What is CalAIM?

Stands for “California Advancing and Innovating Medi-Cal” (CalAIM)

Five year (2022-2027) statewide plan under Medi-Cal to streamline and improve delivery of services through managed care.

Major Changes for Aging Adults with CalAIM:

Transition to managed care for 31 counties including people in Skilled Nursing Facilities

14 optional community supports added in most counties to specific high risk populations

Enhanced Care Management (ECM) for high risk populations

CANHR
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What if the Managed Care Plan Does Not Cover the desired Community Support?

- Most plans will offer all supports by 2027, contact the plan to see if they are able to provide comparable services or how soon they plan to implement the desired support.
    - DHCS List of Community Supports by County and Managed Care Plan: https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf
    - CANHR's Community Supports Resources by County List: https://docs.google.com/spreadsheets/d/17xjvj4lBlu7h-owY1yxqsOb3a5i07xIfJsYYmhpbYM8/edit?usp=sharing
- If the desired support is not available consider switching to a plan that offers the support you need.
- Explore if any HCBS Medi-Cal waiver programs can meet your needs. See CANHR's HCBS Quick Guide.

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Santa Clara Family Health Plan™

Enhanced Care Management (ECM) and Community Supports Overview

41144

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Enhanced Care Management (ECM)

Enhanced Care Management

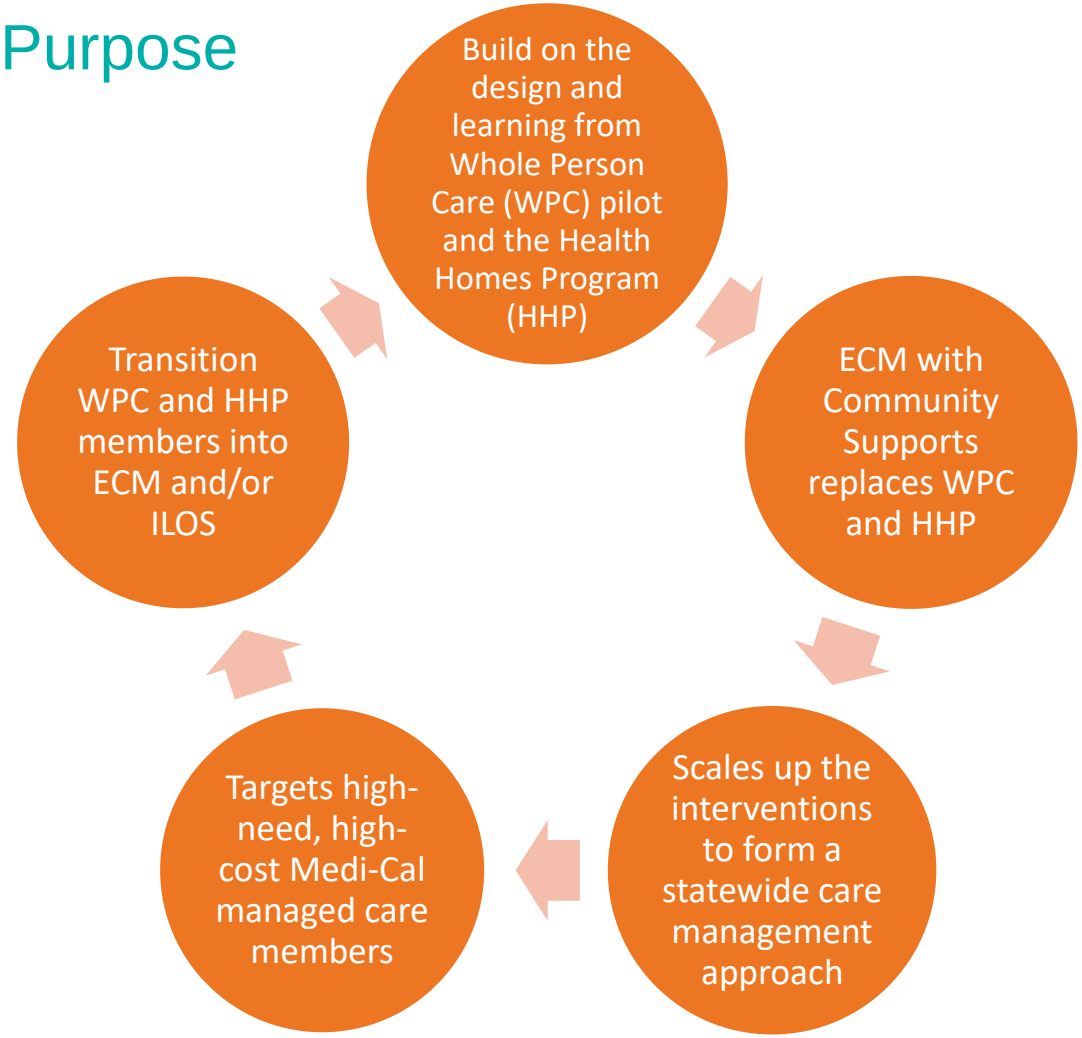
Definition

Enhanced Care Management (ECM) is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals.

Goals of ECM:

- Improve care coordination
- Integrate services
- Facilitate community resources
- Improve health outcomes
