CalAIM Population Health Management and CalAIM Children & Youth Advisory Group Joint Meeting

December 5, 2022

DHCS

Agenda

Welcome and DHCS Notice	2 min
Member Story	5 min
Enhanced Care Management (ECM) • Brief Overview of ECM • Panel Discussion: ECM Implementation for Children/Youth and Maternal Populations of Focus (POFs)	60 min
Population Health Management (PHM) • Key Takeaways from MCP PHM Readiness Deliverable Submissions • New PHM Phased Implementation Policy for Transitional Care Services	20 min
Look Ahead	3 min

Public Health Emergency (PHE) Unwinding

- **The COVID-19 PHE will end soon and millions of Medi-Cal beneficiaries may lose their coverage.**
- **Top Goal of DHCS:** Minimize beneficiary burden and promote continuity of coverage for our beneficiaries.
- **How you can help:**
  - Become a **DHCS Coverage Ambassador**
  - Download the Outreach Toolkit on the DHCS Coverage Ambassador webpage
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available

DHCS PHE Unwind Communications Strategy

- **Phase One: Encourage Beneficiaries to Update Contact Information**
  - **Launch immediately**
  - Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices.
    - » Flyers in provider/clinic offices, social media, call scripts, website banners
- **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information!**
  - **Launch 60 days prior to COVID-19 PHE termination.**
  - Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not done so yet.

Member Story

Member Vignette: Addressing Barriers of Care and PHM

1. Client MB,[1] who is an immigrant from Mali, was pregnant with her first child and referred to the **Nurse Family Partnership (NFP) home visiting service** by her OB provider.
2. The NFP's Public Health Nurse (PHN) developed a strong trusting relationship with MB over the course of more than 10 prenatal home visits with **in-depth assessments** and an **individualized care plan**.
3. After a challenging labor resulting in delivery via c-section, MB's daughter was born. MB was sent home, but 6 days after delivery, went **back to the ED for wheezing and swelling**.
4. On day 9, the PHN arrived for her regularly scheduled home visit and learned of the ED visit. The PHN was able to take MB's blood pressure, noting that it was high, and called the OB clinic, **educating MB to return to the ED if symptoms worsened**.
5. MB returned to the ED on day 10 for worsening symptoms. Despite having elevated blood pressure, **she did not receive any medication or treatment from the ED**.
6. After education and advocacy from the PHN with her concern for pre-eclampsia, the patient returned to the ED again on day 11. MB was finally admitted and **treated for pre-eclampsia for 3 days**.
7. After discharge, MB continued to monitor her blood pressure and **communicated regularly with her PHN**. MB is now working again, and she and her daughter doing well.

1. The client's initials were changed for privacy protection.

Member Vignette: Addressing Barriers of Care and PHM

- This story highlights the possibilities of a **high-touch and longitudinal care model with a trusted care team member** to address unconscious bias, health inequities and maternal health outcomes. The PHN was able to help MB advocate for herself and get a life-threatening condition identified and treated, resulting with a healthy mom and baby.

- Through **Enhanced Care Management (ECM)**, managed care plans (MCPs) can contract with programs like NFP to provide these **high-touch services for high-risk members**.

- This story highlights the importance of **ECM's new Population of Focus launching on 1/1/2024, focused on high-risk pregnant individuals and specifically focused on improving racial disparities**. Once this new population of focus launches, MB would have qualified for ECM, and if NFP was a contracted ECM provider, NFP could provide this service on behalf of the MCP.

Enhanced Care Management (ECM)

CalAIM Care Management Continuum

In 2023, managed care plans (MCPs) are required to have a broad range of programs and services to meet the needs of all members organized into the following three areas.

Enhanced Care Management (ECM) is for the **highest-need members** and provides intensive coordination of health and health-related services.

Complex Care Management (CCM) is for members at **higher- and medium-rising risk** and provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions.

Basic Population Health Management (BPHM). BPHM is the array of programs and services for **all** MCP members, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care.

