Enhanced Care Management and In Lieu of Services CalAIM Workgroup

December 19, 2019

Agenda

10:00 – 10:05	Welcome and Introductions
10:05 – 10:15	Recap of Last Meeting and Tentative Agenda for Future Meetings
10:15 – 12:00	Enhanced Care Management Deep Dive
12:00 – 1:00	Break for Lunch
1:00 – 1:45	Enhanced Care Management Timelines and Expectations
1:45 – 2:30	Targeted Case Management
2:30 – 2:45	Financing Overview for Enhanced Care Management
2:45 – 2:55	Public Comment
2:55 – 3:00	Closing and Next Steps

Welcome and Introductions

Recap of Last Meeting

- Overview of Enhanced Care Management
  - Target Populations
  - Services
  - Provider Types
  - Case Study Review
- Overview of each In Lieu of Service and Plan Incentives
- Presentations by LA County and Partnership Health Plan

➢ DHCS solicited feedback on In Lieu of Services write-ups and workgroup focus questions

Workgroup Expected Deliverables

- Policy recommendations based on workgroup focus questions (see attached updated list)
- Vet Enhanced Care Management target populations and timelines
- Vet In Lieu of Services Eligibility, services, and restrictions
- Vet enhanced care management model of care template and instructions for plans to complete
- Vet transition plan template and instructions for plans to complete

Tentative Agenda for Future Meetings

Thursday, December 19th

- Deep Dive into Enhanced Care Management
- Review Targeted Case Management

Wednesday, January 22nd

- Deep dive into In Lieu of Services (based on public comment period)
- Review Enhanced Care Management Model of Care Template
- Review Transition Plan Template and Instructions
- UCLA presentation of Interim WPC Evaluation

Wednesday, February 19th

- Post Managed Care Plan Convening Report Out
- Data Sharing, Data Collection, Monitoring and Oversight
- Review DHCS proposed incentive program
- Review final policy recommendations

Parking Lot

Enhanced Care Management Deep Dive

Whole Person Care

Target Populations may include, but are not limited to, individuals:

- with repeated incidents of avoidable emergency room use, hospital admission or nursing facility placement;
- with two or more chronic conditions;
- with mental health or substance use disorders;
- who are currently experiencing homelessness; and/or
- who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (e.g. hospital, skilled nursing facility, rehab, jail/prison, etc.

