CALAIM PHM AND CHILDREN & YOUTH ADVISORY GROUPS APRIL JOINT MEETING

APRIL 29, 2024

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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VISUAL	SPEAKER - TIME	AUDIO
Slide 1	Alice - 00:00:07	Hello and welcome. My name is Alice and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the Q&A. We encourage you to submit questions at any time using the Q&A. The chat panel will also be available for comments and questions during today's event. During today's event, live closed captioning will be available in both English and Spanish. Thank you. You can find the link in the chat field. With that, I'd like to introduce Palav Babaria, Chief Quality and Medical Officer and Deputy Director of the Quality and Population Health Management Division at DHCS.
Slides 2-3	Palav Babaria - 00:00:52	Thank you so much, Alice, and huge welcome to our CalAIM Population Health Management Advisory Group and our CalAIM Children & Youth Advisory Group today for this joint meeting on a few really critical topics that span both of these groups. We can go to the next slide. So a few announcements, which hopefully you all are getting a little tired of hearing and have memorized by heart by now, is that we are still in the unwinding period, which means that Medi-Cal members that had continuous eligibility throughout the Public Health Emergency are undergoing re-determination for Medi-Cal eligibility. For some of our members, this is the first time that they're going through that, and we want to minimize the number of people who are still eligible for Medi-Cal who get dis-enrolled for procedural reasons as possible. So if you haven't already, please join our ambassador mailing list and also check out the Unwinding Plan. And we can go to the next slide. And please keep sharing the Community Covered Resources Hub and the Medi-Cal facing websites that are linked in this meeting.

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VISUAL	SPEAKER - TIME	AUDIO
Slides 3-4	Palav Babaria - 00:02:00	And then perhaps most excitingly, as we DHCS continue our journey to become a data-driven organization, we hope that you all are leveraging the Continuous Coverage Unwinding Dashboard as much as we are, which really allows for specific demographic and geographic insights to really see what's happening in local communities and local trends around enrollment and renewal data, which has spotlighted a lot of opportunities that we have collectively across the state. We can go to the next slide. So we have a jam-packed agenda for the next 90 minutes together today. We are going to be looking at our ECM, specifically focusing on the recently released Children and Youth Utilization data for the first quarter of our Children and Youth Population of Focus, as well as introducing draft new referral and authorization standards, which is part of our action plan to improve ECM and community supports roll out across the state and has really come about based off of the feedback of pretty much everyone on this advisory group as well as the larger state who's involved in this program.
Slides 4-5	Palav Babaria - 00:03:10	Then we'll have Dr. Jeff Norris, who is our Value-Based Payment Branch Chief here at DHCS, present on our Equity and Practice Transformation Payment Program, which launched earlier this year, and then we'll look at upcoming meetings. We can go to the next slide. So before we turn it over to our member's story, just a reminder that we very intentionally keep this meeting as an open chat. So we obviously want to hear from everyone on our advisory group, but really we also want to hear from all of you who have joined this meeting who have tons of expertise and thoughts and feedback to share with us even if you're not formally on the advisory group.
Slide 5	Palav Babaria - 00:03:48	So please make use of the chat. We capture all of it and really do take all of that feedback very seriously.

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		As is our normal custom for the Population Health Management Advisory Group, we really want to root and ground everything that we are doing for pop health in our member experiences and member stories. So really thrilled to introduce Sarah Christensen from Inland Empire Health Plan to walk us through one of those member stories. Sarah, I will turn it over to you.
Slide 5	Sarah Christensen – 00:04:18	Thank you so much for having me. Can you hear me?
Slide 5	Palav Babaria – 00:04:23	Loud and clear.
Slides 5-6	Sarah Christensen – 00:04:24	Okay, great. Thank you. Yes, I'm Sarah with the ECM department. I work with the Riverside team two location, and we serve the Perris, Riverside and Moreno Valley area. We currently have 15 members that are part of the peace population on our caseload, and this is one of those stories, Ms. baby Sarah. So I do want to emphasize the importance of our persistence on engaging the caregiver and team member, I'm sorry, the family member of the child because that's ultimately who our connections are with. So our biggest struggle with our peace population is making those connections and engaging the family members, and we had that example in this story. So I had tried to reach Ms. baby Sarah's family for over a month with multiple voice messages and doing a cold visit to the home to try to get in contact with the family. I left a brochure at the door, still no success.
Slide 6	Sarah Christensen – 00:05:22	So again, with the persistence the next month doing the same thing, I happened to take a chance in the parking lot outside of her apartment unit. I've seen a mother with a toddler matching that same age of the member that I'm trying to make contact with. I happened to approach her, and she confirmed she was the mother. I said, "I'm so sorry, I've been trying