Transitional Care Services are also available for all Medi-Cal MCP members transferring from one setting or level of care to another.

For more information on the CalAIM Care Management continuum, see the PHM Policy Guide

ECM Overview

ECM for adult POFs went live January 1, 2022 and will go live for children/youth POFs on July 1, 2023.

- ECM is a whole-person approach to **comprehensive care management** that addresses the clinical and non-clinical needs of high-need, high-cost MCP members.
- ECM is interdisciplinary, high-touch, person-centered, and **provided primarily through in-person**[1] **interactions** with Members where they live, seek care, or prefer to access services.
- DHCS' vision for ECM is to **coordinate all care for eligible Members**, including **across the physical, behavioral, and dental health delivery systems**.
- Every MCP member enrolled in ECM will have **a dedicated care manager**.
- ECM is available **to MCP Members who meet ECM "Population of Focus" definitions; Members may opt out at any time.**[2]

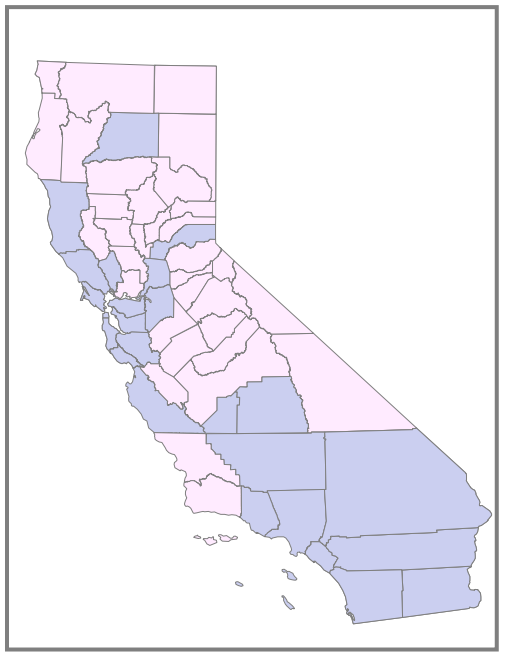
1. As of January 2022, due to the extended Public Health Emergency, ECM Providers may temporarily implement telephonic and video call ECM services to substitute for face-to-face ECM services
2. For more information on adult ECM Populations of Focus, see ECM Policy Guide (May 2022) on the DHCS ECM & Community Supports Website

ECM Core Services

- Comprehensive Assessment and Care Management Plan
- Coordination of and Referral to Community and Social Support Services
- Enhanced Coordination of Care
- Member and Family Supports
- Health Promotion
- Comprehensive Transitional Care
- Outreach and Engagement

For more information on ECM Populations of Focus, see ECM Policy Guide (May 2022) on the DHCS ECM & Community Supports Website

ECM Launch and Expansion Timeline



Counties in pink began implementing ECM in July 2022, making ECM statewide

ECM Populations of Focus (POFs)	Go-Live Timing
• Individuals and Families Experiencing Homelessness • Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization • Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs • Individuals Transitioning from Incarceration (some WPC counties) ○ Individuals with Intellectual or Developmental Disabilities (I/DD) ○ Pregnant/Postpartum Adults	January 2022 *(Whole Person Care Pilots (WPC) and Health Home Program (HHP) counties)* July 2022 *(all other counties)*
• Adults Living in the Community and At Risk for Institutionalization and Eligible for Long Term Care (LTC) Institutionalization • Adults who are Nursing Facility Residents Transitioning to the Community	January 2023
• **Children / Youth Populations of Focus**	**July 2023**
• **Birth Equity Population of Focus** *(Members of this POF who are subject to racial and ethnic disparities)*	**January 2024**
• Individuals Transitioning from Incarceration	2024 (Date TBD)

