The CalAIM Information & Referral Highway to ECM Enrollment: What Organizations Need to Know

June 25, 2024

Logistics

- The webinar is being recorded.
- Please submit your questions through the Zoom Q&A function at the bottom of your screen at any time.
- The presenters will select questions to be answered live during the webinar as time allows.
- Webinar materials will be made available on the Archstone Foundation website after the webinar.

Agenda

- Introductions
- CalAIM Context, Background and Benefits
- Information & Referral Opportunities
- AAA/ADRC Experience
- *Sourcewise*
- Caregiver Resource Center Referral Experience
  - *Family Caregiver Alliance*
- Q&A and Discussion

Today's Speakers

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Moderator

ARCHSTONE
FOUNDATION

Laura Rath, PhD, MSG
Vice President of Programs


ARCHSTONE
FOUNDATION

MISSION

To improve the health and well-being of older Californians and their caregivers.

ARCHSTONE FOUNDATION

VISION

All older Californians have access to high-quality coordinated care that effectively integrates health and social services.

ARCHSTONE FOUNDATION

CalAIM Statewide Dementia Learning Collaborative

- Opportunities
- Challenges
  - Identifying eligible persons
  - Organizational sustainability

THE WAY FORWARD

California Department of Health Care Services

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Laura Miller, MD
Medical Consultant, Division of Quality and Population Health

CalAIM Enhanced Care Management and Community Supports: Focus on Older Adults

California Department
of Health Care Services

June 25, 2024

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. CalAIM aims to:

Implement a whole-person care approach and address social drivers of health.

Improve quality outcomes, reduce health disparities, and drive delivery system transformation.

Create a consistent, efficient, and seamless Medi-Cal system.

For more information, please see: [Medi-Cal Transformation]

CalAIM Initiatives

Behavioral Health Initiative

Medi-Cal is strengthening mental health and substance use disorder services and better integrating them with physical health care.

Community Supports

New services as part of the transformation of Medi-Cal help members address unmet basic needs that can impact their health, whether they're clinical or non-clinical. These include support to secure and maintain housing, and access to medically tailored meals to support short term recovery.

Dental Initiative

Medi-Cal is expanding dental benefits for children and those with conditions that are more likely to lead to dental disease.

Justice-Involved Initiative

Medi-Cal is providing services to justice-involved adults and youth while they are incarcerated, and as they re-enter their communities.

Population Health Management

Medi-Cal is requiring managed care plans to use a concentrated holistic approach to improving the health outcomes of a group of individuals.

Providing Access and Transforming Health (PATH)

PATH funds are an investment in the capacity and infrastructure of local community-based organizations to provide services to Medi-Cal members in their communities.

Enhanced Care Management

Medi-Cal is providing high-need members with in-person care where they live.

Incentive Payment Program

Medi-Cal is supporting the implementation and expansion of Enhanced Care Management, Community Supports and other initiatives by providing incentives to Medi-Cal managed care plans to invest in improving the quality of care, reducing health disparities, and promoting health equity.

Integrated Care for Dual Eligible Members

Medi-Cal is better integrating care for members who are dually enrolled in both Medicare and Medi-Cal.

Statewide Managed Long-Term Care

Medi-Cal is introducing a better way to coordinate care for those with very complex or long-term care needs.

Supporting Health and Opportunity for Children and Families

Medi-Cal is improving the health of children in California, supporting their families, reducing disparities in care, and strengthening accountability and oversight of children's services.

Enhanced Care Management (ECM) & Community Support (CS)

On January 1, 2022, DHCS launched the first components of CalAIM: Enhanced Care Management (ECM) and Community Supports.