Health Homes Eligibility

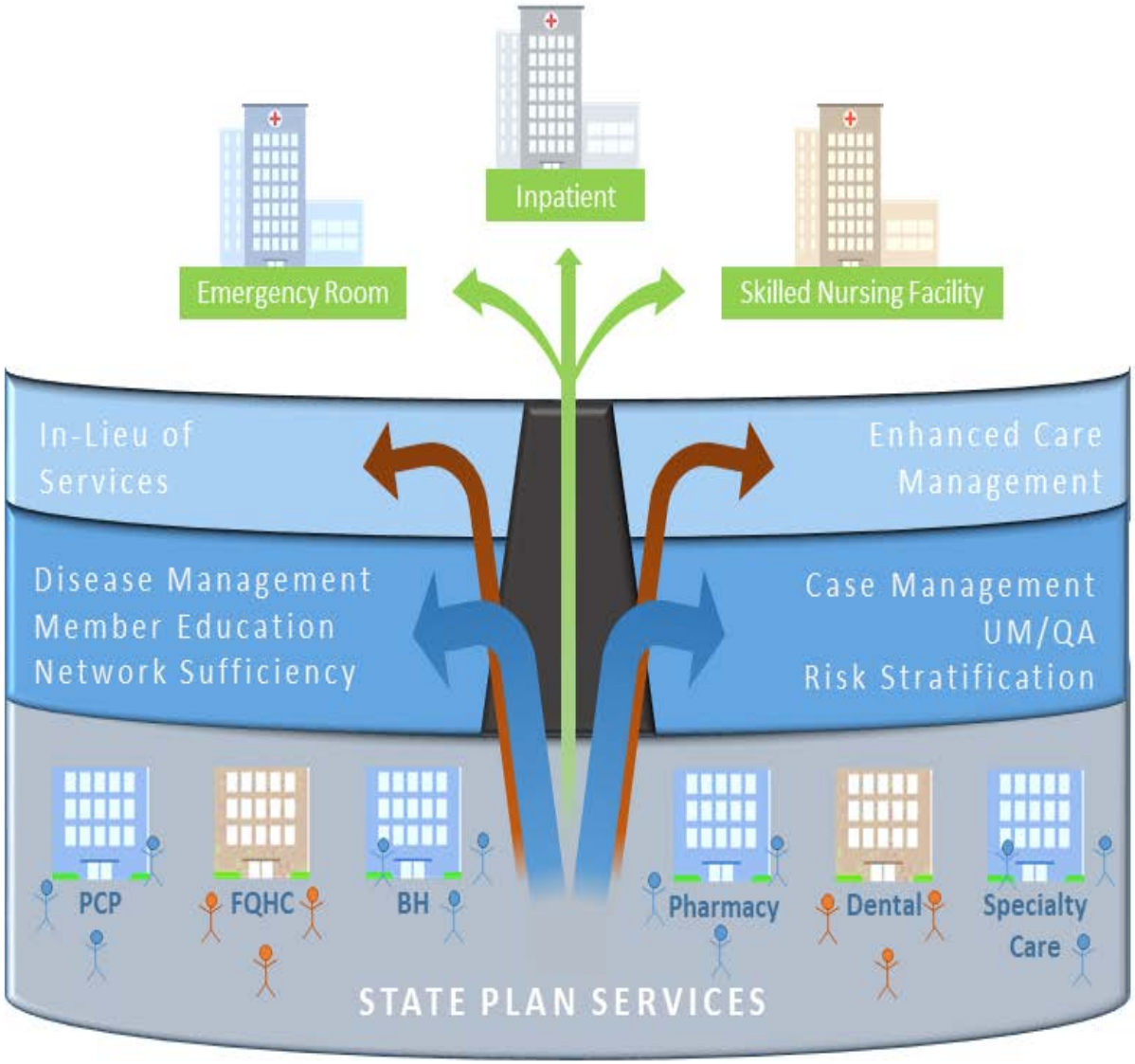
The conditions are:
1. You have at least two of these conditions: COPD, diabetes, TBI, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic kidney disease, dementia or substance use disorder.
2. You have hypertension and one of these conditions: COPD, diabetes, coronary artery disease, or chronic or congestive heart failure
3. You have one of these conditions: major depressive disorders, bi-polar disorders, or psychotic disorders including schizophrenia
4. You have asthma

And have one of the following acuity:
1. You have 3 or more conditions listed above
2. You stayed in the hospital in the past year
3. You visited the ED three or more times in the past year
4. You do not have a place to live.

Enhanced Care Management

Enhanced Care Management mandatory 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); and
- Individuals experiencing homelessness, chronic homelessness or at risk of becoming homeless.
- Reentry of individuals transitioning from incarceration


Inpatient
Emergency Room
Skilled Nursing Facility
In-Lieu of Services
Enhanced Care Management
Disease Management
Member Education
Network Sufficiency
Case Management
UM/QA
Risk Stratification
PCP
FQHC
BH
Pharmacy
Dental
Specialty Care
STATE PLAN SERVICES

Enhanced Care Management Target Population Deep Dive

Review each target population write-up (attached document)

Exercise Assumptions

- DHCS builds in adequate funding into the managed care plan's capitation
- Adequate and trained workforce
- Managed care plan contracted with public or private provider for Enhanced Care Management

Committee Discussion Driven by Workgroup Focus Questions

Targeted Case Management and Enhanced Care Management

What is TCM?

