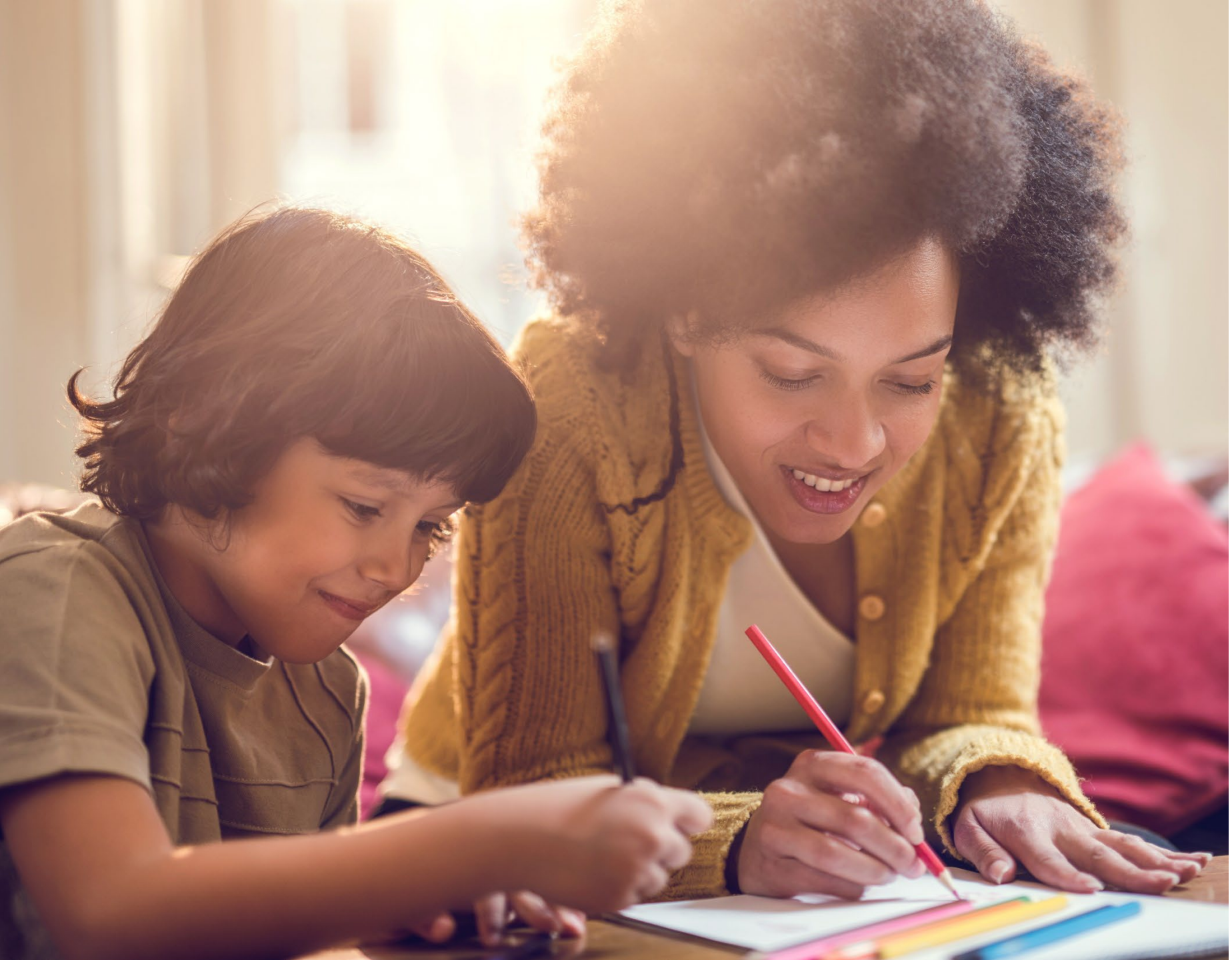


PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

California Advancing and Innovating Medi-Cal, Enhanced Care Management, and In Lieu of Services

June 24, 2021

ACCREDITED NCQA HEALTH PLAN

Meeting Logistics

- **All attendees are muted upon entry.**
- Due to the large attendee participation and bandwidth limitations, we are **kindly asking for participants to keep their cameras off**.
- The **webinar will be recorded** and uploaded as a resource to PHC's external CalAIM webpage.
- At the end of the presentation we will stop recording and open it up for questions and comments. Please **use the chat box feature.** We may not be able to get to all of them live, but they are valuable and an FAQ will be provided after the meeting.

