CalAIM 101

October 23, 2024

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

in partnership with

Institute *for* Healthcare Improvement

Agenda

Your CalAIM journey
Medi-Cal and CalAIM
How CalAIM works
Next steps

Your CalAIM Journey

Where are you in your CalAIM journey? Please select the answer that best fits your situation.

1. I am curious and want to learn more about it.
2. My organization is new to CalAIM and wants to learn more.
3. My organization wants to explore contracting to become a CalAIM Enhanced Care Management and/or Community Supports provider.
4. My organization is a contracted CalAIM Enhanced Care Management and/or Community Supports provider, and I’m new to this work and want to learn more.
5. My organization wants to learn more about referring clients to CalAIM services.
6. Other

CalAIM: California Advancing and Innovating Medi-Cal

- California's unprecedented 5-year, multi-billion-dollar plan to:
  - Advance the Medi-Cal program
  - Make it more streamlined and community-based
  - Expand the network of community partners
  - Ensure Medi-Cal services are more equitable, coordinated, and person-centered
- Multiple initiatives and measurement dashboards at county level: https://calaim.dhcs.ca.gov/

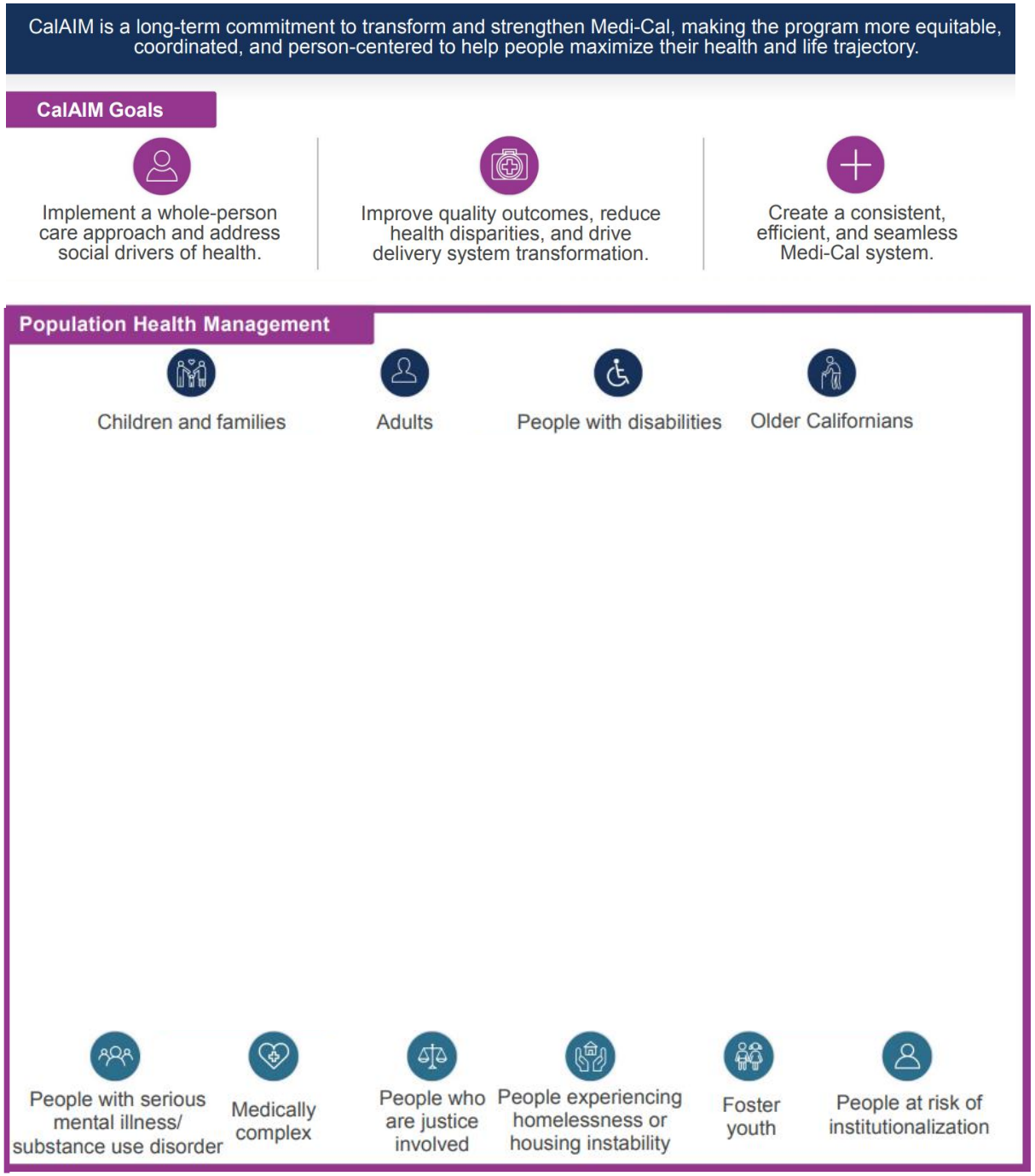
CalAIM Overview: Goals

Help Medi-Cal members thrive

CalAIM Overview:
People Served

Traditional
1. Children and families
2. Adults
3. People with disabilities
4. Older Californians

CalAIM Populations of Focus
1. People with serious mental illness/ substance use disorder
2. Medically complex: Individuals who are at risk of avoidable hospital or emergency care
3. People who are justice-involved
4. People experiencing homelessness or housing instability
5. Youth enrolled in CCS or child welfare (foster care)
6. Nursing facility residents transitioning to community
7. People at risk of long-term care institutionalization
8. Birth equity



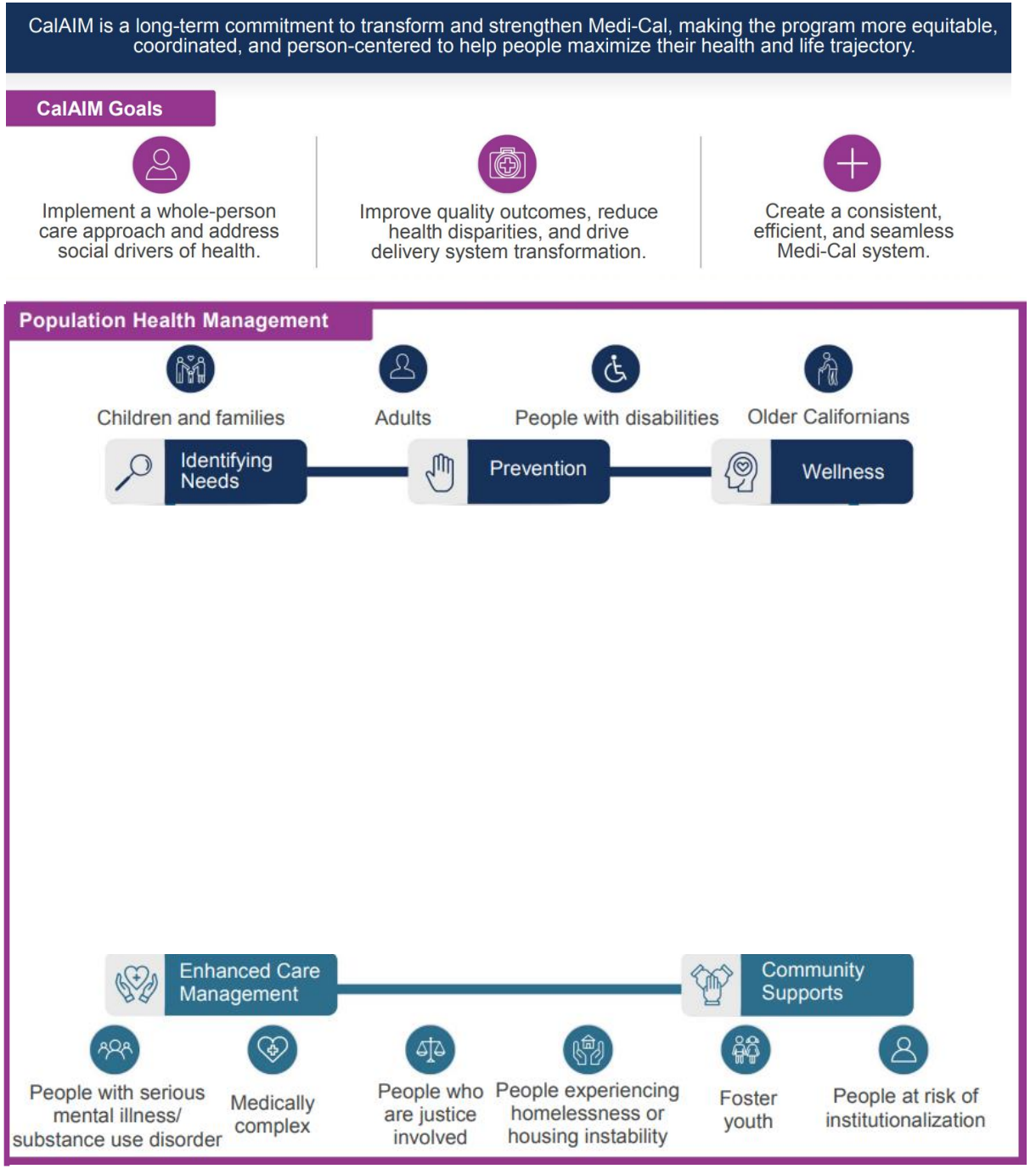
CalAIM Overview: Areas of Service and Support

