CalAIM Enhanced Care Management and Community Supports: Long-Term Care Populations of Focus
Technical Assistance Webinar

Thursday, September 8, 2022

1:30 – 3:00 PM PT

DHCS

4/15/2019

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.

Today's Session

» **Welcome & Introductions**

» **DHCS Policies:**

   » **Understanding CalAIM, ECM, and Community Supports**

   » **Coming to CalAIM in 2023**

      » **ECM Long-Term Care Populations of Focus**

» **Spotlight: Partners in Care Foundation and Health Net**

» **Q&A**

Understanding CalAIM, ECM, and Community Supports
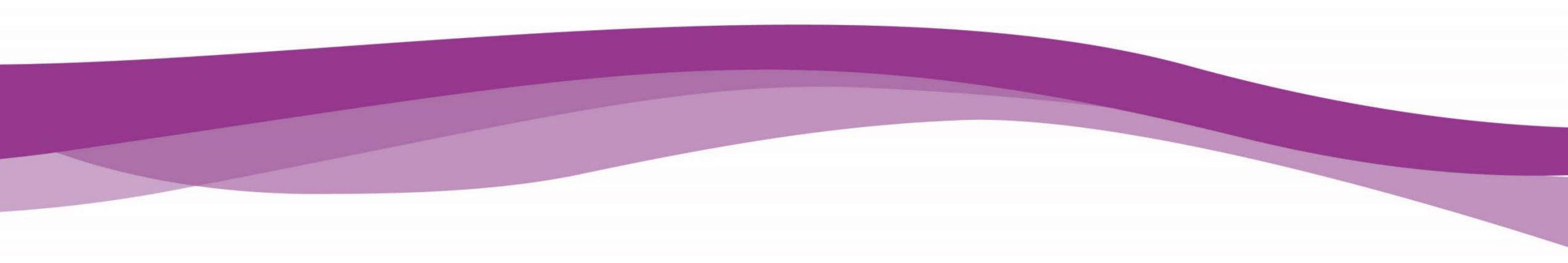
California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. The goals of CalAIM include:

Implementing a whole-person care approach and address social drivers of health.

Improving quality outcomes, reduce health disparities, and drive delivery system transformation.

Creating a consistent, efficient and seamless Medi-Cal system.

Key CalAIM Components in 2022:
Enhanced Care Management (ECM) and Community Supports

On January 1, 2022, DHCS launched the first components of CalAIM: Enhanced Care Management and Community Supports.

Enhanced Care Management (ECM)

A **Medi-Cal managed care benefit** that will address clinical and non-clinical needs of high-need, high-cost individuals through the coordination of services and comprehensive care management

Community Supports

Services that **Medi-Cal managed care plans are strongly encouraged, but not required, to provide** as medically appropriate and cost-effective alternatives to utilization of other services or settings such as hospital or skilled nursing facility admissions

What is ECM?

ECM is a new Medi-Cal benefit to support comprehensive care management for enrollees with complex needs that must often engage several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder (SUD), and long-term services and supports (LTSS).

» ECM is designed to address both the clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services, meeting enrollees wherever they are – on the street, in a shelter, in their doctor's office, or at home

» ECM is part of broader CalAIM Population Health Management system design through which MCPs will offer care management interventions at different levels of intensity based on member need, with ECM as the highest intensity level

For more details, see ECM Policy Guide (May 2022).

Seven ECM Core Services

Outreach and Engagement

Member and Family Supports

Comprehensive Assessment and Care Management Plan

Health Promotion

Enhanced Coordination of Care

Comprehensive Transitional Care

Coordination of and Referral to Community and Social Support Services

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Launch and Expansion of ECM

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

ECM Populations of Focus	Go-Live Timing
• Individuals and Families Experiencing Homelessness • Adult At Risk of Avoidable Hospital/ED Utilization • Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD) • Transitioning from Incarceration (some WPC counties)	**January 2022** (WPC / HH counties) **July 2022** (all other counties)
• At Risk for Institutionalization and Eligible for Long Term Care • Nursing Facility Residents Transitioning to the Community	**January 2023**
• Children / Youth Populations of Focus • Transitioning from Incarceration (statewide)	**July 2023**

What are Community Supports?

Community Supports are services that Medi-Cal managed care plans (MCPs) are <u>strongly encouraged but not required</u> to provide as substitutes for utilization of other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

» Community Supports are designed as cost-effective alternatives to traditional medical services or settings and to address social drivers of health (factors in people's lives that influence their health)

» Different MCPs offer different combinations of Community Supports

» MCPs must follow the DHCS standard Community Supports service definitions in the policy guide, but they may make their own decisions about when it is cost effective and medically appropriate

» Community Supports are not restricted to ECM Populations of Focus and should be made available to all Members who meet the eligibility criteria for a specific Community Support

For more details, see Community Supports Policy Guide (April 2022).

