UCLA CENTER FOR HEALTH POLICY RESEARCH

ISSN 2691-7475

Health Policy Brief

January 2022

Whole Person Care Program Successfully Navigated Around COVID-19 Challenges in 2020

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"The state's five-year Whole Person Care (WPC) program was extended to December 2021 due to the COVID-19 pandemic."

SUMMARY: California implemented the Whole Person Care (WPC) Pilot program under "Medi-Cal 2020," a Section 1115 Medicaid Waiver program designed to coordinate the care of high-utilizing Medi-Cal beneficiaries across medical, behavioral health, and social service sectors. The COVID-19 pandemic stay-at-home orders began in mid-March 2020, during the last year of WPC implementation, and disrupted California's plans to transition WPC enrollees into a new program under the California Advancing and Innovating Medi-Cal (CalAIM) initiative. In this policy brief, we examine the impact of the pandemic on WPC implementation, enrollment, and health service utilization. We found that all WPC Pilots reported at least some pandemic-related alterations to WPC implementation. Total enrollment increased in 2020, with lower rates of new enrollment and disenrollment. The mid-March shutdown also resulted in an initial decline in enrollee health service utilization. However, by the end of 2020, primary care and specialty services had reverted to pre-pandemic patterns, while emergency department and hospitalization rates remained lower than pre-pandemic rates. In this policy brief, we discuss the implications of these findings for the transition to CalAIM and WPC evaluation.

At the request of the California Department of Health Care Services (DHCS), the state's five-year Whole Person Care (WPC) program was extended to December 2021 due to the COVID-19 pandemic. The extension was intended to prevent disruption of WPC services to enrolled beneficiaries while the state prepared for their transition to other programs planned under the CalAIM initiative. A statewide shelter-in-place order was enacted in California on March 20, 2020. The impact of the pandemic and its associated consequences —such as recession, job loss, and reduction in utilization of health care—are well documented and suggest a disproportionate impact on many WPC enrollees. In this policy brief, we examine the progress of the COVID-19 pandemic in California and its effects on WPC implementation and enrollee health care utilization. Our findings illustrate changes during the pandemic in WPC implementation and enrollment and in four categories of health service utilization. We also discuss potential implications for the evaluation of WPC and the implementation of CalAIM.

Spread of COVID-19 in California and WPC Counties

Nearly 2.3 million confirmed COVID-19 cases and 25,986 resulting deaths were reported in California in 2020. Our analysis of confirmed cases in WPC counties showed

"Most pilots said that pandemic-related shutdowns and social distancing requirements limited their ability to deliver WPC services in person."

a cumulative rate for that year of 5,844 confirmed cases per 100,000 residents, relatively similar to the statewide rate of 5,822. When examining the 14-day average daily case rate, we found two distinct peaks among WPC rates in late July (24 confirmed cases per 100,000) and late December (108 confirmed cases per 100,000; data not shown). Most WPC counties had peaks in the same time frame, but there were variations in the magnitudes of these peaks by county (data not shown). Trends in daily hospitalizations from COVID-19 mirrored trends in confirmed cases, peaking at 18 and 52 hospitalizations per 100,000 in July and December, respectively.

The Impact of the COVID-19 Pandemic on WPC Implementation

WPC Pilots reported the impact of the COVID-19 pandemic on WPC infrastructure and service delivery. Most (20 of 25) pilots said that pandemic-related shutdowns and social distancing requirements limited their ability to deliver WPC services in person. While many providers transitioned to care delivery through telehealth, pilots explained that it was difficult to make meaningful progress toward care management goals when enrollees frequently had inadequate access to cell phones, computers, the internet, or electricity. *"For many of our patients … {without} access to a smartphone … delivering telehealth services was virtually impossible. We … create{d} a room … and set up telehealth equipment … {for} our provider {to} see the patients from another room in the clinic." – WPC Pilot, Kern County*

More than two-thirds of pilots (17 of 25) reported limited capacity to deliver WPC services due to hiring freezes, staff safety concerns, or reassignment of staff to support other urgent COVID-response activities. For more than half of the pilots (16 of 25), pandemic-related restrictions also limited the ability of staff to engage in field-based outreach and provide warm handoffs or other supports needed to effectively engage certain enrollees in care, particularly those living on the streets or in homeless encampments. In some pilots (11 of 25), frontline staff also experienced challenges with the remote work environment, which impacted their ability to effectively collaborate with their care team and other WPC partners.

