Los Angeles RECUPERATIVE CARE LEARNING NETWORK

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Welcome Los Angeles Hospitals & Recuperative Care Providers

CalAIM Training Agenda

- ☐ Welcome
- ☐ LA Recuperative Care Learning Netwo
- ☐ Overview of CalAIM Recuperative Care County
- ☐ Challenges – MCP Referrals & Authoriz Processes
- ☐ MCP Updates on CalAIM Provider Ince (IPP), PATH and Housing & Homelessn Program (HHIP)
- ☐ Discussion and Q&A

LA Recuperative Care Learning Network Purpose

- Create a forum for Los Angeles payers and provi
  partnership issues emerging from the CalAIM M
  have resulted in Recuperative Care being covere
  Service. This forum will provide an opportunity f
  from each other, create consistency across the r
  scale and spread of promising practices
- Identify priority issues for, characteristics of, and
  pain points with the payer/provider partnerships
- Pave the way for payers and providers to engage
  partnerships that ultimately result in the increas
  utilization of Recuperative Care beds for individu
  homelessness.
- Identify high-priority issues for the field, for polic
  philanthropy to focus on in subsequent years to
  health care needs of this population, in addition
  and levers for doing so.

LA Recuperative Care Learning Network Current Priorities

- Ensure each **recuperative care provider** receives
  building funding through CalAIM homeless-relate
  programs.
- Ensure all providers have internal operations and
  facilitate contracting and are able to submit claim
  /encounters and share data for services.
- Ensure referrals and authorizations are occurring
  adequate source of income for **recuperative care**
  demonstrates that the immense need for this ser
- Provide additional assistance, as requested and a
  facilitate successful partnerships and contractual
  between payers and providers.

Private Los Angeles Recuperative Care Providers

- A Brighter Day (ABD) Recuperative Care
- Blue Sky Recuperative Care
- Community of LA Recuperative Care
- Golden State Recuperative Care
- Harbor Recuperative Care
- HOLA
- Horizon Recuperative Care
- Illumination Foundation (IF)
- JWCH Institute
- National Health Foundation (NHF)
- Serenity Recuperative Care
- The People Concern - SOLAR

LA Recuperative Care Learning Network Issues & Concerns

- Contracting & Credentialing
- Eligibility Criteria and List of Exclusions Medical Respite
- Obtaining Authorizations & Concerns ab (Health Plans and Hospitals)
- Sufficient Rates
- Authorization of Sufficient Length-of-St
- Payments – Claims / Invoice Submission
- Technology – Data Reporting
- Quality Monitoring & Oversight
- Access to sufficient Capacity Building Fu

CA Advancing & Innovating Med

**CalAIM will implement broad program, delivery sys
payment reforms statewide to advance three prima**

Identify and manage member risk and need throu
whole-person care approaches and addressin
social determinants of health (SDOH)

Move Medi-Cal to a more consistent and seamless
by **reducing complexity** and **increasing flexibi**

Improve quality outcomes, **reduce health disparitie**
and drive delivery system transformation and innova
through value-based initiatives, modernization of
systems, and payment reform

Population Health Management

SUMMARY

The launch of PHM is part of a broader arc of chan
outcomes across the state that began with CalAIM
Care Plans to develop and maintain a person-cent
health strategy for addressing member health and
needs across the continuum of care based on data
level assessment, and risk stratification and segm
submit Population Health Plans to DHCS annually
to collaborate with local community leaders and p
single, focused strategy for PHM, and respond to
their PHM program and attest to their readiness p
2023.

Implementation Date: January 1, 2023

Population Health Management Key Changes

- Clarifies MCPs must partner with comm
  providers to address member needs
- Clarifies that strategies should be devel
  coordination with bot County Behaviora
  Public Health Departments
- Details added to 'Assessment of Risk an
  on data collection expectations, risk stra
  segmentation, risk tiering, and develop
  individual risk assessment tool
- Addition of planned learning collaborat
  continuing areas of policy development

Enhanced Services to Promote Health Equity
Vulnerable Medi-Cal Beneficiaries

Based on the success of the Whole Person Care (WPC) pilots and Health Homes Progr
DHCS launched ECM as a statewide benefit, as well as Community Supports (ILOS) a
health plan and member option to offer members cost-effective alternatives to Medi
Plan benefits.

