Medi-Cal Managed Care Advisory Group Meeting

June 13, 2024
Webex Event Number (Access Code): 2663 003 4458
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DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Thank you for joining!

Please place all calls on **mute**, not hold, to avoid hold music

To ask a question throughout the presentations, please send to **everyone** through chat

Once each presenter is done, we ask that you utilize the 'raise your hand' function to ask questions

At the end of each presentation the host will read off any questions posed in chat

Introductions and Agenda Overview

Amara Bahramiaref

Branch Chief,

Managed Care Policy Branch

DHCS

Agenda

- Doulas
- Transitional Care Services (TCS)
- Transitional Rent (TR)
- Tribal Liaisons in Medi-Cal Managed Care
- Managed Care Accountability Sets (MCAS)
- Enhanced Care Management (ECM)
- Justice Involved (JI) ECM Population of Focus
- Collaborative Planning and Implementation (CPI) Initiative – Providing Access and Transforming Heath (PATH)
- Open Discussion

Doulas

Erica Holmes, Division Chief
Benefits Division

Sa Nguyen, Health Program Specialist
Managed Care Program Oversight Branch

DHCS

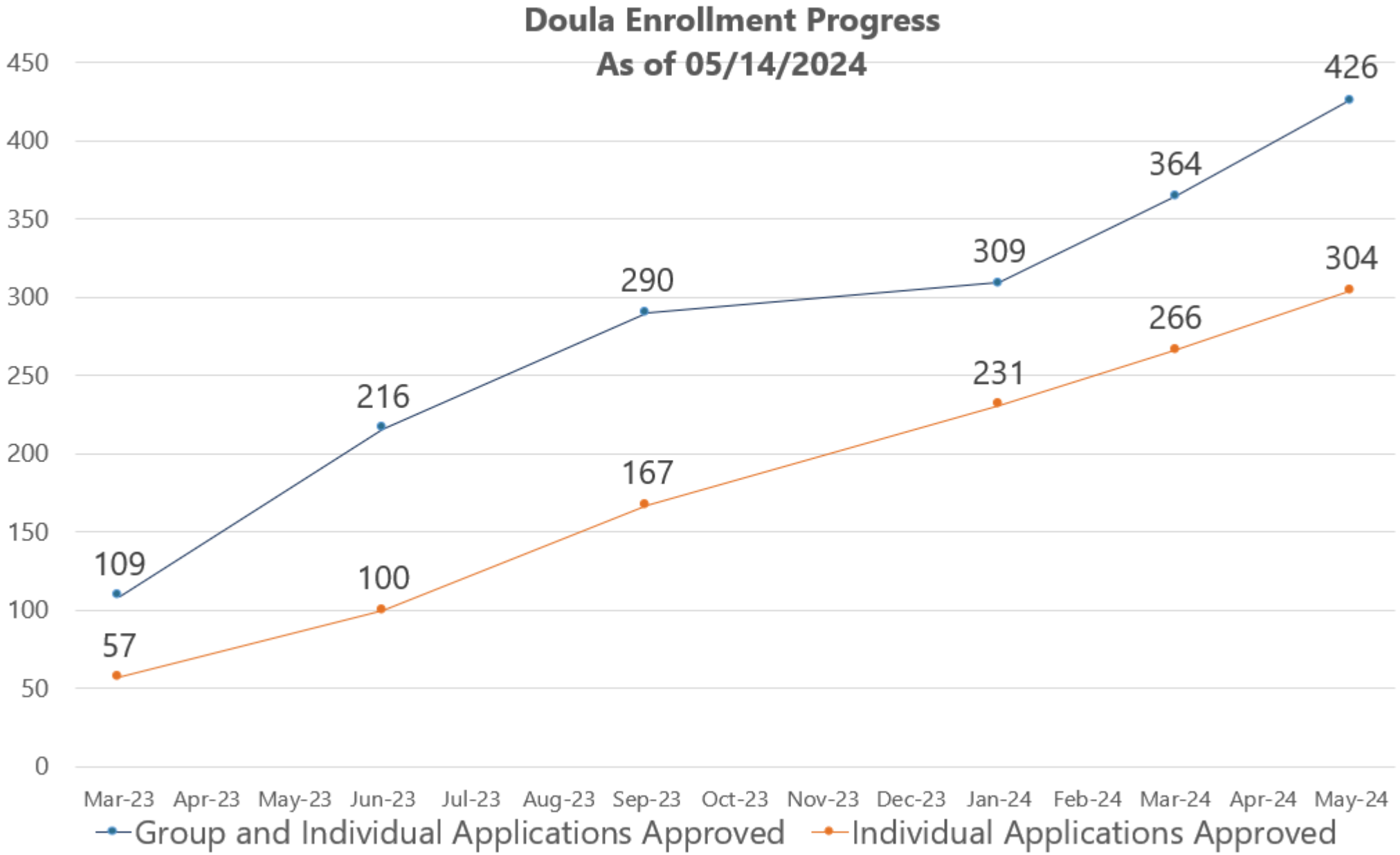
Doula Services

- The DHCS added Doula Services as a covered benefit on January 1, 2023. Doula Services are available in both the Fee-For-Service (FFS) and managed care delivery systems.
- Doula Services encompass health education, advocacy, and physical, emotional and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the postpartum period.
- Doula Services include presence during labor and delivery and doula support for miscarriage, stillbirth, and abortion.

Requirements to Become Doula Provider

- There are two qualifications pathways to become a Doula in Medi-Cal, as follows:
  - **Training Pathway**
    - Complete a minimum of 16 hours of training.
    - Attestation of providing support as a doula at a minimum of three (3) births.
  - **Experience Pathway**
    - At least five (5) years of active doula experience within the previous seven (7) years.
    - Attestation to skills in prenatal, labor, and postpartum care as demonstrated by three (3) written client testimonial letters or professional letters of recommendation.

Medi-Cal Provider Enrollment



Medi-Cal FFS Doula Reimbursement

- Current maximum per pregnancy with standing recommendation*: $3,152.65
- Previous maximum per pregnancy with standing recommendation*: $1,514.34
- Maximum reflects the total number of services that may be provided with the initial recommendation:
  - One initial visit
  - Eight visits that may be provided in any combination of prenatal and postpartum visits
  - Support during vaginal labor and delivery
  - Two extended postpartum visits
- With a second recommendation, a doula to receive an additional $1,458.99, on top of the maximum amount above if they provide all nine postpartum visits.
- For more information regarding the rate increase, visit: Medi-Cal Targeted Provider Rate Increase page

*Maximum reimbursement amount can vary slightly depending on type of birth

Standing Recommendation

- DHCS issued a Standing Recommendation to meet the federal requirement that Doula Services be recommended by a physician or other licensed provider.
- The Standing Recommendation authorizes the following services:
  - One initial visit;
  - Up to eight additional visits that may be provided in any combination of prenatal and postpartum visits;
  - Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage;
  - Up to two extended postpartum visits.
- The Standing Recommendation does not authorize additional postpartum visits beyond the initial eight perinatal visits.
- Medi-Cal-Doula-Standing-Recommendation.pdf

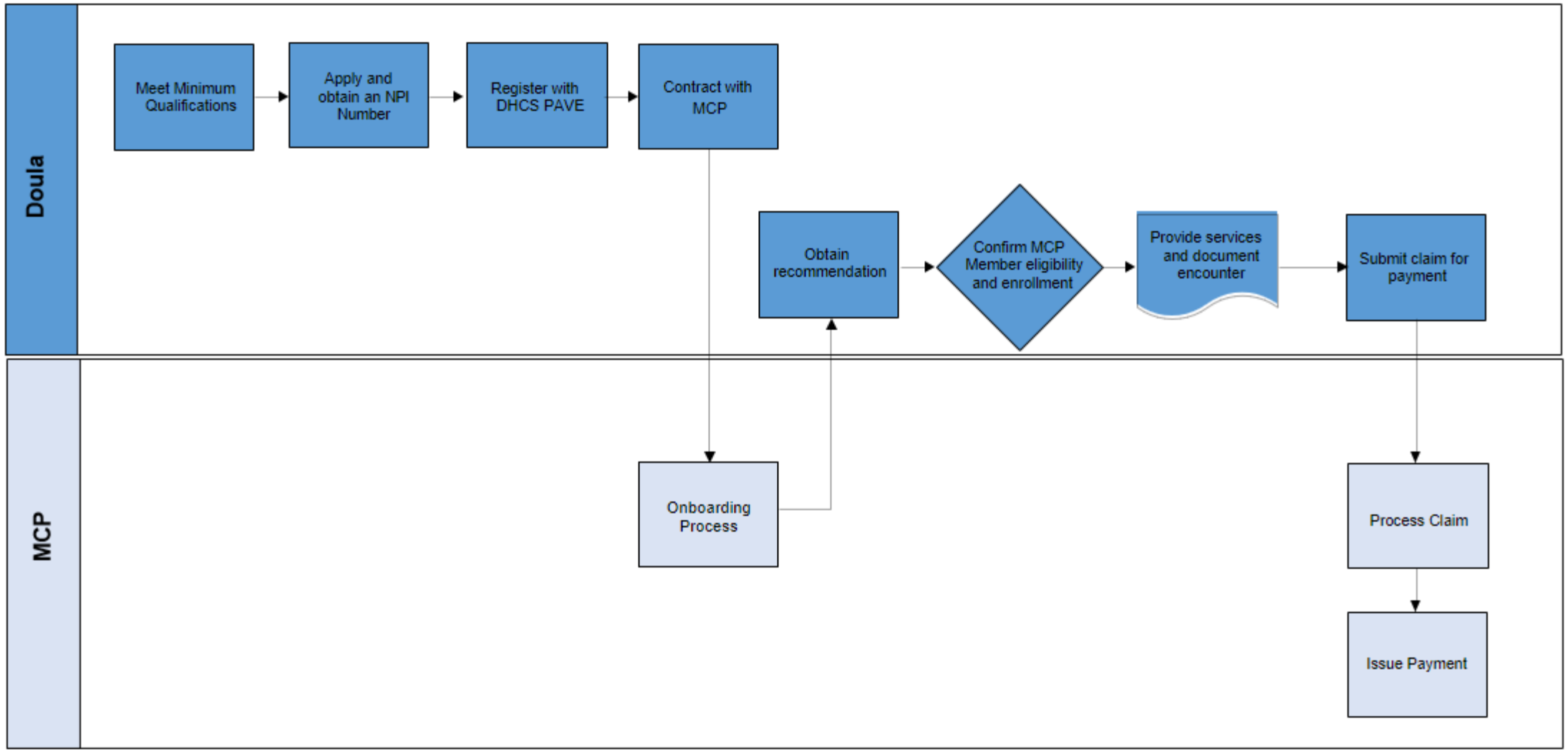
Managed Care
Doula Services Implementation, Monitoring, and Oversight

- DHCS is responsible for the monitoring and oversight of all MCPs. It is a goal of the Department to increase transparency pertaining to managed care data
- Performance monitoring, such as surveys and reporting templates, aids DHCS in creating appropriate policies for improving health outcomes and to ensure access to high quality health care for all health plan members.
- For more information please visit: DHCS Managed Care Monitoring

