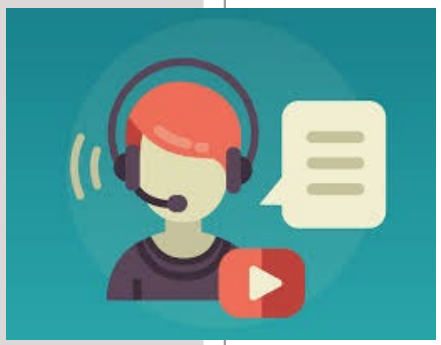
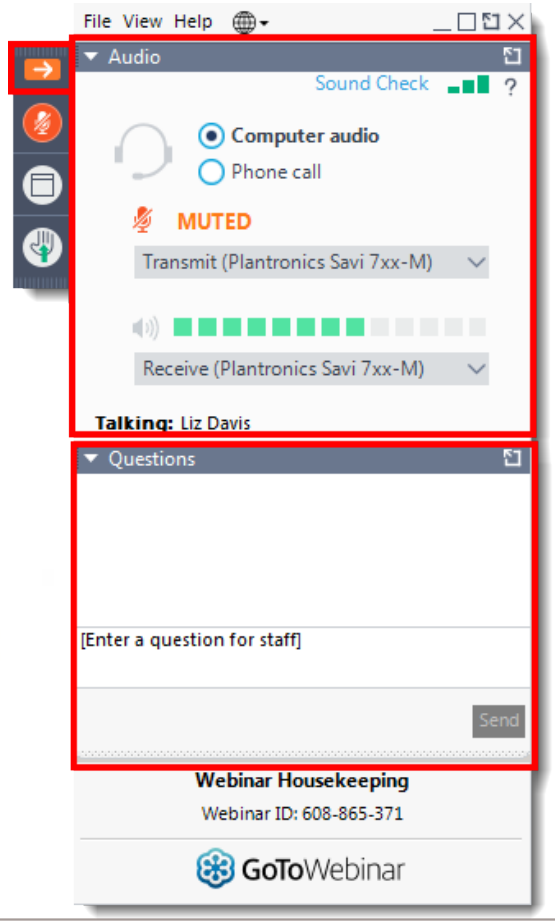
ITUP Sacramento Issue Workgroup

October 26, 2021

ITUP
Insure the Uninsured Project

Welcome to the Webinar!





Your Participation

Open and close your control panel

Join audio:

- Choose **Mic & Speakers** to use VoIP
- Choose **Telephone** and dial using the information provided

Submit questions and comments at any time via the Questions panel

Reminder: Today's presentation is being recorded and will be available within 48 hours.

ITUP
Insure the Uninsured Project

ITUP Mission / Vision

Mission

ITUP's mission is to promote innovative and workable policy solutions that expand health care access and improve the health of all Californians. ITUP implements its mission through policy-focused research and broad-based stakeholder engagement.

Vision

ITUP believes that all Californians should have a fair opportunity to live their healthiest lives.

ITUP
Insure the Uninsured Project

ITUP Vision / Values

ITUP Seeks a Health Care System that is:

Universal – All Californians are eligible for comprehensive health coverage and services, including primary, specialty, behavioral, oral, and vision health services, as well as services that address the social determinants of health

Equitable – All Californians receive health care coverage, treatment, and services that address the social determinants of health regardless of health status, age, ability, income, language, race, ethnicity, gender identity, sexual orientation, immigration status, and geographic region

Accessible – All Californians have access to coverage options and services that are available, timely, and appropriate

Effective – Health, health care, and related services that address the social determinants of health are person-centered, value-based, coordinated, and high-quality

Affordable – Coverage and services are affordable for consumers at the point of purchase and care; and, at the health system level for public and private purchasers

Today's Agenda

ITUP
Insure the Uninsured Project

ISSUE WORKGROUP

Making Medi-Cal Meaningful: Procurement and CalAIM Implementation

AGENDA

Tuesday, October 26, 2021
11:30 a.m.-1:30 p.m.

GoToWebinar Link:
https://attendee.gotowebinar.com/register/2642997672480922124

11:30 – 11:35 a.m.	**Welcome and Introductions**
11:35 – 12:05 p.m. *Includes Q&A*	**State Perspective: CalAIM in Action** **Susan Philip, M.P.P.**, Deputy Director, Health Care Delivery Systems at California Department of Health Care Services **Katie Heidorn, M.P.A.**, Executive Director, Insure the Uninsured Project (Moderator)
12:05 – 12:50 *Includes Q&A*	**Medi-Cal Procurement: Impact of Managed Care Model Change on California Communities** **Chevon Kothari, M.S.W.**, Director, Department of Health Services, County of Sacramento **Jenine Spotnitz, M.P.P.**, Program Planner, Department of Health Services, County of Sacramento **Nichole Williamson**, County Administrative Officer /Director of Health and Human Services, Alpine County **Katie Heidorn, MPA**, Executive Director, Insure the Uninsured Project (Moderator)
12:50 – 1:25 p.m. *Includes Q&A*	**Local Spotlights: Making CalAIM Meaningful** **Pooja Bhalla, D.N.P., R.N.**, Executive Director of Healthcare Services, Illumination Foundation **Nataly Santamaria**, Kern County Promotora Network Manager, Visión y Compromiso **Greg Garrett, M.P.H.**, Chief Operating Officer, Native American Health Center, Inc. **Katie Heidorn, M.P.A.**, Executive Director, Insure the Uninsured Project (Moderator)
1:25 a.m. – 1:30 p.m.	**Wrap Up**
1:30 p.m.	**Adjournment**

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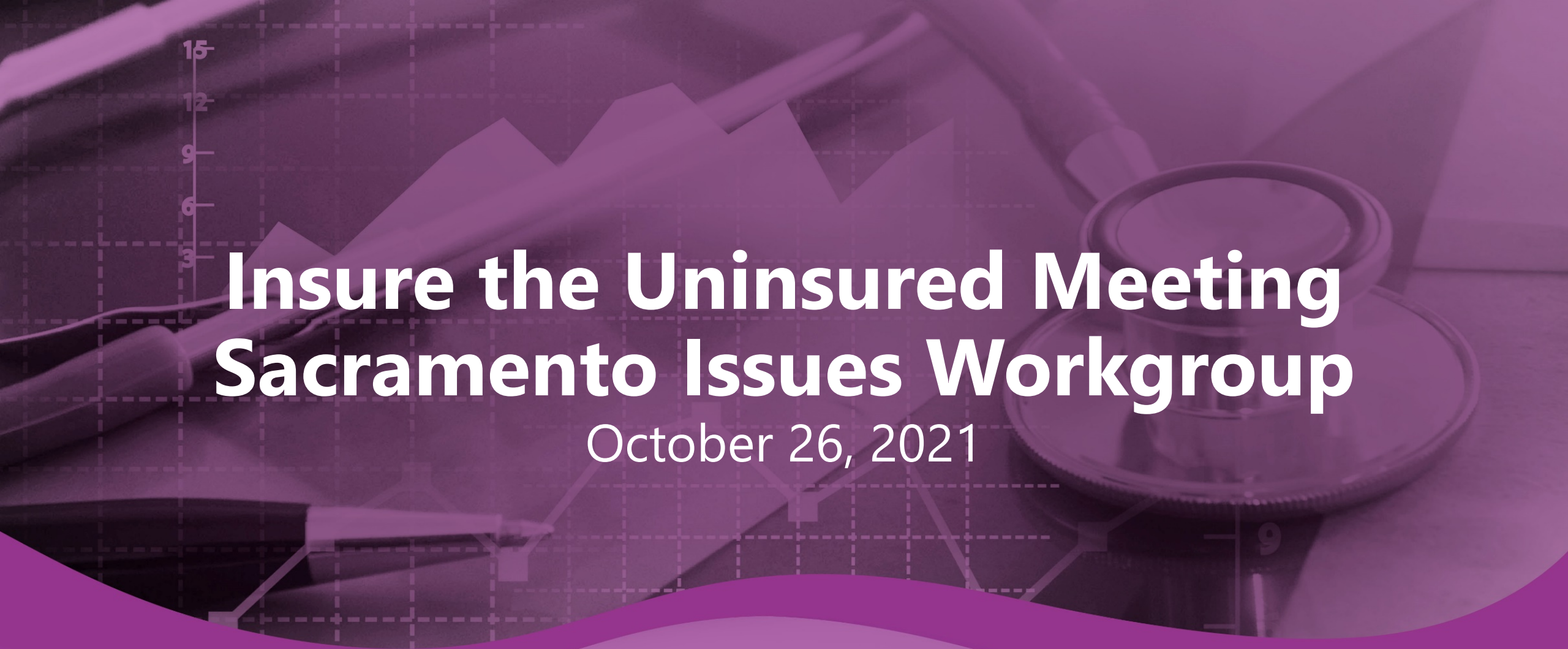
Insure the Uninsured Project

Susan Phillip, M.P.P.

