Aligning Medical, Behavioral, and Social Services in California’s Whole Person Care Pilot Program

Strategies to Achieve Alignment, Collaboration, and Synergy Across Delivery and Financing Systems

Research-in-Progress Webinar
February 8, 2023
12-1pm ET / 9am-10am PT
WPC evaluation team

• Nadereh Pourat, PhD, co-Principal Investigator
• Emmeline Chuang, PhD, co-Principal Investigator
• Brenna O’Masta, MPH
• Leigh Ann Haley, MPP
• Xiao Chen, PhD
• Weihao Zhou, MS
• Menbere Haile, PhD, MS

Student Researchers:
Anthony Gómez, MSW; Elaine Albertson, PhD; Kelly Royan, MPH; Nadia Safaeinili, MPH; Rachel Ross, MPH; Ammar Bhaiji
Medi-Cal Whole Person Care (WPC) Pilot Program

- Implemented as part of California’s Section 1115(a) Medicaid waiver

- Aim of improving health and well-being of high-risk, high-utilizing Medicaid beneficiaries

- $3 billion budget ($1.5bn from Pilots and $1.5bn matching from CMS)

Must provide care coordination and demonstrate increased access to social services

Must focus on >1 of six target populations

Must be implemented by collaborative, cross-sector partnerships

Can use funds to develop data system and delivery system infrastructure
Medi-Cal Whole Person Care (WPC) Pilot Program

- 25 Pilots implemented WPC

- 247,887 unique enrollees (Jan 2017 – Dec 2021)
  57% High utilizers
  53% Experiencing homelessness
  25% Justice-involved
  24% Serious mental illness and/or substance use disorder
  22% At-risk of homelessness
  16% COVID-19
  10% Multiple chronic physical conditions

- Considerable heterogeneity across Pilots
Evaluation of WPC Pilot Program

• **Mixed methods evaluation**

• **Key data sources**
  - Medi-Cal enrollment and utilization data (for WPC enrollees and matched control group)
  - Bi-annual narrative reports (2017-2021)
  - Quarterly enrollment and utilization reports (2017-2021)
  - Organizational surveys of lead entities and key partners (2018, 2020, 2021)
  - Frontline worker survey (2020)
  - Partner classification sheets
  - Key informant interviews (2018-2019 and 2021)
**Aim 1:** Assess changes to WPC Pilot partnerships in response to COVID-19

**Aim 2:** Determine whether impact of COVID-19 on WPC varied across demographic groups

**Aim 3:** Examine Pilot-level characteristics associated with improved outcomes for WPC enrollees
AIM 1: ASSESS CHANGES TO WPC PILOT PARTNERSHIPS IN RESPONSE TO COVID-19

1a: Descriptively examine patterns of change over time
1b: Comparative case analysis to identify factors associated with stronger inter-agency collaboration
Aim 1a: Partnership changes in response to COVID

Data sources

- Partner classification lists (2017-2018, 2020)
- Organizational surveys (2018 and 2020)

Key survey measure (assessed 3 time points)

Please indicate the ways in which your organization currently interacts with each of the following WPC partners:

- Joint advocacy or planning
- Data sharing
- Client referrals
- Communication about client needs or care
- Joint service delivery

Partnership composition: Who are Pilots partnering with?

Tie churn: Changes in ties between 2017-18 and 2020

Network density: % ties out of possible ties in Pilot network

Average degree: average # ties with other partners reported by each agency

Centralization: Degree to which Pilot’s network clustered around a few organizations

Multiplexity: Average # ways partners working together (strength of ties)
Aim 1a: Partnership changes in response to COVID-19

• Total # partners increased from 508 in 2017/2018 to 570 in 2020

• Majority of partners were community-based

• Few partners discontinued (n=14, 3%)
  - Majority (12) due to lack of engagement or inability to follow partner agreement
  - 2 due to organization no longer existing

Types of Participating Organizations (n=570)

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical / physical health</td>
<td>23%</td>
</tr>
<tr>
<td>Housing or housing support</td>
<td>18%</td>
</tr>
<tr>
<td>Other social services</td>
<td>17%</td>
</tr>
<tr>
<td>County or city entity</td>
<td>12%</td>
</tr>
<tr>
<td>MH/SUD</td>
<td>11%</td>
</tr>
<tr>
<td>Managed care plan</td>
<td>9%</td>
</tr>
<tr>
<td>Justice</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
</tbody>
</table>
Average values over time [Mean (SD)]

