CALAIM & THE COUNTY IMPACTS

LIVE WELL
SAN DIEGO

COUNTY OF SAN DIEGO WHOLE PERSON WELLNESS

Linking Housing and Health for Better Outcomes

LIVE WELL SAN DIEGO

INTRODUCTIONS & TOPICS

Objective	Speaker
Introduce objective of webinar – Our experience living the transition from WPC/HHP to ECM/ILOS	Jennifer Tuteur , MD, FAAFP - Deputy Chief Medical Officer, Medical Care Services Division
Overview of the Whole Person Care (WPC) program, highlighting key program features or services	Amaris Sanchez - Program Coordinator George Scolari - Chair, Healthy San Diego, CalAIM Work Group
Overview of the Health Homes Program (HHP) experience from a Community Based Care Management Entity (CBCME) and lessons learned that should be considered for the transition to Enhanced Care Management (ECM)	Katherine Bailey - Executive Director, Neighborhood Networks
Overview of the CalAIM (big picture) program, with a focus on Enhanced Care Management (ECM) and In Lieu of Services (ILOS) and the current DHCS implementation timeline	Sydney Turner - Manager of Health Policy
• Transition progress and structure we are implementing (Sydney) • MCP collaboration (George & Sydney) • Lessons learned (All)	All

COUNTY OF SAN DIEGO VISION

LIVE WELL SAN DIEGO

Building Better Health

Living Safely

Thriving

HEALTHY SAN DIEGO

Healthy San Diego

Overview 2021

Formed in 1998, Healthy San Diego is the umbrella in which Medi-Cal Managed Care Plans operate. There are 3 Medi-Cal Managed Care Models. County Operated Health Systems (COHS), Two Plan Models and Geographic Managed Care. San Diego and Sacramento are Geographic Managed Care.

- COHS is a system in which a County runs the Medi-Cal Managed Care system. For example, Orange County is a COHS. CalOptima is the one and only Medi-Cal Managed Care Plan.
- Two Plan model is a system in which there are two basic plans to choose. 1 would be a County managed plan and 1 a private plan. For example, LA is a Two Plan Model. In LA County, you choose LA Care or Health Net. Under LA Care and Health Net are other contracted plans like Kaiser, Blue Cross, Blue Shield etc... However, a members card will say LA Care or Health Net.
- Geographic Managed Care is in San Diego and Sacramento only. Any plan can apply to be a Medi-Cal Managed Care Plan in these two Counties. It promotes healthy competition among Plans and consumer choice.

HSD STRUCTURE

Healthy San Diego Joint Consumer & Professional Advisory Committee. Monitors Medi-Cal Managed Care issues affecting San Diego County and advises the Director of San Diego Health and Human Services Agency (HHSA).

Healthy San Diego QI Subcommittee. The QI Subcommittee consists of the health plans, AIS, BHS, Hospitals, Providers, CCHEA and HHSA. All of our Work Groups report up to the QI Subcommittee.

Healthy San Diego BH Subcommittee. The BH Subcommittee consists of the health plans, BHS, BHS Organizational Providers, Hospital Association, Psychiatric Health Facilities, The Patient Advocacy Program, CCHEA and HHSA. (See reverse side for details)

Work Groups. Work Group's report to either the QI or BH Subcommittee.

- Health Plan Work Group
- Regional Center Work Group
- Health Ed/Cultural Linguistics Work Group
- Facility Site Review Work Group
- Health Homes Work Group
- BH Operations Work Group
- CalAIM Work Group
- CalAIM Leadership Team
- Health Plan-AIS Work Group
- Health Plan-Consumer Center Work Group
- COVID-19 Task Force

MOU's. Within HSD we manage MOU's with several agencies, mostly HHSA. Examples are Behavioral Health, AIS, Regional Center, California Children's Services (CCS), CHDP, TB Program, Polinsky Center for Children, Women, Infants & Children (WIC) and several others.

Behavioral Health Subcommittee

The Healthy San Diego (HSD) Behavioral Health Subcommittee was formed in 1998 when Specialty Mental Health was contractually carved out of Medi-Cal Managed Care. At this time, San Diego County Behavioral Health Services became the Mental Health Plan (MHP) for all Medi-Cal beneficiaries including those in a Medi-Cal Managed Care Plan. The HSD Behavioral Health Subcommittee consists of membership from the following:

- Medi-Cal Managed Care Plans
- County Mental Health Plan Leadership
- Health Plan Providers
- MHP Providers including psychiatric facilities
- Hospital Association of San Diego & Imperial Counties
- Patient Advocacy Program
- Consumer Center for Health Education & Advocacy
- Federally Qualified Health Centers
- County Mental Health Contractors Association
- County Alcohol & Drug Services Providers Association
- Aurerra Health (representing DHCS)

The primary purpose of the HSD Behavioral Health Subcommittee is to ensure our mutual members/clients have access to quality physical and behavioral health services that is well coordinated and to break down any barriers to care. The HSD BH Subcommittee meets monthly and has over 150 members. There are two primary sub groups that report up to the HSD BH Subcommittee:

HSD Behavioral Health Operations Work Group

The HSD Behavioral Health Operations Work Group was formed in 2014 when the State's Coordinated Care Initiative and the Health Plans new Mild to Moderate Mental Health Benefit became effective. This smaller Work Group updates and maintains our existing Memorandums of Understandings (MOU's), Care Coordination Forms and Policy & Procedures. Meetings are held monthly or as needed.

