5 CALAIM IMPLEMENTATION: ENHANCED CARE MANAGEMENT AND COMMUNITY SUPPORTS

5.1 Enhanced Care Management and Community Supports (ECM/CS)

In 2021, the San Diego County Board of Supervisors committed to a core set of values as established by Framework for the Future, which prioritizes racial justice, health equity, economic opportunity, environmental protection, government transparency, and fundamental changes to County operations. These principles drive our policy approach and allocation of resources.

In order to bring our Framework for the Future vision to fruition, it is incumbent on us to form strong partnerships to collaborate and coordinate with a full spectrum of providers and payers in our community that have a similar commitment to improve the health and wellness of our residents. The Board of Supervisors intends to be an active partner in working with San Diego's Medi-Cal MCPs to ensure quality services for our mutual clients, address social determinants of health, and mitigate disparities and inequities as illustrated in the State procurement and California Advancing and Innovating Medi-Cal (CalAIM). This represents our core values in the Framework for the Future.

CalAIM is a multi-year initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reform across the Medi-Cal program. The major components of CalAIM build upon the successful outcomes of various pilots (including but not limited to the Whole Person Care Pilots (WPC), Health Homes Program (HHP), and the Coordinated Care Initiative) from the previous federal waivers and will result in a better quality of life for Medi-Cal members as well as long-term cost savings/avoidance.

CalAIM has three primary goals:

1. Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

The County will determine the stipulations and process for obtaining the County Letter of Support and is responsible for communicating these requirements to potential Proposers. Possible items for the County to include in the communication to the MCPs include but are not limited to: key milestone and dates associated with Letter of Support process, how the County will communicate the process to interested parties intending to submit a proposal in response to the MCP RFP, how the interested party will request a County Letter of Support, how the County will determine whether to provide a Letter of Support, conditions under which the County will not

provide a Letter of Support, how the County will communicate the response to interested parties, and County point of contact for additional questions or information.

The Board of Supervisors deliberated on the local CalAIM implementation including the criteria and process of requesting and receiving a Letter of Support (LOS) from the County at the July 13 meeting. Acceptance of the terms of this MOA upon signature will be considered as agreeing to and meeting established criteria as part of the process to receive a LOS from the County.

Important components of CalAIM implementation are already in progress in 2021 to meet a start date of January 1, 2022. Of immediate interest to the County of San Diego is the transition of the Whole Person Wellness (WPW) Pilot and the Health Homes Program (HHP) to the new Enhanced Care Management (ECM) benefit and associated Community Supports (CS), formerly referred to in the original CalAIM proposal as In Lieu of Services, and the expansion of ECM/CS to other MCP members who meet DHCS-specified Target Populations criteria, according to timelines set by DHCS.

Core ECM Components

1. Comprehensive Assessment & Care Mgmt Plan
2. Enhanced Coordination of Care
3. Health Promotion
4. Comprehensive Transitional Care
5. Member & Family Supports
6. Coordination of Referral to Community and Social Support Services

5.2 Meaningful Coordination, Collaboration, and Transparency

The County views ECM/CS implementation as the essential foundation for further success of CalAIM. The initial focus populations for ECM per the State guidelines are individuals and families experiencing homelessness, high utilizer adults, and adults with Serious Mental Illness/Substance Use Disorder (SMI/SUD). Later populations of focus will include individuals transitioning from incarceration, members eligible for LTC and at-risk of institutionalization, nursing home residents transitioning to the community, and other Children and Youth. These are populations in which County departments have heavily invested in and delivered services to for many years.