Traditional

1. Identifying needs
2. Prevention
3. Wellness

CalAIM Additions

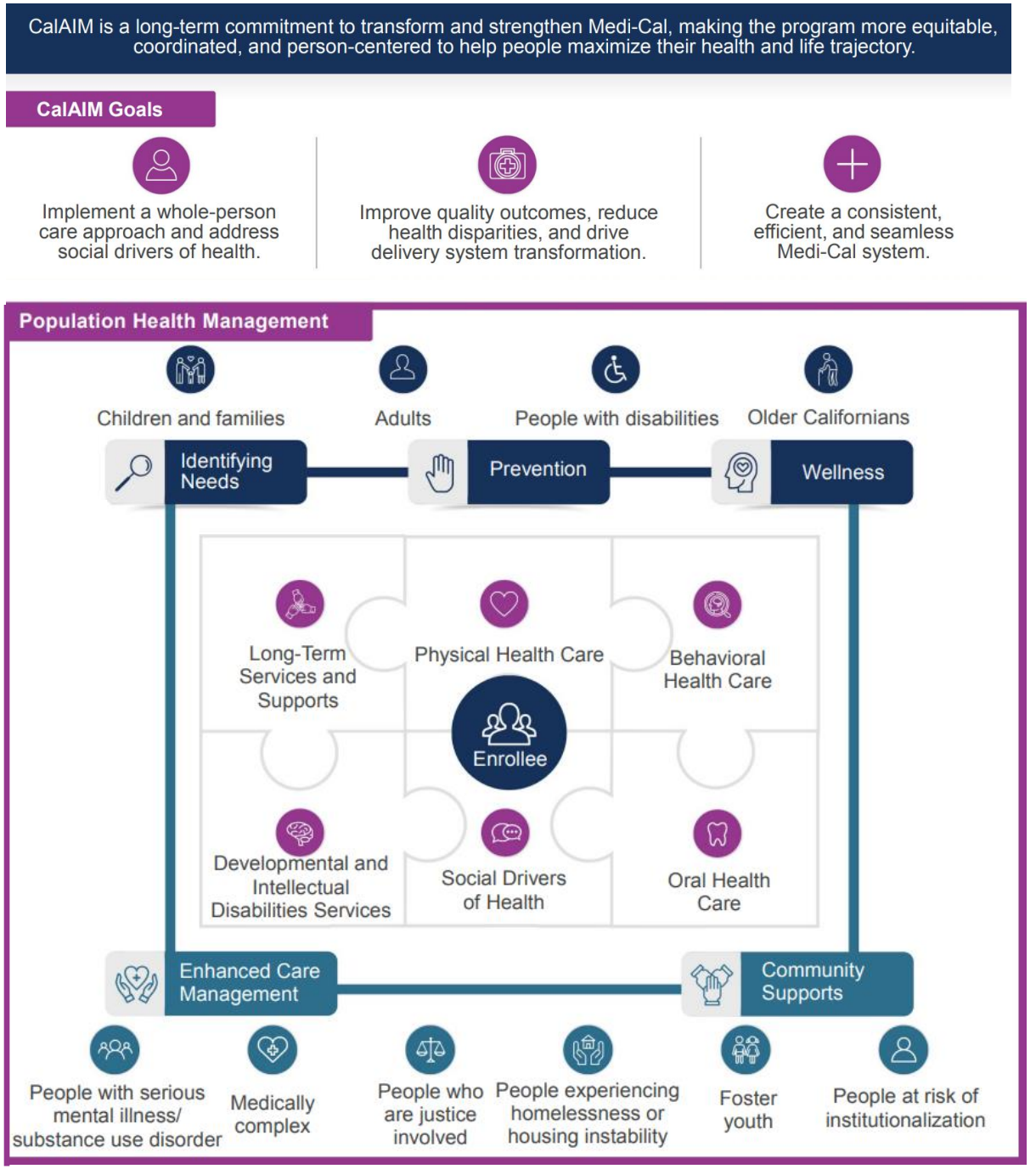
1. Enhanced Care Management (ECM)
2. Community Supports

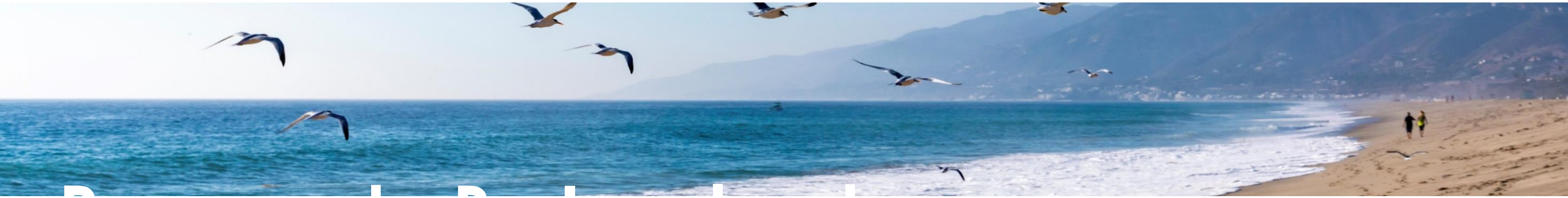


CalAIM Overview: Care Connections

Enrollee is at the center of services:

1. Long-term services and supports
2. Physical health care
3. Behavioral health care
4. Developmental and intellectual disabilities services
5. Social drivers of health
6. Oral health care





1. Make a difference in members' lives
    a) CalAIM can improve and lengthen lives by addressing the factors that affect members' ability to access health care services, follow care plans and live healthy.

2. Build your services for your community
    a) Expand and coordinate services for clients by connecting with other providers.
    b) Tap sustainable and targeted funding sources.
    c) Use CalAIM funds to invest in your infrastructure and capacity to serve more community members.

3. Improve your community's health by working together to serve unmet needs
    a) Develop Enhanced Care Management and/or Community Support services that help people in your community live their best lives and become community contributors.
    b) Better serve your community by being part of your community and attracting investment.
    c) Build a network to care for the clients that you and other organizations are serving.
    d) Be better stewards of your community's limited resources.
    a) Build services that are needed the most.

How CalAIM Works

How CalAIM Works

Department of Health Care Services (DHCS)

- DHCS sets objectives, targets, and reporting requirements for managed care plans.
- Managed care plans are also required to submit and publish gap-filling plans to achieve targets.

Managed Care Plans

- Managed care plans contract with community-based organizations and others to provide Enhanced Care Management and Community Support services to meet DHCS objectives.