- Voluntary reimbursement program - $35m FFP annually based on CPE

- DHCS contracts with local governmental agencies (LGA) – currently 29 LGAs
  - Participation fee to each LGA
  - Required annual cost report and time survey
  - DHCS: Desk review/site visits - 1 each every 4 years
  - DHCS: A&I cost report audit - annual

- Target populations:
  - Children under age 21
  - Medically fragile individuals
  - Individuals at risk for institutionalization
  - Individuals in jeopardy of negative health or psycho-social outcomes
  - Individuals with a communicable disease

How to Qualify for TCM

1. Children under 21:

Medi-Cal eligible children, under the age of 21 years old, who are:

a) At risk for medical compromise due to one of the following conditions:

(i) Failure to take advantage of necessary health care services, or

(ii) Non-compliance with their prescribed medical regime, or

(iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or

(iv) An inability to understand medical directions because of comprehension barriers, or

(v) A lack of community support system to assist in appropriate follow-up care at home, or

(vi) Substance abuse, or

(vii) A victim of abuse, neglect, or violence, and

b) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

How to qualify for TCM Continued

2. Medically fragile individuals:

Medi-Cal eligible individuals, 18 years or older, who are medically fragile, and have multiple diagnoses. Such individuals must also be:

a) At risk for medical compromise due to one of the following conditions:

(i) Failure to take advantage of necessary health care services, or

(ii) Non-compliance with their prescribed medical regime, or

(iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or

(iv) An inability to understand medical directions because of comprehension barriers, or

(v) A lack of community support system to assist in appropriate follow-up care at home, or

(vi) Substance abuse, or

(vii) A victim of abuse, neglect, or violence, and

b) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

How to Qualify for TCM Continued

3. Individuals at risk for institutionalization:

Medi-Cal eligible individuals 18 years or older, are in frail health, and meet the following criteria:

a) Have been identified as needing assistance due to one of the following reasons:

(i) Are in need of assistance to access services in order to prevent medical institutionalization, or

(ii) Exhibits an inability to independently handle personal, medical or other affairs, or

(iii) Are transitioning to a community setting, who due to socioeconomic status, substance abuse, neglect, or violence have failed to take advantage of necessary health care services, and

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How to Qualify for TCM Continued

3. Individuals at risk for institutionalization, continued:

b) At high risk for medical compromise due to one of the following conditions:

(i) Failure to take advantage of necessary health care services, or

(ii) Noncompliance with their prescribed medical regime, or

(iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or

(iv) An inability to understand medical directions because of comprehension barriers, or

(v) A lack of community support system to assist in appropriate follow-up care at home, or

(vi) Substance abuse, or

(vii) A victim of abuse, neglect, or violence, and

c) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

How to Qualify for TCM Continued

4. Individuals in jeopardy of negative health or psycho-social outcomes:

Medi-Cal eligible individuals who have been determined to be in jeopardy of negative health or psycho-social outcomes and meet the following criteria:

a) At risk due to one of the following disparity factors:

i. Substance abuse in the immediate environment, or
ii. History of, or in danger of family violence, or
iii. History of, or in danger of physical, sexual or emotional abuse.
iv. Experiencing substandard housing, or
v. Illiteracy, and

b) In need of assistance in accessing necessary medical, social, educational, or other service

How to Qualify for TCM Continued

5. Individuals with a communicable disease:

Medi-Cal-eligible individuals infected with a communicable disease, including tuberculosis, HIV/AIDS, etc.; or individuals who have been exposed to communicable diseases, until the risk of exposure has passed. Such individuals must also be:

a) At risk for medical compromise due to one of the following conditions:

(i) Failure to take advantage of necessary health care services, or

(ii) Noncompliance with their prescribed medical regime, or

(iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or

(iv) An inability to understand medical directions because of comprehension barriers, or

(v) A lack of community support system to assist in appropriate follow-up care at home, or

(vi) Substance abuse, or

(vii) A victim of abuse, neglect, or violence, and

b) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

TCM Services

One of the four TCM service components must be preformed by a case manager during an encounter:

- Comprehensive assessment and periodic reassessment
- Development or periodic revision of specific care plan
- Referral and related activities
- Monitoring and follow-up activities

Roughly 80% of TCM services occur in the client's home.

