CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

ALL COMER WEBINAR ON CLOSED-LOOP REFERRAL IMPLEMENTATION GUIDANCE

Date: Thursday, February 13, 2025

Time: 10:00 – 11:00am PT

Speakers:

- Palav Babaria
- Sarah Allin

TRANSCRIPT:

00:00:19.440 --> 00:00:20.990

Alice K - Events: Hello and welcome.

2

00:00:21.090 --> 00:00:29.789

Alice K - Events: 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.

3

00:00:30.060 --> 00:00:32.030

Alice K - Events: Finally, during today's event.

4

00:00:33.240 --> 00:00:39.a210

Alice K - Events: live closed. Captioning will be available in English and Spanish. You can find the links in the chat field.

5

00:00:39.670 --> 00:00:50.839

Alice K - Events: With that I'd like to introduce Dr. Olive Babaria, the chief quality and medical officer and deputy director for Quality and Population Health management at the Department of Health Care Services.

6

00:00:53.340 --> 00:01:07.229

Palav Babaria: Thank you so much, Alice. Hi, everyone, Paula Babaria from Dhcs. Thank you all for joining us today to review Dhcs's recently released closed loop referral guidance. We can go to the next slide.

7

00:01:09.754 --> 00:01:13.000

Palav Babaria: Obviously, Hi, I'm the presenter. We can go one more.

8

00:01:15.710 --> 00:01:34.900

Palav Babaria: So the purpose of today, I think, is hopefully, all of you who have joined today's webinar have been tracking. We at Dhcs have been now on a multi-year journey to really make sure that the true vision of Calaim is rolled out as seamlessly as possible, and that we, in collaboration with all of our managed care, plan partners.

9

00:01:34.900 --> 00:02:03.239

Palav Babaria: all of the various providers across the State can really make sure that these brand new transformative services can reach members who are eligible and really support them on their journey to health and wellness as a part of that Dhcs. Did a broad listening tour about 18 months into Caling Rollout to really understand what were the pain points. What were some of the problems and challenges that our communities and Ecm. And community supports. Providers in particular, were facing.

10

00:02:03.240 --> 00:02:16.650

Palav Babaria: and as a part of that, over the last year we have rolled out a number of policy revisions based off of feedback from many of you who are probably on the call today. And so in December 2024, we released this bundle.

11

00:02:16.650 --> 00:02:34.359

Palav Babaria: and all these 3 things fit together. So there is new closed loop referral implementation guidance, which we are going to be going through today. There's also updated member sharing Member Level information sharing guidance in our Ecm manual as well as in our community supports manual.

12

00:02:34.760 --> 00:02:36.390

Palav Babaria: we can go to the next slide.

13

00:02:40.370 --> 00:02:57.590

Palav Babaria: So today we're going to cover. Why do we even have closed loop referral requirements? What are closed loop referral requirements. What is the framework? How

does this actually work in the real world? And then, you know, for the 570 plus of you who joined us hopefully, a robust Q&A session.

14

00:02:57.730 --> 00:03:01.380

Palav Babaria: and then next steps so that you can see where the department is headed.

15

00:03:01.810 --> 00:03:03.449

Palav Babaria: We can go to the next slide.

16

00:03:04.946 --> 00:03:28.970

Palav Babaria: So we have very intentionally kept the chat on today. So all of you should be able to type in the chat. You can also use the Q&A feature, and we'll try to get to as many of those questions at the end as possible. We will absolutely be collecting and preserving all the information in the chat, so that we can take your suggestions and questions and address them in other venues. If we don't get to all of them. Today

17

00:03:29.170 --> 00:03:30.689

Palav Babaria: we can go to the next slide

18

00:03:33.420 --> 00:03:35.220

Palav Babaria: and we can go one more.

19

00:03:37.390 --> 00:03:58.209

Palav Babaria: So I think many of you have been aware, for all of our population health work. It is really important to us that we are grounded in the why of all of these policies. And really that starts and ends with our medi-cal members. So I'm really excited today to share a real life, not made up example of how we envision this policy really touching medi-cal member experience

20

00:03:58.800 --> 00:04:00.030

Palav Babaria: and play the video.

21

00:04:00.510 --> 00:04:13.410

Palav Babaria: I've been a medical member for 30 years, having health coverage, has helped me with transportation groceries. Medicine. I 1st heard of tailored meals through an app.

22

00:04:13.520 --> 00:04:39.190

Palav Babaria: I saw it would deliver groceries to your home. I was able to apply and receive my food within a week. The difference is, I receive my food at home through a delivery company. They give you the meals that will help you in the condition you're in. It's catered to my diet. It's convenient. I love it. I recommend it to everybody.

23

00:04:44.050 --> 00:05:06.559

Palav Babaria: So this is a real life member who is receiving community supports through Calaim, as you saw in the video. This member was referred by a provider to receive medically tailored meals, and was really successfully able to get the services that

she needed to help improve her health and well-being. Unfortunately, we know that this is not always how the story ends. We can go to the next slide.

24

00:05:08.010 --> 00:05:32.249

Palav Babaria: I think all of us have examples, and I say this as a primary care provider that still provides patient services once a week, that often we make referrals, and the ball gets dropped for a whole host of reasons, and sometimes the services that members have been referred for never actually reach the member. And often the member doesn't know what happened to the referral and the referring provider doesn't know. And it's really hard to troubleshoot.

25

00:05:32.300 --> 00:05:57.499

Palav Babaria: Why wasn't the service rendered? Is it because someone refused the service. Is it because there was an incorrect contact information or phone number, so that the community supports or Ecm. Provider couldn't reach the member? And I think any of us who've worked in healthcare for even a day know that this results in a lot of duplicate efforts, wasted time re-referrals, and people spending a lot of time on phone and email trying to track down what happened.

