MANAGED CARE TRACK – TUESDAY NOV 16, 2 PM

CHANGES AND CHALLENGES UNDER CAL AIM

Panelists:

SYDNEY TURNER, MANAGER HEALTH POLICY, MEDI-CAL, HEALTH NET

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Big Picture Timeline

	CalAIM Opportunities	Non-CalAIM Opportunities
2022	• Phased Implementation of **Enhanced Care Management (ECM)** benefit for people experiencing homelessness, SMI/SUD, high utilizers • Transition to statewide **Medi-Cal Long Term Services & Supports (MLTSS)/Community Supports (formally ILOS)** • **CalAIM Performance Incentive** for capacity & infrastructure development • **Provider Access & Transforming Health (PATH)** incentive program – Pending CMS approval • MSSP Carve Out in CCI counties	• Implementation of **Medi-Cal Rx**

2023	• Phased Implementation of **Enhanced Care Management (ECM)** benefit for **Individuals at risk of institutionalization, Nursing Facility Residents**, Individuals transitioning from incarceration, Children or youth with complex conditions
	• **Discontinue CCI and CMC**
	• Lift & shift CMC members to the **Dual Special Needs Program (DSNP)**
	• **Aligned Managed Care enrollment** in CCI Counties
	• **Long Term Care (LTC)** benefits carved in, includes Intermediate Care Facilities (ICF), health facilities licensed by state public health, to provide 24-care.
	• Payment reform including LTC and blended rates
		• **Home & Community Based Services (HCBS) Spending Plan** – Pending CMS approval
		  • Community based residential continuum pilots for vulnerable, aging, and disabled populations
		  • Eliminating ALW waiting list
		  • Housing & homelessness incentive program
		  • Community care expansion program
		• **Electronic Visit Verification** for IHSS caregivers and home health workers

2024		• Implementation of new MCP contracts in counties up for re-procurement (**RFP**)
2025	• **Dual Special Needs Program (DSNP) Aligned Managed Care enrollment** in non-CCI Counties	
2026	• **NCQA accreditation** for Medi-Cal MCPS and subcontractors	
2027	• **Statewide Medi-Cal Long Term Services & Supports (MLTSS)** • LTSS **Distinction**	

Anthem BlueCross

California Advancing and Innovating Medi-Cal (CalAIM)

Preparing for Long Term Care Integration

Beau Hennemann
Director, Special Programs

Anthem CA Medi-Cal Overview

Anthem has been helping Medi-Cal families since 1994. We serve over 1.3M members throughout 29 counties.

Managed Long Term Services and Supports

Inclusion of SNF transitions under CS Jan 2022	MSSP Carve Out Jan 2022	Statewide expansion for LTSS/LTC Jan 2023
Inclusion of ICF DD and pediatric subacute populations under LTC Jan 2023	Payment reform including LTC and blended rates Jan 2023	The end of Cal MediConnect duals demonstration Jan 2023
Required D-SNP offering and integration with LTSS Jan 2025	Full LTSS integration 2027	LTSS Distinction requirement 2027

Enhanced Care Management

- Outreach and Engagement
- Comprehensive Assessment/Care Management Plan
- Enhanced Coordination of Care
- Health Promotion
- Comprehensive Transitional Care
- Member and family supports
- Coordination of and Referral to Community and Social Support Services
- Additional services specific to target population

St. Anthony's
San Francisco, CA

Enhanced Care Management Target Populations

Population	Description
Homeless	Individuals and families (including children) experiencing homelessness and who have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage
High utilizers adults	Adult high utilizers with five or more preventable emergency room visits, or 3 or more unplanned hospital and/or short-term skilled nursing facility (NF) stays in a 6-month period
SMI/SUD risk adults	Adults with county severe mental illness (SMI) or substance use disorder (SUD) diagnosis *and* experiencing one complex social factor, and are (high risk or institutionalization, or user of crisis services, two or more ED visits or IP in past 12 months due to SMI/SUD-related hospitalizations, or pregnant)
Nursing facility diversion	**Adults at risk for long-term care (LTC) institutionalization who, in the absence of services and supports, would otherwise require care for 90 consecutive days or more in an inpatient NF**
Nursing facility transition	**Adult NF residents who want and, with supports, are able to transition to the community**
Jail transition adults	Adults transitioning from incarceration in the past 12 months who have a chronic mental illness, chronic disease, SUD, intellectual or developmental disability, traumatic brain injury (TBI), HIV, or pregnancy
Children and youth	High utilizers; complex physical, behavioral, or developmental health needs; serious emotional disturbance; California Children's Services (CCS), child welfare (including foster care); incarcerated and transitioning

Community Supports

- Implemented Statewide in January 2022
- New services can be added every six months
- Expands on Whole Person Care Services and SDOH efforts
- Goal is to build capacity to fully integrate into MLTSS in 2027

CS

- **SNF Transition Services**
  - **RCFE, ARF, Board and Care**
  - **Transition CM services**
- Housing Navigation
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short Term Post Hospitalization Housing
- Recuperative Care
- Day Habilitation Programs
- Non-IHSS Personal Care/Homemaker Services
- Home Modifications
- Meals/Medically Tailored Meals
- Sobering Centers
- Respite (for caregivers)
- Asthma Remediation

