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

August 26, 2021

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 a Q&A document will be provided after the meeting.

Agenda

- **Welcome Remarks**
  - Speaker: Amy Turnipseed, Sr. Director of External and Regulatory Affairs

- **What Does It mean To Be a Contracted Medi-Cal ECM Provider?**
  - Speaker: Katherine Barresi, RN, Director of Care Coordination (Southern Region)
    Danielle Biasotti, RPhT, Sr. Program Manager, Care Coordination (Northern Region)

- **Collective Plan Data Sharing Platform**
  - Speaker: Melissa McCartney, Director of Care Coordination Operations (Northern Region)

- **ILOS**
  - Speaker: Debra McAllister, RN, Associate Director of UM Strategies (Southern Region)

- **PHC ECM and ILOS Resources**
  - Speaker: Danielle Biasotti, RPhT, Sr. Program Manager, Care Coordination (Northern Region)

Welcome!

Amy Turnipseed
Sr. Director of External and Regulatory Affairs

What Does it Mean to be a Contracted Medi-Cal ECM Provider?

Katherine Barresi, RN
Director of Care Coordination (Southern Region)

Danielle Biasotti, RPhT
Sr. Program Manager, Care Coordination (Northern Region)

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 encouraged to contract with WPC counties
- Members can opt-out at anytime
- 7 Populations of Focus eligible for the benefit

ECM Benefit Recap

- Populations of Focus Eligible for ECM

1. Homeless with physical, behavioral or developmental need
2. High Utilizers
3. SMI / SUD with Chronic Conditions
4. Transitioning from Incarceration
5. At Risk of Institutionalization
6. Nursing Facility Transition to the Community
7. Children / Youth with Complex

https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Key-Design-Implementation-Decisions.pdf

ECM Benefit Recap

- Core Services of ECM
  - Primarily Face-to-Face
  - Lead Care Manager
  - Case management & care coordination services to address all needs across:
    - Medical Health Needs
    - Behavioral Health Needs
    - Oral Health Needs
    - Long Term Services Supports (ex: CBAS, IHSS, etc.)
    - Community Referrals (ex: Housing, Transportation, Social Services, etc.)
- Better improve the quality and health outcomes for members with the highest level of need; who access multiple payers and systems

ECM Member Experience

- 41y/o female Homeless, SMI/SUD currently pregnant.
  - Frequent ED utilizer, unmet mental health needs, homeless, known to local law enforcement, living in a tent with boyfriend for the past 4 months.
- Lead Care Manager coordinated with Hospital, County Mental Health, Primary Care Office and Shelter Manager to coordinate needs.
- Before delivery of a healthy baby, connected with housing, primary and maternal care.

ECM Provider Requirements

- **Experience and expertise in serving the population(s) of focus**
  - Primary Care Provider, County Behavioral Health, Tribal Health, Local Government Agency, Community Based Organization, etc.
- **Medi-Cal Certified, if current pathway exists**
  - If no pathway exists, PHC contracting and credentialing standards
- **Comply with all state and federal laws**
- **Treatment Authorization Request (TAR) for ECM Services**
- **Bill for ECM services**
  - Invoicing permissible
- **Submit necessary reports to PHC**
  - Encounter Data
  - ROIs
  - Individualized Care Plans (ICPs)
  - Quality Oversight Monitoring Reports

ECM Benefit Timeline

	County	Population of Focus	Start Date
Phase I	Napa, Marin, Sonoma, Mendocino, Shasta	• High Utilizers • Homeless (adults/children) • SMI/SUD	1/1/2022
Phase II	Yolo, Solano, Lake, Humboldt, Del Norte, Trinity, Modoc, Lassen Siskiyou,	• High Utilizers • Homeless (adults/children) • SMI/SUD	7/1/22
Phase III	All Counties	• Incarceration • Individuals at risk for institutionalization • Nursing facility residents transitioning to the community	1/1/23
Phase IV	All Counties	• Children and youth with complex physical, behavioral and/or developmental health needs	7/1/23