- Decrease inappropriate utilization and duplication of services

Purpose



Enhanced Care Management (ECM)

Populations of Focus (POFs)

Adults living in the community who are at risk for Long-Term-Care (LTC) institutionalization (January 1, 2023)

- Adults living in the community who meet the SNF level of care or require lower acuity skilled nursing **AND**
- Are actively experiencing at least one complex social and environmental factor influencing the health **AND**
- Are able to reside continuously in the community with wraparound supports

Overview of ECM

Seven Core Services

- **Outreach and Engagement**
- **Comprehensive Assessment and Care Management Plan**
- **Enhanced Coordination of Care**
- **Health Promotion**
- **Comprehensive Transitional Care**
- **Member and Family Supports**
- **Coordination of and Referral to Community and Social Support Services**

ECM Contracted Providers

Adults Only

- Avenidas
- Bay Area Community Health*
- Valley Medical Center and Clinics*
- Indian Health Center of Santa Clara County*
- Institute on Aging
- Master Care Plan
- Mayview/Ravenswood Clinic*
- Peninsula Healthcare Connections-New Direction
- Oversight MD
- Silicon Valley Independent Living Center
- Sourcewise
- Star Nursing

Children/Youth Only

- Full Circle Health Network *(hub)*
- Hope Services
- Seneca Family of Agencies

Hub: Holds the ECM contract with the health plan but does not provide direct services. Hub will contract-out services to other entities in the community

Both

- Access Care Management
- Asian American in Community Involvement*
- Gardner Family Health Network*
- Healthier Kids Foundation
- North East Medical Services*
- Pacific Clinics
- Pacific Health Group
- Roots Community Health Center
- School Health Clinic
- Serene Health
- Titanium Healthcare
- VyncaCare