HSD Behavioral Health Operations Dispute Resolution Team

The HSD Behavioral Health Operations Dispute Resolution Team consists of members of the HSD Operations Work Group and additional members as needed. The last hour of the HSD Behavioral Health Operations Work Group is set aside for the Dispute Resolution Team to meet in the event of a dispute between a Medi-Cal Managed Care Plan and the MHP. To date, we have never had the need to activate the Dispute Resolution Process which is in our existing MOU.

Behavioral Health Case Consultations

The MHP Office of the Clinical Director oversees our County's Behavioral Health Case Consultation Process. On an as-needed basis, representatives are invited to participate to assist with care coordination between Health Plan and MHP providers and stakeholders. These meetings have become the initial step in identifying needs and issues and working to resolve them.

HEALTHY SAN DIEGO

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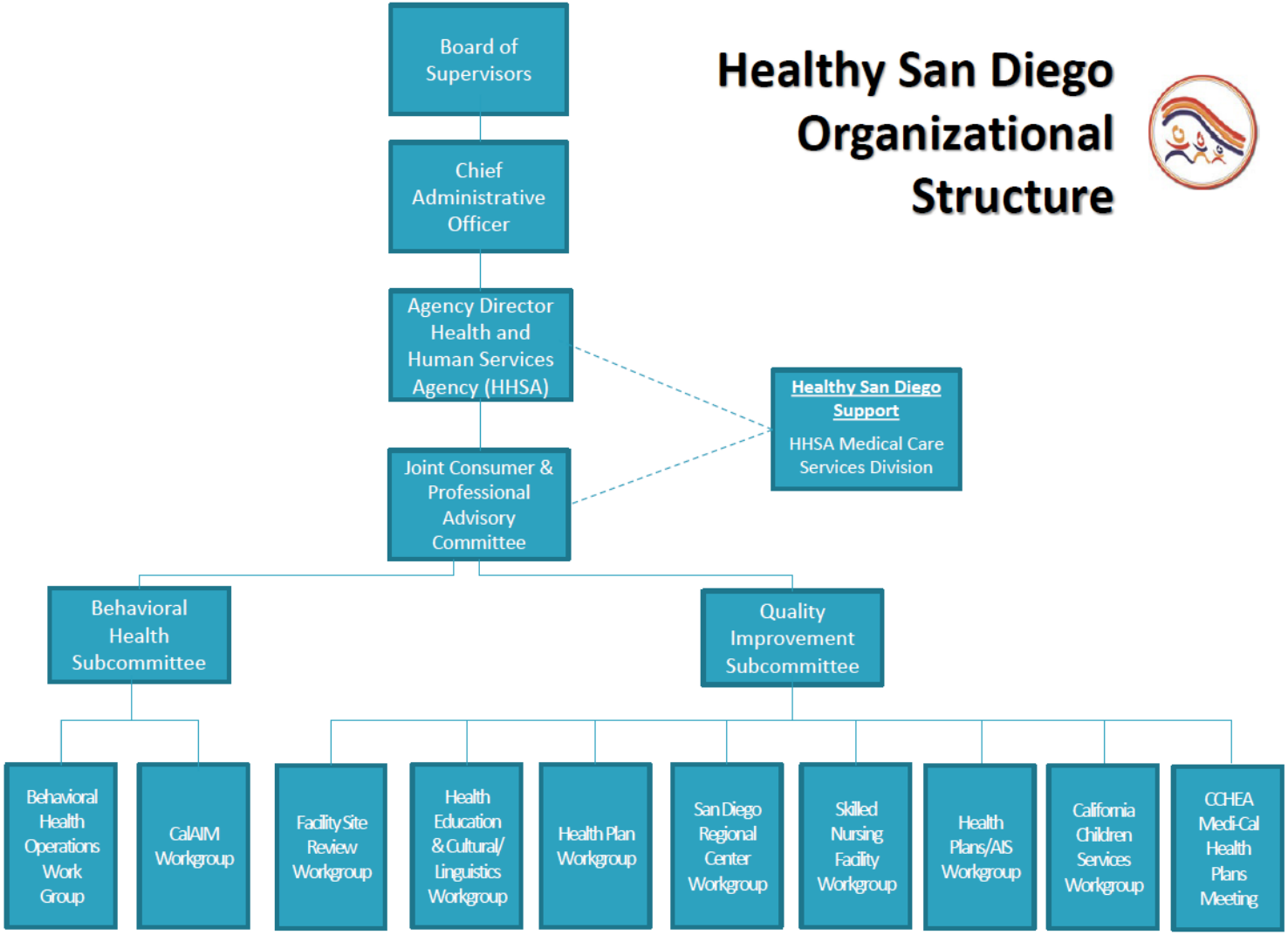
Healthy San Diego Organizational Structure