ECM Populations of Focus

ECM Population of Focus		Adults	Children & Youth
	1 Individuals Experiencing Homelessness	✓	✓
	2 Individuals At Risk for Avoidable Hospital or ED Utilization (formerly called "High Utilizers")	✓	✓
	3 Individuals with Serious Mental Health and/or SUD Needs	✓	✓
	4 Individuals Transitioning from Incarceration	✓	✓
	5 Adults Living in the Community and At Risk for LTC Institutionalization	✓	
	6 Adult Nursing Facility Residents Transitioning to the Community	✓	
	7 Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
	8 Children and Youth Involved in Child Welfare		✓
	9 Individuals with I/DD	✓	✓
	10 Birth Equity Population of Focus	✓	✓

New

Panel Discussion: ECM Implementation

Today, we are joined by guest speakers for a panel discussion on ECM implementation best practices, potential challenges, and other considerations for children/youth and maternal POFs.

Discussion Topics

1. Identifying Eligible Children/Youth Members
2. Becoming an ECM Provider
3. Providing ECM Services
4. Navigating Program Overlaps

Panel Discussion: Speakers

Name	Title	Organization
Dr. John Connolly	Chief Strategist	Los Angeles County Department of Public Health
Dr. Lakshmi Dhanvanthari	Chief Medical Officer	Health Plan of San Joaquin
Leticia Galyean, LCSW	CEO	Seneca Family of Agencies
Dr. Mary Giammona	Medical Director, Pediatrics and CCS Support Team	Molina
Dr. Joan Jeung	Clinical Professor of Pediatrics	UC San Francisco
	Executive Committee Member, Council on Healthy Mental and Emotional Development	American Academy of Pediatrics (AAP)
Katie Schlageter	CCS Administrator-Deputy Director (Retired)	Alameda County Public Health Department
Dr. Melanie Thomas	Psychiatrist, Team Lily	Zuckerberg San Francisco General Hospital

Population Health Management (PHM)

MCP PHM Readiness Deliverable Submissions
Key Takeaways (1)

- **25 MCPs** submitted PHM Readiness Deliverables in October for DHCS review, describing specific components of their PHM Programs and attesting to their readiness to implement for 1/1/2023 PHM Program launch.

- DHCS has completed the first round of reviews and believes **MCPs are ready for PHM Program launch**. However, DHCS has requested some additional information from all MCPs on Complex Care Management (CCM), Enhanced Care Management (ECM), Basic Population Health Management (BPHM), Transitional Care Services (TCS), and the Community Health Worker (CHW) Integration Plan.

MCP PHM Readiness Deliverable Submissions
Key Takeaways (2)

- **Gathering Member Information**
  - ***Initial Screening:***
    - MCPs are planning to take steps to improve HIF/MET response rates and Initial Health Appointments (IHAs) completion rate, such as allowing members to complete HIF/MET via an online portal in 2023.
  - ***Data Collection:***
    - MCPs have access to many of the required data sources. However, many MCPs noted barriers to obtaining specific types of data, such as behavioral health data, to inform RSS.
- **Understanding Risk**
  - ***RSS:***
    - Nearly all MCPs have a range of standard to more complex RSS approaches. All MCPs have attested to having an RSS methodology in place by 1/1/2023.
    - Some plans provided detailed approaches on how they assess and avoid potential bias and improve equity in their RSS approaches, while nearly all MCPs stratify RSS outputs by race, ethnicity, and other SDOH factors.
  - ***Assessment:***
    - Most plans will continue to use the optional HRA tool for LTSS assessment and referral.

