Birth Equity Tools for Potential Providers and Referring Agencies

October 3, 2023

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Agenda

- Welcome and Introductions
- Learning Objectives
- Birth Equity Outcomes in California
- ECM Population of Focus: Birth Equity Population of Focus: Eligibility, Network Development, Referrals and Services
- Provider Spotlight: First 5 Sacramento
- Value Proposition and Case Studies
- Overview of Home Visiting and Doula Benefit
- Important Considerations for ECM Providers and ECM Engagement Opportunities
- Q&A

Welcome and Introductions

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Senior Director, Systems of Care

Today's Presenters

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First 5 Sacramento

Learning Objectives

- Understanding how birth outcomes can be impacted by race/ethnicity.
- Explain the new ECM Birth Equity Population of Focus going live January 1, 2024.
- Illustrate how First 5 Sacramento is advancing care for ECM Birth Equity Population of Focus.
- How to partner with Birth Equity providers in the state.
- Apply engagement process for interested providers for ECM Birth Equity Population of Focus in Los Angeles County.

Birth Equity Outcomes in California

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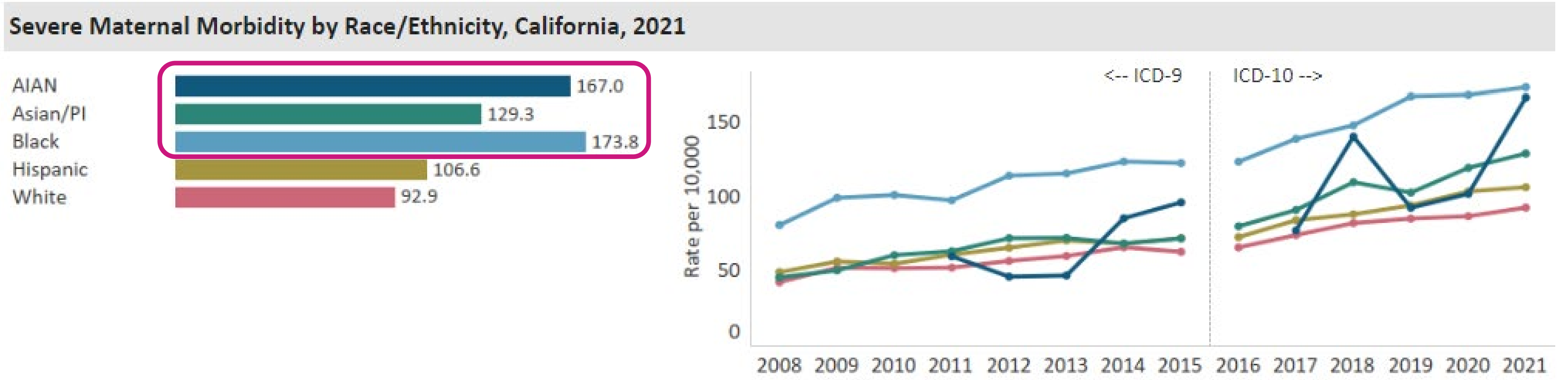
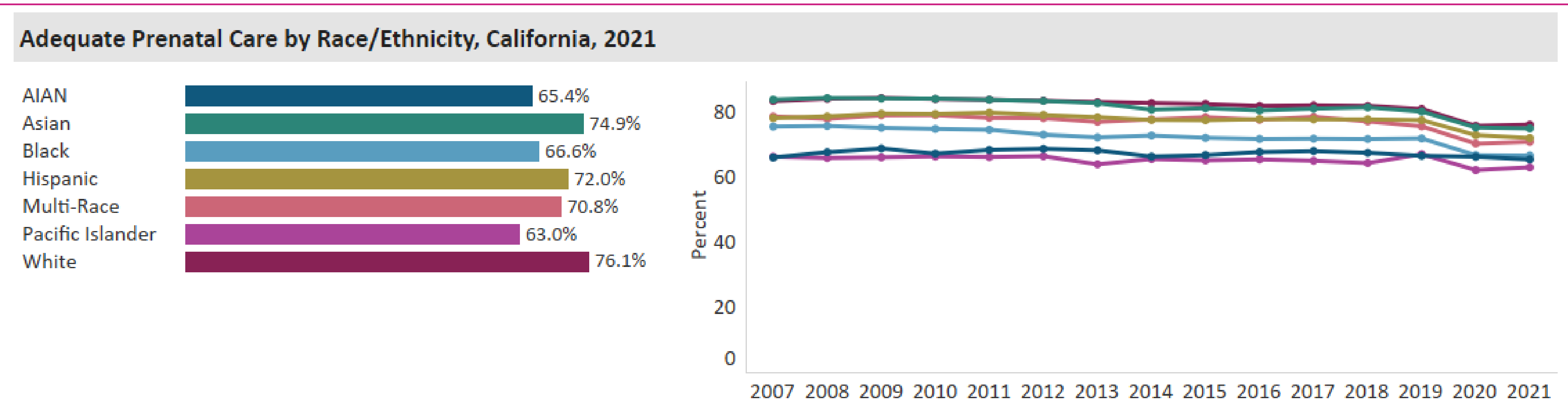
Severe Maternal Morbidity by Race/Ethnicity



Blacks, American Indians/Alaskan Natives (AI/AN), and Asians/Pacific Islanders (A/PI) have the highest pregnancy-related morbidity in the state, as well as the lowest percentage of receiving adequate prenatal care.



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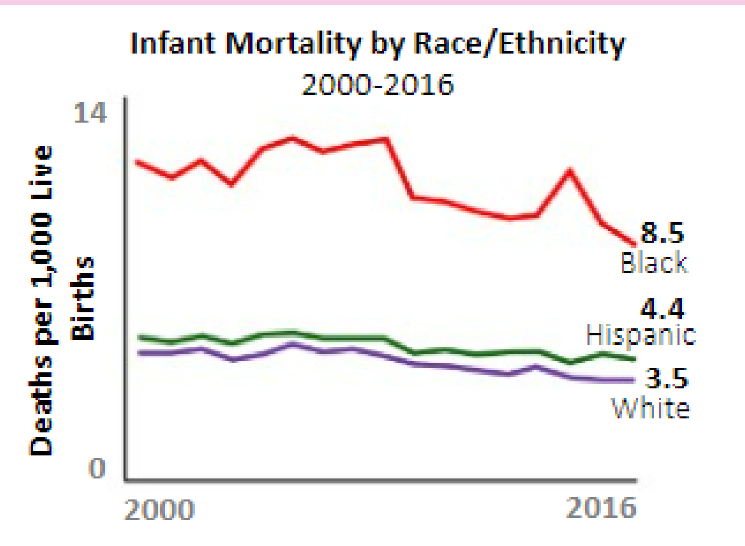
Source: https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Births.aspx

Black Maternal Health and Infant Outcomes

- In California, Black mothers / birthing people* experience the highest rates of maternal morbidity (serious complications) and mortality (death) of any racial/ethnic group.
- Poor birth outcomes persist even when Black women have a pregnancy at an optimal age, high income, or are well educated. A recent study in California shows these racial disparities by income.



Black mothers/birthing people are

4 to 6 times

more likely to die from pregnancy/birth-related causes.

