Community Care Settings Program Overview

November 30, 2017

HealthPlan OF SAN MATEO

Healthy is for everyone

Health Plan of San Mateo - Overview

The Health Plan of San Mateo (HPSM) is a local non-profit health care plan founded in 1987 that offers health coverage and a provider network to San Mateo County's underserved population, currently serving more than 147,000 County residents across five programs:

- Medi-Cal (California Medicaid): (114,000 enrolled)—State and federally funded insurance program for individuals and families who qualify for Medi-Cal in San Mateo County. It includes seniors and persons with disabilities as well as newborns.
- CareAdvantage Cal Medi-Connect Plan (9,200 enrolled)—A Cal Medi-Connect plan for adults and seniors who qualify for Medi-Cal and Medicare in San Mateo County.
- ACE (21,500 enrolled)—A County-sponsored coverage program that provides health benefits for eligible low-income adult residents of San Mateo County.
- Healthy Kids (1,000 enrolled)—A locally funded insurance program for children who are not eligible for Medi-Cal.
- HealthWorx (1,000 enrolled)—A program provide exclusively for three categories of employees: 1) Extra Help employees of San Mateo county, 2) In-Home Supportive Services workers for the San Mateo County Public Authority, and 3) Part-time employees of the City of San Mateo.

Community Care Settings Program

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Goal: Flexibly support those at nursing home level of care to thrive in the community

- Intensive transitional case management program designed to help members in/or at risk of long term care return to (or maintain) community living
- Case management for 2-3 months pre-transition and 9-12 months post-transition at 1:15 ratio
  - In-depth, interdisciplinary assessment of needs and coordination of services to support transition to community or prevent unnecessary institutionalization
  - Integration of medical/social/behavioral services and supports
  - Housing services include: Housing search, unit repairs and modifications, lease arrangements, owner-resident liaison
- Launched in late 2014 and delivered in partnership with the Institute on Aging (Case Management) and Brilliant Corners (Housing services)
- Integrates community and county-based services and resources (e.g., IHSS, county Behavioral Health and Recovery Services, HUD housing vouchers and set-asides, Alzheimer's associatio, Meals on Wheels, Redi-Wheels) and a network of assisted living facilities

Member Story

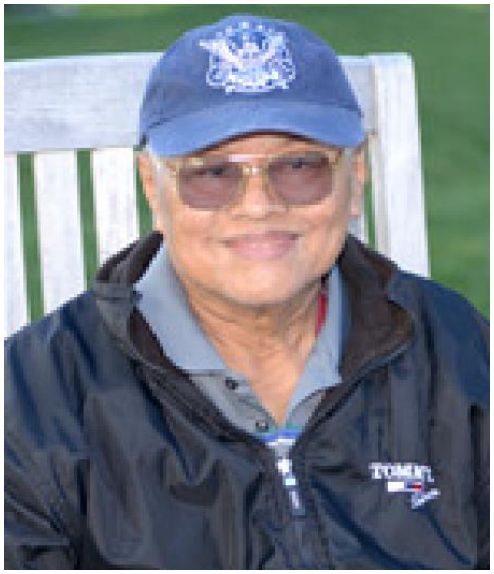
From immobility to a rich, full life

Before CCSP: Mr. Solano's house was foreclosed on after medical bills for hip replacement surgery and kidney failure left him unable to pay his mortgage, leaving Mr. Solano living in a long term care facility for over 3 years.

Enrolled in CCSP in March 2015, as his doctor felt that he could do well in the community

In December 2015, he moved into his own apartment that Brilliant Corners found for him, in partnership with the Housing Authority and MidPen Housing. HPSM and IOA coordinated with his current care providers and arranged for him to get help at home through IHSS, to attend a CBAS center, to have meals on wheels delivered and to get transportation to his medical appointments, including dialysis and physical therapy.

He graduated from CCSP in September 2016, and now is receiving care at home through our HomeAdvantage in conjunction with his primary care physician, physical therapist, dialysis clinic & CBAS. He also receives ongoing case management through the MSSP program as his needs continue to be complex.