Deputy Director, Health Care Delivery Systems, California Department of Health Care Services



Insure the Uninsured Meeting Sacramento Issues Workgroup

October 26, 2021

DHCS

Update on MCP Procurement

Managed Care Procurement Objective

- Procure commercial plans to provide high quality, accessible, and cost-effective health care through established networks of organized systems of care, which emphasize primary and preventive care.

Managed Care Procurement Update

- On October 8, DHCS announced that the release date of the Medi-Cal managed care plan (MCP) Request for Proposal (RFP) has been adjusted from the end of 2021 to February 2, 2022.
- The additional time allows DHCS to continue to review and incorporate the input provided by stakeholders.
- This change will not affect the implementation date of January 1, 2024.
- Updates regarding the RFP schedule are posted on the DHCS website.

Update on CalAIM Implementation

Enhanced Care Management (ECM) and Community Supports: Current and Future

CURRENT PROGRAMS

Whole Person Care (WPC)

- Limited pilot program supported across delivery systems (Medi-Cal managed care, fee-for-service, or uninsured)
- Administered by county-based "Local Entities"

Health Homes Program (HHP)

- Benefit (state plan service) in select counties
- Medi-Cal managed care members only
- Health plan-administered with care management contracted out to providers

FUTURE SERVICES

ECM

- Care coordination as a new managed care benefit
- Medi-Cal managed care members only
- Health plan-administered with care management delivered through community providers

Community Supports:

- Optional services, but strongly encouraged
- Medi-Cal managed care plan members only
- Health plan-administered with services delivered through community providers and integrated with ECM

ECM & Community Supports Implementation Timeline

Beginning on January 1, the ECM go-live will occur in stages, while Community Supports will launch statewide; MCPs in all counties may elect to offer additional Community Supports every six months.

Go-Live Timing	Populations of Focus
January 2022[1] (WPC/HH counties); **July 2022** (other counties)	***MCPs in all counties are able to offer Community Supports*** 1. Individuals and Families Experiencing Homelessness 2. Adult High Utilizers 3. Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)
January 2023	4. Adults & Children/Youth Incarcerated and Transitioning to the Community 5. At Risk for Institutionalization and Eligible for LTC 6. Nursing Facility Residents Transitioning to the Community
July 2023	7. Children / Youth Populations of Focus

1. In January 2022, the Adults & Children/Youth Transitioning from Incarceration Population of Focus will also go live in the WPC counties where the services provided in the Pilot are consistent with those described in the ECM Contract.

CalAIM Incentive Payment Program Year 1 Priorities

DHCS focused initial Program Year 1 (Calendar Year 2022) funding on priority areas, including capacity building, infrastructure, Community Supports take-up/offerings by MCPs, and quality.

PY 1 Priorities	Measure Domains
1. Delivery System Infrastructure	Fund required core MCP, ECM and Community Supports provider health information technology (HIT) and data exchange infrastructure
2. ECM Provider Capacity Building	Fund ECM workforce, training, technical assistance (TA), workflow development, operational requirements, and oversight
3. Community Supports Provider Capacity Building and Take-Up	Fund Community Supports training, TA, workflow development, operational requirements, take-up, and oversight
4. Quality	Fund baseline data collection reporting and Pay for Reporting (P4R) to inform quality and outcome improvements in future program years

Program Year 1 Reporting and Payment

DHCS will use a biannual payment cycle to issue $600 million in payments to MCPs in PY1 (CY 2022). The first payment will be tied to the MCP's submission of a Needs Assessment and Gap-Filling Plan, and the second payment will be tied to the MCP's progress against their Gap-Filling Plan.

Winter 2021

MCPs Submit Needs Assessment and Gap-Filling Plan

- Measures tied to each priority area for PY1

February 2022

DHCS Issues Payment 1

- 50% of PY1 available dollars
- Payment 1 is an upfront *advance*
- DHCS may recoup a portion of the advance from MCPs that fail to achieve a minimum level of effort

Fall 2022

MCPs Submit Gap Assessment Progress Report

- Measures tied to each priority area for PY1
- MCPs to show progress against Gap-Filling Plans

December 2022

DHCS issues Payment 2

- 50% of PY1's available dollars

What is PATH?

California's 1115 demonstration renewal and amendment request includes expenditure authority for the "Providing Access and Transforming Health" (PATH) program to take the state's system transformation to the next phase, refocusing its uses to achieve the CalAIM vision. DHCS is seeking $1.8 billion in federal support to maintain, build, and scale the capacity necessary to ensure successful implementation of CalAIM.*

PATH is comprised of two aligned initiatives:	
PATH Initiative	**High-Level Description**
Justice-Involved Capacity Building	Funding to maintain and build pre-release and post-release services to support implementation of the full suite of statewide CalAIM justice-involved initiatives in 2023 (e.g., 90-day pre-release and post-release services).
Support for Implementation of ECM and Community Supports	Support for CalAIM implementation at the community level, including payments for provider and community-based organization (CBO) infrastructure and capacity building, and interventions and services that will enable the transition from Medi-Cal 2020 to CalAIM.

* DHCS initially request $2.17B in PATH funding, however, DHCS intends to fund the Population Health Service outside of the state's 1115 waiver (i.e., outside of PATH). As such the amount has been reduced.

DEEPER DIVE: Support for Implementation of ECM and Community Supports

ECM/Community Supports PATH Program Name	High-Level Description
WPC Pilot Continuity and Managed Care Migration Program	Funding for WPC pilot lead entities to sustain WPC pilot capacity and infrastructure through the migration to managed care as required for ECM, Community Supports, and other Medi-Cal initiatives. Services and infrastructure that will not continue under CalAIM would be ineligible for this funding.
Technical Assistance Program	Registration-based TA program for counties, providers, and other CBOs in defined domains to support the development, transition, and expansion of ECM and Community Supports capacity and infrastructure.
Collaborative Planning and Implementation Program	Funding to support collaborative planning efforts across counties, CBOs, MCPs, providers, tribes, and others.
Capacity and Infrastructure Transition, Expansion and Development Program	Funding available to all counties, providers, CBOs, tribes, and others to build and expand capacity and infrastructure necessary to support ECM and Community Supports.

Managed Care Benefit Standardization

Background

Medi-Cal managed care exists statewide, but operates under six different model types that differ based on whether certain benefits are part of the Medi-Cal managed care plan's responsibility or provided through a different delivery system.

Goals

DHCS is standardizing the benefits that are provided through Medi-Cal MCPs statewide, so that regardless of a beneficiary's county of residence or plan in which they are enrolled, they will have the same set of benefits delivered through their MCP as they would in another county or plan.

Benefits

- Beneficiaries **no longer have to deal with confusion** that may arise when moving counties/plans (e.g., different benefits covered by their new plan).
- Standardization **reduces administrative burdens and challenges** associated with developing capitation payment rates on a county-by-county and plan-by-plan basis.

Managed Care Benefit Standardization: Timeline and Major Milestones

Major Milestones	Timeline
Planning (information technology [IT] systems, data and reporting, payment and contracts, plan readiness, etc.)	**Q4 2020 – present**
Beneficiary Outreach	**Q4 2021**
Implementation: Phase 1 • Major organ transplants will be added to all MCPs statewide for all Medi-Cal members enrolled in a plan • The Multipurpose Senior Services Program will be removed from Medi-Cal MCPs in seven Coordinated Care Initiative counties	**January 1, 2022**
Implementation: Phase 2 Institutional long-term care services will be added to all MCPs statewide for all Medi-Cal members enrolled in a plan	**January 1, 2023**
Implementation: Phase 3 Specialty mental health services that are currently included for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties will be removed from all Medi-Cal MCPs	**July 2023** ***(pending)***

Mandatory Managed Care Enrollment

Background

The Medi-Cal program provides benefits through both a fee-for-service (FFS) and managed care delivery system. Enrollment into one of two systems is based upon specific geographic areas, the health plan model, and/or the aid code for which the beneficiary is determined to qualify.

Goals

Starting in January 2022, select aid code groups and populations will transition into mandatory managed care enrollment or mandatory FFS enrollment.

Benefits

- Mandatory managed care enrollment will **standardize and reduce the complexity of the varying models of care delivery** in California.
- Medi-Cal MCPs can **provide more coordinated and integrated care and provide beneficiaries with a network of primary care providers and specialists.**
- DHCS can move to a regional rate setting process to **reduce excessive administrative work.**

Mandatory Managed Care Enrollment: Timeline and Major Milestones

Major Milestones	Timeline
Planning (IT systems, data and reporting, payment and contracts, plan readiness, etc.)	**Q4 2020 – present**
Beneficiary Outreach	**Q4 2021**
Select populations/aid code groups (e.g., non-dual beneficiaries living in rural zip codes) that currently receive benefits through the FFS delivery system would **transition to mandatory Medi-Cal managed care.**	**January 1, 2022**
Select populations/aid code groups (e.g., those covered under the Omnibus Budget Reconciliation Act [OBRA] in Napa, Solano, and Yolo counties) that currently receive benefits through Medi-Cal managed care will **transition into mandatory FFS enrollment.**	**January 1, 2022**
All dual populations/aid code groups, except share of cost or restricted scope, will be **mandatory Medi-Cal managed care.** Dual and non-dual individuals in long-term care will also be **mandatory in Medi-Cal managed care.**	**January 1, 2023**

Questions?

