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GOLD COAST HEALTH PLAN

CalAIM Overview Agenda

Agenda Item	Facilitator
Introductions	Susana
Welcome	Erik
CalAIM Overview	Marlen
Enhanced Care Management and Community Supports	Rachel
CalAIM Components	Marlen
Q&A and Closing Remarks	Susana

Introductions

About Us

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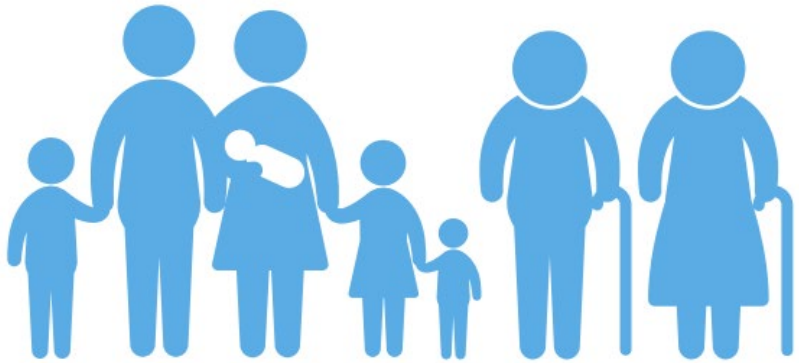
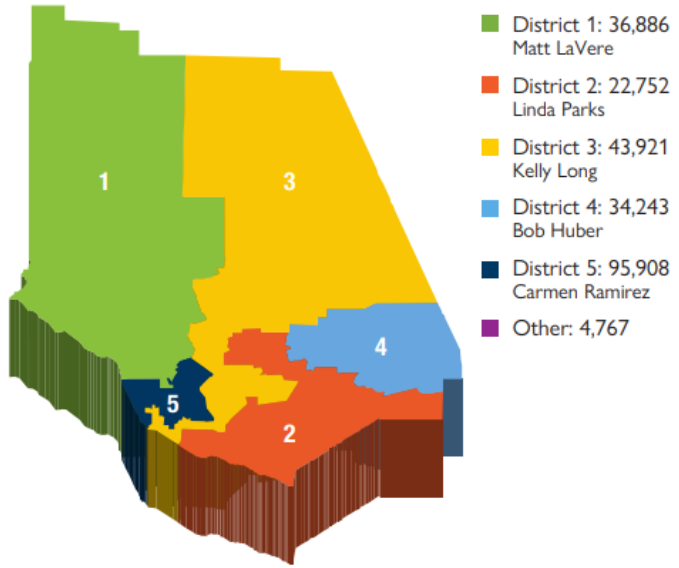
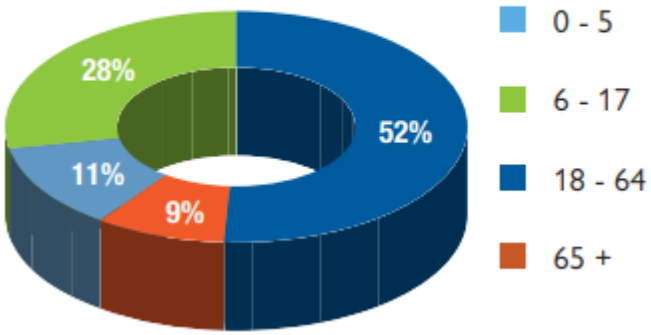
Members 238,477



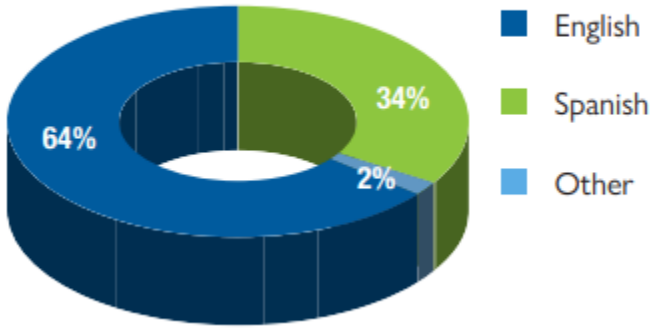
Membership by Supervisorial District



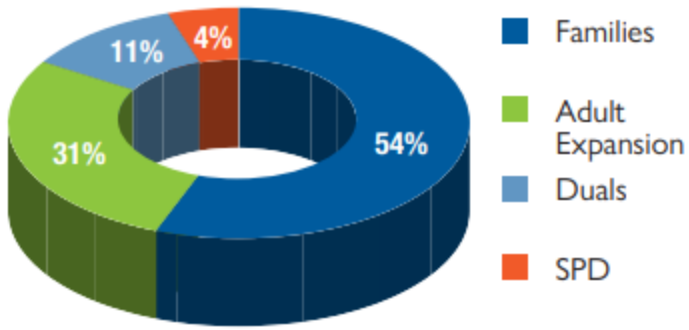
Membership by Age



Membership by Spoken Languages



Membership by Aid Category



SPD: Seniors and Persons with Disabilities
Duals: Dually Eligible for Medicare and Medi-Cal

