CalAIM Enhanced Care Management

Objectives

- Background of CalAIM
- Goals of Enhanced Care Management
- Core components of Enhanced Care Management
- Structure of Enhanced Care Management
- Fiscal Assumptions
- Additional Funding opportunities
- Summary & Discussion

CalAIM

- Adopted by Department of Health Care Services (DHCS) after Center of Medicaid and Medicare services approval on December 29, 2021 after almost a year of public comments and planning.
  - CalAIM was informed by multiple taskforces and two pilot projects, Whole Person Care and Health Homes Program.
- Three main goals of CalAIM
  - Identify and manage comprehensive needs through whole person care approaches and social drivers of health.
  - Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.
  - Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility.
- Enhanced Care Management, one component of the larger CalAIM initiative, assists with all portions of all three goals of CalAIM

Goal 1 - Whole Person Care Approaches

- Enhanced Care Management (ECM) begins with a complete assessment of the eligible individual to determine their baseline and future goals for:
  - Physical Health
  - Behavioral Health
  - Social Factors like housing, access to food/water, education, consistent income sources, ETC
  - Personal motivation
- Eligible individual works with a Multi-Disciplinary Team to establish goals.
  - Multi-Disciplinary Team can include LCSW, Nurse, AOD, Social Worker, Self-Sufficiency Counselor, other various community or health Providers, support system of eligible individual, and any other entity or person the eligible individual wants to include in their team.
- Lead Case Manager and Community Health Worker assist eligible individual with achieving the established goals.

Goal 2 – Improve Quality Outcomes

- Encourage and teach self management skills needed for their physical and/or behavioral health condition(s) up to and including those with addictions.
- Connect eligible individuals with appropriate services that best address their needs including those associated with social factors such as housing, access to food/water, education, reliable source of income including employment or disability, ETC.
- Guide eligible individual through the sometimes confusing networks of care including primary care, specialty care, health insurance authorization processes, government and community resources, ETC.

Goal 2 – Reduce Health Disparities

- ECM has a total of seven Populations of Focus (PoF) that target individuals that typically have higher levels of health disparities.
- The seven PoF are:
  - Homeless adults & children
  - Severe Mental Illness & Substance Use Disorder (SMI/SUD) adults
  - High Utilizers
  - Justice Involved adult and children
  - Nursing Facility Transition
  - Nursing Facility Diversion
  - Children/Youth (Foster Care, Ca. Children Services, Severe Emotional Disorder, High Utilizer)

Goal 3 – Reducing Complexity

- Every enrolled eligible individual will be assigned an LCM as a primary point of contact for ECM services.
- Each LCM will be part of a larger Multi-Disciplinary Team to support LCM with understanding and navigating each system of care in a holistic way.
- Entire team will be trained and provided resources to identify and connect eligible individuals with the various resources in the community as well as peer reviewed best practices in assisting those with co-occurring complex needs.

ECM Core Components

1. Outreach & Engagement
   - Primarily in person and in settings most comfortable for the eligible individual (home, encampment, community)
2. Assessment & Care Plan
   - Information gathered regarding all aspects of the person which are incorporated into a person-centered care plan
3. Care Coordination
   - All services and organizations stay in communication through LCM
4. Health Promotion
   - Education and accountability for self management skills needed for chronic conditions
   - Linkage and accountability for necessary health appointments
5. Transitions in care
   - Ensuring all elements are in place when an eligible individual transitions from one setting to another
6. Promotion of Social and Family Support
   - Help eligible individual build social and family support systems
   - Education and mentorship with support system to providing the appropriate support for the eligible individual
7. Referrals and follow through with various services available in the community
   - Connecting eligible individuals with government and community provided resources to address their needs

Structure of ECM

DHCS

- Provides the overall guidance including minimum levels of qualification and service delivery.
- Provides funding for ECM
- Contracts with Managed Care Plan for create and monitor network of care for ECM

