CHCF INNOVATION LANDSCAPE SERIES

MARCH 2022

by Nigel Smith, MBA

Medi-Cal and Opportunities for Health Tech in Home-Based Medical Care

For people living with complex health needs, the usual model of going to the clinic or hospital for care does not always work well.[1] Home-based medical care programs have been designed to fill this gap, providing better care to people living with multiple chronic conditions, functional limitations, and often social risk factors who have difficulty accessing care in traditional settings.

This group, which includes seniors as well as younger people living with physical, mental, or developmental disabilities, is large. The state's Medicaid program, Medi-Cal, plays an outsized role in covering their care. Although Medi-Cal covers one in three Californians, it covers more than 50% of those living with a disability.[2] In fact, there are 2.1 million seniors and people with disabilities covered by Medi-Cal, who represent roughly one in seven Medi-Cal enrollees.[3] The senior population in particular is quickly growing, with people age 75 and older representing the fastest growing demographic segment in California.[4]

Medical services provided in the home can result in better outcomes, lower costs, and higher satisfaction for patients and their caregivers, and there is evidence of these improvements with home-based models.[5] The benefits are most pronounced for patients with the most complex and overlapping needs. The COVID-19 pandemic reinforced this demand and underscored the importance of equitable access to these services.

Growing demand from consumers and their caregivers and a favorable policy environment create an opportunity for entrepreneurs and safety-net plans and providers to work together to improve access to these innovative models.

What Is Home-Based Medical Care?

Home-based medical care is care that is provided where one lives and can be longitudinal or episodic. Longitudinal care is continuous care over an extended period, such as home-based primary care, home-based medical comanagement models, integrated medical/social models, and home-based palliative care. Episodic care is primarily confined to a single incident or time-limited episode of care over days to weeks and includes community paramedicine / acute in-home, hospital-at-home, and transitional care models.[6]

Read more about home-based medical care in CHCF's report ***Medical Care at Home Comes of Age***.

Opportunities for Innovation

Seniors and people with disabilities are more likely to use acute services. Some of these acute services could be replaced with care delivered in the community. Seniors and people with disabilities are almost twice as likely to use the emergency department and nearly six times as likely to be admitted to the hospital as other people with Medi-Cal coverage.[7] Being hospitalized can lead to greater frailty and disorientation and is expensive.[8]

In addition to complex medical needs, seniors and people living with disabilities often have functional impairments, and need help with bathing, dressing, taking transportation, or managing their medications. Enrollees eligible for both Medicare

and Medi-Cal (dually eligible enrollees) are more likely than their Medicare-only counterparts to have a condition resulting in a functional limitation or disability, including, for example, mobility impairments, intellectual disabilities, dementia, depression, anxiety, bipolar disorder, and schizophrenia.[9] These functional impairments often make it difficult for them to access care in traditional settings outside the home.

Seniors and people with disabilities with low incomes often face additional challenges, like food insecurity and social isolation that need to be addressed to support health and healing.[10] The most common social risk factors reported by a sample of managed care plans that offer both Medicaid and Medicare benefits include housing instability, lack of access to transportation, food insecurity, as well as social isolation and loneliness.[11] These needs are additional barriers to getting care and managing chronic illness and can result in higher rates of hospitalization.[12]

"In the home, it's very eye-opening. You see the fall risk, the empty fridges, the lack of support. Then it makes sense, and you address those things which you would never know about in your post-discharge appointment, and they get better."

— Mike Le, Landmark Health

Reimbursement Challenges Abound

While demand for home-based medical care is growing, access to it remains limited. Outside of the Program of All-Inclusive Care for the Elderly (PACE), a home- and center-based care program with a unique reimbursement model that delivers fully integrated social and medical care, reimbursement pathways for home-based medical care are complicated. More information on PACE is provided in the Innovation in Action section at the end of this paper.