INTEGRATIVE SERVICES

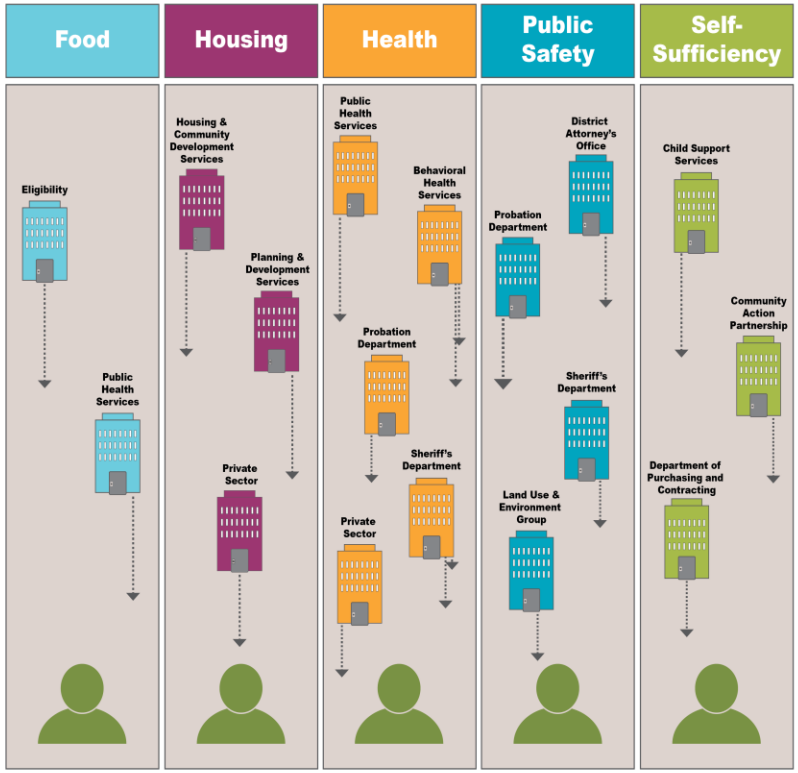
To enable every San Diegan to live well and with dignity

LIVE WELL SAN DIEGO

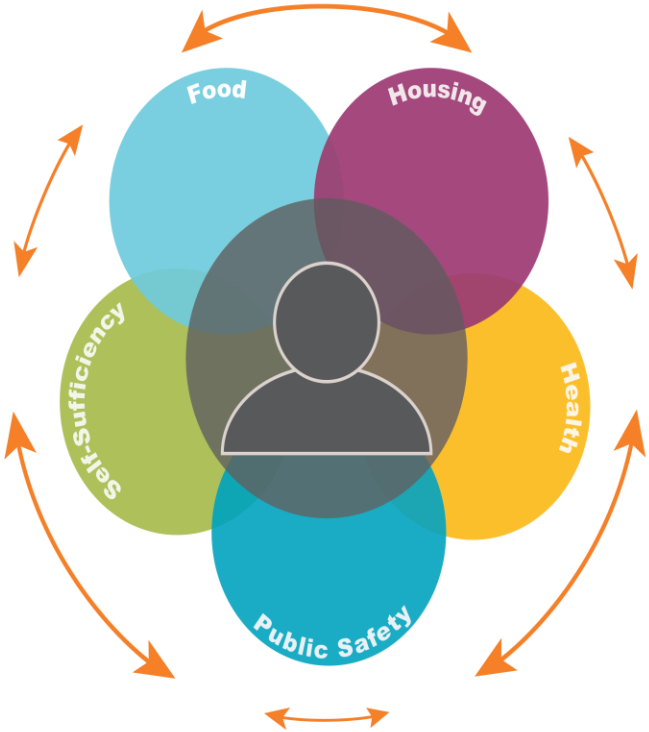
PERSON-CENTERED APPROACH

LIVE WELL SAN DIEGO

Current: Some Cooperation, Some Silos



Integrative Services: Person-Centered Solutions



WHOLE PERSON WELLNESS

LIVE WELL SAN DIEGO

DATA DRIVEN BEGINNINGS…

Partnerships within County government and 7 local MCP's to take learnings from "Project 25" that showed us how investments in permanent housing and deep services for homeless individuals who use hospital and public services at a high rate can save money:

*Median expenses for public services per user at program inception: $110,715/year

*Median expenses for public services per user at year 3 of the program: $11,717

SIGN AN MOA THEY SAID!