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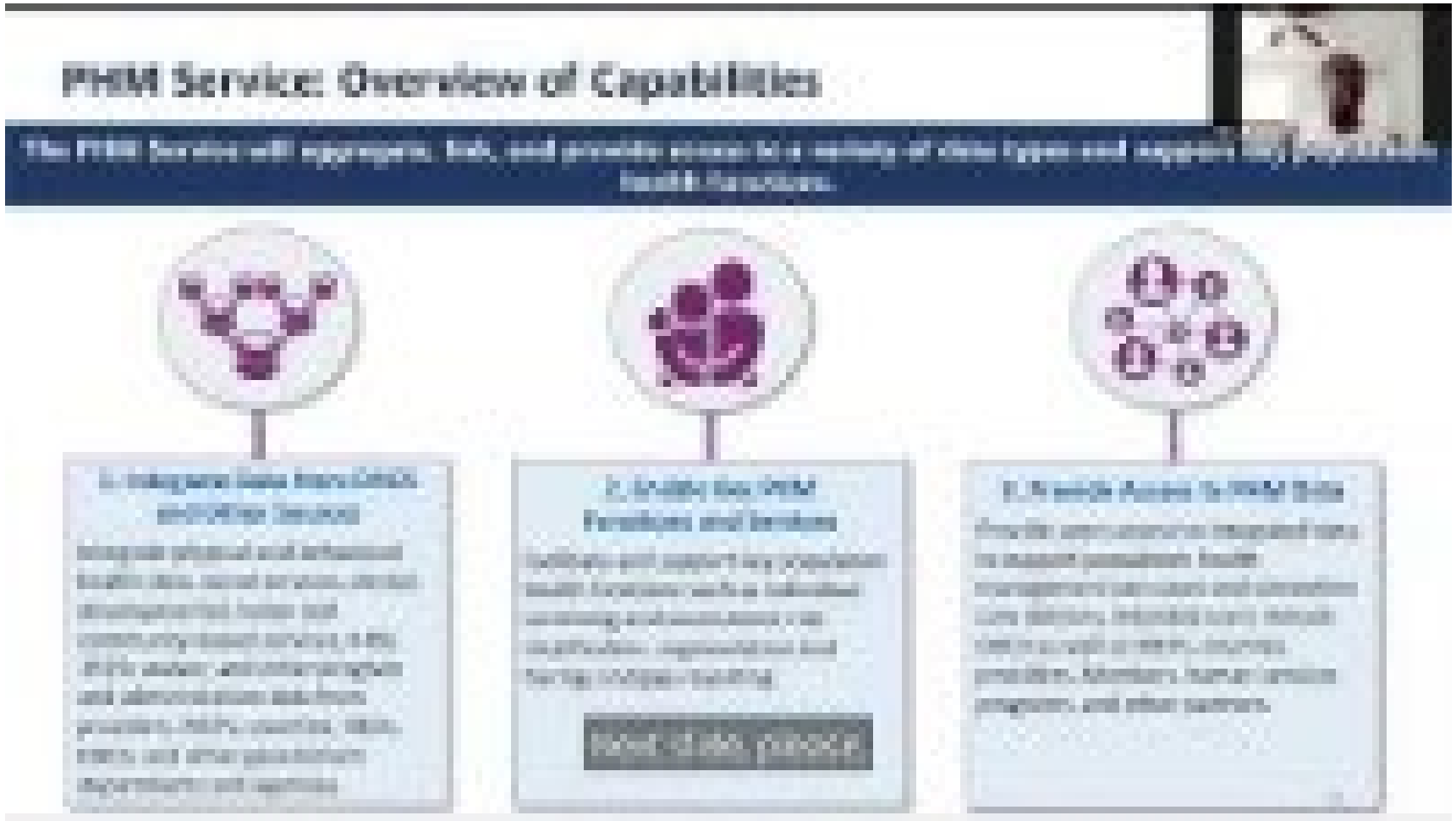
CalAIM