26

00:05:57.540 --> 00:06:20.910

Palav Babaria: The purpose of closed loop referrals, which is standard new language that we put into the medi-cal managed care contracts with the new contracts in 2024. The purpose of this is really to make sure that this doesn't happen, and to improve communication and information sharing, so that Mcps and providers know what is the status of the referral? Why wasn't it completed?

27

00:06:20.910 --> 00:06:33.260

Palav Babaria: What is the next step to make this referral work, and can also make sure that all of the services that are needed for our members are reaching them efficiently and promptly.

28

00:06:33.740 --> 00:06:35.300

Palav Babaria: We can go to the next slide.

29

00:06:38.360 --> 00:07:02.290

Palav Babaria: So the closed loop referral and existing Mcp requirements. So already, as a part of our population health management program managed care. Plans are supposed to be tracking closed loop referrals for services that the plan does not provide and are sent outside of the plan. The new closed loop referral guidance gets really nitty, gritty and specific about what exactly needs to be tracked by when and who needs to be notified about that.

30

00:07:02.290 --> 00:07:13.880

Palav Babaria: so that members can really, in a rapid fashion, get connected to services they need. And if for something, some reason, something breaks along the way, we can make sure that is fixed and corrected as quickly as possible.

31

00:07:14.140 --> 00:07:15.770

Palav Babaria: We can go to the next slide.

32

00:07:18.360 --> 00:07:46.910

Palav Babaria: So today, we're going to walk through the goals and definitions for the closed loop referrals. We've started, as you'll see, and as we walk through with Ecm. And community supports, because these are new medical services that are really critical to many of the members, and directly came out of the listening tours that we did, and a huge desire from members, providers and Ecm. And community supports providers to make sure they knew what was happening. With these referrals we can go to the next slide.

33

00:07:49.380 --> 00:08:03.080

Palav Babaria: So the definition of a closed loop referral. I know this may sound basic, but there's a lot of back and forth and debate about this is that when a referral is initiated on behalf of a medi-cal managed care member that that referral is tracked.

34

00:08:03.080 --> 00:08:20.070

Palav Babaria: supported, and monitored and results in a known closure. And I'm going to sort of underscore that known closure. Known closure could be a number of different things. Either it means this was a success. The member actually got the services, or maybe the member didn't want the services we, you know.

35

00:08:20.140 --> 00:08:45.460

Palav Babaria: we provide the services, but at the end of the day it is up to each and every member to decide if they want them, and if they will benefit them and their family. And so sometimes the member declines. We also know that sometimes the service provider is unable to accept that member or reach that member. And so these are different examples of known closures. But that information isn't always communicated back to the individuals that need to know.

36

00:08:45.530 --> 00:09:01.240

Palav Babaria: So the goal of closed loop referrals is really at the end of the day to increase the number of medi-cal members who are successfully connected to services by improving the information that the Mcp collects and tracks, and then also by addressing system level gaps

37

00:09:01.240 --> 00:09:26.019

Palav Babaria: in referral practices and service availability. So you know, looking at those trends, are there a high rate of members declining? What is the demographic information? Is it because they speak a different language, and maybe they don't have a linguistically concordant provider who can understand and meet their needs. Is it that a certain service provider is at capacity and unable to meet the needs of those members. So really, looking at those systems, level trends can help us figure out

38

00:09:26.210 --> 00:09:33.900

Palav Babaria: what's going on and why isn't Ecm and community supports getting to everyone who is eligible and could benefit from these services.

39

00:09:34.250 --> 00:09:37.280

Palav Babaria: We can go to the next slide.

40

00:09:39.350 --> 00:10:05.360

Palav Babaria: so this will be rolling out in a phased fashion. So, as mentioned, Dhcs released this guidance, there's a lot more detail on our websites in December. We do know that there's a lot of systems, changes, technology upgrades information that needs to be put into place to make closed loop referrals work, and so managed. Care

plans are all working on that diligently right now with their providers, and these new requirements go into effect on July first, st

41

00:10:05.360 --> 00:10:17.949

Palav Babaria: for all Ecm populations of focus and for all 13 community supports, that a plan may be providing currently sobering centers are not included in this definition.

42

00:10:18.120 --> 00:10:38.510

Palav Babaria: The reason we've started, as mentioned with Ecm and community supports is that these services are really critical for our highest need members, and the Mcp plays a critical role in the referral loop because these services go through an authorization process and then are assigned to an Ecm or community supports provider.

43

00:10:38.510 --> 00:11:00.429

Palav Babaria: You'll see at the end of the webinar when we look forward to other types of closed loop referrals. Sometimes the Mcp managed Care Plan is not even in that referral pathway, and may or may not even know that a referral is happening. But for Ecm and community supports. This data is already regularly being shared with providers Mcps and Dhcs. This seems like a really good place to start.

44

00:11:00.780 --> 00:11:02.569

Palav Babaria: We can go to the next slide.

45

00:11:06.770 --> 00:11:18.310

Palav Babaria: So there's 3 basic pillars of what we are hoping to achieve and what we expect to achieve starting in July from closed loop referral requirements. So number one is members, often members

46

00:11:18.310 --> 00:11:30.319

Palav Babaria: whom the services are intended for are kept out of the loop, and don't always know what the status of their referral is so moving forward, members are going to get a notice from their Mcp when the service is authorized, so that they know

47

00:11:30.320 --> 00:11:53.209

Palav Babaria: my Mcp has approved me receiving community supports or Ecm. And then they will also receive support from Mcps to identify other service providers. If a re-referral is needed, so if the provider that they're assigned to for community supports or Ecm. Doesn't work out for some reason there will be an actual entity helping to redirect and make sure that services are provided by a different provider.