What are Community Supports?

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications)
12. Meals/Medically-Tailored Meals or Medically-Supportive Foods
13. Sobering Centers
14. Asthma Remediation

For more details, see [Community Supports Policy Guide](#) (April 2022).

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Community Supports for Members in Long-Term Care Populations of Focus

The entire menu of Community Supports may be applicable to Members in the Long-Term Care Population of Focus, but each Member will have different needs and functional limitations.

Community Supports that may benefit members in the Long-Term Care Populations of Focus include, but are not limited to:

» Nursing Facility Transition/Diversion to Assisted Living Facilities

» Community Transition Services/Nursing Facility Transition to a Home

» Environmental Accessibility Adaptations (Home Modifications)

» Respite Services

» Personal Care and Homemaker Services

For more details, see [Community Supports Policy Guide](#) (April 2022).

Community Supports For Long-Term POF: Example
Nursing Facility Transition/Diversion to Assisted Living Facilities (ALF)

This Community Support facilitates nursing facility transition back into a home-like, community setting and/or prevents skilled nursing admissions for Members with an imminent need for nursing facility level of care.

» Providers of this Community Support are responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration
  » Includes 24-hour direct care staff on-site to address unpredictable needs and ensure safety

» Allowable expenses are those necessary to enable a person to establish a community facility residence
  » **Can** include identifying/securing housing options and on-site services needed, coordinating a move into an ALF, and ongoing expenses for Members receiving the service in an ALF (such as ongoing companion services, therapeutic social/recreational programming, medication oversight, and assistance with ADL/IADL)
  » **Cannot** include room and board or other living expenses

» The organizations that MCPs contract with for this Community Support must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner
  » Providers include (but are not limited to) case management agencies, Home Health agencies, adult residential facility (ARF)/Residential Care Facilities for the Elderly (RCFE) operators

For more details, see [Community Supports Policy Guide](#) (April 2022), [ECM & Community Supports FAQ](#) (August 2022).

Community Supports For Long-Term POF: Example
Nursing Facility Transition/Diversion to ALF- *Continued*

Eligibility Criteria

For **Nursing Facility Transition,** eligible individuals:
- Have resided 60+ days in a nursing facility;
- Are willing to live in an assisted living setting as an alternative to a Nursing Facility; and
- Are able to reside safely in an assisted living facility (ALF) with appropriate and cost-effective supports.

For **Nursing Facility Diversion**, eligible individuals:
- Are interested in remaining in the community;
- Are willing and able to reside safely in an ALF with appropriate and cost-effective supports; and
- Must be currently receiving medically necessary nursing facility level of care or meet the minimum criteria to receive nursing facility level of care services and in lieu of going into a facility, are choosing to remain in the community and continue to receive medically necessary nursing facility level of care services at an ALF.

For more details, see Community Supports Policy Guide (April 2022).

Community Supports For Long-Term POF: Example
Community Transition Services/Nursing Facility Transition to a Home

This Community Support covers non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for their own living expenses.

» Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and are payable up to a total lifetime maximum amount of $7,500
  » **Can** include: assessing housing needs, assisting in housing search, coordinating funding for environmental modifications
  » **Cannot** include: monthly rent or mortgage expenses

» Providers must have experience and expertise with providing these unique services and may include (but are not limited to): case management agencies, Home Health agencies, CCT/Money Follows the Person providers.

Eligibility Criteria

Eligible individuals:
- Are currently receiving medically nursing facility level of care (LOC) services and, in lieu of remaining in the facility or medical respite setting, are choosing to transition home and continue to receive medically necessary nursing facility LOC;
- Have lived 60+ days in a nursing home and/or Medical Respite setting;
- Are interested in moving back to the community; and
- Are able to reside safely in the community with appropriate and cost-effective supports/services.

For more details, see Community Supports Policy Guide (April 2022).