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Multiplexity</td>
<td>1.91 (0.95)</td>
<td>3.05 (1.03)</td>
<td>2.72 (0.90)</td>
<td>0.7 – 4.82</td>
</tr>
<tr>
<td>Density</td>
<td>0.54 (0.18)</td>
<td>0.59 (0.27)</td>
<td>0.35 (0.18)</td>
<td>0.06 – 0.97</td>
</tr>
<tr>
<td>Average degree</td>
<td>8.87 (3.92)</td>
<td>9.74 (4.32)</td>
<td>6.37 (3.37)</td>
<td>1.46 – 17.46</td>
</tr>
<tr>
<td>Centralization</td>
<td>0.48 (0.17)</td>
<td>0.45 (0.18)</td>
<td>0.65 (0.15)</td>
<td>0.23 – 0.86</td>
</tr>
</tbody>
</table>

- On average, multiplexity, density, and average degree of ties increased following implementation of WPC.
- Ties weakened during the pandemic.

14 Pilots meaningfully increased multiplexity and/or density of ties even after the pandemic; 12 did not.
Aim 1b: Partnership changes

Goal: Identify factors associated with differences in collaboration over time

Data sources
- Partner classification lists (2017-2018, 2020)
- Organizational surveys (2018 and 2020)
- Key informant interviews (2018-19 and 2021)
- Bi-annual narrative reports (2017-2021)

Full sample: 26 networks (25 Pilots)

Subsample for preliminary analyses:
- 8 Pilots focused on serving enrollees with SMI
- Changes from “before WPC” to “mid-implementation” (2018)
Aim 1b: Preliminary results (8 Pilots focused on SMI)

Case Selection:

<table>
<thead>
<tr>
<th>Density</th>
<th>Multiplexity</th>
<th>Before WPC</th>
<th>After WPC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low</td>
<td>G</td>
<td>A, B</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>C, E</td>
<td>D, F, H</td>
</tr>
<tr>
<td>High</td>
<td>Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** High density if >0.7; high multiplexity if average ties in Pilot ≥2

<table>
<thead>
<tr>
<th>Density</th>
<th>Multiplexity</th>
<th>Before WPC</th>
<th>After WPC</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change</td>
<td>No change</td>
<td>B, C</td>
<td>A, F, G</td>
</tr>
<tr>
<td>Increase</td>
<td>Increase</td>
<td>D</td>
<td>E, H</td>
</tr>
</tbody>
</table>

**Note:** Increased density if ≥5% change; increased multiplexity if change ≥1

- 2 Pilots increased multiplexity and density of ties after WPC
- 4 increased multiplexity or density of ties after WPC (but not both)
- 2 Pilots did not increase multiplexity or density of ties after WPC
Aim 1b: Preliminary results (8 Pilots focused on SMI)

• Pilots that did not increase multiplexity of ties did not meaningfully change how they interacted with partners or focused only on data sharing (n=2)
  o Pilot D contracted with new CBO to deliver services but did not engage in other partner-level systems change

• Pilots that improved multiplexity of ties implemented new relational mechanisms (n=4)
  o Pilot A created new interdepartmental multidisciplinary teams to provide care
  o Pilot G held monthly WPC meetings and encouraged participation in local community coalition meetings

• Pilots that improved density and multiplexity also leveraged other funds to support broader systems change in care for individuals affected by serious mental illness (SMI) (n=2)
AIM 2: DETERMINE WHETHER IMPACT OF COVID-19 ON WPC ENROLLMENT AND SERVICE UTILIZATION VARIES ACROSS DEMOGRAPHIC GROUPS

Policy brief assessing impact of COVID-19 on overall enrollment and service utilization:

Aim 2: COVID-19 Impact on WPC Enrollment and Utilization

Data sources
• Quarterly enrollment and utilization reports (Jan 2019 – Dec 2020)
• Medi-Cal enrollment and claims data (Jan 2019 – Dec 2020)

Measures
• **Enrollment** (average, new enrollment, disenrollment)
• **Utilization** (emergency department (ED), inpatient, primary care, mental health, and substance abuse treatment visits)
• **Race/ethnicity**: White, Hispanic, Black, Asian, Alaska Native or American Indian, Native Hawaiian and Pacific Islander, Other

Analyses
• Descriptive statistics
• Difference in difference models by race/ethnicity (Mar-Dec 2019 to Mar-Dec 2020)*
• Difference in difference (white vs. other race/ethnicity)

