Medi-Cal Healthier California for All
Whole Person Care, Health Homes Program and Targeted Case Management
Transition Plan Template for Managed Care Plans
DRAFT

Overview: Medi-Cal Healthier California for All is a multi-year initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program. The enhanced care management benefit and in lieu of services are major components of this initiative -- they demonstrate the proposal's focus on ensuring Medi-Cal beneficiaries have access to high quality health and care coordination services. These components build upon the successful outcomes from the Whole Person Care Pilots and Health Homes Program and overlap with some services offered through the optional Targeted Case Management program operating in 29 local government agencies as of 2019. DHCS's focus is on ensuring that the work counties, cities, providers, health systems, and health plans have done to implement these programs is maintained and transitioned to the enhanced care management benefit and in lieu of services where applicable.

Purpose & Directions: This template is intended for Medi-Cal managed care plans currently operating a Health Homes Program or operating in a county with a Whole Person Care pilot and/or Targeted Case Management program. Each managed care plan, in collaboration with WPC pilots, counties, local government agencies (LGAs), tribal partners and community-based care management entities (CB-CMEs), must fill out this template once per each applicable county in which it operates.

Medi-Cal managed care plans are expected to build upon the expertise and infrastructure of existing programs in order to achieve the goals of the Medi-Cal Healthier California for All initiative. Plans should use this opportunity to work together with Whole Person Care partners, community-based care management entities (CB-CMEs), counties, LGAs and tribal partners to develop a transition plan that accounts for the infrastructure and partnerships developed though these programs. While plans are expected to inform this template based on conversations with partners, DHCS is not requiring the submission of contracts and/or letters of intent.

Using this template and accompanying Excel sheet, please explain which elements of the Whole Person Care Pilot and Health Homes Programs the health plan will carry over to the enhanced care management benefit or offer as an in lieu of service, as well as other discussions and partnership with counties, LGAs and tribal partners.

Health Plan Name	
County Name	
Put an 'X' next to the program(s) that are applicable in this county.	
Health Homes	
Whole Person Care	
Targeted Case Management	

Health Homes

Please fill out this section if the health plan is operating a Health Homes Program in this county.

1. Using the *CB-CME Transition* tab of the Excel Sheet, list the Community-Based Care Management Entities (CB-CMEs) the plan currently contracts with as part of the Health Homes Program and what enhanced care managed target Populations they currently serve. Explain if and how the plan will continue to work with each CB-CME to provide the enhanced care management benefit. If the plan does not intend to continue contracting with the CB-CME, please explain why not. Map what enhanced care management target populations the CB-CME will provide services for.

2. Explain which in lieu of services the health plan will offer to sustain the housing services included in the health plan's Health Homes Program. If the heath plan does not plan on offering housing in-lieu of services that would sustain efforts underway in the Health Homes Program, please explain why not.

3. Members currently enrolled or engaged in enrolling in the Health Homes Program will be grandfathered into eligibility for the enhanced care management benefit. Please describe how the plan will work with the member and care team to reassess the member following the transition to enhanced care management benefit to determine the most appropriate level of services for the member, whether that is the enhanced care management benefit or a lower level of care coordination.

4. Other than any DHCS mandated notifications, explain how the health plan will ensure that impacts to the member are mitigated through outreach strategies the health plan will use to educate members about the transition from the Health Homes Program to the enhanced care management benefit and in lieu of services. If the plan will provide a warm hand-off in the case a member needs to change care teams in the transition, please explain in detail.

Whole Person Care

This section is focused on the transition of Medi-Cal beneficiaries currently receiving intensive care coordination and other supportive services through a Whole Person Care pilot. Please fill out this section if the county, a city within the county, or a health system within the county is operating a Whole Person Care pilot program.

1. Using the *WPC Services Transition* tab in the Excel spreadsheet, list **all** of the services provided through the Whole Person Care pilot and explain what will be transitioned to an in lieu of service or become a part of the enhanced care management benefit. For Whole Person Care services that the health plan will not be transitioning please explain why (e.g. “This service will not be transitioned as there is no equivalent services offered in the in-lieu of services menu”).

2. How will the plan provide continuity of care, including but not limited to enhanced care management and in lieu of services for plan members (i.e. managed care only—does not apply to fee-for-service Medi-Cal) enrolled in Whole Person Care at the point of transition?

3. Other than any DHCS mandated notifications, explain how the health plan will work with the Whole Person Care entity to ensure that impacts to the member are mitigated through outreach strategies to educate members about the transition from Whole Person Care to the enhanced care management benefit and/or in-lieu of services. If the plan or the Whole Person Care entity will provide a warm hand-off in the case a member needs to change care teams and/or providers in the transition, please explain in detail.

4. Describe your plan's strategy, in coordination with the Whole Person Care entity, for identifying and assessing care needs for any enhanced care management target populations and implementing in lieu of services that are not going to transition from Whole Person Care and/or the Health Homes Program. Include a timeline for how you will address this population in preparation for the January 1, 2021 effective date.

Targeted Case Management

Targeted Case Management Populations

1. List the Targeted Case Management populations that local government agencies (LGAs) are serving in this county and explain how the health plan will work with the LGA to ensure that members receiving enhanced care management **do not** receive duplicative Targeted Case Management services. What mechanisms for communication does the health plan and LGA anticipate using?

2. Given the unique skillset that the LGA uses in providing Targeted Case Management services, does the health plan anticipate contracting with the LGA to provide enhanced care management? If yes, please describe what enhanced care management target populations will be contracted for.

Other Key Collaborations

1. Provide an update regarding discussion with county behavioral health systems (mental health and substance use disorders) to provide enhanced care management services for individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions.

2. Provide an update regarding discussions with tribal partners to provide enhanced care management and in-lieu of services.

In Lieu of Services

1. Use the *ILOS* tab of the Excel to indicate which in lieu of services the plan intends on offering beginning on January 1, 2021.

Appendix: Enhanced Care Management Target Populations and In Lieu of Services Menu

Enhanced Care Management Target Populations
High utilizers with frequent hospital or emergency room visits/admissions
Individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions
Individuals at risk for institutionalization, eligible for long-term care
Nursing facility residents who want to transition to the community
Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High Risk syndrome or first episode of psychosis)
Individuals transitioning from incarceration
Individuals experiencing chronic homelessness, homelessness, and those at risk of homelessness

In Lieu of Services Menu
Housing Transition Navigation Services
Housing Deposits
Housing Tenancy and Sustaining Services
Short-term Post-Hospitalization Housing
Recuperative Care (Medical Respite)
Respite
Day Habilitation Programs
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly & Adult and Adult Residential Facilities
Nursing Facility Transition to a Home
Personal Care (beyond In Home Services and Supports**)** and Homemaker Services
Environmental Accessibility Adaptations (Home Modifications)
Meals/Medically Tailored Meals
Sobering Centers