Issues ECM & Community Supports are Designed to Address in California

Medi-Cal members typically have **several complex health conditions**

About 20% of Californians are **food insecure**

Enrollees with complex needs must often engage in **several delivery systems to access care**

People experiencing homelessness have **higher rates of diabetes, hypertension, HIV, and mortality**

Addressing SDOH is key to advancing health equity and helping people with high health care and social needs. **More than 65% of Medi-Cal members are from communities of color.**

Enhanced Care Management and Community Supports Overview

- The ECM and CS Quarterly Implementation Report was updated April 2024 and reflects data from January 1, 2022, to September 30, 2023, and includes the total population receiving Enhanced Care Management (ECM) and Community Supports (CS).
- Dual eligible beneficiaries, with both Medicare and Medi-Cal, can access all available CS through their Medi-Cal plan regardless of enrollment in Original Medicare or a Medicare Advantage (MA) plan. If the MA plan offers supplemental benefits comparable to CS, Medicare is the lead.
- Dual eligible beneficiaries are most likely to fall into one of the following ECM Populations of Focus (POF):
  - Adults Experiencing Homelessness
  - Adults at Risk for Avoidable Hospital or Emergency Department (ED) Utilization
  - Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
  - Adults Living in the Community and At Risk for Long-Term Care Institutionalization
  - Adult Nursing Facility Residents Transitioning to the Community

Community Supports

14 services to address members' social drivers of health and help them to avoid higher costlier levels of care

- Housing Transition Navigation Services
- Housing Deposits
- Housing and Tenancy Sustaining services
- Short-term post hospitalization housing
- Recuperative Care
- Day Habilitation Programs
- **Respite Services**
- **Nursing Facility Transition to Assisted Living Facilities**
- **Community Transition Services**
- Personal Care and Homemaker Services
- Home Modifications
- **Medically-Tailored Meals**
- Sobering Centers
- Asthma Remediation

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

Dual Eligible Beneficiaries who Received ECM in the LTC POFs -- Q3 2023

- Of Adults Living in the Community and at Risk for LTC Institutionalization, dually eligible beneficiaries total 2,792 and represent about 47.4% of the POF.
- Of the Adult Nursing Facility Residents Transitioning to the Community, dually eligible beneficiaries total 171 and represent about 34.3% of the POF.

NOTE: There may be differences between the ECM data reported in this slide deck and the information published on the DHCS webpage.

Dual Eligible Beneficiaries who Received ECM in other POFs -- Q3 2023

- Of the Individuals Experiencing Homelessness dually eligible beneficiaries total 2,919 and represent about 13.7% of the POF.
- Of the Individuals at Risk for Avoidable Hospital or ED Utilization dually eligible beneficiaries total 4,955 and represent about 15.4% of the POF.
- Of the Individuals with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD) Needs dually eligible beneficiaries total 3,649 and represent about 12.1% of the POF.

NOTE: There may be differences between the ECM data reported in this slide deck and the information published on the DHCS webpage.

Released: Spotlight on ECM for LTC Populations

DHCS is excited to release the **Enhanced Care Management (ECM) for Long-Term Care Populations of Focus Spotlight**.