- SEVEN plans! Lots of lawyers and Compliance
- Strong relationship building skills and an eye for the long game
- Be clear about what to share and why
- Get the right players at the table

JUST SHARE DATA THEY SAID!

- Based off of existing "Business Associate" status of State Department of Health Care Services
- Minimally necessary PHI for the purpose of treatment, coordination of care and/or other health care operations
- Established a Data Work Group to work through data elements and logistics

Pilot Overview

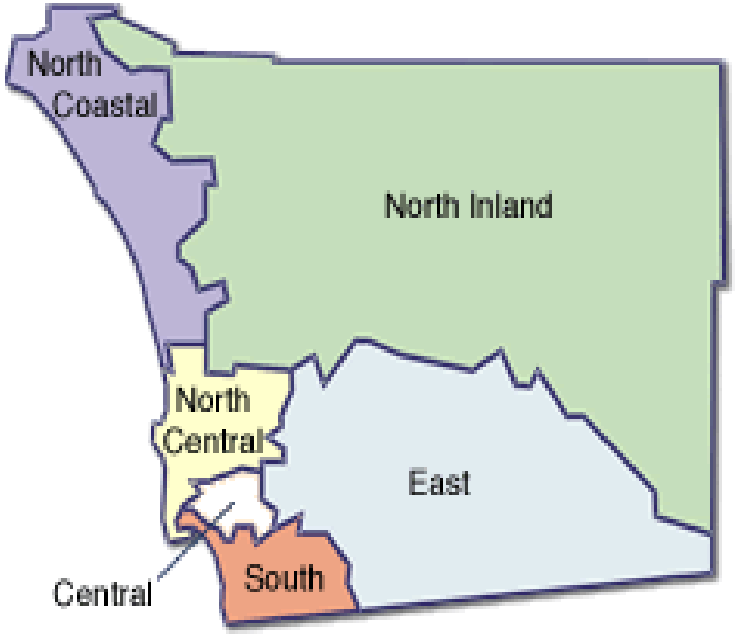
***We serve: Individuals who are homeless/at-risk of homelessness, with a behavioral health, substance use disorder, and/or chronic physical health condition**

***Filling a gap** in our local homeless and mainstream medical systems

***Creating connections** between managed care, social services, hospital system, law enforcement, HMIS, County services

***Instituting a Care Coordination model** for use with similar high-need populations

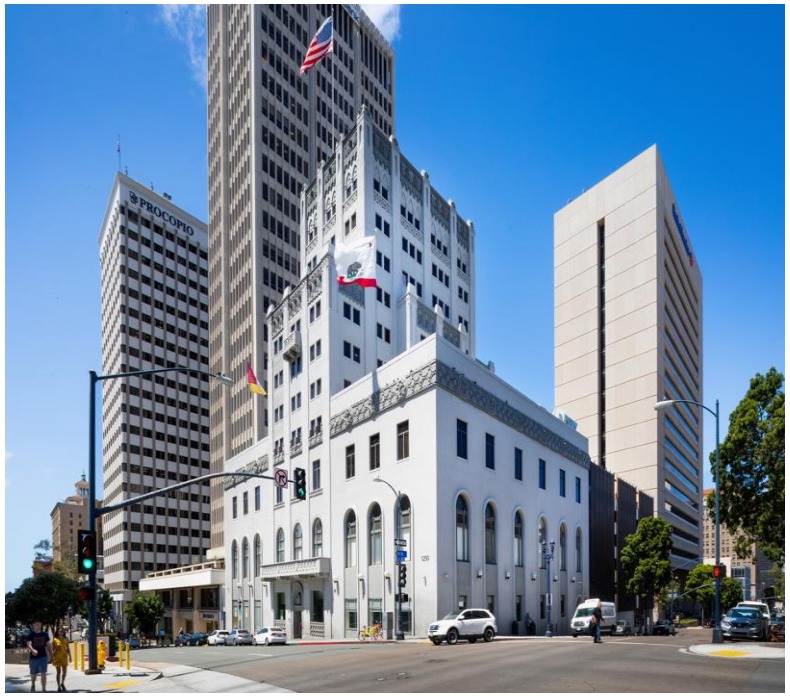
ALL SERVICES ARE CONTRACTED OUT FOR COUNTY-WIDE COVERAGE



WHOLE PERSON WELLNESS

LIVE WELL SAN DIEGO

PATH MAKING IT HOME



EXODUS RECOVERY

The pathway to freedom begins with you.