Fragmented accountability and financing. Many of the people that would benefit from home-based medical care are dually eligible. For them, Medicare pays for physician and hospital services, prescription drugs, short-term postacute care (in the home or at a skilled nursing or rehab facility), and medical equipment needed in the home (e.g., walker, oxygen equipment). Medi-Cal, on the other hand, pays for long-term nursing home care, transportation, medical equipment needed outside the home (e.g., power wheelchair) or that is disposable (e.g., incontinence supplies), and other services that support independent living (e.g., personal care services). Providers, particularly those seeking to provide integrated, whole-person care, may need to contract with both Medicare and Medi-Cal. Less than 10% of people eligible for both are enrolled in a managed care plan that combines both Medicare and Medi-Cal coverage, so for providers caring for the more than 90% without integrated plans, contracting is complicated.[13] In addition, while about 70% are enrolled in a Medi-Cal managed care plan, some important Medi-Cal benefits, like personal care services, specialty mental health services, substance use services, and services for people with developmental disabilities are carved out of Medi-Cal managed care and managed by counties or regional centers.

Low fee-for-service reimbursement requires value-based payment. For seniors and people with disabilities enrolled exclusively in Medi-Cal, there is no fragmentation for physical health care services, but reimbursement levels are very low, presenting a real barrier to adoption. Alex Foxman, president of Mobile Physician Associates, summarizes this pain point well: "Medi-Cal reimbursement is 30% of Medicare, and without a capitation attached, it would be impossible to provide our level of service to Medi-Cal patients." Value-based models have emerged as the preferred payment path, with most of the home-based medical care service providers pursuing per-member per-month capitation and shared savings pathways. Value-based payments can help with low fee-for-service rates in two ways. Capitation can enable team-based care, where more of the care is provided by lower-cost team members who do not have the licensure to bill on their own. Value-based payments can include shared savings, where savings from avoided hospital and other costs are shared with ambulatory providers, helping to offset low rates. These models can be complicated and become more so with the attribution of savings across benefits split between Medicare and different aspects of the Medi-Cal system.

Regulatory Tailwinds

CalAIM and Home- and Community-Based Spending Plan

The reform elements included in the CalAIM (California Advancing and Innovating Medi-Cal) initiative and the home and community-based services (HCBS) spending plan should reduce the barriers to adoption.[14] These reforms offer the potential to increase system integration and coordination of care. The HCBS spending plan allocates funds for residential continuum pilots under which Medi-Cal managed care plans would provide integrated medical and supportive services in the community. And under CalAIM, a statewide Enhanced Care Management benefit provides high-touch care coordination to the highest-need Medi-Cal enrollees. If implemented as proposed, by 2023, more Medi-Cal members will be enrolled in a managed care plan with long-term responsibility for nursing home care and its community-based alternatives, with the potential to incentivize more home-based care. And in 2026, all Medi-Cal plans may be required to offer an aligned Medicare Advantage plan, increasing access to health plans that manage both Medicare and Medi-Cal. Managed care plans, especially those that integrate benefits, have historically been more likely to offer access to innovative home-based care models.[15]

Hospital at Home

For Hospital at Home services, the regulatory landscape has evolved significantly, driven by the COVID-19 pandemic. In March 2020, the Centers for Medicare & Medicaid Services (CMS) announced the Hospitals Without Walls program,[16] providing broad regulatory flexibility that allowed hospitals to provide services in locations beyond their existing walls.[17] In November 2020, CMS announced the creation of the Acute Hospital Care at Home (AHCAH) program to help health systems and hospitals further increase care capacity. The AHCAH program allowed for Medicare fee-for-service reimbursement of home-based hospital services. The new CMS waiver was expected to help hospital-at-home programs thrive and spread.[18]

The AHCAH program does not apply to longitudinal care. It is for patients who require acute inpatient admission to a hospital and require at least daily rounding by a physician and a medical team monitoring their care needs on an ongoing basis. Services could include telehealth, remote monitoring, and regular in-person visits by nurses.[19]

When the CMS program was announced, it was determined that Medi-Cal would pay hospitals for acute inpatient care for all Medi-Cal enrollees receiving care under this waiver program. Managed care plans must authorize and reimburse hospitals providing inpatient acute care services at home through the AHCAH

program at the same rate they would if the services were provided in a traditional hospital setting.

