



CALIFORNIA'S 1115 WAIVER:

***An Opportunity to Move from
Coverage to Whole-Person Care***

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EXECUTIVE SUMMARY

The primary theme of the 2010 waiver was Expanding Coverage; the 2015 waiver theme could be From Coverage to Whole-Person Care. Whole-person care can be defined as the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources. In many ways, whole-person care represents a promising vision and strategy for how California will reach Triple Aim goals in Medi-Cal. California has the opportunity to achieve the transformative promise of the Affordable Care Act by aligning its 1115 waiver around activities and incentives that support counties and providers as they move toward whole-person care.

Whole-person care is one vision that has resonated with many audiences across California. The need for net financial neutrality of the waiver centers many waiver discussions on high-cost populations. However, the waiver presents a platform for California to innovate for the future by focusing on high-cost individuals and by operationalizing whole-person care for the broader Medi-Cal populations. Based on our research nationally¹ and in California,² there are three key levers and seven associated recommendations that state policymakers should consider in order to use the 1115 waiver to advance whole-person care and population health for California's Medi-Cal population:

Lever 1: Increase access to effectively coordinated care

- ▶ **Recommendation 1:** Utilize waiver funding to galvanize a ready enrollment workforce to connect covered individuals to care.
- ▶ **Recommendation 2:** Support provider-led health homes with a per-member-per-month (PMPM) payment for integrated behavioral health.

Lever 2: Increase financial flexibility and capacity for shared risk among Medi-Cal providers and delivery systems

- ▶ **Recommendation 3:** Fund infrastructure for virtual Medi-Cal accountable care organizations and risk-bearing provider networks.
- ▶ **Recommendation 4:** Pilot blending funding for mental health, substance use disorders, and health in select counties.

Lever 3: Incorporate focus on social determinants of health

- ▶ **Recommendation 5:** Set aside 1% of waiver funding for a defined set of prevention and policy activities to support whole-person care for the Medi-Cal population.
- ▶ **Recommendation 6:** Create financial incentives for providers and payers for achieving select population health metrics and pilot collecting community-level data.
- ▶ **Recommendation 7:** Use Medicaid resources to address housing as part of care for chronically homeless high-utilizers.

1 JSI. National Approaches to Whole-Person Care in the Safety Net. Prepared for the Blue Shield of California Foundation. San Francisco, CA; March 2014. Available at: www.blueshieldcafoundation.org/publications... .pdf

2 JSI. Opportunities for Whole-Person Care in California. Prepared for the Blue Shield of California Foundation. San Francisco, CA; September 2014. Available at: www.blueshieldcafoundation.org/sites/default/files/... .pdf

INTRODUCTION

The primary theme of the 2010 waiver was Expanding Coverage; the 2015 waiver theme could be From Coverage to Whole-Person Care. Whole-person care can be defined as the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources. In many ways, whole-person care represents a promising vision and strategy for how California will reach Triple Aim³ goals in Medi-Cal. California has the opportunity to achieve the transformative promise of the Affordable Care Act by aligning its 1115 waiver around activities and incentives that support counties and providers as they move toward whole-person care.

The whole-person care framework outlines how targeting populations, sharing data, coordinating services across sectors, patient-centered care, collaborative leadership, and flexible financing are all essential elements for state and county leaders to consider in order to meet the Triple Aim for Medi-Cal populations. Other states' waivers have been criticized as unrelated "wish lists" for funding, and the Centers for Medicare & Medicaid Services (CMS) has asked states to crystallize their vision for the future and how the waiver will help to reach that vision.

Whole-person care is one vision that has resonated with many audiences across California. The need for net financial neutrality of the waiver centers many waiver discussions on high-cost populations. However, the waiver presents a platform for California to innovate for the future by focusing on high-cost individuals and by operationalizing whole-person care for the broader Medi-Cal populations. Based on our research and experience, there are three key levers that state policymakers should engage in order to use the 1115 waiver to advance whole-person care: 1) access to effectively coordinated care, 2) financial flexibility, and 3) incorporating a focus on social determinants of health. The purpose of this brief is to outline specific ideas for utilizing these levers. The recommendations herein are not intended to provide comprehensive elements of an 1115 proposal but rather a set of ideas that could bend the waiver proposal development toward whole-person care for improved population health among California's Medi-Cal beneficiaries.