48

00:11:53.630 --> 00:12:03.210

Palav Babaria: We also, from Ecm. And community supports. Providers are going to be collecting 3 new data elements via the return transmission file each month, the Rtf

49

00:12:03.621 --> 00:12:11.770

Palav Babaria: and this is really the referral status, the date of referral status update and reason for referral closure which we're going to get into some more details.

50

00:12:11.820 --> 00:12:34.879

Palav Babaria: And then, also, most importantly, whoever the referring entity is. So, if the primary care provider or a community based organization made the referral on behalf of the member. They will also get updates on when the service is authorized and when the referral is closed. So they know, hey, this member that I referred actually got what they needed, or they declined. And maybe that's an opportunity for a follow up conversation.

51

00:12:34.880 --> 00:12:42.309

Palav Babaria: And if the referral is not authorized. They will also know why. Sometimes we know that it's just missing information, or they needed to submit

52

00:12:42.310 --> 00:12:48.879

Palav Babaria: some extra documentation and they will have an opportunity to correct those. If that is what is holding up the authorization.

53

00:12:49.250 --> 00:12:50.930

Palav Babaria: We can go to the next slide.

54

00:12:54.460 --> 00:12:56.480

Palav Babaria: We can keep going one more

55

00:13:00.160 --> 00:13:00.870

Palav Babaria: so

56

00:13:00.910 --> 00:13:28.470

Palav Babaria: as we rolled out these requirements, it was really important that we had a framework. Again, what is the purpose of this? How do we add these requirements without adding a lot of administrative burden. And the goal of this is not to generate more faxes and more paper that goes straight to the shredding bin. It is really to leverage modern day technology, electronic means and making sure that we are effectively getting member services. So firstly, there is the tracking element.

57

00:13:28.470 --> 00:13:52.729

Palav Babaria: Mcps are required under the closed loop referral guidance to track a minimum set of data elements on each member referral. And again, these should be electronic data elements, not pieces of paper Mcps are also required to support referrals, so that both the member and whoever referred the member are notified of changes and that everyone is collaborating and working to troubleshoot the challenges.

58

00:13:52.760 --> 00:14:07.739

Palav Babaria: The last is the monitoring piece that they should be looking at systemic trends and patterns to identify where there are issues or problems, or where there are things getting stuck, so that we are continuously improving on the process and removing barriers and pain points

59

00:14:08.080 --> 00:14:10.180

Palav Babaria: we can keep going to the next slide.

60

00:14:12.860 --> 00:14:18.850

Palav Babaria: So, as mentioned, the Mcps have to track a minimum data elements for each phase of the referral.

61

00:14:18.930 --> 00:14:43.630

Palav Babaria: The requirements here are really making sure that everyone is acting in a timely manner, and that Dhcs can also make sure that these things are happening in a timely fashion, and that challenges are being resolved. When we did our statewide listening tour, we often heard that referrals were sitting stuck somewhere in the system for often weeks or months at a time, and the purpose of close lip referrals is to make sure, both at the Mcp level

62

00:14:43.630 --> 00:14:49.020

Palav Babaria: and at Dhcs's State monitoring level that we are making sure that is not happening. Moving forward.

63

00:14:49.080 --> 00:15:08.100

Palav Babaria: we recognize all of our managed care. Plans have their own systems and processes today. And so the Dhcs, similar to other policies that we've issued. Each managed care plan can choose what system they use to store data and process referrals to implement closed-lip referral tracking requirements. Dhcs has

64

00:15:08.100 --> 00:15:21.169

Palav Babaria: intentionally not selected a single statewide system to do this, because we know the ecosystem is very different, depending on what part of the state you're in, and we don't want to disrupt processes that are locally already working today.

65

00:15:21.590 --> 00:15:23.189

Palav Babaria: We can go to the next slide

66

00:15:26.630 --> 00:15:55.450

Palav Babaria: so to our policy guide that we linked at the very beginning, and that our colleagues have dropped in the chat has a lot more details. But to give you some specific examples. We've been very prescriptive about the required data, elements and sources, and where possible, these align with existing State and federal laws, including interoperability, to make sure that we are in alignment with larger changes happening to data storage and transmission in California and federally. So, for example, there's

67

00:15:55.650 --> 00:16:15.089

Palav Babaria: specific elements that are supposed to be collected, such as the date of referral, the referral authorization status, the referral status and the reason for referral loop closure. You'll see here, then, in column 2. There's, you know, examples of what this could look like. So the authorization status could be approved. If it's already been reviewed by the Mcp.

68

00:16:15.090 --> 00:16:39.619

Palav Babaria: it could be. They need additional information, or it could be that it's been reviewed and has been denied. Similarly for referral status, it could be accepted, declined pending outreach initiated referral loop closed. And then, whenever there is a referral loop closed, there's a reason entered. So this could be that services were received like the video, we saw our member actually got the medically tailored meals.

69

00:16:39.700 --> 00:16:49.400

Palav Babaria: Success referrals made services provided it could be that the service provider couldn't take on the referral, and it was declined, or that they were unable to reach the member.

70

00:16:49.450 --> 00:17:14.260

Palav Babaria: And then you'll see on the right. We have different sources for the data. So some of the pieces come from managed care plans, such as referral authorization status. That is a step that the managed care plans do and that they house in their data systems. Some of the information comes from the actual Ecm or community supports provider, as you'll see in column 3, the last 2 boxes, the Rtf. The return transmission file.

