CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

# MEETING TRANSCRIPT

## STREAMLINING ACCESS TO ECM: NEW ECM REFERRAL STANDARDS AND PRESUMPTIVE AUTHORIZATION GUIDANCE ALL COMER WEBINAR

**Date:** October 9, 2024

**Number of Speakers:** 5

**Duration:** Fifty-eight minutes, nineteen seconds

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**Speakers:**

- Alice Keane
- Tyler Sadwith
- Dr. Palav Babaria
- Dr. Laura Miller
- Sarah Allin

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## TRANSCRIPT:

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| Slide 1 | Alice Keane – 00:15 | Hello, and welcome. My name is Alice, and I'm available to answer any technical questions. We encourage you to submit written questions at any time using the chat. Attendees who have dialed in by phone only can press *9 on your phone to raise your hand to enter the line task or question. Finally, during today's event, live close captioning will be available. Please click on the CC button to enable or disable. With that, I'd like to introduce Tyler Sadwith, state Medicaid director for the California Department of Healthcare Services. |

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| Slides 2-3 | Tyler Sadwith – 00:48 | Great, thank you so much and good morning everyone. Thank you for joining our webinar today. We're going to focus on a really exciting set of work to improve access to Enhanced Care Management. I think if we could go to the next slide and just get an overview of some of the content we're focusing on. Over the last 18 months, the Department of Healthcare Services has been working really closely with providers, community-based organizations, managed care plans and other partners to understand what is and what isn't working well with Enhanced Care Management and community supports. Today we'd like to share more information about steps that we're taking to enable members to access these services more easily. Taking a step back, we really view ECM as one of the cornerstones of CalAIM and in many ways as the foundation of the transformation of Medi-Cal that DHCS is leading in partnership with all of you with the goal of creating a more coordinated, person-centered and equitable health system for Californians. |

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| Slide 3 | Tyler Sadwith – 02:04 | Those principles really are at the heart of ECM and they're embedded in ECM, which of course is a key service being provided through our managed care delivery system to provide high-touch comprehensive care management to members who are experiencing some of the greatest vulnerabilities wherever they are, including in community-based settings outside of the four walls of a clinic. We've listened and heard from you, including through a set of in-person listening sessions, about the values and the promises of ECM and community supports and about some of the operational challenges that we've collectively faced as we have launched these innovative new initiatives at scale in Medi-Cal for the first time. Based on what we heard over the past year and a half and what we have learned from initial implementation experience, the department developed a comprehensive action plan of strategies to improve the availability and the uptake of these vital services. |

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| Slides 3-4 | Tyler Sadwith – 03:08 | In particular, the action plan includes a commitment to streamline the way that providers and partners are able to submit referrals to managed care plans for ECM, and a commitment to streamline the way that managed care plans provide authorization for ECM services. These standardized, streamlined policies are critical to making ECM easier to deliver on the ground, so members can get the support they need from providers that they trust, and so that providers can focus on direct patient care. These two changes may sound straightforward, but we have worked extensively with stakeholders to design the guidance so that we get it right. That's what we'd like to walk through today. If we can go to the next slide. We know Medi-Cal policy is only impactful if it reaches and helps to transform the lives of members. We know continuous feedback and improvements in our policies are critical to the success of our program. |

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| Slide 4 | Tyler Sadwith – 04:12 | The ECM and Community Supports Action Plan and specifically the revisions to ECM policy that you'll hear today are a demonstration of our commitment to continuing to reform programs to best meet the needs of our members and strengthen the delivery of care even after services initially launch. We're committed to continuous improvement of our policies and of implementation so people can get the services they need. We're grateful to all of our plan partners and our provider partners who help shape this guidance through insights, recommendations, deep-dive discussions, and rich perspectives. As shown on this slide, the new ECM referral standards in the ECM presumptive authorization requirements are available on DHCS's webpage for ECM and Community Supports resources, and a summary of the ECM and Community Supports Action Plan is also available on this website. We encourage you to review these resources. We invite you to share questions throughout this webinar using the chat function, and later on we'll share information about how you can send us additional thoughts and additional feedback after the discussion. |

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| Slides 4-5 | Tyler Sadwith – 05:31 | I would also like to highlight that today, of course, is just a walkthrough of some of the policy adjustments to ECM as part of the action plan. In the near future we'll walk through additional policy adjustments to community supports as well. If we can move to the next slide. It's helpful just to take a step back and reflect on why are these changes so important? Why do these changes matter? We recognize that the ECM benefit is truly designed to serve Medi-Cal members with some of the greatest health and complex social needs with in-person care management delivered where they live. There are nine separate populations of focus across adults and children and youth. These populations of focus are comprised of Medi-Cal members living with significant needs who will undoubtedly benefit from enhanced support. Starting these ECM services quickly is important for members who are hard to reach or who would really benefit from services immediately, including individuals experiencing homelessness, children who are entering foster care and adults who are transitioning from prison or from jail and reintegrating back into the community. |

