CalAIM Implementation in Sacramento County

Program Updates for Sacramento County Health Authority Commission

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MOLINA HEALTHCARE

Today's Purpose

1. Overview of Medi-Cal Managed Care Plan (MCP) CalAIM Collaboration
2. Enhanced Care Management (ECM) Benefit and Community Supports Implementation Update
3. Street Medicine Implementation Update
4. Looking Ahead – What's Next in 2024?

Overview of Medi-Cal Managed Care Plan (MCP) CalAIM Collaboration in Sacramento County

MCP CalAIM Collaboration in Sacramento County

- Sacramento Medi-Cal managed care plan (MCP) collaboration is a cornerstone of CalAIM implementation in Sacramento County.
- Joint MCP collaboration activities, include but are not limited to, the following:
  - Joint standing workgroups with Sacramento County and Sacramento Steps Forward
  - Launched Sacramento County CalAIM Roundtables in 2022 to ensure there was a transparent, inclusive forum to engage stakeholders to assess CalAIM implementation in Sacramento County.
  - Partnered on joint ECM and Community Supports application process to minimize provider burden
  - Aligned on joint ECM Referral Form to minimize provider burden
  - Collaborated on joint investments:
    - CalAIM Incentive Payment Program (IPP)
    - Housing and Homelessness Incentive Program (HHIP)
    - Student Behavioral Health Incentive Program (SBHIP) investments
  - Aligned on joint Population Health Management (PHM) Program Strategy Deliverable SMART goals

Enhanced Care Management (ECM) Benefit and Community Supports Implementation in Sacramento County

A Journey to a Healthier California for All

CalAIM is a long-term commitment to transform and strengthen Medi-Cal, making the program more equitable, coordinated, and person-centered to help people maximize their health and life trajectory.

ENHANCED CARE MANAGEMENT (ECM):

- **ECM is a benefit**, and is intended to be rendered in person
- **The role of the ECM provider** is to coordinate all services and supports for the member, including participating in the care planning process, regardless of setting
- Serves specific **Populations of Focus** who have complex care needs or are otherwise vulnerable

ECM Core Service Components:

- Outreach & engagement
- Comprehensive Assessment & Care Management Plan
- Enhanced Coordination of Care
- Health Promotion
- Comprehensive Transitional Care
- Member & Family Supports
- Coordination of Referral to Community & Social Support Services

COMMUNITY SUPPORTS (CS):

- **Community Supports** are services that help address members' health related social needs, help them live healthier lives, and avoid higher, costlier levels of care

Community Supports Services (14 services in all):

- Housing: Navigation Services, Deposits, Tenancy and Sustaining
- Short-Term Post-Hospitalization Housing and Recuperative Care
- Day Habilitation Programs and Sobering Centers
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Respite Services, Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically-Tailored Meals or Medically-Supportive Foods
- Asthma Remediation

Enhanced Care Management (ECM) Benefit Populations of Focus

- Individuals Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experiencing Homelessness
- Individuals Experiencing Homelessness: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness
- Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly “High Utilizers”)
- Individuals with Serious Mental Health and/or SUD Needs
- Individuals Transitioning from Incarceration
- Adults Living in the Community and At Risk for LTC Institutionalization
- Adult Nursing Facility Residents Transitioning to the Community
- Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition
- Children and Youth Involved in Child Welfare
- Birth Equity Population of Focus

2023 Q3 ECM Enrollment Data – Sacramento County

Population of Focus	Aetna	Anthem	HealthNet	Kaiser Permanente	Molina	Total
	Q3 2023	Q3 2023	Q3 2023	Q3 2023	Q3 2023	Q3 2023
Adult – At Risk for Institutionalization eligible for LTC	58	36	1	4	4	81
Adult – Experiencing Homelessness	130	370	170	221	19	540
Adult – High Utilizers	363	311	494	115	309	1305
Adult – Nursing Home Transition to Community	15	4	21	0	0	38
Adult – Transitioning from Incarceration (WPC)	0	4	9	-	6	16
Adult – SMI/SUD	343	797	251	202	318	1227
Child – Homelessness	2	8	2	42	0	46
Child – High Utilizers	0	3	4	7	14	25
Child – SED	6	10	11	38	2	57
Child – Child Welfare	2	0	3	17	0	22
Child – CCS	2	0	2	2	0	6
Total	921	1543	1106	648	672	4890