** May accept populations outside of their ECM focus, if member is assigned to the provider for primary care services*

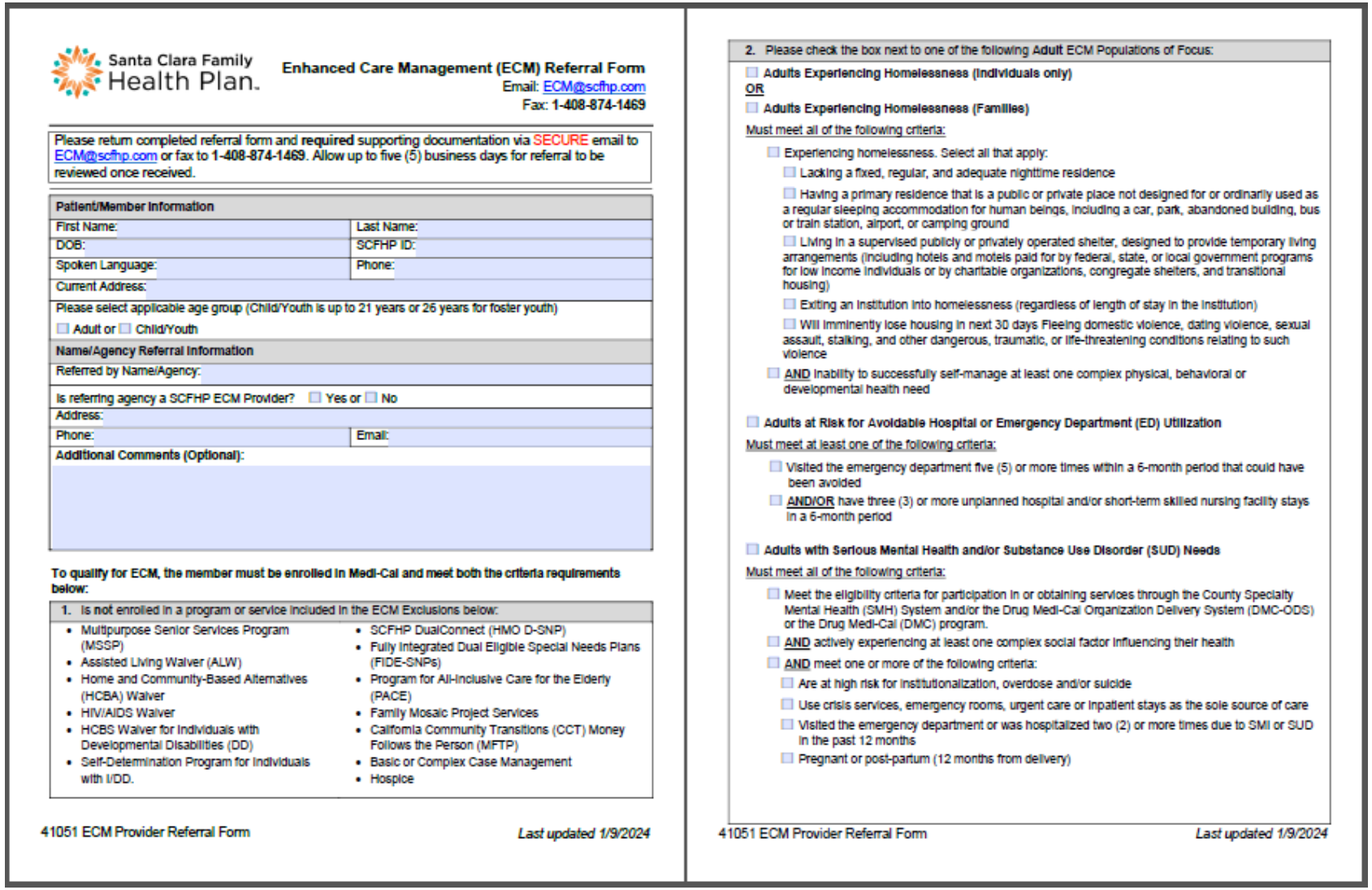
ECM Referral Process

1. Referring entities can access the *SCFHP ECM Referral Form* on SCFHP's website at **www.scfhp.com/ecm**.
2. A referring entity must complete a referral form and submit it with the required documentation to SCFHP via secured email to **ECM@scfhp.com** or by fax to **408-874-1469**.
3. SCFHP reviews referrals and accompanying documentation, determines if member is eligible for ECM; and if eligible, assigns the member to a contracted ECM provider. This process takes 3 – 5 business days once SCFHP receives the member's medical records.
4. SCFHP sends an eligibility letter to the member with general information on ECM and the name and contact information of their assigned ECM provider.
5. SCFHP sends an email to the assigned ECM provider notifying them of the assignment and places the member on the subsequent eligibility file. The ECM provider begins outreach and engagement activities shortly after assignment.