Collective Plan Data Sharing Platform

Melissa McCartney
Director of Care Coordination Operations (Northern Region)

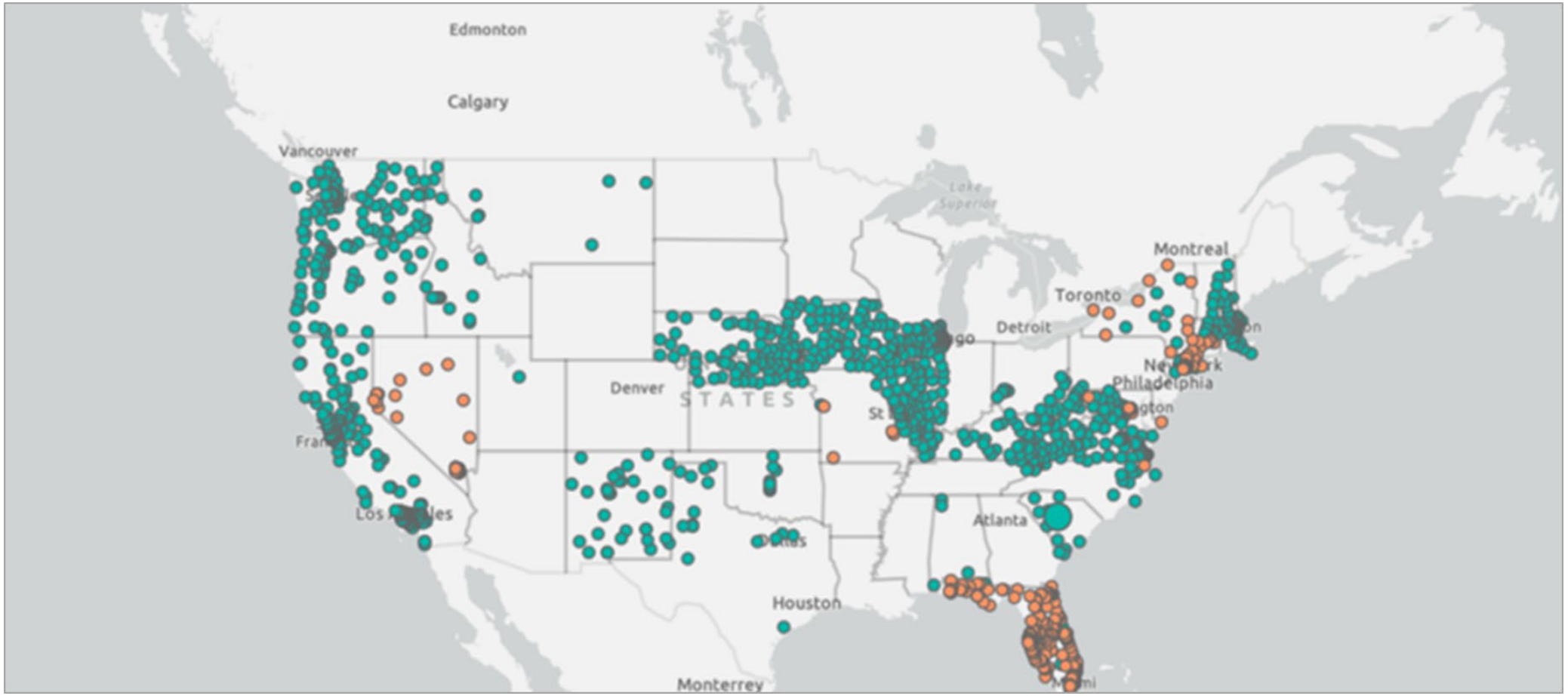
Data Sharing

- **CalAIM's Data Sharing and Information Exchange Requirements:**
  - Data sharing between organizations to standardize and improve patient care
    - Release of Information (ROI) and affiliated entities
    - Management of patient assignment, engagement, referrals, authorizations, care plans, billing, reporting, and quality and performance.