Black mothers/birthing people are

2 times

to suffer a maternal morbidity (such as hemorrhage and infection) than those in all other racial/ethnic groups.

Black babies are

2 times

more likely to be born with a low birth weight than infants of other racial or ethnic groups

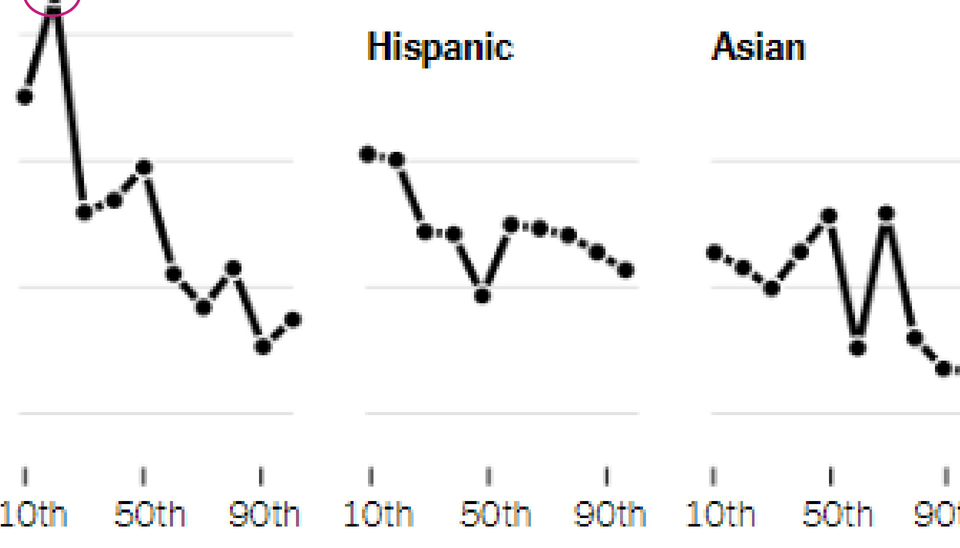
Source: https://www.cdph.ca.gov/Programs/CFH/DMCAH/PEI/Pages/default.aspx

TheUpshot

Childbirth Is Deadlier for Black Families Even When They're Rich, Expansive Study Finds

By Claire Cain Miller, Sarah Kliff and Larry Buchanan
Produced by Larry Buchanan and Shannon Lin
Feb. 12, 2023

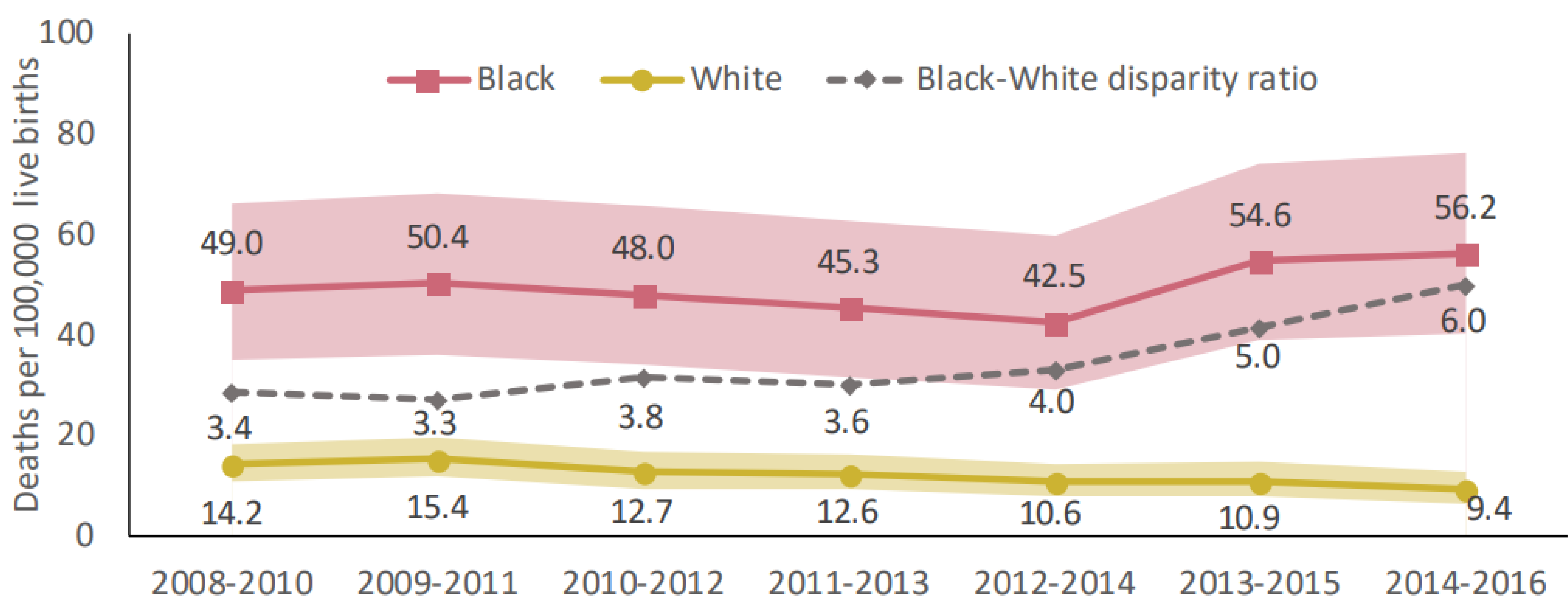
In California, the richest Black women have infant mortality rates at about the same level as the **poorest white women.**



Infant mortality rates for Hispanic and Asian mothers track more closely to rates of white mothers than Black mothers.

Sources: Childbirth Is Deadlier for Black Families Even When They're Rich, Expansive Study Finds - The New York Times (nytimes.com)

Disparities in Pregnant-Related Outcomes



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Source: https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Births.aspx

ECM Population of Focus: Birth Equity Population of Focus: Eligibility, Network Development, Referrals and Services

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ECM's 7 Core Services: A Whole-Person approach with a focus on In-Person Services

1. Outreach and Engagement
2. Comprehensive Assessment & Care Plan
3. Health Promotion
4. Comprehensive Transitional Care
5. Enhanced Care Coordination
6. Individual and Family Social Supports

ECM Population of Focus Roll-Out

Jan 1, 2022

Adults and Their Families Experiencing Homelessness;

Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization;

Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs;

Adults 18+ Transitioning from Incarceration

Adult Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes.

Jan 1, 2023

Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization;

Adult Nursing Facility Residents Transitioning to the Community.

Jul 1, 2023

Children & Youth Populations of Focus

Existing PoF's (listed left) expanding to Children & Youth;

Children & Youth Enrolled in CCS or CCS WCM;

Children & Youth Involved in Child Welfare.

Jan 1, 2024

Expanded eligibility to Adults & Youth Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes ***who are subject to racial and ethnic disparities*.**

The Focus of Today's Webinar

ECM Population of Focus Going Live 7/1/23
Pregnant & Postpartum Individuals who meet other Qualifying ECM Eligibility

ECM Birth Equity Population of Focus Going Live 1/1/24
Pregnant & Postpartum Individuals who are subject to racial & ethnic disparities as defined by California public health data on maternal morbidity and mortality

Adults and Youth who:

1. Are pregnant or are postpartum (through 12 months period); **and**
2. Are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality *

Notes on the Definition:

- "Postpartum" means having delivered, whether a live birth or stillbirth; or a late term abortion.
- This PoF is already live statewide as of January 1, 2022 for adults and is live statewide starting July 1, 2023 for children & youth PoF
- **Pregnant & Postpartum Individuals who are subject to racial & ethnic disparities as defined by California public health data on maternal morbidity and mortality, will go-live statewide on January 1, 2024*

No further criteria are required to be met to qualify for this ECM Population of Focus.