Enhanced Care Management

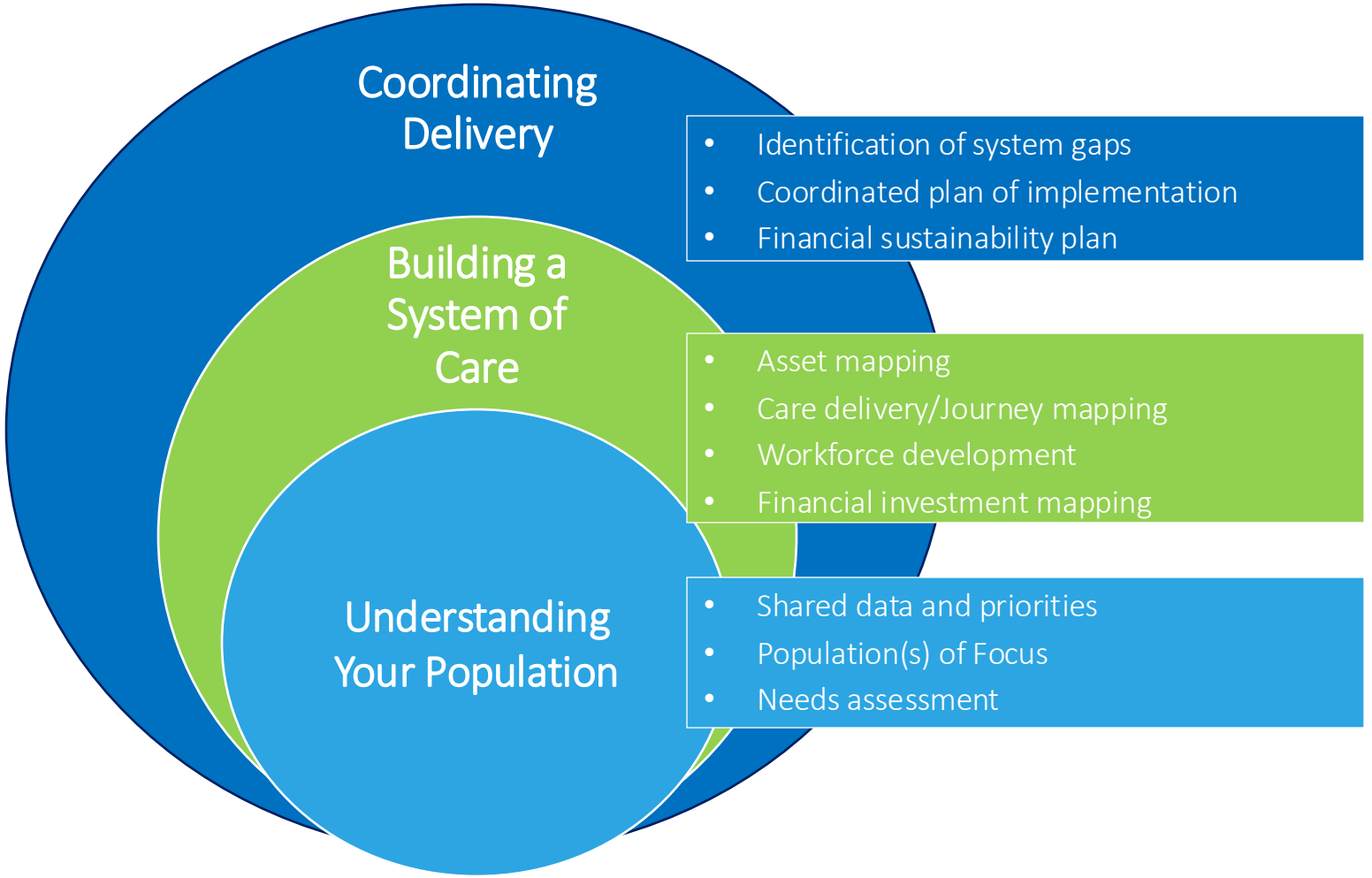
Community Supports

- Enhanced Care Management and Community Supports providers work closely with managed care plans to 1) understand requirements and processes, and 2) meet goals and gap-filling plans.
- Providers are expected to report on their results.

- Contracting with managed care plans also gives providers access to other DHCS funding sources.

Building a Connected Community of Care

CalAIM as a Community of Care for Socially Complex Communities



Source: https://www.bettercareplaybook.org/_blog/2019/1/using-asset-maps-match-community-supports-patients-complex-care-needs-interview-camden

Enhanced Care Management (ECM) and Community Supports Benefits

Enhanced Care Management (ECM):

A Medi-Cal managed care benefit that addresses the clinical and non-clinical needs of high-need, high-cost individuals through the coordination of services and comprehensive care management.

Enhanced Care Management benefits give Medi-Cal members with complex needs the support that will help them stay healthy and thrive.

Community Supports (CS):

Optional non-clinical services provided by Medi-Cal Managed Care Plans to help avoid utilization of other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

Community Supports are designed for members' social needs. Members can now receive healthy food, housing support, and other services as Medi-Cal benefits.

Both ECM and Community Supports are administered by Medi-Cal managed care plans.

Plans are listed by county at this link:
https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

ECM Populations of Focus

	Populations of Focus	Adults	Children & Youth
1	Individuals Experiencing Homelessness	✓	✓
2	Individuals at Risk for Avoidable Hospitalization or ED Utilization	✓	✓
3	Individuals with Serious Mental Health and/or Substance Use Disorder Needs	✓	✓
4	Individuals Transitioning from Incarceration (October 2024)	✓	✓
5	Adults Living in the Community and at Risk for Long-Term-Care 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 (MCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity	✓	✓

Details about Populations of Focus may be found in the Enhanced Care Management Policy Guide.

7 Core ECM Services

- 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

Community Supports

14 Community Supports Benefits

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Day Habilitation Programs
7. Caregiver Respite Services
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications)
12. Medically Supportive Food/Meals/Medically Tailored Meals
13. Sobering Centers
14. Asthma Remediation

More information: Community Supports Policy Guide

Community Supports Elections by County

What are Community Supports?

Community Supports (CS) are non-medical, wrap-around services provided as a substitute or support to avoid other Medi-Cal covered services such as emergency room visits, an avoidable hospital or skilled nursing facility admission, or a discharge delay.

Supports for Housing Insecurity

Primary Audience: Individuals experiencing homelessness

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy & Sustaining Services
4. Short-Term Post Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Day Habilitation

Supports to Keep People at Home

Primary Audience: Individuals at risk for institutionalization in a nursing home

7. (Caregiver) Respite Services
8. Nursing Facility Transition/ Diversion to Assisted Living Facilities
9. Community Transition Services/ Nursing Facility Transition to a Home
10. Personal Care & Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications)

Supports to Improve a Chronic Condition

Primary Audience: Individuals who have certain chronic conditions and require support

12. Meals/Medically Tailored Meals
13. Asthma Remediation

Support to Recover from Acute Intoxication

Primary Audience: Individuals found publicly intoxicated to divert from jail or the Emergency Department

14. Sobering Centers

Note: majority of the referrals for this service are from law enforcement and stays must be less than 24 hours.

More information: [Community Supports Policy Guide]

CalAIM Funding Streams

CalAIM Sources

1. **Incentive Payment Program** – Provider capacity, infrastructure, quality
   - **Apply through MCP process** – ENDS in 2024
2. PATH CITED – workforce & infrastructure
   - **Final round coming soon**– ENDS December 2025 (average previous awards, $1 million)
3. TA Marketplace – Indirect funding for organizations
   - **Apply here** – ENDS December 2025

Support for Your Services

Funding Opportunities Cheat Sheet (ca.gov)

What is "Providing Access and Transforming Health" (PATH)?

California has received targeted expenditure authority as part of its Section 1115 demonstration renewal for the "Providing Access and Transforming Health" (PATH) program to take the state's system transformation to the next phase, refocusing its uses to achieve the CalAIM vision.

DHCS has received authorization for funding for PATH to maintain, build, and scale the infrastructure and capacity necessary to ensure successful implementation of Enhanced Care Management (ECM) and Community Supports under CalAIM.