Agenda

- Welcome Remarks
  - Speaker: Sonja Bjork, Chief Operating Officer
- CalAIM Overview
  - Speaker: Amy Turnipseed, Senior Director of External and Regulatory Affairs
- Enhanced Care Management (ECM)
  - Speaker: Katherine Barresi RN, Director of Care Coordination
- In Lieu of Services (ILOS)
  - Speaker: Debra McAllister RN, Associate Director of Utilization Management Strategies
- Data Sharing
  - Speaker: Dr. Robert Moore MD MPH MBA, Chief Medical Officer
- Next Steps
  - Speaker: Danielle Biasotti MBA RPhT, Senior Program Manager
- PHC's external CalAIM webpage launch
  - Speaker: Danielle Biasotti MBA RPhT, Senior Program Manager
- Questions & Answers

Welcome!

Sonja Bjork, Chief Operating Officer

CalAIM Overview

Amy Turnipseed, Senior Director of External and Regulatory Affairs

What is CalAIM?

- CalAIM stands for ***"California Advancing and Innovating Medi-Cal."*** It is a multi-year initiative by Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of individuals on Medi-Cal by implementing broad delivery system, program and payment reform across the Medi-Cal program.
- CalAIM contains various proposals within it that focus on this stated goal.

CalAIM Proposal	Timeline**
Enhanced Care Management (ECM)	1/1/2022, 7/1/2022
In-Lieu of Services (ILOS)	1/1/2022, 7/1/2022
Population Health Management	1/1/2023
Incarcerated population eligible for ECM services	1/1/2023
Dual Eligible Special Needs Program (D-SNP) Required	1/1/2025
NCQA Accreditation Required	1/1/2026

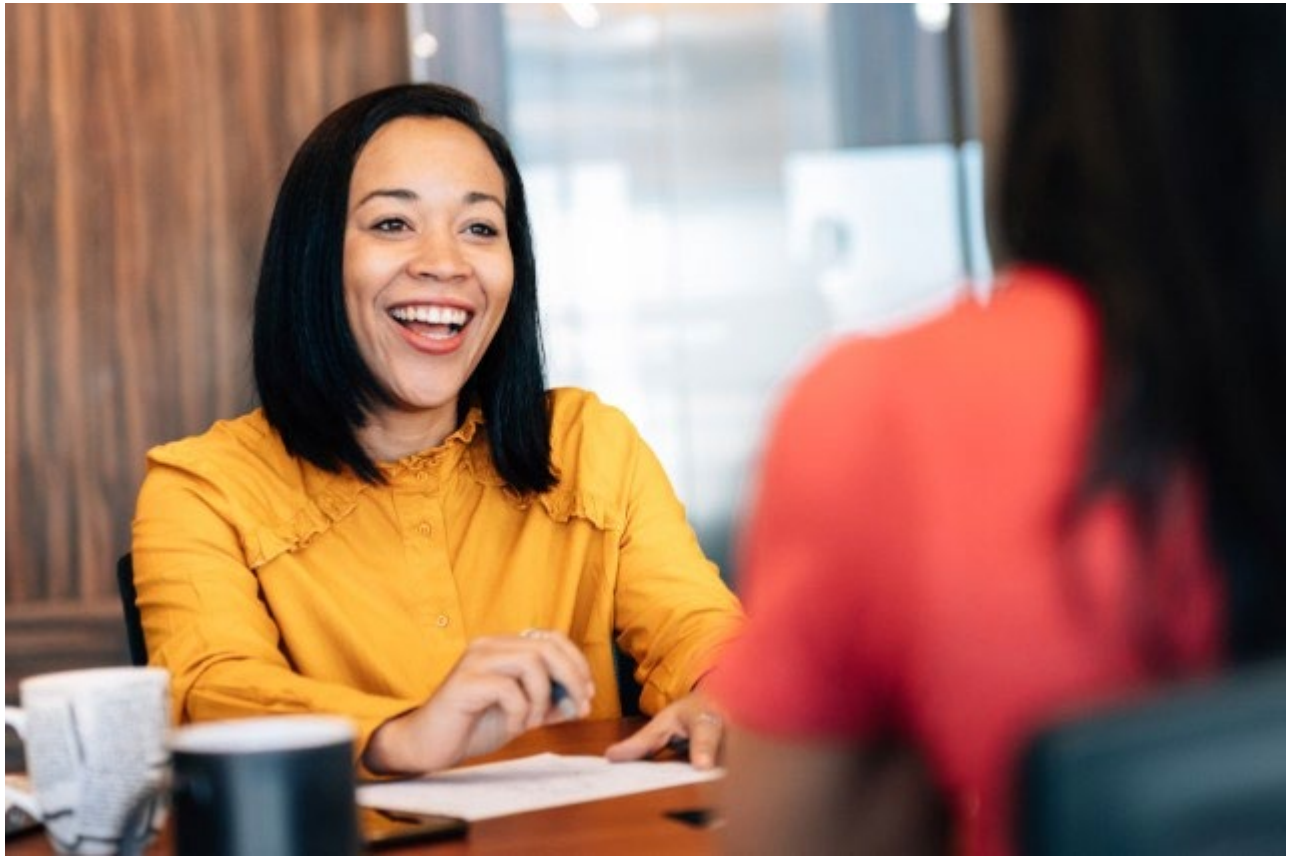
** DHCS proposed dates may be subject to Centers for Medicare and Medicaid Services (CMS) approval/change