ECM Birth Equity Population of Focus Going Live 1/1/24

Pregnant & Postpartum Individuals who are subject to racial & ethnic disparities as defined by California public health data on maternal morbidity and mortality

Maternal morbidity and mortality data will be calculated at the State level (not county level) to guide ECM eligibility at the MCP and Member level

Based on the California Department of Public Health's (CDPH) most recent State public health data (including the Prenatal Care Dashboard and Pregnancy-Related Mortality Dashboard), the racial and ethnic groups experiencing disparities in care for maternal morbidity and mortality are:

- **Black,**
- **American Indian and Alaska Native,**
- **Pacific Islander pregnant and postpartum individuals**.

DHCS is adding this eligibility pathway in recognition that living within communities subject to historically poor birth outcome disparities related to social inequity is itself a risk factor that can be addressed through comprehensive, whole-person care management.

MCPs are interested in expanding their ECM network to include ECM Providers with special expertise in pregnancy and postpartum care.

ECM Systems Integration Expectations

1) 1915(c) Waivers	2) Services Carved Out of Managed Care	3) Services Carved into Managed Care	4) Dual-Eligible Members	5) Other Programs	6) Programs Serving Pregnant & Postpartum Individuals
Multipurpose Senior Services Program (MSSP)	California Children's Services (CCS)	CCS Whole Child Model (WCM)	Dual Eligible Special Needs Plans (D-SNPs)	California Community Transitions (CCT) Money Follows the Person (MFTP)	Comprehensive Perinatal Services Program (CPSP)
Assisted Living Waiver (ALW)	County-Based Targeted Case Management (TCM)	Complex Care Management (CCM)	D-SNP Look-Alike Plans	Family Mosaic Project	Black Infant Health (BIH) Program
Home and Community-Based Alternatives (HCBA) Waiver	Specialty Mental Health Services (SMHS) TCM	Community-Based Adult Services (CBAS)	Other Medicare Advantage Plans	Hospice	California Perinatal Equity Initiative (PEI)
HIV/AIDS Waiver	SMHS Intensive Care Coordination for Children (ICC)		Medicare Fee For Service (FFS)	California Wraparound	American Indian Maternal Support Services (AIMSS)
HCBS Waiver for Individuals with Developmental Disabilities (I/DD)	Drug Medi-Cal Organized Delivery System (DMC-ODS) & Drug Medi-Cal (DMC) Program Care Coordination & Management Programs		Cal MediConnect		CDPH California Home Visiting Program (CHVP)
Self-Determination Program for Individuals with 1/DD	Full Service Partnership (FSP)		Tully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)		CDSS CalWORKs Home Visiting Program (HVP)
	Health Care Program for Children in Foster Care (HCPCFC)		Program for All-Inclusive Care for the Elderly (PACE)		
	In Home Supportive Services (IHSS)				*Doula services
	Genetically Handicapped Person's Program (GHPP)				

- ECM is only a benefit for beneficiaries enrolled in managed care (not FFS)
- Members can be enrolled in both ECM and the highlighted programs
- ***Managed care plan must ensure non-duplication of services between ECM and case management services that may be provided under highlighted programs***

1. ECM and the other program	MCP Members can be enrolled in both ECM and the other program. ECM enhances and/or coordinates across the case/care management available in the other program. MCP must ensure non-duplication of services between ECM and the other program.
2. Either ECM or the other program	MCP Members can be enrolled in ECM or in the other program, not in both at : the same time.
3. Not Eligible to Enroll in ECM	Medi-Cal beneficiaries enrolled in the other program are excluded from ECM

Source: DHCS ECM Policy Guide p. 56

Perinatal Services with Which Coordination is Required

California Perinatal Equity Initiative (PEI) serves pregnant and parenting Black individuals and their partners, up to the child's first birthday. PEI complements the BIH program for whole family care with home visitation programs, group interventions, and fatherhood and partnership initiatives. California PEI is administered by county agencies, with funding and oversight provided by CDPH

Comprehensive Perinatal Services Program (CPSP) serves low-income pregnant and postpartum individuals enrolled in Medi-Cal from the start of pregnancy to 60 days PP. CPSP provides obstetric services, health education, nutrition services, case coordination including strengths-based assessments, individualized care planning (reassessed each trimester), and PP assessment.

Black Infant Health Program (BIH) serves Black pregnant and postpartum (up to 6 months) living in select California counties and cities, regardless of income, starting at age 16. BIH provides prenatal and postpartum group sessions, case management, skills-based interventions (e.g., stress management, empowerment, healthy behaviors), and individual client-centered life planning. BIH is administered by county agencies, with funding and oversight provided by CDPH

American Indian Maternal Support Services (AIMSS) provides perinatal case management and HV services to American Indian pregnant and postpartum individuals through the infant's first year of life. The program assists program participants with receiving health care, education, emotional support, referrals to services (social and health), and follow-up visits. AIMSS is administered by the Primary, Rural, and Indian Health Department (PRIHD)

CA Home Visiting Program (CHVP) is a voluntary program serving pregnant/parenting families with at least one risk factor (e.g., domestic violence, inadequate income or housing, <12 years of education, SUD or mental health concerns. Services generally begin prenatally or right after delivery until about age three and may include, parenting skills, information and guidance on newborns and infants, referrals to community resources, screening children for developmental delays and facilitating interventions.

The CalWORKs Home Visiting Program (HVP) is a voluntary program servings individuals who are pregnant/parenting a child <24 months of age and are eligible for CalWORKs aid. HVP services may include, prenatal, infant, and toddler care; infant and child nutrition; child developmental screening/assessments; parent education; child development and care; job readiness and barrier removal; and treatment and supports for domestic violence and behavioral health concerns.