Managed Care
Doula Services Guidance

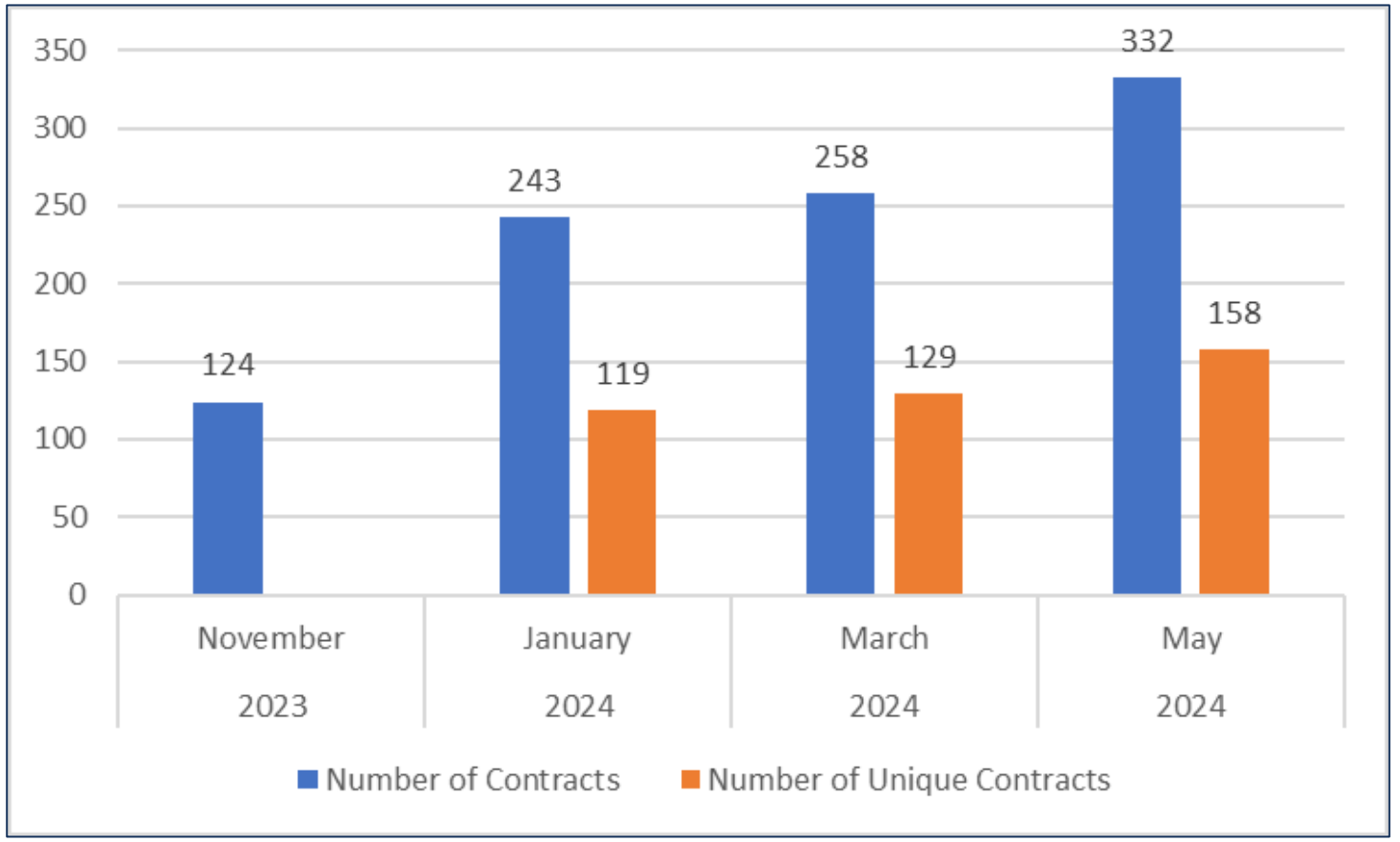
- DHCS issued policy guidance to MCPs via All Plan Letter (APL) 23-024
- DHCS issued Standing Recommendation for Doula Services for pregnant and post-partum Medi-Cal members on November 1, 2023.
- DHCS maintains a dedicated Doula Services as a Medi-Cal Benefit Webpage, with guidance including:
  - Doula directory, FAQs, standing recommendation form, provider application information, etc.
- Additional DHCS support examples:
  - Doula Services Provider List

Managed Care
Doula Process Flow Example



Managed Care
Doula Services Contracting Update

- As of May 2024, 21 MCPs have contracts or single case agreements/letter of agreements with Doulas.



Managed Care
Doula Services Marketing and Communications

- MCPs have informed Members, Health Care Providers, and Hospitals/Birthing Centers about Doula Services in several ways:
  - Host webinars, forums, or focused meetings
  - Partner with local health jurisdictions and collaboratives
  - Conduct provider training with education materials
  - Send newsletters, bulletins, or mailers

Managed Care
Doula Services Promising Practices

- The following strategies have been shared by MCPs to help prevent barriers to Members receiving Doula Services:
  - Flexibility when contracting with individual and group Doulas
  - Hospital/Labor and Delivery staff education
  - Internal MCP staff education
  - Region wide marketing campaigns and communicating with local community organizations can help MCPs create a large doula provider network
  - Designating an MCP Liaison
  - Develop resource document that can be shared with Doulas so that they can reference the requirements placed on them by the Plan
  - Publish resources on Plan webpage

Resources for Doulas

- The DHCS Doula Services webpage contains helpful resources to all Doula Providers:
  - Medi-Cal Provider Manual for Doula Services
  - MCP Contact List
  - Doula Training regarding enrollment and billing
  - DHCS Medi-Cal Doula Services Recommendation Form
  - DHCS Standing Recommendation for Doula Services
  - Frequently Asked Questions for Doulas
  - Doulas – Training as Medi-Cal providers webpage
  - DHCS Doula Directory

Questions?

Please send any Doula Services questions or comments to
doulabenefit@dhcs.ca.gov

Transitional Care Services (TCS)

Bonnie Kwok

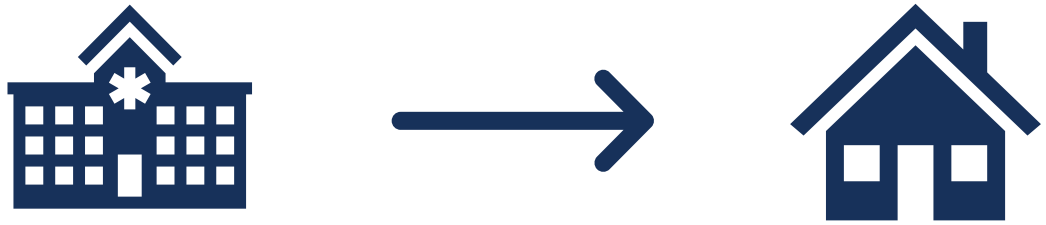
Medical Consultant I, Population Health Management

DHCS

Today's Agenda

- Overview of Transitional Care Services (TCS)
- Phased TCS Requirements Effective since 1/1/23
- Updated TCS Requirements Effective 1/1/24
- DHCS Support for TCS Implementation
- Priority Areas for TCS Implementation

Transitional Care Services (TCS)



Transitions of care occur when a Member **transfers between settings or levels of care**, 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 services, post-acute care facilities, or long-term care settings

All DHCS TCS policies are included in the Population Health Management (PHM) Policy Guide

Goals for TCS

- 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.**

Phased TCS Requirements since 1/1/23

DHCS implemented TCS with a phased approach. Services were implemented for high-risk Members on 1/1/23 with a ramp up to serve all Members starting 1/1/24.

Phase 1: January 1, 2023

- DHCS required MCPs to ensure **high-risk Members receive all transitional care services including having a care manager/single point of contact** to assist in their transition.

Phase 2: January 1, 2024

- MCPs are required to ensure **transitional care services are complete for all Members**, with different minimum requirements for **high-risk Members** and **lower-risk Members.**
- The high-risk definition has been updated so that **ALL members transitioning into or out of a skilled nursing facility (SNF) are considered high-risk members in 2024**.

DHCS acknowledges the practical challenges and resource needs for TCS implementation on the ground. Based on the expected increased resource needs, ***DHCS adjusted the prospective rates to account for the increased work effort in TCS.***

"High-Risk" vs. "Lower-Risk" for TCS

Different minimum TCS requirements apply for high-risk and lower-risk Members.

Defining "High-Risk" for TCS

For the purposes of TCS, **"high-risk" transitioning Members** are defined as:

- Those with long-term services and supports (LTSS) needs
- Those in or entering CCM/ECM
- Children with Special Health Care Needs
- All pregnant individuals, including those admitted during the 12-month postpartum period
- Seniors and persons with disabilities
- Members assessed as high-risk by Risk Stratification, Segmentation, and Tiering (RSST)
- SMH/SUD population
- Members transitioning to or from SNFs
- Members identified as "high-risk" by a discharging facility

Defining "Lower-Risk" for TCS

All other Members are considered "lower-risk" for the purposes of TCS.

TCS Requirements for All Members *(Effective 1/1/24)*

Beginning in 2024, MCPs are required to implement TCS for **all Members** to ensure they are supported from discharge planning until they have been successfully connected to all needed services and supports.

General MCP Requirements for TCS

- Know when a Member is **admitted/discharged/transferred** (A/D/T)
- Ensure each Member is **evaluated for all care settings** appropriate to their needs
- Oversee the completion of the discharging facility's **discharge planning process**
- Ensure all Members being discharged have a **primary care provider** who can provide follow up care.
- Ensure **referrals** to Community Supports, ECM, and waiver agencies for In-Home Supportive Services (IHSS) and other Home and Community Based Services (HCBS) programs
- Ensure **timely prior authorizations**

TCS Requirements for All Members *(Cont.)*

TCS for High-Risk Members

- MCP must ensure the Member has a **single point of contact** for the duration of the transition. The care manager is responsible for:
  - Outreach to Member
  - Assessment of Member's risk
  - Review of discharge summary
  - Ensure appropriate **clinical information is shared with** the **Member** and follow-up **providers**
  - Ensure **medication reconciliation** is complete post discharge
  - Ensure Members with SUD/mental health needs receive treatment for those conditions upon discharge
  - **Ensure the completion of all recommended follow-up care, including primary care visit**
  - Ensure Members are assessed for **ECM, CCM, and Community Supports** eligibility and referred within 30 days post discharge

TCS Requirements for All Members *(Cont.)*

TCS for Lower-Risk Members

- Ensure each Member has at a minimum telephonic access to a dedicated TCS team for at least 30 days after discharge.
- Ensure the Member **completes a follow-up primary care/ambulatory visit** within 30 days post discharge, including a **medication reconciliation.**
- Ensure Members are assessed for **ECM, CCM, and Community Supports** eligibility; referred; and outreached for enrollment

DHCS Support for TCS Implementation

To ensure effective TCS implementation on the ground, DHCS is engaging with various stakeholder groups to lift up promising practices and providing technical assistance through multiple channels.

