federal Medicaid matching funds<br><br>Counties provide a certified public expenditure (CPE)[4] that is matched with federal Medicaid funds |
| **Health Homes Program (HHP)** coordinates the full range of physical health, behavioral health and many community-based services needed by eligible beneficiaries through comprehensive care management, care coordination, health promotion, transitional care, individual and family support, and referral to community and social services. | Beneficiaries with a chronic condition, as specified, and a demonstrated high level of acuity/ complexity | MCMC plans work with Community-Based Care Management Entities (CB-CMEs). 18 health plans are participating in 13 counties.[5] | ACA (§2703) authorizes program as a Medicaid benefit with higher matching rate in first two years<br><br>§1115 Demonstration Waiver and Medicaid State Plan[6] | Local grant[7] and federal Medicaid matching funds provided at 90 percent for first two years<br><br>State law allows the program to use State General Fund if program does not result in net costs. |
| **HIV/AIDS Waiver** provides a continuum of care for individuals with HIV/AIDS to remain in their homes. Services include enhanced case management, attendant care, nutritional counseling, and others. | Beneficiaries with late stage HIV/AIDS | Local agencies under contract with CA Department of Public Health, Office of AIDS | §1915(c) Home and Community-Based Services Waiver<br><br>Effective through December 31, 2022 | State General Funds and federal Medicaid matching funds |

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| PROGRAM | TARGET POPULATION | COORDINATING ENTITY | FEDERAL AUTHORITY | FUNDING SOURCE |
|---|---|---|---|---|
| **Home and Community-Based Alternatives (HCBA) Waiver** provides care management services for beneficiaries at risk of institutional placement. Comprehensive care management services are provided by a multidisciplinary care team including a nurse and social worker. Services covered under this waiver include habilitation, home respite, community transition, and others. | Beneficiaries at risk for nursing home or institutional placement | State contracted waiver agencies that function as "organized health care delivery systems" approved by DHCS; can include non-profits, counties and other entities | §1915(c) Home and Community-Based Services Waiver<br><br>Effective through December 31, 2022 | State General Funds and federal Medicaid matching funds |
| **In-Home Operations (IHO)** offers care management and coordination, home respite, habilitation, community transition, and other services in lieu of an institutional setting. Beneficiaries will have the option to transition to the HCBA waiver program because IHO will not be renewed beyond 2019. | Beneficiaries with long term medical conditions who receive direct care services from a licensed nurse, as specified | Individual nurse practitioners, home health agencies and personal care agencies | §1915(c) Home and Community-Based Services Waiver<br><br>Effective through December 31, 2019 | State General Funds and federal Medicaid matching funds |
| **Multipurpose Senior Services Program (MSSP)** seeks to avoid premature placement of seniors in nursing facilities. MSSP provides services to help seniors remain safely in their homes or in community settings through services such as case management, respite care, meal services, personal care, and others. MSSP is scheduled to transition to a managed care benefit effective January 1, 2023 as a result of the CCI. MSSP is already a plan benefit in San Mateo County. | Beneficiaries age 65 or older who are eligible for skilled nursing placement | State-contracted local governments and private nonprofit agencies | §1915(c) Home and Community-Based Services Waiver<br><br>Effective through June 30, 2019 | State General Funds and federal Medicaid matching funds |
| **Program of All-Inclusive Care for the Elderly (PACE)** is a managed care, facility-based model of care that provides and coordinates all needed preventive, primary, acute, and long-term care services to help beneficiaries remain safely at home or in a community setting. The PACE model includes an interdisciplinary team approach to care including physicians, nurse practitioners, nurses, social workers, therapists, and others. | Beneficiaries age 55 or older that qualify for nursing facility level of care but can live safely in the community in a PACE service area | PACE Organizations (POs) approved by DHCS; 11 are currently in operation | Balanced Budget Act of 1997 and several other federal authorities | State General Funds and federal Medicaid matching funds<br><br>The State pays POs a capitated rate for services. |

**Appendix A: Selected Care Coordination Programs Serving Medi-Cal Recipients, June 2019**

| PROGRAM | TARGET POPULATION | COORDINATING ENTITY | FEDERAL AUTHORITY | FUNDING SOURCE |
|---|---|---|---|---|
| **Public Hospital Redesign and Incentives in Medi-Cal (PRIME)** is designed to achieve better value and improve hospital infrastructure and care delivery through a range of interventions. PRIME entities may receive up to $3.7 billion in federal Medicaid funding over five years for achieving metrics in implementing clinical projects designed to change the way care is delivered. Program elements include those focused on care management, care transitions, integration of physical and behavioral health, and others. | Beneficiaries with encounters at safety net hospitals, including those that are high risk and high cost, as specified | Designated Public Hospitals<br><br>District and Municipal Public Hospitals | §1115 Demonstration Waiver | Local funds and federal Medicaid matching funds<br><br>Local funds are submitted through an intergovernmental transfer (IGT)[8] provided by participating hospitals. |
| **Specialty Mental Health Services Waiver** services are provided by State contracted mental health plans (MHPs) in each county who are required to arrange or provide comprehensive specialty mental health services to eligible beneficiaries. MHPs provide a range of services, including intensive care coordination, medication support, targeted case management, psychiatric health facility services, and others. MHPs are required to meet federal managed care requirements. | Beneficiaries who have a mental illness or mental health treatment need serious enough to require the services of a mental health specialist | MHPs | 1915(b) Freedom of Choice Waiver[9]<br><br>Effective through June 30, 2020 | Local funds and federal Medicaid matching funds<br><br>Counties submit CEPs to receive federal matching funds |
| **Whole Child Model (WCM)** is a pilot project to integrate California Children's Services (CCS) program services into certain managed care plans to improve care coordination, streamline care delivery, and other goals. Services integrated include medical case management services, care coordination and program administration services previously the responsibility of the State or counties. (While the managed care plan is responsible for most CCS related services under WCM, counties and the State still retain some functions). | Children with certain diseases or chronic health conditions such as cerebral palsy, hemophilia, and cystic fibrosis | County Organized Health Systems (COHS) plans in 21 counties[10] | §1115 Demonstration Waiver[11] | State General Funds, local funds, and federal Medicaid matching funds.<br><br>MCMC plans receive a capitated rate for WCM beneficiaries. |