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		to reach you. I'm not sure if you're receiving the voice messages." And the messages, she confirmed. She did receive the brochure also at the door. She said, "I'm very busy. I'm on my way to an appointment right now." "Not a problem. Here's my brochure, here's my contact. I just wanted to see if you guys had any struggles with health and wellness and if you guys are struggling or having any difficulties with baby Sarah's health. Please give me a call. I'd really love to help."
Slide 6	Sarah Christensen – 00:06:09	So she was initially cold and hesitant, but that broke down some barriers. She said that she was having some issues with rent and health concerns of baby Sarah, and she said, did we provide housing? I let her know that IEHP does have a Community Supports department that helps with housing navigation and sustaining services. And if she would like me to put in that referral, she agreed. And so I asked her a little bit more about the health of baby Sarah and also a little bit more about the rent situation she was facing. She let me know that she was a single mom, working mom with three young children, and unfortunately have been facing some concerns with baby Sarah's health. And unfortunately, she had suffered some abuse at her local licensed child care and she was having APS, I'm sorry, CPS and law enforcement and an attorney involved, not to mention a new diagnosis of autism that she was showing some increased in triggers and so needed more appointments.
Slide 6	Sarah Christensen – 00:07:12	She said because of all the appointments that she had, she was missing work and had fallen behind on rent. I provided resources to food banks. I provided our IEHP Call the Car transportation so that gas costs were not going to be an issue with connecting with treatment. I also provided the Autism Speaks Connection. I let her know that someone from housing would be contacting her, but to screen

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		every call and that we would follow-up. She said that one of the triggers to baby Sarah was unfamiliar places and faces, and so she was in fear of losing the only home that baby Sarah has known. I followed up with her probably less than two weeks from that initial meet, and she was so excited to announce to me that a housing agency did contact her, and they were helping her move from her one-bedroom, one-bath to a two-bedroom, two-bath.
Slide 6	Sarah Christensen – 00:08:05	She said that the housing agency was also helping her with new furniture, which was unexpected. She said with the new space available, she was very happy that baby Sarah was going to be starting ABA therapy and now she can have that ABA therapy in the home. So she was just very grateful and appreciative to the connection. We also started diving into her health appointments that were coming up. She had told me she had a specialist appointment in 2025, so that was concerning to me. I relayed the concern of the delay in treatment and asked if I could redirect that referral. She had no idea that you could do that. I quickly got on the phone on speaker, contacted the provider who initiated that referral and let them know of the delay in treatment and that we needed to redirect that referral to an available provider can see her sooner.
Slide 6	Sarah Christensen – 00:08:57	So she was super appreciative of that. The next visit, we made contact with her, and I tried to ask her how ABA therapy was going. It was going to be about a week into ABA therapy. She says, "You know what, Sarah? I unfortunately never started. They called, they canceled, they rescheduled." She says, "And now they're telling me that ABA therapy isn't going to happen until the following week." I said, "Oh my gosh, I'm so sorry to hear that." She says, "Yes, her behavior has become more of an issue, and she really needs this ABA therapy started." She says, "Is there any way we can redirect

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		that referral?" So I, "Absolutely." So that right there just showed me that she was understanding how to navigate through her healthcare plan and benefits. So she said she didn't know any ABA therapy providers, and that's why I love working for IEHP because all those resources are at my fingertips.
Slide 6	Sarah Christensen – 00:09:48	I quickly jumped in our Microsoft Teams chat. I reached out to our internal Specialty Kids Intervention team, also known as SKI. Reached out to them, let them know the situation, asked if there was any BH providers in the area. They provided me this beautiful resource list of all the BH providers in that area that provide ABA therapy and filtered beautifully by location, hours of operation, in-home versus at the clinic. So with the mother, we filtered it down. She chose one of her liking and we helped with the referral redirection on that as well. We're still actively caring for baby Sarah. She is probably shy of two months of us actually making that first initial contact. So I'd just like to highlight the importance of being persistent on engaging the families and the parents or the caregivers or guardians, whoever's caring for that child because had we not taken that chance in that parking lot, baby Sarah's story probably wouldn't have been as successful.
Slide 6	Sarah Christensen – 00:10:51	So we also, we have talked with the mother, and we discussed the plan moving forward. She wanted to wait as baby Sarah got settled into having her healthcare needs met, but we are going to be actively enrolling the mother as well. So a lot of the times what I'm coming to find out is that with these pediatric patients, there's always a family member or caretaker involved that is not so much or taken a backseat on their health and wellness as well and so we really like to just have that full circle of supportive services. So I almost always enroll the family member or the caretaker that's taking care of