71

00:17:14.260 --> 00:17:27.300

Palav Babaria: What is happening with the member, and whether or not they received or declined services. Those are pieces of information that our Ecm. And community supports. Providers know and update in the Rtf. But the goal is by then combining

72

00:17:27.300 --> 00:17:51.600

Palav Babaria: all of these pieces of information. We all collectively, everyone who's working to serve medi-cal members as well as Dhcs. Can get a clear picture of how long are these steps taking? What are success rates? And then we can identify best practices. We know that some of our plans and service providers have amazing rates of acceptance. We know that there are others where there are very, very high rates of

73

00:17:51.810 --> 00:18:07.170

Palav Babaria: decline services. And those are areas that we can dig into from a performance, improvement and quality improvement standpoint to understand what is that one Ecm. Provider doing where everyone is accepting their services that is different than the other one, where maybe everyone is refusing services.

74

00:18:07.580 --> 00:18:09.380

Palav Babaria: we can go to the next slide.

75

00:18:12.110 --> 00:18:40.960

Palav Babaria: So the other major goal, as mentioned earlier, is that we really do want to make sure that both the member and whoever referred the member are really understanding what is happening with this referral. And I say this again, from my own lived experience as a provider, there is nothing more painful than sending referrals off into the black void and the ether, and never knowing what has happened or meeting my patients. And they tell me I never heard from anyone, and I have no idea where the ball got dropped, or why.

76

00:18:40.960 --> 00:18:48.180

Palav Babaria: So, in terms of the privacy and security constraints around this referral loop closure information is

77

00:18:48.180 --> 00:19:12.990

Palav Babaria: protected health information under hipaa, but that information can be shared with covered and non-covered entities without authorization for care, coordination purposes. So this is compliant under existing Federal and State laws, so

both within the Apl. That is cited here, as well as in the policy Guide Mcps are required to notify members within 2 business days

78

00:19:12.990 --> 00:19:36.489

Palav Babaria: of when they decide a service is authorized or not authorized, so that the member knows, can they expect an Ecm. Or community supports provider to show up and provide them services or not. The Mcp is also required to notify the referring entity within one business day of making this decision, and again, that is an opportunity for whoever the referring provider entity is to know

79

00:19:36.490 --> 00:19:48.150

Palav Babaria: why was this approved, or this is approved, and my member is going to get services, or maybe more information is needed, or this decision was not approved, and they can follow up and make sure that that is appropriate.

80

00:19:48.190 --> 00:20:05.379

Palav Babaria: And then Mcps are also required to share the referral loop closure. So that is actually what happened. Once the service was authorized and someone tried to go deliver it with the referring entity within 2 business days of receiving that information from the Ecm or Community supports provider.

81

00:20:05.560 --> 00:20:12.216

Palav Babaria: And then we do require that Mcps use electronic methods to communicate the information above.

82

00:20:12.970 --> 00:20:38.030

Palav Babaria: because, again, the goal is not that we are generating reams and reams of paper that goes straight to the shredding bin. I think all of us, most of us have been on the receiving end of those, and we know that they're highly ineffective. There is a provision that if both the receiving party and the Mcp agree on a nonelectronic method that that is allowed, there may be some cases where that is necessary, but it needs to be mutually agreed upon.

83

00:20:38.540 --> 00:20:40.290

Palav Babaria: We can go to the next slide.

84

00:20:43.920 --> 00:21:07.799

Palav Babaria: So for supporting, pending, and re-referrals, we also wanted to make sure that the systems improvements are happening along the way. So we are requiring in the policy Guide that Mcps use this data that's collected to look at what is happening. And if there have been referrals that have been open for long periods of time without status updates that they're following up with those Ecm and community supports providers to understand?

85

00:21:07.800 --> 00:21:14.189

Palav Babaria: Why is this referral still open? Were you unable to reach the member? Are you doing the effective outreach? Are you getting out into the field.

86

00:21:14.190 --> 00:21:22.990

Palav Babaria: and that we really want to make sure again that we're doing process improvement and learning lessons from those providers with more successful outreach and engagement rates

87

00:21:22.990 --> 00:21:41.709

Palav Babaria: and then sharing and scaling those lessons across the networks over time. So Mcp actions that we expect to take to support these referrals are looking at the data following up with anyone who's an outlier and has large volumes of referrals that are still open and or they've been open for a really long time

88

00:21:41.710 --> 00:21:46.900

Palav Babaria: really helping service providers to get additional contact information. We know

89

00:21:46.900 --> 00:22:11.870

Palav Babaria: that the data we have at Dhcs for Member Contact information usually filled in at the time of their application to medi-cal often becomes outdated. People move, they don't always update their address. They may have a different phone number. Their phone number may be disconnected. There are numerous sources of more up-to-date contact, information available from providers, from Hies. And really, how are our plans supporting providers to use

90

00:22:11.870 --> 00:22:15.719

Palav Babaria: of those pieces of information to outreach our members.

91

00:22:15.720 --> 00:22:42.330

Palav Babaria: and then Mcps also are required to have clear procedures for member follow up and re-referral where the referral was declined because of service provider capacity. So if the Mcp. Assigned the member to a community supports or Ecm. Provider and that provider was full or couldn't take them on the burden of reconnecting that member to the new service provider is really on the managed care plan, and not on the member or the referring provider.

92

00:22:42.780 --> 00:23:01.590

Palav Babaria: and then Dhcs at this point will not require a specific timeline or follow up action, because we know that you know some of these services. Take a while if you're doing asthma home modifications or housing deposits, but it is something that we will be looking at over time and looking at the data.

93

00:23:02.850 --> 00:23:04.739

Palav Babaria: he can go to the next slide.

