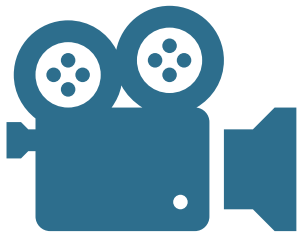
CalAIM: How Medi-Cal Managed Care Supports Subacute Care Facility and ICF/DD Home Residents Webinar

December 15, 2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Meeting Management



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Agenda

Topics	Time
Welcome and Introductions	9:00 – 9:05 AM
LTC Carve-In: Background and Overview of ICF/DD and Subacute Care Facility Carve-Ins	9:05 – 9:10 AM
Medi-Cal Managed Care Benefits Review	9:10 – 9:25 AM
Q&A	9:25– 9:35 AM
Medi-Cal Managed Care Benefits Review (Continued)	9:35 – 9:45 AM
Q&A	9:45 – 9:55 AM
Next Steps & Closing	9:55 – 10:00 AM

Long-Term Care Carve-In: Background and Overview

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CalAIM Long-Term Care Carve-In

- On January 1, 2023, MCPs in all counties began covering the LTC benefit in Skilled Nursing Facilities (SNFs).
  - APL 23-004 (supersedes APL 22-018) was released on March 14, 2023.
- On January 1, 2024, MCPs in all counties will cover the LTC benefit in ICF/DDs, ICF/DD-Hs, ICF/DD-Ns, Subacute Care Facilities, and Pediatric Subacute Care Facilities.
  - APL 23-023 (revised) was released on November 28, 2023 and focuses on the ICF/DD Carve-In.
  - APL 23-027 was released on September 26, 2023 and focuses on the Subacute Care Facility Carve-In.

ICF/DD & Subacute Care Facility Carve-In

- Coverage for ICF/DD and subacute care services currently varies depending on county of residence.
- Effective January 1, 2024, all Medi-Cal beneficiaries residing in ICF/DD, ICF/DD-H, and ICF/DD-N Homes or Subacute Care Facilities are mandatorily enrolled into a Medi-Cal MCP for their Medi-Cal covered services.

Goals for the ICF/DD & Subacute Care Facility Carve-In

- Standardize LTC services coverage under managed care statewide.
- Advance a more consistent, seamless, and integrated system of managed care that reduces complexity and increases flexibility.
- Increase access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal members in ICF/DD Homes and Subacute Care Facilities.
- Facilitate a seamless transition for Subacute Care Facility and ICF/DD Home residents with no disruptions in access to care or services.

Medi-Cal Managed Care Key Benefits Overview

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Medi-Cal Managed Care Key Benefits

Basic Population Health Management (BPHM)	**Complex Care Management (CCM)**	**Enhanced Care Management (ECM)**
Transitional Care Services (TCS)	**Community Supports**	**Transportation**

Population Health Management (PHM)

Medi-Cal's Transformation establishes a cohesive, statewide approach to PHM that ensures all members have access to a comprehensive program that leads to longer, healthier lives, improved outcomes, and health equity.

PHM will provide a comprehensive, accountable plan of action that:

- Builds trust and meaningfully engages with members.
- Gathers, shares, and assesses timely and accurate data on member preferences and needs to identify effective benefits and services.
- Connects members to preventive care and other care management and transitional care services.
- Reduces health disparities by linking members to public health and social services that address their health-related social needs.

Medi-Cal MCP Care Management Continuum

ECM
For Members with highest needs

CCM
For Members with higher- and medium-rising risk

BPHM
For all MCP Members

Transitional Care Services
For all MCP Members transitioning between care settings

Overview of Required PHM Programs

As part of PHM, MCPs are required to have a broad range of programs and supports to meet the needs of all Members; required PHM programs and supports are grouped in the following three areas:

PHM Programs and Services

- **Basic Population Health Management (BPHM) Program.** These are programs and supports for all MCP members. Basic PHM includes engagement with primary care, care coordination and referrals, wellness and prevention programs, and more.

- **Care Management Services.** These are services for MCP members that qualify as a result of their risk status and/or as a result of an assessment for care management services (include Complex Care Management [CCM] and Enhanced Care Management [ECM]).