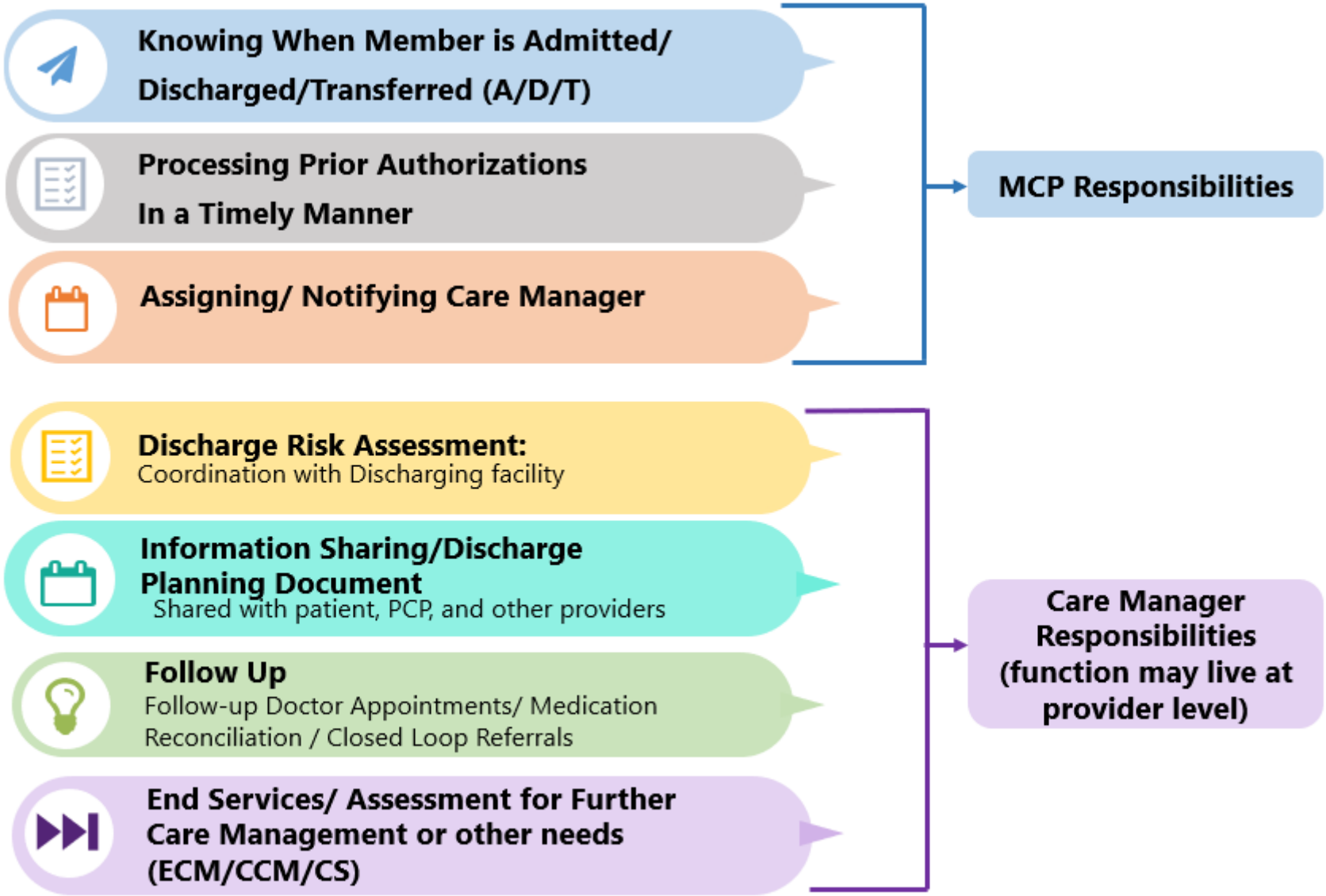
MCP PHM Readiness Deliverable Submissions
Key Takeaways (3)

- **Providing Services and Supports**
  - ***BPHM:***
    - MCPs focus on primary care engagement via IHAs
    - Most MCPs reported active care coordination with other delivery systems. DHCS is requesting more information on additional details, such as how care is coordinated for substance use services.
    - MCPs also reported partnerships with schools, local health departments, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Early Start programs.
    - Nearly all MCPs have innovative wellness and prevention programs and practices to improve EPSDT utilization via incentives and community partnerships.
    - CHWs: Nearly all MCPs will use data-driven approaches to identify eligible members for CHW services and will expand their CHW network by partnering with existing providers (including ECM and Community Supports providers) and CBO partners. In addition, 7 MCPs noted CHWs will be embedded in community settings, and multiple MCPs will collaborate with community partners with CHW training and certification.