MCP Survey in Summer 2023

Engagement with and TA for MCPs, Hospitals, SNFs, and PCPs

TCS All-Comer Webinar (January 2024)

PHM Advisory Group

TCS Summit (March 2024)

PHM Policy Guide Update

- In October 2023, DHCS released an updated version of the PHM Policy Guide that incorporates stakeholder feedback received on TCS policy.
- DHCS revised the TCS policy for lower-risk Members and issued clarifications for high-risk Members.

Technical assistance on TCS will be ongoing.

DHCS' Priorities for TCS Implementation in 2024

To continue on the journey of TCS implementation, DHCS has identified the following three priority areas for 2024.

- Connecting Members to **primary care for follow-up** post-discharge.
- Ensuring smooth transitions for those transitioning into or out of **SNFs and/or needing LTSS.**
- Tailoring TCS to **birthing individuals** by supporting transitions of care from pregnancy to the postpartum period.

For these TCS priority areas, DHCS is likely to provide additional TA and/or release further guidance to MCPs to ensure Members are fully supported during transitions of care.

Questions?

Please send any TCS questions or comments to PHMSection@dhcs.ca.gov.

Transitional Rent

Glenn Tsang

Policy Advisor for Homeless and Housing

DHCS

Goals of CalAIM Transitional Rent Services Amendment Request

DHCS is requesting a Section 1115 amendment to cover up to 6 months of rent for eligible high-need Medi-Cal members in the Medi-Cal managed care delivery system. DHCS seeks to improve the health and well-being of Medi-Cal members who are homeless or at risk of homelessness during critical transitions, as well as those who meet the criteria for unsheltered homelessness or for a Full-Service Partnership (FSP) program.

Goals of CalAIM Transitional Rent Services Amendment

- Addressing unmet housing needs
- Reducing long-term homelessness
- Increasing utilization of preventive and routine care
- Reducing utilization of and costs associated with potentially avoidable, high acuity health care services
- Improving physical and behavioral health outcomes

To ensure a "no wrong door" approach to accessing key housing services, the BH-CONNECT demonstration would cover transitional rent services for individuals in the SMHS, DMC, and DMC-ODS delivery systems.

Proposed Eligibility Criteria for Transitional Rent

Under both 1115 Demonstrations (CalAIM and BH-CONNECT), DHCS seeks approval to provide up to six months of Transitional Rent and has proposed the following broad eligibility criteria:

1) Homeless or at risk of homelessness as defined by 24 CFR 91.5**,** with two minor modifications[1]; **AND**

2) Meet one or more of the following criteria:

- *Transitions from medical settings*
  - Are transitioning out of an institutional care or congregate residential setting, including but not limited to an inpatient hospital stay, an inpatient or residential substance use disorder treatment or recovery facility, an inpatient or residential mental health treatment facility, or nursing facility;
  - Are transitioning out of recuperative care facilities or short-term posthospitalization housing;
- *Transitions from other public systems or settings*
  - Are transitioning out of a state prison, county jail, or youth correctional facility;
  - Are transitioning out of the child welfare system;

(Note: Transitional Rent will be covered at the option of Managed Care Plans and/or County Behavioral Health delivery systems)

Proposed Eligibility Criteria for Transitional Rent (Cont.)

Under both 1115 Demonstrations (CalAIM and BH-CONNECT), DHCS seeks approval to provide up to six months of Transitional Rent and has proposed the following broad eligibility criteria:

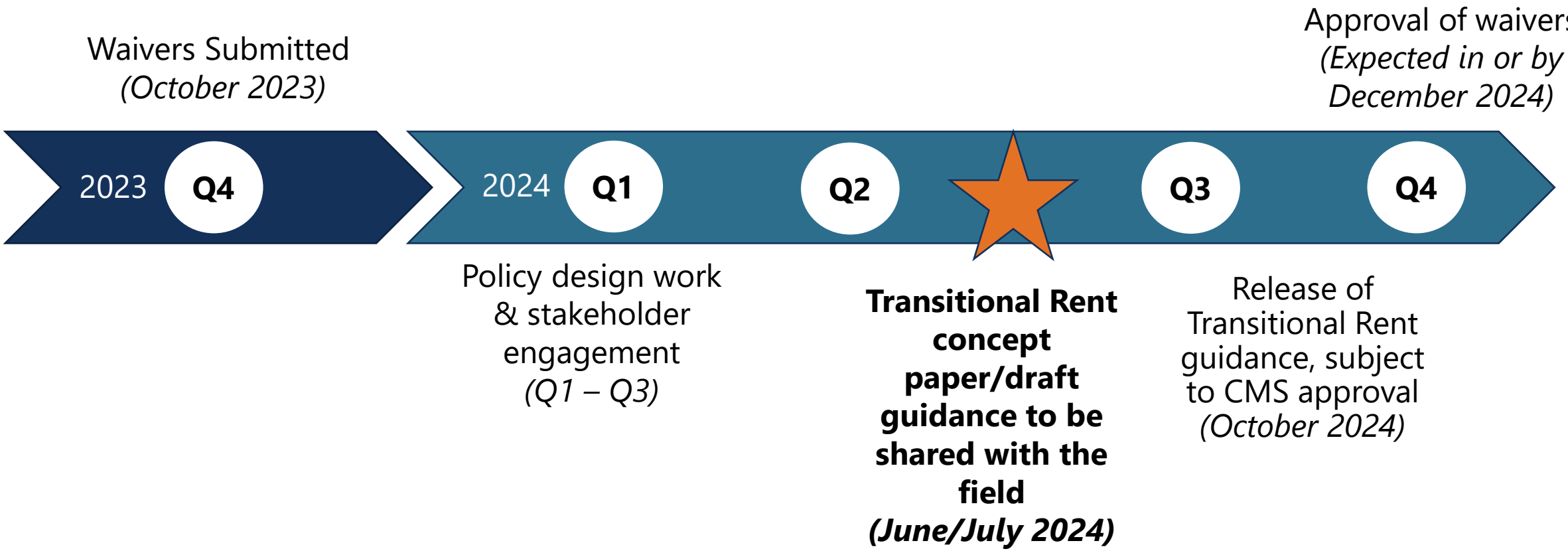
2) Meet one or more of the following criteria (Cont.):

- *Transitions from shelter, transitional housing, or re-housing*
  - Are transitioning out of transitional housing or rapid re-housing;
  - Are transitioning out of a homeless shelter/interim housing, including domestic violence shelters or domestic violence housing;
- *Other very high-needs populations*
  - Meet the criteria of unsheltered homelessness as described at 24 CFR part 91.5; or
  - Meet eligibility criteria for a Full-Service Partnership (FSP) program.

(Note: Transitional Rent will be covered at the option of Managed Care Plans and/or County Behavioral Health delivery systems)

Timeline of Transitional Rent Design

Transitional Rent will go live, on a rolling basis, in the MCP and County BH delivery systems on 1/1/25. Concept paper/draft guidance is slated to be shared with the field in late June 2024.



Transitional Rent: Key Design Issues

Working list of issues to be addressed in the concept paper/draft guidance released for public comment in June/July 2024:

- **Further defining eligible populations**
- **Allowable housing settings**
- **Concurrent supports to improve bridge to permanence:** *Building from ECM and Community Supports*
- **Payment model for MCPs and Counties**
- **Coding and reporting**
- **Housing First application**
- **Limitation of once per lifetime or once per demonstration**
- **Habitability standards**
- **Application to families**
- **Avoiding the Bridge to Nowhere**
- **Operational/Administrative Requirements**
- **Planning or implementation deliverables** that will be due from MCPs and County BH plans to DHCS, and when
- **Supporting coordination with local homelessness and housing response systems**

Questions?

DHCS

Tribal Liaisons in Medi-Cal Managed Care

Robert Moore, MD MPH MBA

Chief Medical Officer, Partnership HealthPlan

DHCS

Undercounting of American Indian/Alaska Natives (AI/AN)

- A total of 55,302 (0.4%) individuals enrolled in Medi-Cal as of July 2023 self-identified as AI/AN alone (not in conjunction with other ethnicity (Medi-Cal Fast Facts)
- In the 2020 census, 1,073,000 individuals identified themselves as AI/AN, including those of mixed ancestry or those who identify as indigenous in addition to other racial/ethnic categories (2.7% of the population). Of these 723,225 identified as AI/AN
- Initial findings suggest official Medi-Cal demographic data *under-counts* those who self-identify as having some AI/AN ancestry. DHCS recognizes these deficiencies and is working with tribal partners to improve data collection
- Systematic undercounting is part of a continued legacy of pretending there are no longer Indians, called "erasure."

Mount Shasta, named after the Shasta tribe, no longer federally recognized.

Current Landscape

- California has 109 federally recognized tribes and approximately 62 non-federally recognized tribes
- Seven Urban Indian Health Organizations (UIOs) serve AI/ANs living in urban settings with 17 sites statewide. Four of these are in Northern California and the Bay Area
- There are 38 tribal health clinic corporations with 127 sites statewide in California

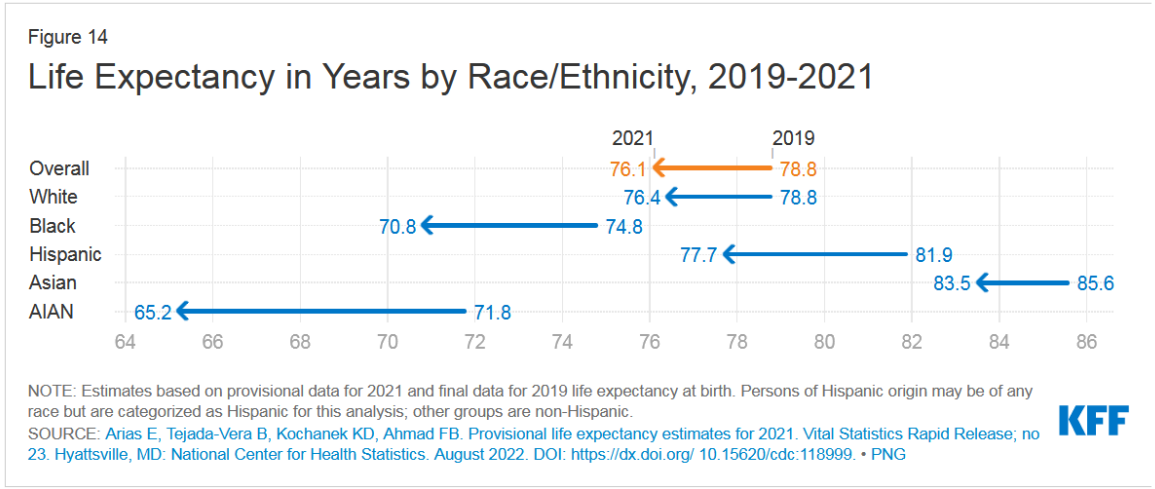
Partnership HealthPlan of California

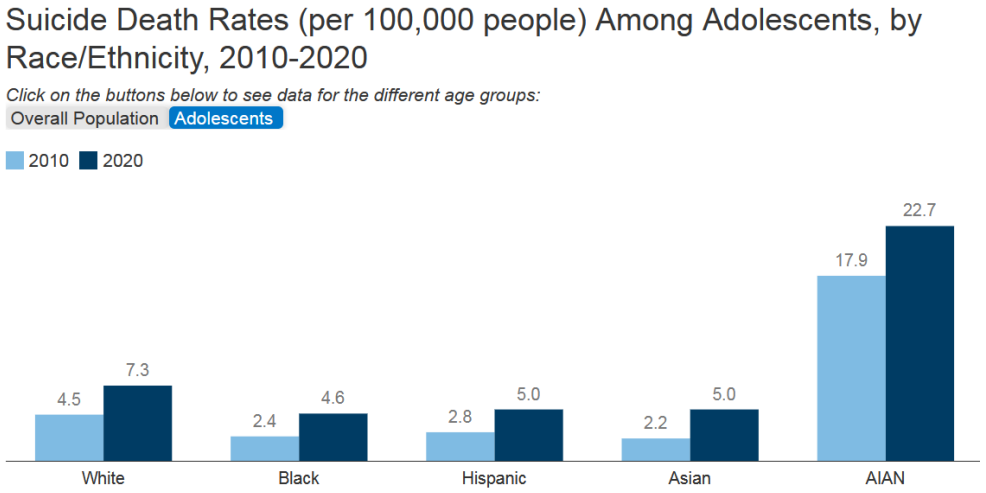
- Founded in 1994
- County Organized Health System Currently serving 905,000 members in 24 Counties