- **Transitional Care Services**. These services are available for all MCP Members transferring from one setting, or level of care, to another.

Overview of BPHM

BPHM means an approach to care that ensures needed programs and supports are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting to address their health and health-related needs.

The key components of BPHM include:

- Access, utilization and engagement with primary care
- Care coordination and referrals to all health and social services
- Information sharing and referral infrastructure
- Integration of Community Health Workers (CHW)
- Wellness and prevention programs
- Programs addressing chronic disease
- Program to address maternal health outcomes
- PHM for children

Health education and cultural & linguistic (C&L) programs and resources, along with linkages to public health, schools, and social service programs, are foundational for the effective delivery of BPHM.

The components of BPHM are not new, and many are included in NCQA PHM standards; however, DHCS has not previously articulated them as a comprehensive a package of programs and supports.

Overview of Complex Care Management

DHCS established common terminology and set of expectations that apply across populations who need care management, establishing a continuum between care management approaches, including CCM and ECM.

Complex Care Management

- Equates to "Complex Case Management" as defined by NCQA.
- For both higher and medium/rising-risk Members.
- Includes chronic care management and interventions for episodic, temporary needs.
- Must include comprehensive assessment and adhere to all NCQA PHM CCM requirements.
- Medi-Cal MCPs may use their own staff as care managers.

What Is Enhanced Care Management (ECM)?

ECM is a statewide Medi-Cal Managed Care Plan (MCP) benefit to support comprehensive care management for Members with complex needs.

- DHCS' vision for ECM is to **coordinate all care for eligible Members**, including **across the physical, behavioral, and dental health delivery systems**.
- ECM is interdisciplinary, high-touch, person-centered, and **provided primarily through in-person interactions** with Members where they live, seek care, or prefer to access services.
- ECM is the **highest tier of care management** for Medi-Cal MCP Members.

ECM Core Services

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

ECM: ICF/DD and Subacute Care Facility Residents

- Members living in ICF/DD Homes are not currently eligible for ECM, but if there are other individual care needs or concerns, their needs can be reviewed for consideration.
- Members residing in Subacute Care Facilities are excluded from receiving ECM during their stay on the basis that the care they are receiving in the facility is comprehensive and highly specialized.
- If a member transitions out of an ICF/DD Home or Subacute Care Facility, the restriction of duplicative services is removed, and the member can be assessed to determine eligibility for ECM services.

Transitional Care Services

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Population Health Management: Transitional Care Services

- As part of their PHM Program, MCPs must provide strengthened Transitional Care Services (TCS).
- Effective January 1, 2024:
  - MCPs must ensure that prior authorization determinations are rendered in a timely manner for all members and have a process to track when all members are admitted, discharged, or transferred from facilities, including ICF/DD Homes and Subacute Care Facilities.

Overview of Transitional Care Services

Care Transitions Definition:

When a member transfers from one setting or level of care to another, including but not limited to, discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities to home or community-based settings, Community Supports, post-acute care facilities, or long-term care settings.

Goals for Transitional Care

- Members can transition to the least restrictive level of care that meets their needs and is aligned with their preferences in a timely manner without interruptions in care.
- Members receive the needed support and coordination to have a safe and secure transition with the least burden on the Member as possible.
- Members continue to have the needed support and connections to services that make them successful in their new environment.

TCS Policies for CY 2024 and 2025

- In October 2023, DHCS released the updated PHM Policy Guide with modified guidance on TCS, which includes general requirements and requirements specific to high- and lower-risk members.