California Advancing and Innovating Medi-Cal

Video

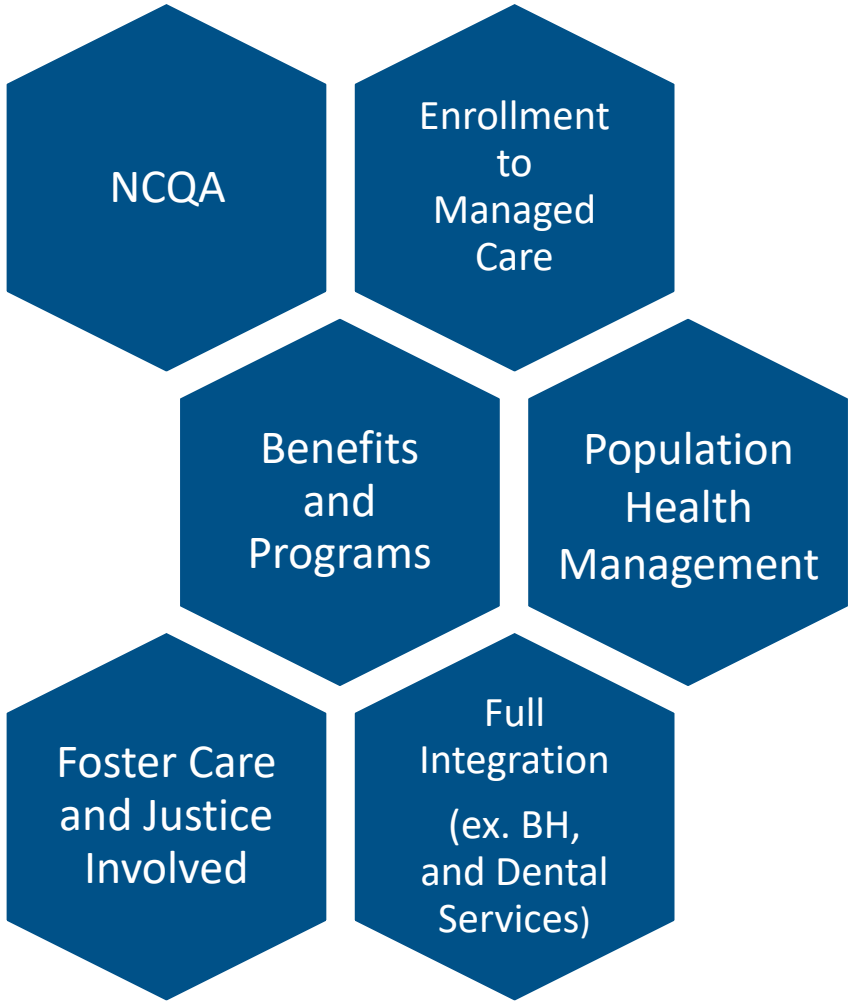


https://www.youtube.com/watch?v=nvXuzWJHzvI

What is CalAIM?

- CalAIM is a multi-year initiative led by DHCS. The goal is to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing delivery system and payment reforms across the program.

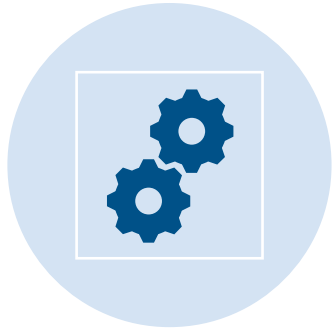
- CalAIM leverages Medicaid as a tool to help address many of the complexities and challenges facing the most vulnerable individuals. The model is a person-centered approach targeting social determinants of health to reduce health disparities and inequities.



Enhanced Care Management (ECM)

ECM is a new, statewide Medi-Cal benefit providing intensive care management to address clinical and nonclinical needs for the most vulnerable members.

ECM builds off the successful community-based care management programs piloted in the Medi-Cal 2020 waiver's Whole Person Care (WPC) Pilots.



In addition to ECM, enrollees may have connections to Community Supports to address social needs.

ECM Populations of Focus

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January 1, 2022 (Phase 1)	January 1, 2023 (Phase 2)	July 1, 2023 (Phase 3)
• Whole Person Care transition • High utilizers • Homeless individuals • Severe Mental Illness (SMI) / Substance Use Disorder (SUD)	• Youth / Adults transitioning from incarceration • Members at risk for Long-Term Care / Institutionalization • Nursing home residents transitioning to the community	• All other children and youth populations of focus

Community Supports (CS)

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Community Support	Description	Eligible Population
Housing Transition Navigation Services	Developing member housing plan and assistance with obtaining housing, including assistance with searching for housing or completing housing applications.	Homeless / at risk of homelessness AND at least one of the following: • One or more serious chronic conditions • Serious Mental Illness (SMI) / Substance Use Disorder (SUD) • At risk of institutionalization • Serious Emotional Disturbance (SED) (children / adolescents), OR • Exiting incarceration • Transitional-aged youth with significant barriers to housing (juvenile justice involvement, one or more convictions, SMI/SUD/SED, welfare system involvement, and victims of trafficking / family violence)
Housing Deposits*	Funding for one-time services necessary to establish a household, including security deposits to obtain a lease, first month's coverage of utilities, or first and last month's rent required prior to occupancy.	
Housing Tenancy and Sustaining Services	Assistance with maintaining stable tenancy once housing is secured, including interventions for behaviors that may jeopardize housing, such as late rental payment or behaviors resulting from unaddressed behavioral health conditions. Interventions may include financial literacy support; coordination with the member's ECM provider, behavioral health providers, and other providers; and/or landlord relationship management services.	
Recuperative Care (Medical Respite)	Short-term residential care for beneficiaries who no longer require hospitalization but still need to recover from injury or illness and whose condition would be exacerbated by an unstable living environment.	Members who are at risk of hospitalization or post hospitalization, AND at least one of the following: • Are homeless or at risk of homelessness • Live alone with no formal supports • Housing insecurity jeopardizing their health and safety
Medically Tailored Meals	Meals provided to members that are tailored to meet their unique dietary needs, within 30 days following discharge from a hospital.	Members discharged from the hospital within the past 30 days who were hospitalized for a Congestive Heart Failure (CHF)-related primary diagnosis

* Must be receiving Housing Transition Navigation Services.