*For referring entities that are conducting business in a language other than English, it is best for them to call SCFHP's Customer Service at **1-800-260-2055 (TTY: 711)**.

ECM providers, primary care physicians (PCPs), specialists, Community Supports providers, community-based organizations, members, authorized representatives, and supportive individuals can submit a referral form to SCFHP for ECM services.

ECM Referral Form



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Enhanced Care Management (ECM) Referral Form
Email: ECM@scfhp.com
Fax: 1-408-874-1469

Please return completed referral form and **required** supporting documentation via SECURE email to ECM@scfhp.com or fax to **1-408-874-1469**. Allow up to five (5) business days for referral to be reviewed once received.

Patient/Member Information	
First Name:	Last Name:
DOB:	SCFHP ID:
Spoken Language:	Phone:
Current Address:	
Please select applicable age group (Child/Youth is up to 21 years or 26 years for foster youth) ☐ Adult or ☐ Child/Youth	
Name/Agency Referral Information	
Referred by Name/Agency:	
Is referring agency a SCFHP ECM Provider? ☐ Yes or ☐ No	
Address:	
Phone:	Email:
Additional Comments (Optional):	

To qualify for ECM, the member must be enrolled in Medi-Cal and meet both the criteria requirements below:

1. Is not enrolled in a program or service included in the ECM Exclusions below:

- Multipurpose Senior Services Program (MSSP)
- Assisted Living Waiver (ALW)
- Home and Community-Based Alternatives (HCBA) Waiver
- HIV/AIDS Waiver
- HCBS Waiver for Individuals with Developmental Disabilities (DD)
- Self-Determination Program for Individuals with I/DD.
- SCFHP DualConnect (HMO D-SNP)
- Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
- Program for All-Inclusive Care for the Elderly (PACE)
- Family Mosaic Project Services
- California Community Transitions (CCT) Money Follows the Person (MFTP)
- Basic or Complex Case Management
- Hospice

41051 ECM Provider Referral Form — *Last updated 1/9/2024*

2. Please check the box next to one of the following Adult ECM Populations of Focus:

☐ **Adults Experiencing Homelessness (Individuals only)**
OR
☐ **Adults Experiencing Homelessness (Families)**
Must meet all of the following criteria:

- ☐ Experiencing homelessness. Select all that apply:
  - ☐ Lacking a fixed, regular, and adequate nighttime residence
  - ☐ Having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground
  - ☐ Living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by federal, state, or local government programs for low income individuals or by charitable organizations, congregate shelters, and transitional housing)
  - ☐ Exiting an institution into homelessness (regardless of length of stay in the institution)
  - ☐ Will imminently lose housing in next 30 days Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence
- ☐ **AND** inability to successfully self-manage at least one complex physical, behavioral or developmental health need

☐ **Adults at Risk for Avoidable Hospital or Emergency Department (ED) Utilization**
Must meet at least one of the following criteria:

- ☐ Visited the emergency department five (5) or more times within a 6-month period that could have been avoided
- ☐ **AND/OR** have three (3) or more unplanned hospital and/or short-term skilled nursing facility stays in a 6-month period

☐ **Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs**
Must meet all of the following criteria:

- ☐ Meet the eligibility criteria for participation in or obtaining services through the County Specialty Mental Health (SMH) System and/or the Drug Medi-Cal Organization Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) program.
- ☐ **AND** actively experiencing at least one complex social factor influencing their health
- ☐ **AND** meet one or more of the following criteria:
  - ☐ Are at high risk for institutionalization, overdose and/or suicide
  - ☐ Use crisis services, emergency rooms, urgent care or inpatient stays as the sole source of care
  - ☐ Visited the emergency department or was hospitalized two (2) or more times due to SMI or SUD in the past 12 months
  - ☐ Pregnant or post-partum (12 months from delivery)

41051 ECM Provider Referral Form — *Last updated 1/9/2024*

Santa Clara Family Health Plan™

Community Supports

Community Supports

Definition:

- Medically-appropriate and cost-effective alternatives to services that can be covered under Medi-Cal that are typically delivered by different providers and/or in different settings than traditional Medi-Cal services. These services do not replace benefits that you already get under Medi-Cal, are optional for members, and may be available under an Individualized Care Plan.