Pilots met these challenges by capitalizing on existing WPC infrastructure and, when possible, finding synergies with COVID-19 response activities. Many pilots (18 of 25) reported increased engagement of enrollees, as people could be reached more easily at home or shelters due to the shutdown.

CALIFORNIA'S WPC AT A GLANCE:

Purpose

WPC was a Medicaid Section 115 Waiver demonstration project designed to coordinate medical, behavioral health, and social services for high-utilizing beneficiaries with complex needs.

Enrollees

Those enrolled were Medicaid beneficiaries with high service utilization, multiple chronic conditions, mental health conditions or substance use disorders, experiencing or at risk of homelessness, or recently incarcerated.

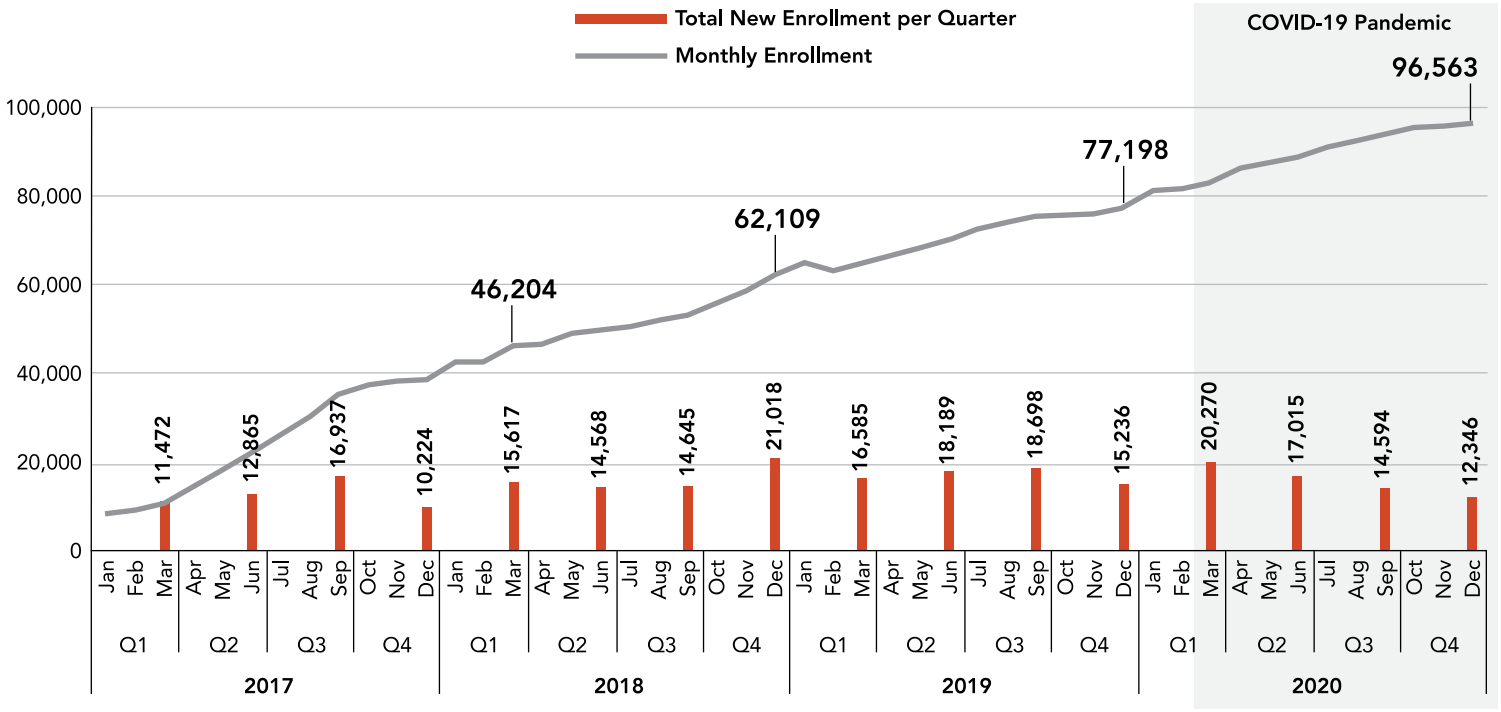
Pilots

Twenty-five entities from 26 of the 58 California counties provided WPC services using local partners. All pilots provided care coordination and housing support but varied in other services and enrollees targeted.

Timeline

The WPC Pilot program, begun in January 2016, was extended by one year beyond its original end date of December 2020 due to the COVID-19 pandemic.

Monthly Enrollment and Total Quarterly New Enrollment in WPC, January 2017 to December 2020 **Exhibit 1**



Source: UCLA analyses of WPC Quarterly Enrollment and Utilization Reports from January 2017 to December 2020

Note: 23 of 25 pilots started enrolling throughout 2017, and two pilots started enrolling in early 2018.