Coming to CalAIM in 2023
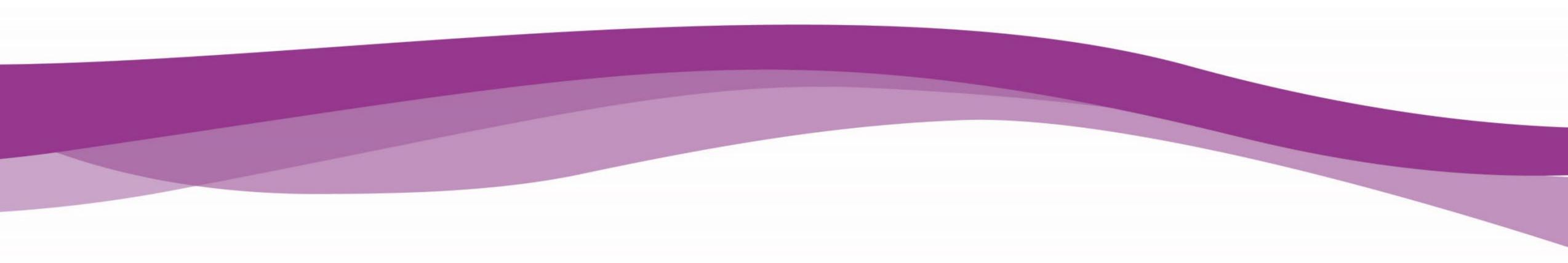
CalAIM Components that Go-Live in 2023 that Impact Dual Eligible Members / Seniors & Persons with Disabilities (SPDs)

Cal MediConnect (CMC) ends and **Medicare Medi-Cal Plans (MMPs or Medi-Medi Plans),** formerly known as Exclusively Aligned Enrollment (EAE) Dual Special Needs Plans (D-SNPs), will be launched in the Coordinated Care Initiative (CCI) counties.

Long Term Care (LTC) carve-in in remaining Two-Plan, Geographic Managed Care (GMC) and Regional Model Counties

Statewide **mandatory Medi-Cal managed care enrollment** for dual eligible members

Population Health Management (PHM) Program go-live in the Medi-Cal Managed Care Delivery System

Enhanced Care Management Long-Term Care (LTC) Populations of Focus launch

Two New Long-Term Care Populations of Focus for ECM

On January 1, 2023, two new Populations of Focus will launch for Enhanced Care Management:

Adults Living in the Community Who Are At Risk for LTC Institutionalization

Nursing Facility Residents Transitioning to the Community

Adults Living in the Community Who Are At Risk for LTC Institutionalization
Population of Focus Definition

Definition
(1) Adults living in the community who meet the Skilled Nursing Facility (SNF) Level of Care criteria;[1] **OR** who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury;[2]   **AND**   (2) are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring),[3]   **AND**   (3) are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).

For more details, see ECM Policy Guide (May 2022).

Adults Living in the Community Who Are At Risk for LTC Institutionalization

Population of Focus Definition - Continued

Notes on the Definition:

» **Living in the Community:** Members who meet this Population of Focus may live in independent housing, Residential Care Facilities, Residential Care Facilities for the Elderly (RCFEs), or any other dwelling that meets the requirements established in the Home and Community Based Services (HCBS) Settings Final Rule.[4]

» **Exclusions:** Adults living in the community who are at risk of institutionalization into Intermediate Care Facilities (ICF) and subacute care facilities are excluded from this Population of Focus.

1. As established in the California Code of Regulations 51335: Link
2. Criteria adapted from the 2020 Medi-Cal Long-Term Care At Home proposal: Link
3. Criteria adapted from the Community-Based Health Home eligibility criteria: Link
4. CMS Final Rule 79 FR 2947, Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; 42 CFR 441.301(c)(4) and (5)

For more details, see ECM Policy Guide (May 2022).

Adults Living in the Community Who Are At Risk for LTC Institutionalization
Summarized Operational Guidance

Identification

» **Referrals** will be the predominant pathway MCPs use to identify eligible Members

» MCPs may also leverage existing **Member data**, data sharing with contracted Providers, 1915 (c) HCBS waiver program wait lists, previous SNF Level of Care determinations to identify members

Assessment and Care Plan

» **Assessment:** For Members who may have LTSS needs, MCPs must continue to include DHCS' standardized Long-Term Services and Supports (LTSS) referral questions[1] as part of the assessment

» **Care Plans:** If the Member has LTSS needs, the care plan must be developed by an individual who is trained in person-centered planning, should reflect Member preferences, and should incorporate LTSS and all wraparound services and supports that will ensure the Member is setup to live continuously in the community

Provider Contracting

» MCPs are required to contract with **providers who have experience** serving Members who meet this POF, which may include CBAS Centers, Area Agencies on Aging, Home Health Agencies, and Centers for Independent Living

1. As established in APL 17-013: Link
2. As established in 42 CFR § 438.208: Link and 42 CFR § 441.301: Link

For more details, see ECM Policy Guide (May 2022).