Susan Phillips, M.P.P.
Deputy Director, Health Care Delivery Systems,
California Department of Health Care Services

Medi-Cal Procurement: Impact of Managed Care Model Change on California Communities

Today's Panelists

Chevon Kothari, M.S.W.

Director, Department of Health Services, County of Sacramento

Jenine Spotnitz, M.P.P.

Program Planner, Department of Health Services, County of Sacramento

Nichole Williamson

County Administrative Officer /Director of Health and Human Services, Alpine County

SACRAMENTO COUNTY

Making Medi-Cal Meaningful: Procurement and CalAIM Implementation

Chevon Kothari, Director

Jenine Spotnitz, Program Planner

Sacramento County Department of Health Services

Agenda

1. Brief History of Medi-Cal Managed Care in Sacramento County

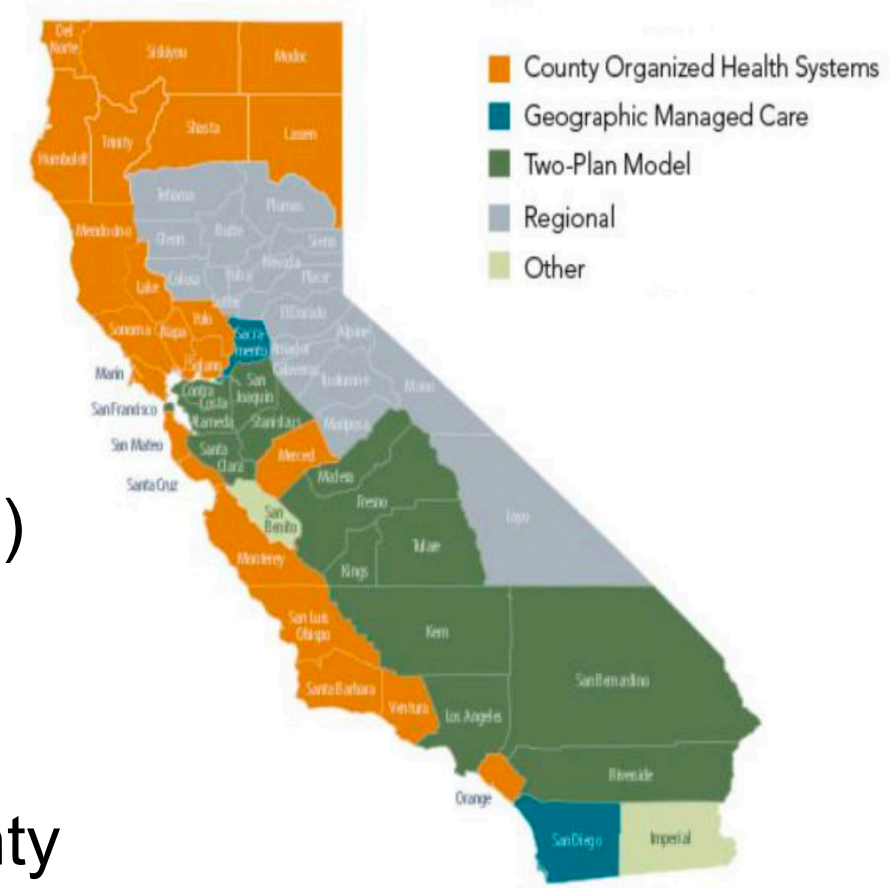
2. Sacramento County Health Authority Commission (SCHA)
    - Overview
    - Progress to Date
    - Current and Future Work

3. SCHA Impact on Medi-Cal Procurement and CalAIM Implementation

Brief History of Medi-Cal Managed Care in Sacramento County

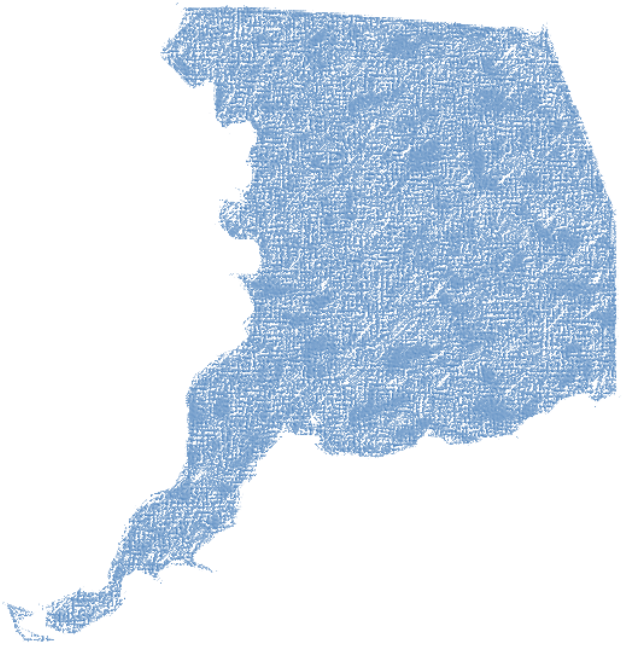
GMC in Sacramento County

- 1990s: State initiated Geographical Managed Care (GMC) as a pilot project in Sacramento
- 2010: Sacramento County established a stakeholder advisory committee to provide input to DHCS on the delivery of health care services provided in the county (via SB 208)
- 2017: Two more Managed Care Plans (MCPs) entered the Medi-Cal market in Sacramento, resulting in a total of 6 MCPs
- 2018: One MCP exited Sacramento, resulting in the 5 MCPs currently operating in the County



Sacramento County At A Glance

- Medi-Cal Population
  - 583,155 Medi-Cal certified eligible individuals
  - 479,522 were enrolled in an MCP
    - 82% of the County's Medi-Cal population
    - 31% of all County residents
- Health System
  - 5 managed care plans (MCPs)
  - 4 independent practice associations (IPAs) with GMC enrollment
  - 7 FQHCs
  - 4 hospital systems



Sacramento County's Challenges with GMC

- Lack of local control
- Concerns regarding inadequate access to care and poor quality
- Difficult for beneficiaries and providers to navigate multiple plan authorization processes and networks
- Shifts among GMC managed care plan (MCP) participants, independent practice associations (IPAs) and contracted providers

Average Quality Composite Score by Plan Model

Plan Model Type	Plan Type and Number	Average Score
County Organized Health System (COHS)	1 Local Plan	4.0
Imperial	2 Commercial Plans	3.3
San Benito	1 Commercial Plan	3.2
Two Plan	1 Commercial Plan & 1 Local Plan	3.1
Regional Model	2 Commercial Plans	3.0
Geographic Managed Care (GMC)	Multiple Commercial Plans	2.4

State MCP Procurement

- Procurement allows DHCS to:
  - Evaluate whether or not it should maintain current MCPs and/or enter into contracts with new MCPs
  - Change MCP contract structure and requirements
- Process for Procurement

Date	Activity
June 2021	DHCS released draft RFP for public comment
July 2021	Public comments were due
February 2022	Final RFP release
February – March 2022	Plan responses to RFP due (60 days post release)
By end of 2022	DHCS awards RFP contracts to selected MCPs
CY 2023	MCP readiness process
January 1, 2024	New MCP contracts begin

Sacramento County
Health Authority Commission

Sacramento County Health Authority (SCHA) Commission

- 2020: Sacramento County ordinance provides that the Health Authority shall recommend at least two plans to the Department of Health Care Services, until the Health Authority implements a county-sponsored local initiative health plan
- Only MCPs that participate in the Health Authority Commission's RFQ process are eligible to receive a County letter of support; the top 3 highest ranked plans by the Commission will be recommended to receive County letters of support
- 2021: SB 226 codified the role of the Health Authority

SCHA Progress to Date

- Established Commission and seated Commissioners
  - Representation from advocates, beneficiaries, clinics, hospitals, physicians, County Health Services, and Board of Supervisors as voting members
  - MCPs and IPAs serve as non-voting members
- Developed Bylaws and Commission goals
  - Restriction on Chair and Vice Chair
  - Treatment of conflicts of interest: none given that the Commission is recommending MCPs; this may change if model changes
- Developed the MCP assessment process and scoring criteria; released a Request for Proposals
- Ongoing dialogue with all five MCPs, CBOs, partners, elected officials, and other stakeholders about CalAIM to find the best model of care for Sacramento