ECM/CS Referral Process and Contact

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Enhanced Care Management (ECM)

- ECM Referral Form
- ECM Authorization Request Form

Community Supports (CS)

- CS Referral Form
- Housing Suites Authorization Request Form
- Medically Tailored Meals Authorization Request Form
- Recuperative Care Authorization Request Form

Visit: Gold Coast Health Plan CalAIM
Contact: CalAIM@goldchp.org

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ENHANCED CARE MANAGEMENT (ECM)
REFERRAL FORM

MEMBER INFORMATION
Please print or type

Last Name: First Name: Date:
Mailing Address: City: Zip:
Medi-Cal ID: Phone: Birth Date:
Language Preference: ☐ English ☐ Spanish ☐ Other:

REFERRAL SOURCE INFORMATION

Last Name: First Name:
Mailing Address: City: Zip:
Phone: Email:

RELATION TO MEMBER: ☐ Self ☐ Parent / Guardian ☐ Family / Friend ☐ Primary Care Provider (PCP) ☐ ECM Provider ☐ Other Service Provider ☐ GCHP Staff ☐ Community Based Organization (CBO)

PREFERRED CONTACT METHOD: ☐ Email ☐ Phone ☐ Mail

REFERRING ORGANIZATION (if applicable):

HAS MEMBER BEEN INFORMED THAT A REFERRAL WAS BEING SUBMITTED? ☐ Yes ☐ No

REASON FOR REFERRAL (CHECK ALL THAT APPLY)

All Ages:
☐ Homeless or at risk of becoming homeless.
- Staying outside, in a car, in a tent, in an overnight shelter, temporarily in someone else's home (i.e., couch-surfing).
- Fleeing domestic violence.
- Leaving residential program, jail, hospital, or other institution without housing.
- Losing housing within 30 days.

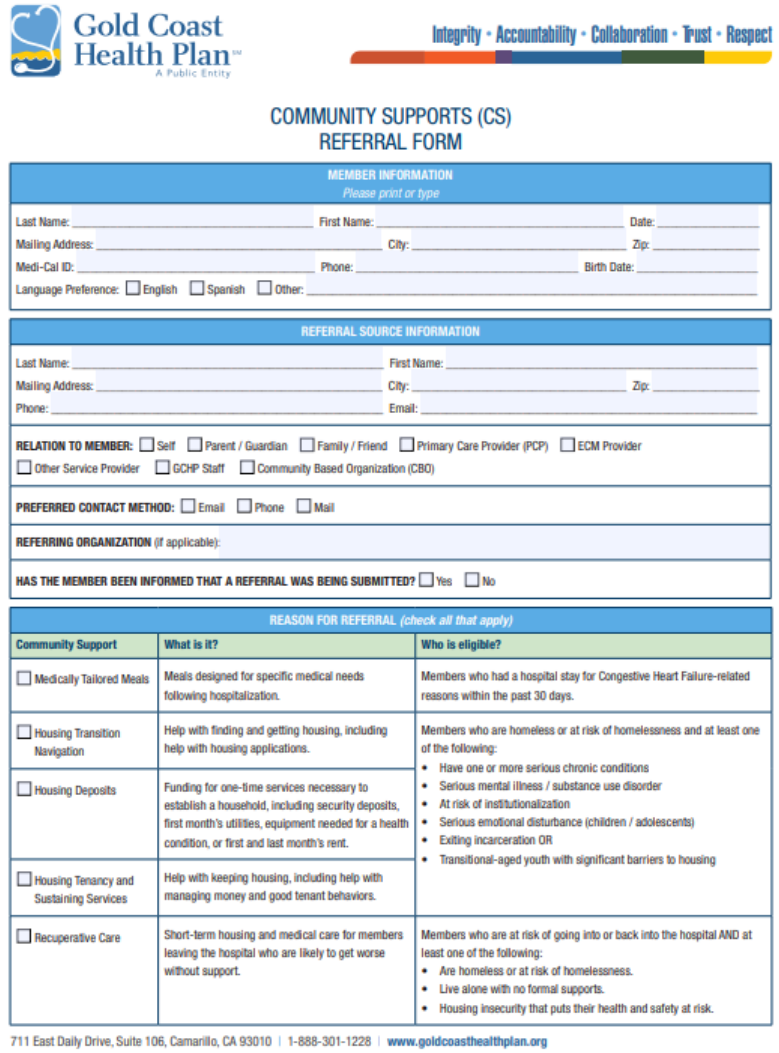
☐ Has been incarcerated within the last year.