As of April 5, 2021, five health systems in California had been approved by CMS to offer acute hospital-at-home care under strict guidelines:[20]

- Adventist Health (9 hospitals in California)
- Loma Linda University Medical Center
- Sharp Healthcare (1 hospital in California)
- UC Irvine Health
- UC San Diego Health

"The hospital 5 to 10 years from now will be OR, ER, and ICU. Everything else will move into the home."

— Dan Trigub, MedArrive

Implications for Innovators

For this landscape report, interviews with a range of stakeholders were conducted to understand their perspectives on home-based medical care.[21] These revealed that there is not widespread adoption of home-based medical care services by Medi-Cal plans, despite benefits to outcomes, cost, and patient satisfaction. For those plans that have adopted home-based medical care services, the initial focus was transitional and longitudinal. Episodic care has come afterward. As these models have been embraced, there is now a desire for comprehensive models that encompass transitional, longitudinal, and episodic home-based medical care services.

Interviewees at Medi-Cal plans seeking to offer home-based medical care services expressed a desire to better understand the service mix, contracted providers, and data exchange capabilities as key considerations. They are also interested in providers that have a track record of efficiency and effectiveness, and they identified the following four points of operational excellence they look for when evaluating potential home-based medical care service providers.

Population Segmentation

Determining the populations to target for home-based medical care services is challenging. It is not a one-size-fits-all path, as home-based medical care services are expensive interventions but can generate a positive return on investment with the right audience. Prior research[22] suggests that the following population segments may be good fits for home-based medical care:

- Older, homebound community-dwelling adults and younger adults with disabilities are the prime targets for longitudinal primary care.
- Patients with multiple chronic conditions who account for a disproportionate share of health care spending are the primary targets for longitudinal home-based medical comanagement and home-based integrated medical and social care.
- Patients with serious illnesses in advanced stages and with significant symptoms are the primary targets for longitudinal palliative care.
- Community-dwelling adults who have multiple chronic conditions and are frequent users of avoidable emergency department or inpatient services are the prime candidates for episodic community paramedicine care. This population may or may not be homebound.
- Hospitalized adults at risk for poor posthospitalization outcomes are targets for transitional care, and adults who require acute hospital admission for certain qualifying conditions are candidates for the Hospital at Home program.

Employing solutions that can be tailored to each patient more effectively and efficiently can be a key driver to the success of the home-based medical care model.

Patient Engagement

Those who could benefit most from home-based medical care services often aren't aware they exist, and even when they are aware, many must be convinced to give it a try. Once patients are enrolled in a home-based medical care service program, there are sometimes challenges with engagement and ensuring that they follow the protocols of their care plan — including medication adherence.

There is a tremendous range of considerations with Medi-Cal and dually eligible enrollees, including:

- Different levels of trust in the health care system. For example, some patients have a strong relationship with their existing primary care provider while others are dissatisfied.
- Multiple languages and cultural considerations alongside unique family and caregiving contexts.
- Social risk factors, including food and housing insecurity, as well as hardware, software, and broadband digital divides.

Unlike a traditional provider setting where the patient comes in and must conform to the provider's environment, home-based medical care presents the opposite scenario where the primary care provider (PCP) and care team must adapt to the patient's environment.

Caregiver Engagement

One of the key measures of a successful home-based medical care program is patient satisfaction. These measures extend to caregivers as well. The challenge is that caregivers spend up to 24 hours each day with their loved ones without a medical expert in the home, and a fairly sizable percentage take care of relatives with complex needs without sufficient help or training, resulting in emotional stress.