WHOLE PERSON WELLNESS

LIVE WELL SAN DIEGO

KEY PROGRAM FEATURES: CLINICAL REVIEW TEAM

Lead by County and Plan clinical leaders

- Comprised of providers and their medical staff, MCP's, County LE, Behavioral Health Services and Medical Care Services
- Meets twice per month
- **Reviews high risk cases with significant challenges** – medical care coordination, SMI and substance use service advocacy and determination, respite and transition planning

SERVICE INTEGRATION TEAMS

- 1:25 Case Ratio
- Housing Navigator
- Clinician
- Case Manager
- Peer Support Specialist

HIGH ACUITY TEAMS

- 1:10 Case Ratio
- Housing Navigator
- Clinician
- Case Manager
- Peer Support Specialist

INTEGRATING HOUSING SUPPORTS

Incorporated **Housing Disability Advocacy Program** (**HDAP**) into our contracts:

***Flexible Housing Supports**: hotel/motel, SRO, shared housing, move-in costs, secondary security deposits, home habitability improvements, utility assistance & storage fees

***Rent Subsidies**: at 30% of income

***Individual Expense Cap** at $9,000, option for approval to exceed the cap

***Legal Aid Society of San Diego**: Direct Connect to Disability Advocacy

HOUSING ACCOMPLISHMENTS

*90% permanent housing retention rate at 6 months, an increase of 58% over prior year annual reporting

*80% retention rate at 12 months

*65% of those ever enrolled have been housed

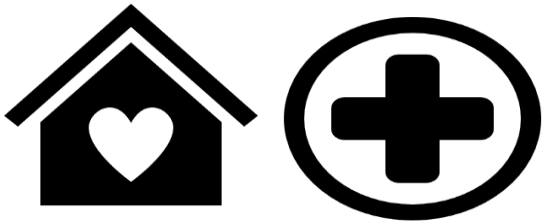
*55% of enrollees have been permanently housed

HOUSING IS HEALTHCARE

*18% decrease in number of Emergency Department visits; for those permanently housed 29% decrease

*38% decrease in number of days spent in Psych Inpatient Units; for those permanently housed 57% decrease

*6% decrease in days spent in the hospital; for those permanently housed 57% decrease



THANK YOU!

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AMARIS.SANCHEZ@SDCOUNTY.CA.GOV

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NEIGHBORHOOD NETWORKS

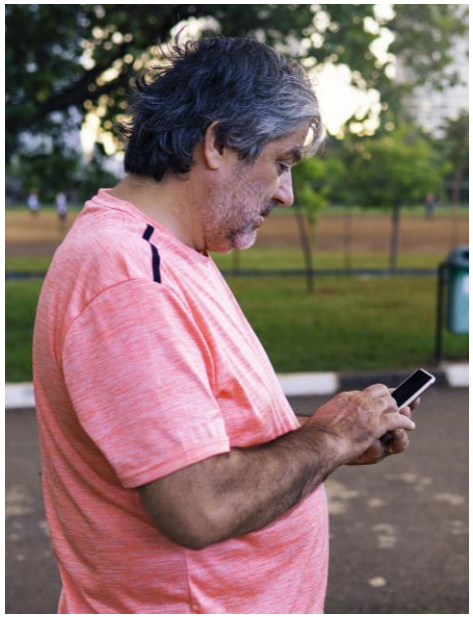
NEIGHBORHOOD NETWORKS

Neighborhood Networks is an innovative intermediary service designed to address health related social needs and coordinate care. Our network includes trusted community-based organizations with highly trained “Neighborhood Navigators” at the center.

OUR APPROACH: IDENTIFY AND ADDRESS COMPREHENSIVE NEEDS ACROSS 4 DOMAINS

NEIGHBORHOOD NETWORKS

Eduardo



Social Domain

- Single, employed part time
- Monolingual, Spanish
- Not enough money for food
- No car, lacks transportation
- Sleeping on a friend's couch
- Has poor nutrition

Medical Domain

- Diabetes
- Hypertension
- Asthma
- Has been to the ER twice recently for treatment of asthma