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| Slides 5-6 | Tyler Sadwith – 06:56 | We've heard that today different referral pathways can be complicated and they can vary by each managed care plan even within a county, and we know that this may deter some community partners and providers from making referrals to ECM who otherwise would if it were not for the administrative burden. We are excited about this new guidance because it will make it easier to place a referral for ECM and to start serving members more quickly. Again, we are grateful to all of the stakeholders who helped shaped this design and this new guidance that will enhance access to these critical services for Medi-Cal members. We can move to the next slide. At this point, I would like to pass it over to the team who is leading the charge, Doctors Palav Babaria and Laura Miller, who will carry us through the rest of the discussion. Palav, I turn it over to you. Palav, I think you're on mute. |
| Slides 6-7 | Dr. Palav Babaria – 08:05 | Thank you, Tyler. I was saying thank you so much for that introduction and for your leadership as our state Medicaid director. Really excited to be here with you all today because so many of you who are on this call have really informed and shaped the policy revisions that we are going to walk through today. We can go to the next slide. Today's agenda, we are going to start by walking through just how we envision improving access to ECM, do a deeper dive on the overview of the new ECM referrals and authorization guidance that has come out, which includes universal ECM referral standards to create a state standard as well as the new ECM presumptive authorization requirements. We'll walk through what this means for referral partners, providers and managed care plans, and then we will give you all a sneak preview of the ECM monitoring program that we will be strengthening and launching in the months and years to come. |

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| Slides 7-9 | Dr. Palav Babaria – 09:04 | Then we hope to reserve enough time for Q&A at the end. We can go to the next slide. Before we begin, just a reminder that today's slides and the webinar will all be posted online. As soon as that is ready, you'll be able to access all of this from our website. Let's go one more slide. Let's start just for those of you who may be newer to ECM with a brief recap of what is Enhanced Care Management. As everyone recognizes, there is a spectrum of needs that all individuals and especially Medi-Cal members have to manage their healthcare social needs, behavioral health needs, and health and wellness. ECM is the highest tier of care management for Medi-Cal managed care plan members. Really reserved for those individuals with the most complex needs who need the highest touch in-person care possible. |

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| Slides 9-10 | Dr. Palav Babaria – 09:56 | We see it as a spectrum of care management needs and also, as described in our population health management policy guide, all managed care plans also provide complex care management for members that have medium or higher risk needs but do not qualify for ECM as well as basic population health management for all Medi-Cal members that is designed to keep them healthy and well. As described in the population health management guide, all members are also eligible for transitional care services when they're transitioning between settings, like if they've been admitted to the hospital and are being discharged to a skilled nursing facility or to home. We know those can be really vulnerable periods of time and have provided additional services for all Medi-Cal members to get them through those transitions. We can go to the next slide. Those of you who have been on this journey know we have a lot of populations of focus in ECM. This chart goes through what those populations of focus are. I'm not going to read all of them out loud, but all to say that many of them involve both adults and children and youth. |

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| Slides 10-11 | Dr. Palav Babaria – 11:04 | Some of the populations of focus such as adults living in nursing facilities or at risk for institutionalization only apply to adults, and some of them such as those children involved in our CCS or Whole-Child Model program only apply to children. I'll call a special attention to our birth equity population of focus and our justice-involved populations of focus, which went live in January of 2024, and are the newest populations of focus to go live. We can go to the next slide. I think the biggest thing to take away here is we recognize that there is still, despite having launched ECM now statewide more than two years ago, a lot of lack of information in our communities, among our members, among our providers about ECM and who qualifies for ECM and how members can be enrolled into ECM. Part of the purpose of these revisions is to really reduce barriers to access so that each and every single individual who's eligible for ECM can receive ECM. This has been in place since the beginning of the policy guide, but ECM referrals can come in from a variety of sources. |

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| Slide 11 | Dr. Palav Babaria – 12:16 | Providers, community partners, school teachers, social workers, anyone who is interfacing with Medi-Cal members can refer them to ECM. Ideally they will screen for eligibility, but otherwise the plans can do that. We'll do those checks, so it's really getting the referral made so that the plan can check for eligibility and authorize those services. Members themselves and their families can also refer themselves or their loved ones through self-referrals. Then MCPs in addition to receiving incoming referrals also use data that they have in eligibility files to do outreach to members. I will say, and we've said this before, that we know from previous data and data that we get from our plans today that when someone is referred in for ECM, their uptake and responsiveness of that member is significantly higher than when managed care plans are using data and doing cold calls to engage members. Our goal and vision is that as close to 100% as possible of all referrals are coming from the community or providers or members themselves. Once the managed care plan receives the referral, they have to review eligibility and authorize services within five business days. |