General Requirements	Responsible Entity
Knowing when a member is Admitted/Discharged/Transferred (A/D/T)	MCP
Processing Prior Authorizations in a Timely Manner and when possible, prior to discharge.	MCP
Identifying members that belong to the high risk and the lower risk group for transitional services	MCP

TCS Policies for CY 2024 and 2025

Requirements for High-Risk Members Transitioning (Clarification)	Responsible Entity
Assign/Notify Single Point of Contact/Care Manager If the member is enrolled in CCM or ECM at the time of transition, the assigned care manager must be the ECM Lead Care Manager or CCM care manager.	MCP
Discharge Planning Process The assigned care manager should receive and review discharging facility's discharge information and ensure it is shared with members and post-discharge providers.	Care Manager
Complete All Follow Ups The assigned care manager must ensure the completion of medication reconciliation and any recommended follow-up doctor appointments/ referrals to social services or community organizations	Care Manager
Evaluate and Refer Members for ECM/CCM/CS The assigned care manager must ensure any eligible member is referred, including assessing eligibility after discharge and within the 30 days post discharge.	Care Manager
End TCS Ends when all needs are met (30 days or longer)/enrolled in ongoing care management programs (CCM/ECM)	Care Manager

TCS Policies for CY 2024 and 2025

Requirements for Lower-Risk Members Transitioning (Modification)	Responsible Entity
Dedicated Team/Phone Number for Member Contact MCP must ensure transitioning members have a dedicated number to call to connect to a dedicated TCS team who can access discharge documents, if needed.	MCP/ Delegate
Discharging Planning Process MCPs must oversee and ensure facilities complete a discharge planning process in accordance with federal and state requirements.	Discharging Facility with MCP Oversight
Complete PCP/Ambulatory Follow-Up Visit MCP must ensure ambulatory follow up appointment is completed within 30 days, for necessary post-discharge care and services, such as medication reconciliation.	MCP/ Delegate
Evaluate and Refer Members for ECM/CCM/CS MCP must ensure discharging facility assesses and refers members for ECM/CCM/CS. MCPs must also use their data and admission info to evaluate eligibility for ECM/CCM/CS and conduct outreach for enrollment.	MCP/ Delegate
End TCS/Enrollment in Care Management MCPs must continue to offer TCS support through dedicated telephonic team for at least 30 days post-discharge.	MCP/ Delegate

Care Coordination: ICF/DD Homes

MCPs are required to coordinate and work with Regional Centers in the identification of services that will be provided to the Members by the plans.

- The **Regional Center Service Coordinator** will be the ICF/DD Home Member's primary source for accessing Regional Center funded services and supports **identified in the Individual Program Plan (IPP)**.
- **MCPs** are responsible for coordinating care for Members for **MCP-covered services** as well as carved-out services such as specialty mental health services and dental services.
- Following a leave of absence or bed hold, if Member does not wish to return to the same ICF/DD Home:
  - The **Regional Center** will take the lead on discharge and transition planning if the Member wishes to transition to a **non Medi-Cal funded living situation**.
  - The **MCP** will take the lead on discharge and transition planning if the Member chooses to transition to a **different Medi-Cal level of care**, in collaboration with the Regional Center.
- Regional Centers and MCPs must agree on processes for coordinating care for members, which will be documented in a Memorandum of Understanding (MOU) as required by APL 23-029.

Questions?

Community Supports

What are Community Supports?

Community Supports are services that Medi-Cal managed care plans (MCPs) are strongly encouraged but not required to provide to eligible Members 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 Medi-Cal MCPs offer different combinations of Community Supports.
- Medi-Cal 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 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.

What are Community Supports?

Pre-Approved DHCS 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.

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:

- Medically Tailored Meals/Medically-Supportive Food
- Day Habilitation Programs
- Environmental Accessibility Adaptations (Home Modifications)
- Respite Services
- Personal Care and Homemaker Services

How Do Members Access Community Supports?

- **Members who qualify may be contacted directly by their health plan and/or a Community Supports provider.** Medi-Cal health plans are responsible for regularly identifying Members who may benefit from Community Supports and who meet the criteria for the program. Once a Member is identified, the health plan and/or their assigned Community Supports provider will contact them to discuss Community Supports.
- **A health and social services provider, including an ECM or Community Supports provider, may submit a referral for Members.** If a member has not yet been identified by the Medi-Cal health plan as eligible for Community Supports, but appears to meet the requirements, their provider can submit a referral to the Member's health plan. The health plan is required to have a referral process that is available for health and social service providers. You do not need to be a clinician to refer someone to Community Supports.
- **Members may self-refer or ask for information to see if they qualify.** A Member or the Member's family can contact their Medi-Cal health plan to see if they qualify for Community Supports. Members can contact their health plan by calling the number on the back of their insurance card.