Adults Living in the Community Who Are At Risk for LTC Institutionalization
Interactions with Other Programs

Community-Based Adult Services (CBAS)	• Members in a CBAS program are eligible to receive ECM if they meet POF criteria
In-Home Support Services (IHSS)	• Members receiving IHSS are eligible to receive ECM if they meet POF criteria
1915(c) Waiver Programs	• Members can be enrolled in ECM *or* in a 1915(c) waiver program, but not both at the same time • If space is available in a 1915(c) waiver program, members may choose between ECM and the waiver program

For more details, see ECM Policy Guide (May 2022).

Nursing Facility Residents Transitioning to the Community
Population of Focus Definition

Definition
Nursing facility residents who are: » Interested in moving out of the institution; » Are likely candidates to do so successfully; and » Able to reside continuously in the community.

Notes on the definition:

» **Able to Reside Continuously in the Community**: Members transitioning to the community may need to return to the hospital or SNF intermittently for short admissions (potentially due to changes in medical conditions or other acute episodes). They should not be precluded from being considered able to reside continuously in the community.

» **Exclusions**: Individuals residing in Intermediate Care Facilities (ICF) and subacute care facilities are excluded from this Population of Focus.

For more details, see ECM Policy Guide (May 2022).

Nursing Facility Residents Transitioning to the Community
Summarized Operational Guidance

Identification

» To identify eligible Members, MCPs can rely on **referrals, analysis of their own data, or direct data feeds/established relationships with SNFs or other Providers**.

Assessment and Care Plan

» **Assessment:** MCPs must assess Members against criteria to determine who could be **successful to reside continuously in the community.**
  » *DHCS encourages MCPs to use the California Community Transitions (CCT) assessment tool for this Population of Focus.*

» **Care Plan:** The ECM Care Manager is responsible for identifying all resources to address all needs of the Member, including coordinating with local housing agencies/identifying the least restrictive community housing option, ongoing medical care that may be needed, and other needed community-based services.

Provider Contracting

» MCPs are **strongly encouraged** to contract with **CCT Lead Organizations.** These providers have existing relationships with community-based organizations, can coordinate community wrap around supports effectively, and have extensive knowledge of existing local community resources (e.g., housing wait lists).

For more details, see ECM Policy Guide (May 2022).

Nursing Facility Residents Transitioning to the Community
Interactions with Other Programs

California Community Transitions (CCT) Money Follows the Person (MFTP)	• Members can be enrolled in ECM *or* in CCT MFTP, but not both at the same time

Planning for ECM Long-Term Care Populations of Focus:
Partners in Care Foundation & Health Net
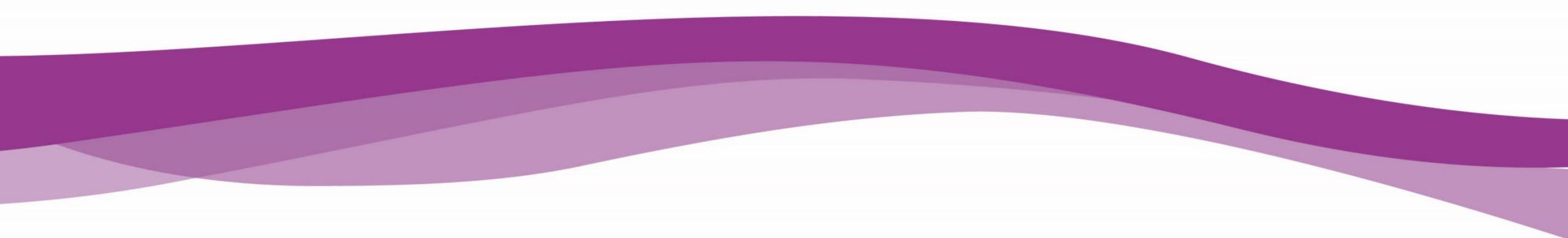
Featured Presenters

Partners in Care
F O U N D A T I O N

health net

Anwar Zoueihid
Vice President, Long Term Services & Supports
Partners in Care Foundation

Ed Mariscal
Director, Public Programs & Long-Term Services & Supports
Health Net

Today's Presentation

» Background

   » About Partners in Care Foundation and its CalAIM Programs
   » About Health Net and its CalAIM Programs
   » History of the *Partners* & Health Net Partnership

» How *Partners* and Health Net Support Long-Term Care Transitions

» How *Partners* and Health Net Are Preparing for the Long-Term Populations of Care

About Partners in Care Foundation and its CalAIM Programs

Who We Are

Since 1997, **Partners in Care Foundation** has been a nationally recognized leader working at the regional, state, and national levels to disseminate evidence-based models of care and assure quality staffing to address social determinants of health for older populations and other complex populations with needs for crucial in-home support.