CATEGORY	COUNTY HEALTH AND HUMAN SERVICS AGENCY	MEDI-CAL MANAGED CARE PLAN
5.2.1 **MEANINGFUL COORDINATION, COLLABORATION, AND TRANSPARENCY**	a. Actively participate in Healthy San Diego (HSD) and other committees formed by the County Board of Supervisors or County HHSA pertaining to improving care of Medi-Cal eligible individuals and Medi-Cal beneficiaries. b. Coordinate with MCPs in designing an approach for pooling and allocating Providing Access and Transitions Health (PATH) and incentive funds to support the community service infrastructure required by In Lieu of Services (CS). c. Coordinate with MCPs and key community stakeholders to develop a joint Population Health Management Program for San Diego. d. Coordinate with MCPs to approve care and linkages for school children in order to ensure timely access to mental health services in the community. e. Coordinate with MCPs for the care of specific CalAIM-related services for populations, including, but not limited to, Foster Youth, Justice Involved, aging, SMI/SUD, homeless and housing, rural and trafficking, and crime victims.	a. Actively participate in Healthy San Diego (HSD) and other committees formed by the County Board of Supervisors or County HHSA pertaining to improving care of Medi-Cal eligible individuals and Medi-Cal beneficiaries. b. As soon as details become available on Providing Access and Transitions Health (PATH) funding from DHCS to Counties and incentive funding from DHCS to MCPs, collaborate with the County, community providers, and other San Diego MCPs in designing an approach for pooling and allocating these funds to support the community service infrastructure required by Community Supports (CS). c. MCPs agree to offer all of the initially specified CS that are offered by the County Whole Person Wellness program on January 1, 2022 for all MCP beneficiaries in San Diego County who meet eligibility criteria. MCPs will collaborate with Healthy San Diego and the HHSA to deliver remaining CS of the initially specified list from DHCS by January 1, 2023: 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. Respite Services 7. Day Habilitation Programs

		8. Nursing Facility (NF) Transition/Diversion to Assisted Living Facilities 9. Community Transition Services/ NF Transition to a Home 10. Personal Care & Homemaker Services 11. Environmental Accessibility Adaptations (Home Modifications) 12. Meals / Medically Tailored Meals 13. Sobering Centers 14. Asthma Remediation d. Participate in a collaborative effort with the County HHSA, other San Diego MCPs, and key community stakeholders to develop a joint Population Health Management Program for San Diego (Section 2.1. of the CalAIM Proposal requires each MCP to develop its own Population Health Management Plan by January 1, 2023). e. Partner with County Behavioral Health Services and providers to approve care and linkages for school children in order to ensure timely access to mental health services in the community. f. Commit to joint strategies and coordination with County departments serving the following CalAIM specific populations, including, but not limited to, Foster Youth, Justice Involved, aging, SMI/SUD, homeless and housing, rural and trafficking, and crime victims.

5.3 Person-Centered Care Coordination

The following is a list of requirements that MCPs shall commit to:

CATEGORY	COUNTY HEALTH AND HUMAN SERVICS AGENCY	MEDI-CAL MANAGED CARE PLAN
5.3.1 **PERSON-CENTERED CARE COORDINATION**	a. Perform outreach and engagement, as delegated by MCPs, to ensure enrollment in ECM for all eligible Medi-Cal members.	a. Perform outreach and ensure enrollment in ECM for all eligible Medi-Cal members. b. Contract with County HHSA to provide ECM for the following populations: • Seriously Mentally Ill/Substance Use Disorder/Serious Emotionally Disturbed populations. • Complex patients for whom they serve as the clinical and/or social service experts (including, but not limited to, Tuberculosis Control and Refugee Health Branch; California Children's Services; and HIV, STD, and Hepatitis Branch). • Other CalAIM identified populations b. Agree to "guaranteed enrollment" criteria with all other MCPs, as it has been done with HHP, allowing the County to enroll members in ECM. c. Ensure there are sufficient ECM and CS providers to serve members. d. Create and accept a standardized application form, agreed upon by all MCPs, for providers who wish to contract as ECM and/or CS entities. If an application form is approved by one MCP, it would convey approval of all MCPs (following a model set by HSD's Facility Site Review workgroup).

		e. Transition all members enrolled in the Whole Person Wellness (WPW) and the Health Homes Program (HHP) as of 12/31/21 to Enhanced Care Management (ECM) and the relevant Community Supports (CS) as of 1/1/22, ensuring continuity of care for the case management component as well as the service providers and level of services for each new ECM enrollee. f. MCP shall use best efforts to contract with the community providers currently serving WPW enrollees and the Community-Based Care Management Entities (CB-CMEs) participating in the HHP at a mutually agreed upon rate, in order to ensure continuity of care.