For example, in episodic care situations, 7 of 10 family caregivers who perform medical or nursing tasks face the practical and emotional strain of managing pain.[23]

This strain is magnified when caring for loved ones with mental or behavioral challenges. After even minor surgical procedures, it is not uncommon for patients to experience a level of delirium. Being trained to identify, interpret, and manage these symptoms — and as needed escalate to a clinician — could be critical to a patient's recovery care plan.

Throughout the interviews with home-based medical care episodic service providers, a recurring theme was that caregiver training is an important element of the onboarding process.

> *"Whether it's a family caregiver or a professional caregiver, they have a direct impact on patient outcomes."*
>
> — Mark Treat, Upward Health

Ability to Deliver Quality "High-Touch" Teams at Scale

One of the success factors of the home-based medical care service model is the integration of high tech with high-touch. A team often composed of PCPs, specialists, registered nurses, and emergency medical technicians all work to administer care, observe, and make sense of the environment, coordinate with other care providers, provide technical assistance, train caregivers, and provide relief to socially isolated patients and their caregivers.

The innovation challenge is how to achieve scale with high-touch while maintaining quality and minimizing costs. The approach can vary significantly. Home-based medical care service providers featured in this paper's "Solutions Landscape" offer examples:

- Contessa and Current Health leverage resources of their client health systems and provider organizations to bring medical staff to the home.
- Current Health's tech platform integrates and manages connectivity with external solution providers

and provides its own 24/7 clinical command center as nights-and-weekends backup for its provider client teams.

- MedArrive leverages emergency medical technicians and paramedics for in-home care.

Solutions Landscape

Multiple organizations, big and small, with innovative technologies and business models have come to the fore. A sample of home-based medical care service providers were interviewed for this landscape to highlight different approaches (see Table 1). Not intended to be exhaustive, the landscape's goal is to showcase how different models can work within the construct of the California health ecosystem.

The home-based medical care service providers featured in this landscape differ in their business models and go-to-market strategies. The central tension with each is how to maintain quality and differentiation while scaling to meet demand.

- **Primary customer.** Most of the home-based medical care service providers interviewed identified the health plan as their primary customer, while others named health systems as the customer of focus. Selling to plans can be challenging, at least in part because it is difficult to identify the optimal plan participants for home-based medical care services without detailed cost and health information on plan members. Working with health systems creates opportunities for home-based medical care providers to leverage and benefit from their trust-based brands.
- **Control of wraparound service delivery.** Every home-based medical care service provider interviewed acknowledged the significance of wraparound services as key to better outcomes with Medicaid and Medi-Cal and dually eligible enrollees. These services include mental health, behavioral health, and social services. Landmark Health recognized that community-based behavioral and social resources are so strained that waiting periods can sometimes stretch into weeks, so they decided to employ a roster of psychiatrists, psychiatric nurse practitioners, social workers, and other behavioral and social experts to provide same-day access and have greater control of these needed resources. Most of the other remaining home-based medical care service providers have some of these resources on staff but coordinate the delivery of these services with community agencies in a hybrid approach.
- **Breadth of services provided.** With one exception, all home-based medical care service providers interviewed provided some longitudinal home-based medical care. A few provided episodic care, including Hospital at Home. Several started off as with a single service and expanded into adjacent areas to have more impact.
- **Reimbursement.** These pathways vary significantly by home-based medical care service provider, driven by the type of services offered and the population being served. Some are in the fee-for-service camp, others value-based, and others offer both.

Each of the featured home-based medical care service providers claims to be unique and to have a competitive advantage over everyone else — be it a technology, process, or orientation to the ultimate consumer. These differentiators have been highlighted to illustrate the innovation pathways being pursued in this rapidly growing industry.