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| Slides 11-12 | Dr. Palav Babaria – 13:32 | Another point that I will lift up here is we've heard as we've been working with providers and community-based organizations concerns about the network. Maybe some people are not referring members because they're worried there aren't enough slots and there isn't enough space. ECM is a managed care benefit, and therefore our managed care plans are required and ready to provide ECM services to every single person who is eligible for those services. We really encourage all of our providers on this call, community-based organizations, partners do not be gatekeepers. If you think that someone is eligible for ECM and could benefit from those services, please, please refer. The plans are ready. They have networks built, and we have heard in some parts of our state that ECM providers have capacity and actually need more referrals to stay in business. There is space and we really want to get those referrals coming. We can go to the next slide. To share a little bit of data. This data summarizes our first two years of implementation, 2022 and 2023, and showing how ECM has grown over time. |

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| Slide 12 | Dr. Palav Babaria – 14:47 | You'll see for adults ECM has been steadily growing. Some of the declines that you see in 2022 are because individuals that got rolled over from our legacy programs in whole person care graduated, so some of those populations declined as new populations came in. Then very excitingly, you'll see the orange bars, which is our members under age 21. The children and youth populations of focus went live in July of 2023 and have steadily been increasing every single quarter, which is really exciting for all of the children and youth in our state. In total we served about 183,700 unique members in the first 24 months of the ECM program. I recognize in Medi-Cal when we cover 14 million people, 183,700 members may not sound like a lot, but every single person who has ever worked with or observed the ECM program knows that these individuals are the most complex individuals due to very complicated medical, behavioral health and social needs. 183,000 of those numbers is really a tremendous feat. We can go to the next slide. |

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| Slides 13-14 | Dr. Palav Babaria – 16:06 | We'll also call attention to, we've tried to really bring transparency to all of our ECM and community supports go live and have been releasing quarterly implementation reports. The latest release which came out at the tail end of this summer provided data all the way through the end of quarter four 2023, and we are hoping to get quarter one and quarter two data from 2024 out before the end of the year. We get the data about a month and a half after the quarter closes. We have to process it, clean it up and get it out. There is about a six-month lag in these reports, but the data really can drill down to specific population of focus, and I see questions about that in the chat, as well as by county and by plan to really give you a sense of what is happening granularly in your communities. We can go to the next slide. I'm going to now turn it over to Dr. Laura Miller, who has been our ECM subject matter expert and really working on the referral guidance and authorization guidance to lead us through the next section. |

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| Slides 14-15 | Dr. Laura Miller – 17:11 | Great. Thank you so much, Palav. It's a pleasure to be here to present really the nitty-gritty on the new ECM referrals and authorization guidance. There will be more opportunities to dive in, but I want to give an overview of really what we have proposed with these two sets of policy. Next slide. I'm going to talk first about the ECM referral standards and forms template. One of the things we heard from providers is that it's very challenging if you're in a county with multiple plans to work with multiple forms that one must fill out in order to get services for members. We released in August of '24 this year ECM referral standards and forms templates. This is a unified set of information that all MCPs collect as part of any referral for ECM. The guidance was released in August and must be adopted by January 1st, 2025. Essentially there will be one referral standard across the state. The standards include technical information that plans can use to build referrals electronically into portals, into electronic medical records, into health information exchanges, et cetera. |

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| Slide 15 | Dr. Laura Miller – 18:37 | The standards are really the list of elements that must be present. The referral form templates, I think of them as a hard copy version of the standards, so all of those elements that a referring entity can use if they cannot use an electronic format. We wanted really to be able to meet everybody where they are with the technology that they have. We do encourage and prefer electronic referrals over PDF and hard copy, but we do understand that not all community entities can refer members in this way. I think one of our key goals is really widening that net of people in the community who can refer. I always envision the wall pocket with lots of Xerox forms in the school office, referral forms, such that people all over can be able to refer in members for ECM. There is a lot of language on the forms, and so we split them into two. There is one for adults and another for children and youth. If you are an entity that works with both, you'll need to have two chunks of forms. |

