CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: December 22, 2023

ALL PLAN LETTER 23-032
SUPERSEDES ALL PLAN LETTER 21-012

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: ENHANCED CARE MANAGEMENT REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to all Medi-Cal managed care plans (MCPs) regarding the provision of the Enhanced Care Management (ECM) benefit.

BACKGROUND:
The Department of Health Care Services (DHCS) released its California Advancing and Innovating Medi-Cal (CalAIM) proposal on October 29, 2019, in anticipation of the expiration of its Medi-Cal 2020 1115 Demonstration and 1915(b) Specialty Mental Health Services Waiver authorities. DHCS postponed the planned implementation of the CalAIM initiative, which was originally scheduled for January 1, 2021, due to the COVID-19 public health emergency, and released a revised CalAIM proposal on January 8, 2021. DHCS also submitted its CalAIM Section 1115 Demonstration and 1915(b) Waiver applications to the Centers for Medicare and Medicaid Services on June 30, 2021.[1] DHCS obtained statutory authority to establish the CalAIM initiative to support the stated goals of identifying and managing the risks and needs of Medi-Cal beneficiaries, transitioning and transforming the Medi-Cal program to a more consistent and seamless system, and improving quality outcomes.[2]

CalAIM is a multi-year initiative to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of broad delivery system, program, and payment reforms across the Medi-Cal program. The ECM benefit is a component of the CalAIM initiative that will be delivered through Medi-Cal managed care.

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[1] Information regarding CalAIM, including updates regarding the implementation of various components of CalAIM, can be found at: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx.
[2] Assembly Bill 133 (Committee on Budget, Chapter 143, Statutes of 2021) can be accessed at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133.

ECM is a whole-person, interdisciplinary approach to comprehensive care management intended to address the clinical and non-clinical needs of high-cost, high-need managed care members through systematic coordination of services that is community-based, interdisciplinary, high-touch, and person-centered. ECM will build on the Whole Person Care (WPC) Pilots and Health Homes Program (HHP) efforts and activities.[3,4] The care coordination and care management services that are currently being provided under WPC Pilots and HHP will transition to and be replaced by ECM. The ECM benefit will be phased in over time and available statewide through the managed care delivery system starting January 1, 2022. The WPC Pilots and HHP are scheduled to conclude on December 31, 2021.

POLICY:
Effective upon the DHCS determined ECM implementation date for each MCP in its respective county of operation, the MCP must administer ECM and provide the following seven core ECM services to eligible Members in applicable ECM Populations of Focus: 1) Outreach and Engagement; 2) Comprehensive Assessment and Care Management Plan; 3) Enhanced Coordination of Care; 4) Health Promotion; 5) Comprehensive Transitional Care; 6) Member and Family Supports; and 7) Coordination of and Referral to Community and Social Support Services.[5]

ECM Core Service Components:

The requirements under each core service component are described below.

1) Outreach and Engagement:

a. The MCP is responsible for reaching out to and engaging Members who are identified to be eligible for ECM.

[3] The WPC Pilots webpage can be accessed at the following link: https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.
[4] The HHP webpage can be accessed at the following link: https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx.
[5] The ECM and In Lieu of Services (ILOS) implementation timelines are available in the ECM and ILOS Model of Care Cover Note, released in June 2021, and subject to any subsequent updates, which is available on the ECM and ILOS webpage at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

2) **Comprehensive Assessment and Care Management Plan**, which must include, but is not limited to:
   a. Engaging with each Member authorized to receive ECM, primarily through in-person contact;
      i. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider must use alternative methods (including use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
   b. Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan;
   c. Developing a comprehensive, individualized, person-centered Care Management Plan with input from the Member and their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate, to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
   d. Incorporating into the Member's Care Management Plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, substance use disorders (SUD), Long Term Services and Supports (LTSS), oral health, palliative care, necessary community-based and social services, and housing;
   e. Ensuring the Member is reassessed at a frequency appropriate for the Member's individual progress, changes in needs, and/or as identified in the Care Management Plan; and
   f. Ensuring the Care Management Plan is reviewed, maintained, and updated under appropriate clinical oversight.

3) **Enhanced Coordination of Care**, which must include, but is not limited to:
   a. Organizing patient care activities, as laid out in the Care Management Plan; sharing information with those involved as part of the Member's multi-disciplinary care team; and implementing activities identified in the Member's Care Management Plan;
   b. Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team since their input is

necessary for successful implementation of the Member's goals and needs;

c. Ensuring care is continuous and integrated among all service Providers and refers to and follows up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
d. Providing support to engage the Member in their treatment, including coordination for medication review and reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;
e. Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
f. Ensuring regular contact with the Member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as appropriate, consistent with the Care Management Plan.