Birth Equity Population of Focus: ECM Providers

1. OB/GYNs (Obstetrics/Gynecology)
2. Family Medicine Physicians
3. Doulas
4. Promotoras
5. Midwives
6. Home Visitors

Potential (“Natural Fit”) Providers

Provider Readiness Requirements
(see MCP Readiness Applications for Complete list)

Providers must have systems in place to:

- Document and track care management
- Timely identify pregnant members by leveraging multiple data sources and partnerships
- Keep local programs engaged and/or informed of members' care plan status (especially if not ECM Provider)
- Submit claims (or use an invoicing template)
- Leverage comprehensive assessments from other programs and provide care coordination
- Conduct additional assessment as needed to ensure whole-person approach to addressing members needs
- Training, technical assistance and financial support is available for ECM providers to build readiness and capacity to become ECM providers (e.g., PATH/CITED funds from DHCS, IPP from MCPs)

Source: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf and https://www.healthnet.com/content/dam/centene/healthnet/pdfs/provider/ca/hn-medi-cal-ecm-provider-certification-application.pdf

Operational Guidance for Birth Equity POF

Identification	Comprehensive Assessment and Care Management Plan	Contracting Considerations	Outreach and Engagement
• Encounter data • Provider records or reports • Race and ethnicity data at multiple interventions (e.g., eligibility, enrollment, Provider recorded) • Comprehensive Perinatal Services Program (CPSP) • Black Infant Health (BIH) Program • California Perinatal Equity Initiative (PEI) • American Indian Maternal Support Services (AIMSS) • CDPH's California Home Visiting Program (CHVP) • CDSS' CalWORKs Home Visiting Program (HVP) • Maternity care providers, including midwives, doulas, and hospitals • ADT feed data, when available • Members and their families (self-refer)	• Comprehensive assessments conducted by CPSP ▪ Steps to Take ▪ CPSP individualized care plan and postpartum assessment • Additional assessments to address those needs across the areas of physical health care, mental health care, SUD care, community-based LTSS, oral health care, palliative care, social supports, SDOH care, and others. • Member who is enrolled in ECM through this Population of Focus would only disenroll if they meet graduation criteria.	• ECM Providers specializing in each of the specific Populations of Focus, who have an existing footprint in the communities they serve. • There are no limitations on who can be an ECM Provider for this Population of Focus. • Natural fits ▪ OB/GYNs ▪ Family Medicine Physicians ▪ Doulas ▪ Promotoras ▪ Midwives • Existing California programs that support pregnant and postpartum individuals ▪ Home visiting programs ▪ CPSP ▪ BIH Program ▪ PEI ▪ AIMSS • Members receiving doula services who also quality for ECM are not precluded from receiving ECM as long as the MCP ensures that Providers do not receive duplicative reimbursement for the same services provided to the same Member	• Where the Member is also enrolled in a local pregnant or postpartum program (i.e., CPSP, BIH Program, PEI, AIMSS, CHVP, HVP) and that program is also their ECM Provider • In instances where the Member is enrolled in a local pregnant or postpartum program (i.e., CPSP, BIH Program, PEI, AIMSS, CHV, HVP) and that program is not their ECM Provider, the ECM Provider is expected to consult with the local pregnant or postpartum program and keep them informed as appropriate

Source: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

Supplemental Birth Equity Model of Care (MCP Requirement)

What Data are the MCPs Using to Identify Birth Equity Members? (Q11)

- Local or regional Health Information Exchange (HIE) feeds with data elements specifying pregnancy
- Laboratory test results
- Diagnostic results
- Screenings and assessments
- Claims and encounters (Managed care and fee-for-service medical and dental; pharmacy)
- Inbound requests for prenatal care directly from the Member
- Social service reports (e.g., WIC, IHSS, CalFresh)
- Managed care plan portal data entry
- Network provider EHR feeds
- Referrals from network providers to the MCP
- ADT feeds
- Justice-involved data
- Housing reports (i.e., HDIS, HMIS)
- MCP behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT), medications for addiction treatment (MTOUD, also known as Mediations for Opioid Use Disorder), and other substance use disorders (SUD), and other non-specialty mental health services information
- County behavioral health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health System (SMHS) information available through the Short-Doyle/Medi-Cal and California Medicaid Management Information Systems (CA-MMIS) claims system
- Other notification or alert system for pregnant and postpartum Members not otherwise specified

What's the Referral Pathway to/from ECM for These Organizational Types? (Q12)

- Comprehensive Perinatal Services Program (CPSP), or CPSP-like service Providers (e.g., not affiliated with a LHD)
- Black Infant Health (BIH) Program
- California Perinatal Equity Initiative (PEI)
- American Indian Maternal Support Services (AIMSS) and other Providers supporting Native American Health
- Home visiting programs (CDPH's California Home Visiting Program (CHVP), CDSS' CalWORKs Home Visiting Program (HVP), and/or others)
- Other preexisting local interventions designed to support Black, American Indian and Alaska Native (AIAN) and/or Pacific Islander birthing populations
- Community Based Organizations or other Non-Governmental Organizations
- Women Infants and Children (WIC) service providers
- Women's and family shelters
- Doulas and doula practices/doula circles
- Midwives and midwifery practices
- Other Provider type not listed above

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Source: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

Screening and Referral Process

Complete the ***Population of Focus Screening Checklist*** to confirm member eligibility in **one or more** Populations of Focus.

If determined to be eligible for ECM based on **both Screening Checklists**, complete the ECM Referral Form and submit **all three forms** securely to the member's Health Plan. Include supporting documentation as evidence of meeting criteria.

The Managed Care Plan will review and provide referral status within one business week

If approved, move forward with member outreach and engagement

Step 1 - Population of Focus Screening

Complete **Exclusionary Screening Checklist** to prevent duplicative member enrollment with ECM services prior to submitting the ECM Referral

Step 3 - ECM Referral Form and Supporting Documentation

Health Net provides a validation tool to support your determination of member's eligibility prior to submitting an ECM Referral

Birth Equity Population of Focus: Examples of Services

Pregnant & Postpartum Individuals who are subject to racial & ethnic disparities as defined by California public health data on maternal morbidity and mortality

Examples of applicable ECM services for this Population of Focus include (but are not limited to):

- Facilitating access to Community Supports that will help the pregnant or postpartum individual as they prepare for or recover from labor and delivery, including housing, food related, or pre-entry for the justice involved.
- Coordinating the transition from hospital to home after labor and delivery and with various health and social services providers, including sharing data (as appropriate), to facilitate better-coordinated whole-person care.
- Supporting Member treatment adherence, including scheduling prenatal and postpartum appointments and well-child visits, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
- Connecting the pregnant or postpartum individual, their partner, and/or their family with resources regarding the Member's conditions to assist them with providing support for the Member's health and newborn or infant's health.
- Coordinating care across all applicable delivery systems (Medi-Cal Managed Care or Medi-Cal FFS; SMHS; DMC or DMC-ODS; Dental Managed Care or Dental FFS; and Medi-Cal Rx) and care coordinators.

Birth Equity Population of Focus: Examples of Services

Pregnant & Postpartum Individuals who are subject to racial & ethnic disparities as defined by California public health data on maternal morbidity and mortality

MCPs are strongly encouraged to offer CS to Members who enroll in ECM under this Population of Focus to enhance care and prevent costly, unnecessary hospitalizations. Beneficial examples may include:

- Housing Transition Navigation Services.
- Housing Deposits.
- Housing Tenancy and Sustaining Services.
- Short-Term Post-Hospitalization Housing.
- Housing Transition Navigation Services.
- Medically Tailored Meals/Medically-Supportive Food.
- Sobering Centers

Provider Spotlight:
First 5 Sacramento

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FIRST 5 SACRAMENTO

- Prop. 10 dollars to fund programs and services to improve health and well-being of children prenatal through age five

- Data and community input determined areas of disparity and recommendations for addressing Black infant and child deaths

- **Funded $20M** from 2013 -2023 in complementary efforts addressing perinatal, ISR, CAN, and BCLC staffing