Whole-Person Care Framework



3 Institute for Healthcare Improvement. The Triple Aim. Available at: <http://www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx>

RECOMMENDATIONS

Lever 1: Increase access to effectively coordinated care

The 1115 waiver should be designed to build the pathway from increasing enrollment to increased access to health, behavioral health, and social services and to improve coordination of services that meet patient needs. Evidence from other states and initiatives in California demonstrate the importance of addressing both “connection to care” and “coordinated care” for improving patient experience and efficient utilization.

■ **RECOMMENDATION #1**

Utilize waiver funding to galvanize a ready enrollment workforce to connect covered individuals to care

The first critical step in whole-person care is ensuring covered individuals are appropriately engaged and linked to the services they need. Navigators, assisters, counties, unions, health centers, and community-based organizations have enrolled millions of Californians in Medi-Cal and in plans offered through Covered California, starting to create a much-needed culture of coverage in the state. Many of the newly enrolled have never had coverage or access to a consistent source of care.⁴

For the newly insured population, enrollment is not always synonymous with access to care: there exists a chasm between enrollment and receiving or seeking out the social services, health services, and behavioral health services that optimize health outcomes and prevent avoidable hospitalization. JSI’s research in Massachusetts in the years following coverage expansion⁵ suggests that newly insured populations—especially those who have never been insured—continue to experience barriers to care. Such barriers include lack of knowledge about using the health system and language and cultural barriers that can prevent an individual from receiving the health, behavioral health, and social services he/she needs to be healthy. Furthermore, our research in five California counties revealed that with Medi-Cal expansion and the carve in of mild-to-moderate behavioral health into managed care Medi-Cal, Medi-Cal coverage now serves as the “gateway” for individuals to be assessed and eligible for an array of behavioral health and social services as well as health services. With additional resources and explicit accountability, the “ready workforce” of individuals and organizations who have helped to cover millions of Californians could now help the newly enrolled population access care.

The 1115 waiver could include the following funded provisions in order to ensure that Medi-Cal members, especially the newly insured who have never been enrolled, are actively engaged in appropriate care:

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- 4 DiJulio B, Firth J, Levitt L, Claxton C, Garfield R, and Brodie M. Where Are California’s Uninsured Now? Washington, DC: Kaiser Family Foundation; July 2014. Available at: <http://kff.org/health-reform/report/where-are-californias-uninsured-now-wave-2-of-the-kaiser-family-foundation-california-longitudinal-panel-survey/>
 - 5 Massachusetts enacted statewide health reform in 2006, which included implementation of universal coverage and expansion of access to affordable healthcare for all residents. This legislation later became the model for the Affordable Care Act.

- ▶ Expand patient navigator and assister contracts to include resources and accountability for ensuring patients are connected to care. The waiver could include a “Connect to Care” financial incentive to entities formerly only responsible for enrollment. Monitoring metrics might include measures such as all newly enrolled members who visit his/her assigned primary care provider (PCP) at least once during the year.
- ▶ Train community health workers to be knowledgeable about behavioral health and social services available in local communities and how their eligibility guidelines align with Medi-Cal.
- ▶ Incent providers and other community-based organizations to engage and educate patients on how to use the health system, including the benefits of having a PCP and after-hours access to primary care. If patient engagement and education sessions reveal key barriers, require that barriers are incorporated into a Community Needs Assessment process for local federally-qualified health centers (FQHCs) and hospitals.

Potential matching funding: Inter-governmental transfers (IGTs) from entities already doing community health worker training and patient enrollment.

■ **RECOMMENDATION #2**

Support provider-led health homes with a per-member-per-month (PMPM) payment for integrated behavioral health.

Integration of behavioral health with primary care has consistently emerged in our research and that of others as a high-priority strategy for improving cost and health outcomes of populations and is a component of 1115 waivers in numerous other states. Behavioral health integration is critically needed because of the high prevalence of behavioral health issues in the Medi-Cal population (often co-occurring with chronic disease). There is significant interest in improved coordination and integration among health, mental health and substance use disorder service providers and also recognition that significant barriers exist. The 1115 waiver could catalyze a substantial move toward integration by providing the necessary funding to address barriers such as staff training, shared data systems, and care coordination capacity in the form of a PMPM payment.