Some pilots (17 of 25) that partnered with short-term housing programs, such as Project Roomkey, were able to better identify eligible enrollees, engage them, and enroll them in WPC services, while also making progress toward care plan goals and increasing short-term housing opportunities. One pilot noted: *"Housing {homeless} individuals in hotels not only helped reduce the spread of COVID-19, it allowed for co-location of physical health, mental health, substance use, {and} housing services." – WPC Pilot, Kings County*

Several pilots (15 of 25) succeeded in improving collaboration in emergency operations and structures among county partners, as well as establishing closer collaboration with provider networks. Fewer than half of pilots (12 of 25) utilized centralized data systems to find and deliver WPC services to enrollees who were at higher risk from COVID-19.

The Impact of the COVID-19 Pandemic on WPC Enrollment

Exhibit 1 illustrates the trends in monthly enrollment and the total new enrollment per quarter during WPC, including the pandemic. A total of 96,563 Medi-Cal beneficiaries were enrolled in WPC in December 2020, an increase from 77,198 in December 2019. Total new enrollment in the last three quarters of 2020 was lower than it had been in the same quarters in 2019. There was also a 20% decline in average monthly disenrollment in 2020 compared to 2019 (data not shown).

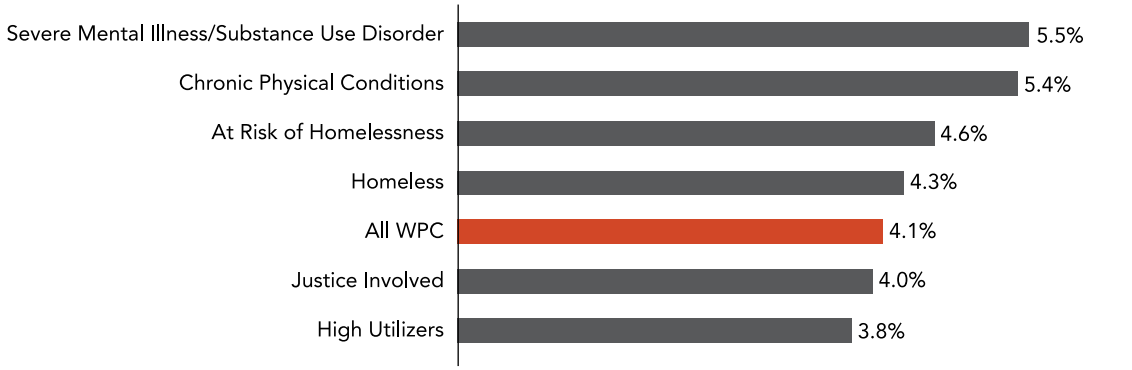
Estimated Prevalence of COVID-19

The diagnosis code for COVID-19 was developed and utilized by providers starting in late March 2020. To estimate the prevalence of COVID-19 among WPC enrollees, we analyzed Medi-Cal claims starting in March 2020 and identified enrollees with services for which COVID-19 was the primary or

"Many pilots reported increased engagement of some enrollees because they could be reached more easily at home or shelters due to the shutdown."