SCHA Current and Future Work

- Received MCP responses to the RFQ for MCPs who would like to receive a county letter of support
- Will convene an ad-hoc committee with Commissioners and expert reviewers to review and score the RFQ responses
- The top 3 highest ranked plans will be recommended to receive County letters of support
- Priorities for next year
  - MCP review and monitoring
  - CalAIM and health & homeless system integration
- Future: Assess if a model change is needed

Sacramento County Health Authority Commission Impact on Medi-Cal Procurement and CalAIM Implementation

Impacts to Date

- Stronger local governance and community involvement
  - Articulation of goals, plan selection process, criteria, number of plans and aspects of CalAIM
- Strengthened MCP partnerships & accountability mechanism
  - Administered provider and beneficiary survey, reviewed DMHC complaint data, and drew from Commissioner experience of challenges in Sacramento County to develop comprehensive questions for MCPs in each of the key goal areas
    (see Commission goals, RFQ, and other materials here)

Future Impacts

- Ongoing community engagement and assessment of beneficiary and provider experiences
- Plan to closely track & analyze performance, identify system challenges, and develop strategies for:
  - Improving quality of care
  - Increasing access/network
  - Promoting health equity
  - Responsive CalAIM implementation
  - Investment in community

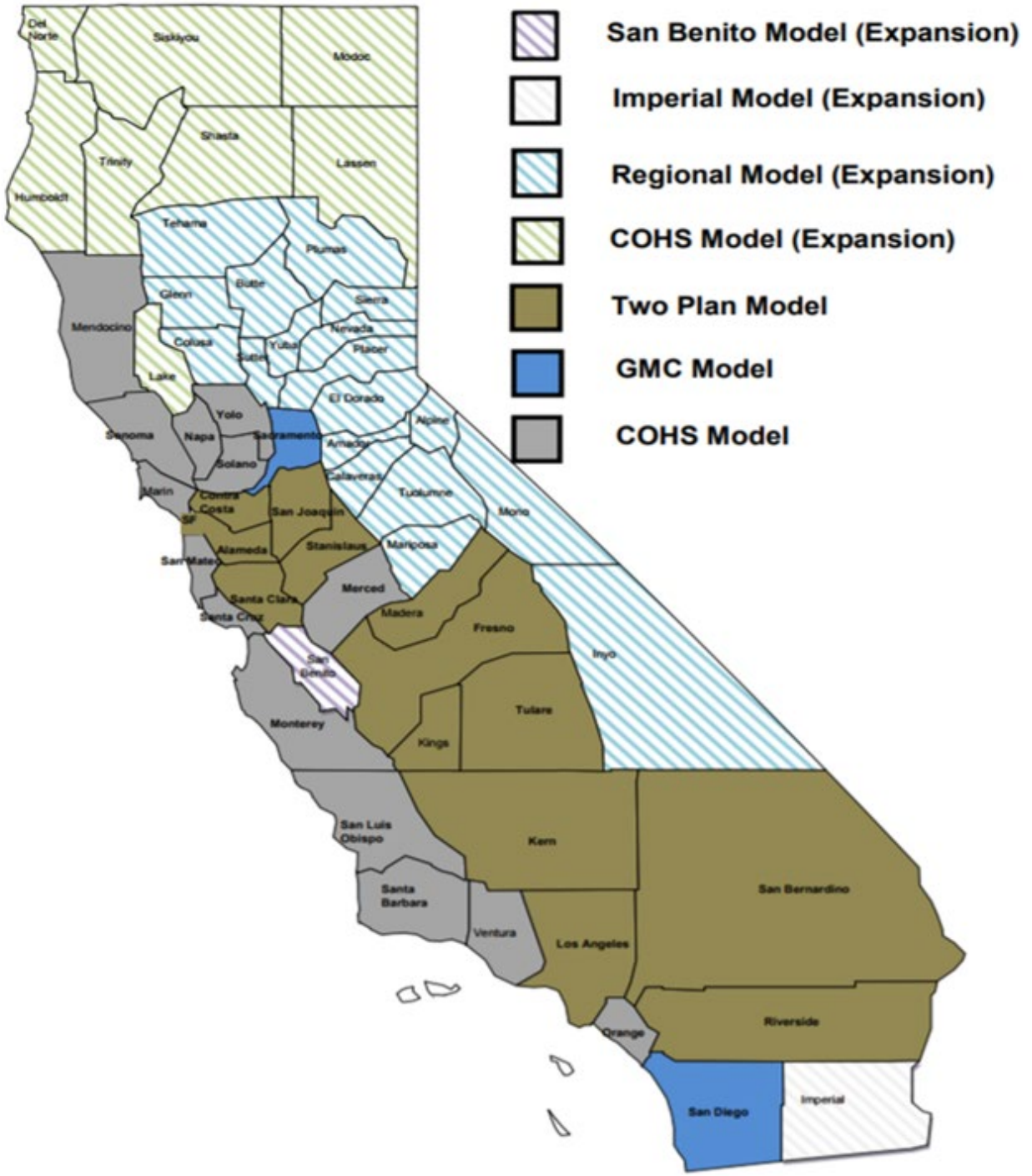
Alpine County
Managed Care Medi-Cal Presentation
October 26, 2021
ITUP Sacramento Issue Workgroup

What is Medi-Cal Managed Care

- The California of Health Care Services is California's Medicaid agency, and is responsible for procuring health plans, administering contracts, providing oversight, and including performance measurement.
- Medi-Cal (California Medicaid Program) is the largest provider of health insurance to Californians, covering one third of the population or 14 million residents.
- Medi-Cal Managed Care moved away from fee for service Medi-Cal to "managed" or paying a flat rate per member.
- Of that number, nearly 80% (10.6 million) of Medi-Cal beneficiaries receive their care through a managed care delivery system.
- In Alpine County there are approximately 250 Medi-Cal recipients.

6 Managed Medi-Cal Models

1. County Operated Model (COHS)- one local COHS plan
2. Geographic Managed Care (GMC) – several commercial plans
3. Two Plan Model – one commercial plan and one local initiative (LI)
4. Regional Model – two commercial plans
5. San Benito Model – one commercial plan and one fee for service
6. Imperial Model - two commercial plans



Regional Model Counties aka rural small counties

Alpine
Mono
Inyo
Mariposa
El Dorado
Placer
Amador
Calaveras
Tuolumne
Nevada
Sierra
Plumas
Yuba
Sutter
Colusa
Glenn
Butte
Tehama

Rural health issues & outcomes

- Medi-Cal enrollees access to primary care in Regional Model counties is comparable to enrollees in the other rural areas.
- Access to specialty care is difficult for enrollees in Regional Model counties.
- The quality of care provided to enrollees in Regional Model counties was worse on average, than enrollees in other models.
- Overall satisfaction of Regional Model enrollees is lower relative to other rural counties in the state.
- Providers and county officials in Regional Model counties are concerned with the performance of the two Regional Model Managed Care Plans (MCP's)
- Representatives of the two Regional Model MCP's state they are taking steps to address the concerns raised by stakeholders.
- Rural Californian's struggle to find specialty health care.
- Rural beneficiaries tend to be older, lower income, more likely to be unemployed and in poorer health, making them more expensive to provide health insurance to.
- Health plans have difficulty distributing the risk and cost of health care through out a smaller population because there are insufficient numbers of healthier people enrollees to offset higher cost enrollees.
- Building a comprehensive provider network that meets standards is very difficult and lack of competition can result in health plans that do not have leverage when negotiating contracts, driving up the cost of health care in rural areas.

Alpine County concerns with regional model plans:

Anthem

1. Transportation
2. Transportation
3. Transportation
4. Lack of understanding of rural health issues by plan
5. Plans are difficult to work with as a provider

HealthNet

1. Transportation
2. Transportation
3. Transportation
4. Lack of understanding of rural health issues by plan
5. Plans are difficult to work with as a provider

DHCS Managed Medi-Cal contract change and procurement timeline

- Current contracts expire in 2024
- Timeline for new contracts:
- March 31, 2021, Alpine County submitted a LOI indicating to DHCS our intent to change models and enter into partnership with Health Plan of San Joaquin
- September 2021: Alpine County's request to join HPSJ was denied by DHCS
- October 2021 Alpine County appealed denial and DHCS reversed their decision
- October 2021 Alpine County submitted required ordinance to DHCS
- Late 2021: Final RFP Release
- 2021-2022: DHCS will work with federal Centers for Medicare & Medicaid Services (CMS) for any necessary federal waiver amendments after state authority is enacted
- January 2024: New contracts and plans begin

DHCS Procurement: What it means for Alpine County

- All commercial Medi-Cal plans are to be re-procured. This impacts urban and rural counties, including small, rural Eastern Sierra and Gold Country counties.
- Anthem and Health & Wellness contracts must be re-procured.
- Rural counties are taking this opportunity to re evaluate potential plans and models that will best serve beneficiaries and providers.
- The current Regional Model is likely to be split into different plans and models.
- Alpine County Medi-Cal enrollees must travel to South Lake Tahoe, Placerville or Sacramento for specialty care.
- Washoe Tribe members who are also Medi-Cal enrollees often seek specialty care from the Tribal Clinic
- Therefore, Alpine County decision needs should be aligned with El Dorado County in order for enrollees to access their providers.
- The Health Plan of San Joaquin is approved to expand into Alpine and El Dorado County.