It is important to note that this approach would be consistent with the State implementing a Section 2703 State Plan Amendment (SPA) of the Affordable Care Act, which would provide a funding stream, matched at a 90/10 Federal rate for eight calendar quarters, for providers to render a novel set of care coordination and case management services to individuals with chronic conditions and serious and persistent mental illness in designated geographies. Waiver funds would support upfront training and infrastructure costs that are not supported by a 2703 SPA; behavioral health integration in geographies that are not immediately selected to implement the 2703 SPA; and in patient populations that do not qualify for the 2703 SPA. The PMPM payment for behavioral health integration could be most effectively used to provide the

necessary training and infrastructure support for a range of care management and case management approaches, depending on the current status of integration efforts, health system structures, and 2703 implementation. For example, a public hospital or globally capitated hospital might focus PMPM resources on creating a system for emergency department diversion by having staff from local primary care health centers on site. A health center might use the PMPM funds to establish data sharing and staff training in coordination with local mental health professionals at the county.

It should be noted that whole-person care interviews in California repeatedly arrived at the same conclusion that other states, such as New York, have come to in determining how to implement health homes: care coordination is most effective at the patient/provider level, rather than at the plan level. The waiver funding should focus on building capacity among providers to serve as “community-based care management entities” as envisioned in the Health Homes for Patients with Complex Needs (HHPCN) California Concept Paper⁶ by requiring that a substantial portion of waiver funds for behavioral health integration are used at the provider level.

Potential matching funding: Savings relative to average national Medicaid spend per capita. Patient-centered health home (PCHH), when well-implemented, is correlated with decreased spend per capita and increased quality and patient experience. The key to achieving these positive outcomes demonstrated by some, but not all, PCHHs is a successful implementation of PCHH strategies and services, including forging new relationships among and between care teams, data infrastructure and training for providers on how to optimally deliver PCHH services such as empanelment, population health management, motivational interviewing and trauma-informed care for patient engagement.

Lever 2: Increase financial flexibility and capacity for shared risk among Medi-Cal providers and delivery systems

Payment reforms are likely to be the most powerful levers that an 1115 waiver can put in place. Incentives and regulatory guidelines shape the ability of health systems and organizations to impact patient experience and coordinate care within and across systems, while spending resources in the most efficient manner to achieve desired Triple Aim outcomes. Waiver resources should be deployed to build the necessary infrastructure that is likely to produce impact.

■ **RECOMMENDATION #3**

Fund infrastructure for virtual Medi-Cal accountable care organizations (ACOs) and risk-bearing provider networks.

Whole-person care will require more flexibility in payment systems and increased accountability for health and cost outcomes. One way to achieve the necessary mix of

6 California Department of Health Care Services (DHCS). Health Homes for Patients with Complex Needs (HHPCN) California Concept Paper. Sacramento, CA: DHCS; November 2014. http://www.dhcs.ca.gov/provgovpart/Documents/HealthHomes/DHCS_Health_Homes_Concept_Paper_111714_final.pdf

accountability and financial flexibility to optimize health outcomes for populations is through partial or global capitation contracts. As more health systems in a community operate under global capitation, there will be greater incentive to invest in upstream health-generating activities or broad interventions that prevent hospitalization, rather than just medical services. However, accepting and being able to successfully perform under increased financial risk arrangements, such as partial or global capitation, requires new levels of sophistication, organization and/or network size, data sharing and analysis, and tools and practices for managing population health.⁷