5.4 Data Sharing/Information Technology (IT) Infrastructure

Key factors in the success of CalAIM will be the ability to characterize the population, collaborate in care management, and measure outcomes. Data sharing and IT infrastructure are essential elements recognized throughout the DHCS draft procurement and CalAIM.

The following is a continued list of requirements that MCPs shall commit to:

CATEGORY	COUNTY HEALTH AND HUMAN SERVICS AGENCY	MEDI-CAL MANAGED CARE PLAN
5.4.1 **DATA SHARING/ INFORMATION TECHNOLOGY (IT) INFRASTRUCTURE**	a. Directly contract with San Diego Health Connect including payment of any associated participation fees, to facilitate bi-directional information exchange with participating healthcare providers in San Diego's Health Information Exchange (HIE).	a. Directly contract with San Diego Health Connect including payment of any associated participation fees, and contract with providers who are members of San Diego Health Connect, to facilitate bi-directional information exchange with participating healthcare providers in San Diego's Health Information Exchange (HIE). b. Be a member of 211 San Diego Community Information Exchange (211 SD-CIE) to facilitate bi-directional information exchange, in compliance with health data security standards, with participating community-based organizations as well as supporting ECM and CS organizations in becoming full partners of 211 SD-CIE. c. Ensure that the use of MCPs' proprietary case management and/or billing system is not required by the MCP. If an ECM provider chooses not to use the proprietary case management or billing system of an MCP, MCPs may require the provider to use the file exchanges and/or billing guidance as put forth by DHCS. d. Agree to share de-identified enrollment and outcome data with the County for the purpose of guiding development of infrastructure and interventions.
5.4.2 **BEHAVIORAL HEALTH SERVICES DATA SHARING**	a. Behavioral health administered programs and MCP care management services shall share data to support care coordination	a. Behavioral health administered programs and MCP care management services shall share data to support care coordination

	needs for shared clients. Data shared shall include, at a minimum, these fields subject to any member consent requirements under applicable law:
	
	• Unit ID/Sub Unit ID
	• Sub Unit Description
	• Single Accountable Individual (SAI)
	  ◦ SAI Name
	  ◦ SAI Phone
	  ◦ SAI Email
	• Date Opened/Closed to Program
	• Data on Most Recent Service
	  ◦ Service Date
	  ◦ Service Code
	  ◦ Service Description
	• Level of Care
	• Medi-Cal/Private Insurance Eligibility
	• Plan Type
		needs for shared clients. Data shared shall include, at a minimum, these fields subject to any member consent requirements under applicable law:
		
		• Plan Information:
		  ◦ Active in plan
		  ◦ Plan effective date
		  ◦ End effective date
		  ◦ ECM Program and other care management program enrollment
		• Claim Information:
		  ◦ Claim/encounter ID
		  ◦ Claim line number
		• Visit Information:
		  ◦ ICD code 1
		  ◦ ICD code 2
		  ◦ Admit date
		  ◦ Discharge date
		  ◦ Service date
		  ◦ Discharge disposition
		  ◦ Service type
		  ◦ Servicing provider

5.4.3 **ENHANCED CARE MANAGEMENT DATA SHARING**		a. Ensure through use of San Diego Health Connect, timely member information including ECM enrollment status and the ECM contact person is accessible to all appropriate entities for care coordination. b. Agree to maintain the data sharing in place with the County for WPW to support the exchange of information on the Plan's Medi-Cal members, as applicable.
5.4.4 **CONFIDENTIALITY**	a. Maintain the confidentiality of member information and data in accordance with applicable state and federal laws and regulations.	b. Maintain the confidentiality of member information and data in accordance with applicable state and federal laws and regulations.