Exhibit 2

Proportion of WPC Enrollees With a COVID-19 Diagnosis From March to December 2020, by WPC Target Populations



Source: UCLA analyses of Medi-Cal enrollment and claims data from March 2020 to December 2020, and WPC Quarterly Enrollment and Utilization Reports from January 2017 to December 2020

Notes: COVID-19 diagnosis was identified using ICD code U07.1 in primary or secondary diagnosis per claim. Enrollees can be reported in more than one target population.

"WPC enrollees with a COVID-19 diagnosis were more often female, ages 50 to 64, and Latinx."

secondary diagnosis. A total of 8,738 WPC enrollees (4.1%) had at least one service with COVID-19 as the primary or secondary diagnosis (Exhibit 2). This proportion was highest for enrollees identified by the pilots as having severe mental illness or substance use disorders.

UCLA compared the demographics of WPC enrollees who had a COVID-19 diagnosis with the demographics of those who did not have this diagnosis (data not shown). WPC enrollees with a COVID-19 diagnosis were more often female (47% vs. 44%), ages 50 to 64 (35% vs. 31%), and Latinx (42% vs. 26%).

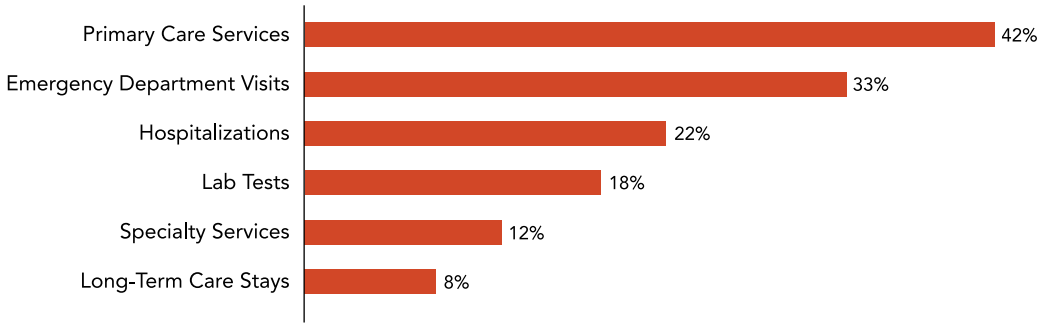
COVID-19–Related Service Use of WPC Enrollees

We examined the types of health services for COVID-19–related care utilized by WPC enrollees with a COVID-19 diagnosis in 2020. Enrollees most frequently used primary care services (42%) and emergency department visits (33%), followed by hospitalizations (22%), lab tests (18%), specialty services (12%), and stays in long-term care facilities, such as nursing homes and assisted living (8%) (Exhibit 3).

The median length of hospitalization for those with a COVID-19 diagnosis was five days (maximum of 114 days; data not shown).

Exhibit 3

Proportion of Enrollees With a COVID-19 Diagnosis Who Received Specific COVID-19–Related Services