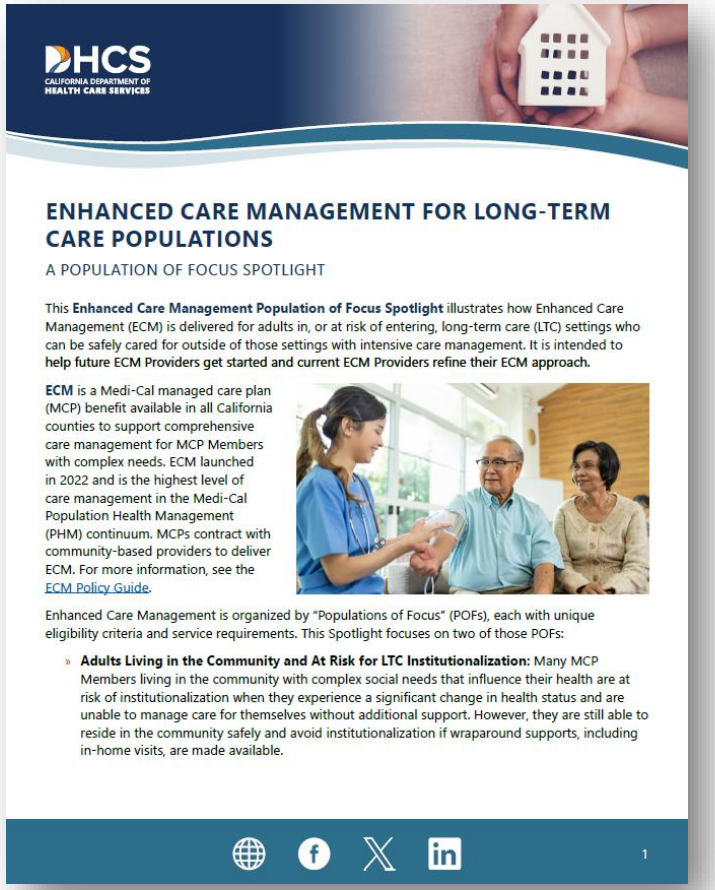
- ✓ Lifts up key DHCS policies and resources on serving individuals in, or at risk of entering institutional Long-Term Care in ECM settings; including, a crosswalk of how members with LTSS needs receive care management support .
- ✓ Contains Member vignettes that illustrated how to implement ECM for these Populations of Focus:

Older adult living with Parkinson's disease who wishes to remain at home

Older adult temporarily residing in a skilled nursing facility and recovering from a stroke

- ✓ Explains how Community Supports and Transitional Care Services can be integrated to best serve Members and their caregivers.

This is the third in a **series of Spotlights** on how Providers can deliver ECM models tailored to the needs of different Populations of Focus.



DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

ENHANCED CARE MANAGEMENT FOR LONG-TERM CARE POPULATIONS

A POPULATION OF FOCUS SPOTLIGHT

This **Enhanced Care Management Population of Focus Spotlight** illustrates how Enhanced Care Management (ECM) is delivered for adults in, or at risk of entering, long-term care (LTC) settings who can be safely cared for outside of those settings with intensive care management. It is intended to **help future ECM Providers get started and current ECM Providers refine their ECM approach.**

ECM is a Medi-Cal managed care plan (MCP) benefit available in all California counties to support comprehensive care management for MCP Members with complex needs. ECM launched in 2022 and is the highest level of care management in the Medi-Cal Population Health Management (PHM) continuum. MCPs contract with community-based providers to deliver ECM. For more information, see the ECM Policy Guide.

Enhanced Care Management is organized by "Populations of Focus" (POFs), each with unique eligibility criteria and service requirements. This Spotlight focuses on two of those POFs:

- **Adults Living in the Community and At Risk for LTC Institutionalization:** Many MCP Members living in the community with complex social needs that influence their health are at risk of institutionalization when they experience a significant change in health status and are unable to manage care for themselves without additional support. However, they are still able to reside in the community safely and avoid institutionalization if wraparound supports, including in-home visits, are made available.