Enhanced Care Management (ECM)

- ECM will be a **statewide benefit** available to **members with the most complex health and social needs** as defined by **Populations of Focus**
- ECM Core Services are defined in the **Medi-Cal Managed Care MCP Contract,** with MCPs expected to coordinate all carved out services (e.g., SMHS, DMC-ODS)

Community Support

- Community Supports fo
addressing **medical and**
to avoid higher levels o
associated costs
- Specified in the **MCP Co**
MCPs **strongly encoura**
required, to provide "in
substitute for utilizatio
services or settings (e.g
skilled nursing facility a
discharge delays or ED)

CalAIM ECM Populations of Focus

Population	Description
Homeless	Individuals and families (including children) experiencing **homelessness** and who hav physical, behavioral, or developmental health need with inability to successfully self-
High utilizers adults	Adult high utilizers with five or more preventable emergency room visits, or 3 or mor short-term skilled nursing facility (NF) stays in a 6-month period
SMI/SUD risk adults	Adults with county **severe mental illness (SMI) or substance use disorder (SUD)** dia complex social factor, and are (high risk or institutionalization, or user of crisis service IP in past year due to SMI/SUD-related hospitalizations or pregnant
Nursing facility diversion	Adults at risk for long-term care (LTC) institutionalization who, in the absence of serv otherwise require care for 90 consecutive days or more in an inpatient NF
Nursing facility transition	Adult NF residents who want and, with supports, are able to transition to the commu
Jail transition adults	Adults **transitioning from incarceration** in past 12 months who have a chronic menta SUD, intellectual or developmental disability, traumatic brain injury (TBI), HIV, or pre
Children & youth	High utilizers; complex physical, behavioral, or developmental health needs; serious California Children's Services, child welfare & foster care; incarcerated and transition

CalAIM Community Supports

- **Housing Transition Navigation Services:** Assistance with obtaining housing. T assistance with searching for housing or completing housing applications, as w an individual housing support plan.
- **Housing Deposits:** Funding for onetime services necessary to establish a hous security deposits to obtain a lease, first month's coverage of utilities, or first an rent required prior to occupancy.
- **Housing Tenancy & Sustaining Services:** Assistance with maintaining stable t housing is secured. May include interventions for behaviors that may jeopardiz late rental payment and services, to develop financial literacy.
- **Short-term Post-Hospitalization Housing:** Setting in which beneficiaries can receiving care for medical, psychiatric, or substance use disorder needs immed exiting a hospital.
- **Recuperative Care (Medical Respite):** Short-term residential care for benefici longer require hospitalization, but still need to recover from injury or illness.
- **Respite Services:** Short-term relief provided to caregivers of beneficiaries who intermittent temporary supervision.