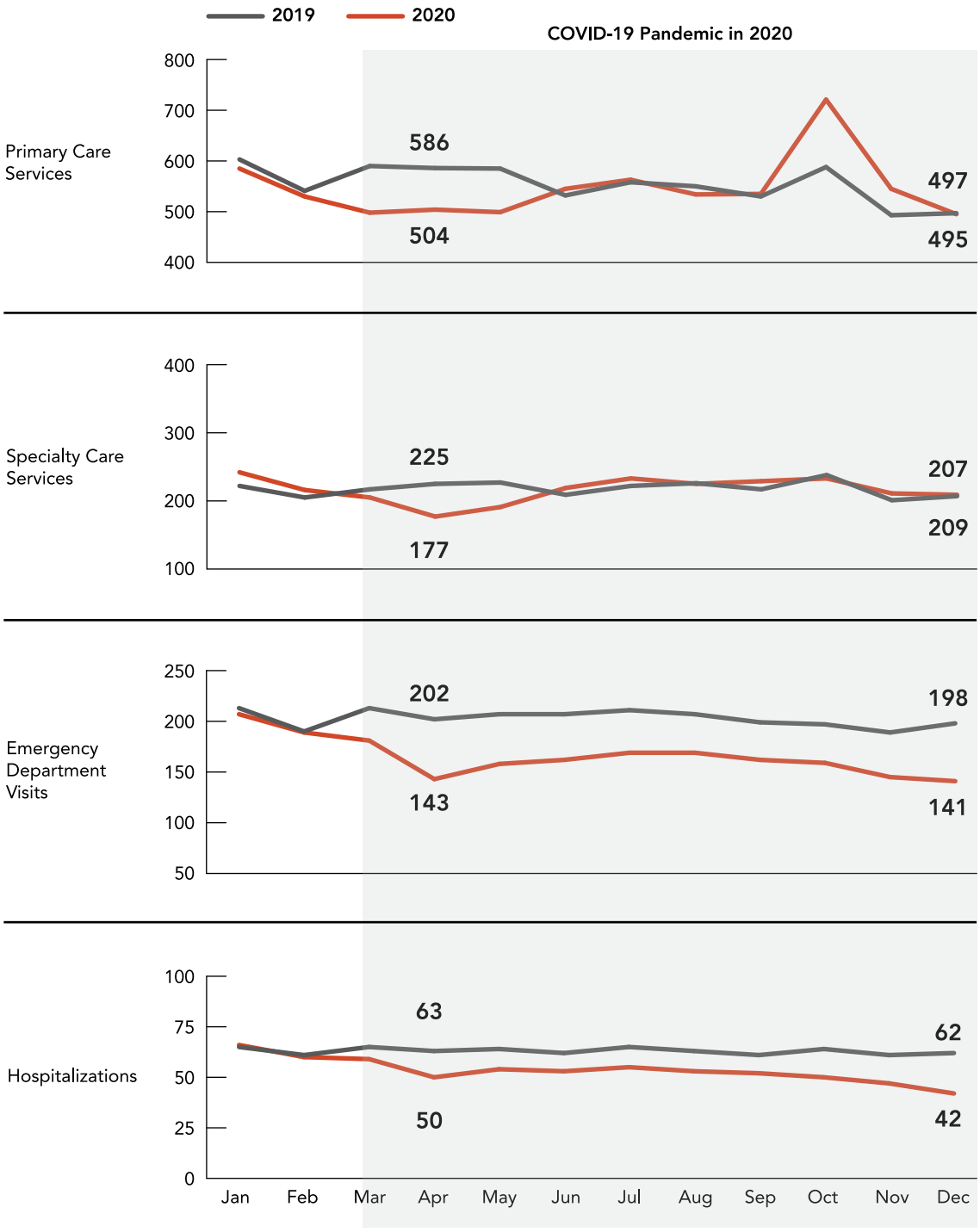


Source: UCLA analyses of Medi-Cal enrollment and claims data from March 2020 to December 2020.

Notes: Services with COVID-19 as the primary or secondary diagnosis (identified using ICD code U07.1) only. Emergency department visits only include visits that did not result in hospitalization.

Monthly Utilization of Health Services per 1,000 Member-Months Among WPC Enrollees, 2019 Compared to 2020

Exhibit 4



Source: UCLA analyses of Medi-Cal enrollment and claims data from March 2020 to December 2020.

Note: Member-months were based on Medi-Cal enrollment.

"The number of ED visits declined in April 2020 relative to April 2019, and remained lower through December 2020 relative to December 2019."