TCM Services Continued

1. Comprehensive Assessment and Periodic Reassessment

Comprehensive assessment and periodic reassessment of individual needs are used to determine the need for any medical, educational, social, or other services. These assessment activities include:

- Taking client history,
- Identifying the individual's needs and completing related documentation, and
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

Assessment and/or periodic reassessment is to be conducted at a minimum of once every six months to determine if an individual's needs, conditions, and/or preferences have changed.

TCM Services Continued

2. Development of a Specific Care Plan

Development (and periodic revision) of a specific care plan based on the information collected through the assessment that:

- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual,
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals, and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

TCM Services Continued

3. Referral and Related Activities

Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:

- Activities that help link the individual with medical, social, educational providers or other programs, and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

TCM Services Continued

4. Monitoring and Follow Up Activities

Monitoring and follow-up activities and contact that is necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs. This can be accomplished with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary. In addition, this shall include at least one annual monitoring encounter to determine whether the following conditions are met:

- Services are being furnished in accordance with the individual's care plan, or
- Services in the care plan are adequate, or
- Changes in the needs or status of the individual are reflected in the care plan, or
- Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

TCM Providers

19/20 TCM Data	
LGA	**Agencies**
Alameda County	Children' Hospital of Oakland,
	City of Fremont
	Fremont Family Resource Center
	Tiburcio Vasquez Health Center
	Covenant House California
	Roots Community Health Center
	Center Force
	City of Oakland Human Services Department
Butte County	Butte County Probation Department
City of Berkeley	City of Berkeley Public Health
	City of Berkeley Aging Services
City of Long Beach	City of Long Beach Dept. of Health & Human Services
Contra Costa	Contra Costa Health Services - Public Health
Humboldt County	County of Humboldt Public Health Department
	County of Humboldt Nurse Family Partnership Program
	County of Humboldt In Home Support Services
	County of Humboldt Adult Protective Services
Imperial County	Imperial County Public Health
Kern County	Kern Probation

TCM Providers

19/20 TCM Data	
LGA	**Agencies**
Los Angeles County	Los Angeles County - Nurse Family Partnership
	Los Angeles County - Community Health Services
Madera County	Madera County Adult Probation
Mendocino County	Health & Human Services Agency - Public Health Nursing
Monterey County	Kinship Center - Seneca Family of Agencies
	Monterey County Health Department
Napa County	Napa County Health and Human Services - Public Health
Orange County	Child Abuse Prevention Center
	Children's Bureau of Southern Ca
	Orange County Health Care Agency
Riverside County	County of Riverside - Disease Control
	County of Riverside - Public Guardian
	County of Riverside - Long Term Care
	County of Riverside - Public Health
	County of Riverside - Probation
	County of Riverside - Linkages
Sacramento County	Dept. of Health Services - Public Guardian
San Diego County	Home Start - First 5 Commission
	South Bay Community Services - First 5 Commission
	Vista Community Clinic - First 5 Commission
San Luis Obispo County	San Luis Obispo County - Public Health Nursing
	San Luis Obispo County - Probation

TCM Providers

19/20 TCM Data	
LGA	**Agencies**
San Mateo County	San Mateo Health - Healthy Families America
	San Mateo Health - Pediatrics
	San Mateo Health - Fathers
	San Mateo Health - NFP
Santa Clara County	Santa Clara County Public Health
Santa Cruz County	Health Services Agency - Family Health
Shasta County	Shasta County Child Abuse Prevention
	Health and Human Services Agency
Solano County	County of Solano
Sonoma County	Dept. of Health Services - Public Health
Stanislaus County	Stanislaus County Health Services Agency
Sutter County	Health and Human Services Dept. - Public Health
	Health and Human Services Dept. - Probation
	Health and Human Services Dept. - Public Guardian
	Health and Human Services Dept. - Children and Families
	Health and Human Services Dept. - Adult Services
Trinity County	Trinity County Probation
Tuolumne County	ATCAA Family Learning Center
	ATCAA Shelter
Ventura County	Ventura County - Public Health
	Ventura County - Probation Dept.

