Leveraging Funding to Support and Sustain Home Visiting: Session 2

January 3, 2022

FIRST 5 CALIFORNIA℠

jba JAMES BELL ASSOCIATES

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

Home Visiting Applied Research Collaborative HARC

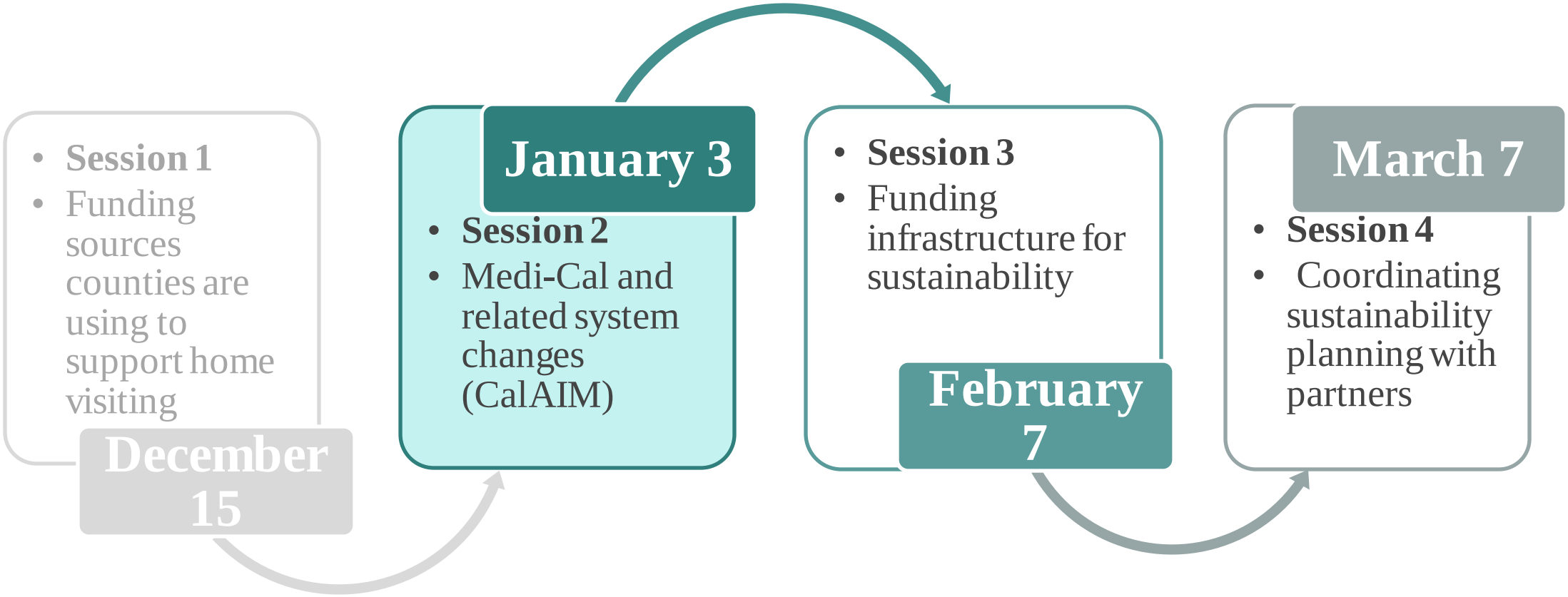
Welcome!

Introductions

This or that?

An empty inbox…	OR	A day with no meetings?
One long vacation…		Lots of long weekends?
Analyze the data…		Present the findings?
Lead the meeting…		Write the reports?

Leveraging Funding TA Roadmap



Today's Session

- Orientation to Medi-Cal
- Implications for First 5 System Change Work and Home Visiting
- Discussion: Opportunities for home visiting to be an eligible service with CalAIM

Orientation to Medi-Cal

Why Focus on Medi-Cal?

- Approximately 50% of children receive their health care through Medi-Cal in California

- Families should have significant engagement with the health care system and preventive services from the prenatal period through the first 5 years

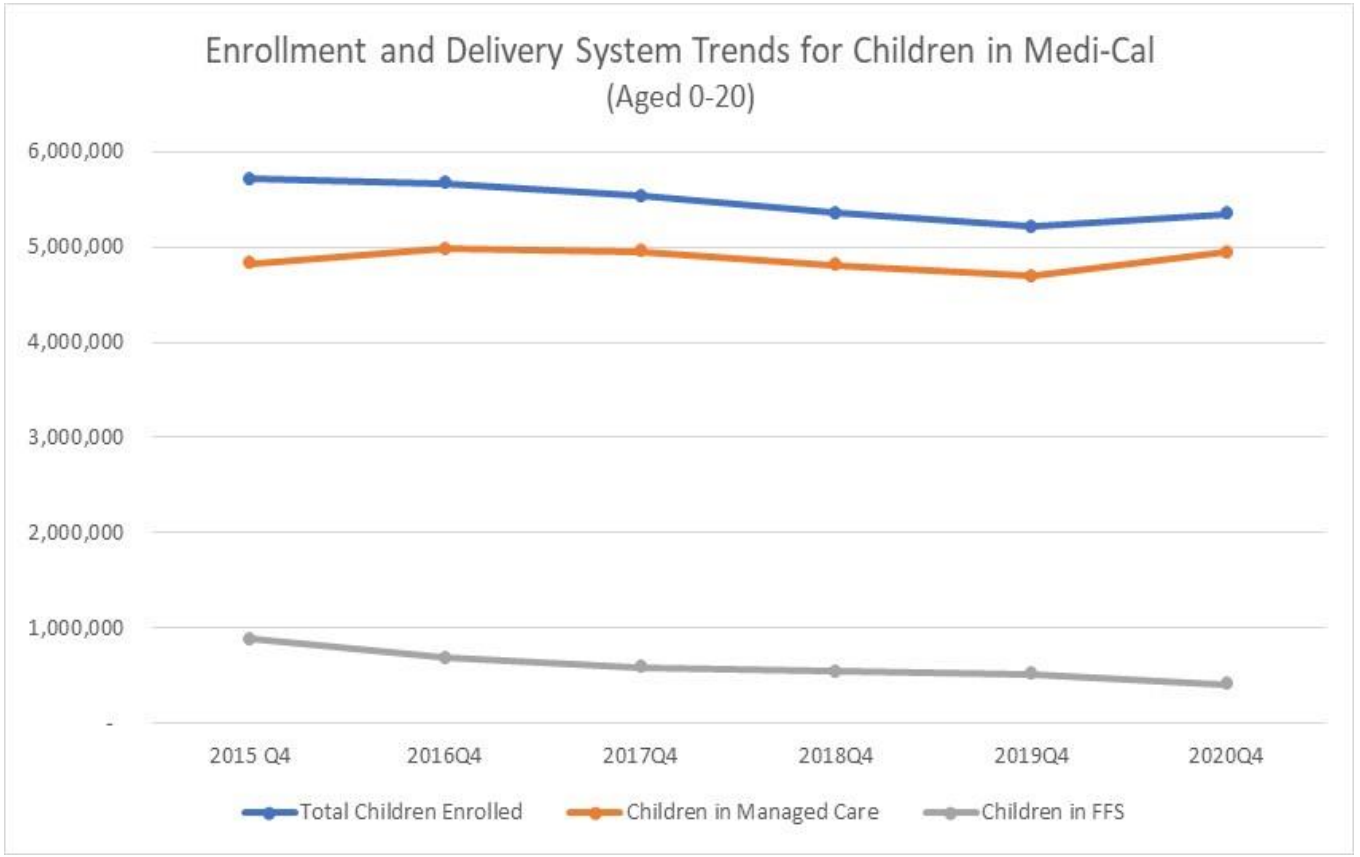
- Medi-Cal system has been under-going significant change with increased responsibilities for managed care plans

What is Medi-Cal?

- "Medi-Cal" is California's version of the Medicaid program, the nation's public health insurance program for low-income individuals and families, people with disabilities and low-income seniors
- Program beneficiaries are legally entitled to health care coverage
  - Unlike Medicare, Medicaid beneficiaries, in general, do not financially contribute to the program. (Some beneficiaries pay share of cost or small premiums)
- Funded by federal and state governments
  - For California, federal government contributes between 50-90% of funds depending on the type of Medi-Cal member
- Regulated by federal and state agencies
  - Centers for Medicare and Medicaid Services (CMS)
  - Department of Health Care Services (DHCS)
  - Department of Managed Health Care (DMHC)
- Administered by the State of California within broad federal requirements

Almost all children in California receive healthcare through a managed care plan

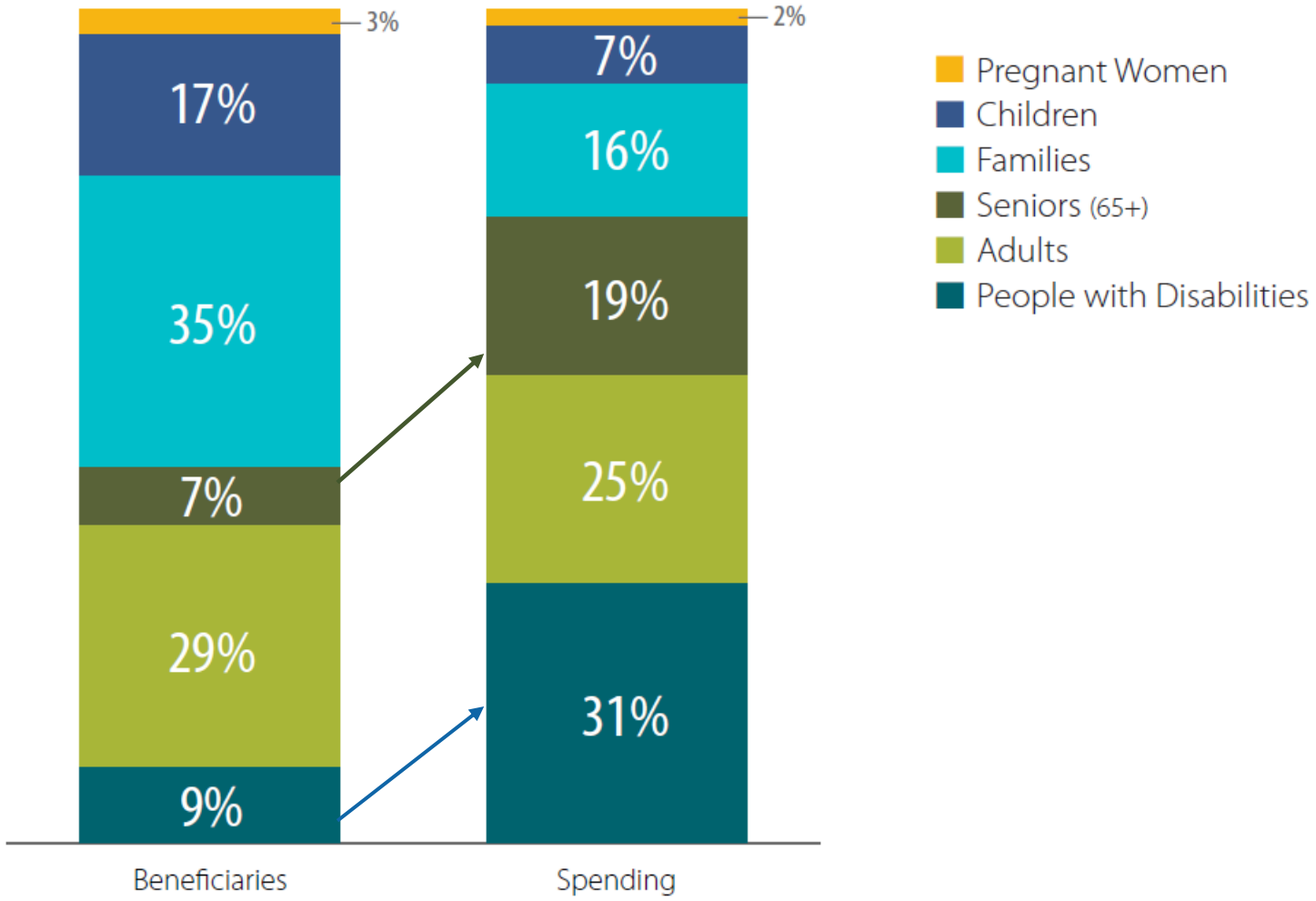
Approximately 50% of children 0-5 are enrolled in Medi-Cal;
90% children are in Medi-Cal managed care



Note: FFS - Children in Fee for Services Medi-Cal

Source: California DHCS - Medi-Cal Children's Health Dashboard (March 2021)

Medi-Cal – Beneficiaries and Spending (2019 Data)



Source: CHCF https://www.chcf.org/publication/2019-medi-cal-facts-figures-crucial-coverage/#related-links-and-downloads

Under managed care, the State contracts with health plans to oversee and coordinate the health of assigned plan members

Department of Health Care Services — Medi-Cal

Administers policy:
eligibility, benefits, reporting, compliance

The State has policy control while the counties have operational control.

DHCS Contracts with health plans to coordinate care

Local Health Plans

- L.A. Care Health Plan
- CalOptima — A Public Agency — Better. Together.
- Alameda Alliance for Health — Health care you can count on. Service you can trust.
- IEHP — A Public Entity — Inland Empire Health Plan
- CalViva Health
- Gold Coast Health Plan — A Public Entity

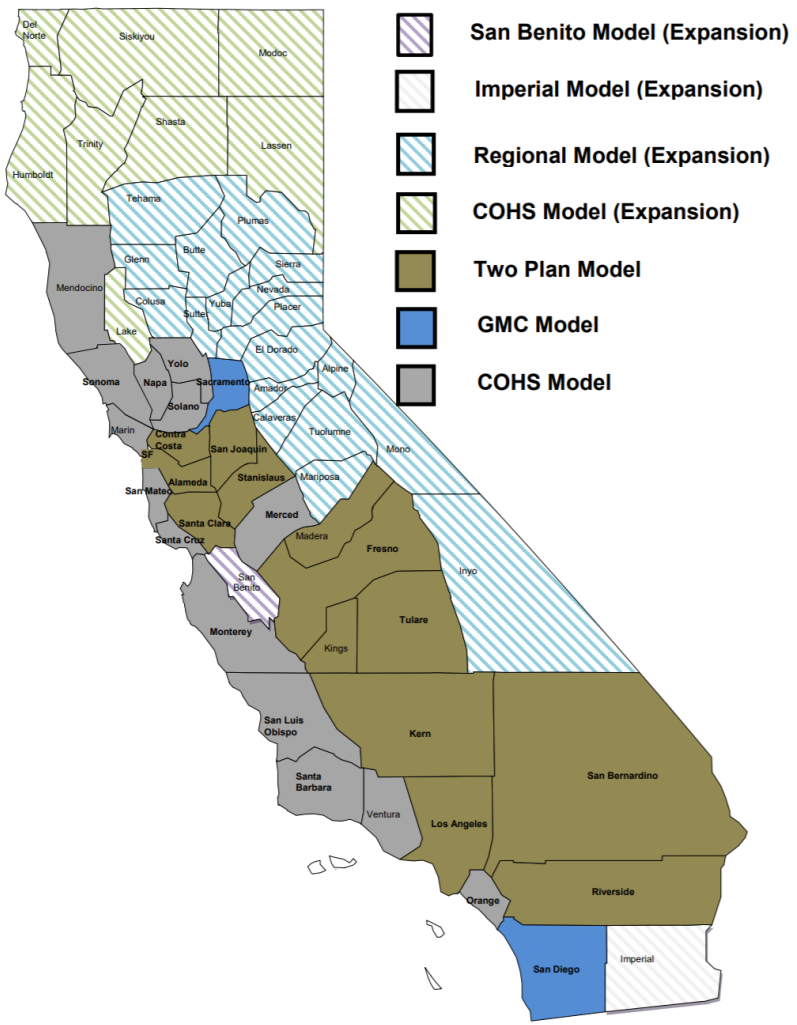
Commercial Health Plans

- blue california
- promise Health Plan
- Kaiser Permanente
- Anthem BlueCross
- Molina Healthcare
- Health Net

Model and specific health plans vary by county

Six different models exist in CA depending on the County

- The California Department of Health Care Services (DHCS) contracts for health cares services through established networks of organized system of care
- California's Medi-Cal managed care program uses six distinct models:
  - Two-plan model counties have a commercial plan and a local, county-organized plan
  - Regional model counties have two commercial plans
  - County Organized Health Systems, in which the state contracts with a plan created by the County Board of Supervisors
  - Geographic Managed Care, with several commercial plans per county
  - Imperial County (two commercial plans)
  - San Benito County (one commercial plan)



Statewide Medi-Cal Managed Care Performance

Recent advocacy reports have highlighted CA's poor performance on prevention services for children; pandemic impact has likely lowered performance

Measure	2017	2018	2019	2020
Adolescent Well-Care Visits*	--	--	--	52.95%
Childhood Immunization Status—Combination 10*	--	--	--	38.32%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	93.14%	92.99%	93.39%	93.69%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	83.92%	84.43%	84.92%	85.75%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	86.29%	86.85%	87.18%	87.88%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	83.50%	84.44%	85.02%	85.88%
Developmental Screening in the First Three Years of Life—Total*	--	--	--	25.42%
Immunizations for Adolescents—Combination 2**	26.89%	37.84%	41.65%	43.57%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation —Total ***	--	–	–	86.71%
Well-Child Visits in the First 15 Months of Life — Six or More Well-Child Visits*	--	--	--	54.62%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.90%	75.44%	73.68%	75.07%

-Data Source: Medi-Cal Managed Care External Quality Review Technical Report July 1, 2019–June 30, 2020.
-Rates reflect Measure Year (MY) data from January 1 through December 31 of each reported year.
-Performance comparisons are based on the Chi-square test of statistical significance with a *p* value of <0.05.
-Additional Data on Medi-Cal Managed Care – Quality Improvement & Performance Measurement Reports is available on the DHCS website.
* This is a new reporting measure starting in CY 2020; therefore, no data is available for CYs 2016 through 2019.
** In CY 2017 DHCS replaced Immunizations for Adolescents—Combination 1 with the Immunizations for Adolescents—Combination 2 measure.
*** This measure was not reported in the Medi-Cal Managed Care External Quality Review Technical Report from 2017 through 2019.

FY 2020/21 Budget included multiple benefit expansions that address maternal and pediatric prevention services

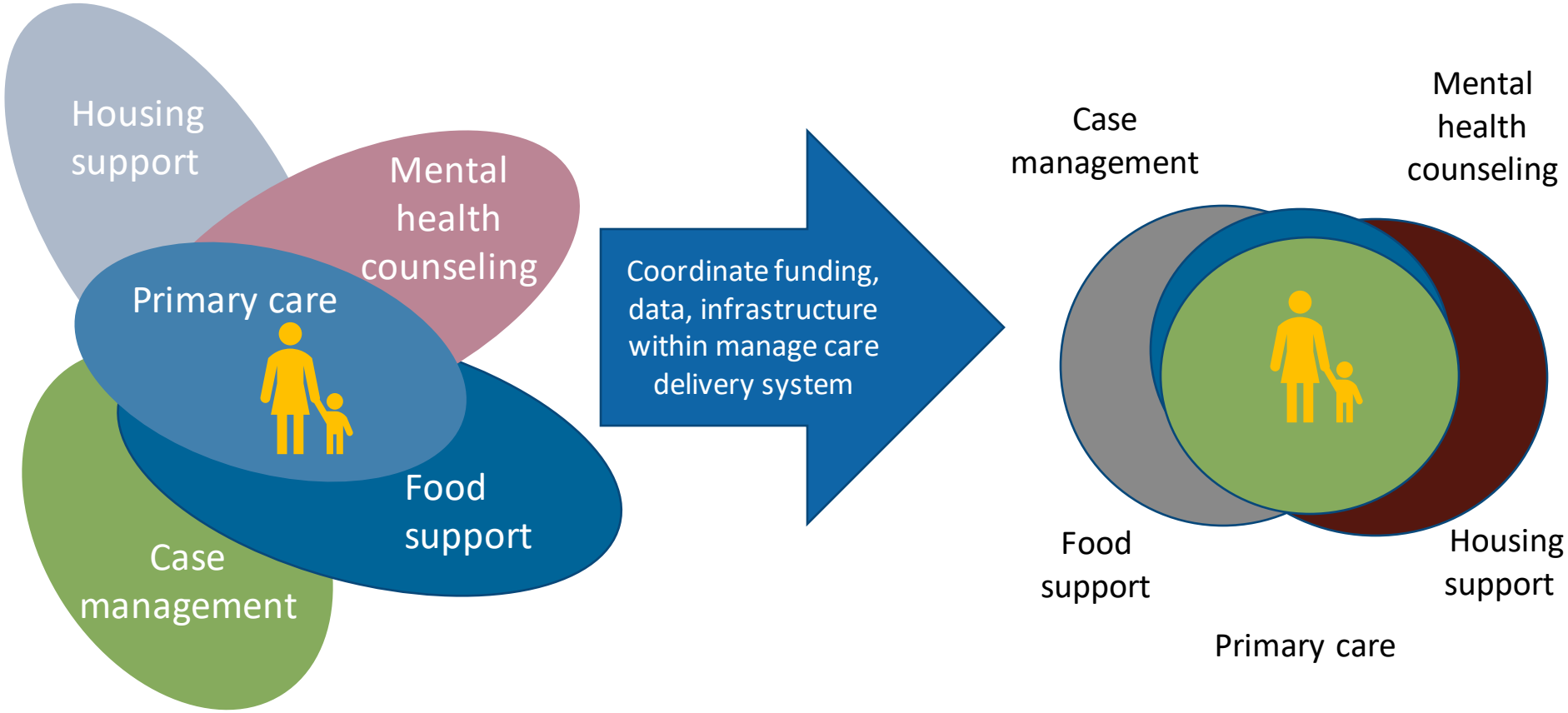
- Five-year extension of **Medi-Cal eligibility for postpartum individuals to 12 months** after birth
- **Addition of doula services as a covered Medi-Cal benefit,** effective July 1, 2022
- Addition of **Community Health Workers to provide culturally responsive care to Medi-Cal clients**, increasing investments up to $201 million by 2026-27
- **Continuance of Prop. 56 supplemental payments that incentivize well-child visits and screenings** for ACES and developmental delays ($550 million, ongoing)
- Other Provisions
  - Coverage of services for 30 days prior to release for justice involved populations
  - Medi-Cal coverage to undocumented adults aged 50 years and older, including access for In-Home Support Services

California Advancing and Innovating Medi-Cal (CalAIM): GOALS

- Provides a framework for broad-based delivery system, program, and payment reform across the Medi-Cal Program. Three goals:

Through CalAIM, Managed Care Plans have increasing responsibilities for highest risk populations, including pregnant women

Over the next five years, managed care organizations (health plans for Medi-Cal beneficiaries) will become the central coordinators of care for the **highest risk populations** and have increased responsibility for all beneficiaries through **population health management**. Plans have increasing responsibility for **managing member risk and needs** including **social determinants of health.**



HEALTH MANAGEMENT ASSOCIATES

Enhance Care Management (ECM) represents the first major implementation step under CalAIM

Provides a whole person care approach to address the clinical and nonclinical supports for high-need/high-cost members through systematic coordination of services

1. Builds on the current Health Homes Program and Whole Person Care Pilots; transitions pilots to a new ECM benefit. All current participants in WPC pilots transition Jan 1, 2022
2. Community Supports provide flexible, wrap around services that are provided as a substitute to avoid other covered services, focus on housing, day programs, meals, sobering centers, asthma remediation
3. Together, provide financial incentives to develop infrastructure and care management models

Enhanced Care Management: Populations of Focus

Adults	Children/Youth up to 21
1) Individuals and families experiencing Homelessness;	
2) High Utilizers;	2) High utilizers;
3) Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD);	3) SED, identified to be at Clinical High Risk (CHR) for psychosis or experiencing a First Episode of Psychosis;
4) Incarcerated and Transitioning to the Community;	
5) At risk for Institutionalization and Eligible for LTC;	5) Enrolled in CCS / CCS Whole Child Model (WCM) with Additional Needs beyond CCS;
6) Nursing facility Residents Transitioning to the Community.	**6) Involved in Child Welfare (including those with a history of involvement, and foster care up to 26).**
January 2022: Begins adult implementation	July 2023: Children implementation

ECM provides an opportunity to provide intensive supports to highest risk populations, including pregnant women, through community-based services

- **Are pregnant women eligible for ECM services?**
  - Pregnant and parenting women are not specifically identified as a target population for ECM
  - May qualify within target populations homeless, at risk of homeless, Seriously Mental Ill/Substance Use Disorder
  - Interventions, such as intensive home visiting, could be eligible services for this high-risk population
- **Who can provide ECM services?**
  - **Community-based entities with experience** and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM
    - Provide culturally appropriate and timely in-person care management activities including accompanying members to critical appointments
    - Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways

Implications for First 5 System Change Work and Home Visiting

Opportunities for First 5s

- Know how your **managed care health plan is performing** in your County
  - Review most recent report on each plan's performance available on DHCS website
  - https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEQRTR.aspx

- **Track implementation** of expanded benefits approved in the FY 2021/22 Budget to support implementation in your county
  - Community Health Workers (July 2022)
  - Doulas (July 2022)
  - Opportunities for First 5s
    - Scope and eligibility requirements currently being developed by DHCS; *potential for HVs to fall under CHW provider definitions*

Opportunities for First 5s

- **Monitor implementation** of CalAIM
  - ECM (2022): Intense care management for high-risk populations
    - Advocate for unique interventions, include intensive home visiting models, to address the needs of pregnant/parenting women who may meet the ECM threshold (housing, dyad interventions)
  - Population Health (2023): Plans have new responsibility to focus on preventive and wellness services, identify and assess members risks and needs, identify and mitigate SDOH and reduce disparities
    - Serve as connector/intermediary between health plans and community providers that are delivering prevention services including home visiting
- Understand how **procurement may impact plans** in your county
  - Potential new partnerships, particularly in competitive counties
  - Some counties may be changing current model (e.g., Alameda, Contra Costs, Imperial, Mariposa, Alpine, El Dorado, etc.)

Discussion

Group Discussion

- What opportunities do you see for your county to take advantage of CalAIM or Medi-Cal funding to support home visiting?
- To what degree have you been involved with your county and managed care partner on ECM and CalAIM implementation?
  - What steps have you taken?
  - What have been barriers?

Thank You!

Katie Brennan

Brennan@jbassoc.com

(703) 552-9098

www.jbassoc.com