Origin of Collective Medical

- Company started in Utah, as Collective Medical Technologies (now shortened to Collective Medical)
- Founded in 2004
- Initial product (2008) Emergency Department Information Exchange (EDie) in Washington State, with a special focus on reducing “shopping” around for opioids from different hospitals
- Many other modules, including Collective Plan (used by health plans and partners)

Collective Medical Hospital and HIE Connections



Hospitals Contracted with Collective Medical

HIE Connections with Collective Medical

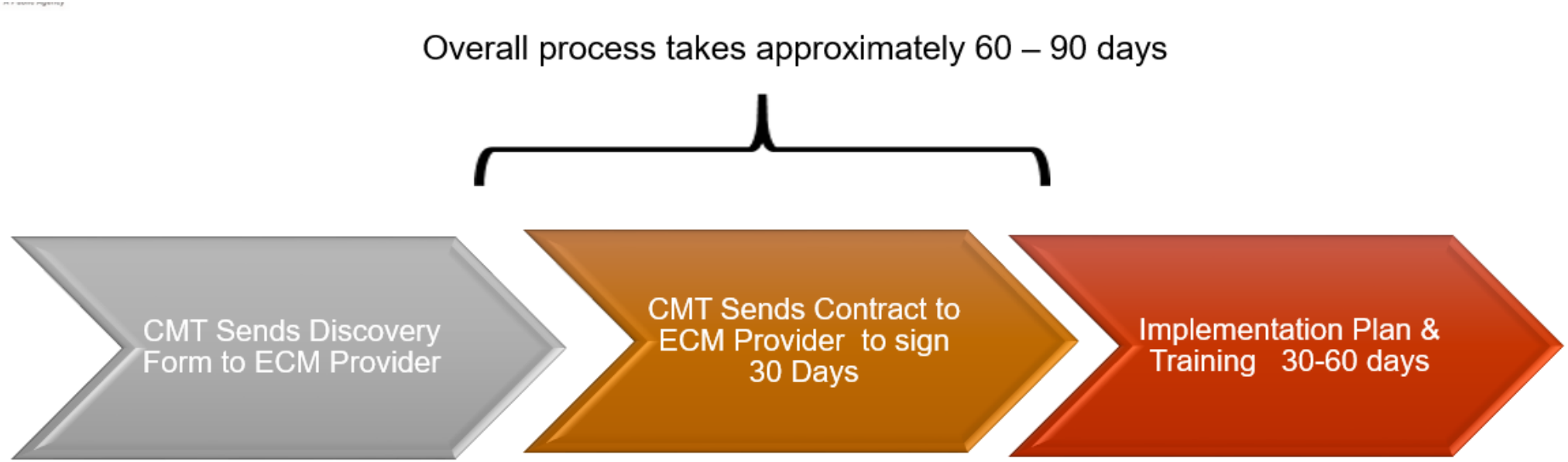
Core PHC Interfaces with Collective Medical

- PHC to Collective Medical:
  - Membership file, currently excluding members assigned to Kaiser or with Medicare primary
  - Columns to indicated assigned PCP, capitated hospital, which county member is assigned to, CCS status
- Collective Medical to PHC:
  - ADT information on hospital admissions and ED admissions
  - Data feeds into data warehouse

Core Functionality for Collective Plan for ECM

- Notification/alerts of Emergency Room and Inpatient Admissions
- Core case management communication functions for out of area facilities
- Management patient assignment and engagement (Targeted Engagement Lists = TELs)
- Communication of Release of Information
- Submission of Care Plans to PHC

Implementation Timeline for Each ECM provider



Sample Timeline	**Timeline**	**Date**
Discovery Form	If signed by 6/30/2021	6/30/2021
CMT sends contract to ECM Provider to sign	30 days	7/31/2021
Implementation and Training	30-60 days	8/31-9/30