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| Slides 15-16 | Dr. Laura Miller – 19:59 | But given that there is specialization, we felt that dividing it that way would be appropriate. Next slide. There's key information collected in these referrals. Again, as I noted starting January 1, all plans must use the ECM referral standards for their ECM referral forms, so that entities referring to ECM fill out the same information across MCPs. It's really pretty standard information. Medi-Cal member information including best contact, alternate contact. We know contacting is challenging. It's important to know the referral source. If the referral source is an ECM provider themselves, we want to know that. Each of the forms, adult and children, include all of the eligibility criteria. In some ways, the form acts as an educational tool about what it takes to qualify for an ECM population of focus. We ask that referring people include enrollment in other programs, but this is not intended as gospel truth to exclude them rather as a clue to the plans that they might be enrolled in another program that might be considered duplicative. Then also the referral transmission method that is also on the standards and form. It does include guidance encouraging batch referrals. |

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| Slides 16-17 | Dr. Laura Miller – 21:43 | We have heard from both providers and plans that batch referrals can be very efficient and we do encourage that. I will note that the referral standards don't change the existing processes for the MIF and the RTF. MIF is the member information file. RTF is the return transfer file. The referral standards do build on previous data sharing guidance, and I will note that we will release an updated version of data sharing guidance to reflect this in the fall of this year. That's coming soon. Great. In order to make this work, we absolutely need local collaboration, and that's one of the reasons why this is an all-comer webinar really for anybody out there who is interested in, involved in ECM. We need local collaboration to promote these new referral standards and really to promote ECM itself. We do hope that the referral standards and the lowering of administrative barriers will help increase referrals. We encourage plans to work with CalAIM local conveners, and these are the PATH CPIs, on the rollout of these new sets of tools. There are 26 PATH funded CPI groups across the state spanning every county and region. |

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| Slide 17 | Dr. Laura Miller – 23:22 | There is a link there to find your local PATH collaborative group. It's a great place for learning about ECM and how it works. We really are wanting the PATH CPI groups to support spreading these standards. Again, second point, we encourage CPIs, providers and really any partner to share the new referral standards to improve awareness of ECM and encourage new referrals when this goes live in on January 1 of 2025. Again, when we were designing this, we were thinking about schools, churches, child care centers, community centers, entities outside of healthcare who are trusted in their communities, who know Medi-Cal members, can tell them about ECM and get them into ECM. It really is a broadening, a desired broadening of the net, bringing in members for this really amazing service, amazing benefit. Also, we welcome best practices on how to use these referrals and standards. You can email us at the email address calaimecmiols@dhcs.ca.gov. Ultimately, we plan on spreading these best practices. We want to learn from you what's working in the field and be able to spread that. Much appreciated in terms of the collaboration to get the word out. Next slide. |

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| Slide 18 | Dr. Laura Miller – 25:10 | We're going to switch gears now. We've talked about the form, statewide form. Have it everywhere. Send it anyway you can. Now we're going to switch gears and talk about ECM presumptive authorization. It's really the second part of this policy chunk, if you will. Starting on January 1, 2025, plans are required to allow select ECM providers to quickly start services before they submit a referral, and thus they will be able to be reimbursed for those services from the first day of start. This presumptive period has a 30-day timeframe. We'll take it slow. We'll go through this. On one side here you see the traditional ECM process. A referral is done. It goes to the plan, and the plan authorizes services. Now, that referral may oftentimes happens after a provider has talked to a member. One of the things we want to guard against or one of the things we want to be able to have happen is that the provider can start services on that very day as opposed to saying, "Nice to meet you. I'll be back in a week when I get permission." We really services to start immediately. |

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| Slides 18-19 | Dr. Laura Miller – 26:45 | Under the new presumptive authorization process, services can begin. Providers can start services before a referral is submitted. Then they submit that referral, and then the plan authorizes. Again, key piece here is the initiation of services, and then the referral happens. This is not for every single provider and POF. We have selected pairs that I will go into in the next slides that really it's a pair in which there is an extremely high likelihood of authorization. Next slide. This is a rundown of the presumptive authorization. It's the beginning of... We have more detail later, but you can see all of the populations of focus, and all the POFs have corresponding requirements for ECM presumptive authorization. Each one for specific ECM provider types. For instance, if a street medicine provider reaches out to a person in pop of focus one, adults and children experiencing homelessness. That combination of street med provider and person experiencing homelessness, that is a presumptive authorization pair. That is the scenario in which services and being paid for services can begin on day one. We'll walk through this a little bit more. |

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| Slides 19-20 | Dr. Laura Miller – 28:33 | We've required pairings of ECM providers and POFs. What we have required is a minimum. Okay? It's the floor. We do not limit plans from extending presumptive authorization arrangements to more ECM providers and/or additional populations of focus. Again, this is a minimum floor that's being set that goes into effect January 1, 2025. Next slide. We're going to dive into some more detail here. The slide is very wordy. If you print out two slides and tack them onto your file cabinet, these would be the two. It essentially tells you each population of focus and then the ECM provider that can serve members eligible for that population of focus through the presumptive authorization period. I've noted children and adults experiencing homelessness, pop of focus number one. ECM providers that are presumptively authorized to serve those members include street medicine providers, community supports providers of the housing trio, etc. You can see through here what we've tried to do is align the population of focus with ECM providers who are seeing those members, have connections with those members and where the specialty of the provider matches with the population of focus. |