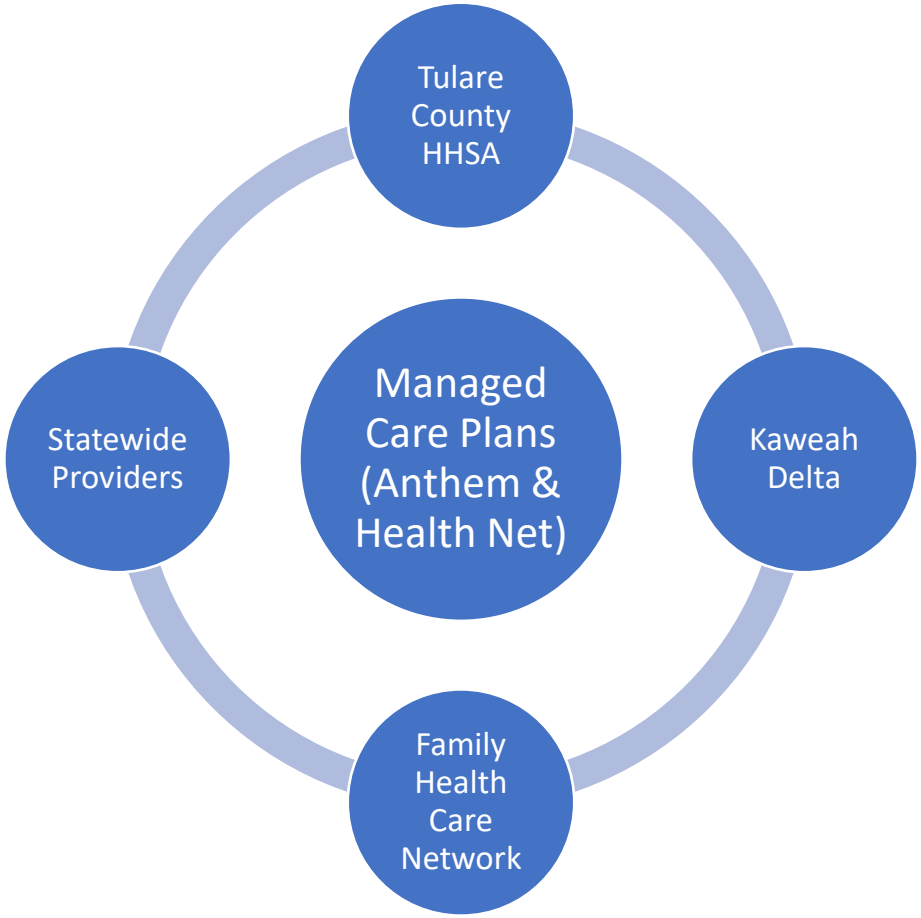
Managed Care Plan

- Develop network of Providers in each county to administer ECM.
- Certify Providers meet minimal qualifications to administer ECM.
- Monitor service delivery of Providers.

Provider (Tulare County HHSA)

- Administer ECM services to the following PoF:
  - Homeless
  - SMI/SUD
- Obtain certification for additional PoF in future months.
  - Incarcerated adults/children
  - Children/Youth (SED, CCS, & Foster Care)