2023 Q3 Community Supports Enrollment Data – Sacramento County

Community Support	Aetna	Anthem	HealthNet	Kaiser Permanente	Molina	Total
	Q3 2023	Q3 2023	Q3 2023	Q3 2023	Q3 2023	Q3 2023
Housing Transition Navigation Services	101	1520	312	564	151	**2648**
Housing Deposits	6	159	15	126	26	**332**
Housing Tenancy and Sustaining Services	0	176	60	13	3	**252**
Short-Term Post-Hospitalization	0	0	2	0	4	**6**
Recuperative Care (Medical Respite)	8	23	27	0	9	**67**
Respite Services	0	2	0	0	1	**3**
Day Habilitation Programs	0	14	0	0	0	**14**
Nursing Facility Transition/Diversion to Assisted Living Facilities	2	161	0	0	0	**163**
Community Transition Services	2	0	0	0	0	**2**
Personal Care and Homemaker Services	0	19	7	0	11	**37**
Environmental Accessibility Adaptations	0	4	0	0	0	**4**
Medically Tailored Meals/Medically-Supportive Food	9	82	70	0	25	**186**
Sobering Centers	13	0	18	0	20	**51**
Asthma Remediation	0	0	0	0	0	**0**
Total	141	2160	511	703	250	**3765**

Aligned MCP CalAIM Incentive Payment Program (IPP) Investments in Sacramento County

Joint MCP IPP Investments	Amount
IPP Round 1 – 15 Sacramento County providers funded	$3,527,015.32
IPP Round 2 – 16 Sacramento County providers funded	$3,240,956.30
Sacramento County Social Health Information Exchange (SHIE)	$9,863,796.00
Total	**$16,631,767.60**

*Amounts to Sacramento County providers do not reflect funding a provider may have received through DHCS PATH Capacity and Infrastructure Transition, Expansion and Development (CITED) Rounds 1 or 2, or PATH Technical Assistance Marketplace.

Street Medicine Implementation in Sacramento County

“The fundamental approach of street medicine is to engage people experiencing homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through.”

– Street Medicine Institute

Street Medicine Overview

Street medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment through street medicine providers in the role of the Member's assigned Primary Care Provider (PCP), through a direct contract with the Plan, as an ECM Provider, as a Community Supports Provider, or as a referring or treating contracted Provider.

Street Medicine Provider: Refers to a licensed medical provider (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas).

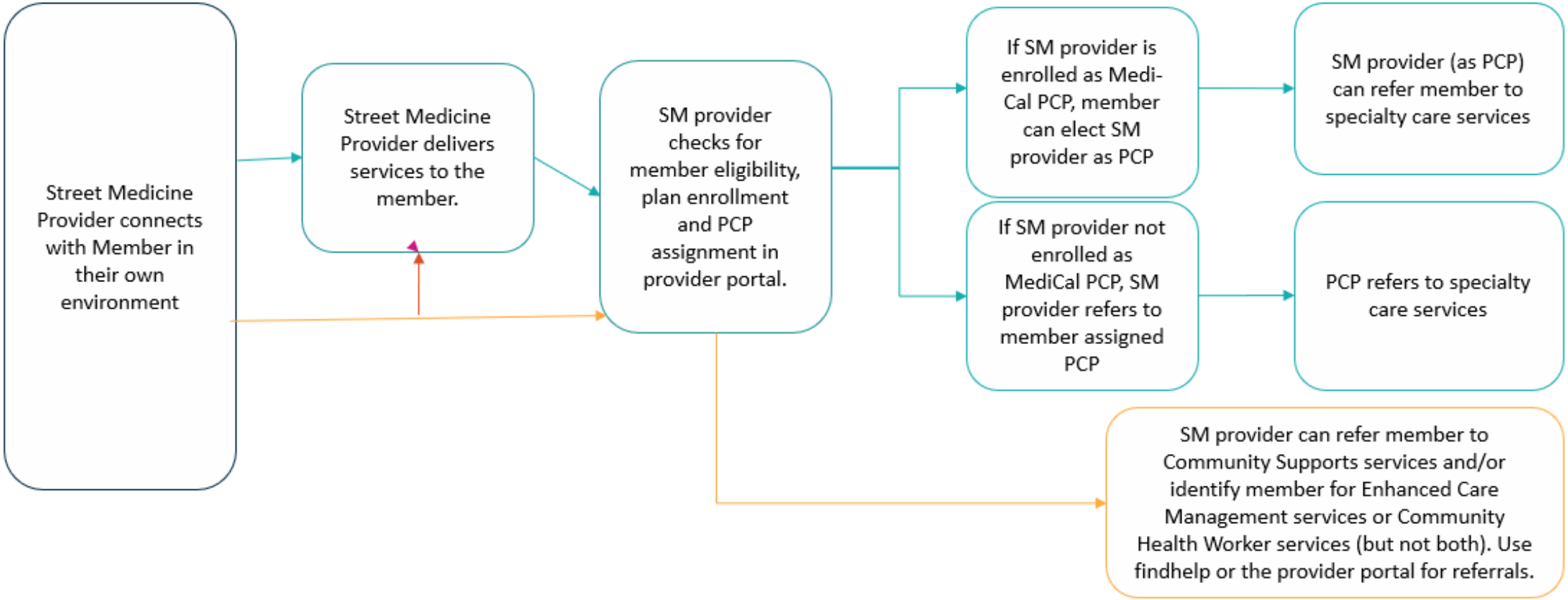
Primary Care Provider (PCP): Providers can elect to serve as PCPs. In order to serve as a PCP, the street medicine Provider must meet the Plan eligibility criteria for being a PCP, be qualified and capable of treating the full range of health care issues served by PCPs within their scope of practice and agree to serve in a PCP role.