"The program gave me a place to call home where I have made many friends"

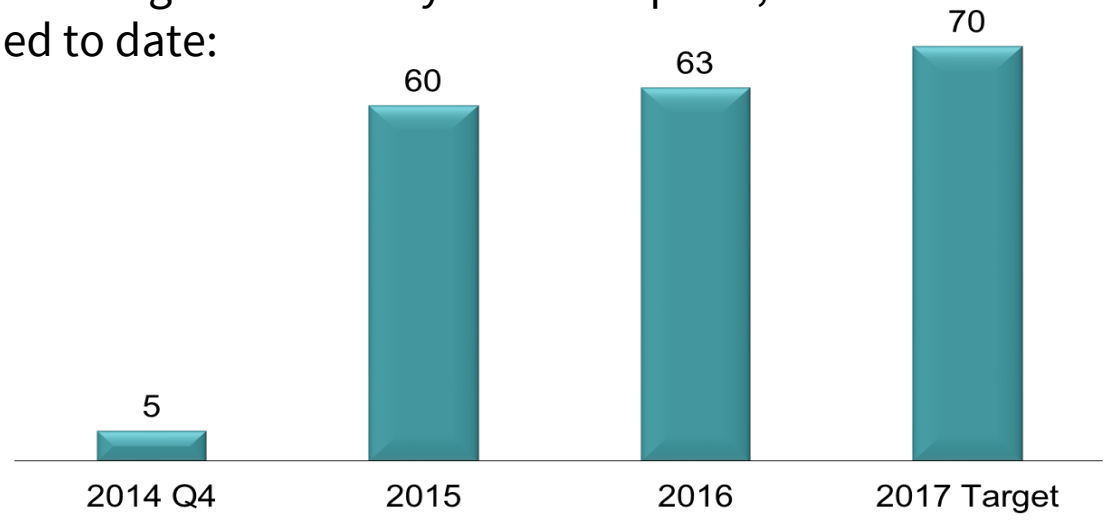
Conrado Solano

Participant Overview

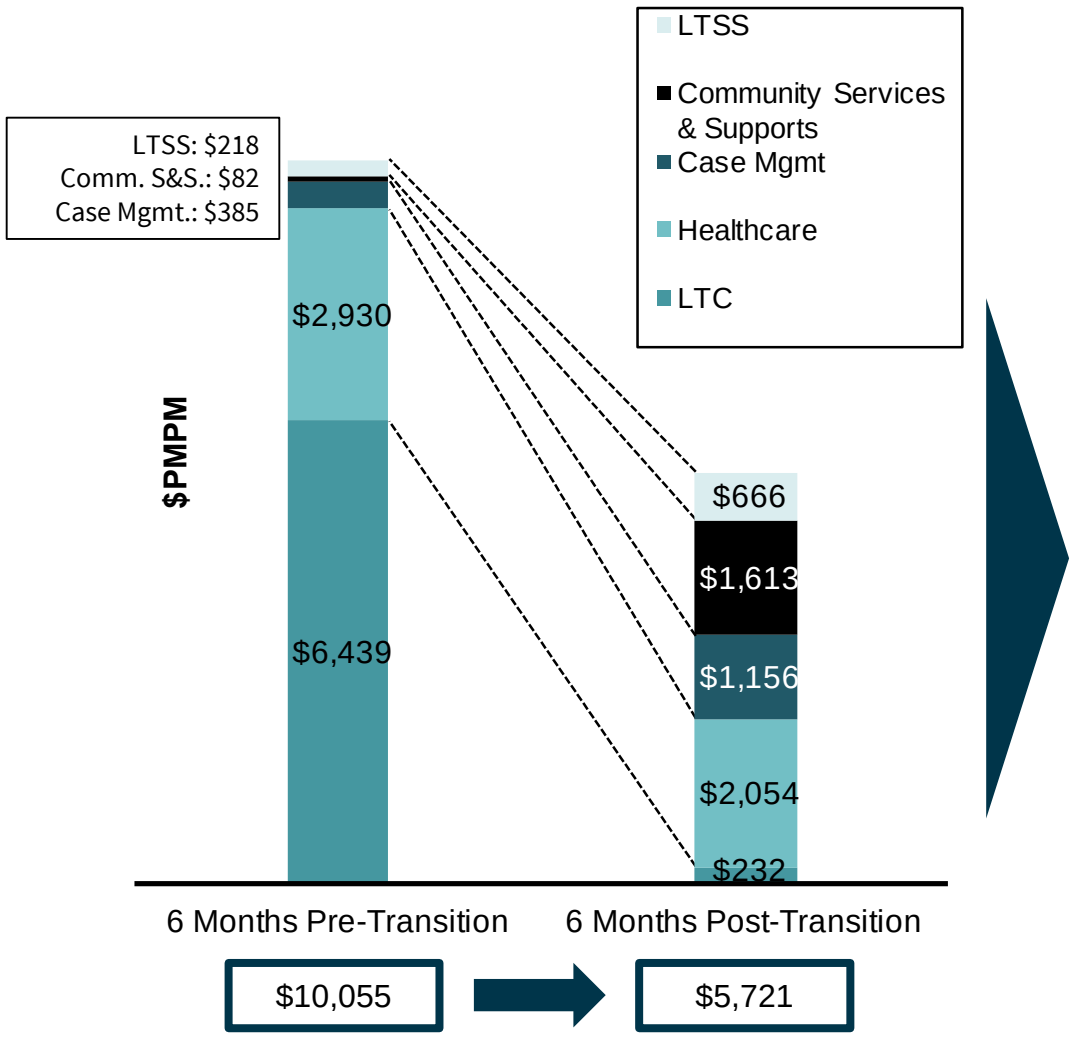
- Three segments

LTC Residents – 56% Return to Independence	SNF Diversions – 27% LTC Avoidance	Community Diversions – 17% Extending Independence
• ~10-30% of LTC residents able to migrate to lower level of care	• Acute health incidents prompting change in health or functional status	• Individuals struggling in the community, at-risk of acute incident or LTC admission

- Participants remain in the community over time, with 80% still in the community two years later.
- Transitions have grown steadily since inception, with over 190 members transitioned to date:



Supporting community living results in cost-savings



- Data through Q4 2016
- ~ 50% cost savings across project population
- Savings are sustained over time (8 quarters)
- Utilization:
  - Primary savings from reduced Long Term Care costs
  - Healthcare costs are also reduced, though there may be some regression to the mean
  - Primary ongoing costs are LTSS (e.g., IHSS and CBAS), case management, and community services and supports

* Community services and supports largely funded through care plan options.

Source: Based on claims data and program costs for CCSP participants with at least 6 months in the community since transition, as of Q4 2016.

Members and stakeholders report high satisfaction

- Members report strong outcomes and high satisfaction with the program:
  - 90% felt that their CCSP care manager had the knowledge and skills needed to help them
  - 90% would recommend the service to their family or friends
  - 85% felt that CCSP services maintained or improved their quality of life.
  - 84% felt satisfied or very satisfied with the services provided

- Providers and stakeholders are also satisfied:
  - 100% felt that CCSP staff developed trust and rapport with their clients and are strong advocates for their clients
  - 83% felt that CCSP staff followed through on agreed upon plans and were quick to respond to phone calls and emails

Member survey completed in July 2016 with 85% response rate. Provider survey completed in March 2016 with 36% response rate.

Lessons learned

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- Start with areas where there is financial alignment
  - For us, that was long term care and other complex discharges
  - Both areas where social determinants led to predictably high, avoidable costs
- If you are working at the “top of the pyramid,” the approach needs to be personalized and flexible to work
  - Focus on clients expressed needs and preferences
  - Choose staff that are willing to be flexible and have a “whatever it takes” approach
  - Provide funding flexibility to enable that approach
- If you are working across the pyramid, it is important to ensure that workflows and processes ensure resources go to the most vulnerable
  - Health and housing partnerships
  - Patching services while people are connected to long term benefits
  - Embed health coverage units in behavioral health care systems, corrections, safety net systems

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