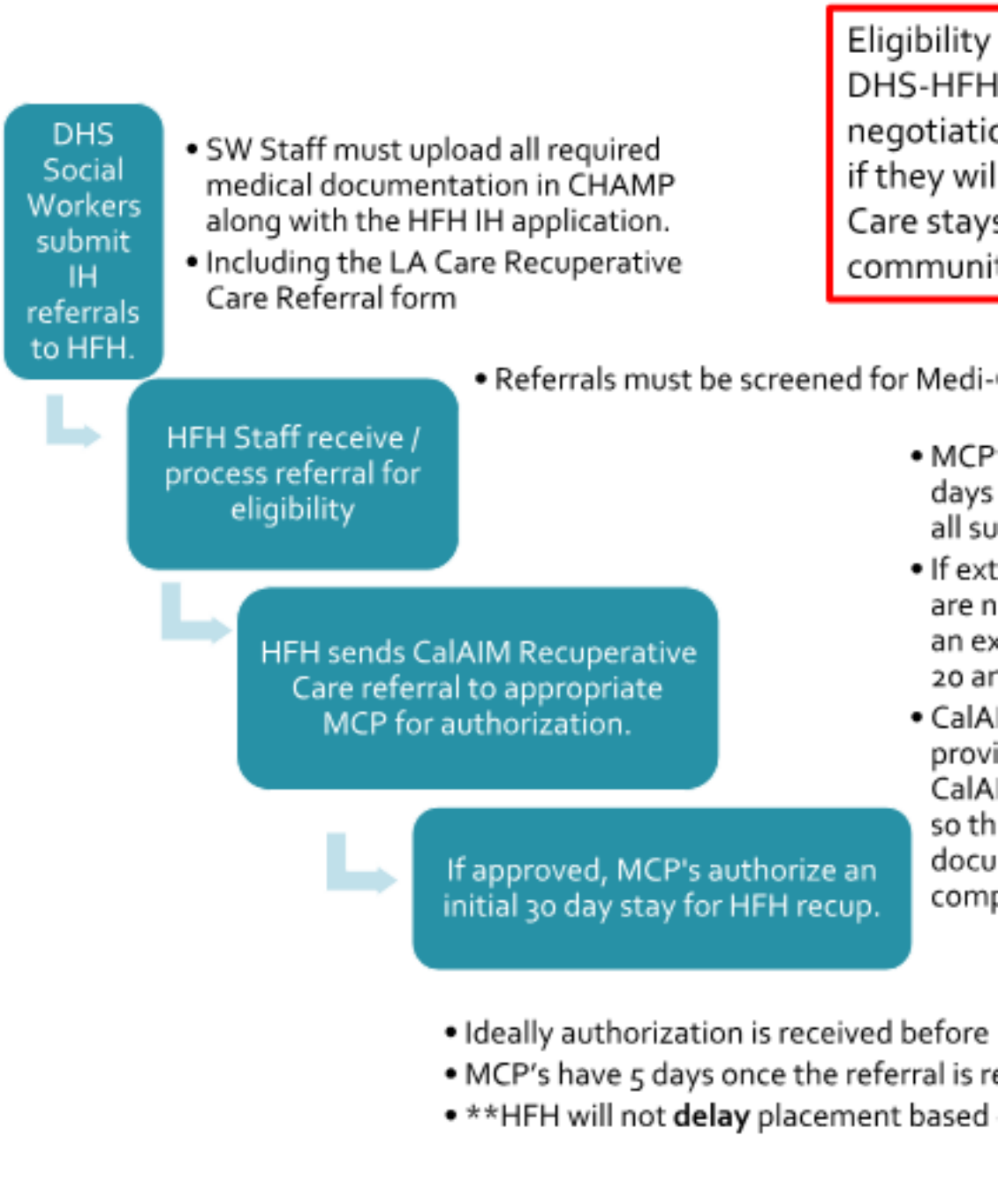
CalAIM Community Supports

- **Nursing Facility Transition & Diversion to Assisted Living:** Services provided beneficiaries transitioning from nursing facility care to home settings in which for living expenses.
- **Community Transition Services/NH Transition to Home:** Services provided transitioning from nursing facility care to home settings in which they are res expenses.
- **Personal Care and Homemaker Services:** Services provided to assist benefic from nursing facility care to home settings in which they are responsible for li
- **Day Habilitation Programs:** Programs provided to assist beneficiaries with c necessary to reside in homelike settings, often provided by peer mentor type programs can include training on use of public transportation or preparing m
- **Environmental Accessibility Adaptations:** Physical adaptations to a home t and safety of the beneficiary. These may include ramps and grab bars.
- **Meals/Medically Tailored Meals:** Meals delivered to the home that are tailor beneficiaries' unique dietary needs, including following discharge from a hos