Behavioral Health Domain

- Has been feeling sad and depressed

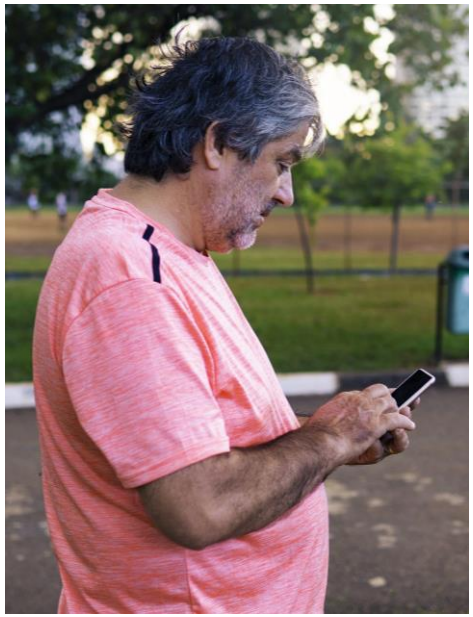
Safety Domain

- Gun in the home

MEDICAL HOME'S PERSPECTIVE

NEIGHBORHOOD NETWORKS

Eduardo



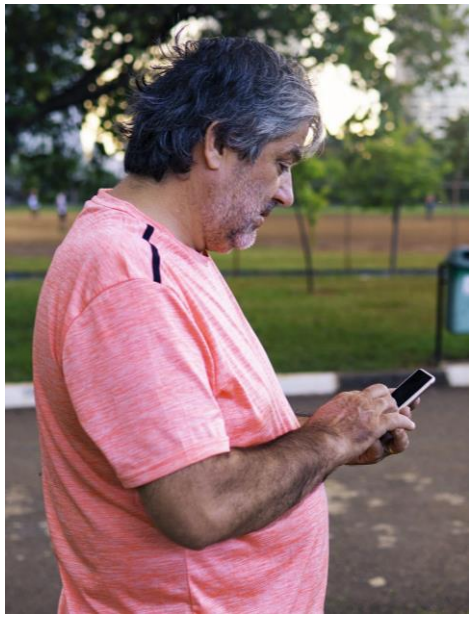
Eduardo's primary care provider sees:

- Frequently misses appointments
- Chronic conditions are difficult to control
- Considered non-compliant and a difficult patient
- Impacting quality scores, potential pay for performance payments

HEALTH PLAN'S PERSPECTIVE

NEIGHBORHOOD NETWORKS

Eduardo



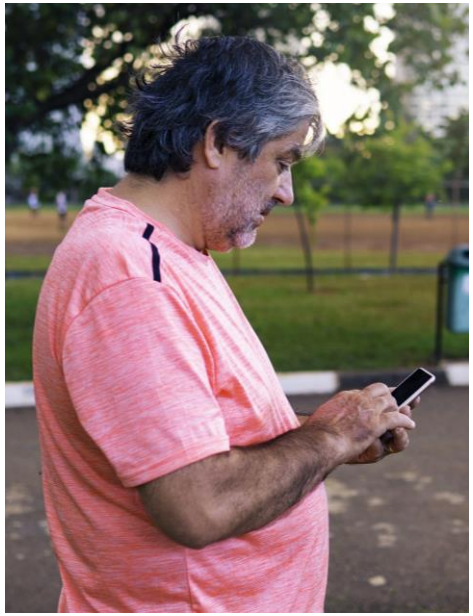
Eduardo's health plan sees:

- Care gaps impacting HEDIS scores
- High risk for avoidable hospitalizations
- High cost member
- May be eligible for case management

ONE COORDINATED SOLUTION

NEIGHBORHOOD NETWORKS

Eduardo



Today, Eduardo does not have one community-based central source of referrals and support.

Need a ***coordinated and community-based approach*** to support Eduardo across all domains:

- Connect with Eduardo's primary care provider
- Support Eduardo with his asthma action plan
- Educate Eduardo on how to properly use home monitoring for all of his chronic conditions
- Connect Eduardo with community-based food assistance (e.g., local food pantries, CalFresh enrollment)
- Connect Eduardo with a community-based mental health provider
- Arrange transportation to and provide reminders for all medical appointments
- Support Eduardo in finding stable housing
- Educate Eduardo regarding gun safety

NN HUB: UNIQUE SOLUTION

NEIGHBORHOOD NETWORKS

Three interlinked components make the Neighborhood Network HUB (NN HUB) solution effective at engaging a community-based workforce for clinical and SDoH outcomes:

Neighborhood Navigator Care Coordinators are highly trained and culturally competent

Community Based Organizations are trusted by the community members

Neighborhood Networks acts as a centralized HUB

HUB AT THE CENTER

NEIGHBORHOOD NETWORKS

Community-based Organizations

Community-based organizations hire, train, and supervise **Neighborhood Navigators**, who assess clients' health-related social needs and connect them with direct services

HUB

The HUB effectively **links** referred clients to community-based organizations and provides management services

Referral Sources

Organizations with an interest in **improving the health** of residents

NN HUB SOLUTION

NEIGHBORHOOD NETWORKS

- Contract management
- Fiscal management
- Data management
- Case management systems administration
- Claims systems management
- Community information and health information exchange and platforms
- Community Health Worker (CHW) Framework (we utilize the Pathways Community HUB model)
- Workforce training
- Home visiting
- Quality assurance and continuous learning and improvement
- Cultural and community humility and competence
- Trauma-informed best practices
- Collaboration and workflows across various systems of care, e.g., medical, behavioral health, social services, and public health