MCP PHM Readiness Deliverable Submissions
Key Takeaways (4)

- **Providing Services and Support**
  - ***Transitional Care Services:***
    - Most MCPs receive some ADT feeds, but no MCP has ADT feeds from all hospitals/facilities in their region. MCPs indicated barriers related to contracting and costs.
      - Alternatively, MCPs are leveraging utilization management, Collective Medical Technologies (EDIE), Manifest Medex, or EPIC's Care Everywhere to know when members are admitted, discharged or transferred.
    - The majority of MCPs attested to meeting all TCS requirements, however, some plans attested to not being able to assign a care manager to complete TCS activities or notifying the discharging facility with the name and contact information of the assigned care manager.

Reminder: MCP PHM Requirements on Transitional Care Services



Given market feedback, DHCS is issuing guidance to phase in transitional care services implementation, allowing plans time to ramp up capacity via hiring staff or develop broader relationships with hospitals or facilities. An updated PHM Policy Guide with this new policy will be published in mid-December.

Formal Guidance on Phased Implementation of Transitional Care Services	
By 1/1/23	• MCPs must ensure **all transitional care services are complete (including having a care manager/single point of contact) for <u>all high-risk members</u>**[1] as defined in the PHM Policy Guide. • MCPs must implement **timely prior authorizations** and **know when members are admitted, discharged or transferred for <u>all members</u>.** • MCPs must develop and **execute a plan to ramp up** transitional care services. The plan must address how the MCPs will meet the timeline and requirements.
By 1/1/24	• MCPs are required to ensure **all transitional care services are complete for <u>all members</u>**. As noted in the PHM Policy Guide, MCPs are strongly encouraged to contract with hospitals, Accountable Care Organizations, PCP groups, or other entities to provide transitional care services, particularly for lower- and medium-rising- risk members.

1. MCPs are required to assess high-risk members and populations outlined in the PHM Policy Guide p.g., 13-14, Assessment to Understand Member Needs Section, including but not limited to: Children with Special Health Care Needs (CSHCN), Pregnant Individuals, Seniors and Persons with disabilities who meet the definition of "high risk" as established in existing APL requirements.

Look Ahead

Policy/Guidance	Submission	Launch

May 2022	*Draft PHM Strategy and Roadmap for Public Comment [COMPLETE]*
June 2022	*Final PHM Strategy and Roadmap*
September 2022	*2023 PHM Program Guide* *2023 PHM Strategy Readiness Deliverable Template*
October 2022	*MCP 2023 PHM Readiness Deliverable Submission due*
December 2022	Retirement of APLs 17-012 and 17-013 regarding Duals/Seniors and Persons with Disabilities
December 2022	Amended APLs regarding IHEBA/SHA and Individual Health Assessment released

Policy/Guidance	Submission	Launch

Q1 2023	**PHM Program Launch** **PHM Service Test Launch with Multiple Partners**
Q1 2023	Updated APL 19–011 regarding PNA/PHM Strategy Requirements
Q1 2023	PHM Monitoring Plan published
Q2 2023	PHM Strategy due under revised requirements, to more comprehensively detail the PHM Program's PNA Approach and use of the PHM Service
Q2/Q3 2023	PHM Monitoring Reporting starts
Q3 2023	**PHM Service Statewide Launch and Scaling**

Questions?

Upcoming Webinars of Interest

Stakeholder Advisory Committee (SAC) / Behavioral Health SAC

Thursday, February 16
9:30 AM – 1:30 PM PT

Registration Forthcoming Here

Key Resources:

- DHCS CalAIM Website: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx
- DHCS ECM and Community Supports Website: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx
- DHCS Population Health Management Website: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx
- DHCS Medi-Cal's Strategy to Support Health and Opportunity for Children and Families: https://www.dhcs.ca.gov/Documents/DHCS-Medi-Cal%27s-Strategy-to-Support-Health-and-Opportunity-for-Children-and-Families.pdf

Thank You