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		the child as well, so we can have that full circle of the care. And our ultimate goal is just to have them understand how to navigate through their healthcare plan and benefits, understand there are resource and support services out there. And in this story, you can already tell that that's taking place. So we're going to be continuing to take care of baby Sarah. And yeah, so thank you so much for allowing me to share that story with you guys.
Slide 6	Palav Babaria – 00:12:01	Sarah, thank you so much. And first and foremost, just thank you for the care and attention that you bring every single day in serving our Medi-Cal members and for sharing that story with the entire advisory group at this meeting today. I know we'll dig into some discussion questions with our advisory group and you and our other planned care manager later in the meeting today. A few things that I'll lift up. One is this is just one example of Sarah's story about this two-year-old child that as we look through the numbers, we're going to look at behind every single one of those numbers is a real individual child, youth family member who really desperately needs these Whole Person Care services.
Slide 6	Palav Babaria – 00:12:43	The other few things, as we look through our referral and action plan, clearly outreach attempts were made here and it really took that face-to-face engagement and outreach to get to the progress that's been made to date. And I think that underscores why the department has felt so strongly that ECM really does need to be a face-to-face community and member-centered benefit. I think the other things to lift up is that the housing and behavioral health interventions are so critical for this family and really thinking about the full spectrum of services that our members need is really essential. And also just that it takes time to build this trusted relationship to see the outcomes

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		that we're hoping to get to. So thank you again and we'll dig in more soon.
Slide 6	Sarah Christensen – 00:13:28	Thank you for having me.
Slides 7-8	Palav Babaria – 00:13:29	We can go to the next slide. So I think that's just a nice way to kick off the data that we are going to look at. So for those of you who missed it, we did update our public-facing report for ECM and Community Supports to include all of the quarter three data. So this included data from July, August and September of 2023, which was the first quarter that our Children and Youth Population of Focus went live. It includes data on members under age 21 and really looks at also penetration rates by county and plans so that you can see how uptake varies across the state. And again, we want to push out all the data that we have as rapidly as possible to all of you and the public and plans and providers who are working on ECM and Community Supports. So we anticipate also getting quarter four data out by June of 2024. We can go to the next slide.
Slide 9	Palav Babaria – 00:14:26	So I think a few things to lift up, starting with the April report that we published. This is the data that all of you can expect to see publicly in every single report. So we are publishing statewide data with an explicit call out of what percentage of that statewide rate is ECM members under age 21 so that we can really track the uptake for members under age 21. We also stratify the total ECM members by population of focus. We recognize that in some parts of the state, there is more infrastructure for certain populations of focus than others and really making sure that we're building out that network and reaching some of those newer populations of focus as an explicit priority. And then we also show the provider contracts. So we'll be digging into that, but I think it gives you a high-level overview of what

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		the capacity is of ECM across the state and how much it's actually being utilized.
Slide 9	Palav Babaria – 00:15:18	We also provide drill-down detailed data at the MCP level and the county level for ECM members under age 21 and the penetration rates as I mentioned. So for all of you working locally in your communities, I think that that data and information is really critical to understanding where there are gaps locally and working together to fix them. And in exciting news, our PATH learning collaborative facilitators also are looking at this data regularly and leveraging the PATH learning collaboratives and the CPI groups to really help problem solve and support local entities. So if you are trying to increase ECM and Community Supports activity, please check out our PATH resources as well. We can go to the next slide.
Slide 10	Palav Babaria – 00:16:05	So a few things to lift up. You will see calendar at the bottom, quarter two of 2023 was our last quarter before the Children and Youth Population of Focus officially went live. At that time, we did have 2,928 children enrolled in ECM. Largely, they were either grandfathered in from previous Whole Person Care or Health Homes pilots and or were tied to populations of focus such as those experiencing homelessness that went live a little bit earlier. And so in the first quarter, the exciting news is that the enrollment for children and youth, just even in that first quarter of ECM go live for this population of focus more than doubled from the previous quarter. And we are still looking internally at Q4 data, but it is showing similar promising trends. And so we are seeing a steep uptake of the ECM benefit for children and youth.
Slide 10-11	Palav Babaria – 00:16:58	That being said, we also know that the penetration rates, i.e. what percentage of children who are eligible are actually receiving this service are really,

