HEALTHY SAN DIEGO (HSD)
CONSUMER & PROFESSIONAL ADVISORY COMMITTEE (CPAC)
CalAIM TASK FORCE
MINUTES – April 10, 2025

Members/Alternates Present*: Suzanne Afflalo, Asya Anderson, Jack Dailey, Michelle Darnelle, Kim Fritz (Co-Chair), Eva Matthews, Caryn Sumek, Patrick Tellez, Jennifer Tuteur (Co-Chair), Janet Vadakkumcherry, Ann Warren, Lindsey Wright*

HSD Staff Present: *Jamie Beam, Lynn Carr, Brittany Charity-Walker, Lee Laydon, Kimia Rezai, Alison Sipler, Sam Sonnich, Heather Summers, Michael Worman*

Guests: *Kitty Bailey, Amanda Berry, Erin Brennan-Burke, Camey Christenson, Laurence Gonzaga, Andrew Gregor, Luwam Kidane, Sarah Legg, DeeAnne McCallin, Joanna Oboza, Lyle Pavuk, Joe Prickett, Christy Rosenberg, Judith Yates, Chris LASSD* (Zoom)

ITEM	***DISCUSSION***
I. Call to Order and Introductions	
	The Healthy San Diego (HSD) Consumer & Professional Advisory Committee (CPAC) CalAIM Task Force was called to order by Kim Fritz at 3:02 p.m.
II. Public Comment	
	None
III. Action Items	
A. Approval of Minutes, March 13, 2025	On MOTION of Dr. Jennifer Tuteur, seconded by Kim Fritz, the March 13, 2025, Meeting Minutes were approved, with all Committee Members present voting yes.
B. Review Member Roster	The Member Roster was reviewed. Dr. Tuteur nominated Eva Matthews to serve as a Member representing Community Supports (CS) providers. It was clarified that Members can designate alternates. On MOTION of Dr. Jennifer Tuteur, seconded by Michelle Darnelle, Eva Matthews was approved as a Member, with all Committee Members present voting yes.
IV. CalAIM ECM and Community Supports Overview	
A. Presentation	Lynn Carr, Chief, Agency Operations, County of San Diego, Medical Care Services
B. Comments / Discussion	Summary of participant comments and discussion: <u>Community Supports (CS)</u> 1. Housing Transition Navigation Services ▪ There were no comments or questions asked on this CS. 2. Housing Deposits ▪ The intervention is once in a lifetime per eligible individual. 3. Housing Tenancy and Sustaining Services ▪ There were no comments or questions asked on this CS. 4. Short-Term Post-Hospitalization Housing ▪ This service is intended for individuals with chronic conditions who are transitioning out of a hospital. 5. Recuperative Care (Medical Respite) ▪ An individual needs to be experiencing or at risk of homelessness and recovering from an injury or illness to receive this service.

- If an individual has received 6 months of Recuperative Care services, they cannot move into Short-Term Post-Hospitalization Housing (no service stacking is allowable, per DHCS guidelines).
- The same facility can provide both Short-Term Post-Hospitalization Housing and Recuperative Care. Only in cases of incarceration would both services be utilized.
- This Community Support is intended to be provided in a building/facility (within four walls) and is not recommended to be provided in inclement weather shelters, tents, pop-up boxes, or little homes.
  - Parking Lot: Discharge to shelters from in-patient stays is not encouraged or allowable for medical respite/recuperative care services. Shelter settings are not intended to be used as medical respite. Explore opportunities for Street Medicine teams to meet potential clients upon their hospital admission. This provides an opportunity for the Street Medicine team to assist with an individual's discharge planning and continue to follow up with the individual after hospital discharge to provide additional support.