PATH is intended to complement and enhance other CalAIM funding efforts and should not serve as a primary source of funding. PATH funding for all initiatives is time-limited and should not be viewed as a sustainable, ongoing source of funding. https://www.ca-path.com/

Section 1115 of the Social Security Act *gives the Secretary of Health and Human Services the authority to approve experimental, pilot, or demonstration projects that the secretary considers likely to help promote Medicaid objectives. These projects give states flexibility to design and improve their programs.*

Source: Medicaid.gov

Collaborative Planning and Implementation Initiative

Background

- **Contracted PATH Third Party Administrator (TPA) works with facilitators** to convene and facilitate a single county or regional collaborative planning efforts
- Collaborative planning efforts seek to build off existing collaborative efforts
- Funding will support the designated PATH collaborative planning facilitator in each county or region (i.e., individual collaborative planning participants will not receive funding)

Collaborative Planning Status

DHCS sponsors collaborative planning groups

- DHCS "matched" approved facilitators to counties and participants based on local needs and stakeholder input
- Collaborative planning group participants can register at any time for groups in their county or region.
- **Participants can register at:** https://ca-path.com/collaborative
- Find a local Collaborative here

CITED Initiative

Background

- **Applicants include organizations that are contracted to provide, or that intend to provide ECM/Community Supports:** County, city, and local government agencies; public hospitals; providers; CBOs; tribal partners; and others, as approved by DHCS
- Applicants must meet **minimum eligibility criteria for CITED** (e.g., completed application, demonstration that funding request is reasonable, and attestation that funding will only be spent on permitted uses)
- **Applications request information on** intended use of CITED funds, justification for why funds are needed, sustainability plan for future funding, and how duplication of funding will be avoided
- **CITED funds may only be used on outlined permissible uses** (e.g., increasing provider workforce; developing or modifying referral, billing, and IT processes; and capacity and infrastructure to deliver ECM and Community Supports)
- https://www.ca-path.com/cited

Technical Assistance (TA) Marketplace Initiative

Background

- Entities may register for hands-on technical assistance support from vendors and access off-the-shelf TA resources in pre-defined TA domains.
- TA resources are provided through a virtual TA "Marketplace."
- Vendors contract to provide TA services to eligible entities as part of the marketplace

  Technical assistance resources may include, for example:
  - Hands-on trainings for ECM / Community Supports providers on billing and reporting requirements or contracting with health plans
  - Guidance for data-sharing processes between ECM / Community Supports providers and health plans
  - Accelerated learning sessions or computer-based learning modules for CBOs
  - Strategic planning consultations for entities implementing ECM / Community Supports
  - Customized project-specific support provided by vendors registered with the TA Marketplace

More information: https://www.ca-path.com/ta-marketplace

Justice-Involved Capacity Building Initiative

Background

- **Approved CalAIM 1115 waiver authorizes $151 million** to support collaborative planning and investments in infrastructure, capacity, and IT modifications necessary to support implementation of justice-involved (JI) pre- release Medi-Cal application and suspension processes
- **California statute required all counties to implement pre-release Medi-Cal application** to ensure all eligible individuals released from correctional institutions receive timely access to Medi-Cal services
- **Funding will support correctional institutions, correctional agencies, and county departments of social services** as they develop protocols and workflows and implement IT system upgrades to support pre-release enrollment and suspension processes
- **Approved funding is being made available in two rounds:** the first providing small planning grants and the second providing larger application-based grants to support implementation/modification

For more information: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/home.aspx

Ways to Engage in CalAIM

Connect with the managed care plans in your county

Engage in Collaborative Planning and Implementation Groups

Participate in monthly CalAIM Provider Forum, third Wednesday, 2-3 p.m. PT

Drop in to monthly Office Hours, first Thursday, 1-2 p.m. PT

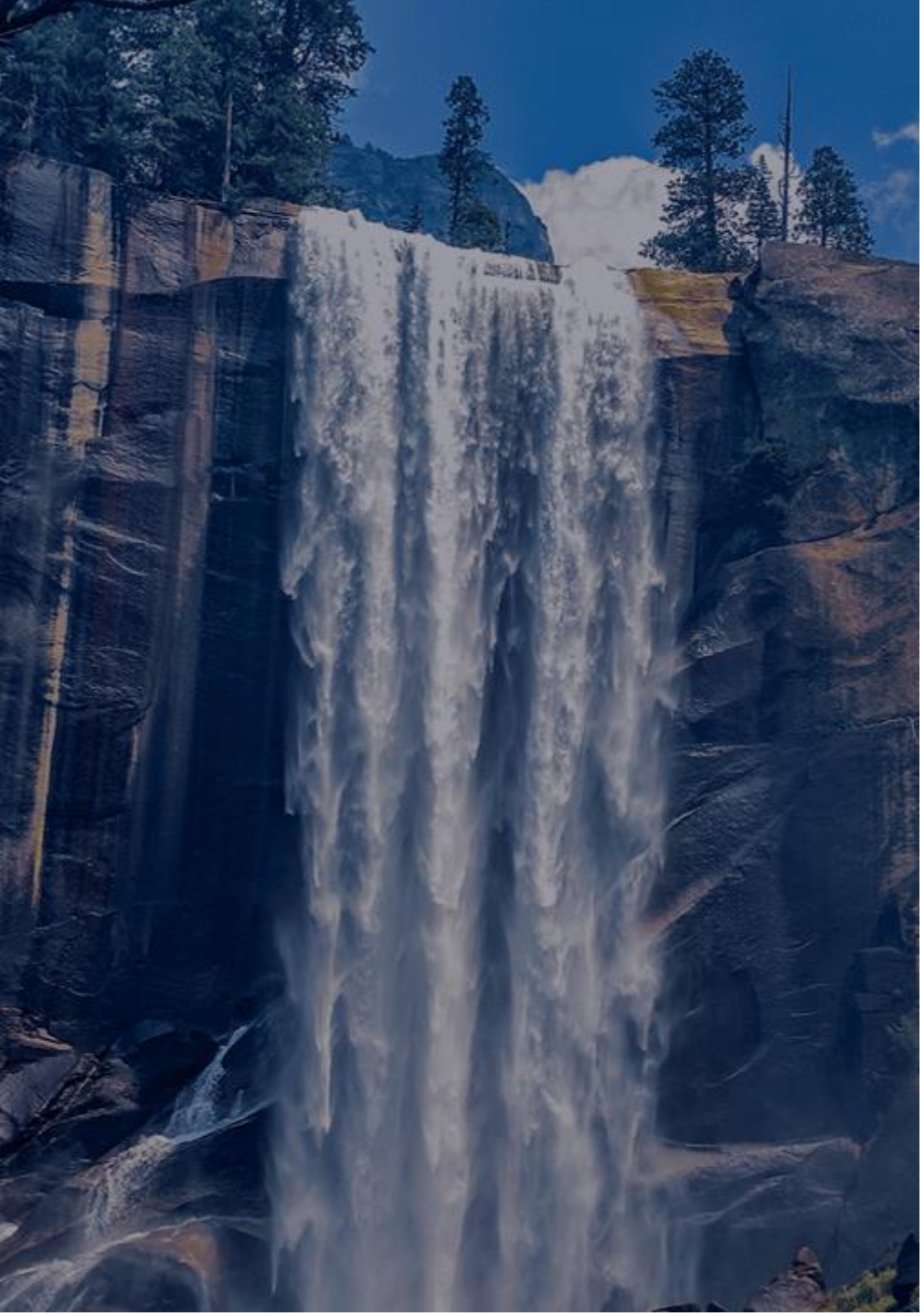
CalAIM Peer Coaching Circles

Access DHCS resources: https://www.dhcs.ca.gov/calaim

- Webinars
- Office Hours
- Online resources
- Managed care plans' gap-filling plans
- Stakeholder email
- PATHways Success Stories website and story submission form

Access CalAIM funding opportunities

- Incentive Payment Program (IPP)
- PATH CITED



Discussion

- Why CalAIM interests you
- Your questions

Thank you!