Table 1. Home-Based Medical Care Service Providers

Underrepresented Founders/CEO*

	LONGITUDINAL AND EPISODIC SERVICES	PAYMENT MODELS	DIFFERENTIATION	CALIFORNIA FOOTPRINT
CONTESSA	*Longitudinal* ▸ Medical comanagement ▸ Palliative care ▸ Primary care *Episodic* ▸ Hospital at home ▸ Transitional	▸ Value based — MCOs ▸ Shared savings with providers ▸ Medicare FFS	Go to market via joint venture partnerships with hospitals; leverage hospital resources.	Yes (via Common Spirit)
current health A Best Buy Health Company	*Longitudinal* ▸ Complex chronic condition management ▸ Medical comanagement ▸ Integrated medical and social ▸ Palliative care *Episodic* ▸ Acute in-home ▸ Hospital at home ▸ Transitional	▸ Value based — total cost of care, global budget, episode bundles ▸ CMS AHCAH waiver (DRG) ▸ Commercial, Medicare, Medicaid FFS	Health system is primary customer; very rich connectivity into the home. Other devices and vendors can seamlessly connect to technical platform. Smartphone or internet connection not needed.	Contracted in California in multiple communities (services commence 2022)
dispatchhealth	*Episodic* ▸ Community paramedicine / acute in-home ▸ Hospital at home ▸ Transitional	Value based — discounted bundled rates	Consumer-driven on-demand "ER in home." Customers are both health plans and health systems.	Yes
Landmark	*Longitudinal* ▸ Integrated medical and social ▸ Medical comanagement ▸ Palliative care *Episodic* ▸ Community paramedicine / acute in-home ▸ Transitional	Value based — shared savings with health plans or take full risk	Predictive modeling / real-time action-able data to send the highest-acuity resources to the "most likely" sickest patients and those with increas-ing risk velocity.	Yes
MedArrive	*Longitudinal* ▸ Medical comanagement *Episodic* ▸ Community paramedicine / acute in-home ▸ Transitional	FFS	Turnkey access to broad network of EMTs and paramedics to extend care into the home under the oversight of telemedicine-based physicians.	Yes (2021 entry)

* The California Health Care Foundation (CHCF) is committed to promoting diversity, equity, and inclusion through its program-related investments, grantmaking, culture, and organizational operations. CHCF supports people from diverse and historically underrepresented backgrounds because such efforts are essential to building an inclusive, innovative, and sustainable health care ecosystem. With that in mind, all the home-based medical care service providers interviewed were asked to identify whether they were founded or are being led today by those with historically underrepresented backgrounds. Some companies did not respond.

Table 1. Home-Based Medical Care Service Providers, *continued*

Underrepresented Founders/CEO*

	LONGITUDINAL AND EPISODIC SERVICES	PAYMENT MODELS	DIFFERENTIATION	CALIFORNIA FOOTPRINT
MEDZED	*Longitudinal* ▸ Integrated medical and social ▸ Palliative care ▸ Primary care *Episodic* ▸ Transitional	Value based — capitation and shared savings	Continuity of virtual PCP and in-person nurse — key to building trust and providing better outcomes. Seamless telemedicine model.	Yes (6 managed care contracts)
MOBILE PHYSICIAN Associates	*Longitudinal* ▸ Primary care	Medicare FFS	Complete group mobile medical practice. PCPs are consistently on the road. Proprietary "Uber for doctors" platform geo-maps PCPs to in-need patients in real time.	Yes
UpwardHealth	*Longitudinal* ▸ Integrated medical and social ▸ Medical comanagement ▸ Palliative care ▸ Primary care *Episodic* ▸ Community paramedicine / acute in-home ▸ Hospital at home "light" ▸ Transitional	▸ FFS ▸ Value based	Truly integrated whole-person model. Physical medicine, behavioral health, and social determinants of health all treated equally.	Yes (via Health Plan of San Mateo)
healthcare Vesta	*Longitudinal* ▸ Integrated medical and social ▸ Medical comanagement	▸ Value based — full population level risk ▸ Medicare FFS	Integrative model but very caregiver-centric.	In process of entering California

Notes: *MCO* is managed care organization. *FFS* is fee-for-service. *CMS* is Centers for Medicare & Medicaid Services. *AHCAH* is Acute Hospital Care at Home. *DRG* is diagnosis related group. *EMT* is emergency medical technician. *PCP* is primary care provider.