ACOs with formal governance structures and similar arrangements to Medicare ACOs have emerged naturally in some commercial markets in California and in other states, have been stimulated to form in Medicaid. However, Medi-Cal ACOs have not emerged in significant number in California to date. Where select public hospitals have accepted global capitation contracts from payers, challenges have emerged in fulfilling the functions of a risk-bearing entity, such as managing out-of-network contracts and claims. In addition, health centers, where almost two-thirds of all Medi-Cal outpatient primary care services are rendered, mostly operate as non-risk-bearing entities. Risk-bearing health center networks do exist in California (e.g., Community Health Center Network in Alameda, Redwood Community Health Coalition in Sonoma, AltaMed and HealthCare LA IPA in Los Angeles). These health center networks accept professional financial risk and assume accountability for populations of assigned Medi-Cal beneficiaries. However, the health centers within the networks receive the majority of their revenue through volume-based payments,⁸ and many health centers do not employ the gamut of population health management tools, patient engagement strategies, and analytics that a capitated entity would need in order to be successful under a risk-based contract for an assigned population. More importantly, most health centers in California do not operate as part of larger networks that might be able to spread risk across a large managed population. Size is a basic tenet for successful risk bearing. Absent sufficient size, risk bearing becomes a challenge.

Furthermore, the need for upfront resources necessary to bear financial risk is a significant barrier for many Medicaid providers. For example, when we interviewed Hennepin Health (a safety-net ACO in Minnesota) about their move to a global capitation contract for a Medicaid expansion population, they cautioned others thinking about bearing more risk in Medicaid: “Estimate the number of analytic resources needed. Then double it.” Indeed, if the provider and health systems responsible for the majority of Medi-Cal services are going to successfully move into bearing more financial risk in the future, they need to have the infrastructure and analytic capacity to bear that risk and optimize the financial flexibility.

7 Such contracts are distinct from the “intermediate” step of shared savings in most Medicare ACOs, which usually preserve fee-for-service payments and provide upside performance-based payments. In either a partial or global capitation contract, withholding a portion of a global contract or having an upside risk contract on top of a partial capitation contract, both of which are only paid if select Triple Aim outcomes are met, can add accountability to the flexibility of capitation.

8 California Primary Care Association, California Association of Public Hospitals and Health Systems, DHCS and Medi-Cal MCOs are working toward an FQHC Payment Reform pilot, which would allow health centers to pilot a payment system under an Alternative Payment Methodology which would provide both more flexibility and risk to health centers. While FQHC Payment Reform represents another key facilitator for giving Medi-Cal providers the needed financial flexibility to provide whole-person care, it will not be addressed in this brief.

Waiver funding has the potential to support Medi-Cal providers and health systems to achieve the adequate scale and capacity to succeed under capitated contracts. This could entail supporting increased collaboration among providers in three key starting places: existing networks of health centers, public hospitals with relationships with primary care and behavioral health providers to build upon, or groups of primary care providers/health centers interested in coming together to have the necessary size to form a “whole-person care” network. Waiver resources could support tools and training for population management, data analytics resources, forging new relationships and data exchange between providers and hospitals, and growing contracting capabilities for health centers interested in forming new risk-bearing networks.

This approach is likely to garner support from stakeholders. For example, many Medi-Cal managed care organizations have consistently expressed interest in delegating more accountability and risk to the provider level through global or partial capitation contracts, sometimes accompanied by shared risk pools for decreasing hospital utilization and increasing quality. By providing resources to move toward shared risk without requiring the governance structure or formal parameters of a Medicare-like ACO, partial or global capitation contracts with shared risk tied to outcomes are a potentially straightforward way to move toward whole-person care within “virtual Medi-Cal accountable care organizations.”

RECOMMENDATION #4

Pilot blending funding for mental health, substance use disorders, and health in select counties.

Untreated or under-treated behavioral health issues and/or uncoordinated behavioral health and health services are well documented as causes of poor health outcomes and high health care costs. Furthermore, our interviews in five California counties consistently pointed to siloed funding streams for Drug Medi-Cal, specialty mental health, and Medi-Cal health services as a key barrier to providing whole-person care to some of the most complex and needy individuals, who are often being served concurrently in all three systems.

One way that the 1115 waiver could promote whole-person care would involve coordinating a vision with the upcoming Drug Medi-Cal Organized Delivery System Waiver and mental health 1915(b) waiver to allow pilots in “ready and willing” counties to “carve-in” severe mental health and Drug-Medi-Cal benefits into managed care Medi-Cal on a county-by-county basis. While agreements would need to be put in place in pilot counties to ensure that behavioral health services were being rendered and that outcomes were being achieved, interviews across the state illustrated pockets of interest in experimenting with such carving in of severe mental health and substance abuse funding to allow provision of more whole-person care. For example, this type of arrangement could stimulate longer-term commitments between managed care Medi-Cal plans and housing providers, allowing ongoing supportive case management to individuals in need, even as an individual might improve from having a severe mental health condition to a moderate mental health condition.

