CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY ("Authority")

California Health Access Model Program

Information Item

January 25, 2018

BACKGROUND

The purpose of the California Health Access Model Program ("CHAMP") is to support innovative methods of delivering health care services more effectively and to improve access and health outcomes for vulnerable populations and community by bringing services, including preventive services, to individuals where they live or congregate.

CHAMP is comprised of two phases:

1. Award grants to one or more demonstration projects up to a combined total amount of $1.5 million.
2. If the demonstration project is determined successful, the Authority may launch the second phase of CHAMP to support additional "replication" projects with grants up to a combined total amount of $5 million.

Any grant funds not expended by January 1, 2020 will revert back to the CHFFA fund.

PHASE ONE: SAN FRANCISCO HEALTH PLAN GRANT AWARD

On January 30, 2014, CHFFA awarded a CHAMP demonstration grant in the amount of $1,426,089 to the San Francisco Health Plan ("SFHP") to expand and evaluate an existing pilot program targeting high-cost patients at high risk due to housing instability, mental illness, addiction, and chronic illness, to improve their health outcomes and experience of care, as well as to lower the cost of delivering care. SFHP is a public Medi-Cal Managed Care Plan ("MCP") serving San Francisco County with more than 94,000 members, which constitutes more than 17% of the entire population in San Francisco and its pilot program is known as Community Based Care Management ("CBCM").

In the CBCM pilot program, care managers connected patients to housing services, behavioral health treatment, access to food resources, and primary care. SFHP expanded its existing pilot program to serve an additional 300 high-risk, high-utilizing SFHP members and to more rigorously evaluate the impact on clinical outcomes, member experience, and costs trends. CHAMP grant funds supported various staff positions, contractors, and enrollee expenses.

SFHP submitted its final evaluation in August 2016 for the original two-year grant period, and an updated evaluation in September 2017 for the additional six months after the grant period. SFHP presented the results of the evaluations at the September 28, 2017 Authority meeting.

SFHP's evaluations found that there were significantly fewer long (7 plus bed days) inpatient visits in the treatment group (the patients who participated in CBCM) than the group that did not receive treatment, and that there were a significantly higher amount of primary care visits in the treatment group. SFHP also found the CBCM model to be almost entirely cost-neutral.

Of the CBCM patients that completed a satisfaction survey, there was a 77 percent response rate, and of those responses, 97 percent of the patients indicated that their experience with SFHP's care team was helpful. According to SFHP, this response rate indicates that SFHP was effective in meeting the patients' needs and that the CBCM model was a success.

PHASE TWO

If the Authority chooses to replicate the CBCM model, there would be up to $5 million available. However, there are two similar programs at the Department of Health Care Services ("DHCS") with significantly more funding resources available: the Health Homes Program ("HHP") and the Whole Person Care ("WPC") pilot program. For a chart outlining all three programs, refer to Attachment A.

HEALTH HOMES PROGRAM

HHP is an ongoing program that is substantially similar to the CBCM model. In fact, SFHP was consulted by DHCS regarding the structure of the CBCM model, and SFHP provided recommendations and feedback throughout the development of the HHP Concept Paper.

HHP is similar to CBCM, in that an HHP provider must be an MCP or Community-Based Care Management Entity ("CB-CME") that targets high-cost patients who may be experiencing chronic homelessness, or have utilized inpatient and emergency department services in the last year. The patients must have at least one chronic physical illness, mental illness, or substance use disorder. HHP will pay for staff services for care coordination.

Similar to CBCM, HHP consists of care teams that link qualifying patients to a wealth of resources: treatment of chronic conditions, primary care, and evidence-based programs such as diabetes management and smoking cessation. HHP also works with the patient's family and identify other resources the patient may need, such as housing, food security and nutrition, employment counseling, child care, and disability services.

DHCS and SFHP both recognize that there is no "one size fits all" model that is reasonable or practical to follow, so HHP offers three different care models, depending on whether the CB-CME is in an urban or rural area.

San Francisco will be one of the first counties participating in HHP, so SFHP will be included as a participating MCP. HHP is scheduled to be implemented in select counties in July 2018 for members with eligible chronic physical conditions and substance use disorder, and in January 2019 for members with a serious mental illness. HHP will be an optional benefit as a part of Medicaid. DHCS estimates to have up to $450 million in funds for the program. There is 90% in federal matching funds, and 10% (up to $25 million per year) from the California Endowment available for the first two years.