Enhanced Care Management (ECM)

Katherine Barresi RN, Director of Care Coordination

What is Enhanced Care Management? (ECM)

- *A Medi-Cal benefit* that would replace the current Whole Person Care (WPC) Pilot activities with a standardized set of case management services and interventions, building on positive outcomes from those programs.
- Face-to-Face with members, in the community
- PHC required to contract with WPC counties
- Members can opt-out at anytime
- 7 Target populations eligible for the benefit

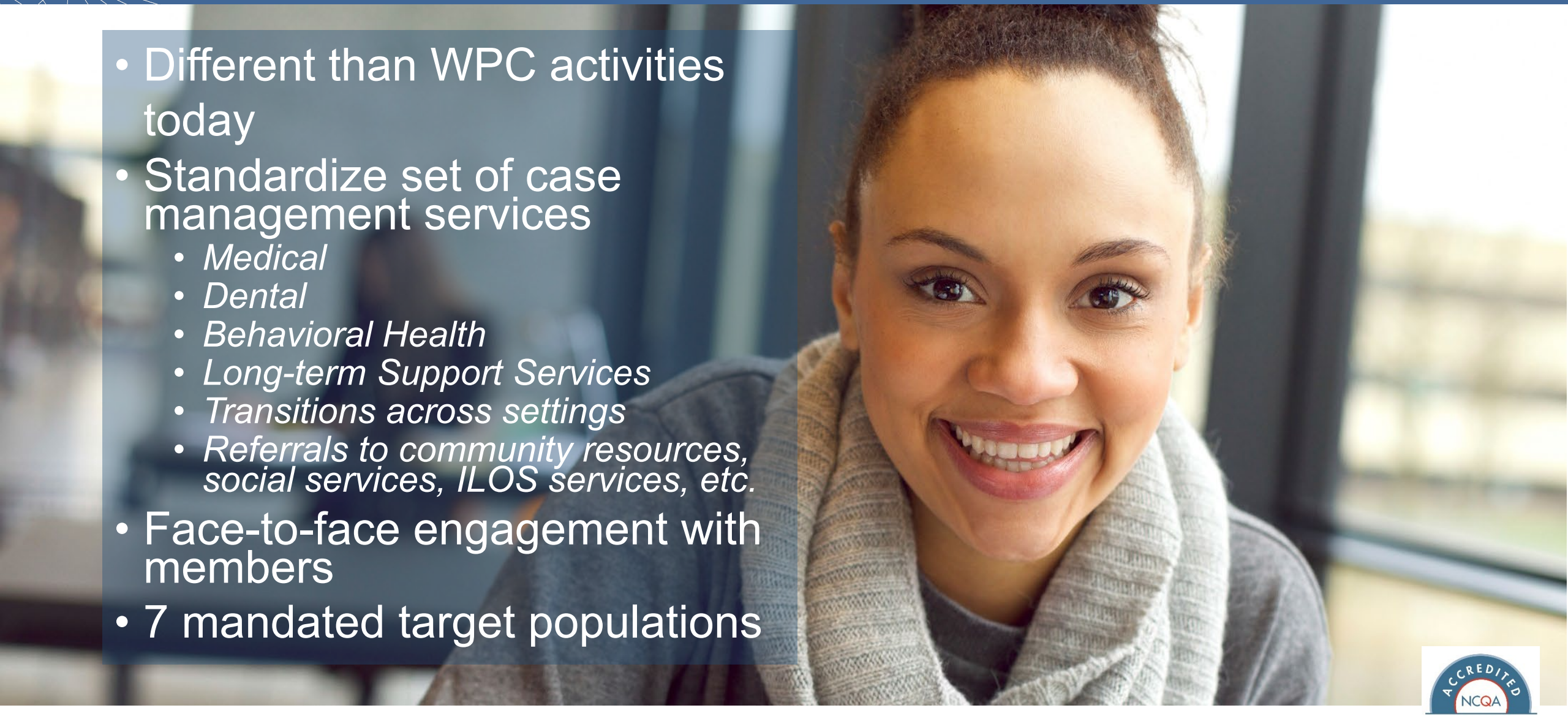


Enhanced Care Management (ECM)

Populations of Focus**: 7 identified groups of individuals that PHC must identify and authorize ECM services.
1. Adult Homeless Individuals experiencing homelessness (as defined by HUD) AND who have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and decreased utilization of high-cost services.
2. Adult High Utilizer Individuals with 6 or more emergency room visits in a 12 month period; OR Two or more unplanned hospital and/or short-term skilled nursing facility stays in a 12 month period.
3. Adults with SMI or SUD Individuals who meet with eligibility criteria for participating in the County Specialty Mental Health (SMH) Plans and/or the Drug Medi-Cal Organization Delivery System (DMC-ODS) AND who are actively experiencing at least one complex social factor influencing their health AND who meet one or more criteria.