4) Health Promotion, which must include, but is not limited to:
a. Working with the Member to identify and build on successes and potential family and/or support networks;
b. Providing services to encourage and support the Member to make lifestyle choices based on healthy behavior, with the goal of supporting the Member's ability to successfully monitor and manage their health; and
c. Supporting the Member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

5) Comprehensive Transitional Care, which must include, but is not limited to:
a. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;
b. For Members who are experiencing or are likely to experience a care transition:
    i. Developing and regularly updating a transition plan for the Member;
    ii. Evaluating the Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions to,

from, and among treatment facilities, including admissions and discharges;

iii. Tracking each Member's admission and discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;

iv. Coordinating medication review and reconciliation; and

v. Providing adherence support and referral to appropriate services.

6) Member and Family Supports, which must include, but are not limited to:

a. Documenting the Member's authorized family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as applicable;

b. Ensuring all required authorizations are in place to ensure effective communication between the ECM Providers, MCP, and the Member and their family members, authorized representatives, legal guardians, caregivers, and authorized support persons, as applicable;

c. Activities to ensure the Member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, are knowledgeable about the Member's conditions, with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state, and local privacy and confidentiality laws;

d. Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as applicable;

e. Identifying supports needed for the Member and/or their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, to manage the Member's condition and assist them in accessing needed support services;

f. Providing appropriate education for the Member and their family members, legal guardians, authorized representatives, caregivers, and/or authorized support persons, as applicable, about care instructions for the Member; and,

g. Ensuring that the Member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, have a copy of the Member's Care Management Plan and information about how to request updates.

7) **Coordination of and Referral to Community and Social Support Services**, which must include, but is not limited to:
   a. Determining appropriate services to meet the needs of the Member, including services that address social determinants of health needs, such as housing, and services offered by the MCP as ILOS; and
   b. Coordinating and referring the Member to available community resources and following up with the Member to ensure services were rendered (i.e., "closed loop referrals").

Additional Guidance:

ECM Populations of Focus (POF)
MCPs must proactively identify and offer ECM to their high-need, high-cost Members who meet the POF criteria listed in the Contract and detailed in Attachment 1 of this APL.

ECM Provider Standard Terms and Conditions (STCs)
MCPs must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for Members and, to this end, must contract with ECM Providers to provide ECM services in a community based, in-person manner. MCPs are required to incorporate STCs provided by DHCS, in addition to their own terms, to develop their contracts with ECM Providers.[6]

ECM Model of Care (MOC)
MCPs must develop and submit to DHCS for review and approval an ECM MOC, which is the MCP's framework for providing ECM. MCPs must complete and submit their MOCs in accordance with the DHCS approved MOC Template.[7] MCPs must submit to DHCS any significant updates to their MOCs for DHCS review and approval at least 60 calendar days in advance of significant changes or updates. Significant changes may include, but are not limited to, changes to the MCP's approach to administer or deliver ECM services, approved P&Ps, and Subcontractor Agreement(s) boilerplates.

ECM Encounter Data Reporting
MCPs must report all ECM encounters to DHCS, using the defined set of ECM

[6] The finalized ECM and ILOS Provider STCs document, released in June 2021, and subject to any subsequent updates, is available on the ECM and ILOS webpage that can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.
[7] The finalized MOC Template document, released in June 2021, and subject to any subsequent updates, is available on the ECM and ILOS webpage that can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

Healthcare Common Procedure Coding System codes and modifiers.[8]

ECM Policy Guide
The ECM Policy Guide outlines ECM policies and contains details of MCPs' contractual requirements for ECM. The ECM Policy Guide includes operational guidelines, including reporting requirements for ECM. MCPs must use the ECM Policy Guide as a key resource for implementation and administration of ECM. The ECM Policy Guide is posted to the ECM and ILOS webpage.[9] The ECM Policy Guide also contains information related to MCPs' use of DHCS ECM/ILOS Billing & Invoicing Guidance as well as ECM Member Information File Guidance. DHCS may update the ECM Policy Guide to reflect the latest ECM requirements and guidelines. DHCS will notify MCPs whenever the ECM Policy Guide is updated.