*Models examining utilization control for enrollee age, gender, language, months enrolled, cohort, pilot, and CDPS score
Aim 2: COVID-19 Impact on WPC Enrollment and Utilization

WPC Enrollees (n=247,887): Race/Ethnicity

- White: 26%
- Hispanic: 28%
- Black: 24%
- Asian: 1%
- American Indian or Alaskan Native: 5%
- Hawaiian or Other Pacific Islander: 2%
- Other: 10%
- Unknown: 7%

Other Enrollee Demographics
- >90% aged 18-64 years
- 86% preferred English for communication
- 51% experienced homelessness
- 74% non-white

Source: Medi-Cal enrollment data and WPC quarterly enrollment and utilization reports
Aim 2a: COVID-19 Impact on WPC Enrollment

- Increased enrollment in 2020 compared to 2019
- Total new enrollment in last 3 quarters 2020 lower than same quarters in 2019
- 20% decline in average monthly disenrollment in 2020 compared to 2019 [not shown in Figure]
Aim 2a: COVID-19 Impact on WPC Enrollment (unadjusted)

Average enrollment
• Average enrollment increased over time for enrollees of all race and ethnicities
• Enrollment of Hispanic and Black enrollees increased more than for whites
• Enrollment of other racial/ethnic groups was lower than whites

New enrollment
• New enrollment decreased for enrollees of all race/ethnicity except “Other”
• New enrollment was higher for Hispanic, Native Hawaiian/Pacific Islander enrollees than whites
• New enrollment was lower for Black, Alaska Native/American Indian, and Asian than for white
Aim 2b: COVID-19 Impact on Enrollee Service Utilization

Monthly Utilization per 1,000 Member Months Among WPC Enrollees, 2019 vs. 2020

- Use of all service types declined in April 2020 compared to April 2019
- By Dec 2020, rates of primary care and specialty care utilization were similar to Dec 2019
- Emergency department and inpatient hospitalizations remained lower in Dec 2020 than in Dec 2019

Source: DCLA analysis of Medi-Cal enrollment and claim data from March 2020 to December 2020.
Note: Member-months were based on Medi-Cal enrollment.
**Aim 2b: COVID-19 Impact on Other Service Utilization**

- ED and inpatient visits significantly decreased for White, Hispanic, and Black enrollees in 2020 relative to 2019. No significant differences between these groups in utilization.

- Primary care visits increased for all enrollees except American Indian and Alaska Native (AIAN) in 2020 relative to 2019. Primary care utilization did differ by race/ethnicity.

- Specialty care increased for all enrollees except American Indian and Alaska Native (AIAN) in 2020 relative to 2019. However, differences by race/ethnicity were not significant.

<table>
<thead>
<tr>
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<th>Primary Care: Difference in Difference (compared to White)</th>
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</thead>
<tbody>
<tr>
<td>White</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>13%*</td>
</tr>
<tr>
<td>Black</td>
<td>5%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>-50%*</td>
</tr>
<tr>
<td>Asian</td>
<td>15%*</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>21%*</td>
</tr>
</tbody>
</table>

* = Significant difference
Aim 2b: COVID-19 Impact on Other Service Utilization

• Mental health and substance abuse treatment visits decreased post-pandemic for enrollees of all races and ethnicities.
  o Decreases in mental health visits were smaller for Asian than white enrollees and greater for Native Hawaiian and Pacific Islanders.
  o Decreases in substance abuse treatment were smaller for Hispanic, Black, Asian, and Native Hawaiian and Pacific Islander enrollees compared to White enrollees.

Further research needed to explore why primary care utilization decreased for AIAN relative to other enrollees and why mental health and substance abuse treatment visits decreased during 2020.
AIM 3: IDENTIFY PILOT-LEVEL CHARACTERISTICS ASSOCIATED WITH IMPROVED OUTCOMES FOR WPC ENROLLEES

Final evaluation report assessing overall impact of WPC:


Webinar presenting selected findings on 02/08/23 12-1pm PT: https://ucla.in/2kJIQt5
Aim 3: Pilot-level characteristics associated with ↑ outcomes

Compared to similar Medi-Cal beneficiaries not in WPC, WPC enrollees’ service use changed from before to during WPC per year per 1,000 beneficiaries by the following amounts:

- 45 fewer hospitalizations
- 130 fewer ED visits
- 56 more substance use disorder services
- 133 more specialty care services