94

00:23:07.840 --> 00:23:34.870

Palav Babaria: So the other big piece is really monitoring member referrals. So, as we've said in other webinars, our number one goal for both Ecm and community supports is that individuals who are serving medi-cal members and are trusted by our members are the ones putting in referrals to Ecm and community supports on the member's behalf, or that the members are doing it themselves, because we know success rates and acceptance rates of these services are much higher

95

00:23:34.870 --> 00:23:47.499

Palav Babaria: when they are recommended by someone that is trusted by the member. And so Mcp should be looking at the referral trends, seeing where they are coming from, what's working, what's not working? And then making sure that they are again

96

00:23:47.500 --> 00:24:09.669

Palav Babaria: scaling the best practices that they see and getting members connected to the right types of services. They're also required to look through the data that is collected through closed loop referrals and look for any bottlenecks, barriers in terms of referring entities, internal operations, authorization timelines and providers. And they're also expected to provide technical assistance

97

00:24:09.670 --> 00:24:31.610

Palav Babaria: to all referring entities and providers when there are consistent delays or issues again, resulting in members not getting connections to services. So if there are certain service providers or types of services where the refusal rate is 80 90%, that is a red flag that our Mcps will be required to dig into to understand why that is happening.

98

00:24:32.860 --> 00:24:34.490

Palav Babaria: We can go to the next line.

99

00:24:37.500 --> 00:24:49.420

Palav Babaria: So we at Dhcs will also be collecting this information, the beginning in July 2025, our managed care plans will be submitting monthly data submissions to Dhcs

100

00:24:49.420 --> 00:25:08.580

Palav Babaria: using the existing Json data Submission process which we are already using for Ecm and community supports that will allow Dhcs to also look at the referral volume timelines, closure reasons and other quality measures and build that into our monitoring technical assistance and enforcement actions at the State.

101

00:25:09.270 --> 00:25:11.059

Palav Babaria: We can go to the next slide.

102

00:25:12.950 --> 00:25:34.160

Palav Babaria: So a few things that are unique requirements for both the Ecm and community supports referrals that I think is useful to lift up. So one, there's streamlined authorization and closed loop referral tracking. So in cases where a member begins receiving Ecm or community supports under a streamlined authorization process.

103

00:25:34.160 --> 00:25:47.429

Palav Babaria: Mcp still have to follow the referral tracking requirements outlined in the closed loop referrals. I think many folks are tracking. We have a presumptive authorization policy that was also rolled out for Ecm and community supports.

104

00:25:47.580 --> 00:26:12.029

Palav Babaria: Even with that presumptive authorization process, a referral is still put in. It just happens later, potentially. And the member can start receiving services earlier. But the closed loop referral process still applies, and the triggering event is that that referral

is still initiated. And then for referrals from correctional facility, pre-release care managers, I think, as everyone is tracking as a part of our justice involved, initiative

105

00:26:12.060 --> 00:26:30.190

Palav Babaria: referrals are going to be made by whoever is providing pre-release services, whether that is the correctional facility or the pre-release care manager to anyone who is in custody prior to release, and then they will be making referrals to Ecm and community supports providers for post-release services.

106

00:26:31.450 --> 00:26:42.880

Palav Babaria: and those are also subject to closed loop referral requirements. So even though the workflow is a little bit different for our Ji individuals. The closed loop referral monitoring tracking process is still the same.

107

00:26:43.710 --> 00:26:45.399

Palav Babaria: You can go to the next slide.

108

00:26:47.090 --> 00:26:58.730

Palav Babaria: so I want to bring us back. I know that was a lot of information, and I think it's hard to put together sometimes without a practical example. So we're going to go back to our member whose video we saw at the very top of this webinar, we can go to the next slide.

109

00:27:00.380 --> 00:27:21.800

Palav Babaria: So this is an example where a primary care provider like myself, initiates a referral for a member to receive the medically tailored meals community support. So I am in clinic. I see my patients. I think they would really benefit from medically tailored meals. So I put in the referral, fill out the form, send it to my managed care plan, using our standardized referral form process.

110

00:27:21.860 --> 00:27:45.139

Palav Babaria: Then the Mcp authorizes the service. In the 1st few days they look at the members eligibility, and they authorize the services within 5 business days as required. They're then required within 2 days of that authorization to both notify the Pcp. About the authorization status that they've reviewed the referral, and they've authorized the medically tailored meals.

111

00:27:45.620 --> 00:28:02.759

Palav Babaria: Sorry within one business day, and then the member and caretaker within 2 business days, so that both the Pcp. Knows this author referral was a success it's gone through, it's authorized, and that the member and their caretaker also know this is authorized, and they can expect that outreach from the medically tailored meals provider.

112

00:28:03.010 --> 00:28:26.009

Palav Babaria: Then the Mcp. Assigns the member to an appropriate, medically tailored meals. Community supports provider and shares the information with them about the authorization status file. The community supports provider, receives the information and does outreach to the member to offer the service and figure out what specific meal intervention is most appropriate for that service. You can go to the next slide.

113

00:28:29.700 --> 00:28:41.709

Palav Babaria: Then, within a few more days the community supports. Provider actually begins providing medically tailored meals to that member. So this is a successful referral authorization and service delivery process.

114

00:28:41.840 --> 00:29:04.129

Palav Babaria: Then, once the service starts that community supports provider as a part of their Rtf. The return transmission file is going to make a status update, saying that the referral loop is closed and the reason for loop closure that they're going to pick is services received because the member accepted. The services services have started flowing, and that is a part of the closed loop referral requirements.

115

00:29:04.240 --> 00:29:33.170

Palav Babaria: Then the Mcp receives that return transmission file, and within 2 business days of receiving that information that yes, they have confirmation. The community supports provider actually got in touch with the member. Medically tailored meals are now being delivered. The Mcp. Will then update the Pcp. To close that loop and say yes, your patient that you referred that was authorized is actually confirmed and successfully receiving medically tailored meals. And there will be electronic notice of this communication.