Structure of ECM - Network of Care



Structure of ECM - Funding

Anthem

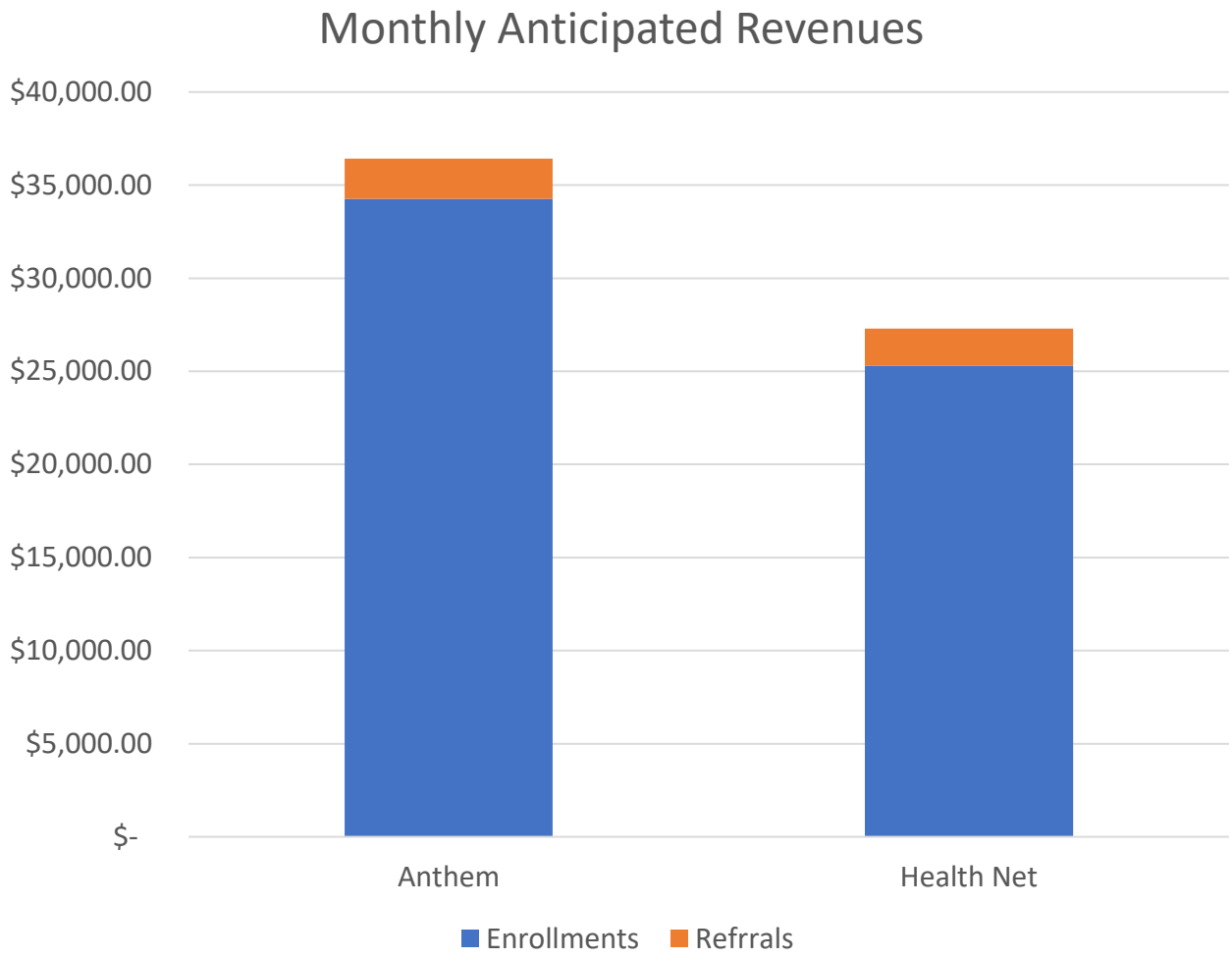
- Funding is based on a Per Member Per Month (PMPM) structure.
  - Flat rate paid upon the first interaction with the eligible individual within the calendar month.
- Funding is received after services are provided.
- Payment is received within 30-90 days.
- One time outreach payment per referral.

Health Net

- Funding based on a Fee for Service (FFS) structure.
  - Rate fluctuates depending on staff and type of interaction. No caps on number of payments per month.
  - Rates range from $30-94.
- Funding received after services are provided
- Payment received within 45-90 days
- One time outreach payment per referral.

Fiscal Assumptions

- Total caseload size of 200 eligible individuals that are receiving services.
- Assumed a 50/50 split between the two Managed Care Plans (Anthem & Health Net)
- Assumed a total of 2 In Person visits and 2 telehealth visits per individual with LCM/CHW and 1 Multi-Disciplinary Team meeting per individual.
- 20 completed referrals per month. (10% of caseload cap)
- 25% of individuals receive both Medi-Cal and Medicare (Dual)
- Amounts reflect a per month revenue flow for services provided.



Additional Funding Opportunities

Incentive Payment Program (IPP)

- Managed Care Plans (Anthem & Health Net)
- Offset costs of hiring, training, and implementing IT solution(s).
- Managed Care Plans determine when/where the funds are administered and the final purpose.
- Flexible and must show how funds will help with implementing ECM and a related service called Community Supports.

Providing Access & Transforming Health (PATH)

- Department of Health Care Services (DHCS)
- Various rounds and targeted organization types for funding.
- Each round has a different focus but initial guidance includes Technical Assistance for ECM implementation, transition from Whole Person Care to ECM, IT & Communication development.