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		really low and in general, definitely lagging behind how many of the adult populations we're reaching. So there is still tons of need and opportunity to get this benefit out to all of the children in youth that are eligible. We can go to the next slide. A few things to call out here. So you'll see this is the breakdown of which populations of focus had greater uptake. So not surprisingly, children and youth who are at risk for avoidable hospital or ED utilization or those experiencing homelessness as well as those with behavioral health needs had the highest rates of uptake. These are also more established subpopulations of focus where we had more activity happening under the Whole Person Care or Health Homes pilots, as well as some earlier eligibility for those individuals' experiencing homelessness.
Slide 11	Palav Babaria – 00:17:58	Where you will see the uptake in quarter three was very low was those children and youth transitioning from incarceration. This is also to be expected because our justice-involved pre-release services had not gone live, haven't gone live at all anywhere in the state. And then at this point, our justice-involved ECM population of focus that we've been intentionally working on had not gone live. The children and youth involved in child welfare as well as those children and youth enrolled in California Children's Services who have additional social needs, the uptake was very low. And those are two areas where we definitely need a lot more partnership and intentional thinking as to how we identify these children and get them linked to ECM because this uptake is incredibly low compared to the number of children and youth that are eligible. We can go to the next slide.
Slide 12	Palav Babaria – 00:18:54	This slide is also split up in the same order of subpopulations of focus and shows how many provider contracts exist for this population of focus.

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		And that basically says, for example, children involved in child welfare. We have 357 provider contracts across the state. Our team did a very detailed review of the model of care submissions from each and every managed care plan. So all of the care plans when this population went live had, sorry, I was just looking at the chat questions, detailed submissions about what their network looked like, where they had gaps, et cetera. We know that these provider contracts have been steadily increasing since Q3, so there's definitely more providers today than there were back in July.
Slide 12	Palav Babaria – 00:19:42	But what I take away from this data is each provider obviously can care for multiple children and youth, one contract does not mean one child. And in general, we have a pretty broad network in place and the network is broader than the uptake that we have seen. So there is, in aggregate across the state, a lot of capacity to provide ECM for children and youth that is not being utilized. And so while our managed care plans and partners continue to grow the networks, I think the urgent burning platform challenge ahead of all of us is how do we get children and youth who are eligible connected to the existing providers because they have space and they have contracts, and yet we are still not effectively connecting children and youth to this benefit. We can go to the next slide.
Slide 13	Palav Babaria – 00:20:29	So we will do a deeper dive into all of this data, but before we get there, we're going to stop to turn it over to Patricia Washington Gordon, who is going to tell us a little bit about a member story from Molina Health Plan. Patricia, I will turn it over to you.
Slide 14	Patricia Washington-Gordon – 00:20:48	Well, good afternoon everyone. That was a mouthful, my whole government name. My name is Tricia, and I am the manager for the Community Support department. I recently joined Molina in

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		mid-January. I'm not unfamiliar with CalAIM and ECM. I just want to begin by sharing how ECM has been impactful just all across the health plans, but of course, especially for our Molina members. And the story that I have for you exemplifies how significant these resources are and can be in enhancing the lives of our members. So we have a single mom of four children who was homeless unfortunately, and living in her car with her children. And our ECM team paired her up with an ECM provider that worked with her not just to get a roof over her head, but also to provide some level of stability and security.
Slide 14	Patricia Washington-Gordon – 00:22:01	And the ECM provider, Ms. Marissa, received personalized support from her lead care manager that her care plan and her needs were basically tailored to her unique situation. They were dedicated to helping her. This lead care manager worked very tirelessly to understand Marissa's needs and her aspirations, crafting a roadmap towards sustainable housing. So Marissa was also involved in Community Support. And another unique feature here, they walked her through finding a job. Now you don't hear that too often about ECM and Community Support providers helping members find job. It's not built in, but it's a unique situation and so this was offered to Marissa.
Slide 14	Patricia Washington-Gordon – 00:23:00	So their focus was on her managing also her health of her children so that Marissa could find a position for work. The lead care manager accompanied Marissa through the process of finding a home and used funding provided by Molina's Community Support program to help pay the deposit and rent for her new home. So this transformation for Marissa and her four children was very profound. With the assistance of the ECM provider and the ECM and Community Support area, Marissa did find a place to call home, but the support did not end