4. Individuals transitioning from incarceration within the last 12 months who have significant complex physical and behavioral health needs requiring immediate transition of services to the community.
5. Individuals at risk for institutionalization who are eligible for long-term care services.
6. Nursing facility residents who want to transition to the community.
7. Children or youth with complex physical, behavioral or developmental health needs (ex: CCS, foster care, youth with Clinical Risk syndrome, or first episode of psychosis.)

***DHCS is currently revising and refining criteria for each of the populations.*

ECM Model – Key Points



- Different than WPC activities today
- Standardize set of case management services
  - *Medical*
  - *Dental*
  - *Behavioral Health*
  - *Long-term Support Services*
  - *Transitions across settings*
  - *Referrals to community resources, social services, ILOS services, etc.*
- Face-to-face engagement with members
- 7 mandated target populations

ECM Implementation Timeline

The ECM services will go-live in PHC Network, in 2 phases:

- Phase I – existing Whole Person Care Programs that will transition the new ECM benefit
- Phase II – counties without existing Whole Person Care Programs

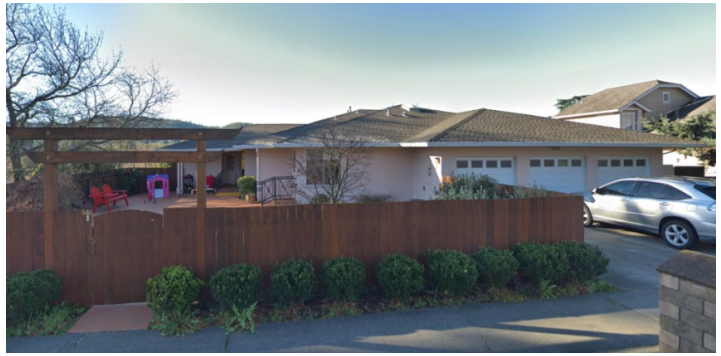
Phase I – January 1, 2022	Phase II – July 1, 2022	
Marin	Solano	Trinity
Napa	Lake	Siskiyou
Mendocino	Yolo	Modoc
Shasta	Humboldt	Lassen
Sonoma	Del Norte	