Adults (18+):
☐ Serious mental illness
☐ Substance use disorder
☐ 5+ ER visits in six months
☐ 3+ unscheduled hospital or nursing facility stays in six months

REASON FOR REFERRAL

What is your concern?	
Desired outcome or result:	
Additional Information:	

711 East Daily Drive, Suite 106, Camarillo, CA 93010 | 1-888-301-1228 | www.goldcoasthealthplan.org



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COMMUNITY SUPPORTS (CS)
REFERRAL FORM

MEMBER INFORMATION
Please print or type

Last Name: First Name: Date:
Mailing Address: City: Zip:
Medi-Cal ID: Phone: Birth Date:
Language Preference: ☐ English ☐ Spanish ☐ Other:

REFERRAL SOURCE INFORMATION

Last Name: First Name:
Mailing Address: City: Zip:
Phone: Email:

RELATION TO MEMBER: ☐ Self ☐ Parent / Guardian ☐ Family / Friend ☐ Primary Care Provider (PCP) ☐ ECM Provider ☐ Other Service Provider ☐ GCHP Staff ☐ Community Based Organization (CBO)

PREFERRED CONTACT METHOD: ☐ Email ☐ Phone ☐ Mail

REFERRING ORGANIZATION (if applicable):

HAS THE MEMBER BEEN INFORMED THAT A REFERRAL WAS BEING SUBMITTED? ☐ Yes ☐ No

REASON FOR REFERRAL *(check all that apply)*

Community Support	What is it?	Who is eligible?
☐ Medically Tailored Meals	Meals designed for specific medical needs following hospitalization.	Members who had a hospital stay for Congestive Heart Failure-related reasons within the past 30 days.
☐ Housing Transition Navigation	Help with finding and getting housing, including help with housing applications.	Members who are homeless or at risk of homelessness and at least one of the following: • Have one or more serious chronic conditions • Serious mental illness / substance use disorder • At risk of institutionalization • Serious emotional disturbance (children / adolescents) • Exiting incarceration OR • Transitional-aged youth with significant barriers to housing
☐ Housing Deposits	Funding for one-time services necessary to establish a household, including security deposits, first month's utilities, equipment needed for a health condition, or first and last month's rent.	
☐ Housing Tenancy and Sustaining Services	Help with keeping housing, including help with managing money and good tenant behaviors.	
☐ Recuperative Care	Short-term housing and medical care for members leaving the hospital who are likely to get worse without support.	Members who are at risk of going into or back into the hospital AND at least one of the following: • Are homeless or at risk of homelessness. • Live alone with no formal supports. • Housing insecurity that puts their health and safety at risk.

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CalAIM Incentive Payment Program

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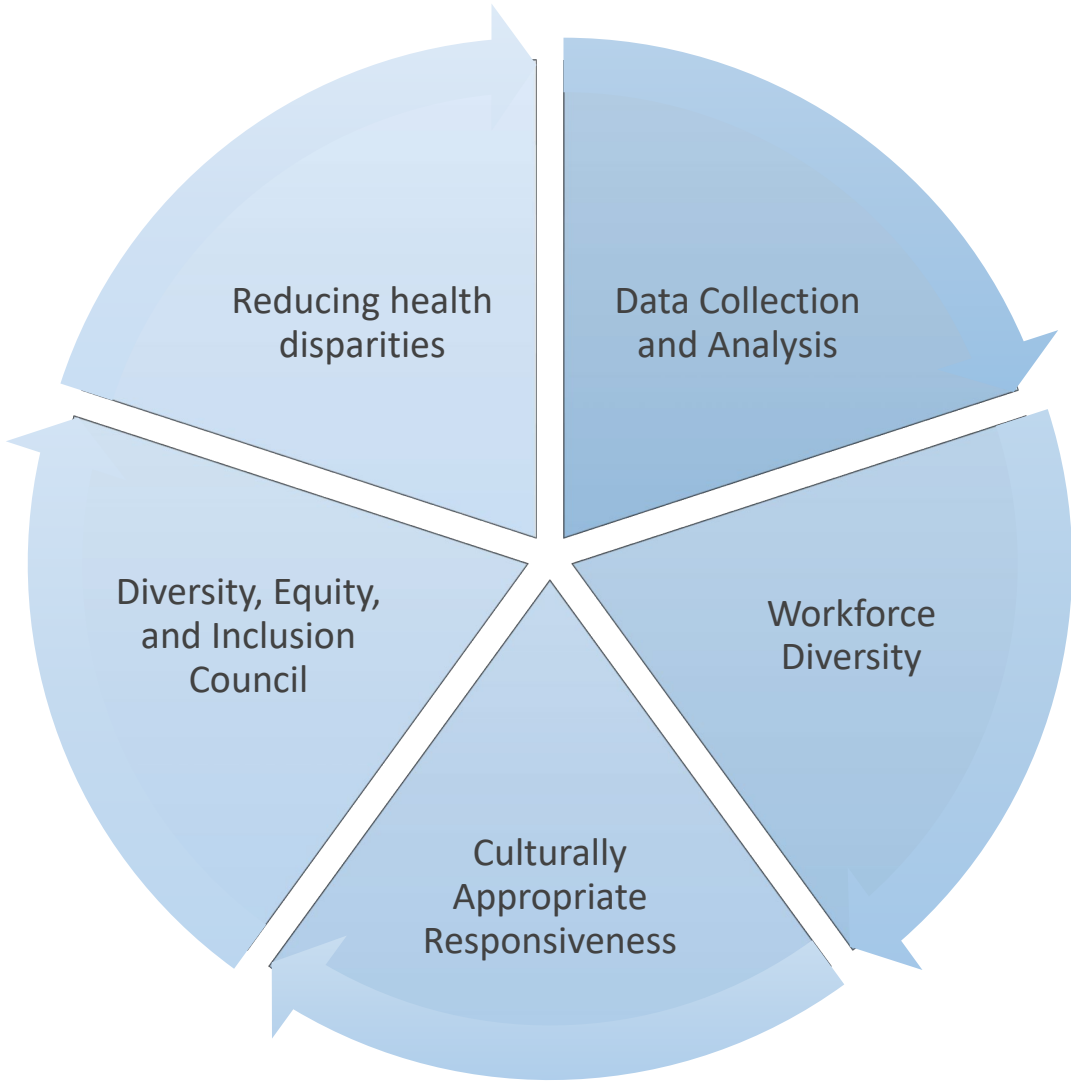
Delivery System Infrastructure	• Purchase or upgrade of ECM and CS IT systems • Closed-loop on referrals • Billing systems/services • Enhancements to health information exchange capabilities
ECM Provider Capacity	• Expand ECM Provider networks • Hire and train ECM care managers, care coordinators, community health workers
CS Provider Capacity	• Build/expand CS Provider networks • Expand reach of CS offered
Quality Performance	• Reduce Health Disparities and Promote Health Equity • Baseline Reporting