- 52 Federally recognized tribes
- Nine (9) Non-federally recognized tribes
- 18 Rural Tribal Health Centers providing Primary Care and other services at 47 sites
- Three (3) Behavioral Health-only Tribal Health Providers
- 15,569 individuals' self identify as AI/AN (1.8% of overall Medi-Cal population)
- Given systematic undercounting noted in US census data, the actual number of AI/AN in whole or part might be as high as approximately 120,000 in Partnership service area (13% of the membership)

Health Inequities in AI/AN Population

- AI/AN populations have more health inequities than any other ethnic group. Here are some examples:





- 6.6 years of life expectancy lost during COVID.
- Teenage suicide rates three (3)x higher than the white population.

Underlying Causes of Inequities in California Indians

- **Discrimination**
  - Overt discrimination
  - Implicit Bias
- **Systematic Issues**
  - Trans-generational trauma
  - Systemic racism (historic oppression and deprivation, plus social influencers of health)
  - Structure/funding/staffing of health care providers
- **Cultural Factors**
  - Relationship between health and spirituality (western medicine vs. Native American health and healing)

Why Health Plan Tribal Liaisons?

Minimum Functions:

- Channel of communication for AI/ANs who are Health Plan members to have issues addressed
- Channel of communication with Tribal Health Centers
- To be the Health Plan expert on regulations and issues affecting the Indian population

Ideally:

- Tribal Liaison is an Native American person who has lived experience with transgenerational trauma and Native American cultural values and practices
- Champion projects and activities designed to build trust between the Tribal community and the Health Plan
- Educate Health Plan staff on AI/AN History and Culture
- All requirements are outlined in All Plan Letter (APL) 24-002 which was informed by Tribal partners

Meet Partnership's Tribal Liaison

Yolanda Latham, BA, MBA

- Chilula and Hupa tribes

- Redwood Creek, ancestral home of the Chilula Tribe.

Tribal Engagement Activities

- Annual in-person meeting of tribal health center leaders
- Health Plan Tribal Health working group (cross-departmental) with a strategic and tactical plan
- Governance: Tribal leader on Partnership Board
- Tribal Perinatal Initiative
- Listening Sessions, Roundtables, Consultation Sessions
- Attending annual meeting of National Indian Health Board
- In person visits to tribal health centers and UIOs

Path to Better Outcomes

- Cultural Understanding and Respect for Autonomy
- Healing of transgenerational trauma through embracing culture and autonomy
- Start with the needs and priorities of tribes and tribal health centers. Do not impose our priorities on them.
- Learn the power of storytelling and restorative justice in teaching and influencing behavior

Fort Bidwell Indian Reservation, Surprise Valley, Modoc County, inhabited by members of the Northern Paiute people.

Resources

- National Indian Health Board: Working with Tribes Training
  - https://www.nihb.org/public_health/working_tribes_training.php
- California Rural Indian Health Board, Inc.
  - https://crihb.org/
- California Consortium of Urban Indian Health: About Urban Indians
  - https://ccuih.org/about/about-urban-indians/
- We Are the Land: A History of Native California, by Damon B Akins.

Questions?

DHCS

Managed Care Accountability Sets (MCAS)

Priya Motz, DO, MPH, CHCQM (she/her/hers)
Quality & Health Equity Transformation Branch Chief
Quality & Health Equity Division

DHCS

Agenda

- Overview of the Medi-Cal Accountability Set (MCAS)
- Review Measurement Year (MY) 2024 measures
  - Discuss MY 2025 additions
- Review the Quality & Health Equity Improvement Framework
- Open Discussion/Questions

MCAS High and Minimum Performance Levels

- Set of performances measures the Department selects for annual reporting by MCPs. The MCAS reflects the quality, accessibility, and timeliness of care MCPs provide to their members
- Reflects the quality, accessibility, and timeliness of care MCPs provide to their members
- The Department establishes high performance levels (HPLs) and minimum performance levels (MPLs) for a select number of MCAS measures
  - HPLs used as performance goals and to recognize MCPs for outstanding performance
  - MCPs are contractually required to perform above MPLs
    - The Department is authorized to impose sanctions (e.g., financial penalties, auto-assignment withholds) on MCPs that fail to exceed the required MPLs on any of the applicable MCAS measures
    - The level and type of sanction depends on the number of deficiencies and the severity of the quality issues identified

Domains	Measures (Measure Year [MY] 2024)
Children's Health	» **CIS-10 -** Childhood Immunization Status: Combination 10 » **DEV -** Developmental Screening in the First Three Years of Life » **IMA-2 -** Immunizations for Adolescents: Combination 2 » **LSC -** Lead Screening in Children » **TFL-CH -** Topical Fluoride for Children » **W30-6 -** Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months (Six or More Visits) » **W30-2 -** Well-Child Visits in the First 30 Months of Life – Well-Child Visits for Age 15 Months to 30 Months (Two or More Visits) » **WCV -** Child and Adolescent Well-Care Visits
Reproductive Health & Cancer Prevention	» **BCS -** Breast Cancer Screening » **CCS -** Cervical Cancer Screening » **CHL -** Chlamydia Screening in Women » **PPC-Post -** Prenatal and Postpartum Care: Postpartum Care » **PPC-Pre -** Prenatal and Postpartum Care: Timeliness of Prenatal Care » **PDS-E -** Postpartum Depression Screening and Follow Up* » **PND-E -** Prenatal Depression Screening and Follow Up* » **PRS-E -** Prenatal Immunization Status* » **COL-E -** Colorectal Cancer Screening*

*Measures anticipated to be held to the MPL for MY 2025

Domains	Measures (Measure Year [MY] 2024)
Chronic Disease Management	» **AMR -** Asthma Medication Ratio* » **GSD -** Glycemic Status Assessment for Patients With Diabetes (>9%) » **CBP -** Controlling High Blood Pressure
Behavioral Health	» **FUM–30 -** Follow-up After Emergency Department Visit for Mental Illness – 30-day Follow-Up » **FUA–30 -** Follow-up After Emergency Department Visit for Substance Use – 30-day Follow-Up » **DRR-E -** Depression Remission or Response for Adolescents and Adults* » **DSF- E -** Depression Screening and Follow-Up for Adolescents and Adults* » **POD -** Pharmacotherapy for Opioid Use Disorder*

*Measures anticipated to be held to the MPL for MY 2025

BOLD GOALS: 50x2025

STATE LEVEL

Close racial/ethnic disparities in well-child visits and immunizations by 50%

Close maternity care disparity for Black and Native American persons by 50%

Improve maternal and adolescent depression screening by 50%

Improve follow up for mental health and substance use disorder by 50%

Ensure all health plans exceed the 50th percentile for all children's preventive care measures

MCAS Measure Alignment

- **Bold Goal: Children's Preventative Care**
  - Infant, child, and adolescent well-care visits
  - Childhood and adolescent immunizations
  - Blood lead and developmental screening
- **Bold Goal: Reproductive Care**
  - Breast cancer, cervical cancer, and chlamydia screenings
  - Prenatal and postpartum care
- **Bold Goal: Birthing Person and Adolescent Depression**
  - Prenatal and postpartum depression screening
  - Adolescent and adult depression screening and follow-up
- **Bold Goal: Mental Health and Substance Use Disorder (SUD)**
  - Follow-up after emergency department visit for mental illness
  - Follow-up after emergency department visit for SUD

Quality Improvement (QI) & Health Equity (HE) Activities for ALL Plans

Performance Improvement Plan (PIP) Project	» 1 clinical PIP (disparity focused) - W30 focus » 1 non-clinical PIP – administrative or systems-based - FUM/FUA focus
Biannual Regional Collaboration Calls with MCPs	» Regional collab calls to be led by assigned Nurse Consultant » Regional linkage across MCPs by Nurse Consultant QI Lead
Biannual Regional Collaboration Call with BHPs	» Regional collab calls to be led by assigned Nurse Consultant » Regional linkage across county Behavioral Health Plans (BHPs) by Nurse Consultant QI Lead
Biannual MCP-County Behavioral Health Plans (BHPs)	» County and MCP infrastructure assessment such as SurveyMonkey and strategies for each reporting unit » Regional county and MCP collaboration call (regular)

Regions

Region	Counties
Central Coast	Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura
Southeastern	Imperial, Riverside, San Bernardino
San Francisco/Sacramento	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma, Sacramento
North/Mountain	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolumne, Placer, El Dorado, Sutter, Yolo, Yuba
San Joaquin Valley	Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare
Southern Coast	Los Angeles, Orange County, San Diego

Quality Improvement & Health Equity Framework

Lean QI & HE Process	» Organizational systems support for QI » Plan- county-focused interventions based on member demographics, network provider needs » Infrastructure processes that bridge local programs to members and providers
Comprehensive QI & HE Process	» Address clusters/patterns of QI weak areas and strengthen infrastructure » Organize and systematically implement sustainable interventions that can move the needle » Root Cause analyses
Transformational Corrective Action Plan	» Sustainability of interventions that address root cause of poor-quality outcomes » Small tests of change on vulnerable areas based on performance » Align QI & HE efforts across the MCP organization

Quality Improvement & Health Equity Framework Triggers for Measurement Year (MY) 2022

Framework	Lean QI & HE Process	Comprehensive QI & HE Process	Transformational Corrective Action Plan
Triggers	Below the State median **or** regional median in **one (1)** of the domains	Below the State median **or** regional median in **two (2)** of the domains	Below **both** the State median **and** regional median in **three (3)** or more domains

Regional Framework Purpose:

- Distribute measures across logical domains
  - Encourage quality focus across multiple areas of care
- Regional – identifies an MCP's performance in specific region
  - Recognize specific strengths and challenges within a given regional

Questions?