Key Takeaways

Innovators

To succeed in Medi-Cal, it is important to:

- Identify your customer in Medi-Cal's fragmented system — a health plan, delegated medical group, or health system.
- Match the service mix and model of care, and reimbursement model, to the specific pain points expressed by the customer, acknowledging both the need for holistic, whole-person care and California's carve-out from Medicaid managed care of specialty mental health and substance use treatment as well as many home and community-based services.
- Be prepared to provide care that is culturally specific and culturally attuned to address significant diversity in languages and cultures. The ability to provide culturally responsive care presents an opportunity to improve equity in outcomes that can only be realized with excellent execution.
- Interface with and acknowledge existing provider networks and be thoughtful about data exchange to reduce the barriers to coordinated care.
- Pay attention to, and move swiftly, to take advantage of the favorable payment and regulatory tailwinds in California.

Plans and Systems

When seeking a partner for delivery of home-based medical care, it is important to:

- Be clear on your goals and the problem(s) you are trying to solve. Your population's needs and the gaps in your network can help determine whether you are trying to improve access to comprehensive primary care for people who are home-bound, to provide enrollees with an alternative to the emergency room, or to offer hospital-level care in a home setting due to limited hospital capacity.
- Identify your target population and ensure the provider's care team and staffing model meet their needs. Also, be realistic about who will be engaged. Some enrollees may be challenging to reach, while others may strongly prefer to stay with their existing care team. All these factors can impact the actual uptake and efficacy of the intervention.
- Consider approaches that include reactive workflows to connect enrollees with home-based medical care (e.g., upon hospital discharge or referral from care coordination) and proactive population health workflows (e.g., those that use claims data to identify enrollees that would benefit). Both approaches can optimize the reach of the intervention.
- Recognize that these models are often more expensive than traditional care settings at a unit cost level and identify a contracting approach that meets both the needs of the plan and the home-based medical care provider. The arrangements may change over time as more information is gathered about uptake, efficacy, quality, and return on investment.

Innovation in Action: Programs of All-inclusive Care for the Elderly

The PACE model[24] is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible, and that by meeting social needs, medical costs are avoided. It is a value-based reimbursement program that delivers fully integrated social and medical care throughout the country, including California. While there is evidence that this model works and creates value for all stakeholders, scalability is a challenge.

California has 20 PACE providers serving patients age 55 or older, deemed eligible by the state to receive nursing home-level care, able to live safely in their community at the time of enrollment, and living in a PACE service area. As of March 1, 2021, over 12,000 participants are enrolled in California:

- Average age is 76, with 33% over age 80.
- Participants have strong racial/ethnic diversity.
- Average 20 medical conditions; 64% have 3+ limitations in daily living activities, and 33% have Alzheimer's or related dementia.
- 100% of enrollees are eligible for Medi-Cal, with 75% dually eligible for Medicare and Medi-Cal and 25% Medi-Cal eligible only.

PACE provides active delivery of preventive care, wraparound social support, and regular access to physicians and other health care professionals predominantly in a center-based model. Services include primary and specialty medical care, adult day care, in-home services, home care, prescription drugs, laboratory and diagnostic services, physical and occupational therapies, meals, transportation, and as necessary, hospital and nursing home care. An interdisciplinary team of physicians, nurses, social workers, therapists, and aides develops each treatment plan and manages all services.