CB-CME EXPERIENCE

NEIGHBORHOOD NETWORKS

- NN HUB holds four Health Homes Contracts
- Unique experience of sub-contracting to community-based organizations (non-clinical) through the HUB model
- 3 Community-Based Organizations
    - 1 school-based Family Resource Center
    - 2 social services

CHALLENGES

NEIGHBORHOOD NETWORKS

- Investing in the initial infrastructure for Privacy & Security
- Enrolling Medi-Cal clients in a new program
- Submitting extensive data reports in TEL/excel
  - Different for each health plan
- Submitting medical claims in addition to TEL/excel reports
- Successfully connecting with small private physician offices – especially during COVID
- Successfully connecting with ED/Hospital staff across our many institutions

KEYS TO SUCCESS

NEIGHBORHOOD NETWORKS

- Partnership between the NN HUB and the community-based partners
- Focus on outreach & enrollment
- Focus on workforce development
  - Already experts in health-related social needs, need more training and support for clinical supports/care coordination/case management
- Focus on continuous quality improvement

FUTURE CONTRACTS

NEIGHBORHOOD NETWORKS

The NN HUB in partnership with the Community-Based Organizations are developing solutions for the

- ECM Target Populations
- In Lieu of Services related to Housing, Meals, Asthma Remediation, Personal Services, Home Modifications
- Creating an integrated network of solutions that create lasting health improvements

CONSIDERATIONS FOR CalAIM

NEIGHBORHOOD NETWORKS

Managed care plans shall develop and maintain a whole system, person centered population health management program, where the plan will partner with contracted health care providers and community-based partners to identify and address members' health and health-related social needs.

– CalAIM Proposal, January 2021

Community-based organizations (those that are not clinical) will face many of the same challenges we faced and will need additional support

Opportunity to leverage/grow the San Diego model

QUESTIONS AND THOUGHTS

NEIGHBORHOOD NETWORKS

Thank you!

CalAIM

California Advancing & Innovating Medi-Cal

LIVE WELL SAN DIEGO

CalAIM OVERVIEW

LIVE WELL SAN DIEGO

What is CalAIM

CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of California residents by implementing broad delivery system, program and payment reform across the Medi-Cal program.

What is Changing?

2022: New **Enhanced Care Management (ECM**) benefit & **In Lieu of Services (ILOS)**

2022: **Major Organ Transplant (MOT)** benefit carved into Managed Care

2022: Update medical necessity criteria for **specialty mental health services (SMHS)** to improve access

2023: **Long Term Care (LTC)** benefits carved into Managed Care

2023: **Dual Special Need Program (DSNP) Aligned Managed Care enrollment** in CCI Counties,

2025: **Aligned Managed Care enrollment** in non-CCI counties

2023: Population Health Management (PHM) strategy

2026: **NCQA accreditation** for Medi-Cal MCPS and subcontractors

2027: **Statewide Managed Long Term Services & Supports (MLTSS)**

ENHANCED CARE MGMT (ECM) & IN LIEU OF SERVICES (ILOS

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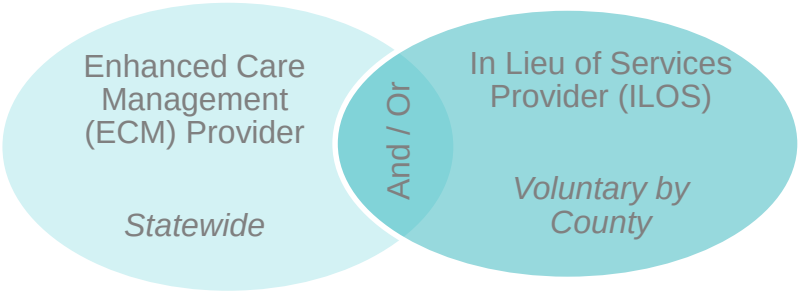
What is ECM & ILOS?

ECM Goal: provide a whole-person approach to care. Addresses the clinical and non-clinical needs.



ILOS Goal: Medically appropriate and cost-effective alternatives to state plan services.

ECM Core Service Components:

1. Comprehensive Assessment & Care Mgmt Plan
2. Enhanced Coordination of Care
3. Health Promotion
4. Comprehensive Transitional Care
5. Member & Family Supports
6. Coordination of Referral to Community and Social Support Services

ECM Provider Examples:

1. Counties and Local Health Depts.
2. PCP, Specialist, and Physician groups
3. Hospitals
4. Rural Health Clinics, Indian Health Clinics, and FQHCs
5. Behavior Health Entities, Community mental health centers, and SUD treatment providers
6. Organizations serving homeless and/or justice-involved individuals
7. Other, as approved by DHCS

14 Pre-Approved ILOS Options

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

ENHANCED CARE MGMT (ECM) & IN LIEU OF SERVICES (ILOS)