Compared to similar Medi-Cal beneficiaries, WPC enrollees estimated Medi-Cal payments declined from before to during WPC. $383 less in Medi-Cal payments per beneficiary per year.
Aim 3: Pilot-level characteristics associated with improved outcomes

Sample: Pilots with >1,000 enrollees (n=16)

Dependent variables: Emergency department visits (ED), Hospitalizations (IP)

Approach:
• Step 1: Pilot-specific difference in difference models assessing WPC impact on ED visits and hospitalizations (on enrollees relative to matched comparison group)
• Step 2: Coincidence analysis (CNA) to identify Pilot-level characteristics resulting in reduced ED and/or IP
  Using R -cna- package
Aim 3: Pilot-level characteristics associated with ↑ outcomes

- 3 separate dependent variables for CNA
  - Pilots reduced both ED and IP (Yes=4)
  - Pilots reduced ED (Yes=12)
  - Pilots reduced IP (Yes=5)

- 105 independent variables

- **Contextual factors:**
  - Urbanicity
  - Average inpatient utilization year prior to WPC enrollment
  - Average ED utilization in year prior to WPC enrollment

- **Partnership characteristics:**
  - # of partners
  - Inclusion of different partner type(s)
  - Strength and quality of collaboration
  - Community engagement

- **Pilot characteristics:**
  - Enrollee characteristics: # enrollees served, populations of focus, % enrollees with different characteristics
  - Staffing: Staff type(s), caseload
  - Identification and enrollment strategies
  - Data sharing infrastructure: Universal consent, care management platform, types of data shared with different partners, real-time access for staff, etc.
  - Care coordination processes: Single care coordinator, standardized protocols for referral or follow-up
  - Services: Housing supports, medical respite, sobering center, employment assistance
  - Organizational climate: Quality of relational coordination, burnout, supervisor support
  - Expenditures: Average overall cost/enrollee; % infrastructure, % services
  - LE contracting practices and contract incentives
  - Other: Whether effort to track or address disparities
Factors explaining whether Pilots reduced inpatient utilization (Yes=5)

• Total mean expenditures per enrollee
• Average inpatient utilization rate in the year prior to WPC enrollment (per 1000 member-months per year)

Summary:
• Pilots that successfully reduced inpatient utilization had above average inpatient utilization rate prior to WPC (>71.8) OR average mean expenditures per enrollee [Coverage 80%]
• Pilots that did NOT reduce inpatient utilization had below-average expenditures per enrollee (<$9200pp) [Coverage 82%]
Aim 3: Preliminary results

Factors that explain whether Pilots reduced ED utilization? (Yes=12)

• Inclusion of local housing authority or other public housing partner that is actively involved in WPC (n=9)
• Use of street- or shelter-based outreach for identifying eligible enrollees (n=11)
• Pilot focused on serving high utilizers (n=10)
• Pilot focused on serving SMI/SUD (n=5)

Summary:

• Pilots that successfully reduced ED utilization focused on serving SMI/SUD enrollees OR focused on serving high utilizers and had at least one public housing partner [Coverage 83%]
• Pilots that did not reduce ED utilization did not have a public housing partner and did not use street- or shelter-based outreach for identifying eligible enrollees [Coverage 75%]
Aim 3: Preliminary results

Factors that explain whether Pilots reduced ED AND IP utilization? (Yes=4)

- Inclusion of local housing authority or other public housing partner that is actively involved in WPC (n=9)
- Electronic data sharing with community-based human services partner (n=7)
- Pilot focused on serving high utilizers (n=10)
- Client-centered enrollment, e.g., at point of care or in the field (n=14)

Summary:

- Pilots that successfully reduced ED and IP utilization focused on serving high utilizers, used client-centered enrollment approaches, had at least 1 public housing partner, AND successfully shared data with at least one community-based human services partner [Coverage 100%]
- Pilots that did not reduce ED and IP utilization either did not have a public housing partner or did not share data electronically with a community-based human services partner [Coverage 85%]
• Effective Jan 1st 2022, WPC enrollees were transitioned to new Enhanced Care Management and Community Support benefits within Medi-Cal

• As of Jan 2023, 18 states have approved Section 1115 waivers with Social Determinants of Health provisions and 11 have pending waivers

• Lessons learned from WPC can inform decision-making and implementation of other, similar programs
Commentary: California Department of Health Care Services (DHCS)
Questions?

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