Transportation Benefits

Medi-Cal: Transportation Benefits

Non-Emergency Medical Transportation (NEMT)

- Transportation by ambulance, wheelchair van, or litter van for members who cannot use public or private transportation to get to and from covered Medi-Cal services, and who need assistance to ambulate.
  - Available when medical or physical condition does not allow travel
  - Services must be prescribed by a health care provider.

Non-Medical Transportation (NMT)

- Private or public transportation to and from covered Medi-Cal services for eligible members.
  - Available to all members with full-scope Medi-Cal and to pregnant women
- Members will need to attest to the provider verbally or in writing that they have an unmet transportation need and all other currently available resources have been reasonably exhausted.

Transportation Benefits

- Providers should work with Medi-Cal MCPs to understand the transportation request processes.
  - Prior authorizations may be needed for NEMT.
- MCPs contract with various transportation vendors and should have policies and procedures in place to ensure timely access and to offer transportation options to meet member needs.
- Transportation services should be coordinated between the MCP and Subacute Care Facility or ICF/DD Home.

Example: MCPs and Subacute Care Facilities should communicate which members may require transport needs for dialysis services outside the facility.

Example: While MCPs are responsible for NEMT and NMT, ICF/DD Homes will continue to be responsible for transportation to and from Day Programs.

Questions?

Next Steps

Additional Resources

- DHCS webpage on ECM and Community Supports
  - ECM Policy Guide
  - Community Supports Policy Guide
- DHCS webpage on Population Health Management
  - PHM Policy Guide

Subacute Care Facility Carve-In: Additional Resources

- Subacute Care Facility Carve-In Transition: Information on the transition, policy guidance documents including the APL and FAQs, as well as past webinar information and recordings.
- Long-Term Care Carve-In Transition: Information on the LTC Carve-In initiative and SNF transition information.
- DHCS' Subacute Contracting Unit: DHCS webpage on Subacute Contracting Unit with list of contracted adult and pediatric Subacute Care Facilities.
- Subacute Care Facility Carve-In Member Information: DHCS webpage with Member Notices and Notice of Additional Information (NOAI).
- California Long-Term Services and Supports Dashboard: DHCS webpage on public-facing LTSS data dashboard to track demographic, utilization, quality, and cost data related to LTSS.
- MLTSS and Duals Integration Stakeholder Workgroup: Registration information for bi-monthly stakeholder workgroup meetings.

ICF/DD Carve-In: Additional Resources

- DHCS policy guidance documents and resources are available on the DHCS ICF/DD LTC Carve-In webpage, including:
  - ICF/DD All Plan Letter (APL) 23-023 (updated November 28, 2023)
  - Model Contract Language (updated November 2023)
  - ICF/DD Carve-In FAQs (updated November 13, 2023)
  - Billing and Invoice Guide (released September 2023)
  - ICF/DD Carve-In Resource Guide (released December 2023)
- Member Notices and Notice of Additional Information (NOAI) are available on the DHCS ICF/DD Member Information webpage.
- Past webinars and recordings are also available on the DHCS ICF/DD LTC Carve-In webpage.

Thank you!

If you have additional questions that were not addressed during this webinar, please email: LTCtransition@dhcs.ca.gov

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Appendix: A
Additional PHM Information

Who Is Eligible for ECM?

ECM is available to MCP Members who meet criteria for ECM "Populations of Focus" (POFs), which are launching in phases from January 2022 to January 2024.

ECM Population of Focus		Adults	Children & Youth
1	Individuals Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization	✓	✓
3	Individuals with Serious Mental Health and/or Substance Use Disorder 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	Birth Equity Population of Focus	✓	✓

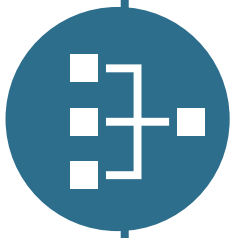
Launching in January 2024: Birth Equity Population of Focus and Individuals Transitioning from Incarceration

How Do Eligible Members Access ECM?