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| PROGRAM | TARGET POPULATION | COORDINATING ENTITY | FEDERAL AUTHORITY | FUNDING SOURCE |
|---|---|---|---|---|
| **Whole Person Care (WPC)** is a pilot aimed at coordinating health, behavioral health, and social services for specified Medi-Cal beneficiaries to achieve better beneficiary outcomes. The pilots implement collaborative leadership, data sharing between systems, and coordination of care in real time, as well as evaluating individual and population progress. WPC pilots test whether local collaborations between systems delivering physical and behavioral health as well as social services can improve health outcomes and reduce costs. | High users of multiple health and social service systems, including those with two or more chronic conditions; those with mental and/or SUD; or those at risk of homelessness | Counties, cities, and health facilities, as specified. Primary counties have chosen to become WPC pilots[12] | §1115 Demonstration Waiver | Local funds and federal Medicaid matching funds.<br><br>WPC pilots provide IGTs to receive federal funds. |
| **Targeted Case Management** services are provided by local governmental agencies (LGAs) and other entities to eligible Medi-Cal beneficiaries, including assessment and reassessment, development and revision of a specific care plan, referral and related activities as well as monitoring and follow-up activities. | Children under age 21 and/or beneficiaries that are medically fragile, at-risk of institutionalization, in jeopardy of negative health or psycho-social outcomes, with a communicable disease | LGAs, Regional Centers | Medicaid State Plan[13] | State General Funds, local funds, and federal Medicaid matching funds<br><br>LGAs provide CPEs to the State to receive federal matching funds |

Source: Insure the Uninsured Project, 2019

## Notes

1. Under the federal Social Security Act waivers provide states flexibility and, in some cases, additional federal funding. §1915 (c) Home and Community-Based Services waivers provide authority and funding for selected target populations and services to support beneficiaries remaining home or in their community instead of in institutional care.
2. §1115 of the federal Social Security Act permits states to waive Medicaid program requirements to further the purposes of the program and provide federal funds for program costs not otherwise reimbursable. California's current §1115 Waiver is known as the Medi-Cal 2020 Waiver. Federal approval and related funding will expire December 31, 2020.
3. Participating counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
4. A certified public expenditure (CPE) is an incurred expense eligible for federal Medicaid matching funds as outlined in federal law and program rules. A state or local governmental entity can certify an eligible expenditure to draw down federal match.
5. Participating counties: Alameda, Fresno, Imperial, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Tulare.
6. The State Plan is the agreement between a state and the federal government describing how the state administers its Medicaid program under existing federal laws and requirements. States are required to offer certain benefits and services and may offer certain optional benefits.
7. The California Endowment (TCE), a private non-profit foundation, provided initial funding for California's HHP. TCE is paying the 10 percent state match for the first 2 years of each phase of HHP implementation.
8. An intergovernmental transfer (IGT) is a transfer of public funds between or within levels of government. The State can use IGTs as the non-federal share to match federal Medicaid funds.
9. §1915 (b) Freedom of Choice waivers require beneficiaries to receive Medicaid services through managed care as specified. The waiver permits states to waive a beneficiary's choice of provider in order to require their participation in a managed care system.
10. County Organized Health System (COHS) plans are county-wide, public health plans originally organized by the county serves all Medi-Cal beneficiaries in the county. Participating WCM counties include: Del Norte, Humboldt, Lake, Lassen, Marin, Merced, Mendocino, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Cruz, Santa Barbara, Siskiyou, Shasta, Solano, Sonoma, Trinity, and Yolo.
11. The Medi-Cal 2020 Waiver authorizes two models for care delivery as CCS integration pilots: (1) a provider-based accountable care organization (ACO) and (2) existing managed care plans. CA has authorized Rady's Children's Hospital in San Diego as a CCS demonstration pilot.
12. WPC pilots exist in the following counties: Alameda, Contra Costa, Kern, Kings, Los Angeles, Marin, Mariposa, Mendocino, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, and Ventura.
13. Targeted case management is an optional benefit offered by California under the terms of the Medicaid state plan.

## About ITUP

Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

***The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad-based stakeholder engagement.***

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- California Community Foundation
- California Health Care Foundation
- Kaiser Permanente
- The California Endowment
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