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		there. So understanding her need for a stable environment, the ECM provider also provided Marissa with essential furniture for turning her new house into a home for her and her four children. And that is our member story for this family that was experiencing homelessness.
Slide 14-15	Palav Babaria – 00:24:09	Thank you so much, Patricia. We can go to the next slide. So we're going to put on the slides in a second so we can have a conversation, but inviting our care managers from both Molina and Inland Empire Health Plans who've been serving children and youth in those health plans, as well as other health plan team members who are on our advisory group to weigh in. We would love to hear a little bit directly for you, and we can take these questions one by one, and I'll read them out to you. But first, we'd like to start to invite both of you to share how did you tackle launching the ECM Children and Youth Benefit? Did you think about this as specific, the whole population of focus at once? Did you tackle subgroups? What have been some of the challenges and lessons learned as you've done this? If we can take down the slide, that would be great.
Slide 15	Neeta Alengadan – 00:25:07	Sure. So this is Neeta with Molina Healthcare, I oversee the ECM and Community Supports programs for our health plan. And I will say with child and youth, we didn't look at a specific delineation or some population, we looked at child and youth as a whole. And looking really at our network who we had as experienced ECM providers, you saw in the earlier slides we did have medical providers such as FQHCs who were already plugged in with that population. So starting there to just start with the network and making sure we had folks available to receive the population, and then expanding out from there. We have homeless services agencies that we were already contracted with who are experienced, right? They're working

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		with families, not just as an individual. You saw that in Tricia's story where the child was identified as part of the homeless, the child and youth homeless population, but the mother also qualified for ECM, and we were able to take care of the family as a whole.
Slide 15	Neeta Alengadan – 00:26:11	So a lot of our providers did have that experience already. So really first starting with our existing network and then we branched out to our other network providers who are pediatric partners, right? They're already experienced with that population, not currently contracted as an ECM provider, but how do we work with them and get them going in that space to share those requirements? And a lot of them had been doing that kind of work already because they are so closely connected to that population. So it was really looking at that and seeing how we can support them, maybe through IPP funding or other opportunities to get them ready for ECM in that aspect.
Slide 15	Neeta Alengadan – 00:26:57	And then we also benefited from our collaborative relationships with the other MCPs in certain regions. So I can say for example, San Diego, we're very known for being very collaborative there where we came together as a work group and identified the major provider there being Rady Children's Hospital and how do we work with them, establish certain referral pathways and things like that so that we were partnering on that contracting effort as well. So I think all of that really helped us inform our approach and think about it from that lens. So maybe not specific subpopulation, at least for us, but starting with our existing network then branching out and identifying additional opportunities.
Slide 15	Palav Babaria – 00:27:45	Thanks, Neeta. One more follow-up question for you before we turn it over to Takashi and IEHP. I'm

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		curious, one of the common challenges we've heard about the Children and Youth Population of Focus is there are a lot of subpopulations and honestly, the needs of each of those subpopulations is very different from one another and probably much more diverse than some of the previous adult populations of focus that have gone live. So how did you all think about the model of care as well as your provider network to really address those unique needs as opposed to having a one-size-fits-all approach?
Slide 15	Neeta Alengadan – 00:26:57	Sure. So with the child and youth population, right, there were a lot of things that we had to consider to operationalize. The whole consent process becomes different, right? What you're asking for and looking at sensitive services, things like that. So we actually, in one of the collaborative counties and then we expanded that, is developing a specific children and youth assessment that addressed differences that you normally wouldn't have in our adult assessment, right? So that approach. And then looking at our existing providers who okay, who does have that experience with foster care youth or children welfare, right? Who's already plugged into those systems or receiving that. And I was pleasantly surprised as working, getting more familiar with some of our network where they're already in that space, right? Working with those folks. And it's just a matter of us understanding their programs and the infrastructure that they have to support more specific populations.
Slide 15	Neeta Alengadan – 00:29:25	And then especially working with our county partners, right? County behavioral health and how they have those programs that address children with SMI, SUD, and their youth programs as well and how that folds into ECM. So we did look at just looking at it from that lens, right? Children have a very specific need that is not covered in all the