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| Slides 20-22 | Dr. Laura Miller – 30:17 | Next example is primary care providers. There are very specific criteria for population to focus number two, children and adults at risk for avoidable hospitalization and ED utilization. However, a primary care provider can see that utilization oftentimes within their medical record, and they can use that and then refer. Again, you'll see all of these pairings as we go through. Again, I'm not going to read them all out, but they are here, and they are the floor of what we're speaking about. Next slide. Just moving on here, you can see for the adult skilled nursing facility, residents transitioning. A easy, very clear pairing is the community supports providers who are providing nursing facility transition diversion. Again, very clear pairings here where we think that the likelihood of denial is quite low because of the match. Next slide please. There are two exceptions here. There are two exceptions to the MCP payment within the presumptive authorization timeframe. Again, that timeframe is 30 days. However, if a member has an existing open ECM authorization with another ECM provider, the plan is not required to reimburse for services delivered in that presumptive off period, the 30-day period. |

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| Slide 22 | Dr. Laura Miller – 32:03 | We allow this exception, in-plan payment, to limit instances of payment for duplicative services. A corollary of this is the orange box here. MCP provider portals need to show active ECM authorizations and ECM providers need to check that. In order to reduce the risk, the ECM providers are not reimbursed because there is an existing open authorization. We want plans to make the member's ECM authorization status accessible via their plan portal or another system by January 1. It is incumbent on providers to do that checking. Plans need to make it possible to check, and providers need to check. We don't want administrative burden on either side with duplication of effort. That's the first scenario where a provider would not get paid because there is an existing open ECM authorization. The next scenario in which an ECM provider would not get paid in the 30-day period is if the individual is not an active member of the plan. If they're not enrolled in the plan, they are hopefully another plan's responsibility. |

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| Slides 22-24 | Dr. Laura Miller – 33:32 | They can get care, but the health plan that... If the health plan receives an authorization request and the member is not theirs, they are not required to pay within the presumptive authorization period. Next slide. What this means to referral partners, providers and plans. Next slide. We're going to run through a scenario here link in that shows how the ECM presumptive auth and referrals link. We're going to use the scenario of an OB/GYN practice that is contracted with a plan to provide ECM to the birth equity population of focus. I like to look at the top line first, the OB/GYN practice, and then we'll talk... I'll flip down to the MCP line, but it's nice because it steps through both from the point of view of the plan and the provider. Under our new presumptive authorization requirements on day one the OB/GYN practice identifies a member eligible for ECM during a routine check, and they begin ECM services. They're contracted with the plan. They know about the birth equity population. They're ready, willing, able. |

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| Slide 24 | Dr. Laura Miller – 35:03 | They've been providing this care. They meet somebody who meets criteria and they start ECM. Next, they do check that provider portal to make sure that there is no other active ECM authorization. That's really important. Then the OB/GYN office will submit the ECM referral to the plan using the new referral standards. Now, the GYN practice could have it built into their EMR. That would be slick. They could have it printed out and on the wall, but they will be using the new ECM referral standards. Then they continue seeing the member, and they continue services beyond day seven. At the same time, we're going to switch to this bottom line now, the plan has made prior ECM authorization status available on the portal such that the provider can look. Again, this ability for providers to see the authorization status must be live by Jan 1, 2025. The plan then also, in order for the OB/GYN to use the new referral form, new standards, they need to make that available on their website. |

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| Slides 24-25 | Dr. Laura Miller – 36:29 | Also, that it must be done by Jan 1, 2025. When that referral comes in, the plan will review that referral in five days and authorize ECM if all the conditions are appropriate. No other MCP. No other open ECM authorization. It is important to note that plans are required to authorize members as soon as possible, i.e., within five working days. That is for all utilization. Five days is the standard that is codified in a APL-21-011. The plan then communicates this back to the OB/GYN that the referral has been approved. Then last box here on the plan row, the plan will reimburse that OB/GYN provider for services provided since day one. That's really important. That is really the goal is to have services be start... Have that trusting relationship begin to get going from day one. Next slide. In terms of what's coming up next, we realize this is an implementation project. |