DHCS

Enhanced Care Management (ECM)
Children and Youth Populations of Focus

Seema Shah, MD

Medical Consultant II

Quality and Population Health Management

DHCS

What Is ECM?

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

- ECM is the **highest tier of care management** for Medi-Cal MCP Members.
- 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.

Medi-Cal MCP Care Management Continuum

ECM Populations of Focus (POF)

ECM POF		Adults	Children & Youth
1	Individuals Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*formerly called "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or Substance Use Disorder Needs	✓	✓
4	Individuals Transitioning from Incarceration ***New in January 2024***	✓	✓
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 POF ***New in January 2024***	✓	✓

ECM has been available for adults with intellectual or developmental disabilities (I/DD) and pregnant and postpartum individuals from the launch of ECM if they meet the eligibility criteria for any existing POF. In July 2023, children and youth with I/DD or who are pregnant/postpartum became eligible for ECM if they meet the eligibility criteria for any existing POF.

What Are the ECM Core Services?

Members in ECM receive seven core services based on their needs, tailored to their POF and their individual needs.

Outreach and Engagement

Comprehensive Assessment and Care Management Plan

Enhanced Coordination of Care

Coordination of and Referral to Community and Social Support Services

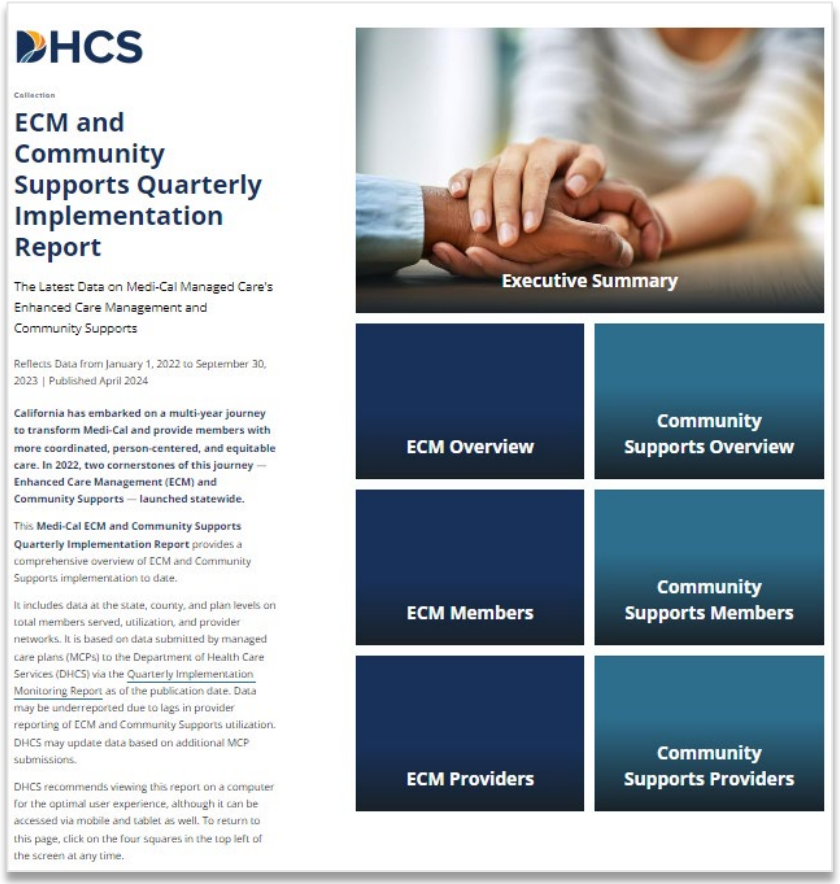
Member and Family Supports

Health Promotion

Comprehensive Transitional Care

Just Released: First Public Data on ECM for Children & Youth POF

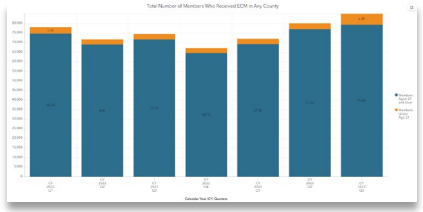
- On April 4, DHCS published the latest **ECM and Community Supports Quarterly Implementation Report** with data through Q3 2023 – the first public release of Children & Youth POF data.
- This report includes data on **total members** and stratifies by **members under age 21.**
- DHCS will continue to release regular updates to this report, with the **Q4 2023 data release planned for June 2024.**



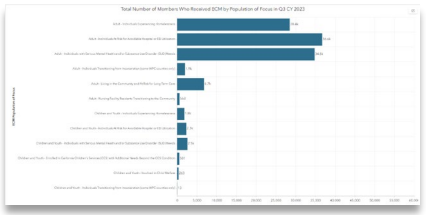
Children & Youth-Specific Data Included in the Public Data Report

Starting with the Quarterly Implementation Report published April 2024, DHCS is releasing the following data on the Children and Youth POFs each quarter:

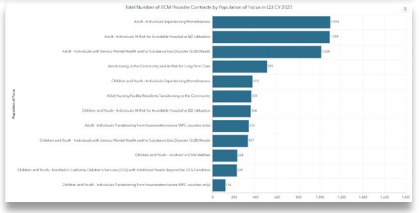
Statewide Data



Total ECM members under age 21

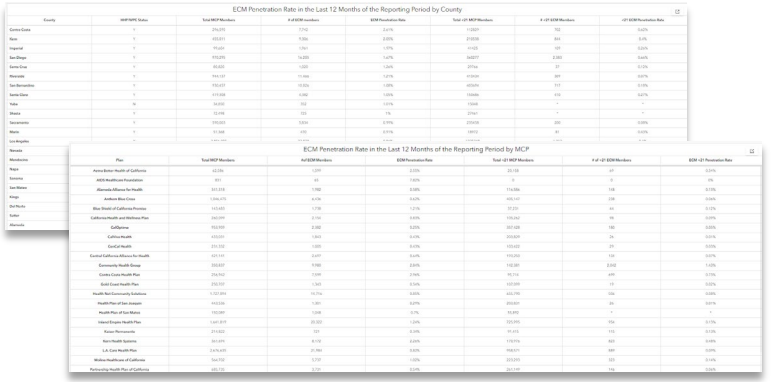


Total ECM members by POF



Total provider contracts by POF

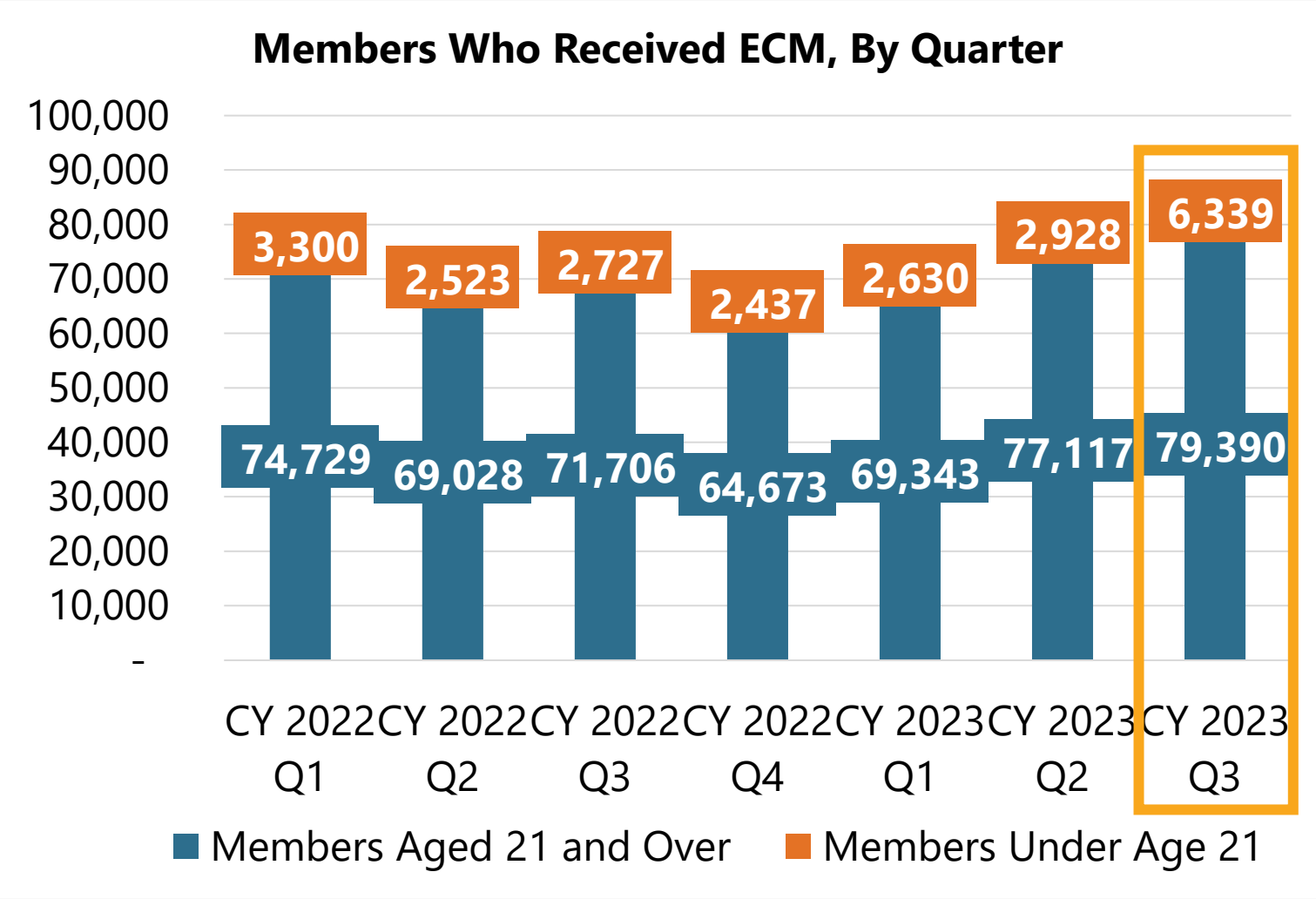
MCP- and County-Level Data



- ECM members under age 21
- ECM penetration rates for members under 21

Detailed plan- and county-level data on ECM members by POF and ECM provider contracts by POF are available for download in DHCS' Data Portal