TCM Case Study

Susan Lee, a 28 year old Medi-Cal beneficiary, was referred by her doctor to the Los Angeles County TCM program because her doctor noticed that Susan's weight was down since their visit last year, possibly due to drug use based on appearance and history of drug use and homelessness.

The doctor's office calls the intake line with the County of Los Angeles and explains why Susan needs TCM services and that she is Spanish speaking only.

The Los Angeles TCM program will evaluate the information from the doctor's office, finalize the intake process, and schedule a TCM case manager to conduct a face to face visit for an assessment of Susan's needs/goals.

TCM Case Study Continued

A Spanish speaking TCM case manager meets with Susan at McDonald's for an assessment and determines that Susan meets the criteria for target population #17 (Individuals In Jeopardy Of Negative Health Or Psycho-Social Outcomes).

Susan shared with the TCM case manager that she would like to get a job but feels that she would not be successful because of her lack of literacy in the English language and her unstable housing situation. Susan mentioned that finding and keeping a job is difficult because she also struggles with depression and bipolar disorder. Susan also explained that she would like to go to rehab to get help with her drug addition.

TCM Case Study Continued

During the same visit, the TCM case manager and Susan created a care plan that they both agreed upon to help her meet the goal of finding stable housing, attending English classes, and attending rehab. The TCM case manager provided a referral to a local night school that offers English as a second language curriculum, a referral to a local clinic that guides clients to becoming sober, and information on local homeless shelters and low income housing.

The TCM case manager also referred Susan to the TCM mental health program and explained that Susan can receive case management for depression and bipolar disorder through this program.

Before leaving the visit the TCM case manager made an appointment with Susan to follow up the next week to see if she followed through the referrals. During the scheduled follow-up face to face visit, the TCM case manager talked to Susan about her experiences to make sure that Susan was comfortable with the locations of the referrals and to make sure that they were going to meet her needs.

TCM Case Study Continued

TCM services would continue for Susan as she is going through the process of having her needs met and being re-evaluated to make sure to see if there are any additional needs/goals.

At the point that each need is solved, the TCM case manager would reassess to see if the client has any other needs. If new needs are identified, then they will be added to the care plan and referrals will be made to help the client with their needs. If there are no further needs the client's case would be closed.

During this example there are two encounters in which Los Angeles County can bill the TCM program. LGAs can only bill for one visit, even if there are more than one TCM service component provided during one face to face visit.

Additional Information

- Voluntary for counties to participate
  - Only 29 counties participate
  - Fewer every year

- Voluntary target population selection
  - Only 15 counties have all target populations

Host County Expenditures			
SFY	Number LGAs	YTD AMT	Cost Per LGA
2016-17	37	$ 854,513.72	$ 23,094.97
2017-18	34	$ 970,084.03	$ 28,531.88
2018-19	30	$ 1,047,895.17	$ 34,929.84

Other Home Visiting or Targeted Case Management Programs

Home Visiting Programs

Name of the Program	Program Overview	How the Program is Specialized
First 5	Home visiting encompasses a wide array of services, from consultations for pregnant women and newborn visits to health and education services for children up to five years old.	Trained professionals including teachers, nurses, public health professionals, and child development specialists conduct home visits during pregnancy and early childhood.
Nurse-Family Partnership	Empowers first-time moms to transform their lives and create better futures for themselves and their babies.	Nurse-Family Partnership works by having specially trained nurses regularly visit young, first-time moms-to-be, starting early in the pregnancy, continuing through the child's second birthday.
SHIELDS' Home Visitation Program	Offers comprehensive services for pregnant and parenting mothers and their children ages 0-5, including home-based case management, developmental assessments, early education activities, and linkage and referral services.	SHIELDS' Home Visitation program only serves at-risk pregnant and parenting women and their children ages 0-5 who are referred through SHIELDS' Welcome Baby program.