- **Partnerships, community voice, commitment to REDI** have been key to efforts

FIRST 5 SACRAMENTO

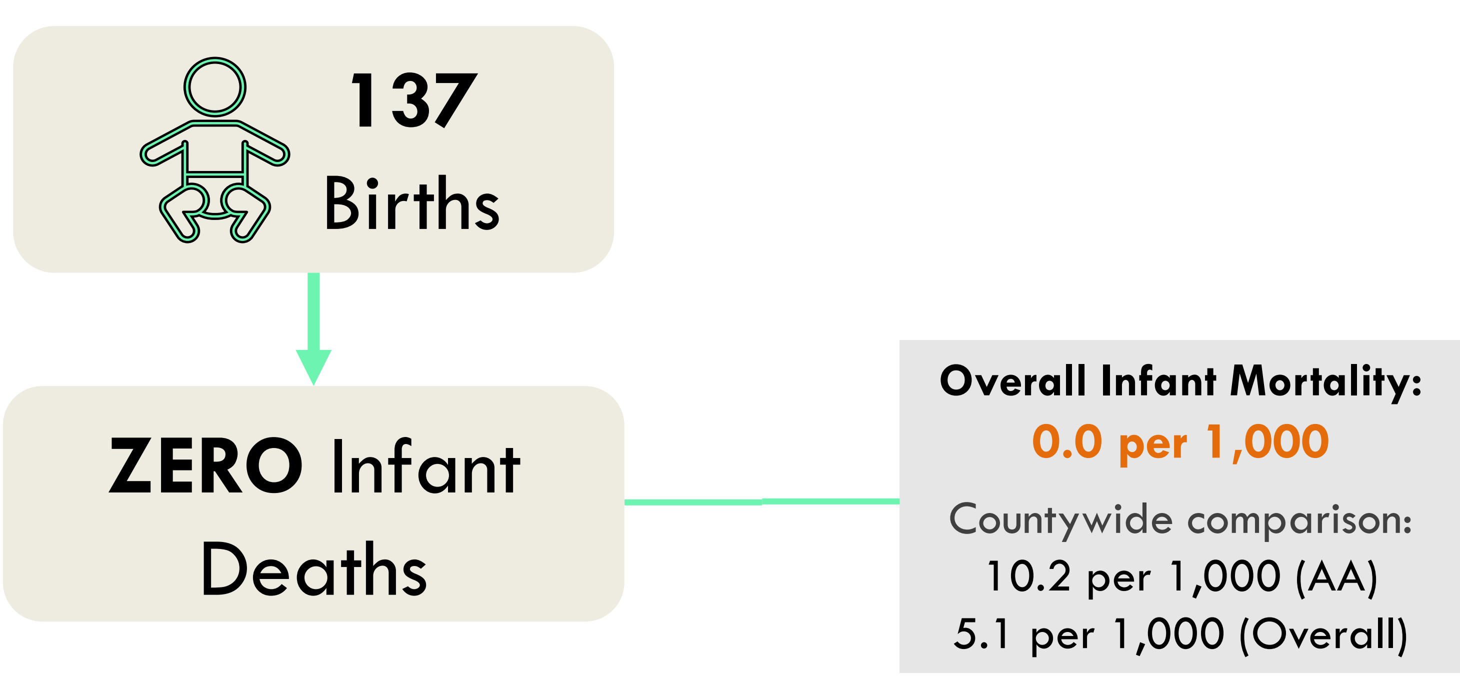
- **Black Mothers United** is a culturally responsive one-on-one education, support & navigation program

- **Peer support** reduced risk factors for moms and babies. From intake to follow up: anxiety decreased 34% to 20%, depression 20% to 5%, DV 8% to 3%, drug use 5% to 2%, unstable housing 13% to 8%, food needs 7% to 0%

- **Positive outcomes** for clients:
  - 71 babies born in FY 20-21: 90% healthy weight, 86% full term
  - Zero stillbirths or infant deaths at exit for 3rd year in a row
  - More check-ins with a Coach and regular prenatal care predicted having a healthy birth

Longitudinal Outcomes of Pregnancy Peer Support Participants

- 12-month outcomes of births to African American mothers served by RAACD Pregnancy Peer Support program during January 1, 2019 and December 31, 2019.



Key Takeaway:

RAACD participants' infant mortality rates remain **lower** than countywide

Reflects mothers served by BMU and WellSpace Health CBP between 2016 and 2018. Aggregate infant death data from Department of Public Health through 2019

Countywide Trend Data

Overview of Progress on 2020 BRC Goals

Leading Preventable Causes of African American Child Death:	2020 Reduction Goal	% Change 2012-2014 to 2018-2020	BRC Goal Status	% Change in Disparity Gap 2012-2014 to 2018-2020
Overall African American child deaths (ages 0-17)	10% to 20%	30% Reduction (ages 0-5)	**Exceeded Goal***	40% Reduction (ages 0-5)
Infant perinatal conditions (ages < 1 month)	At least 23%	4% Reduction (ages 0-1)	**Goal Unmet**	2% Increase (ages 0-1)
Infant sleep related (ISR) deaths (ages 0-1)	At least 33%	54% Reduction (ages 0-1)	**Exceeded Goal**	60% Reduction (ages 0-5)
Child abuse and neglect (CAN) (ages 0-17)	At least 25%	85% Reduction (ages 0-5)	**Exceeded Goal***	93% Reduction (ages 0-5)

* Not intended to be a direct comparison to the BRC goals, which reflected proposed change among all children ages 0-17 and the values presented here are for children ages 0-5.

Value Proposition and Case Studies

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Value Proposition – Birth Equity Partners

- In California, Maternal Mortality for Black birthing people remains three times as high as Asian, Hispanic/Latina, and White birthing people.
- Health Net is partnering with community-based maternal care providers to address disparities in health and birth outcomes in racial and ethnic groups with high maternal morbidity and mortality rates.
  - We will do this together by:
    - Delivering and ensuring patient- and family-centered care and care coordination for Black, American Indian and Alaska Native, and Pacific Islander pregnant or postpartum individuals
    - Coordinating maternity care that is culturally sensitive and evidence-based
    - Collaborating across delivery systems to ensure that the pregnant or postpartum member's health and social needs are met

Improve maternal and adolescent depression screening by 50%

CalAIM's purpose is to improve the quality of life and health outcomes of Medi-Cal Members by implementing delivery system, program, and payment reforms.

ECM is anchored in the community, where services can be delivered in an in-person manner by community-based ECM Providers.