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		things that we were doing with our adults. Our referral forms needed to be updated, our training for our providers on how the folks that are requesting consent, documenting consent, when you talk to the parents and that release of information, all of that we modified and tweaked. And I will say again, collaborative effort with some of our other managed care partners in our counties that we service to come up with that on what makes sense and give that support and guidance for our stakeholders.
Slide 15	Palav Babaria – 00:30:22	Thank you so much, Neeta. IEHP partners, we'll turn it over to you to also tell us about how you've thought about launching this benefit and some of those same questions around really creating unique, appropriate providers for each subpopulation of focus.
Slide 15	Takashi Wada – 00:30:36	Okay. Well, great. Thank you for having me and thank you to the two presenters for the member stories. I mean, those were just wonderful examples of how effective ECM can be in terms of working with these very complex members and their families and getting good outcomes. So just great presentations there. For IEHP, we had participated in the Health Homes program of course, and got very good outcomes, clinical outcomes from that. And then that transitioned on the adult side to ECM. And our basic model was really this, our preferred model was this four-person care team with a nurse care manager, a behavioral health person or social worker, a community health worker, and then some type of coordinator. And it was very primary care-focused. And so we felt that that was really valuable to have these ECM teams located out of the PCP offices, whether they're a clinic or an FQHC because the physician is right there, and they would have

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		that relationship that referrals are getting generated out of there for care planning.
Slide 15	Takashi Wada – 00:31:47	It just made the most sense and we felt that was going to be the most effective, and we got good outcomes again through the early results from ECM on the adult side. But as we thought about the Children and Youth complex children population of focus, we didn't want to make the mistake of thinking that children were just little adults. And so we started six months, maybe even a year prior to the go live of reaching out to key stakeholders who we felt were going to be key partners on the Children and Youth Population of Focus. So our county programs, certain CBOs, other clinics and stakeholders to talk to them about what is this going to look like because we have a feeling it's going to be different than what we've done with the adults. And the feedback that we got was that it was going to be different because with children, if you have a child in CCS for example, that close relationship is going to be with the specialist.
Slide 15	Takashi Wada – 00:32:44	They may not even be seeing their primary care provider or that maybe the trusted relationship in a child that has emotional disturbance is going to be with the CBO or some other type of provider. So we really approached this as we're going to need a very diverse network and we're going to have to be a little bit more flexible with our preferred care team model. And so initially, just because we had a number of these adults teams that we queried and said they would be willing to see some of the older children, whether they were homeless and things like that. So our initial network for the children was our existing network and they just expanded the age ranges. But as we went further, we realized we had the contract more broadly. So in terms of contracts or contracts that we're working on, a very important partner was the counties, I think they may

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		even be on this call because of the overlap potentially with some other county programs, whether it's CCS, child welfare, and they had the assigned public health nurse, the behavioral health department.
Slide 15	Takashi Wada – 00:33:51	And so we felt that the counties were going to be key individual ECM providers. Pediatric specialists, so we had some specialists like a sickle cell clinic that had a very specific targeted population that we thought was going to be very important for us. We had another clinic that specialized in children with trauma as well as the CBO. Again, with children with trauma, they had a very high percentage of foster children. So we also looked at our children's hospitals because a lot of, again, CCS kids are going to the children's hospitals. So we got our children's hospitals or we're in the process of contracting with our children's hospitals. And then of course, the behavioral health network as well. So we really had to go more broadly in thinking about who's going to be that key partner as an ECM provider for the complex children.
Slide 15	Takashi Wada – 00:34:47	I would also like to mention with the counties, we had a lot of discussion with one of our counties about the complexity of all the different county programs. Again, you could have a single child, they could be in CCS program, they could have involvement with their department of behavioral health, they could be a foster child in the child welfare system, they could be in the justice involved. And then our county also has an FQHC clinic. And so how would you know where that child should land in terms of attributing to an ECM team? And so it's very complex because we didn't want that overlap or duplication of services.
Slide 15	Takashi Wada – 00:35:29	And then how do you coordinate across when all these different providers are touching the same