A Provider of Complex Case Management

A Community-Based Organization (CBO) accredited for Complex Case Management by the National Committee for Quality Assurance (NCQA)

A Leader of a Network of CBOs

Pioneers in conceptualizing, developing, and advancing the Home and Community-Based Services Network in California and across the country

Partner's Complex Case Management

Partners collaborates with hospitals, physician groups, health plans, community-based organizations, and government agencies to deliver services that support diverse adults and families with complex health and social services needs and their caregivers and families.

What We Do:

- Create, test, adapt, and disseminate evidence-based models of care applied to care management for community living and aging well.
- Deliver services to improve chronic disease self-management, identify and resolve dangerous medication errors, thus preventing falls, averting costly ER use or hospitalizations, and preventing homelessness or nursing home placement through in-home care coordination.
- Provide care management, both brief and long term, as well as consumer empowerment through evidence-based workshops to enhance health self-management skills and behavior changes.

Portfolio of Medi-Cal & LTSS Services

- Multipurpose Senior Services Program (MSSP)
- Home & Community Based Alternatives Waiver (HCBA)
- Enhanced Care Management (ECM)
- Community Supports (CS)
- Assisted Living Waiver (ALW)
- California Community Transitions (CCT)
- Health Risk Assessments (HRA)
- Face to Face CBAS Eligibility Determination Services
- Care Plan Options (CPO)

The Partners at Home Network

Our work serves as a bridge between medical care and what a person accomplishes in their own home.

We manage the gaps in non-medical care that affect a person's recovery and overall health.

We represent a California network of community-based organizations (CBOs) and a national collection of similar networks providing evidence-based interventions. Over 60 agencies in 20 states license HomeMeds.

The result is happier, healthier people cared for at lower expense in their own homes and communities.

How CBO Networks Address Members' Social Needs

Food, Housing, Transport, Benefits

Access to Care: Coaching & Navigation

Care Coordination & Safe Handoffs

Social Determinants of Health

Community Connection & Caregiver Support

Medication Safety & Management

Patient Activation & Healthy Lifestyle

Partners Network in California

HomeMeds/Med Reconciliation

Care & Service Coordination

Comprehensive Assessments

Caregiver Education & Support/Respite

Evidence-Based Healthy Lifestyle Workshops

LTSS: Meals, Transportation, home mods, etc.

Partners' CalAIM Journey

» **2018:** *Partners* was requested to participate in the Health Homes Program
  » *Request made by a health plan east of Los Angeles*
  » *Request made to help improve the overall health outcomes of the members being served*
» **2019:** Launched Health Homes Program (HHP) in Los Angeles County
  » *5 health plans requested we participate in the HHP Pilot*
  » *Partners maintained an average HHP participation of over 1,000 members*
  » *Partnership = Testament of Historical partnerships with MCPs- COHS/CCI counties*
  » **Successes:**
    » *Health information system*
    » *Diverse team of care managers/care coordinators*
    » *Care coordination with health plans*
    » *Communication, testing new care management models, providing feedback*
    » *Addressing member trust issues*
» **2022:** Partners in Care Foundation became an ECM Provider and Community Supports provider under CalAIM

Partners' Approach to ECM and Community Supports

» Integrated Approach to Comprehensive Care Coordination Model

  » Requires coordination with MCPs, IPAs, hospitals, SNFs, social services providers (housing, home modification, transportation, etc.)

» Diverse care management team

  » Health coaches, navigators, social workers, community health workers

  » Culturally and linguistically matched to members

» Home-based care management

  » ECM program involves home visit when possible and appropriate

» Data management & quality assurance

  » Gather data and information typically not shared in a medical setting or encounter

Partners' ECM Program

» Launched ECM in January 2022

  » Los Angeles, San Bernardino, Riverside, San Diego

  » 5 major Managed Care Health Plans

» Average monthly enrollments: 2,000+

» Populations of Focus

  » Individuals & Families Experiencing Homelessness

  » Adults at Risk of Avoidable Hospital and ED Utilization

  » Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)

» Initial months focused on safe transition from HHP/WPC to ECM

Partners' ECM Program

» **Employee retention**: Essential to keep care managers supporting members and address burnout

» **Quality assurance**: ECM program is NCQA accredited

» **Integrated care coordination**: Working with other health and social services programs is critical to serving members

» **Optimizing outreach & engagement**: Practices include:

  » 7 attempts on the phone + letters + text messaging

  » Locating members through coordination with PCP office, Collective Medical, HMIS (Homeless Management Information System), CES (Coordinated Entry System)

Partners' Community Supports

Partners provides three Community Supports to members enrolled in its ECM program:

» Housing Transition Navigation Services
» Housing Deposits
» Housing Tenancy and Sustaining Services

Partners serves as a community hub connecting members to:

