Maximizing CalAIM's Enhanced Care Management Benefit and Community Supports Services

Homebase
with the support of the California Health Care Foundation

California's new Medi-Cal Initiative, CalAIM (California Advancing and Innovating Medi-Cal) includes two programs that provide coordination and/or housing-related services for its members, including those experiencing homelessness: **Enhanced Care Management (ECM)** and **Community Supports (CS)**. Through the Housing and Homelessness Incentive Program (HHIP), the state Department of Health Care Services has incentivized Medi-Cal managed care plans (MCPs) to connect their eligible members experiencing homelessness to ECM and CS services. In partnership with their local MCPs, CoCs should discuss ways to ensure people they're serving are referred and receiving these vital benefits and services.

The CS services offered in each community through MCPs vary, as do the referral processes for both ECM and CS. CoCs should work directly with their local MCPs to coordinate efforts to refer and connect people to these resources by simplifying and streamlining the referral processes.

This document provides basic information about ECM and CS and offers tools to help CoCs track the resources available and relevant referral processes for the MCPs in their communities.

Basics of ECM and Community Supports

Enhanced Care Management (ECM)

Many Medi-Cal members need the services of multiple social services systems, in addition to the health care system. Enhanced Care Management (ECM) is a Medi-Cal benefit that all Medi-Cal managed care plans (MCPs) are required to provide to eligible members. ECM offers intensive care coordination and services across the multiple systems. The core services offered through ECM are:

1. Enhanced coordination of care
2. Coordination of and referral to community and social support services
3. Outreach and engagement
4. Comprehensive assessment and care management plan
5. Health promotion
6. Comprehensive transitional care
7. Member and family supports

ECM providers help people set clear goals, make sure they receive the full array of benefits they're eligible for to meet those goals, and coordinate across systems to help members achieve their goals. MCPs are required to meet members enrolled in ECM where they are, instead of just at the doctor's office. ECM providers can offer services to members at an emergency shelter, on the street, or at home. Each person enrolled in ECM has a central case manager who coordinates their care and services across all the systems, making it easier "to get the right care at the right time."

Community Supports (CS)

Community Supports are new services that Medi-Cal managed care plans (MCPs) can add to their package of services. They are intended for Medi-Cal members with complex health needs who also have unmet social needs (e.g., due to food insecurity, homelessness, or systemic racism). There are 14 total Community Supports, including housing-related ones. MCPs can decide which Community Supports to offer. The CS services available to eligible members vary across the state and even within a county if multiple MCPs operate there. The six CS services most directly relevant to housing, which many MCPs across the state offer, are:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Day Habilitation Programs

MCPs contract with local providers to provide CS services to members who are referred and approved to receive them. Local housing and homeless service providers who already provide the services covered under CS should consider becoming contracted providers with their local MCPs so they can be reimbursed for providing those services to people experiencing homelessness who are MCP members.

Connecting People Experiencing Homelessness to ECM and CS Services

MCPs are incentivized in various ways, including through HHIP, to connect their members experiencing homelessness to ECM and CS services. CoCs can be critical partners in identifying eligible members and helping to refer them to ECM and whatever available CS services they need and are eligible for. By utilizing these health system resources, CoCs can preserve their own resources to help people who are not enrolled in Medi-Cal or are ineligible for ECM or CS services.

Medi-Cal members who are eligible for ECM and CS services can be referred by anyone (themselves, community members/family members, providers). For people enrolled in ECM, their ECM provider can and should support them to identify the CS services they need and refer them to those.

To be referred for ECM or any Community Supports, a person must be enrolled in Medi-Cal and have selected an MCP. CoCs should support people experiencing homelessness not yet enrolled in Medi-Cal to explore their eligibility, enroll if eligible, and select their MCP. The offices that handle Medi-Cal enrollment in each county in California are listed here.

Once a person is approved and enrolled in ECM or CS, they will be matched with a provider.

- MCPs contract with different providers for ECM and CS.
- People who are enrolled in both ECM and CS may not have the same provider for both (or the same provider for different Community Supports if they are receiving more than one service).
- If a person is enrolled in ECM, their ECM provider can and should assess and refer them to appropriate CS services.

The following pages include additional eligibility information for both ECM and CS, as well as guidance and tools to help ensure as many eligible people as possible are aware of, referred to, and connected to ECM and the CS services they need.