116

00:29:33.330 --> 00:29:52.139

Palav Babaria: And then by day 60. So again, there is a lag. But I will say, you know, getting this information at Dhcs within 2 months is better than a lot of the other data that we often get 6 to 12 to 18 months later. Dhcs is going to get this data via the monthly Json report that our managed care plan sent to us.

117

00:29:52.140 --> 00:30:05.749

Palav Babaria: as well as reports from other community supports and Ecm. Providers, so that we can see what has been happening to our members who were referred for community supports and Ecm. During that time and weave that into our monitoring processes.

118

00:30:07.230 --> 00:30:09.170

Palav Babaria: We can go to the next slide.

119

00:30:11.970 --> 00:30:26.860

Palav Babaria: Okay, we've made it to Q. And a. I know that was a lot of information so happy to go back, and I see the chat has been really active. So I am going to ask my colleagues on the call to lift up and see where we want to start for the Q. And a portion.

120

00:30:29.490 --> 00:30:35.927

Sarah Allin: Great. Thank you. Thank you for walking through all of this. We've had a lot of really wonderful questions in the chat.

121

00:30:36.410 --> 00:30:59.422

Sarah Allin: I think maybe the place I'll just start is, there's a lot of interest in the new noticing requirements. Both think we're getting some questions from plans about operationalizing them. And then some questions from referring entities about how they can kind of expect to receive some of these notices and what to do. So maybe let's just start with

122

00:31:00.480 --> 00:31:08.260

Sarah Allin: just to like recap for everyone. We have notices that will go to members and notices that will go to referring entities. And Paula.

123

00:31:09.480 --> 00:31:21.020

Sarah Allin: What I would love for you to do is just reiterate that these referrals and the clr requirements they apply to all referral sources. Does it matter what the referral source is for these requirements to apply.

124

00:31:21.230 --> 00:31:38.179

Palav Babaria: No. And I think that's specifically why we brought in that hipaa language. So it does not matter what the referral sources. Obviously the example we had was from a primary care provider, but the referral source could have come from a school teacher, and the noticing requirements are the same. Independent of the referral source.

125

00:31:38.180 --> 00:31:56.429

Palav Babaria: and for purposes of care coordination, which is what we are talking about here with closed loop referrals, the managed care plans are allowed to close the loop with both hipaa covered and non-hipa covered entities such as schools, non-contracted Cbos. You know, other community groups.

126

00:31:57.150 --> 00:32:09.449

Sarah Allin: That's great. So that was one of the key questions here, which is as a managed care plan. I think a little bit of concern about sharing this different types of information with different types of entities. And what you're saying is okay, based on

127

00:32:09.590 --> 00:32:15.710

Sarah Allin: sort of Dhcs's guidance. And in this guidance to share with non covered and covered entities, because it's care, coordination.

128

00:32:16.120 --> 00:32:39.380

Palav Babaria: Exactly. And obviously, we. Only we do not want to share everything under the sun. We want to share the minimum necessary data which is really outlined in the data elements in the policy guide. So we, you know you should not. And we are not asking anyone to share medical records. Other things like that. It is really the specific elements that are outlined in the policy guide about what is the status of the referral and the authorization.

129

00:32:40.210 --> 00:32:42.079

Sarah Allin: Great. And maybe while we're on that.

130

00:32:42.230 --> 00:32:45.619

Sarah Allin: a few questions have come in about sort of the electronic

131

00:32:45.740 --> 00:32:48.919

Sarah Allin: sending of some of this. So we've gotten some questions about

132

00:32:49.100 --> 00:32:54.489

Sarah Allin: is a fax allowed, or are there recommendations on different ways to do this? I think?

133

00:32:54.978 --> 00:33:08.240

Sarah Allin: Whenever we've talked through this, some of what we've said is like really having managed care plans, navigate what the best fit is, and hopefully sharing with each other. But do you want to say anything else about electronic methods and the facts in particular. Here.

134

00:33:08.882 --> 00:33:30.800

Palav Babaria: So I'm going to say this publicly on this webinar. My aspiration for 2025, which I also had in 2024 is, you know, no facts and no Pdf. And no excel files as methods of data transmission. So I encourage all of us to aspire to something higher than that. And so really, as we think about electronic data transmission, we are

135

00:33:30.800 --> 00:33:55.789

Palav Babaria: expecting over time for people to get to formats that are interoperability, compliant using formats like Uscdi thinking about Apis and integrated data transfer that can happen between Ehrs and Mcp systems or other electronic systems. We recognize that depending on what the referral source is, you know, for example, a school or a community-based organization.

136

00:33:55.790 --> 00:34:05.460

Palav Babaria: and that may not always be possible, but where possible, really leveraging all of the requirements that are under interoperability. The preferred method.

137

00:34:06.030 --> 00:34:07.430

Sarah Allin: Yeah, that's great.

138

00:34:08.699 --> 00:34:33.569

Sarah Allin: Paula, you know, as as this policy rolls out, so it'll start July right hasn't started yet. It'll start in July as this policy rolls out. If you are a member or referring entity, and you you think maybe you should have gotten some notice, and you haven't yet. There have been a few questions about like, what would you recommend? What would I do? Do you do you have advice on sort of this, the set of steps someone might take in those cases.

139

00:34:34.000 --> 00:34:51.629

Palav Babaria: Absolutely so again. You know, this hasn't gone into effect yet. It will go into effect in July. We recognize, it may be, a little bumpy at the start. And so that feedback of Hey, I never got my notice, or this isn't working is very critical to our managed care plan. So I would say, if you're a referring provider

140

00:34:51.630 --> 00:35:11.419

Palav Babaria: or a member. Well, let's say, if you're a referring provider, your 1st stop should be the managed care plans. Every single managed care Plan is required to have a

website for Ecm. And community supports with referral information for all providers. So reaching out to that point of contact and trying to understand. Why didn't I get my notice? And what's happening is the best step.