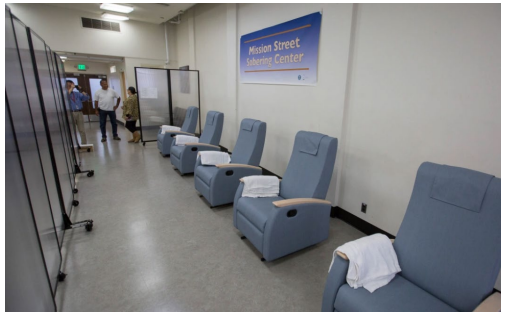
In Lieu of Services (ILOS)

Debra McAllister RN, Associate Director of Utilization Management Strategies

What is In-Lieu Of Services? (ILOS)

- Non-Medi-Cal benefits (services) that PHC may chose to offer in a particular county “in lieu” of a traditional Medi-Cal covered service.
- These services **WILL NOT** receive additional funding. Cost of ILOS will be covered in lieu of normal covered service.
- Allows plans to address Social Determinants of Health in a way that is cost-effective
- DHCS has provided a list of 14 possible services
- PHC can add ILOS over time
- Individuals **DO NOT** need to be receiving ECM in order to receive an ILOS service.





In-Lieu Of Services (ILOS)

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy
4. Short-Term Post Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition / Diversion
9. Nursing Facility transition to home
10. Personal Care / Homemaker Services
11. Home Modifications
12. Medically Tailored Meals or Medically Supportive Food
13. Sobering Centers
14. Asthma Remediation

In-Lieu Of Services (ILOS)

Partnership will provide the following 8 ILOS to eligible members located within Whole Person Care Program Counties beginning January 1, 2022.

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy
4. Short-Term Post Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Personal Care / Homemaker Services
8. Medically Tailored Meals or Medically Supportive Food

In-Lieu Of Services (ILOS) Eligibility

- Partnership will develop specific eligibility criteria for each ILOS offered based on guidance from DHCS.
- Partnership will be responsible for determining what ILOS is, as medically appropriate, and cost effective alternative to a State Plan Covered Service.

In-Lieu Of Services – Key Points

- Optional services
- May vary by county
- In-Lieu of a Medi-Cal benefit;
  - *Must be cost effective*
- Focusing on Social Determinants of Health
- TAR criteria for each service
- PHC can add more later

ILOS Implementation Timeline

The 8 ILOS services will go-live in PHC Network, in 2 phases:

- Phase I – existing Whole Person Care Programs
- Phase II – counties without existing Whole Person Care Programs

Phase I – January 1, 2022	Phase II – July 1, 2022	
Marin	Solano	Trinity
Napa	Lake	Siskiyou
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Sonoma	Del Norte	

Data Sharing

Dr. Robert Moore MD MPH MBA, Chief Medical Officer

Data Sharing

- **CalAIM's Data sharing and Information Exchange Requirements:**
  - Data sharing between organizations to standardize and improve patient care
    - Member consent, Release of Information (ROI) and affiliated entities
    - Management of patient assignment, engagement, referrals, authorizations, care plans, billing, reporting, and quality and performance.
- **Collective Medical Technologies:**
  - Collective Medical's data exchange platform
    - Database with real-time notifications, access for members' entire care team to be kept in the loop on their care and needs
    - Various reporting functions

Next Steps

Danielle Biasotti MBA RPhT, Senior Program Manager

Next Steps

- PHC to host scheduled webinars for county and provider partners to further discuss the ECM and ILOS benefits planning and implementation.
- PHC will also schedule meetings to discuss next steps with existing Intensive Outpatient Care Management (IOPCM) sites.
  - IOPCM services to transition to ECM benefit
- PHC is continuing to work with Collective Medical Technologies to support data exchange requirements. Internal planning and development is active and on-going.

Partnership's External CalAIM Webpage

- CalAIM Initiative and Programs
- http://www.partnershiphp.org/Community/Pages/CalAIM
- Future webinars and meeting information, past recorded webinars, resources and links
- Contact us: CalAIM@partnershiphp.org

Questions & Answers