ECM Rates:

For the Calendar Year (CY) 2022, 2023 and 2024 rating periods, a two-sided, symmetrical risk corridor is in effect for applicable revenues and expenditures associated with ECM, as determined by DHCS. The terms of this risk corridor are set forth in MCPs' contract with DHCS, and further details of this risk corridor are included in Attachment 2 to this APL. DHCS reserves the right to continue the risk corridor for subsequent rating periods, subject to actuarial judgment and consultation with affected MCPs.

If the requirements contained in this APL, including any updates or revisions to this APL and/or ECM Policy Guide, necessitate a change in an MCP's contractually required policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) Contract Manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD Contract Manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

[8] The finalized ECM and ILOS Coding Options document, released in June 2021, and subject to any subsequent updates, is available on the ECM and ILOS webpage that can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.
[9] The ECM Policy Guide released in September 2021, and subject to any subsequent updates, is available on the ECM and ILOS webpage that can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

MCPs are further responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, ECM requirements, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[10] These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager and the DHCS CalAIM mailbox at CalAIM@dhcs.ca.gov.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[10] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

Enhanced Care Management Risk Corridor Methodology
Attachment 2

Scope

A risk corridor shall be in effect for applicable ECM revenues and expenses for the CY 2022, 2023 and 2024 rating periods. For each MCP, the risk corridor calculation will be performed at the MCP level (statewide) across all counties or rating regions in which the MCP operates, and across all population groups eligible for ECM. The risk corridor does not apply to the following programs:

- Dental Managed Care;
- Family Mosaic Project;
- Programs of All-Inclusive Care for the Elderly;
- SCAN Health Plan; and
- Cal MediConnect (program ended December 31, 2022).

Structure

Basis

The basis of the risk corridor will be a Gross Medical Expense (GME) calculation. The risk corridor calculation will compare allowable medical expenses as described in the 'Expenses (Numerator)' section to associated revenues as described in the 'Revenues (Denominator)' section, producing a GME expenditure percentage.

Center-Point and Gain/Loss Bands

The center-point of the risk corridor calculation will be a GME expenditure percentage of 100 percent. MCPs will be fully at risk for gains and losses within 5 percent of the center-point, i.e., from 95 to 105 percent. Gains or losses exceeding 5 percent will be subject to zero MCP risk. Therefore, MCPs will owe a remittance to the State or be owed a payment from the State only if the MCP's gains or losses exceed 5 percent.

Administrative Expenses and Federal and State Taxes and Licensing and Regulatory Fees

The risk corridor calculation will not consider administrative expenses including but not limited to federal and state taxes or licensing and regulatory fees. Revenues and

expenses associated with these costs will be excluded from the denominator and numerator, respectively, of the calculation.

Credibility Adjustments

A credibility adjustment may apply for MCPs with low member months. The State will leverage the methodology described at 42 CFR § 438.8(h) for federally required MLR calculations.

Revenues and Expenses

Revenues (Denominator)

The revenues used for the denominator of the GME calculation will be equal to member months multiplied by the sum, on a per-member-per-month (PMPM) basis, of the targeted GME component of the ECM add-on rate (inclusive of outreach). The GME PMPM will be determined by accounting for the targeted percentage of the ECM add-on rate that is attributable to GME through the rate development process. Applicable revenues will be net of administration and underwriting gain loading.

CalAIM Incentive Payment Program (IPP) revenues that the MCP earns based on performance on ECM-related delivery system infrastructure and provider capacity measures under IPP will be excluded from the denominator.

Expenses (Numerator)

The State will require MCPs to provide and certify allowable medical expense data for ECM services (including outreach) necessary for the risk corridor calculation no sooner than 12 months after the end of the rating period.

Traditional pay-for-performance payments to ECM providers that are linked to utilization of services may be reported as medical expense and will be subject to review by the State in accordance with the review process described in the ‘State Review’ section.

Excluded Expenses

The State will reduce, adjust, or exclude expenses, as appropriate, for:

- Non-medical expenses, e.g., non-service investments for delivery system infrastructure and provider capacity.
- Incurred but not reported expenses that cannot be adequately supported.
- Medical expenses for non-ECM services and populations, including but not limited to expenses for Community Supports services, expenses for members

who are not within ECM Populations of Focus, or that do not meet phase-in criteria.

- Outlier levels of medical expenses—in comparison to other health plan(s) in the county or other counties—for which the MCP does not provide satisfactory justification based on member mix, utilizer acuity, unique network considerations and/or other factors.
- Related party expense levels in excess of unrelated party expense levels.