Potential Impact on LTC

Challenges	Short-term impact on LTC referrals and census
	Adapting to new authorization processes
	Adapting to new claims/billing processes
	Working with multiple plans/processes
	Meeting more robust training/reporting requirements
	Health Plan learning curve on new populations/services
	It takes time to build the new levels of trust needed to succeed
	Learning how to leverage plan resources to navigate barriers

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Questions

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

CalAIM: Opportunities with Enhanced Care Management & Community Supports

Nov. 16, 2021

Katherine Barresi, RN, BSN, PHN, CCM
Director Care Coordination

Partnership HealthPlan of California

- Began in 1994, Solano County
- We are a non-profit, County Organized Health System (COHS) serving the Medi-Cal population in 14 counties in Northern California
- We ensure Medi-Cal recipients have access to high-quality comprehensive cost-effective health care.

To help our members, and the communities we serve, be healthy

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Partnership HealthPlan of California

Phase I: ECM & Community Supports (ILOS) – start 1/1/22

- Marin
- Napa
- Mendocino
- Shasta
- Sonoma

Phase II: ECM & Community Supports (ILOS) – start 7/1/22

- Yolo
- Lake
- Humboldt
- Del Norte
- Trinity
- Siskiyou
- Modoc
- Lassen
- Solano

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Why This? Why Now?

William

William has always lived alone, all of his extended family lives out of state. He paints houses for a living, however as he got older he was more careful with the jobs he took and avoided ones that required him to go on ladders. 2 years ago he started getting numbness in his feet, and the doctor told him he was prediabetic. He couldn't afford to take time off work to go back to the doctor for a check up, so he just shrugged it off.

One day his feet gave out due to numbness and he fell from a second story apartment complex, breaking multiple bones including his hips. He is told he needs intensive rehab, as well as help with cooking, bathing and managing his medications. He is discharged to a nursing home, ***but he wants to return home.***

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Why This? Why Now?

Currently in Medi-Cal his options for returning home are ***limited.***

- His recovery is slow, complicated by poor diabetic control, diagnosed heart failure and Chronic Kidney Disease. He stays in the nursing home for several months.
- He is not able to work as a painter, resulting in the loss of his apartment.
- While in the facility he receives daily physical and occupational therapy, and gets to a level where he could return home with the right supports, but he doesn't have the resources to find an apartment or caregiver once he goes home.
- As a result, the nursing home becomes his home even though he doesn't need that level of care and wants to return a home of his own.

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Why This? Why Now?

- The thought of not being able to return home makes William depressed, and he becomes reluctant to participate in his plan of care at the facility. He stays in bed most days and starts to develop a bedsore. He also is told that he needs to start Dialysis for his kidney disease.
- William then begins to go in and out of the hospital, because his bedsore is not healing and keeps getting reinfected.
- The staff in the nursing home is worried about him, but the administrator can't ignore that every time he is discharged from the hospital, the care he gets in the nursing home is reimbursed by Medicare at three to four times the payment they get from Medi-Cal for the first 60 days.
- A year after his fall, he is still living in the nursing home and has spent more than three weeks in the hospital in the last six months.

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If CalAIM is Successful…

- William will receive a visit from an ECM care manager shortly after his discharge to a facility.
- The ECM care manager will elicit his goals, and working across the Medicare and Medi-Cal benefits (offered by a managed care plan responsible for both) to help him secure things he may need at home such as: therapy, DME, modifications to his apartment to meet any physical needs, and/or personal care services through an agency while the ECM care manager helps him with his In-Home Supportive Services (IHSS) application and caregiver assignment.
- The ECM care manager will also support his changing needs, organizing transportation to appointments, arranging backup care when his usual IHSS worker is unavailable, and working with his primary care physician and nephrologist, and pharmacist to help simplify his medication regimen.
- A year after his fall, he will be living at home with the care he needs to keep him out of a nursing home or hospital.

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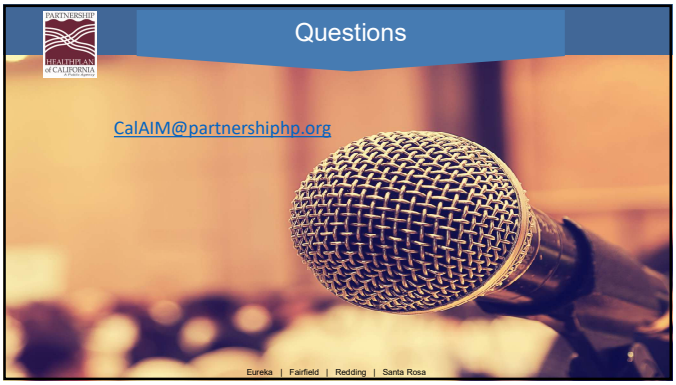
Opportunities in CalAIM

- Alignment in services and benefits
- Enhanced person-centered care
- Greater cross sector partnerships
- Better use of finite resources
- Innovation
- Data Integration
- Incentive dollars & benefit growth

Questions



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