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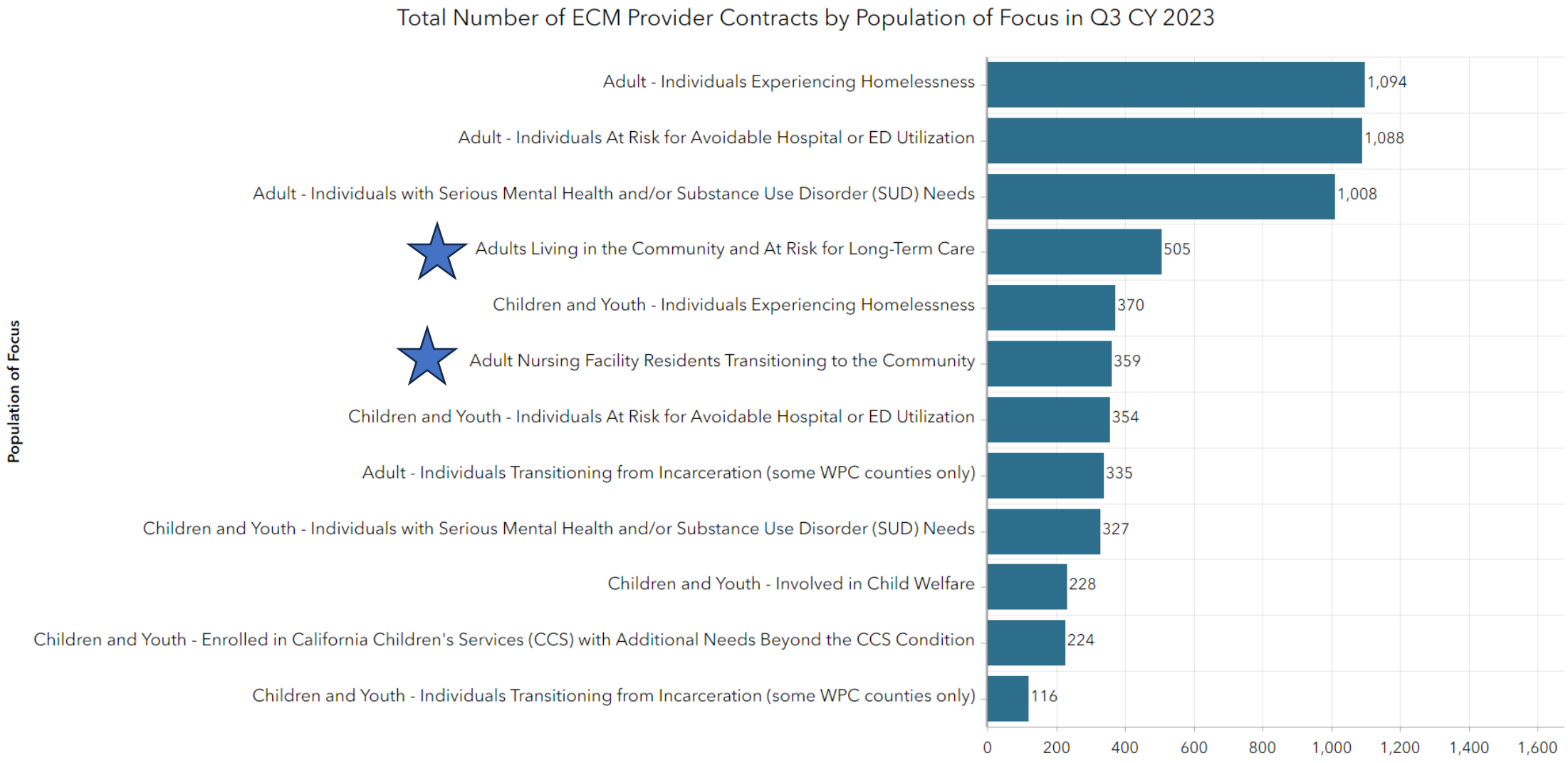
To learn more, please visit the ECM and Community Supports webpage.

ECM Networks



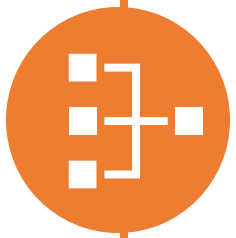
Source: [ECM and Community Supports Quarterly Implementation Report (arcgis.com)]

How Do Eligible Members Access ECM?

Eligible Enrollees…

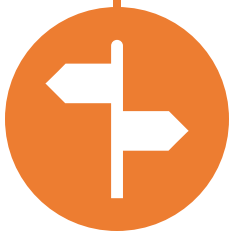
Can be **identified** through their Medi-Cal Managed Care Plan (MCP), provider, family/caregiver, community-based organizations (CBOs), or via a self-referral.

- 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.



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**.