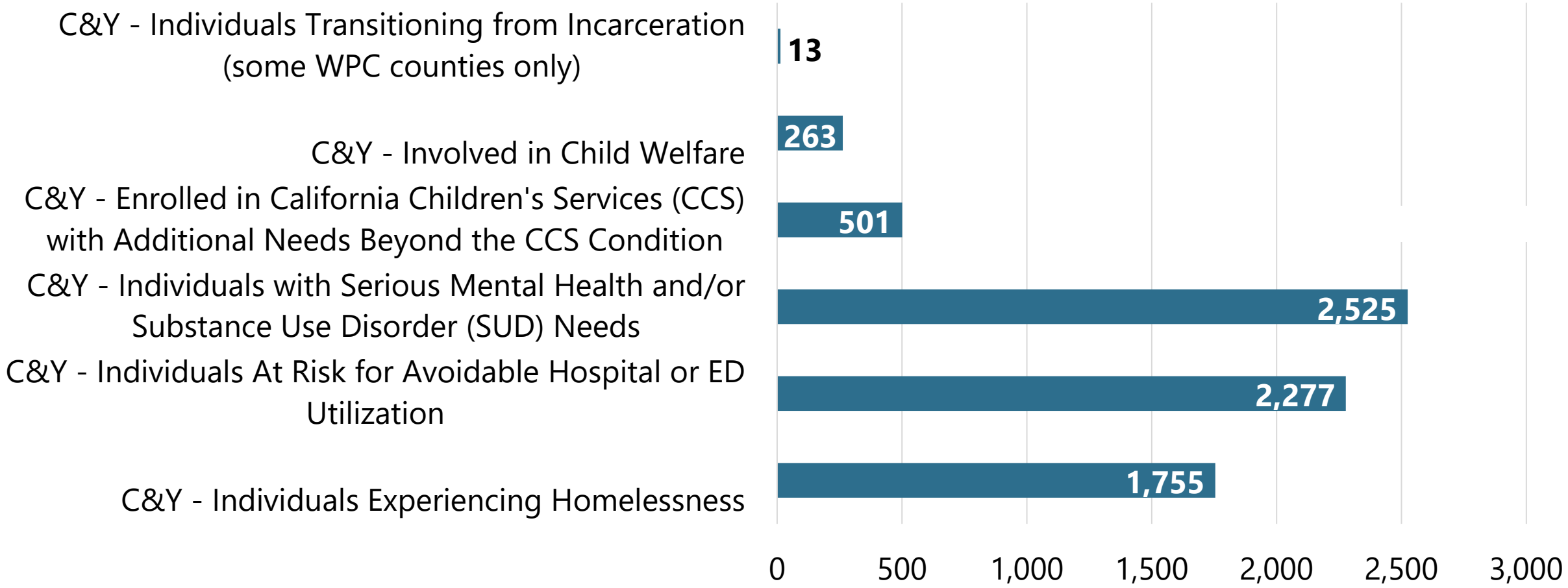
Q3 2023 Data: ECM Members Stratified by Age



Source: ECM and Community Supports Quarterly Implementation Report for Q3 2023

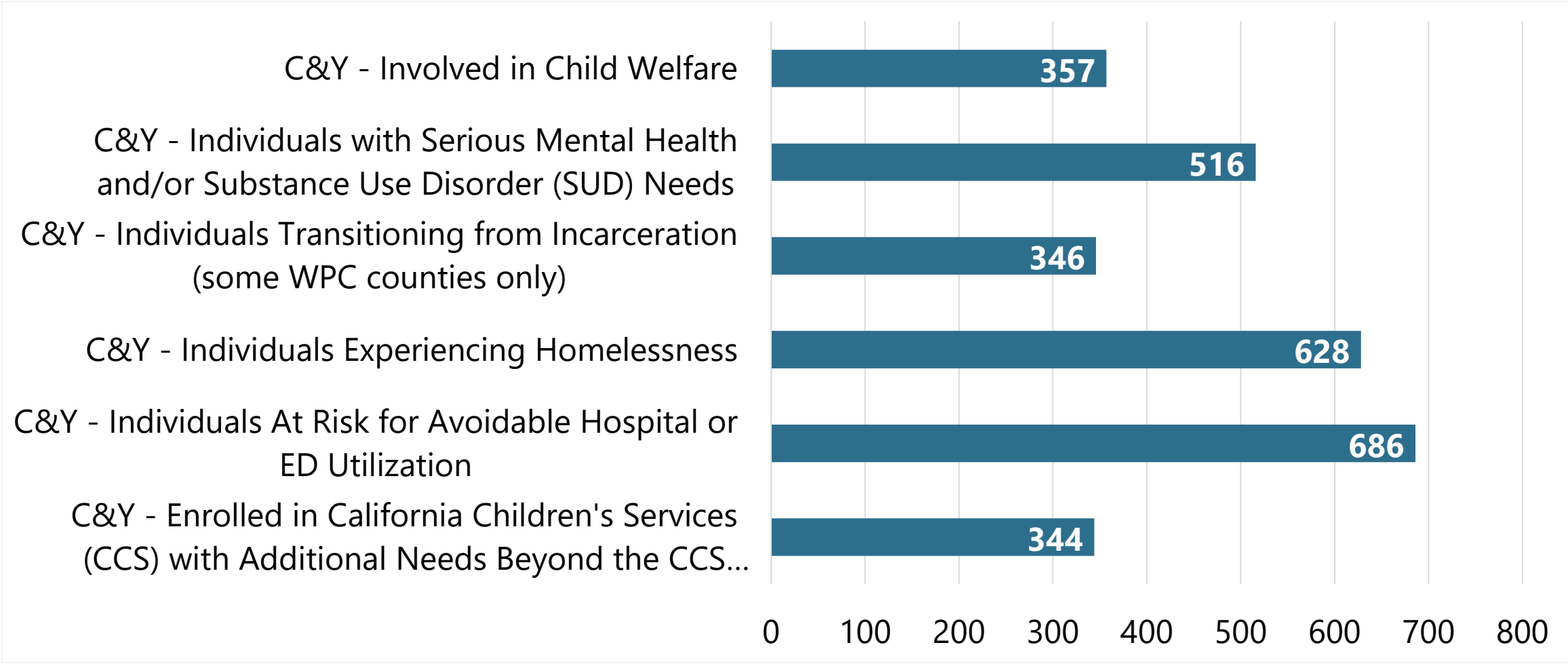
- Prior to Q3 2023, a limited number of Medi-Cal MCP members under age 21 were eligible to receive ECM via an adult POF (i.e., children in families experiencing homelessness; children & youth transitioning from Health Homes Program/Whole Person Care Pilot ECM).
- From Q2 to Q3 2023, the number of total **members under age 21 enrolled in ECM increased by 115%**, largely due to the Children & Youth POFs going live.
- DHCS anticipates growth in Children & Youth ECM uptake as the program ramps up. Preliminary data shows **enrollment in these POFs has significantly increased** between Q3 and Q4 2023.

Q3 2023 Data: ECM Children & Youth Members by POF



Source: ECM and Community Supports Quarterly Implementation Report for Q3 2023

Q3 2023 Data: ECM Providers by Children & Youth POF



Source: ECM and Community Supports Quarterly Implementation Report for Q3 2023

Released: Spotlight on ECM for Children and Youth

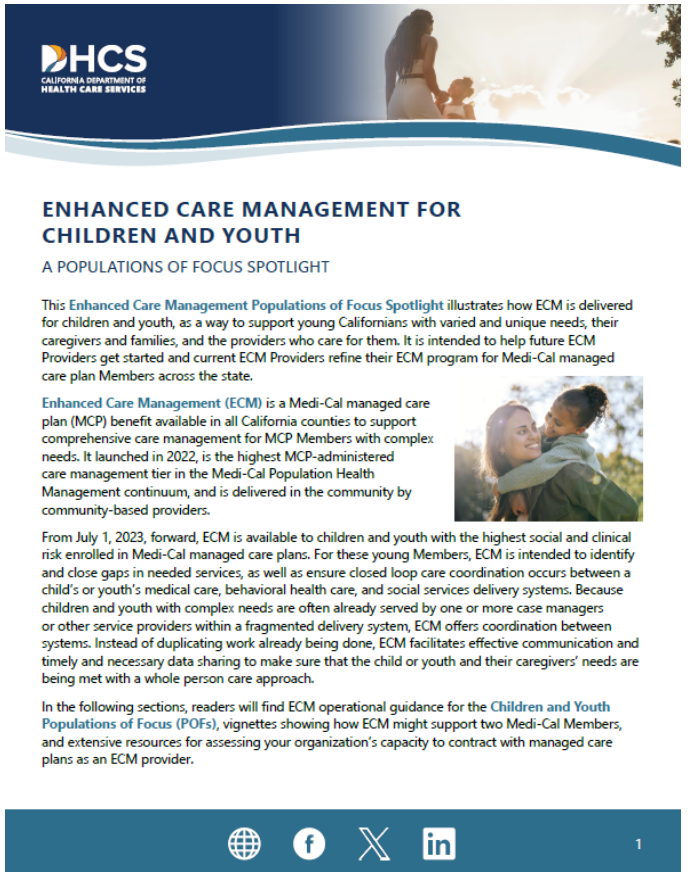
DHCS is excited to release the **ECM for Children and Youth POF Spotlight**

- ✓ Lifts up key DHCS policies and resources on serving Children and Youth in ECM
- ✓ Contains Member vignettes that illustrated how to implement ECM for the Children and Youth POF:

Teen in foster care also receiving Intensive Care Coordination

Child with cerebral palsy enrolled in CA Children's Services

- ✓ Explains how Community Supports can be integrated to best serve children and youth along with their families and caregivers



This is the first in a **series of Spotlights** DHCS plans to release to provide more detail on how Providers can deliver ECM models tailored to meet the needs of different POF

To learn more, please visit the ECM and Community Supports webpage

Questions?

Email: CalAIMECMILOS@dhcs.ca.gov

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Update: Justice Involved (JI) ECM Population of Focus

David Tian, MD, MPP, FASAM

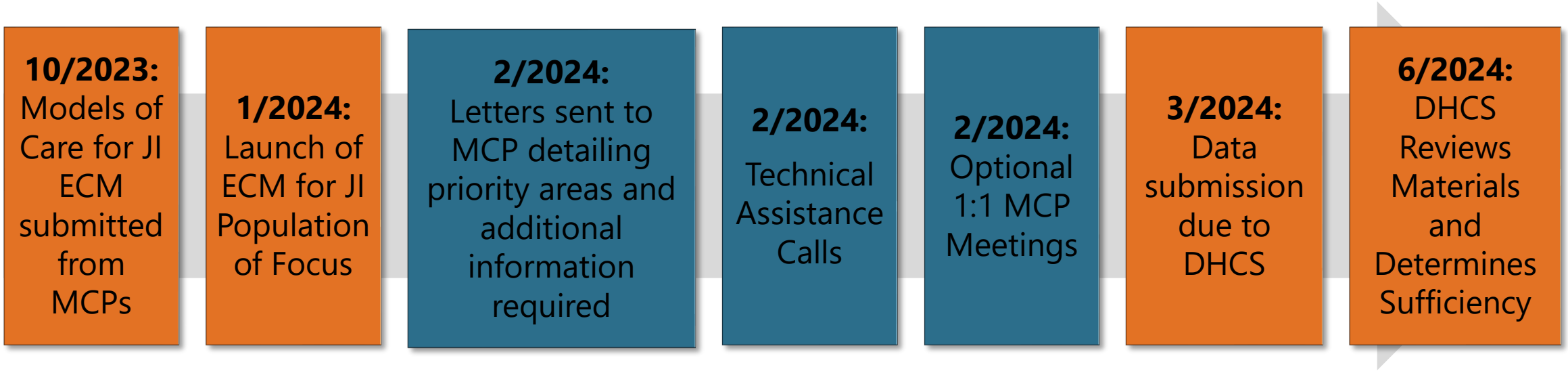
Acting Branch Chief,

Clinical Population Health Care Management

DHCS

Justice Involved ECM Launch Timeline

- Prior to launch of the Enhanced Care Management (ECM) benefit for justice-involved individuals, required **model of care** submissions from Medi-Cal Managed Care Plans showed significant gaps
- The Justice Involved Initiative and Population Health Management launched on 1/1/2024 while concurrently providing intensive technical assistance to MCPs in a **Pre-Corrective Action Plan (Pre-CAP)** process to address gaps in priority areas as soon as possible



Review: Priority Areas and Benchmarks

Where we started in 2/2024…

Priority Area 1 **Provider Network Capacity**	Priority Area 2 **Corrections System Coordination**	Priority Area 3 **Network Overlap Implementation**
I. At least 1 experienced JI ECM Provider in each county of operation II. Using sound methodology to estimate ECM capacity needs III. Network sufficiency to meet the estimated ECM capacity needs IV. Efforts undertaken to identify, conduct outreach to, and contract with established providers and/or community-based organizations that serve justice-involved populations	V. Operational processes in place to engage and coordinate with correctional facilities, including county jails and youth correctional facilities. VI. Standard operating procedures for the MCP JI Liaison's communications with correctional facilities, including specific procedures for supporting transitions from pre-release to post-release settings. The standard procedures must include at least one specific point of contact in each correctional facility in the MCP's area of service.	VII. Collaboration and regular communication with other MCPs in each county with more than one MCP to meet network overlap requirement and share information about new JI ECM providers.