Enhanced Care Management (ECM)

Eligibility

To be eligible for ECM, a person must be:

- Enrolled in Medi-Cal
- Connected to a Medi-Cal managed care plan, and
- Part of one of the following populations of focus
  - **Individuals and families experiencing homelessness <u>and</u>** the individual has at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage for whom coordination of services would likely result in improved health outcomes AND/OR decreased utilization of high-cost services.
  - Individuals at risk for avoidable hospital or Emergency Department utilization
  - Individuals with serious mental health and/or substance use disorder (SUD) needs
  - Individuals transitioning from incarceration
  - Adults living in the community and at risk for Long Term Care (LTC) institutionalization
  - Adult nursing facility residents transitioning to the community
  - Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CSS condition
  - Children and youth involved in Child Welfare
  - Individuals with Intellectual or Developmental Disabilities (I/DD)
  - Pregnant and postpartum individuals

People who are part of a population of focus but not yet enrolled in Medi-Cal or connected to a plan should be supported to enroll in Medi-Cal and select their MCP. The offices that handle Medi-Cal enrollment for each county in California are listed here.

Referrals

Most, if not all, MCPs will accept ECM referrals from anyone: members themselves; providers or case workers; or family members, friends, or other support people.

Every MCP has its own referral forms and processes for ECM. In some communities, all the Medi-Cal MCPs have coordinated to agree on a consistent ECM referral form. CoCs with multiple MCPs operating in their coverage area should work together with the MCPs to establish a jointly accepted ECM referral form (and needed documentation) and a consistent referral process. The process should include what happens after referrals are made, a timeframe and process for MCPs to update the CoC or CoC providers when members are enrolled in ECM, information about who their ECM provider is in the community, and a consistent way for ECM providers to connect with CoC providers working with newly enrolled members.

Most MCPs accept ECM referral forms and supporting documentation through submission to an online portal, secure email, fax, or a combination of those three. Most, if not all, also allow people to call a designated telephone number to begin a referral. The specific websites, email addresses, fax and phone numbers will vary by MCP and by county. At the end of this document is a template CoCs can use to collect and compile the referral information specific to the MCPs in their community.

Examples of Complex Physical, Behavioral, and Developmental Health Needs

Physical	Behavioral	Developmental
• Asthma • Chronic kidney disease • Chronic liver disease • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure • Coronary artery disease • Dementia requiring assistance with activities of daily living • Diabetes (insulin-dependent) poorly controlled • History of stroke or heart attack • Hypertension • Traumatic brain injury • Other*	• Bipolar disorder • Major depressive disorder • Psychotic disorders, including schizophrenia • Substance use disorder • Other*	• Intellectual or developmental disability (I/DD) • Other*

* There may be qualifying conditions not listed in this table

Community Supports (CS)

Eligibility and Availability

Like with ECM, Community Supports are only available to people who are already enrolled in Medi-Cal and connected to a Medi-Cal MCP.

Each Community Support has different eligibility criteria. Details about the service definitions and eligibility for each of the 14 Community Supports can be found in the DHCS Community Supports Policy Guide.

CoCs should work with their local MCPs to understand what Community Supports they offer, which they intend to offer in the future, and to present information about the most relevant CS services for people experiencing homelessness in their communities to CoC providers who can help identify and refer people who may be eligible.

The example template below is intended to help CoCs and their partner MCPs summarize the CS services available to people experiencing homelessness in their communities.

To create your county's Community Supports summary table, fill in a column for each MCP operating in your area, using similar color coding to indicate which Community Supports each MCP currently offers, and which they intend to offer in the future, noting the date each will be available. If you are not already in contact with the MCPs in your area, you can find them on the DHCS website.

Referrals

Like with ECM, MCPs will accept CS service referrals from anyone: members themselves; providers (including ECM and CS providers), case workers; or family members, friends, or other support people.

Because each MCP selects the CS services they want to offer, each MCP has its own referral or authorization forms and processes for CS. Some have separate referral or authorizations forms for each Community Support, although the referral process should be the same regardless of which CS is being requested.

CoCs and their local MCPs should work together to simplify and streamline the forms and processes for people experiencing homelessness as much as possible, including supporting documentation required. As with ECM, the process should include what happens after referrals are made, including a timeframe and process for MCPs to update the CoC or CoC providers when members are authorized to receive a CS, who their CS provider is, and a consistent way for CS providers to connect with CoC providers working with the person who's been enrolled.

As with ECM, most MCPs accept referral or authorization forms and supporting documentation through submission to an online portal, secure email, fax, or a combination. The specific websites, email addresses, fax and phone numbers will vary by MCP and by county. At the end of this document is a template CoCs can use to collect and compile the referral information specific to the MCPs in their community.