CalAIM and Health Equity

CalAIM's objective is to address health inequities through:

- Data collection
- Workforce diversity
- Culturally appropriate responsiveness
- Leveraging GCHP's Diversity, Equity, and Inclusion Council
- Closing racial disparities through quality measures



Population Health

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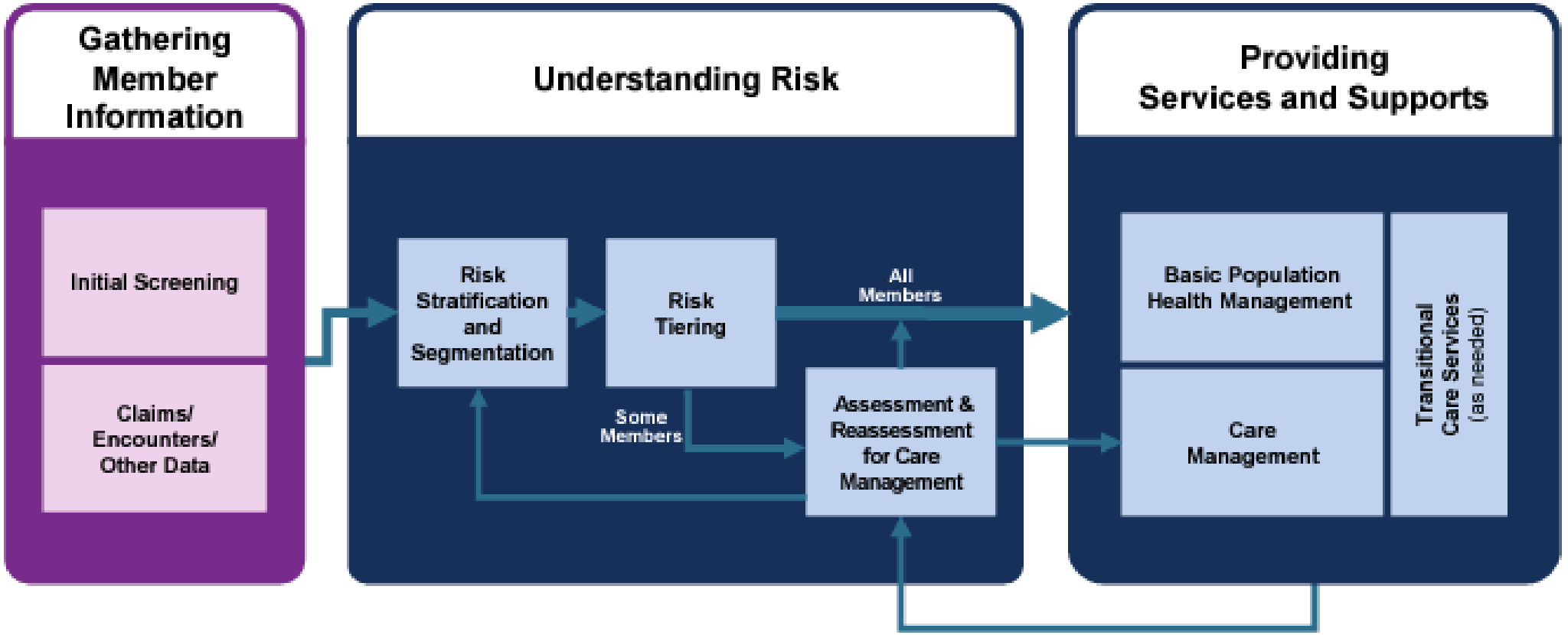
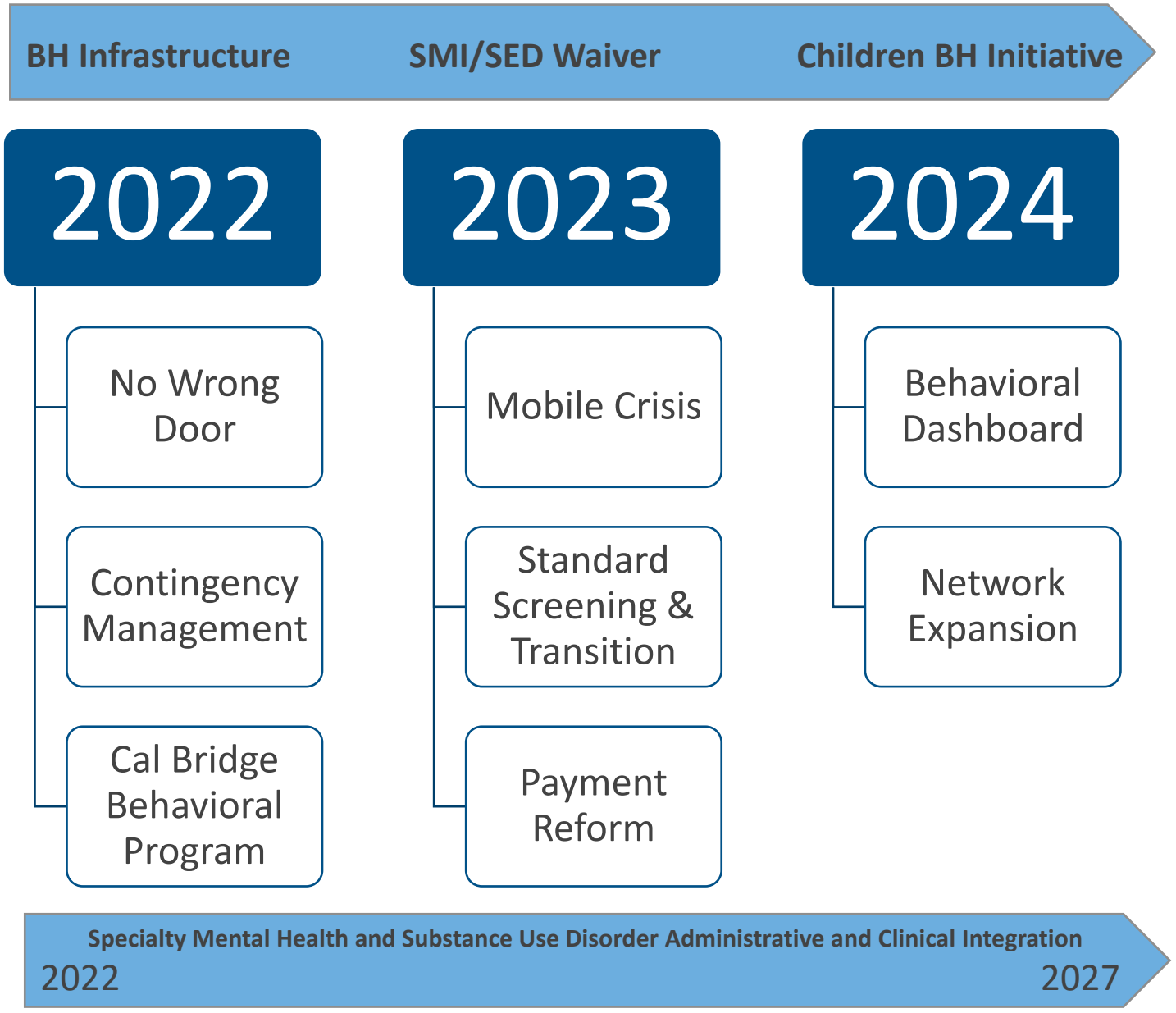
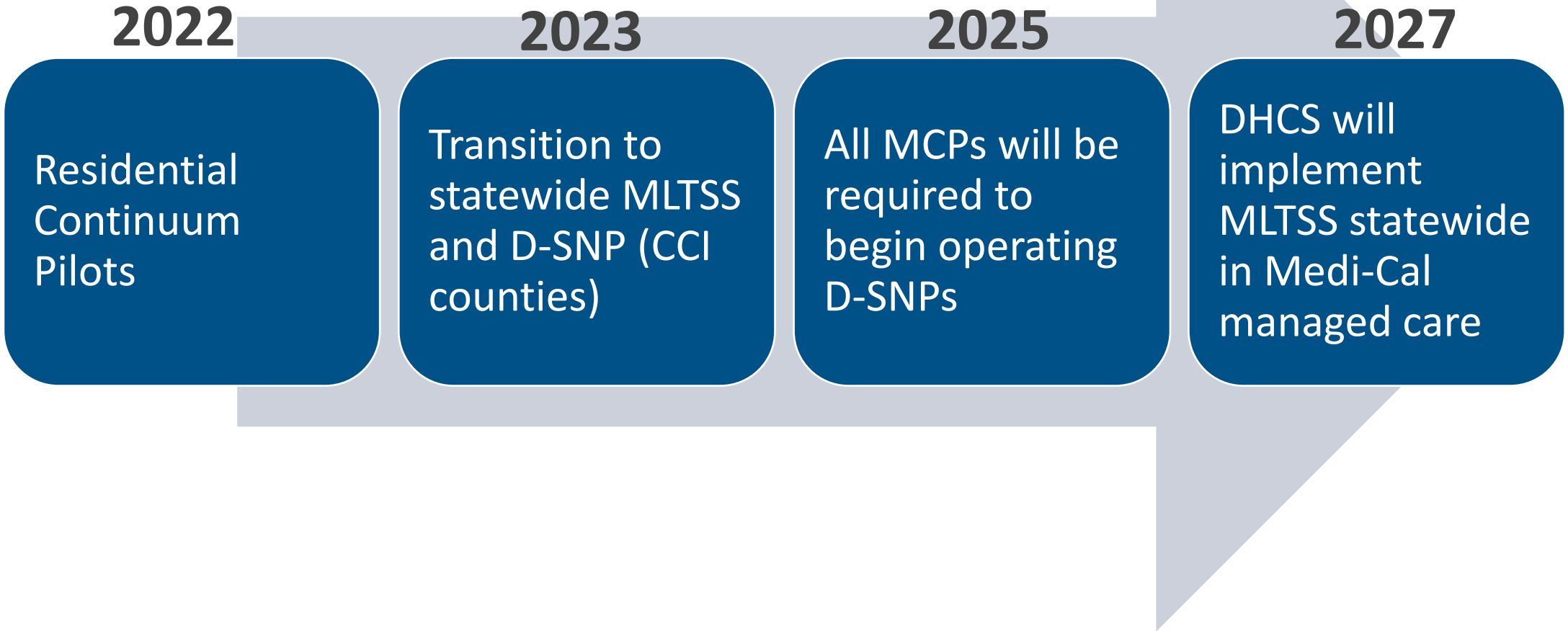