LIVE WELL SAN DIEGO

Milestone	Phase 1 Timing	Phase 2 Timing
MOC Part 1: MCP submit to DHCS	7/1/2021	1/1/2022
MOC Part 2: MCPs submit ECM & ILOS network and contract language	10/1/2021	3/1/2022
GO-LIVE PHASE 1	1/1/2022 ECM available to: + Members enrolled in WPC & HHP + Homeless + High Utilizer + SMI/SED/SUD	NA
GO-LIVE PHASE 2 + additional target populations	7/1/2022 ECM available to: + Members enrolled in WPC & HHP + Homeless + High Utilizer + SMI/SED/SUD + Children or Youth + At risk for institutionalization (LTC) + Nursing Facility (NF) residents	7/1/2022 ECM available to: + Homeless + High Utilizer + SMI/SED/SUD + Children or Youth + At risk for institutionalization (LTC) + NF residents
Re-entry population MOC Part 1: MCPs submit to DHCS	7/1/2022	
Re-entry population MOC Part 2: MCPs submit network and contract language	10/1/2022	
Provide ECM to all target populations + individuals transitioning from incarceration	1/1/2023	

ENHANCED CARE MGMT (ECM) & IN LIEU OF SERVICES (ILOS)

LIVE WELL SAN DIEGO

Timeline & Approach

Deliverables due to DHCS	Phase 1	Phase 2
Transition Plan & MOC Due	July 2021	January 1, 2022
Finalize Contracts w/ Providers	October 1, 2021	March 1, 2022
ECM & ILOS Go-Live	January 1, 2022	July 1, 2022

Additional Guidance In Progress:

DHCS Timeline	ECM / ILOS DHCS Guidance Milestones
Late April 2021	❑ Initial Round of FAQs
By 5/31/2021	❑ Final ECM/ILOS Requirement Documents ❑ ECM & ILOS Coding Guidance ❑ ECM draft rates (individual by MCP & County) ❑ Incentive Payment Design Document
July 2021	❑ ILOS Pricing Guidance

Enhanced Care Management Implementation Dates by County

Counties with Whole Person Care and/or Health Homes[19] (Begin implementation on 1/1/22)		Counties without Whole Person Care or Health Homes (Begin implementation on 7/1/22*)
Alameda	HHP, WPC	Alpine
Contra Costa	WPC	Amador
Imperial	HHP	Butte
Kern	HHP, WPC	Calaveras
Kings	WPC	Colusa
Los Angeles	HHP, WPC	Del Norte
Marin	WPC	El Dorado
Mendocino	WPC	Fresno
Monterey	WPC	Glenn
Napa	WPC	Humboldt
Orange	HHP, WPC	Inyo
Placer	WPC	Lake
Riverside	HHP, WPC	Lassen
Sacramento	HHP, WPC	Madera
San Bernardino	HHP, WPC	Mariposa
San Diego	HHP, WPC	Merced
San Francisco	HHP, WPC	Modoc
San Joaquin	WPC	Mono
San Mateo	WPC	Nevada
Santa Clara	HHP, WPC	Plumas
Santa Cruz	WPC	San Luis Obispo
Shasta	WPC	Santa Barbara
Sonoma	WPC	Sierra
Tulare	HHP	Siskiyou
Ventura	WPC	Solano
		Stanislaus
		Sutter
		Tehama
		Trinity
		Tuolumne
		Yolo
		Yuba

Performance Incentive

$600M from the State's General Fund budget available 2022 – 2024

DHCS Timeline	PIP Incentive Milestones
March – June 2021	Program design sessions
July 2021	DHCS to incorporate final stakeholder feedback
August – December 2021	APL development
January 1, 2022	Implementation
After Jan. 1, 2022	Payment to plans

Goals

- Build appropriate and sustainable ECM and ILOS capacity
- Drive MCP investment in necessary delivery system infrastructure
- Incentivize MCP take-up of ILOS
- Bridge current silos across physical and behavioral health delivery
- Achieve improvements in quality performance
- Reduce health disparities and promote health equity

TRANSITION COLLABORATION

MCPs, Counties, cities, community-based organizations, and Providers are collaborating to ensure the infrastructure & capacity developed through WPC and HHP is maintained, leveraged and transitioned to ECM and ILOS.

- HSD Workgroup made up of 168 entities

Transition Topics:

- Discuss how ECM/ILOS can compliment County program offering
  - Opportunity to contract with MCPs and leverage claims payment as additional funding stream
- Review current County program offering to avoid duplication of services
- Identify priority ILOS; MCPs have the ability to add ILOS over time
- Determine how to accommodate needed ILOS that are not included in DHCS 14 pre-approved ILOS options
- Determine IT infrastructure capabilities
- Data sharing improvement opportunities