Blue = currently available **Purple** = upcoming

Community Supports	[MCP1]	[MCP2]	[MCP3]
1. Housing transition navigation services			
2. Housing tenancy and sustaining services			
3. Housing deposits (Note: With some exceptions, most people must be receiving housing navigation through the MCP to get housing deposits and may need to meet other criteria, such as being placed high on the priority list through the CoC's CE System).			
4. Short-term post hospitalization temporary housing		1/24	1/24
5. Recuperative care/medical respite	1/24	1/24	1/24
6. Respite services		7/23	1/24
7. Day habilitation programs		7/23	1/24
8. Nursing facility transition to assisted living			1/24
9. Community transitions/nursing facility transitions to home			1/24
10. Personal care and homemaker services		7/23	1/24
11. Environmental accessibility adaptations			1/24
12. Medically tailored meals			1/24
13. Sobering centers	1/24	1/24	1/24
14. Asthma Remediation	1/24	1/22	1/24

Recommendations for CoCs to Discuss with their Partner MCPs to Maximize Utilization of ECM and CS

- How to streamline the forms (e.g., make one single form that can be used for all MCPs), required documentation and processes for ECM and CS referrals and clearly outline the steps of the process, timeframes, and information and documentation needed.
- Protocols that apply after referrals are submitted to:
  - Update the CoC (or provider who submitted the referral) on referral status and any missing documentation or issues with the form or authorization request;
  - Confirm enrollment/approval;
  - Provide name and contact information of ECM or CS provider and/or ensure proactive outreach by that provider to the CoC.
- Ensure the success of ECM and CS providers assigned to members experiencing homelessness by:
  - Matching members with providers who have experience working with people experiencing homelessness;
  - Minimizing the number of providers each person is connected to (especially if multiple CS services are involved);
  - Identifying CoC providers to become contracted CS providers.
- The most needed CS services among people experiencing homelessness and how the CoC can help train providers who engage with people most in need of those services to help facilitate successful referrals.

Template for Compiling ECM and CS Referral Information

ENHANCED CARE MANAGEMENT (ECM) REFERRALS IN [COUNTY]

Managed Care Plan	Referral Process
[Name of MCP]	Complete [link to shared ECM referral form, if applicable, and/or MCP's own referral form] ECM Referral Form Gather necessary supporting documentation (see table below) Submit completed ECM Form and supporting documentation via: • [insert link to online portal if applicable] • [provide email address and any additional details, such as what subject line should be and whether a secure email program is required] • [provide fax number if relevant] • [insert any other submission option] OR, call [insert relevant phone number] and mention wanting to make an ECM referral.

Documentation needed to support ECM Referral Form

The following are examples of documentation MCPs might expect or require. CoCs should adjust this as needed after consulting with their local MCPs.

- Documentation of homelessness by service provider, primary care physician (PCP), specialist, or outreach provider
- Eviction Notices
- Documentation of entries / exits from shelters
- Documentation / office visit note with diagnosis or identification of at least one complex physical, behavioral, or developmental health need
- Medication / treatment orders
- Financial statements

CS REFERRALS/AUTHORIZATION REQUESTS IN [COUNTY]

Managed Care Plan	Referral Process
[Name of MCP]	Complete [link to MCP's referral or authorization form] Community Supports Referral/Authorization *Note: If the MCP uses different forms for each Community Support, be sure to list each one separately.* Gather necessary supporting documentation (see table below) Submit completed Referral/Authorization Form and supporting documentation via: • [insert link to online portal if applicable] • [provide email address and any additional details, such as what subject line should be and whether a secure email program is required] • [provide fax number if relevant] • [insert any other submission option] OR, call [insert relevant phone number] and mention wanting to make a Community Supports referral.

Documentation Needed to Support CS Referral Forms / Authorization Requests

The following are examples of supporting documentation that may be expected or required for each housing-related CS. CoCs are encouraged to work with their local MCPs to identify the specific supporting documentation that is most relevant and practical for the CS services most needed by people experiencing homelessness in their communities and adjust this accordingly.

Housing transition navigation services	Documentation of homelessness or risk of homelessness by service provider, Primary Care Physician (PCP), specialist, or outreach provider; documentation of entries/exits from shelters; notices from current landlord if applicable; financial statements
Housing tenancy and sustaining services	Housing support plan (aka housing plan[1]) created by MCP; lease agreement
Housing deposits	Housing support plan; lease agreement; utility bill/deposit agreement; financial statements
Short-term post hospitalization temporary housing	Emergency department or inpatient discharge planning paperwork; documentation of homelessness by service provider, PCP, specialist, or outreach provider; documentation of member participation in housing transition navigation services
Recuperative care (medical respite)	Emergency department, inpatient, or skilled nursing discharge paperwork; documentation of homelessness by service providers, PCPs, specialists, or outreach providers; documentation of entries/exits from shelters; documentation from any support agency indicating services/ supports member needs; documentation/office visit notes with diagnosis and identification of frailty; assessment determining limitations in activities of daily living (ADLs); medication/ treatment orders
Day habilitation programs	Documentation of housing status by service providers, PCP, specialist or outreach providers; documentation of participation in housing transition/navigation or housing tenancy and sustaining services

[1] If you have already created a housing plan for your client, we recommend sending the plan with the referral to the MCP. This will help MCPs to understand the client's needs and can be used as a basis for an MCP-created housing plan, if appropriate.