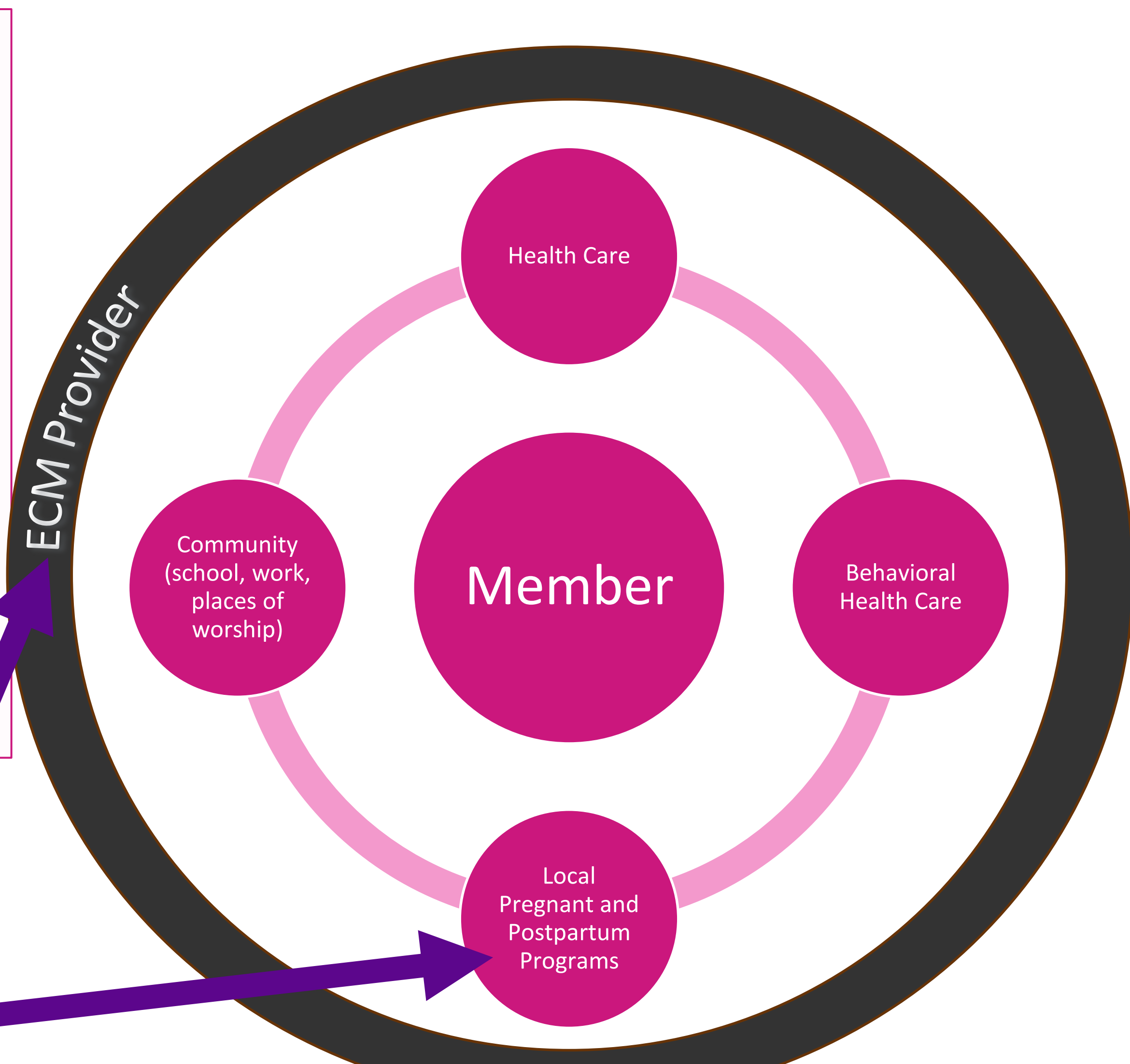
ECM is for Medi-Cal Members with the highest health and social needs. ECM goals are:

- Improving care coordination
- Integrating services
- Facilitating community resources
- Addressing SDOH
- Improving health outcomes
- Decreasing inappropriate utilization and duplication of services

[1] https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/CA-PMSS.aspx

Map ("Where do I Fit In?") for Birth Equity Partners

ECM Services should be provided by trusted community partners.
ECM services are additive to what you are already doing and/or being reimbursed for.
For the Birth Equity PoF Members, ideal ECM Providers include: OB/GYNs, Family Medicine Physicians, Doulas, Promotoras, Midwives, existing California Programs.



This is where you fit in!!

ECM Provider

- **Role**: "Air Traffic Control"
- **Purpose**: To provide an additive "layer" of coordination for C/Y and their families
- **Core ECM Services**:
    - Outreach and Engagement
    - Comprehensive Assessment and Care Management Plan
    - Enhanced Coordination of Care
    - Health Promotion
    - Comprehensive Transitional Care
    - Member and Family Services
    - Coordination of and Referral to Community Social Support Services

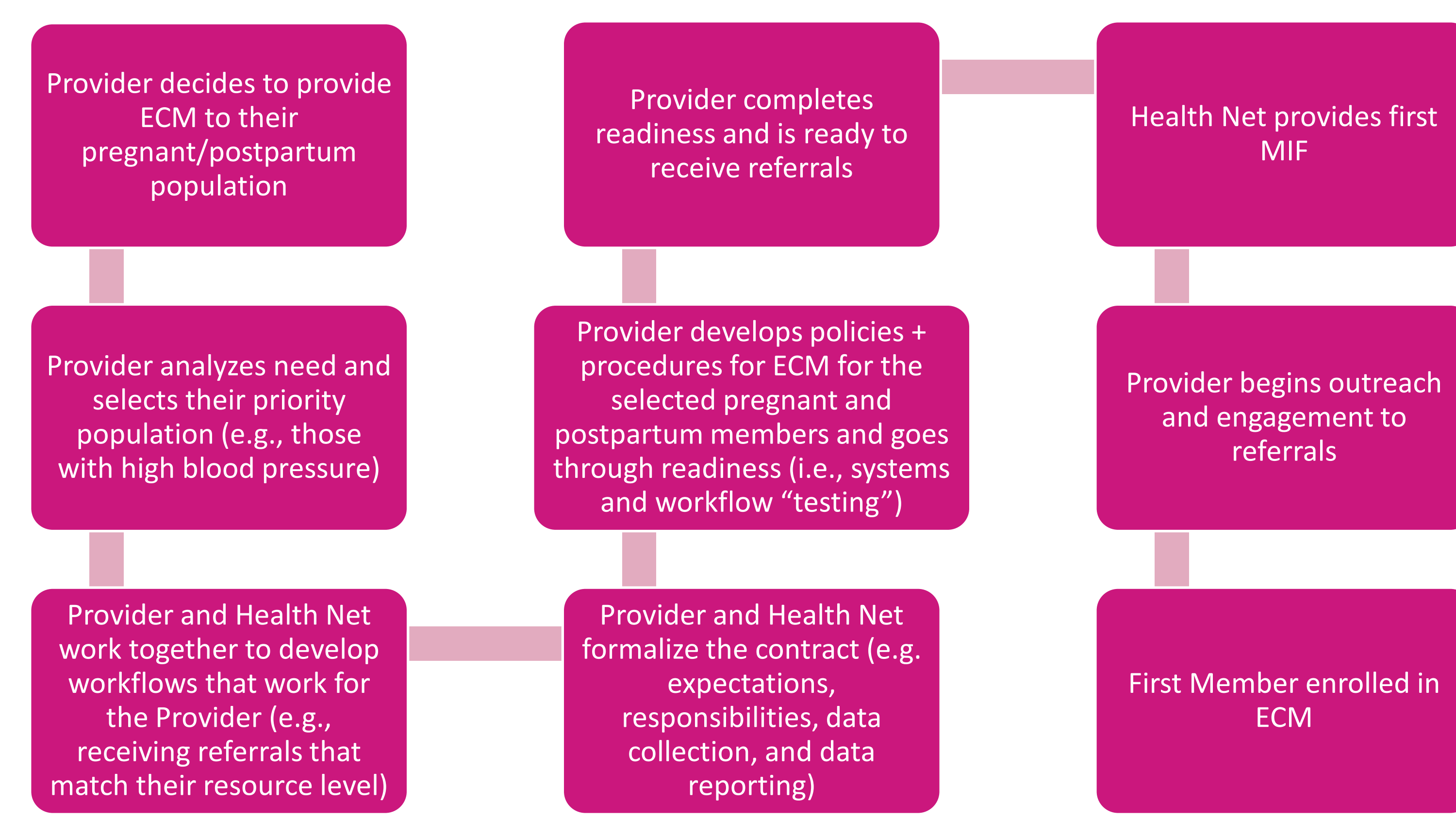
Swim Lane – Delineation of Roles for the Pregnant Member