Goal:

- Build upon success of the Whole Person Care (WPC) and Health Homes Program (HHP) pilots by focusing on combined medical and social determinants of health to avoid high levels of care:
  - Hospital or nursing facility admissions
  - Discharge delays
  - Emergency Department use

Purpose:

- Establish a foundation for implementing community-based services into the managed care Long Term Supports & Services (LTSS) model.
- Complementary to ECM, although members do not need to be enrolled in ECM to be eligible.
- **Not a benefit**, this is a pre-approved optional services that health plans choose to offer members

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Community Supports

Community Support	Launch Date
Housing Transition Navigation Services	1/1/2022
Housing Deposits	1/1/2022
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities	1/1/2022
Community Transition Services/Nursing Facility Transition to a Home	1/1/2022
Medically Supportive Food/Meals/Medically Tailored Meals	1/1/2022
Housing Tenancy and Sustaining Services	7/1/2022
Recuperative Care (Medical Respite)	7/1/2022
Sobering Center	7/1/2022
Personal Care and Homemaker Services	1/1/2023
Respite Services	1/1/2023
Environmental Accessibility Adaptations (Home Modifications)	1/1/2023
Asthma Remediation	1/1/2023
Day Habilitation Programs	7/1/2023
Short-term Post-Hospitalization Housing	1/1/2025

Coming Soon

Overview of Community Supports

Alternative and Appropriate Level of Care Settings

Community Support	Description of Service	Eligibility
Recuperative Care (Medical Respite)	Provides short-term integrated and clinical care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions).	• Individuals who are at risk of hospitalization or are post-hospitalization, and unhoused • Individuals who live alone with no formal or who face housing insecurity or have housing that would jeopardize their health and safety without modification
Short-Term Post-Hospitalization Housing	Provides those who do not have a residence, and who have high medical or behavioral health needs, the opportunity to continue their medical, psychiatric, or substance use recovery immediately after exiting an inpatient institutional setting.	• Exiting recuperative Care **OR** • Exiting a hospital, residential facility (SUD or MH), correctional facility, or nursing facility **AND** • Meet HUD definition of homeless or at risk of homelessness

Santa Clara Family Health Plan

Overview of Community Supports

Services to Prevent Institutionalization

Community Support	Description of Service	Eligibility
Medically Supportive Food/ Meals/Medically Tailored Meals	Helps individuals achieve their nutrition goals at critical times to help them regain and maintain their health by delivering meals to a home.	• Recent discharging from the hospital or Skilled Nurse Facility (SNF) • Has a chronic condition with high risk of hospitalization or nursing facility placement • Has extensive care coordination needs
Personal Care and Homemaker Services	Provides temporary assistance, similar to In-Home Supportive Services (IHSS) for individuals with activities of daily living (ADL) needs who would otherwise not remain in their homes.	• Approved for IHSS but require additional short-term assistance • In an IHSS waiting period but for discharge or admission prevention require caregiver services • Do not qualify for IHSS but, to avoid admission, require caregiver services
Respite Services (Caregiver)	Short-term services provided to caregivers of those who require occasional temporary supervision to give relief to the caregiver.	• Adult-members who are dependent on, or who without a caregiver would be institutionalized • Adults requiring assistance in 2+ ADLs • Children-members with complex care needs • Children who previously received services under: the Pediatrics Palliative Care Waiver; Foster care; CCS; GHPP