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| Slide 25 | Dr. Laura Miller – 38:01 | To implement the new standards and presumptive authorization requirements plans will need to take the following actions to support referral providers, referral partners and ECM providers. With regards to the standards, plans will need to update their existing forms and electronic workflows to align with the standards and the referral form templates. They will need to remove existing requirements for any supplemental documentation for ECM referrals and authorization, so no more can be asked for other than what is on and within the referral standards. They'll also need to update their websites and provider handbooks with clear instructions on how to submit an ECM referral using the new standards. This is part of getting out that word, but we really need plans to get out the word to their networks. With regards to presumptive authorization, plans should go through their existing ECM networks and identify the ECM providers that meet that POF provider-type pairing that is the heart of the presumptive authorization policy. |

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| Slides 25-27 | Dr. Laura Miller – 39:19 | They will need to have a way, if they don't already, to show members ECM authorization status for ECM providers via the plan portal. Again, there is an onus on the providers to check so that they know whether or not there is an open authorization and plans need to make that possible to do. Plans will need to update their ECM provider contracts with the presumptive authorization policy and payment provisions as necessary, as well as developing TA resources for ECM providers that explain the presumptive authorization processes, payment and associated ECM provider responsibilities. Next slide. More assistance is absolutely available through the TA Marketplace. Many of you, I hope, have used this before, and we have the web address there. Next slide. I think at this point I transition it back to my colleague, Dr. Palav Babaria, to give a brief update on ECM monitoring updates. |

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| Slides 27-28 | Dr. Palav Babaria – 40:34 | Thank you so much, Laura. We are shockingly ahead of schedule, which means hopefully we will have enough time for a robust Q&A. We can go to the next slide. There we go. We wanted, as mentioned, to give you all a preview of where we are headed with ECM monitoring really starting in 2025 and beyond. We have really created a longitudinal monitoring goal, which is to make sure that ECM members who need the benefit are receiving that benefit in a timely manner in line with the DHCS policy and that it's really meeting the members' key care management needs. We have an entire theory of change, which you will all be hearing about in much more detail at future webinars and public presentations, but it really underpins the various steps that we've been going through to really launch ECM as a benefit. First and foremost, we need robust provider networks. If there are no providers to provide ECM, it's hard to get it out to our members. |

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| Slide 28 | Dr. Palav Babaria – 41:40 | Second, we know that both access and enrollment in ECM is highly variable across the state and by population of focus. There are certain parts of our state, certain plans, certain populations of focus where it's really taken off and there is robust enrollment meeting our expectations. There's other areas that are really lacking, and how do we really create an even expectation so that no individual member who's eligible for these benefits is being left behind purely based off of where they live or what their zip code is. Number three, and we get this question a lot, is that we know we need to improve the delivery of ECM. Thus far, because this is a new program, we've really been focused on the network and enrollment pathways. But we also have heard loud and clear that ECM is not equal across all providers, and that there is variability in how effectively each individual ECM model or program is meeting members' care management needs. |

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| Slides 28-29 | Dr. Palav Babaria – 42:38 | Then lastly, the whole point of this obviously is to really improve the health outcomes for our ECM members. This is another area where we are starting to explore how we can collect that data and make sure that ECM is having the intended impact it's supposed to. Our goal is by the end of this year, we will share the new monitoring framework and the measures, and we'll make sure that we are measuring the adherence to ECM policy. We are going to start with using data that is already submitted by our plans. We recognize people do not need more administrative burden or more submissions, so really looking at the QMIR reports that we are receiving already, claims and encounters, appeals and grievances. Then we will establish a process for addressing MCP performance where that performance is lacking throughout our state. We can go to the next slide. Lots more to come. I think we can maybe take the slides down so we can see each other, and we will open it up to questions. |

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| [video] | Sarah Allin – 43:40 | That's great. Thank you so much Palav and Laura. What a wonderful conversation. Really helpful. Lots of fantastic questions have come in through the chat, so I'm just going to lift up a few as we walk through. Palav, maybe I'll start with you first. There have been a few questions that have come in really about the different modalities for making a referral, so two questions for you. One is we have these new ECM referral standards, but I think it would be accurate to say it's still more than fine for providers and partners to call and make a referral. They don't necessarily have to still submit a form through the ECM referral standards. Then, so just verifying that for the folks in the audience, and then talk a little bit about what DHCS's expectations are for managed care plans. Making sure their call centers are informed about ECM and the referral process, so folks understand that. |
| [video] | Dr. Palav Babar... – 44:39 | Thanks, Sarah, for lifting those up. Yes, the purpose of these referral standards is to create a standard format that is statewide. It does not sunset any of the previous expectations that existed. Since the launch of ECM, all managed care plans have to post on their website for public view, including providers, including members, how individuals can make referrals. Those websites will obviously be updated with these new forms, but almost all the managed care plans sites that we have audited, they do have a phone number, some of them go to a call center, some also have email. All of those avenues are still open for referrals from members and providers. |