	Identification	Outreach and Engagement	Comprehensive Assessment & Care Management Plan	Coordinating Care	Services	Oversight
Health Plan	Responsible for timely identification					Ensures there is no duplication of care/case management services
Local Pregnancy/Postpartum Program	May refer to the MCP if they suspect eligibility criteria are met				Provides services, in accordance with their program and professional scope	
ECM Provider*		ECM Services offered to the member** and consult with other providers as appropriate	Complete assessment and develop care plan, leveraging existing assessments where appropriate	Facilitating access to services, transition planning, appointment scheduling, treatment adherence, education and resource connections		
Other Provider (e.g., PCP, OBGYN, Midwife, Doula)	May refer to the MCP if they suspect eligibility criteria are met				Provides services, in accordance with their program and professional scope	
Member	May self-refer					

*If the ECM provider is also the local pregnancy/postpartum program, or other provider such as the PCP or OBGYN, they would incorporate these roles into their existing workflows
**If the ECM provider is also the local pregnancy/postpartum program, or other provider, services can be offered in the same setting where the other services are being provided

Provider Example– Birth Equity Partners

- Provider “A” already serves pregnant and postpartum women through their California Home Visiting Program.
- They are ready to expand their service offering to include ECM.
- Through their home visiting model, they will incorporate the 7 ECM core services
- Their CPSP care plan will be enhanced to include additional components, addressing the member’s needs across physical health, mental health, SUD care, community-based LTSS, oral health, palliative care, social supports, SDOH care/needs, and other areas as identified by the Program
- The Program creates P&Ps and workflows that assist the Lead Care Manager provide ECM services



Amy's Journey

Amy finds out she is pregnant. She is 22, Black and this is her first pregnancy. At her first appointment with her OBGYN, she is referred to CDPH's CHVP.

Her local CHVP outreaches to Amy they set up a time to start home visits.

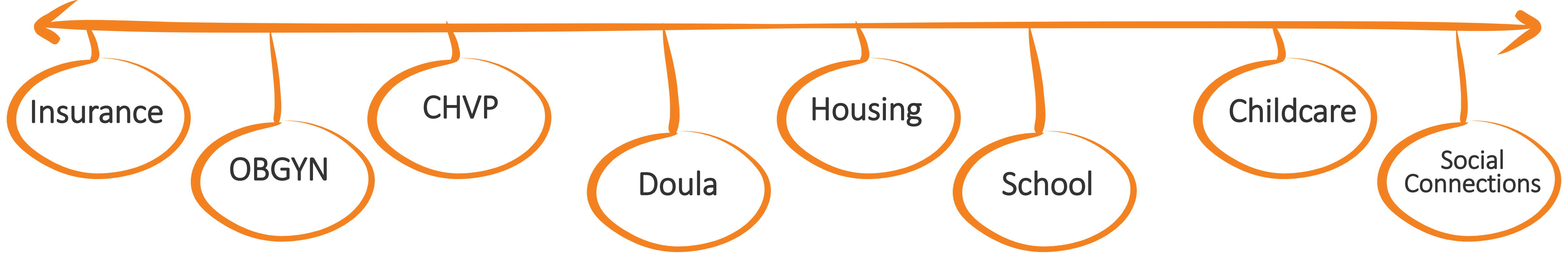
Amy sometimes makes time to keep visits with her CHVP nurse, but she has missed a couple of OBGYN appointments. She is feeling overwhelmed and finds herself too busy to keep up with all of the new appointments as a pregnant woman.

At a visit with her CHVP nurse, they decide that a doula may be a good support for Amy as she nears delivery. Her nurse helps provide a referral but Amy gets busy with work and she ends up not answering her phone when the doula calls to make an appointment.

When Amy's blood pressure is elevated at an OBGYN appointment, the provider educates her on warning signs and when to call the hospital.

Amy knows she needs to watch her health, but she is worried about finding a better place to live and a caring childcare location for her baby. With so many competing priorities, she decides not to enroll in fall classes. She feels overwhelmed and alone.

Amy's Care Needs : No one is communicating and care is fragmented



Amy's Journey – with ECM Services

Amy finds out she is pregnant. She is 22, Black and this is her first pregnancy. At her first appointment with her OBGYN, she is referred to CDPH's CHVP.

Her local CHVP is also an ECM provider and so they get her enrolled for some additional care coordination needs based on her **pregnancy status and race**.

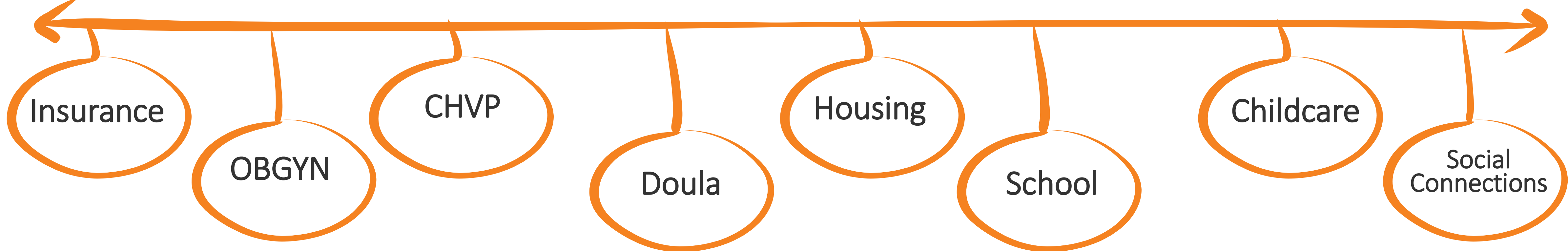
Amy's ECM Care Manager completes an assessment and together they develop a care plan centered on Amy's goals to have a healthy pregnancy, find a nice place for her and her new baby to live, and continue going to college.

With regular interactions with her ECM Care Manager, Amy continues her home visits with CHVP, is connected with a doula, and starts working with a local housing organization to help her find a 2 bedroom apartment near campus.

When Amy's blood pressure becomes elevated, her ECM Care Manager works with Amy's OBGYN and Health Plan to get a home blood pressure cuff and teaches her how to use it. Her ECM Care Manager also makes sure that Amy's doula and CHVP nurse know so they can also help Amy.

After Amy delivers a healthy baby, her ECM Care Manager helps Amy schedule doctor visits, and together they find a great childcare location. Her ECM Care Manager also connected her to a virtual mommy group and has made new connections with moms like her.

Amy's Care Needs : ECM Coordinates it all!