Community Supports in Los Angeles Co

Community Supports	L.A. Care	Anthem	Blue Shield Promise	Kaiser	
Housing Transition Navigation Services	January 2022	January 2022	January 2022	January 2022	Ja
Housing Tenancy and Sustaining Services	January 2022	January 2022	January 2022	January 2022	Ja
Meals/Medically Tailored Meals	January 2022	January 2022	January 2022	January 2022	Ja
Recuperative Care (Medical Respite)	January 2022	January 2022	January 2022	January 2022	Ja
Housing Deposits	July 2022	January 2022	January 2022	January 2023	
Sobering Centers	July 2022	July 2022	July 2022	July 2022	Ja
Personal Care and Homemaker Services	July 2022	July 2022	January 2022	January 2023	Ja
Respite Services	July 2022	July 2022	January 2022	January 2023	Ja
Asthma Remediation	July 2023	January 2022	July 2022		Ja
Environmental Accessibility Adaptations	January 2023	January 2022	January 2022	January 2023	
Short-term Post-Hospitalization Housing		July 2022	January 2022		Ja
Day Habilitation		January 2024	July 2022		Ja
Nursing Facility Trans. / Div. to Assisted Living	January 2024	January 2023	January 2023		Ja
Nursing Facility Trans. / Div. to Home	January 2024	January 2023	January 2023		Ja

LA County DHS Housing for Health Referral Pathways



HealthNet Recuperative Care Referral Criteria

Eligibility

- Members who are at risk of hospitalization or are post-h
- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing
  their health and safety without modification.

Restrictions

- Should not replace or duplicate the services provided to
  enhanced care management program or duplicated state
- Not more than 90 days in continuous duration
- Does not include funding for building modification or bu

Services

- Interim housing with a bed and meals and ongoing moni
  member's ongoing medical or behavioral health conditio
- May also include (if needed): Limited or short-term assis
  Instrumental Activities of Daily Living and/or Activities of
- Coordination of transportation to post-discharge appoin
- Connection to any other ongoing services, including men
  substance use disorder services.
- Support in accessing benefits and housing.
- Stability with case management relationships and progra
- Can be used with other housing Community Supports. W
  housing Community Supports should be provided to men
  recuperative care facility.

HealthNet Referral Authorization Processes

1. The hospital confirms if the member is currently
member.
2. The interdisciplinary team (including the review
member qualifies for recuperative care, based on
Recuperative Care Auth Guide, and advises on the
provider for the member, based on capacity and n
3. The hospital submits the authorization request
obtain recuperative care services to the Health Pla
review updates. The clinical team will review and i
criteria is met for the member to receive services
4. The Health Plan notifies the hospital and recup
with authorization status. After authorization app
hospital can send the member to a recuperative ca
5. The recuperative care provider will provide serv
bill using the authorization number provided.

Other method:

Member is referred to recuperative care provider a
provider determines member's qualifications and
through provider portal or by fax (800-743-1655) w
supplemental support.

L.A. Care Recuperative Care Referral Criteria

Recuperative Care Eligibility

A) Be an active, homeless L.A. Care MCLA c

B) Is post-hospitalization or post-skilled nur

C) Have one of the following:

a. A defined home health skilled need, s

- Physical therapy, occupational the therapy
- Ongoing IV antibiotics
- Wound Care

or

b. Be in the midst of, or in need of, an o treatment that if interrupted or delayed undue harm.

L.A. Care Recuperative Care Eligibility Exclusions

A) Member is unable or unwilling to independently c
for short-term or limited assistance consistent with r
facility capabilities;

B) Member is dependent for medication administrat

C) Member is incontinent of bladder and/or bowel ar
with adult briefs and/or other incontinence supplies;

D) Member is gravely disabled;

E) Members must be medically & psychiatrically stab
hospitalization that or a different higher level of care

F) Member is cognitively impaired (e.g., needs const
monitoring and /or re-direction and verbal cues for ba

G) Member has been recently combative, aggressive
towards staff or other individuals;

L.A. Care Recuperative Care Eligibility Exclusions Continued

H) Member has a peripherally inserted central cathet
on IV medications depending on other factors, e.g., t
administered, mobility, safety of Member and other
about placement of Members with a PICC Line will be
case basis;

I) Member is unable to live independently in housing
care, such as skilled nursing, 24/7 care and supervisio

J) Member has tested positive for Covid-19 within th
still exhibiting symptoms;

K) Active Tuberculosis/C-DIFF/MRSA of sputum (poss
communicable/contagious condition(s) may be a disc
administration, Adult Residential Facility (ARF) / Resi
the Elderly (RCFE), a.k.a. Board & Care services, or et

L) Members are generally ineligible with limited exc
oxygen dependent, has stage 3 or 4 decubitus, is acti
quadriplegic. Decisions about placement of Member
be decided on a case-by-case basis.

