Promising Practices in California’s Medicaid Transformation Initiative: Spotlight on Community Partnerships

October 27, 2022, 1:00 – 2:00 PM PT

Made possible by the California Health Care Foundation (CHCF)
Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.
Welcome & Introductions
Agenda

• Welcome and Introductions
• Expanding Partnerships with Community Based Organizations
• Audience Q&A
• Value-Based Payment Models for Enhanced Care Management
• Audience Q&A
• Closing Remarks
Meet Today’s Presenters

**Diana Crumley**, JD, MPAff
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Executive Director, Medi-Cal/CalAIM, CalOptima

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Chief Medical Officer, Inland Empire Health Plan

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Associate Director, Complex Care, California Health Care Foundation

**Milo Peinemann**, MPL
CEO, American Family Housing

**Matthew Wray**, MPA, PMP
Director of Health Services Special Initiatives, Inland Empire Health Plan
Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

- **Effective models for prevention and care delivery** that harness the field’s best thinking and practices to meet critical needs.

- **Efficient solutions for policies and programs** that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.

- **Equitable outcomes for people** that improve the overall wellbeing of populations facing the greatest needs and health disparities.
National Trend: Medicaid Transformation on a Managed Care Chassis

• Most states have Medicaid managed care.

• Core goal for Medicaid transformation: equitable access to whole-person care.

• To achieve state goals, plans need to partner with community-based organizations, local government, and federally qualified health centers, among other community partners.
California Advancing and Innovating Medi-Cal (CalAIM)

• Launched January 2022, CalAIM is a multi-year care delivery and payment reform initiative.

• Two major components seek to address health-related social needs:
  → Enhanced Care Management (ECM)
  → Community Supports

• ECM and Community Supports build on California’s Whole Person Care Pilots (WPC) and Health Homes Program (HHP), and sustain innovations statewide through Medicaid managed care.
1. New partnerships are necessary, and they take time.

2. These partnerships may require new processes, and payment models that support the real-world needs of community partners.

chcs.org/launching-calaim-10-observations
CHCF Resource Center

Visit CHCF’s website to explore the collection of tools and resources aimed at helping organizations understand and implement CalAIM.  www.chcf.org/calaim
Expanding Partnerships with Community-Based Organizations
Our Mission
To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision
By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members’ social determinants of health.
CalOptima Health Overview

• Mission: To serve member health with excellence and dignity, respecting the value and needs of each person

• Founded as Orange County’s community health plan for low-income families, seniors and people with disabilities

• Serves 950,000 members: 1 in 4 adults and 1 in 3 children in Orange County

• Has 1,500 employees and an annual budget of $4 billion
Managed Health Plans are Complicated

- Presumptive Eligibility
- Auto authorizations
- Community support liaisons
Our Communities are Diverse

Expanded Network

Easy to understand materials
Our Services are Valuable and Unique

- Increased rates
- Outreach/in-reach
- Relaxing contracting requirements
Audience Q&A
Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.
Value-Based Payment Models for Enhanced Care Management
Enhanced Care Management Implementation

Dr. Takashi Wada, Chief Medical Officer
Matthew Wray, Director of Health Services Special Initiatives

October 27, 2022
In 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.
IEHP ECM Care Team Model

Each Community Based ECM Care Team consists of:

• Nurse Care Manager (RN)
• Behavioral Health Care Manager
• Care Coordinator
• Community Health Worker

• IEHP’s ECM Care Team Model consists of the same four-person team that produced successful outcomes in the Health Homes Program (HHP)

IEHP has developed 3 ECM Provider types (models) that provide ECM services to Members who qualify for services:

MODEL 1
• Community based PCP and County DBH clinics that have enough eligible patient enrollment to justify their own internal care teams, which are comprised of their employees

MODEL 2
• Care teams that are staffed by IEHP employees and are community-based and strategically located in regions that have high numbers of ECM eligible patients, but low numbers of PCP offices capable of providing ECM services

MODEL 3
• Specialty care teams uniquely designed to meet the patients where they’re at – even if they are on the street (i.e., CBO’s, street medicine teams, etc.)

All ECM Care Teams are required to utilize the IEHP provided web-based care management platform (Care Director) to support bi-directional data sharing and payment
# ECM Provider Payment Structure