141

00:35:11.420 --> 00:35:21.969

Palav Babaria: If you're a member and you didn't get your notifications, following up with either the managed care plan, or the provider, or entity that referred you. To help troubleshoot would be helpful.

142

00:35:23.650 --> 00:35:24.200

Sarah Allin: Hmm,

143

00:35:26.310 --> 00:35:31.578

Sarah Allin: In the sort of vein of noticing. One of the things we talk about is

144

00:35:32.880 --> 00:35:45.779

Sarah Allin: for refer for referring entity, noticing for member. Noticing. We also talk about this. Apl. Apl. 2111, which is an all for those not in the Medicaid. Speak and all plan. Letter that

145

00:35:46.261 --> 00:36:12.469

Sarah Allin: what we're getting is some questions for plans about how the different noticing templates apply. I think, Paul, of on this one. What I would say I'd love for you

to if you have other thoughts to welcome them. But I think on this one. What I would say is, we definitely plan to answer these questions for plans we are. We've built out a good amount of content for the February 27th Mcpta call. So I just for that set of questions around how the noticing template should work and intersect.

146

00:36:12.490 --> 00:36:18.689

Sarah Allin: I think I would say, wait till that Mcpta call. But is there anything you want to say on those, Paula before we

147

00:36:19.120 --> 00:36:20.979

Sarah Allin: close that set of questions.

148

00:36:20.980 --> 00:36:44.859

Palav Babaria: I would just say, I know the devil's in the details. And so to everyone on this call both our Mcp partners and Ecm. And community supports partners. Please continue dropping those types of questions in the chat. We know we have not thought of every single detail and possibility. And then we'll definitely work offline to, you know, issue Faqs or connect with all of you in other venues to make sure, that we're getting the right guidance out

149

00:36:48.170 --> 00:37:07.010

Sarah Allin: I'm kind of like triaging questions as they're coming in, Paula, so forgive me. But there, there is a question here about like somebody with a large D snip population duals population. Here, I think what we would say on those is because it's right. Now this applies to Ecm and community supports, and it's managed care plans.

150

00:37:07.360 --> 00:37:16.849

Sarah Allin: It would be a referral to Ecm or community supports that these would apply to right for the Dsnp members. Anything else you want to say on the applicability to Dsnps of these requirements.

151

00:37:17.600 --> 00:37:35.710

Palav Babaria: Yeah. So right now, our existing policy is that Dsnp members are not eligible for enhanced care management. So they get those services from the Dsnp. So these requirements technically don't apply there. But definitely, we can take that up on a follow up specifically for duals. Members.

152

00:37:36.590 --> 00:37:37.190

Sarah Allin: Great

153

00:37:37.997 --> 00:37:46.459

Sarah Allin: we've had a few questions. So there are different populations that get referred for Ecm. Different populations that get referred for community supports.

154

00:37:46.980 --> 00:38:08.629

Sarah Allin: Deanne has asked a couple of questions about the justice involved population of focus for Ecm. We mentioned this a little bit in the guidance. Do you want to speak to sort of the set of pre-release services that are being rolled out, and how Clr applies to those individuals that are transitioning from pre-release over to enhanced care, management.

155

00:38:09.690 --> 00:38:19.159

Palav Babaria: Yeah. And I will. I'm gonna phone a friend to maybe drop our justice involved policy guide in the chat which has many more nuances and details at a high level.

156

00:38:19.500 --> 00:38:33.840

Palav Babaria: Anyone who is medi-cal, eligible, who is in custody, that's either in, you know, juvenile or adult facilities, both at the local level, ie. Jails or juvenile facilities, or at the state level in prisons, is

157

00:38:33.840 --> 00:38:57.170

Palav Babaria: potentially eligible for pre-release services. There are specific criteria which are all outlined in our Ji policy guide of what makes someone eligible. So it's not everyone on medical or medi-cal eligible, but they have to have additional conditions if they meet those additional conditions. They can now get medi-cal services while they are in custody, for up to 90 days, which had never previously been allowed.

158

00:38:57.170 --> 00:39:22.759

Palav Babaria: medi-cal was not previously allowed to provide any or cover any services while individuals were in custody. So they start getting what we are calling pre-release services related to those conditions, especially things like for people with mental health issues, substance use issues, chronic diseases, HIV, etc. And then, in addition to getting those services while they're in custody. They get a warm handoff from whoever is coordinating that care while they're in custody

159

00:39:22.760 --> 00:39:44.499

Palav Babaria: to a post-release. Ecm Provider, as well as a community supports provider and behavioral health as needed. So that we're not letting people fall through the cracks, because we know that when people are released from custody that 1st 2 weeks. Post-release is really risky where we see a lot of unnecessary deaths and worsening health, behavioral health and social conditions.

160

00:39:47.370 --> 00:39:48.060

Sarah Allin: And.

161

00:39:48.060 --> 00:39:58.749

Palav Babaria: In terms of closed loop referrals. Closed loop referrals will apply to all of those individuals leaving custody who are referred to Ecm and or community supports.

162

00:39:59.750 --> 00:40:00.340

Sarah Allin: Yep.

163

00:40:01.154 --> 00:40:08.799

Sarah Allin: we've gotten a few questions throughout about behavioral health services and application of clr to behavioral health.

164

00:40:09.020 --> 00:40:28.729

Sarah Allin: You you mentioned a little bit. This may be the next frontier, but all of, I think right now. A lot of what what we've sort of said is like. There's a lot of due diligence to do here a lot of learning for Dhcs to do before any requirements are put in place for Clr. Do you want to share anything else here with the group for questions that they're asking about. This.