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| [video] | Sarah Allin – 45:19 | Great. Then in a second, Laura, I'm going to turn one to you on presumptive. But one more for you Palav is we've gotten several questions about contracting with managed care plans, and how to do that, how to become an ECM provider. Laura briefly mentioned the TA Marketplace that's available. Will you just emphasize for folks what resources are available to support those that are interested in contracting to be an ECM provider? |
| [video] | Dr. Palav Babaria – 45:47 | Absolutely. I think just on the resource front, the TA Marketplace has, and our PATH initiative in general has numerous venues. One is those local learning collaboratives, the CPIs that Laura mentioned, are great entry points. If you just don't know where to start, you don't know how to engage in the process. The facilitators are amazing. They are experienced. They actually gave us amazing advice on all these referral revisions and have been tracking it and can really help navigate that process. In addition to that, if you need actual funding or technical assistance, we do have the CITED program which provides grants to those individuals that are becoming ECM and community supports providers. I believe we still have one more round open, but I'm going to have someone fact check me on that one. |

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| [video] | Dr. Palav Babaria – 46:29 | Then we also have the TA Marketplace where there are experienced organizations who have done this. Either they've done the billing or they are an ECM provider or they know how to set up the care model, and so there's a menu of options on the TA Marketplace depending on what type of help you're looking for, where you can apply. DHCS funds that entirely, so there isn't a cost for that, and you can get extra assistance with whatever your specific problem is to enter in the marketplace. I'll also say we should always assume good intent. Part of why CalAIM is hard is because plans and all of the different types of providers have not had to work together in this way before. |
| [video] | Dr. Palav Babaria – 47:09 | Whether it is the call center question, Sarah, that I didn't answer that you posed of how we're making sure there's access or contracting issues. Please, please, your first stop if you are having problems should be your managed care plan. They're eager to help you. They're eager to work through these issues. There's a lot going on. Maybe you're going to have to reach out 2, 3, 4 times. That is okay. Be persistent, but they do want to work through this. Lots of people come to us and my first question is always, "Have you talked to your plan?" Often the answer is, "No." If you have not talked to your plan, please start there. Then obviously if you're still running into issues or barriers, you're welcome to reach out to DHCS as well. |

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| [video] | Sarah Allin – 47:51 | Fantastic. Thanks, Palav. Laura, we've gotten a few questions on the presumptive authorization structure. One of them is you went through a couple of slides with tables that really outline here are particular populations of focus, and here, if you're an ECM provider contracted to provide ECM, you get access to presumptive authorization. We've gotten some questions about whether those tables and what's listed, which is also now available in the ECM policy guide. Everyone can view it there, but are those the only required providers? Could plans go beyond and offer presumptive to other provider types? |
| [video] | Dr. Laura Miller – 48:36 | They absolutely, positively could go beyond. The provider types that we set forth are really the baseline. The minimum. All plans must do this, but please think with your network, with your providers to expand. Absolutely. It is the minimum requirement. Plans are absolutely welcome to broaden that out. It's a great question. I love it. Yes. No special permission is required for that. It does not require a form. It does not require blessing. Please, you can do more. Not a problem. |

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| [video] | Sarah Allin – 49:25 | That's great. A lot of current ECM providers put questions in the chat about the actual payment and reimbursement in some of these scenarios of presumptive authorization. I'm an ECM provider. I have access to that presumptive policy. I start serving a member, and let's say I submit a referral and... Just so everyone knows, given some of the information and the data, we know almost... A very high portion of individuals are ultimately going to be authorized for that service, which is fantastic. But in this scenario, Laura, where they aren't ultimately authorized, can you just remind folks there's two scenarios where the plan won't pay. But in every other scenario where the member, if they ended up not being eligible, the plan does pay. Will you just remind folks what those two scenarios, and I recap too, but those two scenarios where the plan doesn't have to pay so folks are aware? |
| [video] | Dr. Laura Miller – 50:26 | Right. Exactly. The plan does not have to pay if the person who was referred, the member, is not assigned to that health plan. If they're not the plan's responsibility, the plan does not have to pay the ECM provider. That's the one scenario. The other scenario is if the member is already in ECM with another ECM provider. Again, that's why this piece about the plan having the portal and really an easy look up to see the status of the member. Are they in another ECM program? Are they not in the managed care plan? Those are the two scenarios in which the ECM provider would not get payment. |
| [video] | Sarah Allin – 51:24 | Yeah. It's those really limited scenarios, but if there are other reasons the member ends up not meeting eligibility the plan still pays during the period of presumption authorization? |
| [video] | Dr. Laura Miller – 51:33 | That is correct. |