» Respite Services
» Meals/Medically-Tailored Meals or Medically-Supportive Foods

About Health Net and its CalAIM Programs

About HealthNet
California's Longest-Serving Medi-Cal Managed Care Plan

Founded
1977

~3 Million
Members – 1 in
13 Californians

58
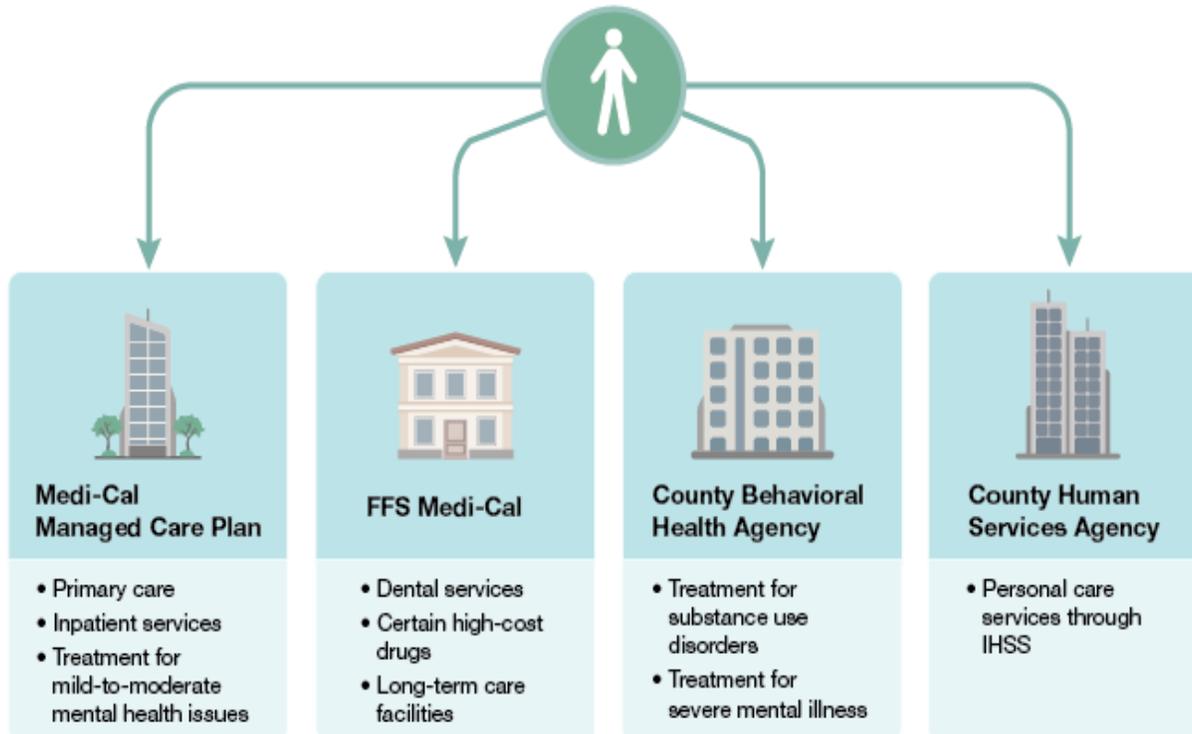Counties

85% Members
in Government-
Sponsored Plans

85,000
Providers

Health Net's ECM Program

Whole-person approach to care to addresses the clinical and non-clinical needs through partnerships with CBOs

Medi-Cal Enrollees Access Services Through Multiple Systems

Medi-Cal Managed Care Plan	FFS Medi-Cal	County Behavioral Health Agency	County Human Services Agency
• Primary care • Inpatient services • Treatment for mild-to-moderate mental health issues	• Dental services • Certain high-cost drugs • Long-term care facilities	• Treatment for substance use disorders • Treatment for severe mental illness	• Personal care services through IHSS

30+ ECM providers statewide

» *Partners* is among Health Net's trusted ECM partners

11,000+ ECM enrollees statewide

Health Net's Community Supports

» Coming in January 2023:
  » Nursing Facility Transition/Diversion to ALF, Nursing Facility Transition to a Home
  » Personal Care/Homemaker Services

» Most other Community Supports already launched in 2022; varies slightly by county

» Working with community partners to help build this infrastructure

Health Net Support for LTC Transitions

SNF transitions of our LTC population has been a priority in Los Angeles and San Diego Counties

» In 2019 (full year prior to public health emergency):
  » 922 transitions to home/B&C/ALF
  » 31% over the age of 80
  » 77 members institutionalized over 1 year (5 institutionalized over 4 years)
» Dedicated team of Social Workers providing training, education, collaboration with SNF social services teams.
» Monthly check-in with SNF
» Reviews of MDS Section Q – even with the response in Section Q indicates the member has no plans to transition, we will offer to have the conversation with the member/member's family.