6. Respite Services
   - A question was raised regarding whether In-Home Supportive Services (IHSS) caregivers can qualify for Respite Services. Clarification was provided that IHSS caregiving and respite services cannot overlap, both services cannot be offered in tandem (no duplication or service stacking is allowed).
7. Day Habilitation Programs
   - This service is offered at various facilities including those that may be providers of other CS services, such as Recuperative Care. Separate contracts for billing and payment are established by the Managed Care Plans (MCPs) for each distinct CS service.
8. Assisted Living Facility Transition (formerly Nursing Facility Transition/Diversion to Assisted Living Facilities)
   - There was a question about room and board. Room and board is not an allowable expense under the Assisted Living Facility Transition CS.
9. Community Transition Services/Nursing Facility Transition to a Home
   - There were no comments or questions asked on this CS.
10. Personal Care and Homemaker Services
    - This service may function as a safety net service for IHSS and is permissible to be used when IHHS services are pending due to identification of a caregiver or service approval. IHSS services and Personal Care and Homemaker Services cannot be provided at the same time.
11. Environmental Accessibility Adaptations (Home Modifications)
    - Landlord approval is needed for rental properties.
    - Common modifications include installation of ramps and grab bars.
    - There is a $7,500 maximum per household. The $7,500 maximum can be reassessed on a case-by-case basis if the individual has to move due to external circumstances.
12. Medically Tailored Meals/Medically Supportive Food
    - DHCS has recently provided clarification around the definition of Medically Tailored Meals/Medically Supportive Food. Meal interventions may range from frozen to made-from-scratch meals. One MCP offers medically tailored produce boxes.

	13. Asthma Remediation ▪ A question was raised about the lifetime maximum service. Similar to Home Modifications, the $7,500 maximum for Asthma Remediation can be reassessed on a case-by-case basis for external circumstances, such as involuntary moves. 14. Sobering Centers ▪ The service is typically billed to MCPs through a retro authorization process. ▪ Referrals are not typically made to this service, as individuals mainly access this service when brought to a facility by family members or law enforcement. ▪ Sobering Center utilization has been limited due to claims and billing issues. <u>General discussion and comments</u> Summary of participant questions, comments, and discussion; some items were marked and flagged as "parking lot" discussions: ▪ Is it a requirement to receive both ECM and CS? Clarification was provided that an individual is not required to be enrolled in both. Both services can be offered as standalone and have separate eligibility criteria. ▪ Can an individual receive more than one CS and also receive ECM? Yes, multiple CS services can be utilized by one individual (e.g., Recuperative Care, Day Habilitation, Housing). Individuals may qualify for ECM and multiple CS services. ▪ There are treatment and reimbursement distinctions between benefits and services. With CS, there are due process rights when accessing care. Legal Aid Society of San Diego has provided assistance, when appropriate. ▪ Additional discussion: - <u>Parking Lot</u>: UCSD Center for Community Health conducted a CalAIM Survey with existing ECM and CS providers. The CalAIM Assessment Feedback and Recommendations was finalized July 15, 2024. Data collection and analysis was conducted by UCSD Center for Community Health in collaboration with the Food is Medicine Workgroup. A question was raised about what San Diego County is doing to standardize ECM and CS authorizations. A request was made to explore different rates of enrollment in ECM and CS, to determine if there is an opportunity to provide CS services to people enrolled in ECM. - <u>Parking Lot</u>: Look at variations by MCPs that could be harmonized that enables congruent stabilization of eligibility as it relates to enrollment in ECM and CS, and authorizations. Further considerations include exploring opportunities to provide CS services to individuals enrolled in ECM. - <u>Parking Lot</u>: A request was made to determine the value of resources being left on the table through under-utilization of ECM and/or CS.
V. Medi-Cal in San Diego Overview	
A. Presentation	Luwam Kidane, Senior Data and Research Analyst, County of San Diego, Medical Care Services Medi-Cal in San Diego County Dashboard accessible at: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/mcsd/SDAIM/data.html
B. Comments / Discussion	Summary of participant comments and discussion; some items were marked and flagged as "parking lot" discussions:

	▪ When asked if the requirements for enrollment in ECM are higher than the requirements for enrollment in CS services, it was clarified that ECM and CS eligibility requirements are distinct and not comparable. - Parking Lot: This is the first time services are being offered through Medi-Cal Managed Care to address Social Drivers of Health (SDOH). This is not on a billing sheet or part of the lexicon. These are growing pains. Draw analogous links to datasets for benchmarking and redefine how we collect data. This item was moved to the parking lot as the services are new and benchmarks in many areas are missing/lacking. ▪ A question was asked about how homeless data is captured. Disparate data systems present challenges. If you are in a hospital, you are not considered homeless. People who are couch surfing or living in their cars do not necessarily consider themselves homeless. - Parking Lot: Consider all the touchpoints where individuals who may qualify for ECM or CS may walk through the door or complete intake appointments for other similar services. Consider opportunities in the future to have service providers ask individuals if they are housed, unstably housed or homeless; as an example to determine if they may qualify for ECM/CS supportive services. What information can be added on intake forms? What information is collected by primary care, Federally Qualified Health Centers (FQHCs), and other service providers that could generate ECM/CS referrals? The Regional Task Force on Homelessness with the Community Information Exchange provides homelessness information was identified as potential touchpoints for data and identified as points to screen for potential ECM/CS referrals. ▪ Parking Lot: A comment was shared that there is a need for nutrition resources to address health disparities including diet-related disease. - Parking Lot: FQHCs collect SDOH data and other population health data required for quality improvement measures. FQHCs may be a good source of data to pull future SDOH data measures for comparison and future outreach to identified populations of focus. ▪ The data show that the CS services most frequently used are the Housing Transition and Navigation services, Medically Tailored Meals/Medically Supportive Food (MTM/MSF), Personal Care and Homemaker Services, and Recuperative Care Services, with utilization of the latter two being a magnitude smaller than the housing or food-related services. ▪ In response to data showing a spike in the CS utilization for the MTM/MSF service, a MTM/MSF provider confirmed they are seeing an increased need for nutritional support in the community and noted that the data shown reflect in the graphs reflect CS billing. Their organization is entering contracts with additional MCPs, which will lead to them billing for more CS in the future. ▪ It was clarified that dual eligibles (Medi-Cal and Medicare) are represented in the dashboard data and are utilizing CS services. Additional data may also be available for dual eligibles' utilization of CS. Because of the high needs of the dual eligible population, we want to be sure they are not underutilizing services and ensure that Medicare is making referrals into the CS system to maximize their utilization.

	- Parking Lot: Drilling down data into Dual Eligible Special Needs Plans (D-SNPs) and dual eligible populations is needed to ensure this population is maximizing utilization of CS. ▪ Further, the data shows that the Assisted Living Facility Transitions, Community or Home Transition Services, Day Habilitation Programs, and Sobering Centers are the lowest utilized CS services. A comment was made that two services, Assisted Living Facility Transitions and Community or Home Transition Services, are severely underutilized, and requested this become a focus area to increase member eligibility and awareness.
VI. Discussion & Next Steps	
	▪ The CalAIM Task Force needs to determine an approach and whether the group will want to tackle all 14 CS services at once or prioritize a few. The goal is to focus on CS service(s) that will take less effort to increase enrollment, while yielding the greatest impact on improving client outcomes (low hanging fruit). ▪ Comments made during discussion: - Consider a survey or assessment to go out to the CalAIM Task Force Members to weigh in on approach and priorities. - HASD&IC has a Case Management Workgroup that would be open to additional training by MCPs. - Request to determine the number of people eligible for each CS. - There is no good coding and there needs to be a better way to characterize need. FQHCs may have proxy data/codes that MCPs do not have. Efforts are underway to develop codes for CSs. - The ECM and CS enrollment data that the MCPs provide to Intrepid Ascent is slightly more current than the DHCS data, but the data Intrepid Ascent receives and therefore publishes is not de-duplicated data. - Suggestion made to determine CS baseline data for where we are and where we are going. ▪ Future agenda items will include an overview of additional data/findings: - ECM/CS Provider Listening Sessions (County 2025) - ECM & CS Capacity Building Assessment (County 2025)
VII. Adjournment	
	▪ The meeting was adjourned at 4:58 p.m.

THE NEXT HEALTHY SAN DIEGO CONSUMER & PROFESSIONAL ADVISORY COMMITTEE CalAIM TASK FORCE MEETING IS SCHEDULED FOR

Thursday, June 12, 2025, from 3:00 p.m. to 5:00 p.m.

Minutes recorded and transcribed by Brittany Charity-Walker