Specialty Mental Health TCM

- A covered service under Medi-Cal Specialty Mental Health. The Mental Health Plan conducts an assessment and determines what services a beneficiary needs.

- Services provided: services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to:
  - communication, coordination, and referral;
  - monitoring service delivery to ensure beneficiary access to service and the service delivery system;
  - monitoring of the beneficiary's progress;
  - placement services;
  - and plan development.
- Primary differences from traditional TCM:
  - Must have a mental health diagnosis to qualify.
  - No target populations.
  - Required in all counties.

LEA TCM

- A covered service to assist eligible children and eligible family members to access needed medical, social, educational and other services when TCM is covered by the student's IEP or IFSP (same requirements as traditional TCM).
  - Upon approval of SPA 15-021 and SPA 16-001, TCM, like all services, will be available for all Medi-Cal children who qualify for the service.
- Services provided: Comprehensive assessment and periodic reassessment, referral and related activities, care plan development, monitoring and follow up activities.
- Primary difference from traditional TCM:
  - On the school campus.

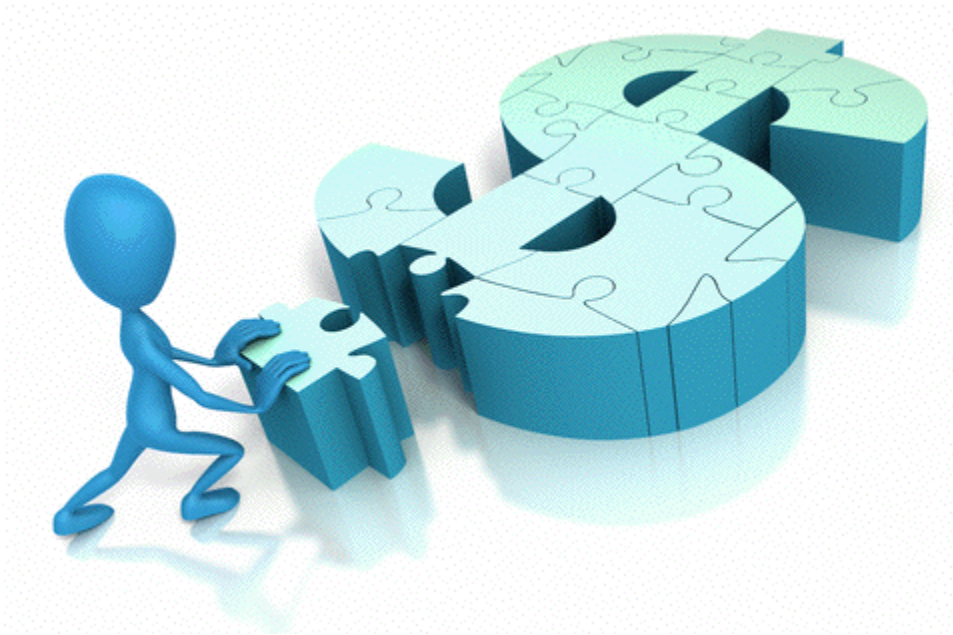
Items for Consideration

- Will all TCM beneficiaries receive ECM benefits?
  - Will all current TCM beneficiaries qualify for the highest risk level in ECM?
  - Communicable diseases is not a target population in ECM

- Reentry of individuals transitioning from incarceration isn't a mandatory target population until 2023
  - How will these individuals receive care during the gap?

Committee Discussion

Financing Overview for Enhanced Care Management



Public Comment

Please limit comments to 2 minutes

Closing and Next Steps

Next Workgroup :

- Wednesday, January 22nd

Other Important Dates

- Monday, February 10th - Managed Care Plan Convening on ECM and ILOS

Feedback Needed

- Early January, DHCS to send ECM Model of Care template and Transition Plan template to workgroup for feedback