Launching as Community Supports in 2023

Building on its existing services, Health Net is launching two Community Supports to further assist members with long-term care transitions:

» Nursing facility transition/diversion to assisted living facilities

» Nursing facility transition to a home

The Partnership Between Health Net and *Partners*

How *Partners* and Health Net Work Together

» *Partners* and Health Net strategic partnership began in 2013

  » *Partners* and Health Net first contracted to support member transitions when the ADHC program became CBAS

  » Today, *Partners* completes ~2,500 assessments per year for Health Net for its CBAS program

» *Partners* and Health Net have since worked together on several care management programs:

  » Connect the Needs

  » Contracted HHP to ECM provider

  » Transition WPC to ECM

» Health Net has provided IPP funding received from CalAIM to *Partners* for:

  » Workforce Development

  » Capacity Infrastructure

How *Partners* and Health Net Support Members in Long-Term Care

Partners and Health Net's Model for LTC Transition Coordination

Goal

» To integrate Community Based Organizations with Managed Health Plans

» To increase successful transitions from Skilled Nursing Facilities

Model of Care

» Co-designed

» Coordinates care across point people at each of the three organizations

  » CBO <> MCP <> SNF

  » Additional Support: Housing, Medical Groups, Family, Developers, CBAS provider, Recuperative Care, etc.

» Team of transition of coordinators and RNs

Partners and Health Net's Model for LTC Transition Coordination

Key elements for comprehensive care coordination:

1. Health Plan identifies potential member
2. Health Plan verify eligibility
3. Health Plan notifies *Partners*/CBO
4. Health Plan submits referral with member enrollment information
5. *Partners*/CBO set Joint Assessment & creates a Plan of Action

CBO

MCP

SNF
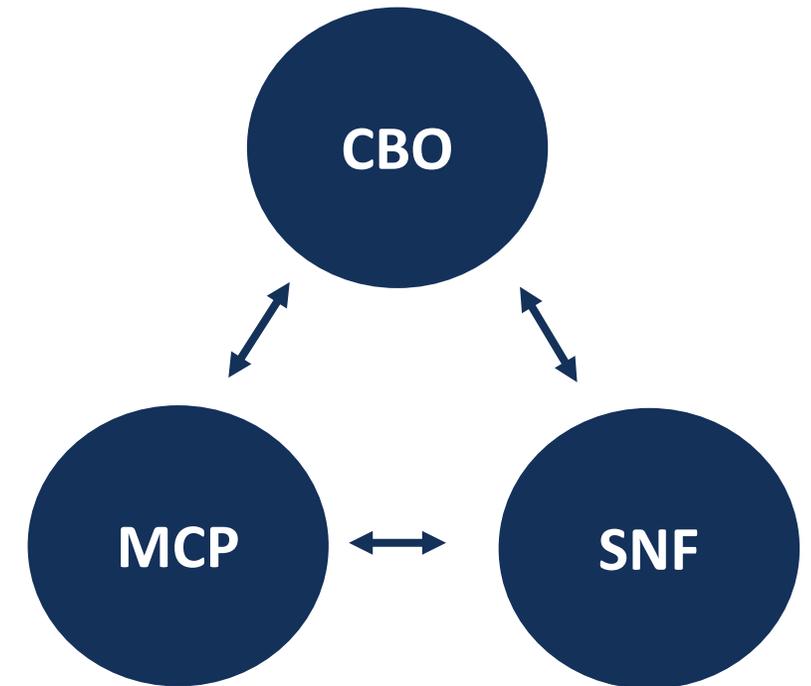
Partners and Health Net's Model for LTC Transition Coordination

» *Partners* launched program as 12-month pilot (2018)

   » *Partners* 5 MCPs (including Health Net) / 28 of SNFs
   » 4 Different Counties (Los Angeles, San Bernardino, Riverside, Orange County)
   » Goal: Enroll a minimum of 10 SNF Residence per month/120 annual goal
      » 127 total enrolled
      » 59 successfully transitioned back to the community

» Integrated coordinated care model resulted in a 47% successful transition to a community setting.

How *Partners* and HealthNet Get Started with a LTCF

» Build a relationship with a SNF and start by learning their systems and requirements:
   » Medicare vs Medi-Cal Services; Part B utilization; Levels of Care
   » MCP information requirements
   » SNF specialty services, unique populations
   » Learning their language/acronyms
   » Build relationship with liaison

» Establish community partnerships essential to integrated coordinated care:
   » CBAS Centers
   » Recuperative Care
   » PPG, PCP, and other provider coordination/collaboration

How *Partners* and Health Net Are Preparing for New ECM POFs

Evolution of Long-Term Care Coordination in California

» Historical HCBS Silos

  » CBO providing nursing home diversion programs (ALW/CCT/MSSP, etc.)