165

00:40:29.790 --> 00:40:37.970

Palav Babaria: Yeah, maybe I'm I'm gonna just push us ahead to our next step slide because you've opened the door for that, and then we can come back to more questions. If that sounds good.

166

00:40:37.970 --> 00:40:38.939

Sarah Allin: That sounds great.

167

00:40:41.440 --> 00:41:04.709

Palav Babaria: So you know, I think again. So people can see what is coming up. We started with Ecm. And community supports, because there is already a really strong workflow and guidance, both between the return transmission file, the monthly reporting the plans do with the Json file and the way the authorization processes work. So not that this is simple, but it is simpler than a lot of other areas.

168

00:41:04.710 --> 00:41:19.620

Palav Babaria: We still have a lot to work out. And I think, like everyone can see with all of the questions in the chat. There's a lot of details to still work through, and you'll see here listed, sort of, you know, some of the next opportunities, especially for Mcps to engage with Dhcs on this.

169

00:41:19.620 --> 00:41:41.449

Palav Babaria: And then we're going to start looking at the data after this goes live. And just like we had to do with Ecm and community support. I am going to guess that we are going to learn after this policy goes, live and go back and refine and improve some of the stuff that we maybe didn't get perfectly right the 1st time around. So this is going to be an iterative process that gets better over time.

170

00:41:41.550 --> 00:41:56.850

Palav Babaria: That being said, closed loop referrals exist in other parts of our contracts, both for medi-cal managed care plans as well as for county behavioral health. So we Dhcs are starting to look at what does closed loop referrals mean

171

00:41:56.850 --> 00:42:21.529

Palav Babaria: starting with behavioral health services in 2026, because this is a major area of focus for this entire State and Dhcs between critical initiatives like Bh connect and prop one and behavioral health transformation. And we know that this is one of the biggest pain points for our members that sort of getting bounced between different behavioral health delivery systems and not having gaps, you know. Loops

172

00:42:21.530 --> 00:42:47.880

Palav Babaria: closed is a major pain point, and we just wrapped up our birthing care pathway report where we listen to medi-cal members and their pain points around getting behavioral health services while pregnant and postpartum really underscored. How dire the need is for us to really figure out what closed loop referrals look like in this space. But we recognize it is incredibly complicated. So it's going to take us some time to get there. But that is what is coming next.

173

00:42:51.310 --> 00:42:52.910

Sarah Allin: Thanks. Thank you, Tyler.

174

00:42:53.561 --> 00:43:04.638

Sarah Allin: One of the things we continue to receive a lot of questions in the chat which is fantastic. I'm gonna I think. Pause this for now, unless there's any other key points that you really want to feature.

175

00:43:05.010 --> 00:43:23.830

Sarah Allin: we have also an email address that we'll put in the chat that folks are welcome to directly send emails to Dhcs. With some of these questions. If your question wasn't answered today, we really tried to get through so many of them. We'll put that email address in the chat. We really encourage you as you continue to review this guidance and implement

176

00:43:24.070 --> 00:43:37.661

Sarah Allin: to come back? And submit those questions. And again we will come to the Mcpta call, which, as folks noted in the chat, they have adjusted the time slightly, very recently on us. So we will make sure everyone knows the right time.

177

00:43:38.210 --> 00:43:44.209

Sarah Allin: Any closing thoughts, Paula, you would like to share before we wrap today.

178

00:43:44.710 --> 00:44:03.110

Palav Babaria: I think just the 2 things sort of skimming what's in the chat one. Still, a lot of questions about like, who can refer how they can refer. If you're newer to Ecm. And community supports in general, I would advise you to look at the policy guides, but we've been very broad, intentionally, so. Medi-cal members themselves can refer.

179

00:44:03.110 --> 00:44:26.510

Palav Babaria: Family members can refer community entities can refer. A teacher can refer is the example I gave earlier. You do not need to be a physician or a nurse, or a licensed person to refer. And we know again, not everyone depending on who's making the referral has the ability to do that electronically. And so each and every single managed care plan has a website

180

00:44:26.510 --> 00:44:51.079

Palav Babaria: that has instructions and information. And we audit these regularly on how to refer. And most of them, from what I've seen, have forms, online submissions, phone numbers that you can call to make that referral. And it is not limited to just medical providers. So encourage you all to look at that, because we do want referrals again, coming in from anyone who knows a member and identifies a need and wants to help that member get connected to services.

181

00:44:51.090 --> 00:44:53.459

Palav Babaria: The other second comment that I'll make is

182

00:44:53.570 --> 00:44:57.759

Palav Babaria: the explicit intention of this is to prevent

183

00:44:58.420 --> 00:45:16.280

Palav Babaria: gaps in care and balls from getting dropped along the way, and to really make the referral authorization and connection to services clear, transparent, visible, and have some process, improvement and accountability to figure out. Where is it not working and improve it? The goal is not

184

00:45:16.280 --> 00:45:40.650

Palav Babaria: to add another layer of administrative burden that is really getting in the way of patient care and service delivery, and so to the extent that any of you are having challenges with how to make this as automated and painless as possible. Please reach out to us on the email. We know it's going to take some time to get there, but we expect these systems, you know. Yeah, it's going to be a little bit more

185

00:45:40.650 --> 00:45:47.930

Palav Babaria: recording, for sure. But to the degree possible. It should be automated, and not causing a ton of extra administrative burden.

186

00:45:51.440 --> 00:46:06.710

Sarah Allin: Great. And thank you so much, Paula. And you can. Folks can see Lauren just put the email address where you can send questions. These go directly to the team that supports clr, and we will try to respond to as many as we can. If you continue to have questions,

187

00:46:07.250 --> 00:46:16.760

Sarah Allin: and you can see the email address on the screen here, too. So thank you all so much for your time today. And we look forward to more conversation about closed loop referrals in the future.