Changes in the Use of Health Services Before and During the COVID-19 Pandemic

We assessed service utilization patterns among WPC enrollees before and during the pandemic, and we found a decline in April 2020 compared to April 2019 for all service types (Exhibit 4). By December 2020, however, rates of primary care and specialty service utilization were similar to those in December 2019. In contrast, the number of

"The rate of services delivered through telehealth increased from fewer than 0.1% of primary and specialty services prior to the pandemic to 9% of primary and 10% of specialty services in December 2020."

ED visits declined in April 2020 relative to April 2019, and the number remained lower in December 2020 relative to December 2019. A similar pattern was observed for hospitalizations.

Further analyses (data not shown) found that fewer than 0.1% of primary care and specialty services were delivered by telehealth prior to the pandemic. This rate changed to 2% of primary and 3% of specialty services in March 2020, and to 9% of primary and 10% of specialty services in December 2020.

Implications

Our analyses indicated that the COVID-19 pandemic altered the type and modality of WPC services and the patterns of WPC enrollment and health service utilization in 2020, which was the last planned year of WPC implementation. The ability of pilots to rely on WPC infrastructure and continue to deliver care coordination and housing support services may have mitigated the impact of the pandemic on enrollees.

These findings highlight the value of having future Medi-Cal programs incorporate an infrastructure similar to that of WPC, integrating elements such as partnerships with community-based organizations and data-sharing capabilities. This evidence supports CalAIM's intent to sustain and strengthen such infrastructure statewide. The ability of pilots to maintain continuity of care coordination and housing support services during the pandemic is likely to have maintained the positive WPC outcomes—for instance, by improving access to needed services and preventing a high use of acute care. Therefore, WPC enrollees might be less likely to have pent-up demand for care coordination and housing support services than Medi-Cal beneficiaries not enrolled in WPC. These advantages are likely to continue after enrollees are transitioned to CalAIM in January 2022.

The low proportion of enrollees with a COVID-19 diagnosis reflects the subset of enrollees who received care for this condition rather than reflecting the prevalence of COVID-19. Nevertheless, the findings likely indicate the limited impact of COVID-19–related service use on our evaluation of WPC.

The pandemic's limited impact on the utilization of primary care and specialty services is likely due to the rapid increase in the provision of care using telehealth under emergency Medicaid waivers that allowed for the reimbursement of such visits on par with in-person visits. These findings further support the need to address digital access barriers to telehealth for WPC enrollees and other Medi-Cal beneficiaries. Lower use of ED visits and hospitalizations from pre- to post-pandemic rates also indicate the importance of addressing these changes in our evaluation of WPC.

Methods

Population-level COVID-19 data were created using the *Los Angeles Times* and the July 2019 U.S. Census population estimates. Subsequent COVID-19 rates were likely underreported at the start of the pandemic. WPC enrollment data were based on an analysis of WPC Quarterly Enrollment and Utilization reports from January 2017 to December 2020. The data on the effects of the COVID-19 pandemic on infrastructure and service delivery, and associated challenges and successes, were based on an analysis of WPC Program Year 5 Annual Narrative Reports from July to December 2020. Identification of enrollees with a COVID-19 diagnosis was based on a primary or secondary diagnosis of COVID-19 (ICD codes U07.1) in Medi-Cal claims data. Health service utilization data were based on an analysis of Medi-Cal enrollment and claims data from January 2019 to December 2020. Utilization rates were not adjusted for patient characteristics.

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Funder Information

Funding for this project was provided by the California Department of Health Care Services.

Acknowledgments

Sincere thanks to Ninez Ponce and Ana Martinez for reviewing this policy brief and providing helpful feedback.

Suggested Citation

Pourat N, O'Masta B, Haley LA, Zhou W, Chuang E. 2022. *Whole Person Care Program Successfully Navigated Around COVID-19 Challenges in 2020*. Los Angeles, CA: UCLA Center for Health Policy Research.

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is part of the
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PB2022-1

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