Pre-CAP Results and Next Steps

- Pre-CAP process results:
  - Minimum requirement to have one experienced provider of ECM JI services improved from **39.4% to 99.1%** of the 114 Plan-County combinations.
  - MCP estimated community need based on local data or publicly available dashboards and compared to existing networks.
  - Pre-CAP response letters were distributed to MCPs in early-mid June 2024.

Where we're headed…

- Looking forward towards the launch of Pre-Release services:
  - DHCS will continue to monitor MCPs' progress in Priority Areas, with the expectation for **continuous improvement and progress** in network capacity, corrections system engagement, and network overlap.
  - **DHCS will follow-up with MCPs in the upcoming months regarding additional requirements in priority areas** to ensure readiness for the increased demand for pre-release in-reach services and post-release ECM services with the launch of pre-release services.

Questions?

- **Justice-Involved Initiative Questions:** CalAIMJusticeAdvisoryGroup@dhcs.ca.gov
- **Enhanced Care Management Questions:** CalAIMECMILOS@dhcs.ca.gov

DHCS

Collaborative Planning and Implementation (CPI) Initiative – PATH)

Shel Wong, Project Coordination Section Chief

Itta Johnson, PCG CPI Workstream Lead

DHCS

CPI Content

- CA PATH Collaborative Planning and Implementation (CPI) Overview
- Participation and Engagement
  - Registration Numbers
  - Types of Participants
- The Role of Managed Care Plans (MCPs) in CPI
- CPI Focus on DHCS Action Plan Priorities
  - Examples of work being done locally in relation to:
    - Increasing Referral Sources
    - Expanding Provider Networks
    - Strengthening Market Awareness
    - Improving Data Exchange

CPI Overview

What is CPI?

The CPI Initiative provides funding for county and regional Collaborative planning efforts to support implementation of Enhanced Care Management (ECM) and Community Supports. **There are 26 Collaboratives led by 9 facilitator organizations in 2024**

- Participant registration will remain open throughout the initiative

CPI Goals and Objectives

Local Collaborative groups work together with the support of an assigned facilitator to **identify, discuss, and resolve topical implementation issues** and identify how PATH and other California Advancing and Innovating Medi-Cal (CalAIM) funding initiatives – including Incentive Payment Program (IPP) – may be used to address gaps identified in MCP Needs Assessments and Gap Filling Plans while avoiding duplication.

Potential focus areas for Collaboratives include:

- Identifying ECM/Community Supports **needs** and **gaps** within the community
- **Identifying** and **resolving** implementation issues
- Monitoring how PATH funds are used to address implementation issues and disseminating **best practices**

CPI Initiative Timeline 1 of 2

Month	Activity
August – December 2022	• Collaborative Participant Registration opened • Collaborative Facilitator Awards Announced • Collaborative Welcome Letters to Participants
January – June 2023	• PATH CPI collaboratives launch in January • Collaboratives establish goals and develop an improvement strategy by March 2023
April 2023 – ongoing	• Using data from previous quarters, CPI Collaboratives begin implementing tests of change to address identified challenges
August – December 2023	• Continue to identify and address challenges; disseminate best practices; and increase CPI participation
October 2023	• CPI team hosted 1st Best Practice webinar highlighting CPI work • Facilitator Year 2 Contracts signed; new Indian Health Collaborative launched

CPI Initiative Timeline 2 of 2

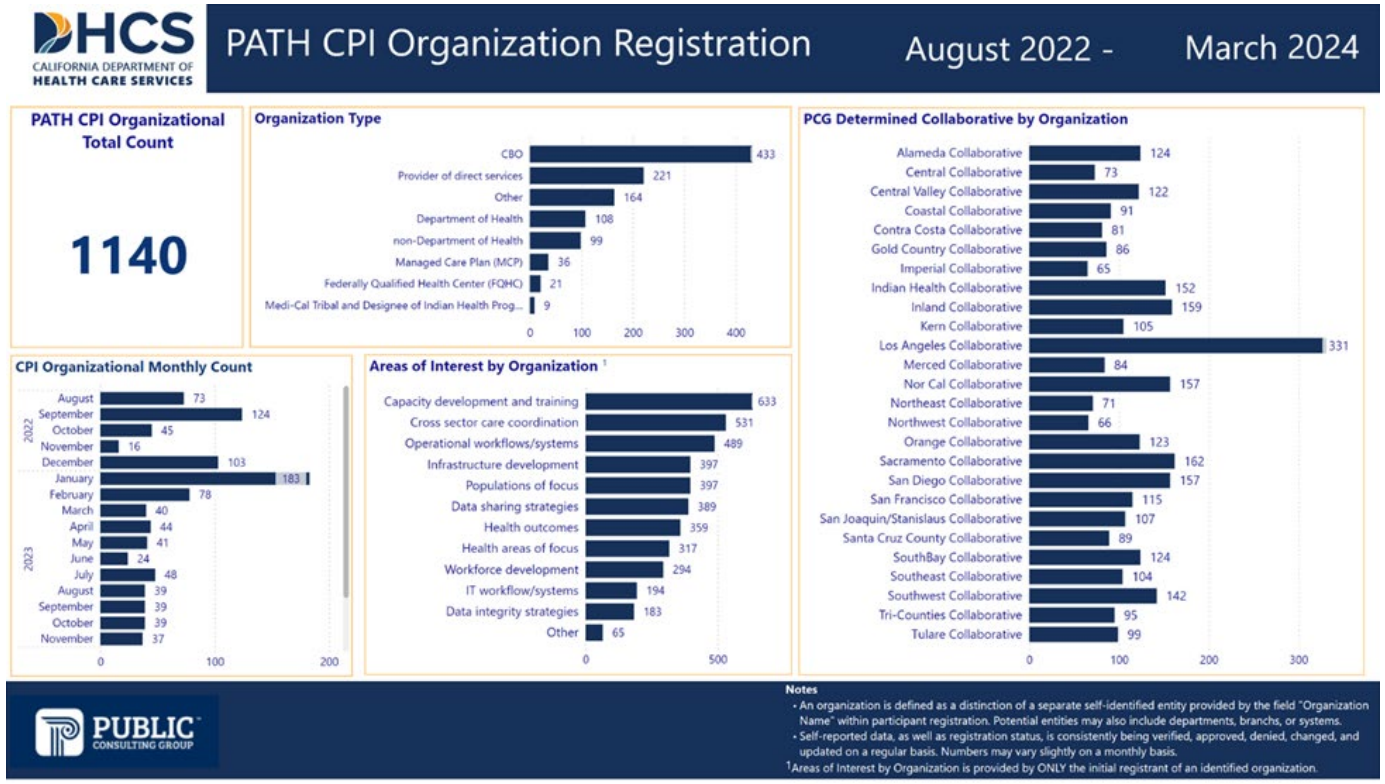
Month	Activity
December 2023	• CPI team host 2nd Best Practice webinar highlighting CPI work
January 2024	• PATH CPI collaboratives continue • 2024 MCP Transitions take affect
June 2024	• CPI team to host 2 Best Practice webinars highlighting CPI work (June & November) • CPI Partners with Justice-Involved Initiative to support provider participation
January 2025	• PATH CPI collaboratives continue

Participation and Engagement

Registration Data

At the end of March 2024:

- The total number of registered organizations was 1140
- The total number of unique individuals registered was 1716
- Approximately 62% of participating organizations were **not contracted** with an MCP to provide ECM or Community Supports services



Types of Eligible Participants:

- Community-Based Organization (CBO)
- County, City, or Local Government Agency
- Federally Qualified Health Center (FQHC)
- MCPs
- Medi-Cal Tribal and Designee of Indian Health Program
- Providers (including, but not limited to, hospitals and provider organizations)

Participant Experience with Medi-Cal and CalAIM

Collaborative Participants include organizations with varied knowledge and experience with Medi-Cal, Managed Care Delivery Systems, and CalAIM initiatives and programs, such as:

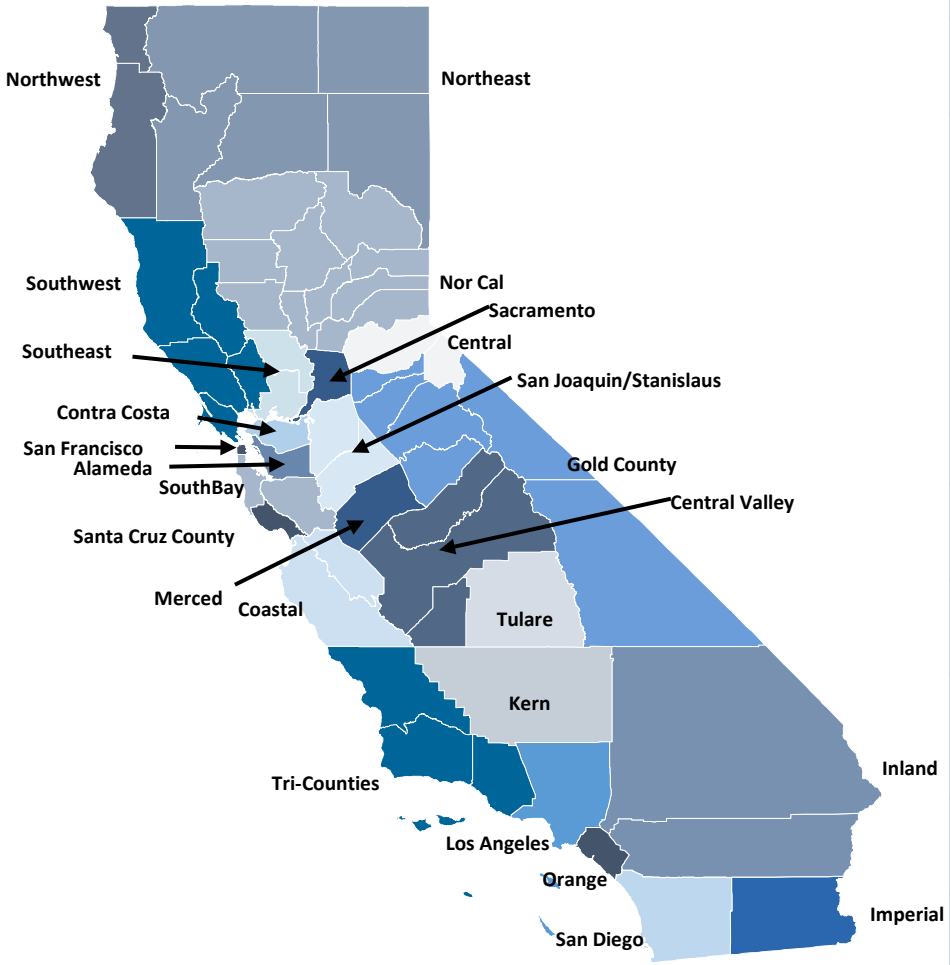
- Providers and MCPs who are scaling, refining, and improving existing systems and processes
- Newly contracted providers who are ramping up and establishing new workflows
- Providers not yet contracted to provide ECM or Community Supports who are interested in becoming contracted
- Referring providers & those otherwise part of the system of care who are not direct providers of ECM or Community Supports

The Role of MCPs in CPI

MCPs actively participate in PATH CPI efforts in the counties they serve and work with CPI facilitator(s) and other partners to address challenges and gaps related to ECM and Community Supports implementation.