Appendix

Acronyms

BH-QIP = Behavioral Health Quality Improvement Program

CES = coordinated entry system

CITED = Capacity and Infrastructure Transition, Expansion and Development

CoC = continuum of care

CS = Community Supports (also known as ILOS or In Lieu of Service)

ECM = Enhanced Care Management

FQHC = Federally Qualified Health Center

HHAP = Homeless Housing, Assistance and Prevention Program

HHIP = Housing and Homelessness Incentive Program

HIPAA = Health Insurance Portability and Accountability Act (patient privacy regulations)

HIT = health information technology

Acronyms

HMIS = homeless management information system

ILOS = In Lieu of Service (also known as Community Supports or CS)

IPP = Incentive Payment Program

PIT = Point in Time homeless survey

LHP = Local Homelessness Plan

MCP = Managed Care Plan

PATH = Providing Access and Transforming Health Program

SB-HIP = Student Behavioral Health Improvement Program

TA = technical assistance

Key Terms

California Advancing and Innovating Medi-Cal (CalAIM): CalAIM is a DHCS initiative to reform the Medi-Cal program and, in turn, improve the quality of life and health outcomes of Medi-Cal members.

Community Supports or In Lieu of Service (ILOS): Services that Medi-Cal managed care plans have the option to provide as a substitute to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

Data-Sharing Agreement (DSA) or DUA (Data-Use Agreement): A data-sharing agreement is a formal contract that clearly documents what data are being shared and how the data can be used. Such an agreement serves two purposes. First, it protects the agency providing the data, ensuring that the data will not be misused. Second, it prevents miscommunication on the part of the provider of the data and the agency receiving the data by making certain that any questions about data use are discussed before the data is shared (University of Chicago, 2011).

Key Terms

Department of Health Care Services (DHCS): is the department within the California Health and Human Services Agency that helps provide low-income and disabled Californians' access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services, and long-term care.

Enhanced Care Management (ECM): A Medi-Cal managed care benefit that will address clinical and non-clinical needs of high-need, high-cost individuals through coordinated services and comprehensive care management.

Managed Care Plan (MCP): MCPs provide health care services for their members through contracts with health care providers and medical facilities. These providers and facilities make up the plan's network.

Protected Health Information (PHI): Protected health information includes all individually identifiable health information, including demographic data, medical histories, test results, insurance information, and other information used to identify a patient or provide healthcare services or health care coverage. 'Protected' means the information is protected under the HIPAA Privacy Rule (HIPAA Journal, 2021).

Resources

Billing and Invoicing Guidance: Submission formats, data elements and information about members, services, billing and administration	**CalAIM News and Updates**
Community Supports Policy Guide	**Data-Sharing Guidance:** Steps to ensure that patients' personal health information, or PHI, is shared among health partners while complying with the Health Insurance Portability and Accountability Act (HIPAA)
ECM, Community Supports and IPP information, FAQs and webinars	**ECM Policy Guide**
Coding Options: Codes and modifiers to use when billing for ECM and Community Support services	**Non-Binding Pricing Guidance for Community Supports or ILOS Services:** Tool discusses methodologies and variations in price midpoints and ranges
Medi-Cal Transportation Benefit	**Medically Tailored Meals Spotlight**
PATH Collaboratives **PATH Technical Assistance Marketplace**	**Standard Terms and Conditions for ECM and Community Supports :** DHCS definitions and requirements for providers

IEHP
Inland Empire Health Plan
Live Wholeheartedly.

Enhanced Care Management 101

Health Services Special Initiatives

Matthew Wray, Director

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 means 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.

Enhanced Care Management
- Medi-Cal 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 enrolled in both Medicare and Medi-Cal

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.

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.

Key

Funding opportunities for providers

Benefits/resources for members

Key Statewide requirements/programs

Statewide frameworks

CalAIM Care Management Continuum

As of 2023, MCPs are required to have a broad range of programs and services to meet the needs of all members organized into the following three areas.

Enhanced Care Management (ECM) is for the **highest-need members** and provides intensive coordination of health and health-related services

Complex Care Management (CCM) is for members at **higher- and medium-rising risk** and provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions.

Basic Population Health Management (BPHM). BPHM is the array of programs and services for **all** MCP members, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care.

Transitional Care Services

are also available for all Medi-Cal Managed Care Plan members transferring from one setting or level of care to another.

What is Enhanced Care Management (ECM) ?

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit effective January 1, 2022. ECM aims to provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need members enrolled in Medi-Cal managed care.

The overall goal of the ECM benefit is to provide comprehensive care and achieve better health outcomes for the highest need beneficiaries in Medi-Cal by:

- Improving care coordination
- Integrating services
- Facilitating community resources
- Addressing social determinants of health
- Improving health outcomes
- Decreasing inappropriate utilization and duplication of services

What Services are Covered by ECM

If a Member qualifies for ECM, he/she will get comprehensive care management from a care team which includes a **Lead Care Manager**, who will serve as the Member's main point of contact. The Lead Care Manager can meet the Member where he/she is- on the street, in a shelter, in the doctor's office, or at home to meet the needs of the Member

The Lead Care Manager will work with the Member, Member's doctors and others to get the care the Member needs. The Lead Care Manager can help link the Member to other non-health services, such as housing, food and childcare in the community.

ECM Services May Involve:

- Coordinating care based on Member needs
- Helping understand and manage medications
- Helping to plan visits with the doctor
- Working with the Member's family to improve his/her health

Who can get ECM Services

Populations of Focus

ECM is for Members, regardless of age, who have Medi-Cal with a Managed Care health plan such as IEHP and meet at least one of these groups (called "Populations of Focus"):

ECM Populations of Focus		Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✓	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
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 CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

Highest need/highest cost patients:

- Hospitalization
- Homelessness
- SUD/SMI
- Individuals with the most significant health and social needs

ECM Services

ECM Providers deliver all core service components of ECM to each of the ECM Provider's assigned Members. The core services of ECM consist of the following core services.

There are seven (7) core services at the point of care:

1. Outreach and Engagement
2. Comprehensive Assessment and Care Management Plan
3. Enhanced Coordination of Care
4. Health promotion
5. Comprehensive transitional care
6. Member and family support
7. Coordination of and referral to community and social supports

Who can provide ECM Services?

To become an ECM provider, your organization must be one of the following:

- City/county government agency
- County behavioral health provider
- PCPs or Specialist or Physician groups
- Federally Qualified Health Center
- Community health center
- Community Based Organizations
- Hospital or hospital-based physician group or clinic (including public hospital and district and/or municipal public hospital)
- Rural health clinic and/or an Indian Health Service Program
- Local health department
- Behavioral health entity
- Community mental health center
- Child Welfare Organization
- Private non-profit organization
- Substance use disorder treatment provider
- Community Based Adult Services (CBAS) Providers
- Skilled Nursing Facilities (SNFs)
- Organizations serving individuals experiencing homelessness
- Organizations serving justice-involved individuals
- California Children's Services (CCS) Providers
- Regional Centers
- First 5 County Commissions
- School-Based Health Centers
- Other qualified provider or entity that are not listed above, as approved by DHCS

ECM Structure

IEHP assigns each potentially eligible ECM member to an ECM provider. ECM Providers are required to assign a Lead Care Manager to each ECM enrolled member. The lead care manager serves as the member's primary point of contact and works with all their providers – such as doctors, specialists, pharmacists, social services providers, and others—to make sure everyone is in agreement about the member's needs and care.

The ECM Provider's multi-disciplinary care team consists of the following roles and/or functions, at minimum:

- **ECM Director -** has the ability to manage multi-disciplinary care teams
- **Registered Nurse Care Manager (RN CM) -** supports ECM Members with complex medical conditions and completes mediation reconciliation with pharmacy as available for all ECM-enrolled Members
- **Behavioral Health Care Manager (BH CM) -** supports ECM Members with behavioral health conditions, with particular attention to ECM Members with SMI and/or SUD needs
- **Care Coordinator (CC) -** provides care coordination and connection to services and social supports for ECM Members, including appointment scheduling and referral management
- **Community Health Worker (CHW) -** a field-based member of the ECM Care Team who has lived experience in the ECM Patients' community and services as the bridge between the ECM Patient and healthcare system

ECM Provider Roles and Responsibilities

Each ECM eligible member is assigned to a contracted ECM provider for outreach and engagement. This provider would also be able to provide the other ECM services should the member opt-in to the ECM benefit.