There is evidence that the PACE program delivers value:

- PACE capitation rates are set below the level the state would pay for a comparable population outside of PACE — on average 40% less than the cost of institutional care for a dually eligible enrollee and 42% less for a Medi-Cal enrollee.
  In 2021, CalPACE (the association for California PACE programs) estimated that California will pay $130.8 million less than it would have if all current PACE participants were served outside of PACE.
- CalPACE identifies fewer hospitalizations, fewer nursing home admissions, an increased number of days in the community, better health, better quality of life, greater satisfaction with overall care arrangements, and better functional status as the key sources of value for its participants. Program data as of July 1, 2020, show that 92% of enrollees were very satisfied with their overall care in PACE, and 92% would refer PACE to a close friend. Ninety-seven percent of caregivers would also recommend PACE.

Note: To find Program of All-inclusive Care for the Elderly (PACE) in your community, enter your zip code below the map on the **CalPACE website**.

Innovation in Action: Health Plan of San Mateo

"In the marketplace, most models have been traditionally one or the other, longitudinal in nature or episodic in nature. But the tides are changing. Most plans now need a hybrid model where both services are available to them, and the marketplace needs to pivot to that."

— Amy Scribner, Health Plan of San Mateo

Health Plan of San Mateo (HPSM) is a local community-based health plan with a vision that "healthy is for everyone."[25] Created in 1987, their programs today cover more than 130,000 people in San Mateo County — roughly one in five residents. In addition to Medi-Cal, they also offer a plan for dually eligible enrollees.

While home-based medical care services are primarily targeted toward their dually eligible population, HPSM offers a way for non-dually eligible Medi-Cal members to be referred in. HPSM started out with longitudinal care because of the volume of members who needed it, and eventually expanded the model to episodic care based on growing needs for stabilization in communities for members three to six months after an acute event.

Some clear benefits realized by HPSM from home-based medical care services include:

- Improvement in readmission rate from both longitudinal and episodic models.
- Rapid and holistic follow-up following an acute stay: It is often challenging to get patients into a follow-up medical appointment after a hospitalization or skilled nursing facility stay. With home-based medical care, this has improved, and home-based medical care providers can write orders and seek authorization for durable medical equipment and other needed services after acute events while surveying the home environment — something community-based providers in a clinic may not be able to do.
- Integration of behavioral and social wraparound services, as medical models alone tend to be insufficient for dually eligible and Medi-Cal populations.
- Better understanding the population and their needs through physical presence in homes.
- Improvement in completion of coding of diagnoses, critical for risk adjustment.

Challenges include:

- Determining the right "graduation point" model for enrolling patients. It's not a one-size-fits-all population approach. Some patients have a positive relationship with their PCP in their community, and home-based medical care may not add much value for them. Their solution came in 2020 with the implementation of Alert Care, a joint endeavor whereby patients were able to have an annual visit with their PCP and home-based medical care service provider, and then have access to urgent care home-based medical care services as needed throughout the year. It was hugely successful and very well received.
- Consistently realizing outcomes beyond readmission rates (e.g., cost containment, HEDIS measures, member/caregiver satisfaction scores).
- Navigating complex payment models. HPSM eventually evolved to a quality and outcomes incentive-based program as a preferred payment structure (per-member per-month).
- Seamlessly integrating the systems of HPSM with the home-based medical care service provider so that data captured by the home-based medical care service provider — claims, utilization, encounters, care plans, and medical records — could be readily available by HPSM.

Health Plan of San Mateo began their home-based medical care program in 2016, working with Landmark Health (featured in this report). In late 2021, Upward Health (also featured in this report) was selected as the new home-based medical care service provider for HPSM.

About the Author

Value Exchange Catalysts is an independent consulting company with expertise in strategy, innovation, and optimization of stakeholder value in complex relationships. Principal Nigel Smith, MBA, is responsible for project management and execution. Nigel was formerly the director of Innovation Labs at AARP, and is currently also CEO of Zurena, a beverage start-up, and board member of TATIL and Tatil Life insurance companies.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

About the Innovation Landscape Series

As part of its efforts to help promising products and services succeed and scale among California's safety-net providers, the CHCF Innovation Fund conducts high-level landscape analyses of issue areas especially ripe for tech-enabled innovation. The Innovation Fund publicizes the findings of these landscape analyses to inform other funders and customers seeking scalable solutions to challenges faced by safety-net providers.