MCP-Delivered ECM Services

Allowable medical expenses may include appropriate expenses for ECM services delivered directly by the MCP, so long as DHCS has previously authorized the MCP's use of their own staff to deliver ECM services as required in the ECM contract and Model of Care requirements.

Sub-Capitation Expenses

In addition to the exclusions described in the 'Excluded Expenses' section all sub-capitation expenses reported as part of the GME calculation will be subject to the following:

- Global sub-capitation payments made by MCPs to global subcontractors will be reduced in recognition of an assumed non-medical component of these payments. Reductions will be applied in a manner that ensures alignment between allowable medical expenses and medical costs considered in the rate development process. Therefore, a 7% reduction will be applied to global sub-capitation payments in CY 2022, an 8% reduction will be applied in CY 2023, and a 9.5% reduction will be applied in CY 2024, except when a lower percentage was assumed in the rate development process.
- Non-global sub-capitation payments made by MCPs to a non-global subcontractor or network provider will be considered allowable medical expenses excluding separate and distinct payments that are exclusively for administrative costs as defined in Title 28, California Code of Regulations, § 1300.78, such as but not limited to network development and claims processing.

Other Expense Items

The State reserves the right to make other appropriate adjustments to MCP-reported expense items that are identified during the State's review of each MCP's reported data. Prior to initiating the risk corridor calculations, the State will develop a detailed reporting template and instructions that will provide additional guidance regarding the inclusion or exclusion of other expense types. The State's review process will include the

opportunity for MCPs to discuss with the State any adjustments identified by the State, and to provide additional information or data to support reported expenses, before the State issues a final determination.

State Review

Following the collection of MCP-reported expense data, which will be initiated by the State no sooner than January 1, 2024 for the CY 2022 rating period, no sooner than January 1, 2025 for the CY 2023 rating period and no sooner than January 1, 2026 for the CY 2024 rating period, the State will perform a desk review of each MCP's reported data, to evaluate compliance with risk corridor definitions, exclusions, and other parameters that will be outlined in the reporting template and instructions. The review will follow a robust process that will be finalized in consultation with its contracted actuarial firm prior to initiating the risk corridor calculations.

Attachment 1: Enhanced Care Management Population of Focus Eligibility Criteria

Adult Populations of Focus

Population of Focus #1:
Individuals and Families Experiencing Homelessness

Individuals and families who:

(1) Are experiencing homelessness (as defined below);

AND

(2) Have at least one complex physical, behavioral or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes **and/or** decreased utilization of high-cost services.

An Individual or Family Experiencing Homelessness is defined as:

- An individual or family who lacks adequate nighttime residence;
- An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation;
- An individual or family living in a shelter;
- An individual exiting an institution into homelessness;
- An individual or family who will imminently lose housing in next **30 days**;
- Unaccompanied youth and homeless families and children and youth defined as homeless under other federal statutes; or
- Individuals fleeing domestic violence or trafficking.

Notes on the definition:

- This definition is taken from the U.S. Department of Housing and Urban Development (HUD) definition of "Homeless"[1] with the following modifications:
  - If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization.
  - The timeframe for an individual or family who will imminently lose housing has been extended from 14 days (HUD definition) to 30 days.

[1] HUD Definition of Homelessness 42 U.S. Code § 11302 - General definition of homeless individual. https://www.govinfo.gov/app/details/USCODE-2010-title42/USCODE-2010-title42-chap119-subchapI-sec11302.

Examples of eligible Medi-Cal managed care health plan (MCP) Members under this Population of Focus:

- Members experiencing homelessness with complex health care needs as a result of an unmanaged medical, psychiatric or Substance Use Disorder (SUD)-related condition.
- Members with complex health care needs as a result of a medical, psychiatric or SUD-related condition, who have recently received an eviction notice and will imminently lose housing in the next 30 days.

Population of Focus #2:
Adult High Utilizers

Adults with:

(1) **Five or more** emergency department visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence;

AND/OR

(2) **Three or more** unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

MCPs may also authorize Enhanced Care Management (ECM) for other individuals with a pattern of very high utilization that could have been avoided with appropriate care or improved treatment adherence.

Notes on the definition:

- The definition allows MCPs to authorize ECM services for very high utilizer individuals who would benefit from ECM but who may not meet numerical thresholds (1) and/or (2).
- However, this flexibility does not displace the numerical thresholds provided in the definition to identify high utilizers. MCPs must use the numerical thresholds to identify Members in this Population of Focus. MCPs must have a consistent approach (e.g., algorithms or other methodologies) for identifying high utilizers and must describe it in their Model of Care Template submission to the Department of Health Care Services.
- MCPs must utilize a “rolling” six-month lookback period based on the most recent month of adjudicated claims data.