Members are matched to ECM providers based on many different characteristics, such as primary care, behavioral health or specialty. For example, if the member's Primary Care Provider is a contracted ECM provider, the member could be assigned to their PCP for ECM services.

A member may choose a different ECM provider organization or a different ECM Lead Care Manager if desired by notifying either their current ECM provider or IEHP.

How to Connect an IEHP Member to ECM Services

Referral pathways

- **Members** can call IEHP Member Services at: (800) 440-IEHP (4347)
- **Providers** can call IEHP Provider Services at: (800) 223-IEHP (4347) OR;
- **Providers** can email the IEHP Care Extender Team at: ECMCareExtenders@iehp.org

To Connect with IEHP ECM Team for more Info please send an email to: **ECM@IEHP.org**

Thank you!

Be sure to visit our ECM Resource Table if you have any questions!


Community Supports
IEHP
Inland Empire Health Plan
iehp.org

IEHP
Inland Empire Health Plan

Mission

We heal and inspire the human spirit.

Vision

We will not rest until our communities enjoy optimal care and vibrant health.

Values

We do the right thing by:

- Placing our Members at the center of our universe.
- Unleashing our creativity and courage to improve health & well-being.
- Bringing focus and accountability to our work.
- Never wavering in our commitment to our Members, Providers, Partners, and each other.

What is CalAIM?

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.
- The goals of CalAIM include:

Implementing a whole-person care approach and addressing social drivers of health

Improving quality outcomes, reducing health disparities, & driving delivery system transformation

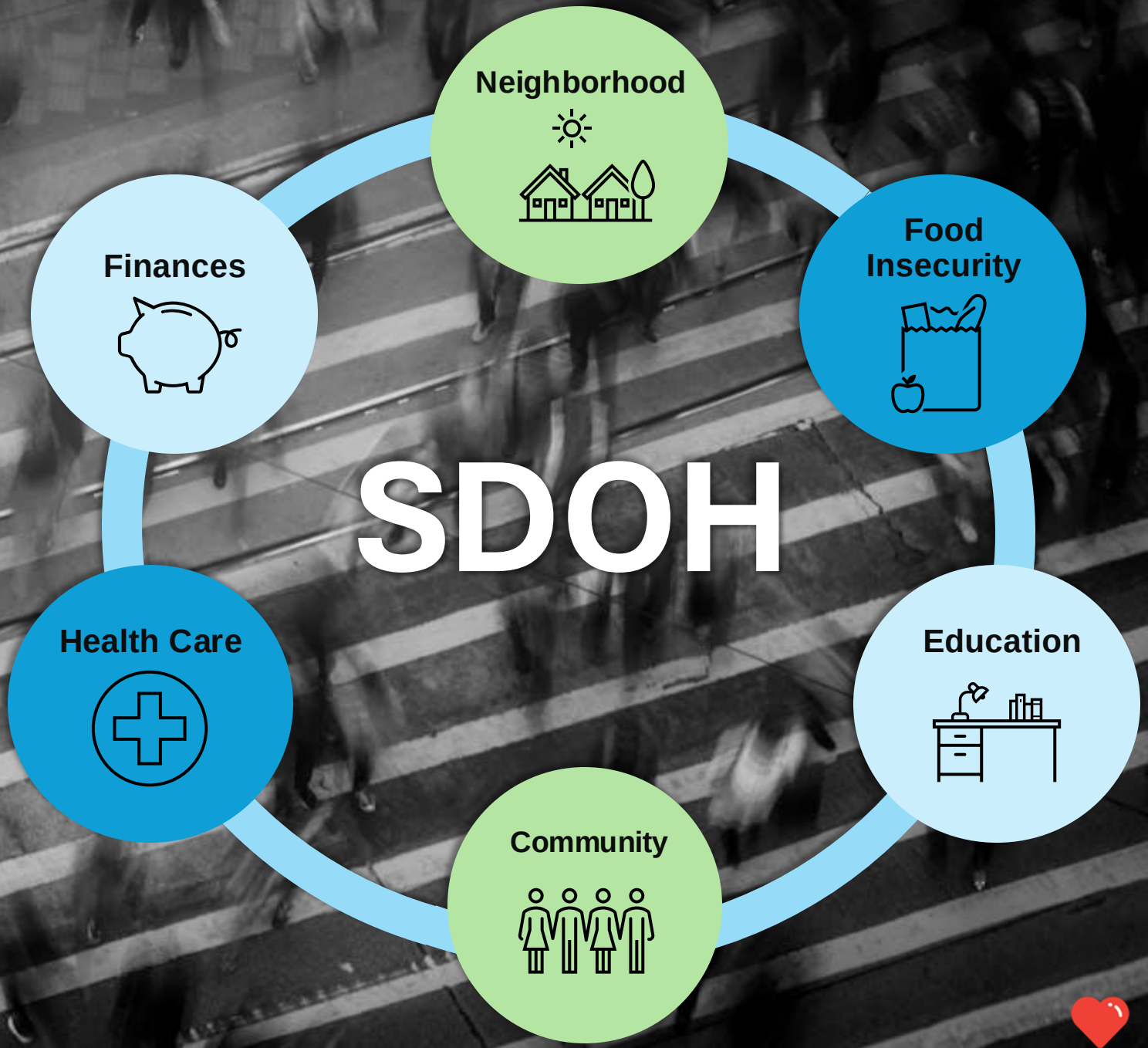
Creating a consistent, efficient and seamless Medi-Cal system

CalAIM: Goals

Address California's physical and mental health needs	Improve and integrate care for Californians	Be a catalyst for equity and justice	Work together to build a healthier state

- A set of ***eleven*** initiatives will help build a more coordinated, person-centered, and equitable health system
- Medi-Cal members will have access to new & improved services both in and outside of the doctor's office or hospital
- New access aims to address physical, mental, and social needs

Social Determinants Of Health



What is Community Supports?

In January 2022, the Department of Health (DHCS) launched a program to assist health plans in delivering essential services to its members. By offering 14 different services, DHCS contributes to the overall health and well-being of our communities.

Community Supports Services

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Recuperative Care
- Short-Term Post Hospitalization Housing
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/ Nursing Facility Transition to a Home
- Home Modifications
- Medically Tailored Meals
- Sobering Centers (Riverside County)
- Asthma Remediation
- Day Habilitation Program
- Respite Services
- Personal Care and Homemaker Services

Housing Services

Navigation

assistance with finding and securing stable housing

Deposits

provides first and last months rent plus the security deposit

Sustaining

assistance with helping tenants keep their housing over time

Eligibility Criteria:

Members who:

- ✓ Meet the Housing and Urban Development (HUD) definition of homeless; **and**
- ✓ Enhance Care Management (ECM) enrolled; **or**
- ✓ Have chronic condition and/or serious mental health illness

Home Modifications

Changes made to a residence to improve its accessibility, safety, and functionality.

Examples of modifications

- Stair lifts
- Ramps and grab-bars
- Doorway widening for wheelchair access
- Wheelchair accessible bathroom and shower

Eligibility Criteria:

Members who:
Have clinical documentation from health professional specifying the requested equipment or service

Asthma Remediation

This service focuses on creating a living environment to prevent asthma symptoms and reduce the need for medical treatment.

Examples of modifications:

- Removing Allergens
- Improving Ventilation
- Air-humidifier
- Allergen-impermeable mattress and pillow dustcovers

Eligibility Criteria:

Members with poorly controlled asthma as determined by:

- ✓ An emergency department visit; **or**
- ✓ Hospitalization; **or**
- ✓ Two sick or urgent care visits in the past 12 months; **or**
- ✓ A score of 19 or lower on Asthma Control Test

Personal Care and Homemaker Services

Provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding.