County options to transition to a different model

- Transition to Two-Plan Model
  - Establish a new or join an existing a Local Initiative (LI)
- Transition to County Operated Health System (COHS)
  - establish a new or join an existing COHS*

* **Note: establishing a new LI or COHS takes significantly more effort/complexity than joining an existing LI or COHS.**

- Options depend on:
  - County model preference, individually or collectively (and implications for remaining county/counties).
  - Available federal/state/local statutory authority for preferred approach.
  - If joining existing local plan, viability of that plan's expansion in compliance with Medi-Cal program requirements.
  - Sequencing with and implications for commercial plan procurement process.

What are “Local Plans”?

In California there are 6 County Owned Health Care Systems (COHS), 9 Local Initiative (LI) and 1 community based non profit plan.

What makes local plans “local?”

- Established by its community to serve the health care needs of underserved populations
- Formed pursuant to state or federal statute as a public agency, independent of the County (exception Contra Costa Health Plan)
- Formed through local ordinance(s) (or joint powers agreements) of one or more Board(s) of Supervisors
- Governed by a commission whose membership is prescribed in the ordinance(s) (or statute)
- Subject to California’s Fair Political Practices Law and Ralph M. Brown Open Meeting Law (Brown Act)
- Operate a health plan that contracts principally with public payors (Medi-Cal)

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Alpine County considerations for a LI or COHS Model

New LI or COHS

- Local leadership must be familiar with and prepared to meet rigorous financial and administrative requirements for operating the managed care plan
- Start-up requires substantial time and investment (beyond initial capitalization requirements)
- Need federal statutory authorization
- Need Center for Medicaid & Medicare Services(CMS) approval
- Not realistic
- Bad idea
- Did I make my point…..

Join existing LI or COHS

- Need CMS approval
- Do NOT need federal statutory authorization
- County Board of Supervisor action is needed to initiate a change in the County's Medi-Cal delivery model
- Most realistic option for Alpine County

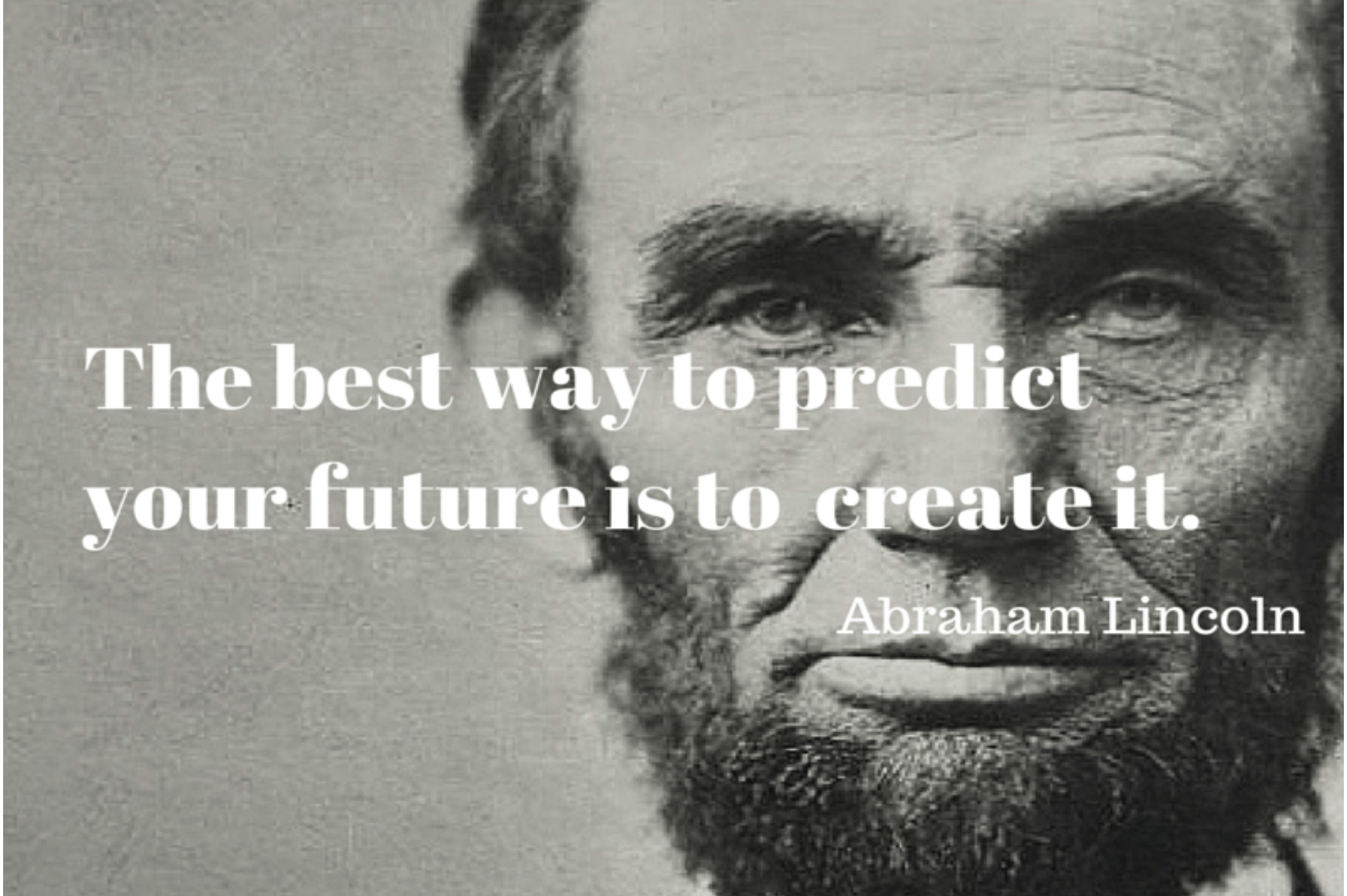
Shared Governance Model:

- Each Regional Plan County making this transition would have seat(s) on the Health Commission
- Advantages for Alpine County
  - County becomes part “owner” of HPSJ
  - County continuously shares in setting strategy and priorities for HPSJ
  - County has a larger voice for all counties that HPSJ serves, not just its own
  - **More ability to collaborate and form a regional vision**

About the HPSJ

- Public agency
- Governed by a commission, comprised of community stakeholders and healthcare leaders
- In adherence with the Brown Act
- Not-for-profit and greatly invested in the communities they serve
- Low overhead so more revenues can be used for paying providers
- **Primarily dedicated to serving Medi-Cal beneficiaries**

Health Plan of San Joaquin


The best way to predict
your future is to create it.
Abraham Lincoln

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County Administrative Officer /Director of Health and Human Services, Alpine County

Local Spotlights: Making CalAIM Meaningful

Today's Panelists

Pooja Bhalla, D.N.P., R.N.

Executive Director of Healthcare Services, Illumination Foundation

Nataly Santamaria

Kern County Promotora Network Manager, Visión y Compromiso

Greg Garrett, M.P.H.

Chief Operating Officer, Native American Health Center, Inc.

ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

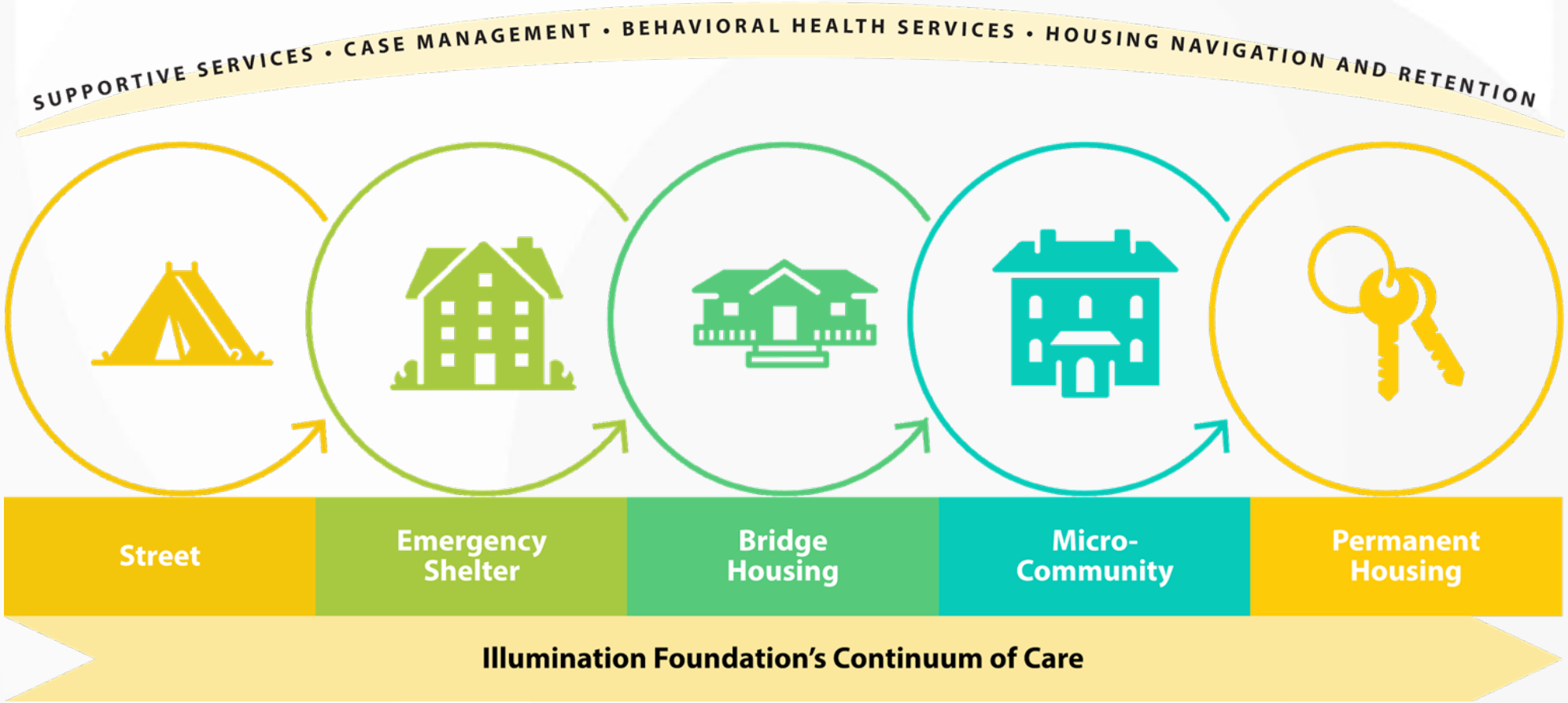
PRESENTED BY

Pooja Bhalla, DNP, RN, Executive Director of Healthcare Services

ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

Street 2 Home System of Care

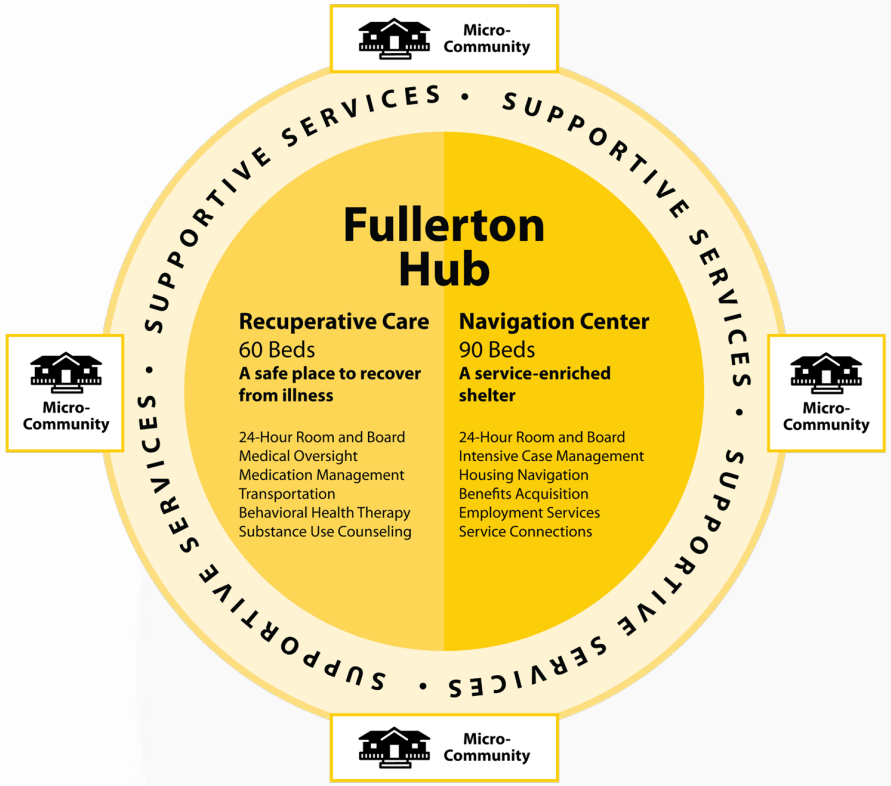


ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

Integrated Care: Navigation Center and Recuperative Care

- Holistic, multi-disciplinary, integrated care model – in 4 program settings:
  - Recuperative care
  - Emergency shelter
  - Housing support
  - Primary care clinic
- Multi-disciplinary services include:
  - 24-hour room and board
  - Intensive case management
  - Housing navigation
  - Medication assistance
  - Behavioral health therapy
  - Substance abuse counseling
  - Primary medical care
  - Transportation services



ILLUMINATION FOUNDATION

DISRUPTING THE CYCLE OF HOMELESSNESS

Recuperative Care

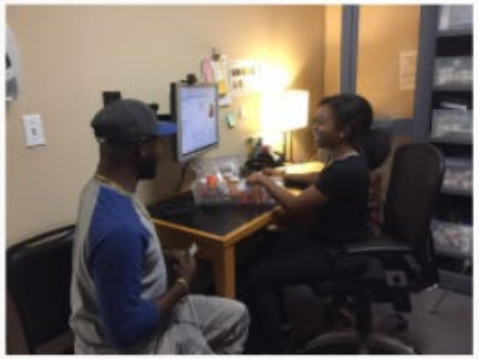
Fullerton

Broadway

Midway City

Riverside

Lincoln Park



Santa Fe Springs

Olive View - UCLA Medical Center in Sylmar

Cost Savings

Saved Health Plan more than $17 Million while clients were in Illumination Foundation's recuperative care program, compared to the year before they entered (based on 1,266 clients).

Before, During, After Breakdowns			
Data Point	**Before**	**During**	**After**
Cost Breakdown	$25,698,776	$7,946,497	$17,797,206

Aligned with CalAIM

Community Supports (Formerly ILOS)

- Housing Transition Navigation Services
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care and Medical Respite

ECM Core Service Components

CalOptima A Public Agency

Challenges/Barriers of CalAIM

- Outreach
- Rates
- Volume

Connect With Us

Visit Us Online: www.ifhomeless.org
Follow us on Social Media: @IFHOMELESS

Visión y Compromiso™

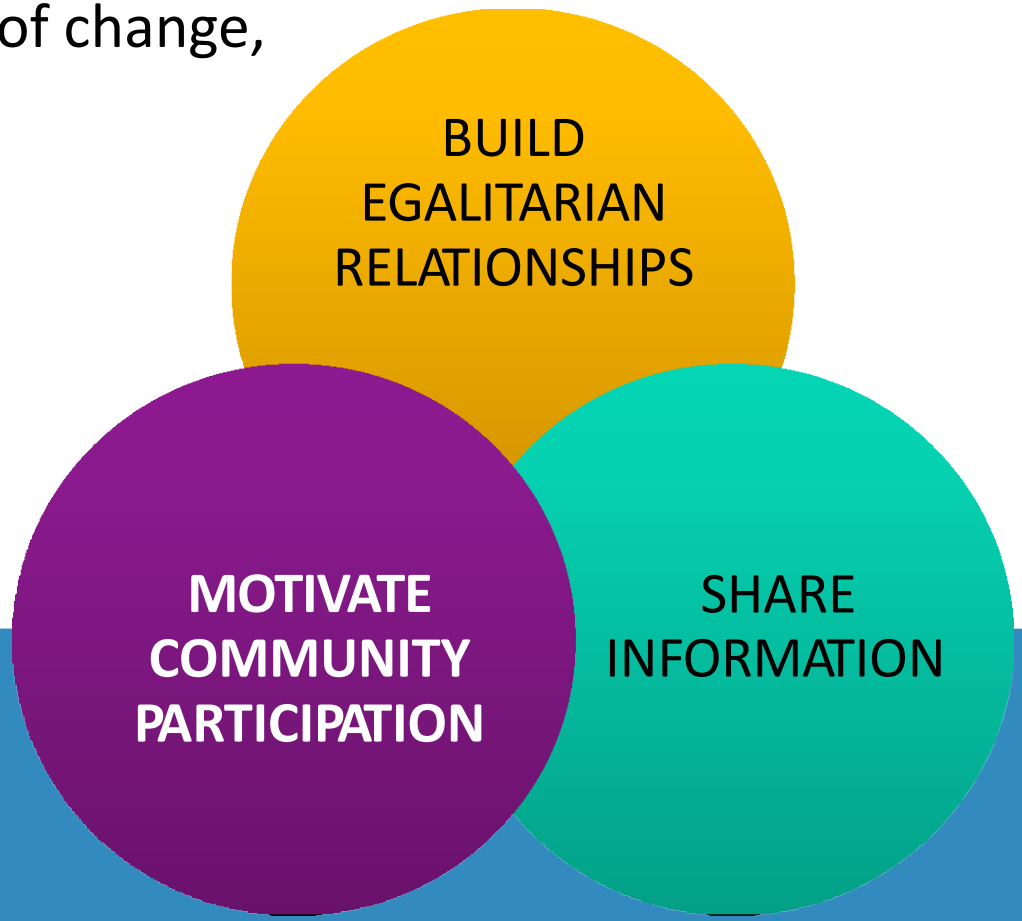
Visión y Compromiso is a national organization that promotes community well-being by providing leadership and capacity building for Promotoras and Community Workers.