Behavioral Health



Dual Eligible Special Needs Plans (D-SNPs) & Managed Long-Term Services and Supports (MLTSS)



CalAIM Timeline

Jan. 1, 2022

- DHCS – Administrative Integration of SMH and SUD
- DHCS – Benefits Standardization
- Transplants In/MSSP Out
- DHCS – Dental (new benefits and P4P)
- GCHP - Launch Enhanced Care Management (ECM)/Community Supports (ILOS)
- GCHP – Incentive Payment Program Launch
- DHCS – Mandatory Managed Care Enrollment
- Non-Duals
- DHCS – PATH Funds
- (ECM, Community Supports, Justice-Involved)
- DHCS – Regional Capitation Rates and Shared Savings/Risk
- DHCS – Specialty Mental Health Services - Criteria for Services
- DHCS – DMC-ODS Renewal and Policy Improvements

July 1, 2022

- DHCS/GCHP – Behavioral Health No Wrong Door
- DHCS – Contingency Management
- DHCS – SMI/SED IMD Waiver
- DHCS – Transition to statewide LTSS and D-SNP (CCI ends)
- GCHP – Community Supports
- Short-Term Post-Hospitalization Housing

Jan. 1, 2023

- DHCS – Behavioral Health CPT Code Transition
- DHCS/GCHP – Behavioral Health Standard Screening and Transition Tools
- DHCS/GCHP – Justice Involved Package
- GCHP – Community Supports
- Day Habilitation Programs
- GCHP – PHM Program Launch
- GCHP – ECM available for Individuals Transitioning from Incarceration (adults and children/youth); Members Eligible for long-term care (LTC) and at risk of Institutionalization; and Nursing Home Residents Transitioning to the Community

July 1, 2023

- DHCS – Population Health Management service launch
- DHCS – Behavioral Health Payment Reform
- DHCS – County CCS Oversight
- DHCS – SMI/SED IMD Waiver
- GCHP – ECM available for all children and youth Populations of Focus

Jan. 1, 2026

- DHCS – Transition to statewide LTSS and D-SNP (CCI ends)
- GCHP – NCQA accreditation

Jan. 1, 2027

- DHCS – Full administrative Integration of SMH and SUD
- GCHP/DHCS – Full transition to statewide LTSS and D-SNP (CCI ends)
- DHCS – Full integration plans

Source: www.dhcs.ca.gov/CalAIM/Pages/timelines.aspx

CalAIM Advisory Committee

The CalAIM Advisory Committee will:

- Assist in promoting culturally and linguistically appropriate care for members.
- Evaluate the performance of the ECM benefit and CS Program.
- Provide feedback to GCHP regarding community, member, and provider experiences.
- Provide guidance on future decisions related to the benefit and program.

Questions?

For more Information please visit:

- Gold Coast Health Plan CalAIM Resources: www.goldcoasthealthplan.org/health-resources/calaim/
- DHCS CalAIM Resources: www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx

Contact:

- CommunityRelations@goldchp.org