WHOLE PERSON CARE PROGRAM

The second program by DHCS, similar to CBCM, is the WPC pilot program. WPC began on January 1, 2016, and the pilot will run until December 31, 2020. Up to $1.5 billion in federal funds are available in the five-year pilot period to match local public funds. Similar to CBCM and HHP, WPC targets patients who have repeated incidents of avoidable emergency department use or hospital admissions, two or more chronic conditions, mental health and/or substance use disorders, or are experiencing homelessness or at risk of homelessness.

Similar to the CBCM model, WPC also focuses on "housing first," and organizations that focus on placing patients in housing may participate in the pilot. The participating organizations may include local housing authorities, local Continuum of Care programs, and community-based organizations serving homeless individuals. The organizations providing medical services may include physician groups, clinics, hospitals, and community-based organizations. These organizations may coordinate physical health, behavioral health, and social services, all with the goal of helping patients achieve better health outcomes. WPC pays for infrastructure, health information technology, respite care, and transportation for patients to their appointments.

STAFF RECOMMENDATION

Staff believes replication of the CBCM model has been achieved by the Department of Health Care Services through HHP and WPC. Staff recommends that the Authority choose not to replicate the CBCM model and allow the remaining CHAMP grant funds to revert back to the CHFFA fund on January 1, 2020.

Another replication program will be redundant and unnecessary because two similar programs are or will be implemented. The WPC pilot is already in place and HHP will begin in the near future.

Also, staff had begun to survey other managed health care plans on their ability to and interest in CBCM model replication. To date, staff has reached out to seven MCPs. One MCP was already engaged in a similar activity. A second MCP showed interest, but expressed that they would not be able to take on the additional workload of the project at this time. The other MCPs have not yet responded. Due to a lack of stakeholder response, CHFFA would not be able to move forward with a second phase.

Topics	CHAMP - COMMUNITY BASED CARE MANAGEMENT (CBCM)	DHCS - HEALTH HOMES PROGRAM (HHP)	DHCS - WHOLE PERSON CARE PILOTS (WPC)
Summary	A one-time program to support innovative methods of delivering health care services for high-risk, high-cost patients to improve their health outcomes and experience of care.	An initiative to develop a network of providers that will integrate and coordinate primary, acute, and behavioral health services for the highest risk Medi-Cal enrollees with chronic conditions.	A pilot program to test county-based initiatives that coordinate health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries.
Program Duration	2-year program from June 2014 to June 2016	Ongoing	5-year program from January 1, 2016 to December 31, 2020
Lead Entities	San Francisco Health Plan (SFHP), a public Medi-Cal managed care plan (MCP) serving San Francisco County.	Medi-Cal MCPs will organize the payment and delivery of services.	County agencies; Cities and counties; Health or hospital authorities; Public hospitals; District municipal public hospitals;
Target Population	300 members of SFHP who high-risk for mortality and morbidity due to factors such as housing instability, mental illness, and addiction and high-utilizing hospital inpatient and emergency departments.	Targets the top 3-5% high-risk and high-utilizing Medi-Cal beneficiaries. Eligibility: a member must meet the following criteria: • Have chronic conditions, and • A required high level of acuity/complexity	High-risk, high-utilizing Medi-Cal beneficiaries. Target populations may include: • With repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement; • With two or more chronic conditions; • With mental health and/or substance use disorders;
Funding	Up to $5 million available for replication	Federal: 90% federal matching funds are available for the first two years, and to 50% federal match thereafter State: The California Endowment provides up to $25 million per year for two years to finance the 10% non-federal share.	Up to $1.5 billion in federal funds over five years.

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Eligible Costs	SFHP used the grant funds to pay personnel, training, purchasing equipment, local travel, food, and temporary house.	HHP only funds the care coordination services. However, HHP does not fund any direct medical or social services.	WPC pilot payments may support 1) infrastructure; 2) providing services not otherwise covered or directly reimbursed by Medi-Cal; and 3) implementing strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.
Services	CBCM care coordinators connect patients with primary and preventive care, mental and behavioral health services, substance use treatment, and supportive housing services, and also escort patients to appointments.	HHP will provide care coordination services/benefits. There are six categories of required services: • Comprehensive care management; • Care coordination and health promotion; • Comprehensive transitional care; • Patient and family support; • Referral to community and social support services; and • The use of health information technology to link services, as feasible and appropriate	WPC pilots determine the specific services that will be provided and the interventions and strategies that will be implemented to meet the goals outlined below: • Increase integration among county agencies, health plans, and providers that serve high-risk, high-utilizing beneficiaries, and develop an infrastructure; • Increase coordination access to care; Reduce emergency and inpatient utilization; improve data collection to support ongoing case management; • Increase access to housing and supportive services.