Street Medicine Services

Street Medicine Providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, including but not limited to:

- Basic Case Management (with transition to Basic Population Health Management when effective);
- Care coordination and health promotion;
- Support for Members, their families, and their authorized representatives;
- Referral to Specialists, including behavioral health
- Referrals to long-term services and supports, community-based organizations, and social support services, when needed;
- The use of Health Information Technology to link services, as feasible and appropriate; and
- Provision of primary and preventative services to assigned Members.

Street Medicine Referral Pathway to Specialists and other Services



Aligned MCP Housing and Homelessness Incentive Program (HHIP) Investments in Sacramento County

Joint MCP HHIP Investments	Amount	Recipient
Street Medicine Capacity Building	$2,233,147	Various Providers
Continuum of Care infrastructure support – funds used to support staffing, consultation, technology, trainings; intake/referral network including data management and reporting/HMIS; equity initiatives; street outreach, Coordinated Access, diversion and housing navigation	$ 3,860,064	Sacramento Steps Forward
Sacramento County Homeless Outreach Expansion Pilot	$2,000,000	Community HealthWorks
Sacramento County Landlord engagement and housing lease up support	$3,461,937	Sacramento County
Total	**$11,555,148**	

Looking Ahead – What’s Next in 2024?

Medi-Cal Program Changes in 2024 and Beyond

2024	• **RFP activities:** Member transitions, Continuity of Care, and implementation of new MCP contract requirements • **Phased Implementation of ECM continues**: Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes who are subject to racial and ethnic disparities. • **Dual Special Needs Program (DSNP) expansion** • **Justice-Involved Initiative:** Justice Involved Individuals eligible to participate in ECM and CS. • Correctional Facilities 24-month phase-in pre-release services begins 4/1/24 through 3/31/2026 • **Phase II of LTC Carve-in**, beneficiaries in **ICF/DD & Subacute Care Facilities** will be carved into Managed Care • **PHM:** Basic Population Health Management & Transitions of Care Services for all Members • No sooner than 2024, **Statewide All-Payer Fee Schedule** and Behavioral Health Network • Transition the **Child Health & Disability Prevention (CHDP) Program** to administration and coordination to MCPs • **Eligibility Efficiencies:** Undocumented individuals ages 26-49 transition to Managed Care, continuous coverage 0-5, and assigning newborns to Managed Care within 24 hours – 5 days of life
2025	• **Dual Special Needs Program (DSNP) expansion –** impacted counties are TBD • Continuous **Coverage for Age 0-5** & Share of Cost Reform – Federal approval required
2026	• NCQA accreditation for Medi-Cal MCPS and subcontractors • Correctional Facilities complete go-live for pre-release services • Statewide DSNP and Aligned Enrollment • All Diversity Equity Inclusion (DEI) training requirements met – Pending DHCS to publish APL and confirm timing.
2027	• Statewide Medi-Cal Long Term Services & Supports (MLTSS) • LTSS Distinction