THE PROMOTOR MODEL

The Promotor model in California is a social change model. It can be implemented with any issue (i.e. diabetes, neighborhood safety, breast cancer) because it is the quality of the relationships, not a particular issue area, which has the potential to create community change.

THE COMMUNITY TRANSFORMATIONAL MODEL

If the Promotor model is allowed to function according to the theory of change, Promotores will:



"Many of us are leaders in our community. We are compassionate and have this desire to serve. We don't just work at an office from 9 to 6. No, we live in the community. And we have to be able to go and talk to people who are in need late at night or during the day – whenever they need it. This is the work and we give it with our hearts."

WHO ARE PROMOTORES?

- Promotores are community members who act as natural helpers and liaisons to their neighbors and local neighborhoods; they are characterized by servicio de corazón – service from the heart – (Visión y Compromiso, 2003).

- Promotores are powerful advocates for individual and community transformation. They share information with community residents about local resources and have the capacity to influence policies related to critical issues facing their communities. The role of the Promotor extends far beyond the disease-related functions (BIO-MEDICAL MODEL) of community health to a passion for human rights and social justice (SOCIO-ECOLOGICAL MODEL).

ROLE OF PROMOTORES IN COMMUNITY HEALTH

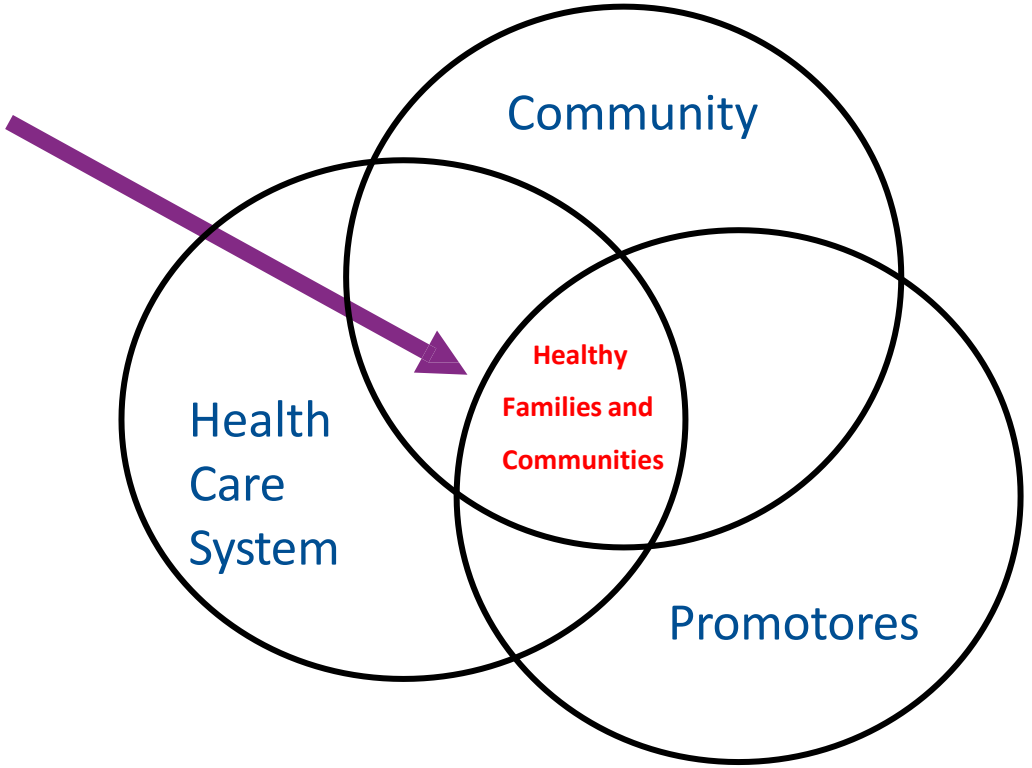
In **1987**, WHO adopted a definition of **community health advisors** and identified several key roles:

- Education
- Promotion
- Prevention and control
- Treatment
- Provision (of essential drugs)

PROMOTORES REDUCE DISPARITIES

PROMOTORES

- Naturally connect with and maximize existing social networks
- Increase trustworthiness
- Local workforce development
- Provide cost-effective services
- Reinforce cultural values and norms
- Encourage community participation in improving health



As Liaisons, they help:

- Keep appointments
- Increase access to prevention, scope of services and follow up care
- Decrease effect of cultural and linguistic barriers for organizations

Primary Characteristics and Values of Promotores

1. Promotores create and cultivate egalitarian relationships based on mutual trust, understanding and respect.
2. Promotores are committed to sharing information and resources.
3. Promotores approach the community with empathy, love and compassion.
4. Promotores are accessible and trusted members of the community where they live.
5. Promotores share similar life experiences as the community.
6. Promotores have a profound desire to serve the community, are tireless in their service, and limitless in their generosity of spirit.
7. Promotores communicate in the language of the people and are knowledgeable about the community's cultural traditions.
8. **Promotores are a two-way bridge connecting the community to resources and ensuring that institutions respond to community needs.**
9. Promotores are natural advocates who are committed to social justice.
10. Promotores are effective role models for community change.

"Warmth and an attitude of service is something we have been raised with – it is not something you can get from a training."

OUR CHALLENGE. OUR OPPORTUNITY

"It is not just the promotora who must fit the organization, but the organization must fit the cultural values of the community-based model too. Organizations who truly understand promotores use popular education methodology appropriate for the community transformational model. Core competencies are also linked to the model. System readiness means you already have in place values and principles to support the model and you understand what the model needs to be successful."

San Diego County

OUR VISION Y COMPROMISO

Visión y Compromiso™

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Central Valley Promotora Network Manager

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Towards a Healthy and Dignified Life