Emergency department visits that result in an inpatient stay must only count as one inpatient visit.

Examples of eligible MCP Members under this Population of Focus:

- Members with repeated incidents of avoidable emergency department visits in a six-month period, who have a medical, psychiatric or SUD-related condition requiring intensive coordination beyond telephonic intervention.
- Members with repeated incidents of avoidable emergency department visits in a six-month period who have significant functional limitations and/or adverse social determinants of health that impede them from navigating their health care and other services.

Population of Focus #3:
Adult Serious Mental Illness (SMI)/SUD

Adults who:
(1) **Meet the eligibility criteria** for participation in or obtaining services through:
- The county Specialty Mental Health System **AND/OR;**
- The Drug Medi-Cal Organization Delivery System **OR;**
- The Drug Medi-Cal program.

AND

(2) Are actively experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, history of Adverse Childhood Experiences, former foster youth, or a history of recent contacts with law enforcement related to mental health and/or substance use symptoms or associated behaviors);

AND

(3) **Meet one or more of the following criteria:**
- Are at high risk for institutionalization, overdose and/or suicide;
- Use crisis services, emergency department, urgent care, or inpatient stays as the sole source of care;
- Experienced two or more emergency department visits or two or more hospitalizations due to SMI or SUD in the past 12 months; or
- Are pregnant or post-partum (12 months from delivery).

Notes on the definition:

- Institutionalization in this context is broad and means any type of inpatient, Skilled Nursing Facility, long-term, or emergency department setting.

Examples of eligible MCP Members under this Population of Focus:

- Members who have the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions, who are experiencing one complex social factor influencing their health and are pregnant.
- Former foster youth Members with a psychiatric or SUD-related condition, who are currently using emergency departments as the sole source of care.

Population of Focus #4:
Individuals Transitioning from Incarceration

Individuals who:
(1) Are transitioning from incarceration or transitioned from incarceration within the past 12 months;

AND

(2) Have at least one of the following conditions:
- Chronic mental illness.
- SUD.
- Chronic disease (e.g., hepatitis C, diabetes).
- Intellectual or developmental disability.
- Traumatic brain injury.
- HIV.
- Pregnancy.

Notes on the definition:

- The conditions listed above align with the eligibility criteria for pre-release coverage in California's 1115 Demonstration Amendment and Renewal Application; as of the date of publication of this guide, the waiver is not yet final, and thus the above criteria are subject to change.

Population of Focus #5:
Individuals at Risk for Institutionalization and Eligible for Long-Term Care Services

Individuals at risk for institutionalization who are eligible for Long-Term Care services who, in the absence of services and supports, would otherwise require care for 90 consecutive days or more in an inpatient nursing facility. Individuals must be able to live safely in the community with wraparound supports.

Examples of eligible MCP Members under this Population of Focus:

- Individuals in need of increasing assistance with Activities of Daily Living and Instrumental Activities of Daily Living.
- Possibly, individuals with changes to family or caregiver status.

- Possibly, individuals with medical or surgical setbacks resulting in a decrease in functional, cognitive or psychological status.
- Possibly, individuals showing early signs of dementia with few or no natural supports.
- Possibly, individuals who are noncompliant with their prescribed medical regime.
- Possibly, individuals who are not appropriately engaged to take advantage of necessary health care services.
- Possibly, individuals who lack a family or community support system to assist in appropriate follow-up care at home.

Population of Focus #6:
Nursing Facility Residents Who Want to Transition to the Community

Nursing facility residents who are strong candidates for successful transition back to the community and have a desire to do so.

Notes on the definition:

- **Individuals should be:**
  - Interested in moving out of the institution;
  - Medically appropriate to live in the community; and
  - Able to reside safely in the community.

Children and Youth Populations of Focus

Populations of Focus for Children and Youth include the following:

1. Children (up to Age 21) Experiencing Homelessness;
2. High Utilizers;
3. Experiencing Serious Emotional Disturbance or identified to be at Clinical High Risk for Psychosis or Experiencing a First Episode of Psychosis;
4. Enrolled in California Children's Services (CCS)/CCS Whole Child Model with additional needs beyond the CCS eligible condition;
5. Involved in, or with a history of involvement in, Child Welfare Services/Programs (Including Foster Care up to Age 26); and
6. Transitioning from incarceration.

Definitions and detailed eligibility criteria for the Children and Youth Populations of Focus are forthcoming.