Eligible Enrollees…

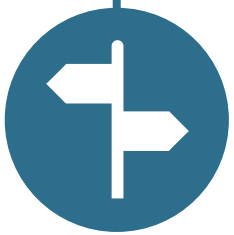
Can be **identified** through their Medi-Cal Managed Care Plan (MCP), provider, family/caregiver, community-based organizations (CBOs), or via a self-referral.

- DHCS's vision is that access to ECM can occur in multiple ways, for both adults and children.
- MCPs must regularly and proactively identify members who may benefit from ECM and meet POF criteria.
- MCPs signed attestations that they have up to date ECM referral forms on their websites.



Are **assigned an "ECM Provider"** who best meets their needs.

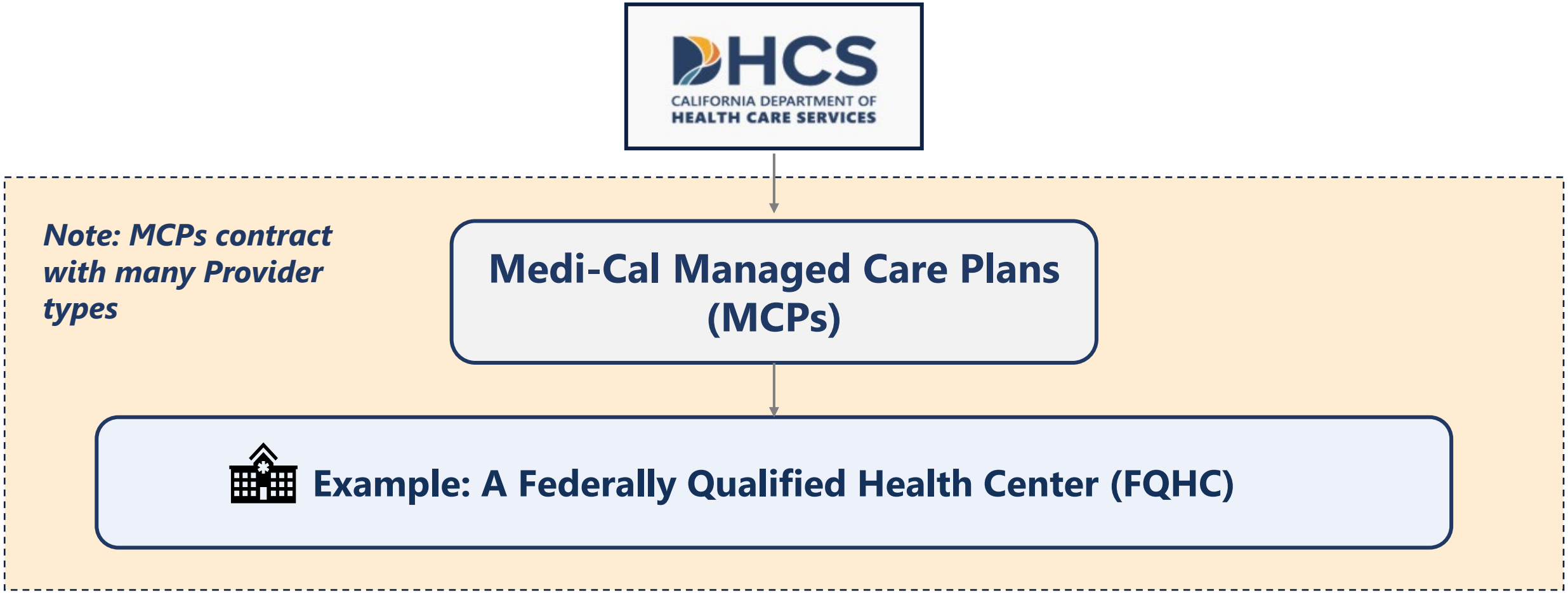
- The ECM Provider makes sure the enrollee has a single "Lead Care Manager" who coordinates their care and services across Medi-Cal delivery systems and beyond.