- **MCPs collaborate with other CPI stakeholders to:**
  - Improve enrollment in, and utilization of, ECM and Community Supports
  - Design and test system level improvements related to the provision of ECM and Community Supports services with CPI participants
  - Support the promotion of streamlined and simplified process and workflow related changes aimed at overcoming barriers and challenges experienced by ECM and Community Supports providers
  - Share information with non-contracted providers to clarify the process of contracting with MCPs, including MCP specific requirements for contracting
- **MCPs can help identify entities that may benefit from participation**, including entities that participated in the development of IPP Gap Filling Plans as well as prospective and contracted ECM/Community Supports network providers that may benefit from participation
  - CPI Facilitators ensure that these entities are invited to join local PATH-funded CPI collaboratives
- MCPs are not eligible to serve as facilitators of these groups to ensure CPI facilitator organizations are neutral entities in the state of California, however, CPI facilitators are encouraged to work closely with MCP representatives and other partners to ensure alignment of regional ECM and Community Supports implementation efforts

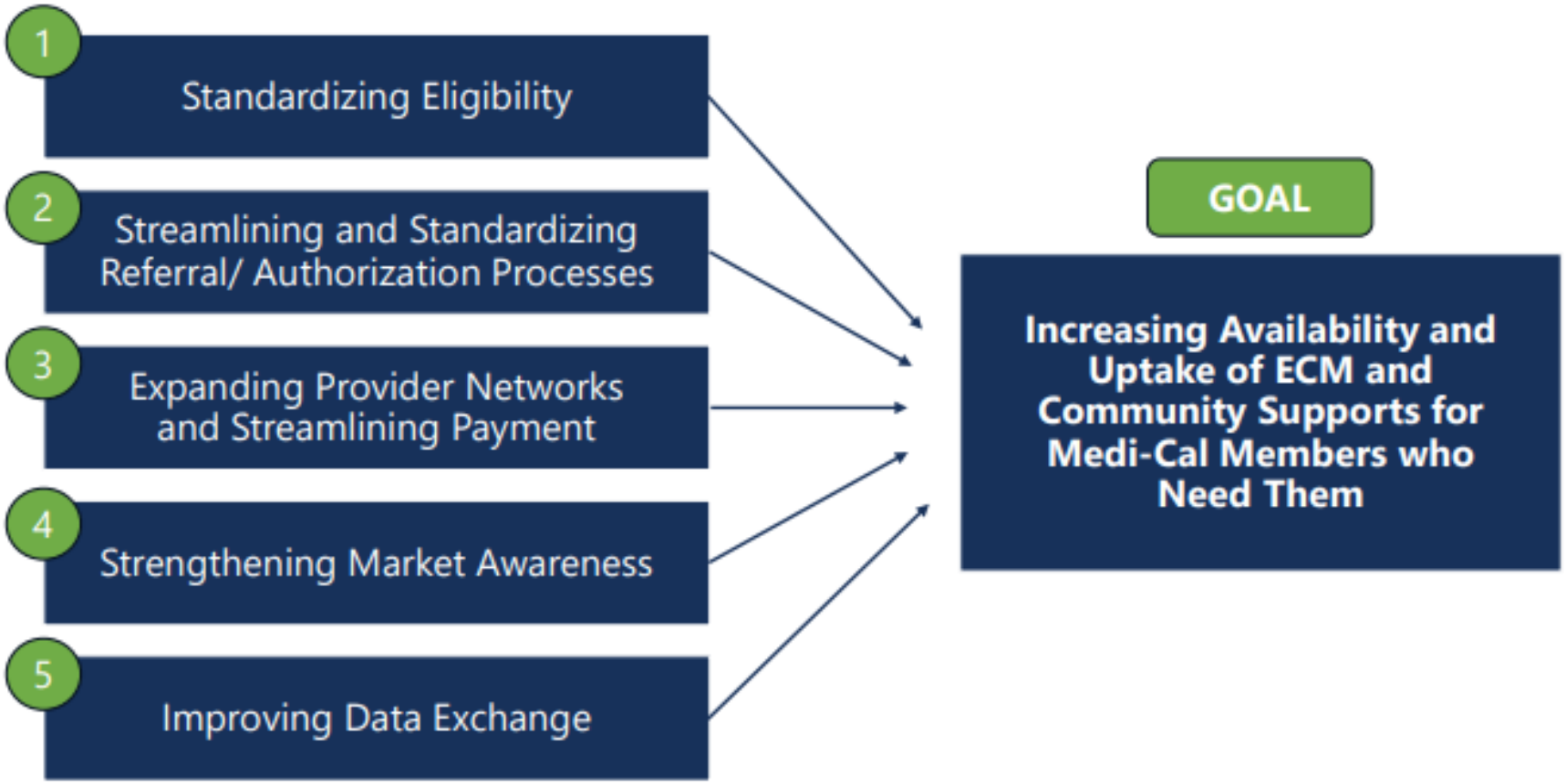
CPI Facilitators



Facilitator	Collaborative	Counties
BluePath Health	Alameda	Alameda
	Tri Counties	San Luis Obispo, Santa Barbara, Ventura
Camden Coalition	Coastal	Monterrey & San Benito
	Merced	Merced
	Southeast	Solano & Yolo
Chapman Consulting, LLC	San Francisco	San Francisco
	Southbay	San Mateo & Santa Clara
HC2 Strategies, Inc.	Central	Alpine & El Dorado
	Gold Country	Amador, Calaveras, Inyo, Mariposa, Mono, Tuolumne
	Imperial	Imperial
	Kern	Kern
	Nor Cal	Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba
	Tulare	Tulare
	Indian Health Collaborative	Statewide
HC2 Strategies, Inc. (Institute for Healthcare Improvement (IHI) Facilitated in 2023)	Inland	Riverside & San Bernardino
	Orange	Orange
Health Begins, LLC	Northeast	Lassen, Modoc, Shasta, Siskiyou, Trinity
	San Joaquin-Stanislaus	San Joaquin & Stanislaus
Healthcare Improvement Partnership (HIP) of Santa Cruz County	Santa Cruz County	Santa Cruz
Intrepid Ascent	Contra Costa	Contra Costa
	San Diego	San Diego
Public Health Institute (PHI)	Northwest	Del Norte & Humboldt
	Southwest	Lake, Marin, Mendocino, Napa, Sonoma
Transform Health, LLC	Central Valley	Fresno, Kings, Madera
	Los Angeles	Los Angeles
	Sacramento	Sacramento

Action Plan:
Key Domains In Response to Data & Feedback

- DHCS has been focused on revising/reinforcing policies and executing against specific design initiatives across these key areas.



CPI focus on DHCS Action Plan Priorities

Examples of work being done locally in relation to DHCS Action Plan Priorities

Topic	Regions	Activity	Impact	MCP Support
Increasing Referral Sources Cheat Sheets and "How To" Guides	Coastal, Southeast, San Francisco	CPI participants work with facilitators and MCPs to develop **provider maps** and cheat sheets showing where and what services CalAIM providers are offering, as well as "how to" **referral tools** for both health systems and CBOs.	The development of easy to use, regionally specific materials focusing on referrals to ECM and Community Supports can help to drive utilization.	Work with CPI Facilitators and other partners to identify commonly asked questions and provide timely answers when they arise so that members can be referred when they need support.
Expanding Provider Networks MCP & Provider Directories	All CPI Collaboratives and regions	CPI participants help facilitators to design and deliver **enhanced provider directories** including ECM and Community Supports and provide updated provider rosters to CPI participants as well as including those directories in centralized resource repositories.	Creation of provider directories serves as a job aid for frontline workers and allows for the "real time" connection of and referral to specific ECM & Community Supports care offered by providers in the region to provide specific care to individuals.	Submit timely and updated rosters of incoming providers to CPIs to maintain and sustain accurate directory and referral of care.

CPI focus on DHCS Action Plan Priorities, cont.

Examples of work being done locally in relation to DHCS Action Plan Priorities

Topic	Regions	Activity	Impact	MCP Support
Strengthening Market Awareness Communication & Market Awareness	Northeast, San Joaquin & Stanislaus, San Diego, Northwest & Southwest	In addition to regular communication with participants, facilitators are planning CalAIM community campaigns with information and analysis done in year one of the CPI initiative. Facilitators will **enlist community-wide marketing campaigns to increase awareness** of services.	Regions engaged in this work are hoping to increase general knowledge of CalAIM related services to increase community sourced referrals to care.	MCPs are invited to collaborate with CPI Facilitators in market awareness events to the extent possible to ensure they are present to answer questions, explain services offered, and to meet regional partners.
Improving Data Exchange Data Sharing & Standardization	San Diego	CPI Facilitators are **planning a test of change** for MCP Data Sharing with the CIE/HIE and continue to use the data standardization workgroup to move discussion on data sharing forward in that region.	A third party responsible for aggregating and exchanging data routinely (CIE/HIE or County) could decrease administrative burden and increase data access.	MCPs come together at an MCP roundtable to work toward improving overall network data transparency and data access.

More Information

Visit the PATH CPI website to learn more:

https://www.ca-path.com/collaborative

Search the CPI Directory to find your local Collaborative:

https://www.ca-path.com/collaborative/collaborative-group-directory

Register to participate:

https://pcgus.jotform.com/222306493964865

Please contact us with any questions: collaborative@ca-path.com or 1115PATH@dhcs.ca.gov

Questions?

DHCS

Open Discussion

If you have questions or comments, or would like to request future agenda items, please email: advisorygroup@dhcs.ca.gov