The Coordinated Care Initiative⁹ is an example of how blending funding has stimulated some experimentation of providing supportive housing for dual-eligible beneficiaries. Blending funding streams for individuals in need of severe mental health, substance use, and health services at the county level under the waiver could stimulate similar experimentation with addressing an individual's needs in a coordinated manner and by focusing on the services that will most help to prevent avoidable hospitalization. Given the prevalence of behavioral health needs in the Medi-Cal expansion (MCE) population and the Federal commitment to paying for MCE individuals, the 2015 waiver is an ideal time and opportunity to pilot new blending of funding for whole-person care.

Lever 3: Incorporate focus on social determinants of health

There is a growing body of evidence demonstrating that behavior and social and physical environments are the primary determinants of health.^{10, 11} By the time an individual walks into a health care setting with a diagnosable condition, it is very difficult and expensive to alter their course and improve outcomes. This is particularly true for individuals with complex health profiles (e.g., multiple conditions, physical and behavioral health issues, often exacerbated by living in poverty), those who have urgent social needs (e.g., stable housing, employment), and people who live in communities that are unsafe or lacking in healthy infrastructure. The Medi-Cal expansion includes a population that is disproportionately likely to fit a complex health and social needs profile. Furthermore, interest in the flexibility and accountability of more capitated payment arrangements and emerging evidence of effective approaches that integrate clinical and community strategies are leading many states and communities to explore multi-strategy approaches to improve the health of geographically defined populations.

California proposed an Accountable Community for Health (ACH) initiative as part of its State Innovation Models (SIM) proposal to CMMI. Even though the CalSIM was not awarded, safety-net leaders are still exploring what it would take to promote an ACH in California. An ACH is an innovative approach to galvanizing a wide range of partners and payers to work collaboratively on identified health outcomes to create a “dose effect” by concurrently addressing an issue at multiple levels. California’s groundbreaking tobacco control efforts are an example of the impact that combined individual (e.g., cessation programs), community (e.g., media campaigns), and policy strategies (e.g., tobacco-free ordinances) can have in substantially changing norms, behaviors, environments, and health outcomes. The 1115 waiver could include elements that, while focusing on Medi-Cal populations, provide building blocks for ACH-type initiatives and the novel set of relationships across the health, behavioral health, and social service sectors necessary to advance whole-person care. Since the waiver

9 California Department of Health Care Services. Coordinated Care Initiative Overview. Available at: <http://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareInitiative.aspx>

10 Robert Wood Johnson Foundation. How Does Where We Live, Work, and Play Affect Our Health? Princeton, NJ: Robert Wood Johnson Foundation; September 2011.

11 RWJF Commission to Build a Healthier America. Overcoming Obstacles to Health in 2013 and Beyond. Princeton, NJ: The Robert Wood Johnson Foundation; 2013. Available at: <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf406474>

has a 5-year course, this is a key opportunity to provide the time and resources necessary to accelerate transformation toward community-wide population health by starting with the Medi-Cal population.

■ RECOMMENDATION #5

Set aside 1% of waiver funding for a defined set of prevention and policy activities to support whole-person care for the Medi-Cal population.

The waiver offers a unique opportunity for the State to play the important regulatory role of directing investment into prevention and policy activities where private markets underinvest in a public good.¹² MCOs tend to underinvest in prevention interventions that address both individual and community-level health both because each payer hopes that others will make the investment from which they can benefit (e.g., the “free rider” problem intrinsic to all public goods), the prospect of “churn,”¹³ (i.e., “my member today will be another payer’s member in the near future”) and because of the long-term time horizon for benefits of such interventions to manifest. Yet, if all payers are investing in population-health endeavors, no individual payer is left at a competitive disadvantage.