Funding Opportunities

	Capacity and Infrastructure Transition Expansion and Development (CITED) Initiative	Technical Assistance Vendor Marketplace	Incentive Payment Program (IPP)
Eligible Entities	Providers, community-based organizations, counties, and others	Providers, community-based organizations, counties, and others	ECM and Community Supports Providers, local partners, and other Providers
Uses of Funds	For capacity and infrastructure Development activities that support the implementation of Enhanced Care Management (ECM) and Community Supports (CS). This includes current operations assessments/gap analyses. Funding Areas: Increasing Provider Workforce Infrastructure to Support Integration into CalAIM Infrastructure to Support ECM/CS Services Monitor ECM/CS Services Outreach to Under resourced/Underserved for ECM/CS Services	To obtain technical assistance resources towards establishing ECM and CS infrastructure. This includes current operations assessments/gap analyses. TA resources are in seven domains: Building Data Capacity: Data collection, management, sharing, and use Community Supports: Strengthening services that address social drivers of health Engaging in CalAIM through Medi-Cal Managed Care ECM: Strengthening care for ECM POFs Promoting Health Equity Supporting Cross-Sector Partnerships, including between MCPs and counties Workforce: Recruiting and retaining a well-prepared, high-performing workforce	Build appropriate and sustainable ECM and CS capacity; Encourage MCPs to invest in necessary delivery system infrastructure; Bridge current silos across physical and behavioral health care service delivery.
When Available	Round 2 application accepted by Third Party Administrator (TPA) until May 31	Registration and application process now open through TPA	Mid-2023 dependent upon MCP meeting 2022 goals
Funding Source	Direct from DHCS through TPA	Direct from DHCS through TPA	Managed Care Plans (MCPs)
Accountability	TPA releases funds to applicant upon milestone completion	TPA releases funds to applicant upon milestone completion	Fulfillment of MCP milestones tied to the IPP funding grant
How to Apply	Through TPA portal	Through TPA portal after registering and receiving approval to participate	Through MCP process or joint MCP ECM/CS application processes
Paying for Services	Applicant would pay for technical assistance (TA) services towards submission of application and budget	Once a project and budget have been approved with a prequalified vendor, DHCS pays for services	Applicant would pay for technical assistance (TA) services towards submission of IPP application

Overview of Home Visiting and Doula Benefit

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Home Visiting Programs By Counties Served by HealthNet

County Served by HealthNet	Will the County continue to be served by HealthNet in 2024?	Home Visiting (HV) Programs Funded by First 5, CalWORKs HV or CDPH*					Other Home Visiting Programs	Total
		Early Head Start - Home Based Option	Family Spirit	Healthy Families America	Nurse Family Partnership	Parents as Teachers	Black Infant Health**	
Amador	Yes	x						1
Calaveras	Yes	x						1
Inyo	Yes		x					1
Los Angeles	Yes	x		x	x	x	x	5
Mono	Yes					x		1
Sacramento	Yes	x	x	x	x		x	5
San Joaquin	Yes	x				x	x	3
Stanislaus	Yes	x			x			2
Tulare	Yes	x				x		2
Tuolumne	Yes	x						1
TOTAL		10	3	3	5	5	5	

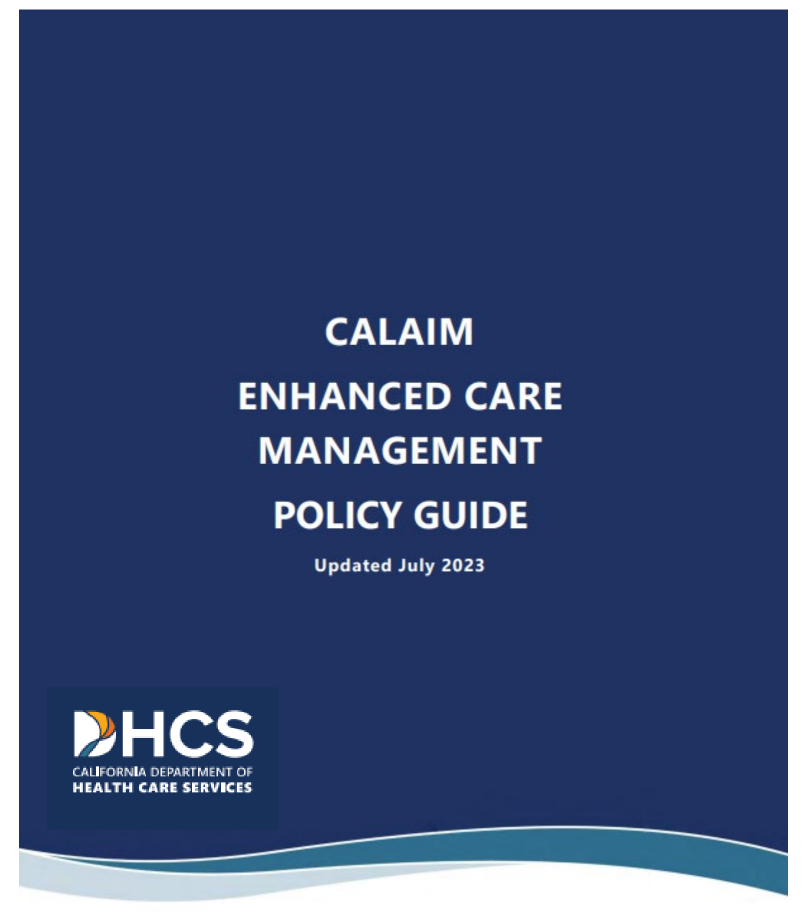
*Source: https://first5center.org/blog/home-visiting-landscape-in-California.May 14, 2020
**Source: https://www.cdph.ca.gov/Programs/CFH/DMCAH/BIH/Pages/Sites.aspx.December 29, 2021

Doula Benefit Overview

Effective January 2023, California added a “doula benefit” all Medi-Cal beneficiaries. The doula service is available in both the fee for service and managed care delivery systems. Doula services include:

- Personal support to women and families throughout a woman's pregnancy, childbirth, and postpartum experience. Includes emotional and physical support, provided during pregnancy, labor, birth, and the postpartum period.
- Pursuant to federal regulations, doula services must be recommended by a physician or other licensed practitioner*
  - An additional recommendation from a physician or other licensed practitioner of the healing arts is required for more than 11 visits during the perinatal period, excluding labor and delivery and miscarriage support.
  - Members receiving doula services who also qualify for ECM are **not precluded from receiving ECM** as long as the MCP ensures that Providers do not receive duplicative reimbursement for the same services provided to the same Member.
- More information is available regarding the doula benefit via the DHCS Doula Services webpage

Resources: DHCS ECM Policy Guide



https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

Important Considerations for ECM Providers and ECM Engagement Opportunities

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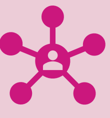
Next Steps



Providers are encouraged to share information on the ECM benefit with other organizations in your network who would benefit from learning more about this Population of Focus (PoF).

Health Net asks Providers to complete the Provider Interest Form (PIF) if interested in supporting the new Birth Equity PoF.

How to Learn More

Please contact Health Net with any questions you have related to ECM for the Birth Equity PoF.

Health Plan	Email Address	CalAIM Website	Additional Instructions
Health Net	ECM_ILOS@healthnet.com	https://www.healthnet.com/content/healthnet/en_us/providers.html	Please note underscores in email address

Questions?