Recuperative Care Referral Supporting Documentation Requirements

The following documents are **required** for an MCP to
recuperative care referral:

- ☐ MCP/LA Care Recuperative Care Referral Form
- ☐ Face Sheet
- ☐ CXR or PPD (within last year)
- ☐ COVID-19 Test Required (from current hospit
- ☐ History & Physical
- ☐ Social Worker Notes
  - ☐ SW Notes should clearly indicate that a patien homelessness
  - ☐ SW notes should also clearly indicate that the informed that an interim housing/recuperative submitted on their behalf and that they will ac
- ☐ Medication List
- ☐ Wound Care Notes (if any)
- ☐ Psych Notes (if applicable) - last two days of n documentation
- ☐ Consultation Notes (if applicable)
- ☐ Recent PT/OT/ Speech Therapy (if applicable)

Common Referral Mistakes & Frequently Asked Requests from MCPs

- Missing documents (SW notes, etc
- Missing home health information (
  contact information)
- Missing follow up PCP appointmen
- Missing indication of homelessness
  willingness to accept recuperative c
- Any of the above will result in an au
  rejection from the MCP or significan
  back-and-forth communication

CalAIM-Related Funding Opportunities

CalAIM Provider Incentive Funding - $1.5 Billion

- Awaiting funding awards to providers for Round One

PATH (Providing Access & Transforming Health) F

- initiative to build and expand capacity and infrastructu
  government agencies and county and community-base
  public hospitals & CBOs to successfully participate in th
  Community Supports and Justice-Involved services unc
- DHCS has appoint a Third-Party Administrator (TPA) t
  stakeholder collaborative planning group

HHIP - $1.228 Billion

- MCPs are currently collaborating with local Continuum o
  Local Homelessness Plan (LHP) due to DHCS on June 30
  submit HHIP Investment Plan to DHCS on August 31st
- Stakeholder meetings re: Investment Plan will be condu

Incentive Provider Program (IPP) Program Year 1 2022-23 Priorities

DHCS focused Year 1 funding priority areas o
infrastructure, Community Supports take-

Delivery System Infrastructure	ECM Provider Capacity Building	Community Supp Provide Capaci Building & MCP T Up
Fund core MCP, ECM and Community Supports provider HIT and data exchange infrastructure required for ECM and Community Supports	Fund ECM workforce, training, TA, workflow development, operational requirements and oversight	Fund Commun Supports traini TA, workflow development, operational requirements, take-up and oversight

DHCS expects MCPs to work closely with local par
developing their Gap-Filling Plan and Needs
meet and achieve the program mea

CalAIM Incentive Provider Progra
Eligibility and Funding Use

WHO IS ELIGIBLE FOR FUNDING

- County Social Services
- County Behavioral Health
- Public healthcare systems/hospitals
- FQHCs
- County/local public health jurisdictions
- Community-based organizations
- Correctional partners
- Housing Continuum
- Tribes and Tribal providers (except for Plans in Counties without recognized tribes)
- ECM providers
- Community Support providers
- Others

WHAT IPP FUNDS CAN

Funds will flow from DHCS to
Meeting set milestones

Sample uses include:

- Purchasing or upgrading IT
  and Community Supports
- Expanding reach of Comm
  offered by developing new
  partnerships with provider
  network capacity
- Developing program comp
  capabilities to ensure popu
  within a county can be effe

PATH is Comprised of two Aligned Programs

PATH Program	High-Level Descri
Justice-Involved Capacity Building	Funding to maintain and build pre- post-release services to support im the full suite of statewide CalAIM j initiatives in 2023 (e.g., pre- and po services).
Support or Implementation of ECM and Community Supports	Support for CalAIM implementatio community level, including payme interventions and services, and sup access to services that will enable t from Medi-Cal 2020 to CalAIM.