We would recommend that the State require 1% of waiver funds to be set aside for prevention. The pool of funding created by this 1% set-aside should be focused on priority health conditions affecting the safety-net population in each geography (potentially drawn from Community Health Needs Assessments) and divided equally between individually focused clinical prevention strategies (such as tobacco cessation or nutrition counseling) and population-focused environmental and policy approaches in communities where there is a high-density of Medi-Cal enrollees (such as policies supporting safe streets, safe and accessible walking/biking routes, or healthy workplace initiatives). The CalSIM Accountable Communities for Health (ACH) workgroup has conducted a review of the literature showing evidence for various clinical, linkage, and community-level interventions, which could be used as the basis for the menu of strategies. Finally, there is evidence from other states that having a public payer as a leader is key for success in drawing other investments in multi-payer initiatives, such as ACHs. While CalSIM was not funded, there still exists substantial interest in advancing the concept of ACH in California. It is quite likely that the 1% fund could draw other investments and bend existing spending in the public and private sectors toward population health priorities at the local level.

Potential matching funding: Savings relative to average national Medicaid spend per capita and County IGTs using county or city funding for public health or health-generating initiatives/environments. The ACH is a unique model that convenes a novel

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- 12 A public, or “collective,” good has two key characteristics: 1) Consumption of the good by one [entity] does not reduce the amount available for others to consume. 2) Benefits that a given [entity] receives from a collective good does not depend on that [entity’s] contribution to funding it, leading to a “free rider” problem, where every [entity] underinvests in hopes that others will make the investment.
- 13 The State’s proposal in the January 2015 Budget to limit some Medicaid “churn” with an annual Medi-Cal enrollment period would mitigate the issue of churn somewhat. However, even “annual churn” would likely still pose an obstacle to longer-term prevention investments.

set of stakeholders and combines public health and health service activities into a portfolio of interventions designed to generate a greater effect than the additive effects of single interventions. In light of this innovation, there may be county funds (tax revenue) currently used for health districts (not just public hospitals) that could be matched because of their use in this “dose effect” manner. Given the population health focus, it would be worth exploring whether there are funds spent at the state, county and city levels that have not traditionally been thought of as (matchable) health dollars but could be reconsidered as key facilitators of population health outcomes. Examples of previously unmatched dollars might include but are not limited to: funds for built environment planning, parks and recreation, and school-based health education.

■ **RECOMMENDATION #6**

Create financial incentives for providers and payers for achieving select population health metrics and pilot collecting community-level data.

Measures of population health have been receiving significant attention from the Institute of Medicine, the National Committee for Quality Assurance, and others as a strategy to better understand patterns of illness and injury at a population level and also to emphasize factors outside of a clinical context that affect health. Furthermore, measuring and/or incentivizing a process or outcome transparently can motivate providers and payers to improve on that outcome. The 1115 waiver could incorporate a focus on population health by requiring implementation of two initiatives focused on specific population health metrics: incentives for providers and payers based on outcomes within their Medi-Cal panel and piloting the collection of data on outcomes for everyone within defined geographies where there is a high proportion of Medi-Cal beneficiaries. We recommend using the metrics “Population Body Mass Index (BMI)” and “Population tobacco non-use rate” for both initiatives for three reasons:

- ▶ Improvements in dietary and physical activity behaviors that contribute to both BMI and tobacco non-use (either cessation or preventing tobacco-use commencement) are correlated with many positive health outcomes and reduced healthcare costs.
- ▶ Research strongly suggests there is a “herd effect” with both overweight/obesity and tobacco use. In other words, both conditions are deeply influenced through social ties: if you have friends who are obese/smoke, you are more likely to be obese/smoke. Thus, it is beneficial for payers and providers to consider members’ social networks, not just members themselves.
- ▶ Population health measures have the potential to motivate major influencers in the health and business economy (payers and providers) to think beyond clinical interventions and shift finding policy solutions that will affect their members and patients while also creating a culture of health. For example, a public hospital might choose to incentivize employees to exercise or work collaboratively with public health and local policymakers to create a walking path to encourage a culture of physical activity in the community.

■ RECOMMENDATION #7

Use Medicaid resources to address housing as part of care for chronically homeless high-utilizers.