Assistance with:

- Meal preparation
- Grocery shopping
- Money management
- House cleaning
- Laundry

Eligibility Criteria:

Members who:

- ✓ Have functional deficits; **or**
- ✓ Have exhausted their In-Home Supportive Services (IHSS) hours; **and**
- ✓ Are pending IHSS approval; **or**
- ✓ Are not eligible for IHSS

Medically Tailored Meals (MTM)

Meals specifically prepared to address the specific nutritional/dietary needs of individuals with certain medical conditions and or chronic illnesses.

*Meals are provided for 12 weeks

Examples of chronic conditions:

- Diabetes
- Cardiovascular disorders
- Congestive heart failure
- Stroke
- Chronic lung disorders
- HIV
- Cancer

Eligibility Criteria:

Members who:

- ✓ Have chronic condition(s)
- ✓ Are being discharged from the hospital or nursing facility; **or**
- ✓ Have extensive care coordination needs

Community Transition /Nursing Facility Transition to a Home

Service covers initial expenses to help individuals move from a licensed facility to a private home where they will manage their own living costs.

Assistance with:

- Security deposit
- Set-up fees
- Pest eradication
- One-time cleaning before occupancy
- Home modifications
- Hospital beds, etc.

Nursing Facility to Assisted Living Facilities

Assists individuals transition back into a home-like, community setting and/or avoid institutionalization when possible.

Assistance with:

Activities of Daily Living (ADLs):

- bathing
- dressing
- eating, etc.

Instrumental ADLs (IADLs):

- meals
- transportation
- medication administration

Eligibility for each service is subject to certain criteria

Community Transition /Nursing Facility Transition to a Home

Eligibility Criteria:

Members who:

- ✓ Are receiving nursing facility level of care services; **and**
- ✓ Resided 60+ days in a nursing facility and/or recuperative care setting; **and**
- ✓ Are interested in moving back and residing safely in the community

Nursing Facility to Assisted Living Facilities

Eligibility Criteria:

Members who:

- ✓ Are interested and willing to live in an assisted living setting; **and**
- ✓ Resided 60+ days in a nursing facility; **or**
- ✓ Are currently receiving or meet the criteria to receive nursing facility level of care

Short-Term Post Hospitalization Housing

Provides temporary housing for individuals who need to continue their recovery immediately after exiting a hospital stay or recuperative care

Assistance with:

- Activities of Daily Living
- Necessary medical care
- Case management
- Housing support

Eligibility Criteria:

Members who:

- ✓ Meet the Housing and Urban Development (HUD) definition of homeless; **and**
- ✓ Are exiting recuperative care; **or**
- ✓ Are existing an inpatient hospital stay

Recuperative Care

Short-term residential care for individuals with critical health needs who still need to heal from an injury or illness, but no longer require hospitalization

Assistance with:

- Vital signs monitoring
- Wound care
- Medication management
- Behavioral Health Assessments
- Activities of Daily Living (ADLs)

Eligibility Criteria:

Members who:

- ✓ Members who are post-hospitalization; **and**
- ✓ Live alone with no formal supports; **or**
- ✓ Are facing housing insecurity

Sobering Centers

Provides a supportive environment for individuals who are found to be publicly intoxicated to become sober and leave safely

Services Include:

- lab testing
- temporary bed
- rehydration and food service
- wound care
- shower and laundry facilities
- substance use education and counseling

Eligibility Criteria:

Available to individuals ages 18+ who are intoxicated but are cooperative and free from any medical distress

*Limitations: Services are covered under a duration of less than 24 hours

Day Habilitation

Assists in acquiring and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's community.

Services Include:

- Education on public transportation
- Personal skills development in conflict resolution
- Community participation
- Daily living skills (cooking, cleaning, shopping)
- Money management

Eligibility Criteria:

Members who:

✓ Are experiencing homelessness; **or**

✓ Enhance Care Management (ECM) enrolled

Respite Services

Provided to caregivers of individuals who require temporary supervision.
(Rest is for the caregiver only)

- Continuation of usual daily routines that would ordinarily be performed by the people who normally care for and/or supervise them

Eligibility Criteria:

Members who:

- ✓ Have limitations in their Activities of Daily Livings (ADLs); **and**
- ✓ Are dependent on a qualified caregiver

How to Obtain Services

Referral

Clinical Documentation from a health professional

Evaluation

Specific services require additional assessment before benefits are rendered

Support

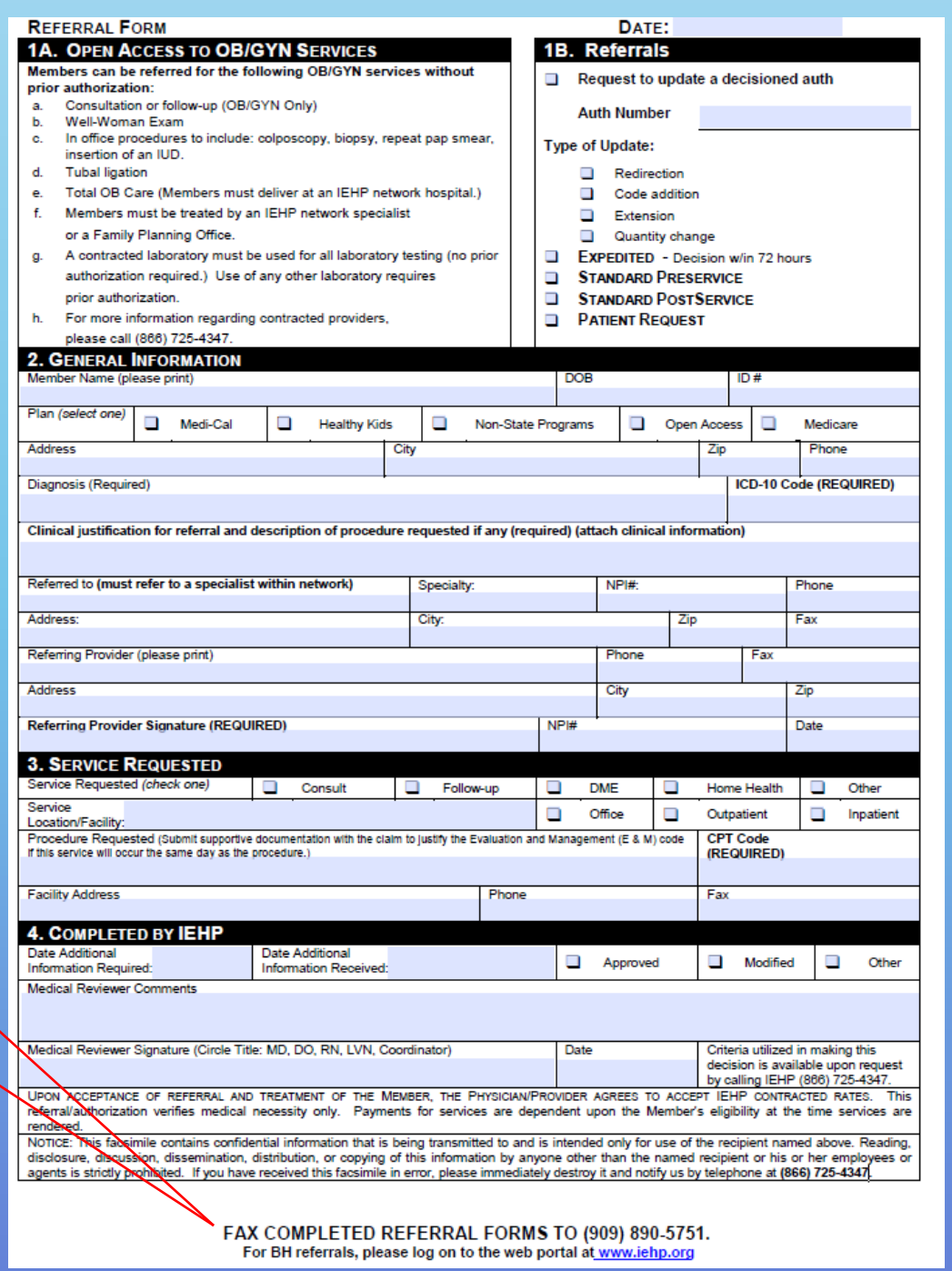
Services are fulfilled by assigned organization

How to Refer

Non-Contracted Providers:

1. Referral form can be found on **iehp.org**
2. Fax completed referral form to IEHP along with supporting documentation from a health professional (specify the service being requested)

FAX COMPLETED REFERRAL FORMS TO (909) 890-5751.
For BH referrals, please log on to the web portal at www.iehp.org



REFERRAL FORM — DATE:

1A. OPEN ACCESS TO OB/GYN SERVICES

Members can be referred for the following OB/GYN services without prior authorization:

a. Consultation or follow-up (OB/GYN Only)
b. Well-Woman Exam
c. In office procedures to include: colposcopy, biopsy, repeat pap smear, insertion of an IUD.
d. Tubal ligation
e. Total OB Care (Members must deliver at an IEHP network hospital.)
f. Members must be treated by an IEHP network specialist or a Family Planning Office.
g. A contracted laboratory must be used for all laboratory testing (no prior authorization required.) Use of any other laboratory requires prior authorization.
h. For more information regarding contracted providers, please call (866) 725-4347.