MCPs will be expected to participate in PATH
but are not eligible to receive PATH fund

PATH Capacity & Infrastructu
Sample Uses of Fund

Category	Sample Activities
Increasing Provider Workforce	» Assessment of current organizational capabilities, infrastructure and systems, and Community Supports » Identification of critical gaps and needs to be addressed for seamless provision of to ensure successful ECM / Community Supports participation » Initial hiring, recruiting, onboarding and training staff that will have a direct role in Community Supports responsibilities Increasing capacity to deliver new services/p beyond current capabilities (e.g., offering a new Community Supports not previous
Developing Necessary Infrastructure/Systems	» Supporting the implementation of a closed-loop referral system » Purchasing enhanced billing systems/services » Enhancing existing systems to support core monitoring/data reporting needs » Transitioning former WPC Pilot infrastructure for integration into ECM / Communit managed care contracted services
Supporting Delivery of ECM/ILOS	» Modifying existing physical infrastructure of ECM / Community Supports provider an organization's capacity to deliver ECM / Community Supports (e.g., replacing in refrigerates fresh food)
Evaluating and Monitoring ECM/ILOS	» Staff time devoted to data collection to establish the evaluation and oversight of E Supports

PATH waiver funding is complementary to and non-duplicative of PI funding
Reference: https://www.dhcs.ca.gov/CalAIM/Documents/PATH-Jan-28-All-Comer-Webinar.pd

Housing & Homelessness In
Program Metrics & Time

Partnerships & Capacity to Support Referrals

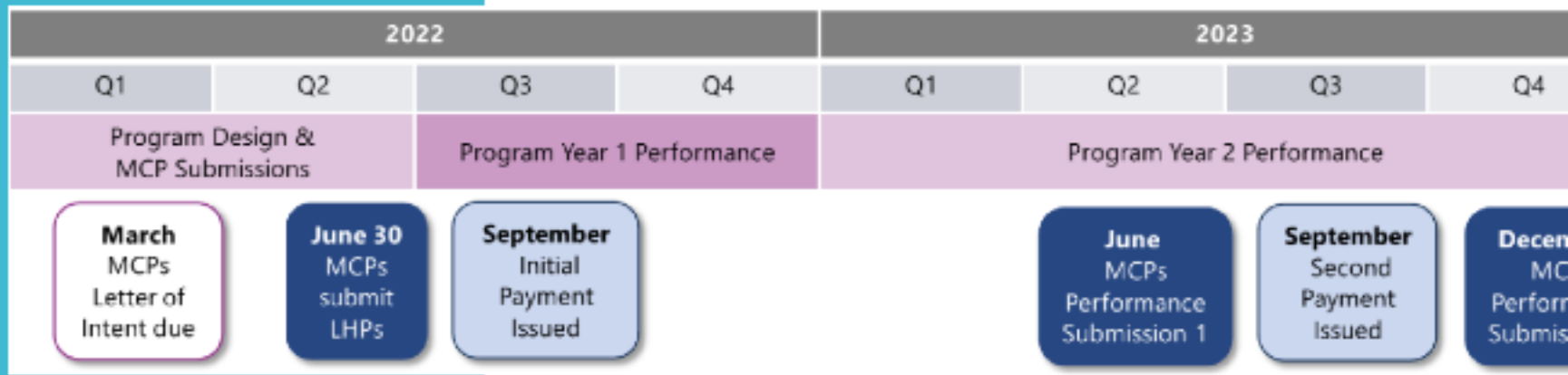
- Engagement with CoCs
- Data Sharing with Stakeholders
- Outreach for Community Supports
- Strategies to Address Equity & Disparities

Infrastructure to Coordinate & Meet Member Housing Needs

- Street Medicine
- Connection with HMIS
- Tracking and Managing Community Supports referrals

Delivery
Member

- Screening o
- homelessne
  homelessne
- MCP Partici
  Time (PIT) c
  experiencin



Los Angeles

RECUPERATIVE CARE LEARNING NETWORK

Thank you for joining us!

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