ILOS

Debra McAllister, RN
Associate Director of UM Strategies (Southern Region)

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)

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 – 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
Mendocino	Yolo	Modoc
Shasta	Humboldt	Lassen
Sonoma	Del Norte	

Housing Transition Navigation Services	TAR Criteria
H0043,H2016	Individuals prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System. Highly vulnerable individuals with disabilities, chronic conditions/mental illness, substance use disorder (upon exiting incarceration 2023).
	Qualifies for HUD definition of homeless: People who are living in a place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last 3 years (must total 12 months).
	Qualifies for experience chronic homelessness: Must have (A) been continuously homeless for the last twelve months OR (B) has a minimum of 4 occasions of homelessness over the past 3 years, totaling a minimum of 12 months.
	Qualifies for HUD definition of at risk homelessness: Have an annual income below 30 percent of median family income for the area, as determined by HUD; and do not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks immediately available to prevent them from moving to an emergency shelter.
	Qualifies for at risk of experiencing homelessness: Those who are at risk of homelessness includes individuals and families who: Have an annual income below 30 percent of median family income for the area, as determined by HUD.
	Qualifies for No Place Like Home definition of “at risk of chronic homelessness”: Adults with serious mental illness, or children with severe emotional disorders and their families and persons who require or are at risk of requiring acute psychiatric inpatient care.
	Individuals who do not receive duplicative support from other State, local tax, or Federally funded programs.
	Identified as reasonable and necessary in the individual’s housing support plan.

Housing Deposits	TAR Criteria
H0044	Individuals prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System. Highly vulnerable individuals with disabilities, chronic conditions/mental illness, substance use disorder (upon exiting incarceration 2023).

Housing Deposits (Cont.)	TAR Criteria
H0044	Qualifies for HUD definition of homeless: People who are living in a place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last 3 years (must total 12 months).
	Qualifies for experience chronic homelessness: Must have (A) been continuously homeless for the last twelve months OR (B) has a minimum of 4 occasions of homelessness over the past 3 years, totaling a minimum of 12 months.
	Qualifies for HUD definition of at risk homelessness: Have an annual income below 30 percent of median family income for the area, as determined by HUD; and do not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks immediately available to prevent them from moving to an emergency shelter.
	Qualifies for at risk of experiencing homelessness: Those who are at risk of homelessness includes individuals and families who: Have an annual income below 30 percent of median family income for the area, as determined by HUD.
	Qualifies for No Place Like Home definition of “at risk of chronic homelessness”: Adults with serious mental illness, or children with severe emotional disorders and their families and persons who require or are at risk of requiring acute psychiatric inpatient care.
	Individuals who do not receive duplicative support from other State, local tax, or Federally funded programs.
	Identified as reasonable and necessary in the individual’s housing support plan.
	Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
	Can only receive once in individual's lifetime.
	Only available when enrollee is unable to meet expense: The liaison will be responsible for payments to the landlord, facilitator and such. Deposit may also include household needed supplies or payment for utilities.
	Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Housing Tenancy and Sustaining Services	TAR Criteria
TBD & T2041	Individuals prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System. Highly vulnerable individuals with disabilities, chronic conditions/mental illness, substance use disorder (upon exiting incarceration 2023).
	Qualifies for HUD definition of homeless: People who are living in a place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last 3 years (must total 12 months).
	Qualifies for experience chronic homelessness: Must have (A) been continuously homeless for the last twelve months OR (B) has a minimum of 4 occasions of homelessness over the past 3 years, totaling a minimum of 12 months.
	Qualifies for HUD definition of at risk homelessness: Have an annual income below 30 percent of median family income for the area, as determined by HUD; and do not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks immediately available to prevent them from moving to an emergency shelter.
	Qualifies for at risk of experiencing homelessness: Those who are at risk of homelessness includes individuals and families who: Have an annual income below 30 percent of median family income for the area, as determined by HUD.
	Qualifies for No Place Like Home definition of “at risk of chronic homelessness”: Adults with serious mental illness, or children with severe emotional disorders and their families and persons who require or are at risk of requiring acute psychiatric inpatient care.
	Individuals who do not receive duplicative support from other State, local tax, or Federally funded programs.
	Identified as reasonable and necessary in the individual’s housing support plan.
	Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
	Can only receive once in individual's lifetime.
	Only available when enrollee is unable to meet expense: The liaison will be responsible for payments to the landlord, facilitator and such. Deposit may also include household needed supplies or payment for utilities.