1B. Referrals

- ❑ Request to update a decisioned auth
- Auth Number
- Type of Update:
  - ❑ Redirection
  - ❑ Code addition
  - ❑ Extension
  - ❑ Quantity change
- ❑ EXPEDITED - Decision w/in 72 hours
- ❑ STANDARD PRESERVICE
- ❑ STANDARD POSTSERVICE
- ❑ PATIENT REQUEST

2. GENERAL INFORMATION

Member Name (please print)	DOB	ID #

Plan *(select one)*	❑ Medi-Cal	❑ Healthy Kids	❑ Non-State Programs	❑ Open Access	❑ Medicare

Address	City	Zip	Phone

Diagnosis (Required)	ICD-10 Code (REQUIRED)

Clinical justification for referral and description of procedure requested if any (required) (attach clinical information)

Referred to **(must refer to a specialist within network)**	Specialty:	NPI#:	Phone

Address:	City:	Zip	Fax

Referring Provider (please print)	Phone	Fax

Address	City	Zip

Referring Provider Signature (REQUIRED)	NPI#	Date

3. SERVICE REQUESTED

Service Requested *(check one)*	❑ Consult	❑ Follow-up	❑ DME	❑ Home Health	❑ Other
Service Location/Facility:			❑ Office	❑ Outpatient	❑ Inpatient

Procedure Requested (Submit supportive documentation with the claim to justify the Evaluation and Management (E & M) code if this service will occur the same day as the procedure.)	CPT Code (REQUIRED)

Facility Address	Phone	Fax

4. COMPLETED BY IEHP

Date Additional Information Required:	Date Additional Information Received:	❑ Approved	❑ Modified	❑ Other

Medical Reviewer Comments

Medical Reviewer Signature (Circle Title: MD, DO, RN, LVN, Coordinator)	Date	Criteria utilized in making this decision is available upon request by calling IEHP (866) 725-4347.

UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE MEMBER, THE PHYSICIAN/PROVIDER AGREES TO ACCEPT IEHP CONTRACTED RATES. This referral/authorization verifies medical necessity only. Payments for services are dependent upon the Member's eligibility at the time services are rendered.

NOTICE: This facsimile contains confidential information that is being transmitted to and is intended only for use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution, or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify us by telephone at **(866) 725-4347**.

FAX COMPLETED REFERRAL FORMS TO (909) 890-5751.
For BH referrals, please log on to the web portal at www.iehp.org

Contact Information

For more information regarding these services please contact IEHP Member Services:

IEHP Medi-Cal Member Services 1-800-440-4347

IEHP Dual Choice Member Services 1-877-273-4347

Monday – Friday 8am - 5pm

These services are available for Medi-cal, Medicare and Dualchoice Members

Covered CA members are not eligible at this time

IEHP
Inland Empire Health Plan
Live Wholeheartedly.

Community Health Worker (CHW) Benefit

Community-Based Organization CHW Benefit

Community Health Worker Benefit

Effective July 1, 2022, CHW services are a covered Medi-Cal benefit.

CHW benefit focuses on:

- Early intervention
- Prevention
- Engaging members in their own health

*Services can be provided via telehealth or in-person

WHO ARE COMMUNITY HEALTH WORKERS?

Who are Community Health Workers?

A Community Health Worker (CHW) is

- A trusted non-licensed public health worker who can connect with the members they serve.
- They serve as an intermediary between health/social services and the community, facilitating access to services and improving health outcomes and quality of care.
- A CHW builds individual and community capacity by increasing health literacy and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy

CHW Qualifications

CHW Minimum Qualifications

- Lived Experience
- CHW Certificate
- Violence Prevention Certificate
- Work Experience Pathway
- 2,000 hours as a CHW in the last 3 years

Continuing Education

- 6 hours per year of additional training

Covered CHW Services

Non-Covered Services

- Clinical Case Management/care management that requires a license.
- Services that duplicate another covered Medi-Cal service already being provided to a beneficiary.
- Services provided to individuals not enrolled in Medi-Cal, except as noted above.

DHCS Guidelines and Requirements

- Effective January 8, 2024, CBO providers may apply for enrollment in the Medi-Cal program (All-Plan Letter- 24-006)
- A CBO provider must be a public or private non-profit organization with a 501(c)(3) status.
- Applicants must apply to enroll in the Medi-Cal program by submitting an electronic application through the Provider Application and Validation for Enrollment (PAVE) online enrollment portal.

Additional Guidelines:

- CBO must enroll as a Medical Provider through PAVE
- Must identify CHW within your staff or hire
- Supervising Provider must be identified to oversee a CHW(s)
- Obtain a contract with IEHP

Michelle’s Place

CBO Partnership: Michelle's Place

CHWs at Michelle's Place serve as a vital link between clients and available resources, guiding them through the complexities of their cancer journey with empathy and expertise.

Infrastructure

- Determining the optimal timing for introducing a CHW to a client.
- Customized assessment tools to better understand each client's unique situation and needs
- Invested in a new CRM system to allow CHWs to access comprehensive client data, make timely referrals, and monitor client progress effectively.

IEHP Support

- CHW training ensured selected CHWs could effectively address the diverse needs of clients.
- Providing education to leadership to understand the CHW Benefit and CHW scope of work
- Facilitate access to a billing clearing house

CBO Partnership: Michelle's Place

Enhanced Patient Support

-CHWs Addressing SDOH, lead to better adherence to treatments, fewer missed appointments, and improved overall wellness.

Preventative Care

-Providing early interventions, clients can avoid costly emergency care or hospitalizations, reducing healthcare costs for both the client and the system

Cost Savings and Reimbursement

- Generating revenue through reimbursement for CHW services

-CHWs help reduce unnecessary healthcare spending, which positively impacts healthcare payers and providers

Operational Efficiencies

- Streamline referrals and case management
- Training and skill development, reducing turnover, and maintaining high quality services

Community Impact & Trust Building

- CHW program scaling potential to reach more members
- Grant and donor appeal for funding support showcasing innovative/impactful health initiatives

CBO Network Support

Linzey Ledesma
Supporting
Riverside County

Tarnia Stanley
Supporting
San Bernardino County

Questions on the CHW Benefit,
please email

CHWBenefit@iehp.org

Want to Join Our Network?

Please Scan the QR-Code or visit the link to help us learn more about your organization

We look forward to hearing from you.

Thank you for your continued partnership!

The Community Health Worker Services Benefit (APL 22-016)

allows us to work with organizations like yours to provide preventive health services to our Members. Let's work together to ensure our communities get the services they need to improve their health and well-being.

This survey will help us understand your organization's capacity to use the Community Health Worker Services Benefit. Please scan the QR code or visit the link to help us learn more.

Please send any questions to *chwbenefit@iehp.org*. We look forward to hearing from you.

Thank you for your continued partnership!

Scan for Survey

Or visit:
https://bit.ly/iehpsurvey

IEHP
Inland Empire Health Plan
iehp.org

Thank you!