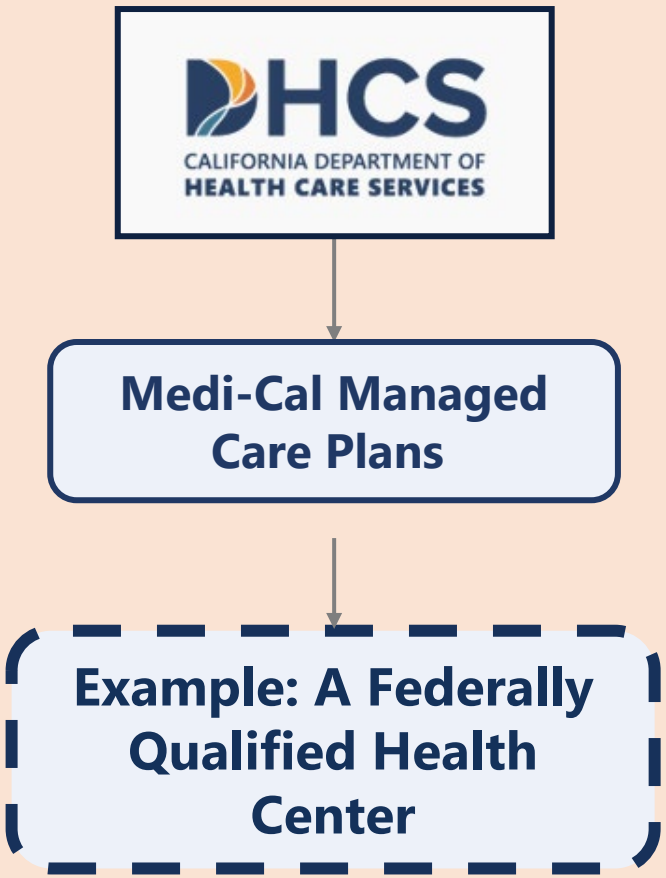
Can opt out of ECM at any time, as ECM is completely **voluntary**.

How Is ECM Provided?

For each POF, MCPs contract with community-based providers to offer ECM.



How Is ECM Provided?
Provider Requirements



ECM Providers must:

- Be **community-based entities**.
- Have **experience** providing care to members of the specific POFs they serve.
- Have **expertise** providing culturally appropriate, intensive, in-person, timely care management services.
- Agree to **contract with Medi-Cal MCPs** as ECM Providers and negotiate rates.
- Must be able to **either submit claims to MCPs or use a DHCS invoicing template** to bill MCPs if unable to submit claims and **must have a documentation system for care management.**
- Assign a dedicated, individual **Lead Care Manager** to each MCP Member enrolled in ECM, who is responsible for meeting with MCP Members in-person to form a trusting relationship and coordinate care across systems.

Phased Transitional Care Implementation:

Definition of High-Risk Members

The PHM Policy Guide defines high-risk members as populations that are required to be assessed after Risk Stratification and Segmentation (RSS) and Risk Tiering processes to understand their needs and preferences and connect them to appropriate services.

1. High risk members include any population listed under Section D. Understanding Risk, 2) Assessment to Understand Member Needs Section of the PHM Policy Guide:
   - Those with LTSS needs;
   - Those in or entering CCM or ECM;
   - Children with special health care needs (CSHCN);
   - Pregnant individuals: for the purposes of TCS, "pregnant individuals" includes individuals hospitalized during pregnancy, admitted during the 12-month period postpartum, and discharges related to the delivery;
   - Seniors and persons with disabilities who meet the definitions of "high-risk" established in existing APL requirements
   - Other members assessed as high-risk by RSST.
2. In addition, MCPs must also consider the following members "high-risk" for the purposes of TCS:
   - Any member who has been served by county SMHS and/or DMC or DMC-ODS (if known) within the last 12 months, or any member who has been identified as having a specialty mental health need or substance use disorder by the MCP or discharging facility;
   - Any member transitioning to or from a SNF;
   - Any member that is identified as high risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS.