Inclusive Alliance

CalAIM, Enhanced Care Management, & Pathways Community HUB: Considerations for Health Homes & Downstream CMAs in New York Preparing for Health Home Changes

Heidi Arthur, HMA Principal
Katie Clay, HMA Associate Principal

1115 Waiver Webinar Series:

July 19, 2023

Logistics & Learning Objectives

- Logistics:
  - Please send your questions in by using the Q&A box in Zoom
  - Slides & recording will be shared with registrants by Friday
- Learning Objectives:
  - Understand the different care management/care coordination programs in use in California & how they are financed
  - Appreciate the differences between California and New York State's care management/care coordination context
  - Generate additional questions to guide future data collection & analysis

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ABOUT US

Our Mission

To advance the growth and quality of cost effective and inclusive individual services for children and adults through innovation, collaboration and coordination.

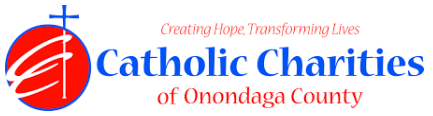
Our Purpose

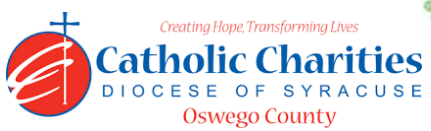
Prepare members for Managed Care and the transition to value-based payment (VBP)

Independent Practice Association (IPA) of community-based organizations of varying sizes and scopes of services.

2016	501c3	39
Year Founded	Not-for-profit	Members (& Growing!)

Meet Our Inclusive Alliance Members – July 2023





Overview of New York's 1115 NYHER Waiver Amendment

New York is requesting $13.52B over five years to fund an 1115 Waiver Amendment.

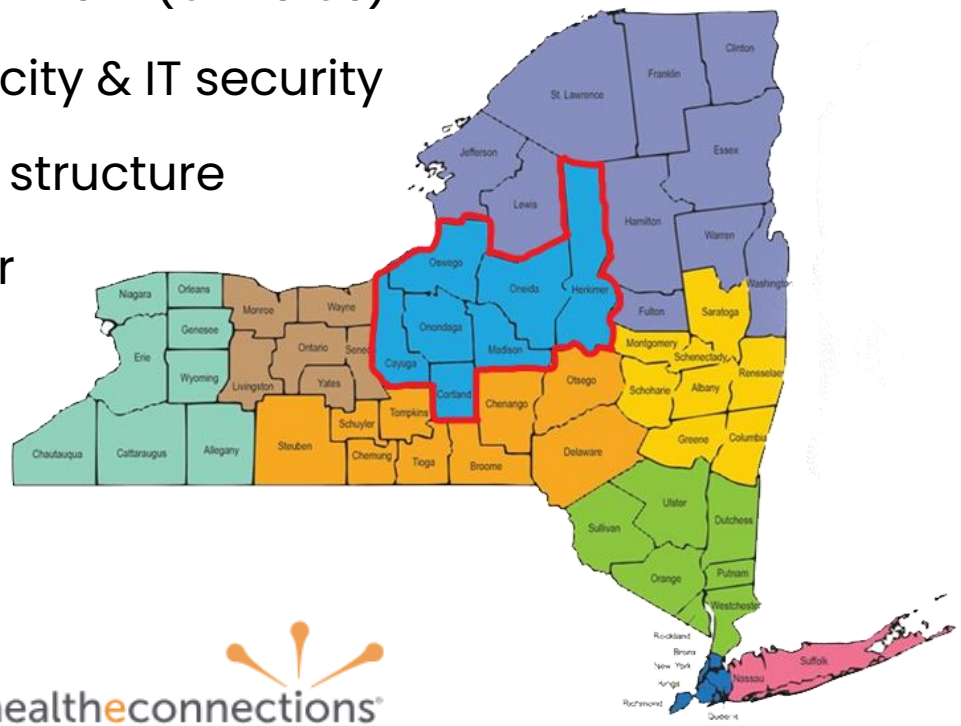
The Amendment includes one goal and four main strategies:

Goal: Reduce health disparities, advance health equity, and support the delivery of social care

Strategy #1	Strategy #2	Strategy #3	Strategy #4
Building a More Resilient, Flexible and Integrated Delivery System that Reduces Health Disparities, Promotes Health Equity, and Supports the Delivery of Social Care	Developing and Strengthening Transitional Housing Services and Alternatives for the Homeless and Long-Term Institutional Populations	Redesign and Strengthen System Capabilities to Improve Quality, Advance Health Equity, and Address Workforce Shortages	Creating Statewide Digital Health and Telehealth Infrastructure

Inclusive Alliance's Qualifications to lead a Social Care Network

- Non-profit IPA network covering all Region 7 counties & HRSNs (food, housing, & transportation)
- 2.5 years' experience co-managing a regional referral network (Unite Us)
- Data warehouse & experience assessing CBO data capacity & IT security
- Local CBO-lead, representative, democratic governance structure
- Central administrative hub for contracting & payment for evidence-based interventions delivered by CBOs
  - Pathways Community HUB
  - National Diabetes Prevention Program
- Key Partners:



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All in for better health

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Independent Pratice Association

Human Services Leadership Council of Central New York

healtheconnections

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1115 NYHER Waiver Amendment Updates

- New York's 1115 NYHER Waiver Amendment Request is still pending approval by CMS
- Despite statements from DOH anticipating initial agreement in July, we now expect approval will not occur before the fall
- The focus on CBO networks organized to deliver new, Medicaid-reimbursable health-related social need (HRSN) services & on improving health equity remains consistent

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HRSN Services Funded by Other State Medicaid Waivers

State	Housing Supports	Air Quality	Food	Transportation	Medical Respite	Care Coordination	Interpersonal Violence/Toxic Stress	Linkage to Legal Support
Arkansas	X		X					
Arizona	X					X		
California	X		X		X	X		
Massachusetts	X	X	X			X		
North Carolina	X		X	X	X	X	X	X
Oregon	X	X	X	X		X		

Source: [Commonwealth Fund]

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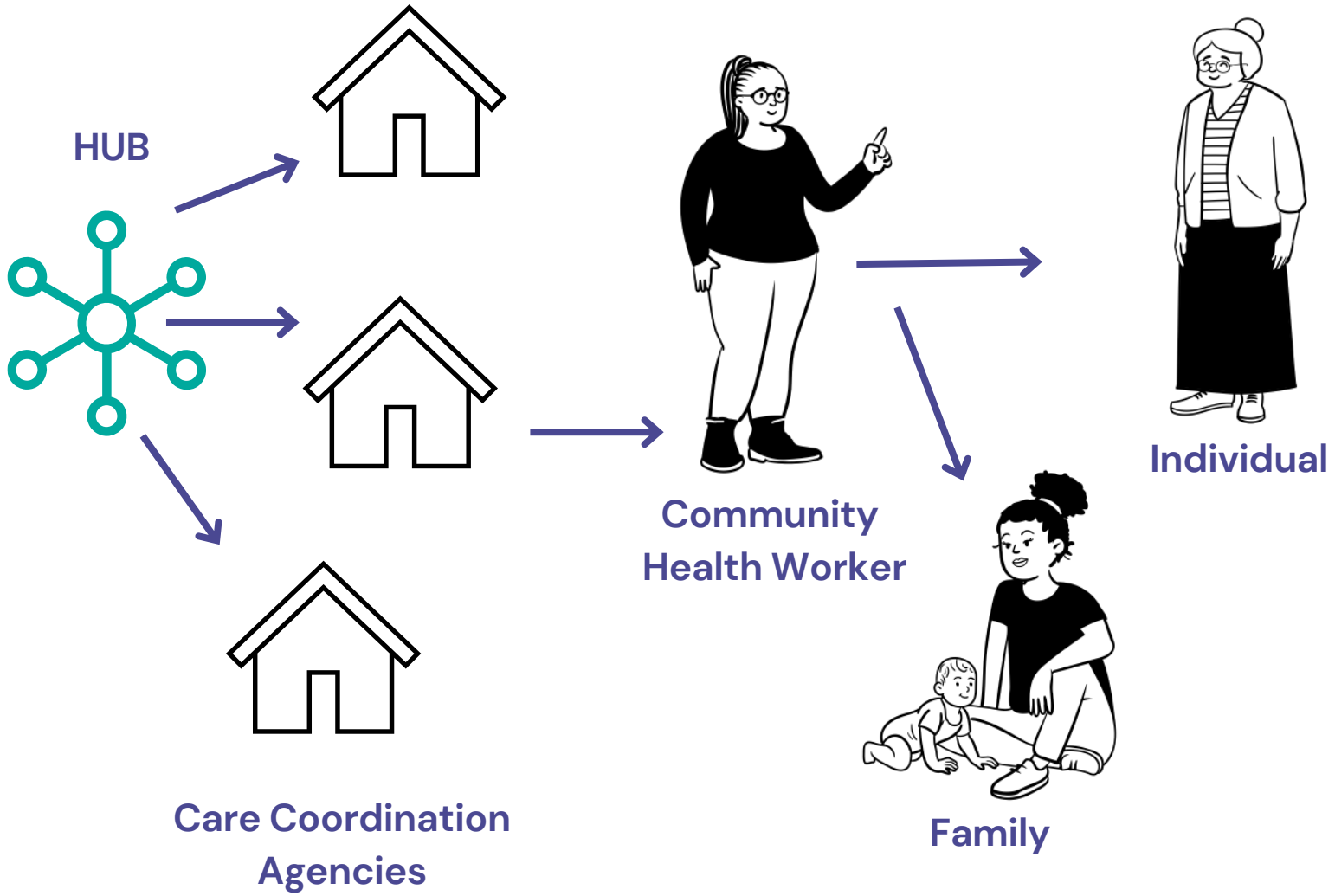
What Is a Pathways Community HUB (PCH)?

Both a standardized, evidence-based approach to community health work AND the central administrative infrastructure that supports CHWs to ensure services have measurable impact, are financially sustainable, & respond to community need



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CalAIM, Enhanced Care Management, and the Pathways Community HUB – Considerations for Health Homes & Downstream CMAs in New York Preparing for Health Home Changes

PRESENTED BY:

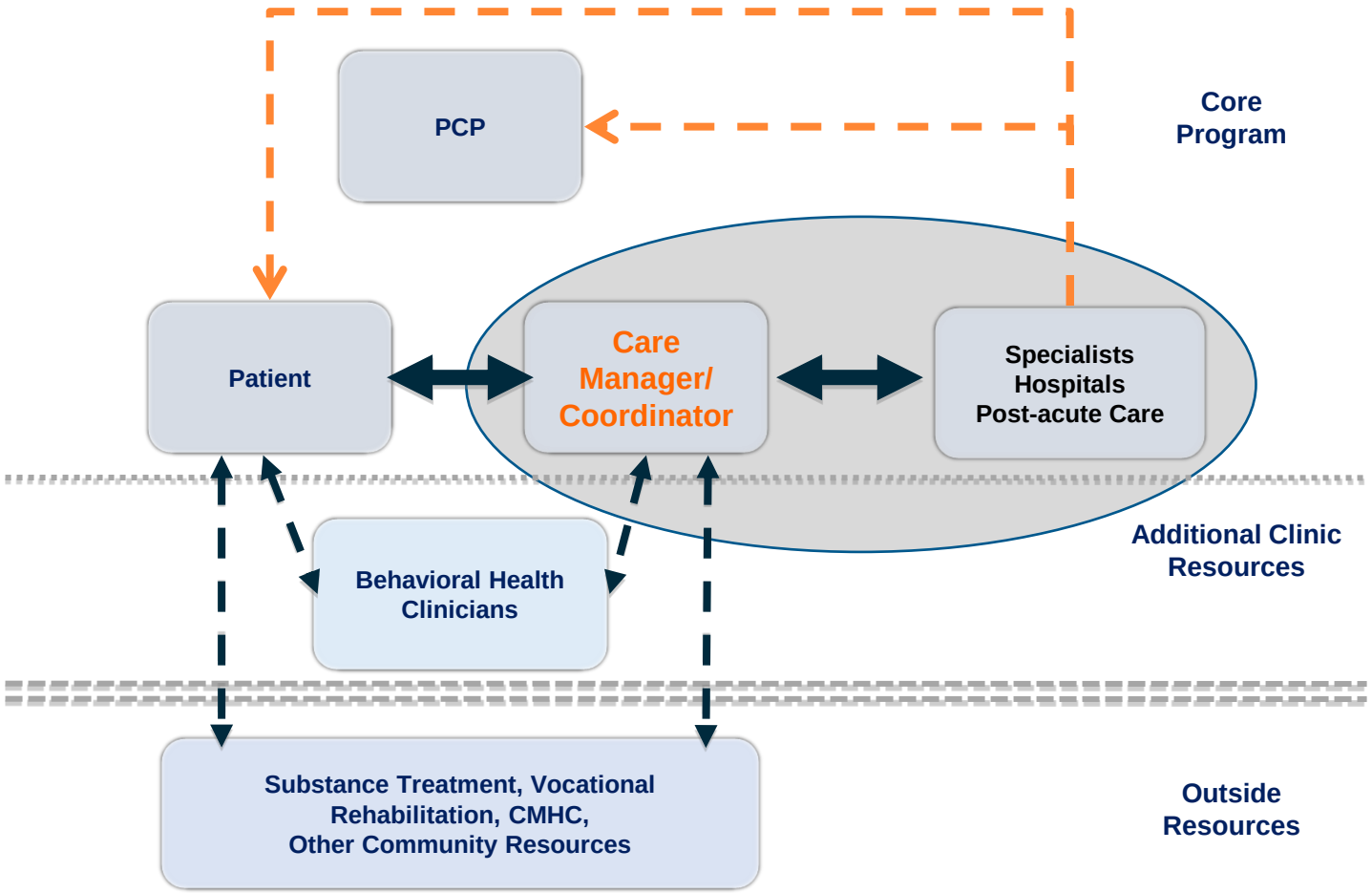
Heidi Arthur, Principal

Katie Clay, Associate Principal

AGENDA

- California’s Enhanced Care Management and Community Supports Program
- Future of Care Management and Community Supports in NY
- The Inclusive Alliance Vision

CARE MANAGEMENT: CRITICAL TO SUCCESS IN INTEGRATED, VALUE-BASED CARE



CALIFORNIA'S ENHANCED CARE MANAGEMENT

CALIFORNIA: ENHANCED CARE MANAGEMENT AND COMMUNITY SUPPORTS

- Enhanced Care Management has recently expanded California's Health Home and Whole Person Care pilot programs to address complex care management for a broader population statewide
- Managed Care Plans have access to funds to support local entities, including CBOs, to provide Medicaid-financed Enhanced Care Management and new Community Supports for Medi-Cal enrollees with complex health needs and unmet social needs
- ECM is reimbursed PMPM
- Networks are developing to deliver ECM and Community Supports

ENHANCED CARE MANAGEMENT

- ECM offers intensive coordination of health and health-related services meeting enrollees wherever they are
- ECM is conducted by a lead CM who can be supported by a CHW; in some cases, the lead CM could be a CHW.
- ECM tasks, activities, and scope will vary by Member, contracting entity, and ECM team composition

Individuals and families experiencing homelessness.

Adults, youth, and children who are high utilizers of avoidable emergency department, hospital, or short-term skilled nursing facility services.

Adults with serious mental illness or substance use disorder.

Children and youth with serious emotional disturbance, identified to be at clinical high risk for psychosis or experiencing a first episode of psychosis.

Adults and youth who are incarcerated and transitioning to the community.

Adults at risk of institutionalization and eligible for long-term care.

Adult nursing facility residents transitioning to the community.

Children and youth enrolled in California Children's Services (CCS) with additional needs beyond CCS.

Children and youth involved in child welfare (including those with a history of involvement in welfare, and foster care up to age 26).

ECM SERVICES

Community-based outreach, Engagement, and Risk Screening

- Outreach to those who are homeless or hard-to-find
- Culturally Competent Communication
- Documentation of Outreach Attempts
- Confidentiality Protection

Comprehensive Assessment and Care Management Plan

- Risks, Needs and Strengths Assessment
- Goal Setting and Prioritizing
- Care Team Identification, Convening, and Facilitation
- Individualized Care Plan Development
- Re-assessment and Care Plan Updates

Enhanced Coordination of Care

- Guide care plan implementation
- Coordinate Care Team Communication
- Coordinate access to care
- Support for treatment adherence, including compliance with medication and attendance at appointments
- Member Advocacy
- Ongoing Engagement

Health Promotion

- Identify opportunities for health within Member's current or potential network
- Health Education and Coaching
- Support for self-management to achieve wellness goals

Comprehensive Transitional Care

- Inpatient Admission/Readmission Prevention
- Transition Planning
- Support for Treatment Adherence, including Medication Review and Reconciliation
- Use technology, tools, and targeted interventions to support successful community integration and avoid re-admission

Member and Family Supports

- Identifying Family Support
- Family Engagement
- ECM Single Point of Contact
- Connection to Wellness Supports
- Health Education
- Sharing the Care Plan and Updates with Member

Coordination of and Referral to Community and Support Services

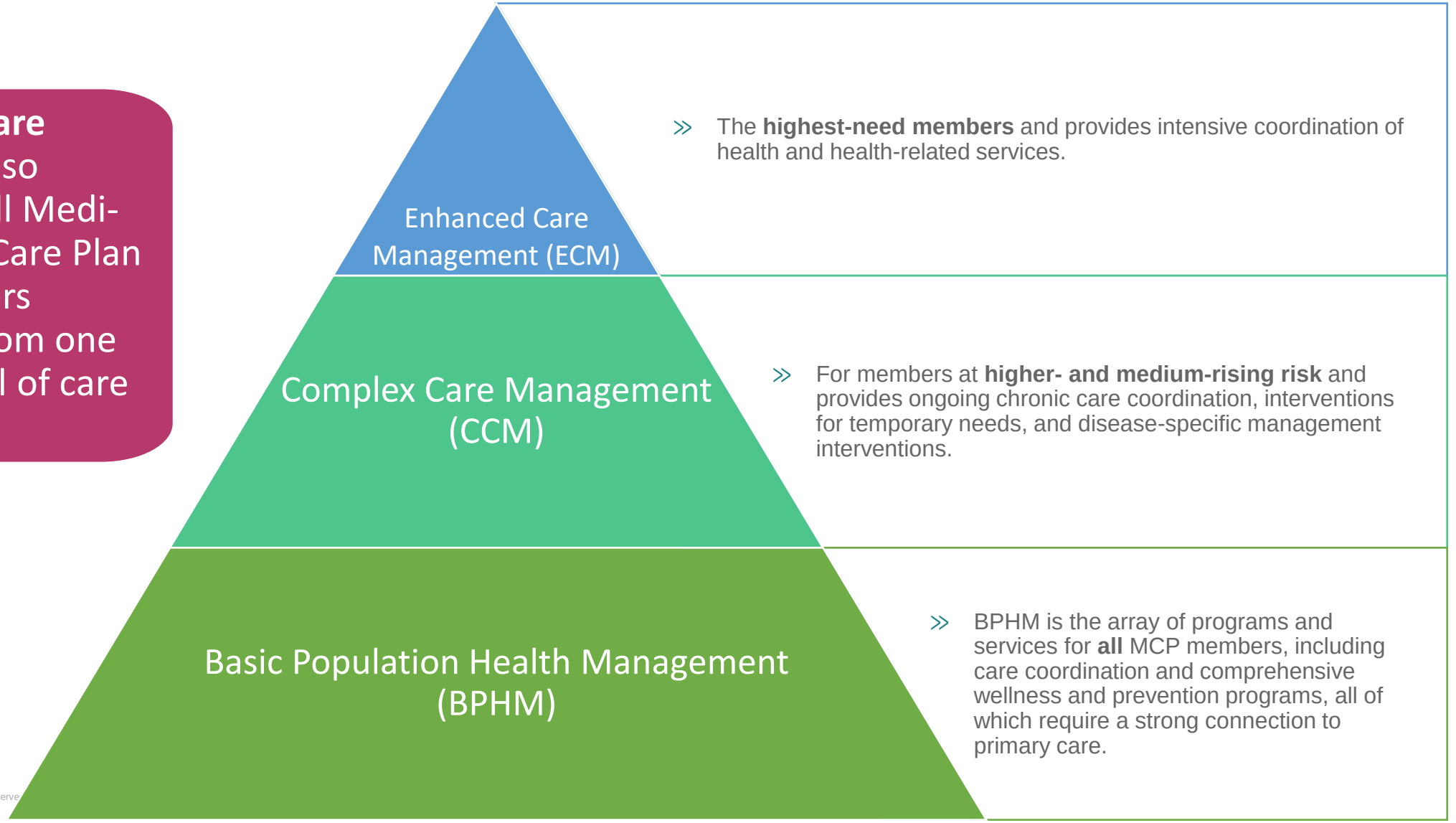
- SDOH Service Planning
- ILOS Screening and Eligibility Assessment
- Closed Loop Referrals

MEDI-CAL'S COMMUNITY SUPPORTS FOR SOCIAL HEALTH

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Day Habilitation Programs
- Caregiver Respite Services
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

CALAIM CARE MANAGEMENT CONTINUUM

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



- The **highest-need members** and provides intensive coordination of health and health-related services.
- For members at **higher- and medium-rising risk** and provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions.
- 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.

FUTURE OF CARE MANAGEMENT IN NY

CARE MANAGEMENT LANDSCAPE

Health Home Budget Cuts

- $30M budget cut in FY2023-2024, $70M budget cut in FY2024-2025
- Focus is on the Health Home CM and Health Home High Risk Rates
- Continued Eligibility Screening Tool
- Step down processes
- Cuts did not include Health Homes Serving Children or CCOs

Sunsetting of State Guaranteed Rates

- Initial state guaranteed rates are currently stipulated in managed care model contract
- Rates could sunset in mid-2024 and MCOs would negotiate rates with Health Homes

NYS 1115 Waiver

- Continued shift towards VBP with 50% of funding allocated for VBP
- VBP attribution could be based on Health Home or CCO
- Creation of Social Care Networks (SCNs)
- Some digital health and telehealth dollars for CM

CHW Benefit

- State Plan Amendment submitted to cover a CHW benefit in NYS

CHALLENGES IN FITTING NEW YORK STATE'S CURRENT HEALTH HOME MODEL INTO A CONTINUUM OF CARE

Health Home assignments are not aligned with VBP attribution

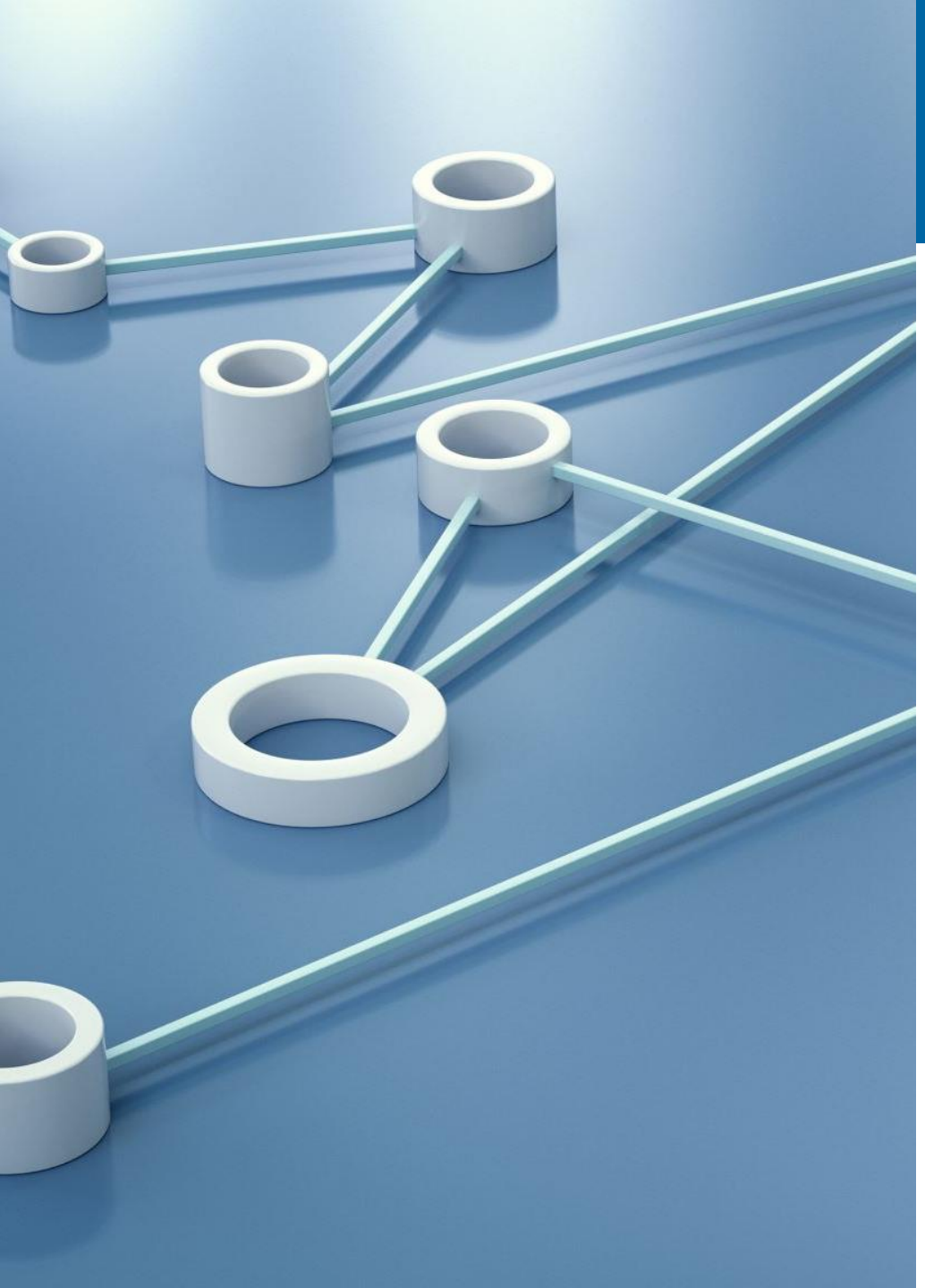
Use of Health Home Care Management is not standardized or mandated in VBP arrangements or networks, leading to the creation of duplicative infrastructure for Care Management

No standardized criteria, processes or programs for risk stratification, stepping up or stepping down levels of Care Management; Health Homes, MCOs or risk-bearing entities in VBP arrangements are all figuring this out differently

Many different payers that have different processes and different levels of integration with Health Homes

HEALTH HOME SUSTAINABILITY

- Cuts will likely lead to disenrollment of significant numbers of members (up to 30-40% of current enrollees)
- New members can be enrolled (NYS is still projecting 500-600,000 members are eligible but not enrolled)
- Health Homes need to consider pathways to sustainability



NYS 1115 WAIVER, BASED ON LATEST INFORMATION

- Regional Social Care Networks will be created to:
  - formally organize CBOs to perform SDH interventions, including requisite infrastructure for network partners
  - coordinate a referral network
  - create a single point of contracting for SDH arrangements
  - screen Medicaid enrollees for key SDH social care issues and make referrals
  - wrap a social service provider network around existing MCO clinical provider networks
- 50% of the Waiver funds will support VBP initiatives
- Social Care Benefits are likely to include:
  - Housing supports
  - Food/nutrition support
  - Transportation

NYS CHW BENEFIT FOR MEDICAID BENEFICIARIES

NYS defines a CHW as a “public health worker who functions as a liaison between healthcare systems, social services, and community-based organizations in an effort to improve overall access to services/resources and encourage improved health outcomes of the population served”

CHWs reflect the community served through lived experience that may include but is not limited to pregnancy and birth; housing status; mental health conditions or substance use; other chronic conditions; shared race, ethnicity, language, sexual orientation, or community of residence.

Requirements include:

- a minimum of 20 hours of training that includes the Centers for Disease Control-endorsed Community Health Worker core competencies and/or
- a minimum of 1,400 hours of work experience as a Community Health Worker in formal paid or volunteer role(s) in the previous three years.

Practice requirements:

- Basic HIPAA and mandated reporter trainings.
- supervision by a Medicaid-enrolled, licensed provider.
- CHW services must be recommended by a physician or other licensed practitioner of the healing arts acting within his or her scope of practice under State law.

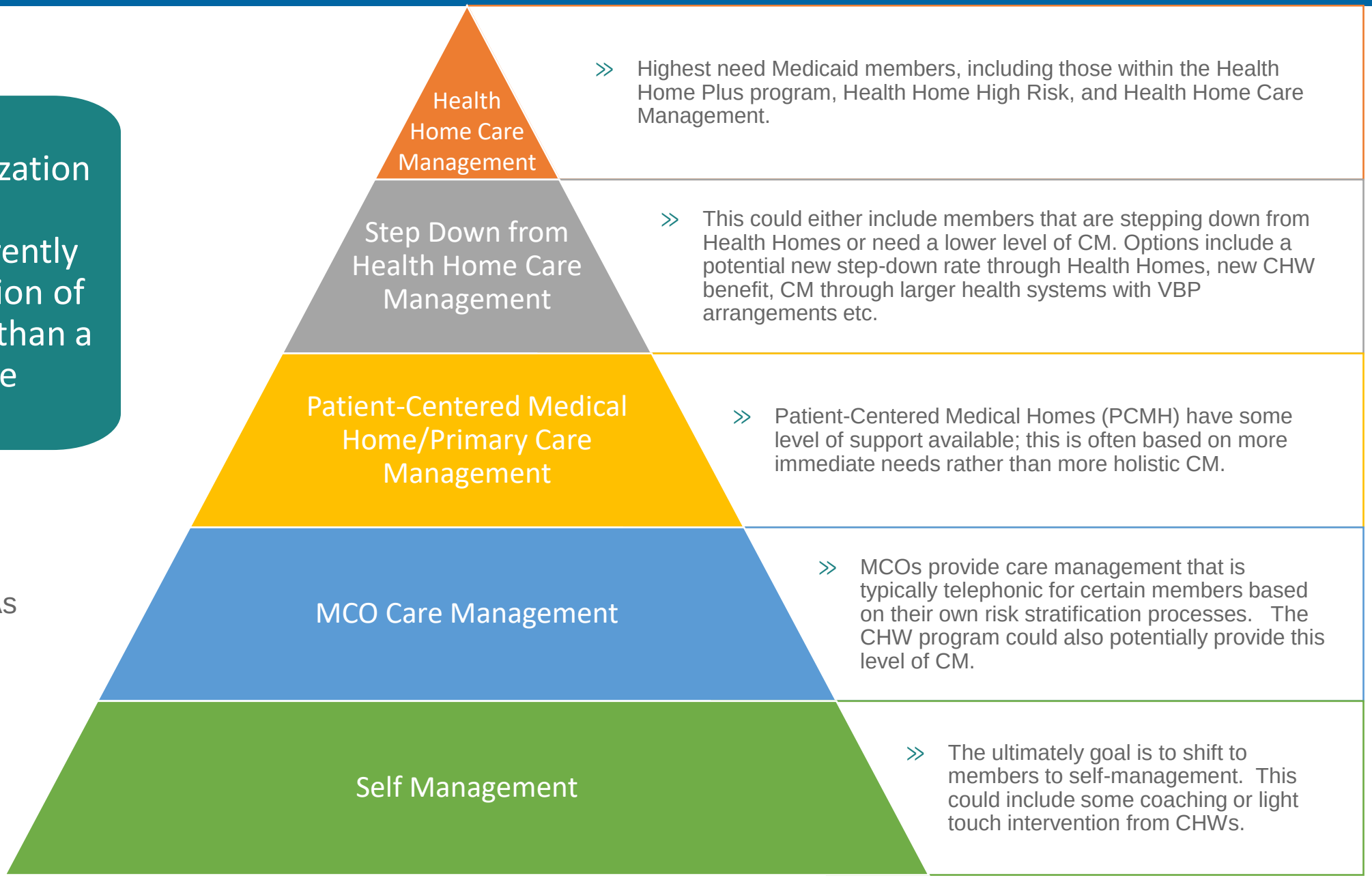
Services include:

- Health advocacy includes addressing the individuals’ needs, needed healthcare services, connection with community-based resources and programming, and support to ensure access to care that is high-quality, respectful, and equitable.
- Health education includes evidence-based and culturally-informed education to optimize the individual’s health, to address barriers to accessing healthcare and/or community resources, and to facilitate knowledge, skills and abilities necessary to support informed decision-making.
- Health navigation includes referrals to community-based and healthcare organizations, screening completion, identification of social care needs, resource coordination, help with enrollment/maintaining enrollment in assistance programs, and assisting the individual to navigate the health system.

NYS CARE MANAGEMENT CONTINUUM: POTENTIAL CONTINUUM MODEL FOR NEW YORK STATE

Lack of standardization means that CM offerings are currently more of a collection of programs rather than a continuum of care

- Health Homes and CMAs should think about how they can be part of a broader continuum



- Highest need Medicaid members, including those within the Health Home Plus program, Health Home High Risk, and Health Home Care Management.
- This could either include members that are stepping down from Health Homes or need a lower level of CM. Options include a potential new step-down rate through Health Homes, new CHW benefit, CM through larger health systems with VBP arrangements etc.
- Patient-Centered Medical Homes (PCMH) have some level of support available; this is often based on more immediate needs rather than more holistic CM.
- MCOs provide care management that is typically telephonic for certain members based on their own risk stratification processes. The CHW program could also potentially provide this level of CM.
- The ultimately goal is to shift to members to self-management. This could include some coaching or light touch intervention from CHWs.

INCLUSIVE ALLIANCE PLAN FOR CARE MANAGEMENT IN CNY

INCLUSIVE ALLIANCE VISION

- Accountable health systems enter into VBP arrangements across multiple payers to improve population health
- Population is stratified based on risk
- CM level is assigned based on risk stratification
- The Inclusive Alliance Social Care Network:
  - conducts health risk screening to assess care needs, including level of CM
  - provides a continuum of CM
  - promotes social care linkages
  - provides community-based outreach and engagement to high need populations disconnected from care
  - Collects and reports data to inform regional population health planning

SCN FUNCTIONS ON BEHALF OF NETWORK MEMBERS INCLUDE

- Single point of contracting, payment, and referrals for social care arrangements, which include housing supports, food/nutrition support, transportation
- Claims review, submission, and Revenue Cycle Management to maximize timely MCO payments for social care service delivery
- Network development to ensure regional referral access to timely, quality services and social care
- QA and QI for social care service delivery
- Data collection, management, reporting, exchange with health care providers related to social care delivery
- Collective credentialing, compliance, resource sharing, advocacy, etc.

INCLUSIVE ALLIANCE: ADDITIONAL VALUE FOR TARGETED POPULATIONS

IA will also be piloting the Pathways Community HUB approach in order to additionally:

- Inform population health planning related to the full array of social health needs, identify local capacity gaps, and target health system barriers related to risk mitigation
- Utilize a pay-for-performance approach to incentivize timely outreach, engagement, risk reduction, and connections to a comprehensive array of health and social care for those with the highest level of need

IA is currently seeking non-Waiver funding for Pathways and will also pursue funding for it as an initial VBP initiative via the Waiver

The high-risk maternal population is IA's initial population of focus for Pathways

HMA

QUESTIONS?

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Coming Attractions – Upcoming Inclusive Alliance Webinars

Presented with Subject Matter Experts from HMA (subject to change):

- **August 16, 12-1:** Revolutionizing Managed Care: A Journey with the I/DD, TBI & Aging Populations in Indiana (rescheduled)
- **September 20, 12-1:** Approved Medicaid 1115 NYHER Waiver: What is Included, What Changed, & What is Still Unknown (tentative)

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Stay Involved & Get in Touch!

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