  » MCP providing nursing home diversion programs (Care Plan Options/Connect the Needs/Care Transitions, etc.)

  » Coordinated Care Initiative – aimed to enhance the coordination between MCP and CBO

» 2023:

  » CalAIM brings together different models and pilots into a coordinated, integrated system between MCPs, CBOs, and SNFs

  » DHCS maintains HCBS program SafetyNet

How *Partners* and HealthNet Are Getting Ready for ECM for LTCF

» Reengaging with Skilled Nursing Providers & Corporate Entities

» Ongoing outreach, education & training
  » In-service trainings: CalAIM 101
  » Discharge planning & leveraging community supports

» Developing campaigns for identifying members in need of transitions support at each SNF

» Establishing contracts (BAA/MOU)

» Establishing secured health information exchange
  » Portals, eFax, Secured Email, etc.

Upcoming Webinars

Two additional sessions this month will focus on long-term care Populations of Focus and Community Supports

Community Supports Spotlight

Nursing Facility Transition & Community Transition Services

Thursday, September 15th
12:00 – 1:30 PM PT
Registration link

Office Hours

ECM and Community Supports Long-Term Care Populations of Focus

Thursday, September 22nd
2:00 – 3:00 PM PT
Registration link

Upcoming Webinars

Community Supports Spotlight: Nursing Facility Transition & Community Transition Services
Thursday, September 15th
12:00 – 1:30 PM PT
Registration link

ECM and Community Supports TA Series: ECM Long Term Care Populations of Focus Office Hours
Thursday, September 22nd
2:00 – 3:00 PM PT
Registration link

ECM and Community Supports TA Series: ECM and Community Supports in Rural CA Office Hours
Thursday, September 29th
2:00 – 3:00 PM PT
Registration link

ECM and Community Supports TA Series: Housing Supports via ECM & Community Supports Webinar
Thursday, October 13th
1:30 – 3:00 PM PT
Registration link

Community Supports Spotlight: Housing Supports
Thursday, October 20th
1:30 – 3:00 PM PT
Registration link

ECM and Community Supports TA Series: Housing Supports via ECM & Community Supports Office Hours
Thursday, October 27th
2:00 – 3:00 PM PT
Registration link

Review DHCS Resources & Materials for Providers

» Learn more about ECM & Community Supports:
- Policy Guides: ECM & Community Supports
- FAQs
- Fact Sheets: ECM & Community Supports

» Review ECM & Community Supports guidance documents:
- Billing & Invoicing Guide
- Coding Options
- Community Supports Pricing Guide (Non-Binding)
- Data Guidance for Member-Level Information Sharing
- Contract Template Provisions
- Standard Provider Terms & Conditions

Thank You!

For more information about CalAIM, visit:
https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

For more information about ECM and Community Supports, visit:
https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices

Send questions or comments to
CalAIMECMILOS@dhcs.ca.gov

ECM Eligibility for Dual-Eligible Members
Overview for 2022

Figure 2: Overview of ECM Eligibility for Dual-Eligible Members in 2022

Medicaid & Medicare Delivery Model or Other Programs	ECM Eligible
Cal MediConnect	No
FIDE-SNPs	No
PACE Programs	No
Medi-Cal MCP + Medicare FFS	Yes
Medi-Cal MCP + Other MA	Yes
Medi-Cal MCP + D-SNP Look-alike	Yes
Medi-Cal MCP + D-SNP	Yes
Medi-Cal FFS + Medicare FFS or Plan *(not MCP enrolled)*	No
Any other excluded program (e.g., 1915(c), CCT)	No

ECM Eligibility for Dual-Eligible Members
Overview for 2023 and Beyond

Figure 3: Overview of ECM Eligibility for Dual-Eligible Members in 2023 and Beyond

Medicaid & Medicare Delivery Model	ECM Eligible
Medi-Cal MCP + <u>EAE</u> D-SNPs	No
FIDE-SNPs	No
PACE Programs	No
Medi-Cal MCP + Medicare FFS	Yes
Medi-Cal MCP + Other MA	Yes
Medi-Cal MCP + <u>non EAE</u> D-SNP	Yes in 2023; No from 2024
Medi-Cal FFS + Medicare FFS or Plan *(not MCP enrolled)*	No
Any other excluded program (e.g., 1915(c), CCT)	No