Overview of Community Supports

Services to Prevent Institutionalization – continued

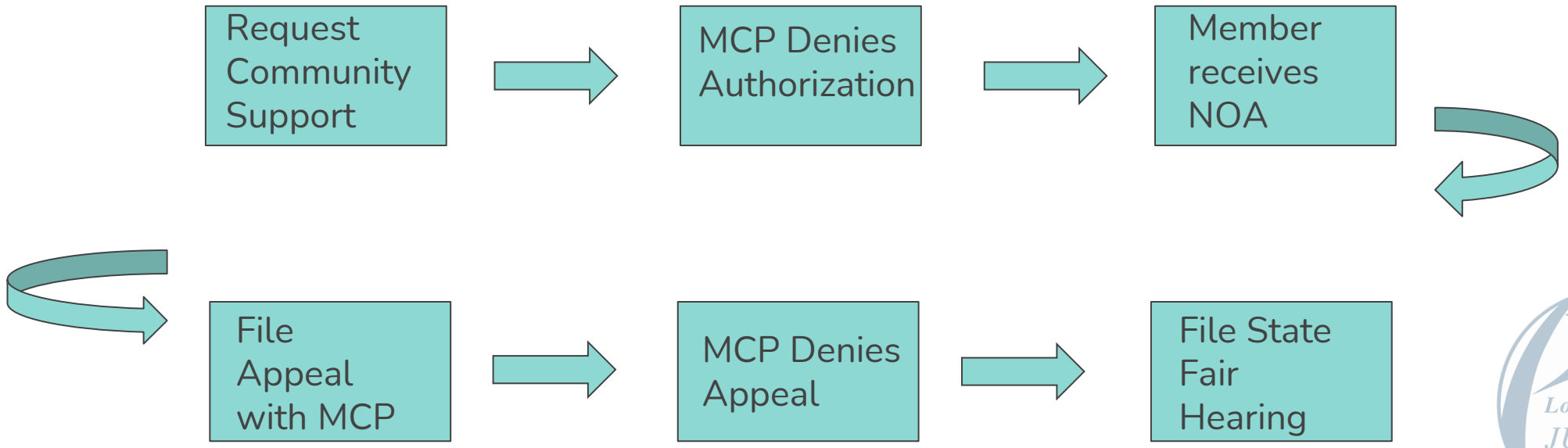
Community Support	Description of Service	Eligibility
Day Habilitation	Provides Services in or out of a person's home to assist them in acquiring or retaining employment, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the community.	• Members who are experiencing homelessness • Members who exited homelessness and entered housing in the last 24 months • Members in the community that are at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program
Environmental Accessibility Adaptations (Home Modifications)	Provides services or physical adaptions to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home.	• Members in the community that are at risk for institutionalization in a nursing facility • Experiencing 1 or more complex social or environmental factor influencing their health • Able to safely remain in the community with requested modification or service

Community Supports Referral Process

- A provider submits a referral form for a member:
  - Providers can submit a referral form to SCFHP for Community Supports through the **SCFHP Provider Portal**.
  - Download and complete a referral form, provide supporting documentation, and send the completed form to SCFHP via secured email to **CS@scfhp.com** or fax to **408-874-1985**.
- A member requests services:
  - Individuals can contact SCFHP Customer Service and ask if they are eligible for Community Supports:
    - SCFHP Medi-Cal Members: **1-800-260-2055 (TTY: 711)**
    - SCFHP DualConnect Members: **1-877-723-4795 (TTY: 711)**
  - If the member is currently enrolled in Enhanced Care Management (ECM), they may also request a referral from their Care Manager (Medi-Cal members only).

Grievances & Appeals

Members always retain the right to file appeals and/or grievances if they request one or more Community Support offered by the MCP but were not authorized to receive the requested Support because of a determination that it was not medically appropriate. The information to appeal with a plan should be included in the Notice of Action (NOA). Community Supports are additionally subject to the State Fair Hearings process.



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How to File a Grievance/Appeal with the Managed Care Plan?

Managed Care Plan standard Notice of Action (NOA) requirements apply to Community Supports.

A NOA should be issued when:

1. Services are in place and are being reduced or discontinued; and/or
2. Member or their Provider explicitly requests a Community Support, but the Plan will not authorize or is denying the service.