One of the six concepts DHCS has put forward for the next 1115 waiver is “Medicaid funded Shelter for Vulnerable Populations.”¹⁴ This is an ambitious idea and reflects a genuine commitment to incorporating a focus on social determinants of health in California’s transformation efforts. Based on our research into approaches for integrating health and housing in California counties and monitoring of the national reform landscape, we would suggest the following elements be built into the next waiver in order to facilitate robust adoption of housing as part of effective and efficient whole-person care:

- ▶ Use Medicaid resources for risk-bearing providers or payers to provide short-term housing for individuals who are likely to be high-utilizers of the medical system, are homeless or housing insecure, and who are likely to be eligible for housing vouchers and subsidies. The funding could create the necessary “bridge” to permanent housing funded through other sources. This would address major barriers to creating a robust “hospital to housing” pipeline, giving local providers resources to get vulnerable individuals into a stable environment quickly, leveraging other public resources, and providing assurance for local housing advocates that adequate resources are available in order to dedicate rental units. Given CMS’s rejection of waiver proposals to directly use Medicaid funds for housing, it might be necessary to create an incentive pool available to health plans (or counties) for housing and utilization outcomes. This is the approach Illinois took in their pending waiver proposal.
- ▶ Use Medicaid resources for care coordination, housing coordination, and “habilitative” services. Transitioning a vulnerable individual from a precarious housing status to a stable, housed situation has been demonstrated to have significant health and financial returns, but requires a high-level of flexibility and responsiveness to the needs of the individual and partners such as housing advocates and landlords. For example, what some individuals most need to avoid hospitalization are “habilitative services,” such as support learning to manage their money in order to pay their rent on time and maintain their housing. Also, landlords want assurance that they have a contact who will intervene if they have an issue with the tenant. These are examples of relatively low-cost activities necessary for successful whole-person care for individuals who are homeless or in unstable housing. Additionally, securing housing units requires focused efforts and partnership development that should be supported as part of an initiative to house high-utilizing homeless individuals.

14 California Department of Health Care Services. Concepts for California’s Next Medicaid Waiver Renewal. Sacramento, CA: DHCS; July 2014. http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Initial_Concepts_for_2015_Waiver-July_2014.pdf

Potential matching funding: Savings relative to average national Medicaid spend per capita. Using Medicaid funding as a bridge funding source until other permanent housing funding sources can be identified and secured for individuals meeting select criteria essentially described as “would otherwise be housed in a hospital,” will allow the Medicaid system to supplant the cost of inpatient hospital days with supportive housing that would cost substantially less than inpatient care.

CONCLUSION

California has a long history of innovation in the health sector and has recently been recognized for commitment and success in expanding coverage under the Affordable Care Act. As the state’s next 1115 waiver application takes shape, the State has an opportunity to communicate a clear vision of where we are headed—improved financial and health outcomes—and how we plan to get there. A clear vision is important both for federal regulators and decision makers and California stakeholders. Whole-person care provides a coherent vision, is based on the wisdom and experience of health, behavioral health, and social service leaders across the state and country, and aligns with the direction that public payers and providers are interested in moving. As California pursues the Triple Aim, the whole-person care vision could guide the State toward paying for value, effectively coordinating across organizations and sectors, and efficiently addressing individual clinical and social needs of the Medi-Cal population.

APPENDIX: STATE WAIVER WORK GROUPS

The recommendations in this brief were identified based on analysis of how to use the 1115 waiver to advance Whole-person care for a broad target population. Given the way that the current stakeholder process has been organized, the table below indicates workgroups for which each recommendation has the greatest relevance.

	Shelter/ Housing	MCO/ Provider Incentives	DSRIP	Workforce	Safety Net Financing - DSH SNCP	Federal/ State Shared Savings	FQHC Payment Reform
Utilize waiver funding to galvanize a ready enrollment workforce to connect coverage to care		X		X			
Support provider-led health homes with a PMPM payment for integrated behavioral health	X	X	X				
Fund infrastructure for virtual Medi-Cal accountable care organizations and risk-bearing provider networks			X		X		X
Pilot blending funding for Mental Health, Substance Use Disorder and Health at County Level	X	X	X				
Set aside 1% of waiver funding for a defined set of prevention and policy activities to support whole-person care for the Medi-Cal population		X	X			X	
Create financial incentives for providers and payers for achieving select population health metrics and pilot collecting community-level data		X	X				
Use Medicaid resources to incorporate housing as part of treatment for chronically homeless high-utilizers	X						