Short-Term Post Hospitalization Housing	TAR Criteria
H0044	Qualifies for HUD definition of homeless: People who are living in a place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last 3 years (must total 12 months).
	Qualifies for experience chronic homelessness: Must have (A) been continuously homeless for the last twelve months OR (B) has a minimum of 4 occasions of homelessness over the past 3 years, totaling a minimum of 12 months.
	Qualifies for HUD definition of at risk homelessness: Have an annual income below 30 percent of median family income for the area, as determined by HUD; and do not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks immediately available to prevent them from moving to an emergency shelter.
	Qualifies for at risk of experiencing homelessness: Those who are at risk of homelessness includes individuals and families who: Have an annual income below 30 percent of median family income for the area, as determined by HUD.
	Qualifies for No Place Like Home definition of “at risk of chronic homelessness”: Adults with serious mental illness, or children with severe emotional disorders and their families and persons who require or are at risk of requiring acute psychiatric inpatient care.
	Individuals who do not receive duplicative support from other State, local tax, or Federally funded programs.
	Can only receive once in individual's lifetime.
	Exiting Recuperative Care
	Individuals exiting an inpatient hospital stay, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility.
	Individuals must have medical/behavioral health needs such as experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care that would likely result in hospitalization, re-hospitalization, or institutional readmission.

Recuperative Care	TAR Criteria
T2033	Individuals who do not receive duplicative support from other State, local tax, or Federally funded programs.
	Individuals who are at risk of hospitalization or are post-hospitalization.
	Individuals who live alone with no formal support: i.e. Services provided by professional, trained employees, typically paid for their work.
	Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.
	Necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions.
	Restrictions & Limitations: Necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions.

Respite Services	TAR Criteria
H0045, S5151, 9125	Individuals who do not receive duplicative support from other State, local tax, or Federally funded programs.
	Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.
	Children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.
	Restrictions & Limitations: Service limit is up to 336 hours per calendar year.
	Restrictions & Limitations: In the home setting these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.
	Restrictions & Limitations: This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Personal Care and Homemaker Services	TAR Criteria
S5130, T1019	Individuals who do not receive duplicative support from other State, local tax, or Federally funded programs.
	Individuals at risk for hospitalization or institutionalization in a nursing facility.
	Individuals with functional deficits and no other adequate support system: Such as vison, hearing or movement limitations or growth, behavioral, language development or physical or spiritual development disorders.
	Individuals approved for In-Home Supportive Services.
	Cannot be enrolled in In Home Supportive Services (IHSS).
	Individuals who do not receive duplicative support from other State, local tax, or Federally funded programs.

Meals/Medically Tailored Meals	TAR Criteria
S5170, S9470	Individuals who do not receive duplicative support from other State, local tax, or Federally funded programs.
	Limitation = Up to 3 meals / day for up to 12 weeks; longer if medically necessary.
	Limitation = Meals are not covered to respond solely to food insecurities.
	Cannot be enrolled in any other alternate food program or delivery service.
	Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
	Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement.
	Individuals with extensive care coordination needs.

ECM and ILOS Resources

- PHC CalAIM Webpage: http://www.partnershiphp.org/Community/Pages/CalAIM.aspx
- PHC CalAIM Email: CalAIM@partnershiphp.org
- DHCS ECM and ILOS Webpage: https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices

Questions and Answers

Amy Turnipseed
Sr. Director of External and Regulatory Affairs