Streamlining access to ECM

- In July 2023, DHCS released a set of ECM and Community Supports policy refinements focused on improving the standardization of the design of both programs, with the goal of increasing the number of Members served and reducing administrative burden.
- As part of the Department's July 2023 policy refinement commitments, **DHCS is developing updated ECM referral and authorization standards to streamline access to the benefit.**

Upcoming Guidance on ECM Referrals and Authorizations

- Universal ECM Referral Standards and Template
  - Streamline and align ECM referral process statewide for all MCPs to support member access to ECM
- Updated ECM Presumptive Authorization Policy
  - Expand use of presumptive authorization so specific ECM providers can start serving members faster.
- Currently in development – DHCS release of Updated Guidance planned for July 2024 with implementation January 2025.

California Department of AGING

50 Years

Susan DeMarois
Director
California Department of Aging

Area Agencies on Aging

SOURCEWISE
COMMUNITY RESOURCE SOLUTIONS

Elizabeth Rodriguez, MSHCA
Senior Director of Operations
Sourcewise

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- Since 1973
- Designated Area Agency on Aging in Santa Clara County
- Programs & Services
- Our Impact

Our CalAim Delivery

2 × Contracts with Managed Care Plans

Enhanced Case Management (ECM)

Enhanced Case Management
Population of Focus (PoF):

- Adults at risk for avoidable hospital or emergency department (ED) utilization (formally high utilizers)
- Adults living in the community and at risk for long-term care (LTC) institutionalization
- Adult nursing facility residents transitioning to the community

Community Supports

- Nursing Facility Transition / Diversion to Assisted Living Facilities
- Community Transition Services / Nursing Facility Transition to Home

Referrals to CalAim ECM & CS

Successes

Trusted Resource in our Community

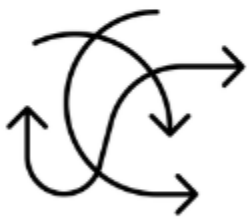
Leverage Internal Programs to Increase Referrals

Institutional Knowledge & Experience

Referrals to CalAim ECM & CS

Challenges

Lack of Awareness



Navigating a system not designed for vulnerable populations

Inconsistent or outdated referral information

Solutions that work

We have....

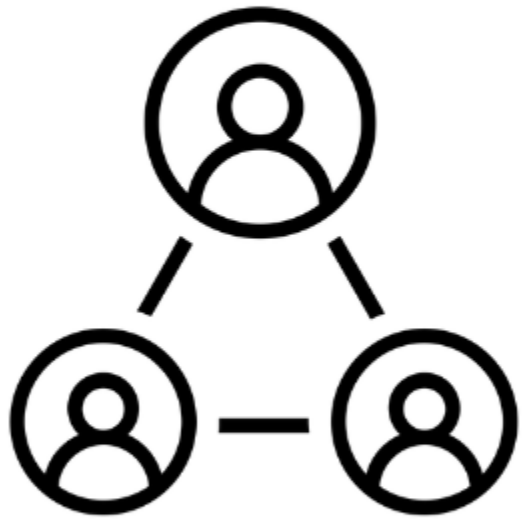
Integrated questions at entry points in our organization to identify eligible individuals

Provide support to individuals to gain access to CalAim Programs through internal referrals

Develop and nurture partnerships with fellow providers to maximize impact

Building Success Together

Increase Awareness



Nurture Partnerships

Increase Coordination

California Caregiver Resource Centers

Family Caregiver Alliance®

Kathy Kelly, MPA
Executive Director
Family Caregiver Alliance

Discussion

RESOURCES

- CalAIM Statewide Dementia Care Learning Collaborative

https://archstone.org/resources/CSDLC

- How CalAIM Supports Best Practices in Dementia Care

https://archstone.org/uploads/ARCHSTONE-CALAIM-WHITEPAPER-FINAL-Nov-2023.pdf

- CalAIM ECM Policy Guide

https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

Thank you!