The NOA should provide information about how to file an appeal with the managed care plan. If you do not receive an NOA you can still file an appeal. Find information about appeals on the plan's website or Member handbook. If you are still unable to find the information contact the Department of Managed Health Care or the Managed Care Ombudsman.

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How to Request a State Fair Hearing

Online: https://acms.dss.ca.gov/acms/login.request.do

By Phone: (800) 743-8525

By Mail: State Hearings Division
P.O. Box 944243, Mail Station 21-37,
Sacramento, California 94244-2430

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Resources for Help During the Process

Managed Care Ombudsman

Serves as an objective resource to resolve issues between Medi-Cal managed care members and Plans.

By Phone: (888) 452-8609

By email*:

MMCDOmbudsmanOffice@dhcs.ca.gov

Health Care Options

Call to change health plans, review options in your county, or ask questions about your current plan.

1-800-430-4263 (TTY 1-800-430-7077)

If you want HCO to contact you, fill out the HCO Contact Form.

Dept. of Managed Care

Contact DMHC for complaints or to request an Independent Medical Review (IMR).

1-888-466-2219

www.healthhelp.ca.gov

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Resource Links

Community Supports by County and Managed Care Plan: https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf

CANHR's Community Supports Resources by County List:
https://docs.google.com/spreadsheets/d/17xjvj4lBlu7h-owY1yxqsOb3a5i07xIfJsYYmhpbYM8/edit?usp=sharing

DHCS Community Supports Policy Guide: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

DHCS Enhanced Case Management Policy Guide:
https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

CANHR's Home and Community Based Services Quick Guide:
https://canhr.org/hcbs-quick-guide/

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SOURCEWISE
COMMUNITY RESOURCE SOLUTIONS

Enhanced Care Management (ECM)

Alice Tran
Lead Care Manager
BS Psychology

Sourcewise Enhanced Care Management

Services members from two health plans

ECM Sourcewise Team

- Services
  - 60 members in our ECM Program by 2 Lead Case Managers
  - 2 outreach specialists and 2 lead case managers
  - Under Director, program will grow exponentially in the coming months
  - Specialty: Adult population, dementia, and the homeless




Success Story 1: Ms. Jane Doe

65 y/o Spanish/English Speaking Female

- Health Conditions: Major depressive disorder, alcohol and substance abuse, hypertension, bad left knee, hypothyroidism, migraines, chronic pain, arthritis, slip disk, and fractured spine.

- Linkages:
  - IHSS SW for IHSS reassessment w/ Supporting documents.
  - Establish care with new PCP.
  - SCFHP transportation to medical appointments.
  - Gardner Healthcare for Psychiatrist and mental health services
  - In-patient recovery program through Community Solutions
  - Referral to PT, and Pain Management at Stanford.

"Thank you for sticking with me during this journey where many would not have put up with my relapse. I know you will be here to help me during this difficult time."

Success Story 2: Ms. Claire
56 y/o English Speaking Female

- Health Conditions: Major depressive disorder, ADHD, social anxiety, back pain, neck pain, migraines d/t cervical spine compression, and spine degeneration, chronic pain, and arthritis.

- Linkages:
  - IHSS advocacy for reassessment.
  - Referral to Public Authority for PA registry and care coaching.
  - Establish care with new Orthopedics.
  - Anthem transportation to medical appointments.
  - Schedule medical appointments for PC follow-up.
  - Community support for home modifications for bathroom safety.

"You and your organization sound like a god send to help me get my life together. I haven't been successful with my lack of motivation to carry this task on my own. With your guidance I know where to start and I know I'm not alone."

SOURCEWISE

COMMUNITY RESOURCE SOLUTIONS

3100 De La Cruz Avenue,
Suite 310
Santa Clara, CA 95054

(408) 350-3200

16340 Monterey Road
Morgan Hill, CA 95037

(408) 762-7362

Email
community@mysourcewise.com

Website
mysourcewise.com

Public Authority Website
pascc.org