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| [video] | Sarah Allin – 51:33 | Okay. |
| [video] | Dr. Laura Miller – 51:35 | Say there is an exclusion. There on hospice, let's say, which is an ECM exclusion. We hope that the ECM provider would see that scenario and not even submit. But should something like that happen where there is an exclusion to ECM, the provider would be paid from the first day of services until the time that they received word from the plan, up to 30 days, but no more than 30 days. |
| [video] | Sarah Allin – 52:13 | That's great. That's really helpful. Palav, coming back to you. There seems to be a lot of enthusiasm and support of the new referral standards for ECM in the chat. The team has said, "What about community supports?" Community supports is this other additional really important set of services, often interconnected as a support for members with ECM. Tyler mentioned the action plan a little bit earlier in this call. Do you know... Can you speak to priorities around referral... Additional support around referral standards for other programs? |

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| [video] | Dr. Palav Babaria – 52:52 | Yeah. I think short answer is yes. A similar package is coming for community supports. That team is definitely looking to obviously not reinvent the wheel and build upon the work that we've already done here for ECM. There are obviously some nuances to community supports that need to be taken into account. That is in the works, and I think we're on track to get that out before the end of the year. More to come on that front, and hopefully there'll be similar enthusiasm because I think it is in a similar vein of how do we really simplify this, streamline, get these services out to more people? Then I will say, just because I've been monitoring the chat while Laura's been taking some questions. Two questions to lift up. One, just people are acknowledging, as Laura was saying, the current portal setups and what you can view and can't view we recognize are different. That is why plans have a few months to implement these standards because we do expect there's going to need to be configurations made to existing workflows and portals so that people can see that ECM enrollment status. |

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| [video] | Dr. Palav Babaria – 53:55 | That's current state is not what should be happening in January, and that is why plans need time to implement these changes. Then the second piece on JI. We have a whole separate JI policy guide that goes into the weeds about ECM as well, but there is no DHCS prohibition on having just one justice involved ECM provider per county. We actually know that many, many providers are going to need to be involved with this population of focus as pre-release services go live, which they did in three counties nine days ago, which is very exciting. But as soon as pre-release services go live, that avalanche of post-release ECM services is going to be coming. Our plans are tracking this. Our ECM team is working with plans to actively build up their capacity in preparation for pre-release services, so plans should be looking to contract with as many justice involved providers as possible to meet that need. We do have specific criteria for who can be a JI provider, which is a little bit more specific and different than the overall ECM criteria. |
| [video] | Sarah Allin – 55:06 | Great. Thank you so much, Palav. So many of these questions have been incredibly helpful to us in our teams. We are making a note of them. Palav, I wonder there have been a few questions in the chat about strategic advice for providers in navigating maybe delays in authorization or other components. I heard you really mentioning throughout this call first really working through things with your managed care plan was a top priority, but just curious if you have any other strategic advice for providers navigating authorization timelines or payment timelines with MCPs? |

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| **[video]** | Dr. Palav Babaria – 55:50 | Absolutely. I think Laura did link to the APL, which is a separate APL which covers authorization and timely payment provisions throughout the Medi-Cal program. I would encourage you to familiarize yourself to that. Those are your rights. If there are issues in getting paid or getting timely authorizations, as mentioned, please work through the plan first, but then there are standard grievance and appeals processes both through the plan and through DHCS that you can avail yourself off if that is not working. |
| [video] | Sarah Allin – 56:21 | Fantastic. Thank you all so much. Thank you Laura and Palav for your time and your conversation today. Laura or Palav, anything else you want to lift up today for the audience before we close our time together? |
| [video] | Dr. Laura Miller – 56:36 | I just really want to express gratitude. This is a very, very intensive lift and change of how we conceive of and do healthcare. It takes a lot of flexibility in every sector. I'm just deeply appreciative of people's willingness to dig in, think outside the proverbial box and this cycle of continuous improvement, which I think is a really important thing. Policy is not one and done and it needs to live. It needs to live on the streets and with members, so just gratitude to everybody for leaning in and trying to get it done. |
| [video] | Sarah Allin – 57:21 | That's great. Thank you all so much. These materials for the webinar will be available on the DHCS website. It takes us a few weeks to process it all and post it, but you have seen in the chat from Megan where those will be available. Palav, I'll give you the final words as we close out. |

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| [video] | Dr. Palav Babaria – 57:44 | Laura said it the best. I just will say we know this is hard. For me every time when I am getting frustrated and down, I think about the stories I've heard about members whose lives have been transformed by ECM and by CalAIM, so just encourage you all when you're feeling down hold onto those stories so we can all keep going. |
| [video] | Sarah Allin – 58:07 | Thank you so much. Have a great rest of the day, everyone. |