Readers should note that these reports are not intended to be exhaustive, nor are they endorsements of the companies included in them. Finally, because solutions landscapes can evolve quickly, these reports may not fully reflect the current market.

www.chcf.org/innovationfund

Endnotes

1. Mattan Schuchman, Mindy Fain, and Thomas Cornwell, "**The Resurgence of Home-Based Primary Care Models in the United States**," *Geriatrics* (Basel) 3, no. 3 (July 16, 2018): 41.
2. William Erickson, Camille Lee, and Sarah von Schrader, ***2018 Disability Status Report: California*** (PDF), Cornell Univ., 2020.
4. Hans Johnson and Laurel Beck, ***Planning for California's Growing Senior Population***, Public Policy Institute of California, August 2015.
5. Christine Ritchie et al., ***Medical Care at Home Comes of Age***, California Health Care Foundation (CHCF), January 2021.
6. *Medical Care*, CHCF.
7. ***Managed Care Performance Monitoring Dashboard Report*** (PDF), California Dept. of Health Care Services (DHCS), January 9, 2020.
8. Harlan M. Krumholz, "**Post-Hospital Syndrome — an Acquired, Transient Condition of Generalized Risk**," *New England Journal of Medicine* 368, no. 2 (Jan. 10, 2013): 100–2.
9. ***Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0 (2006–2012)***, Centers for Medicare & Medicaid Services (CMS), February 2019.
10. Melony E. Sorbero et al., ***Types and Costs of Services for Dual Beneficiaries by Medicare Advantage Health Plans: An Environmental Scan***, RAND Corp., 2018.
11. ***Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans: Gap Analysis and Policy Development***, Center for Health Care Strategies, October 2020.
12. "**Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Payment Programs**," US Dept. of Health and Human Services, December 20, 2016; and ***Accounting for Social Risk Factors in Medicare Payment Programs: Identifying Social Risk Factors, Nat'l Academies of Sciences***, Engineering, and Medicine, 2016.
13. Amber Christ and Georgia Burke, ***A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care***, CHCF, September 2020.
14. Jacey Cooper (state Medicaid dir., DHCS), "**Implementation of the American Rescue Plan Act (ARPA) of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services (HCBS) During the COVID-19 Emergency**" (PDF), September 17, 2021; and ***California Advancing & Innovating Medi-Cal (CalAIM) Proposal*** (PDF), DHCS, January 2021.
15. Giselle Torralba et al., ***Meeting the Moment: Strengthening Managed Care's Capacity to Serve California's Seniors and Persons with Disabilities***, CHCF, April 2021.
16. "**Additional Background: Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge**," CMS, March 30, 2020.
17. CMS, "**CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge**," press release, November 25, 2020.
18. Christopher Cheney, "**CMS Home-Based Hospital Care Waiver Called 'Enormous Step Forward,'**" HealthLeaders, January 6, 2021.
19. "**The Acute Hospital Care at Home Program**," DHCS, last modified January 24, 2022.
20. "**Acute Hospital Care at Home Program: Approved List of Hospitals as of 4/5/2021**" (PDF), CMS.
21. Organizations interviewed include Center for Elders' Independence PACE, CommonSpirit Health, Family Caregiver Alliance, Front Porch, Health Plan of San Mateo, Justice in Aging, LifeLong Medical Care, and SCAN Health Plan.
22. *Medical Care*, CHCF.
23. Susan C. Reinhard et al., "**Home Alone Revisited: Family Caregivers Providing Complex Care**," AARP, April 2019.
24. **CalPACE**.
25. **Health Plan of San Mateo**.