<table>
<thead>
<tr>
<th>Payment Stream</th>
<th>Type of Payment</th>
<th>Pays For</th>
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</thead>
<tbody>
<tr>
<td>Enrollment &amp; Engagement</td>
<td>Per engaged member per month (PEMPM)</td>
<td>Enrollment and ongoing services (engagement)</td>
</tr>
<tr>
<td></td>
<td>• Tiered based on caseload #s</td>
<td></td>
</tr>
<tr>
<td>Value-based</td>
<td>PEMPM based on performance</td>
<td>Performance on select quality measures</td>
</tr>
<tr>
<td>Outreach</td>
<td>Fee-for-service (FFS)</td>
<td>Outreach attempts (Successful &amp; Non-successful)</td>
</tr>
<tr>
<td>Incentive-based (via CalAIM IPP)</td>
<td>Invoiced</td>
<td>For milestone achievements (i.e., ECM transition, enrollment, use of platform, CHW hires, etc.)</td>
</tr>
<tr>
<td>VBP Measure</td>
<td>Description</td>
<td>Level 1</td>
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<tr>
<td>--------------------------</td>
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</tr>
<tr>
<td>Care Planning</td>
<td>The percentage of ECM enrolled Members who had a Care Plan initiated or updated during each month of the measurement period.</td>
<td>$X PMPM</td>
</tr>
<tr>
<td>Blood Pressure Documentation</td>
<td>The percentage of ECM enrolled Members who have at least one blood pressure documented in Care Director during the measurement period.</td>
<td>$X PMPM</td>
</tr>
<tr>
<td>Blood Pressure Control</td>
<td>The percentage of ECM enrolled Members who have a diagnosis of hypertension or who have documented elevated blood pressure in Care Director by the first day of the measurement period whose blood pressure (BP) was controlled (&lt;140/90 mm Hg) by the end of the measurement period.</td>
<td>$X PMPM</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>The percentage of ECM enrolled Members who have a PHQ-9 documented within 90 days of enrollment.</td>
<td>$X PMPM</td>
</tr>
<tr>
<td>Depression Response</td>
<td>The percent of ECM enrolled Members who, in response to a previously elevated PHQ-9, have a subsequent meaningful reduction in PHQ-9 documented during the measurement period.</td>
<td>$X PMPM</td>
</tr>
<tr>
<td>Transition of Care</td>
<td>The Transition of Care measure aims to reduce readmissions by conducting a post-discharge assessment after an inpatient (IP) discharge in a timely manner. This measure is the percentage of Members with a TOC – Post-discharge Assessment completed within 14 days of IP discharge.</td>
<td>$X PMPM</td>
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ECM Provider Ramp-Up & Outreach

RAMP-UP FUNDING

• IEHP provides new ECM providers ramp-up funding to assist with the launch of ECM implementation

• Providers are eligible to receive funding each month for up to 6 months during the ramp-up phase, and are required to meet specific monthly milestones to earn payment

• Funding supports and is generally used to offset the cost of hiring the ECM care team (i.e., RN Care Manager, Behavioral Health Care Manager, Care Coordinator, and Community Health Worker)

<table>
<thead>
<tr>
<th>Ramp-up Month</th>
<th>Payment</th>
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<tbody>
<tr>
<td>1</td>
<td>$XX,XXX</td>
</tr>
<tr>
<td>2</td>
<td>$XX,XXX</td>
</tr>
<tr>
<td>3</td>
<td>$XX,XXX</td>
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<tr>
<td>4</td>
<td>$XX,XXX</td>
</tr>
<tr>
<td>5</td>
<td>$XX,XXX</td>
</tr>
<tr>
<td>6</td>
<td>$XX,XXX</td>
</tr>
<tr>
<td>Total = 6 months</td>
<td>Total = not to exceed $XX,XXX</td>
</tr>
</tbody>
</table>

OUTREACH

• Outreach payment intended to offset unsuccessful outreach efforts

• Payment for any outreach attempt

• Outreach payment will be capped at 15 attempts per Member per calendar year

• Outreach payment will not be made for any Members that are already enrolled in ECM

• IEHP announced in August that Outreach and PMPM payments were scheduled to increase

• Additionally, IEHP announced that one-time bonus payments would be available to ECM providers that achieve certain enrollment milestones

<table>
<thead>
<tr>
<th>FFS Amount</th>
<th>Max Reimbursable attempts/Member/Year</th>
<th>Max Outreach Reimbursement/Member/Year</th>
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<tbody>
<tr>
<td>$XX</td>
<td>15</td>
<td>$XXX</td>
</tr>
</tbody>
</table>

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VBP Outcome Measures: 3/2022 - 9/2022

- Care Plan Documentation
  - 2022-03: 48%
  - 2022-09: 85%
- Transition of Care (TOC)
  - 2022-03: 42%
  - 2022-09: 85%
- Blood Pressure Documentation
  - 2022-03: 65%
  - 2022-09: 80%
- Blood Pressure Control
  - 2022-03: 54%
  - 2022-09: 72%
- Depression Documentation
  - 2022-03: 51%
  - 2022-09: 80%
- Depression Response
  - 2022-03: 27%
  - 2022-09: 39%
Where to Find More

• Related Materials:
  → *Launching CalAIM: 10 Observations About Enhanced Care Management and Community Supports So Far.* Available at: [chcs.org/launching-calaim-10-observations](chcs.org/launching-calaim-10-observations)
  → Additional CHCS resources are also available on supporting the success of California’s CalAIM initiative. Visit, [chcs.org/supporting-the-success-of-calaim](chcs.org/supporting-the-success-of-calaim)
  → CHCF Focus on CalAIM. Visit, [https://www.chcf.org/resource/focus-on-calaim/](https://www.chcf.org/resource/focus-on-calaim/)
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