CalAIM – Opportunities and Challenges

Reducing Healthcare Disparities with Culture & Connection

Greg Garrett, MPH, Chief Operating Officer

NATIVE AMERICAN
HEALTH CENTER
Serving the community since 1972

Native American **Health Center**

OUR MISSION

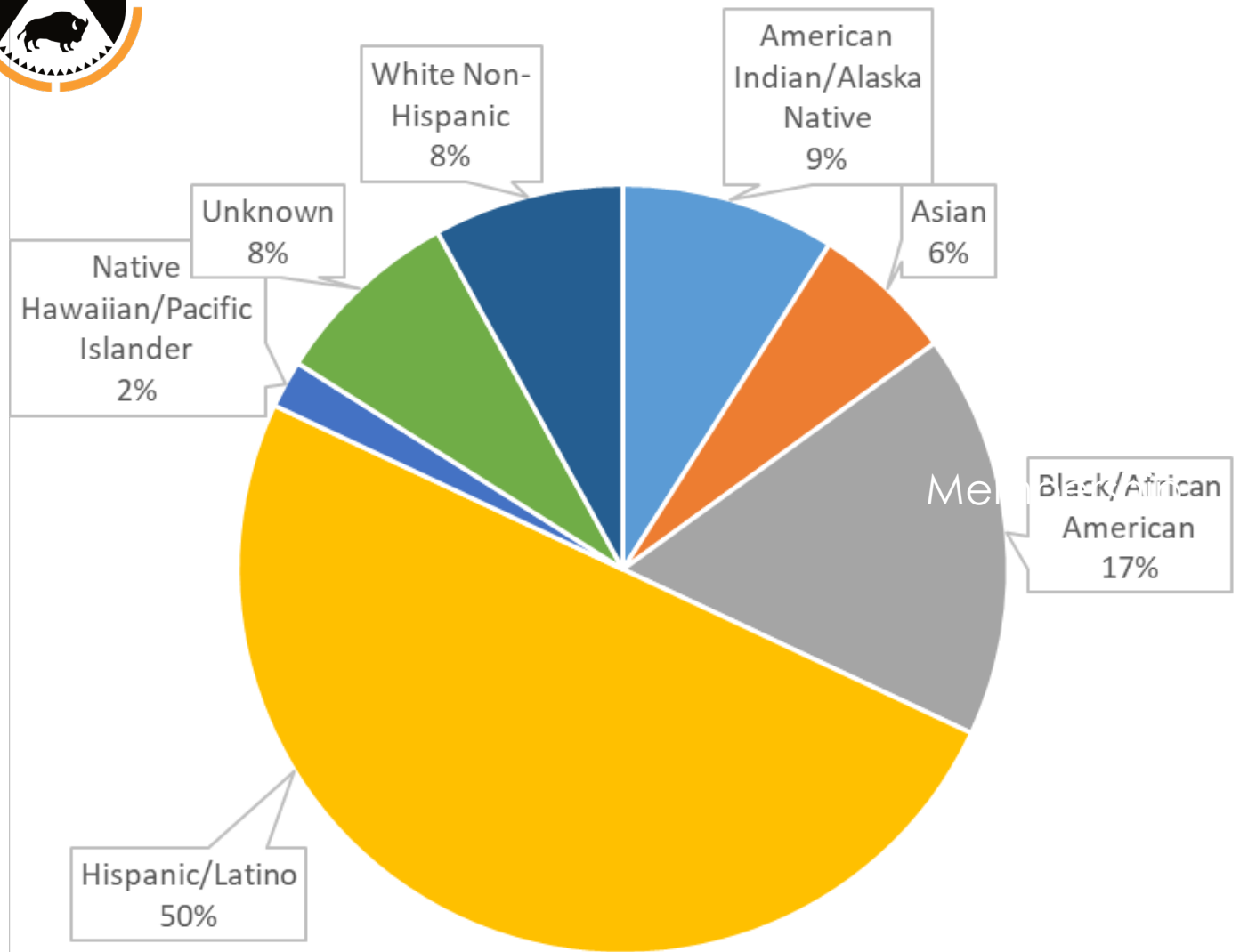
Native American Health Center's mission is to provide comprehensive services to improve the health and well-being of American Indians, Alaska Natives, and residents of the surrounding communities, with respect for cultural and linguistic differences.

15 SITES

Alameda, San Francisco and Contra Costa Counties
8 School Based Health Centers
15,000 members

COMPREHENSIVE WHOLE PERSON CARE

Medical, Dental, Behavioral Health, WIC, Community Wellness Programs (SDOH) and Youth Services



Serving a Diverse Community:

NAHC Membership Race/Ethnicity Demographics

CalAIM Goals & Objectives

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;

- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and

- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

- California Advancing & Innovating Medi-Cal (CalAIM) Proposal January 2021

Opportunity: Policy Alignment

Social Determinants of Health

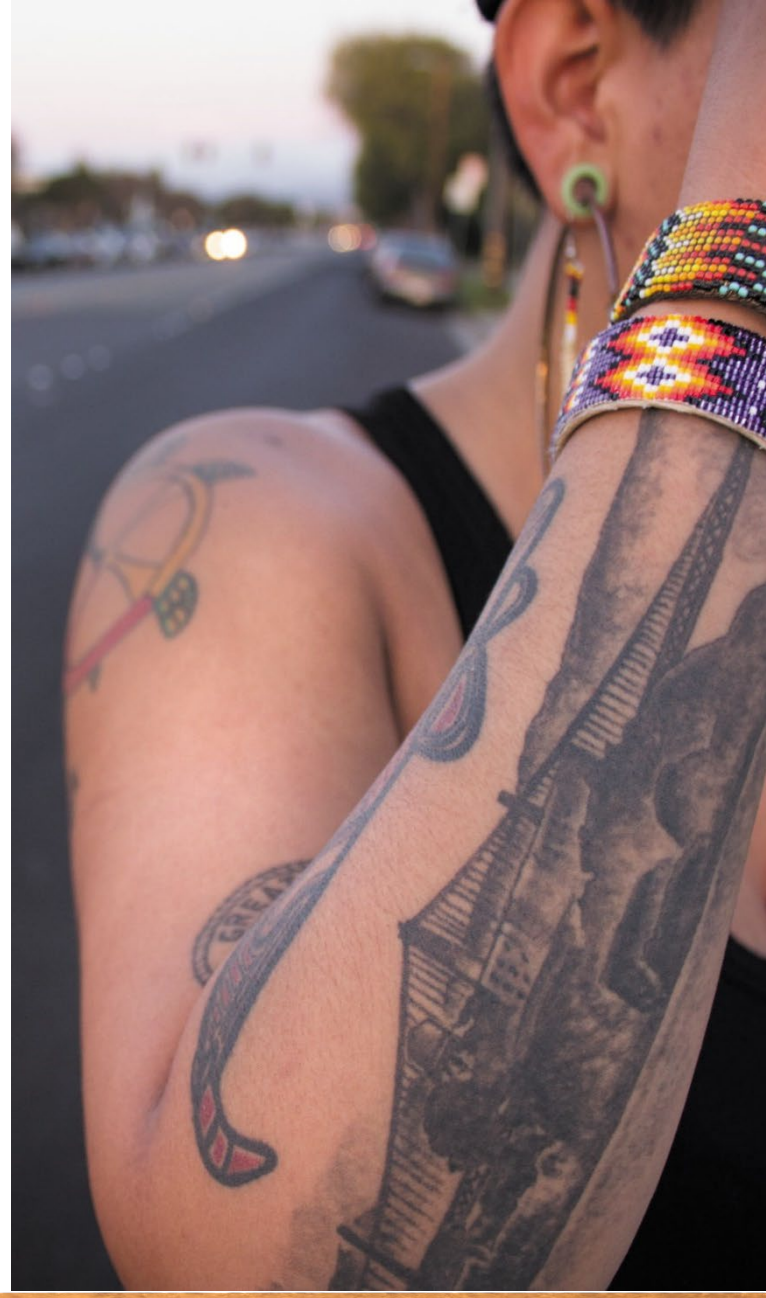
National Academy of Medicine

- Medical care accounts for approximately 20 percent of the modifiable contributors to healthy outcomes for a population
- The other 80 percent are SDoH: health-related behaviors, socioeconomic factors, and environmental factors

Alternative Payment Methodology – FQHCs (2022)

CPCA – Payment Modernization Kick-Off 2021

- Care of the whole person
- GOAL: Reduction in disparities by allowing health centers more flexibility to address member needs, including social determinants of health
- Early intervention and primary care can result in per-capita cost decreases to the larger Medi-Cal program and long-term improvements to health and wellness.



The Challenge: Health Center vs. Medical Center

Investing in community specific, non-clinical, culturally and linguistically tailored social services as a core element of Community-Based Health Care Organizations

- Which SDoH are of most concern to community stakeholders? Gaps?
- Which SDoH will have the greatest effect on population health, well-being, health equity?
  - **2021 – 2022: NAHC Community Health Equity Needs Assessment**

- Readiness Assessment: staffing, programs, services, connection to community services and resources
- Which interventions will decrease per capita spending?
  - **S.W.O.T Analysis**

Care Neighborhood
Care Management Program

- Diabetes
- Hypertension
- Amputations

CP: Care Coordination and Patient Education

- Depression

CP: Refer to behavioral health services
Provided additional counseling

- Limited income, on GA

CP: Applied for SSI and Medi-Cal

44 y/o Male
Risk Score: 14.8
PCP: 9
IP: 6
ER: 10
Member Since: 9/14
CP: Shared Action Plan

- Family steps in for food, but could use assistance

CP: Apply for CalFresh

- Has trouble getting to and from appointments – high no rate

CP: Got on Paratransit, provided Uber rides to appointments, using Alliance benefit

- High crime neighborhood
- Needs to move

CP: Got on Section 8 waitlist

- Started in 2016, Interdisciplinary approach focusing on members with the highest needs
- Eligibility set by county and health plans
- Case Coordination Services provided by Community Health Worker
- Health Plans provide reimbursement for services

Evidence Based Approach:

- ✓ Reduce inpatient admissions (~43% less) and ED visits (~21% less)
- ✓ Increase specialists (~28% more) and PCP visits (~32% more)
- ✓ Reduce overall cost of healthcare (~$700 less per member per month)

CalAIM: Recipe for Success

Trust, Connection, Community, and Culture

Staffing	Cultural & linguistic humility: peer-based, multi-lingual, diverse (promotoras, fire-keepers, care coordinators, CHWs)
Teams	Interdisciplinary, integrated care teams inclusive of ECM/ILOS staff and strong working relationship with local health plans
Access to care	Transportation, childcare, after-hour services and appointments, tech solutions (telehealth, patient portal)
Community	Referrals to culturally tailored community resources (e.g. ILOS); Presence in the community; building community
Culturally tailored programming	Culturally tailored programming (prevention & intervention)

Thank You

http://www.nativehealth.org

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NATIVE AMERICAN
HEALTH CENTER

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We love to hear from you!

Contact us:
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