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		child? So we've actually been working with them, and this is still something in progress, but we've been working with them on a more innovative pilot model where before they get assigned to an individual county ECM team in one of those respective departments, we're going to have an upfront access and assessment team that has multidisciplinary multi-departmental representation to help assess that child that's eligible for ECM and then determine which is the best team that that child should land in and then help coordinate across.
Slide 15	Takashi Wada – 00:36:05	So that was something that we're working on with one of our counties, with Riverside County. In terms of the actual model of care, we also had to be more flexible. We decided to lower the caseload expectations for the complex children because the feedback that we got was that you have to work with the family, you got to work with the schools. It may take a little bit more time. Engagement is another big issue. We have engagement issues on the adult side as well. Our experience there, sometimes it takes 20 or 30 outreach attempts before you gain that trust in an individual with SMI or that's homeless. Not that much different from children, trust is very important in building those connections.
Slide 15	Takashi Wada – 00:36:51	So we have a lot of community connections. We're putting CHWs in schools as navigators to help with that, identifying the eligible and getting them enrolled. We have community health workers that are just out in the communities and fields and through other types of partnerships, really trying to get that. And then we have our regular referral pathways as well through hospitals, through the clinics, of course. We provide targeted engagement lists, other leveraging community-based organizations. We attend community events. So it

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		has been a slow ramp up and rollout. And again, a lot of this is still in progress, but we feel that we're really building toward increasing utilization and effective outcomes.
Slide 15-16	Palav Babaria – 00:37:43	Thank you, Takashi, so much for sharing. We'll put the slides on because I know we're, like usual, a little bit behind schedule and I want to give our advisory group members a chance to weigh in. But I think what we are all, we can go to the next slide, I think what we are all hearing is what we all know, which is it is complicated rolling out this benefit for children and youth. We as a state have a lot less experience in this space than with some of the adult populations of focus and it's going to take some trial and error and scaling to get it right and consistent statewide. So let's open it up to our advisory group. If you want to use the raise hand function, we will call on you and feel free to speak onto any of these points. So as a reminder, our Children and Youth advisory group has looked at these domains before.
Slide 16	Palav Babaria – 00:38:29	Some of the major needs that we know we have are how are we going to identify children and youth who are eligible for ECM and refer them and get them connected to this benefit? What are some of those local strategies that have proven successful? And our goal and vision is that as close to 100% as possible of referrals come from the community or someone who already knows that child and family as opposed to cold calling and outreach from data mining. The second piece is really around the provider network so that we can get providers who really do have explicit experience and expertise to serve the unique needs of each of these subpopulations. And then the third bucket is thinking through, given that many of these children and youth are already enrolled in other programs, how do we maximize continuity for the child and

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		youth and their family as well as coordinate with those other programs? So I know you all know this, but this is just a recap. And let's start with Kim because I saw your hand first.
Slide 16	Kim Lewis – 00:39:26	Thanks, Palav. Kim Lewis from the National Health Law Program. Thanks for going over this. I have to say I'm overwhelmed by it as I'm sure you know this is slow rollout for sure, but particularly concerned I think about some places where the largest counties have zero enrollees, like LA County, no foster care kids at all enrolled in the ECM. And I'm wondering, I do hear a lot of feedback in LA about managed care doesn't work for our kids and yet a lot of the kids are in managed care, which raises the bar for me or the question on if they're not a parent that they are doing things for kids in foster care, then it's not going to help the cause in getting kids enrolled in managed care. So it seems to me really to the question of targeting our strategies, there's the MOUs required between child welfare agencies and managed care plans and other mechanisms to try to have more close relationship building.
Slide 16	Kim Lewis – 00:40:30	But I would certainly expect that those large plans, and especially in those big counties where the highest population, like LA Foster Youth of the state, would do a better job of actually outreaching to the child welfare agency and getting together on all of the kids that need to be identified and getting them in. And that would've started before they actually started to roll out, but the fact that it's zero in the first quarter makes me think that nothing is happening to that effect to really use those strategies. So I'm wondering if we could identify some of those places where there's opportunities to say like, "Hey, this is pretty poor."
Slide 16	Kim Lewis – 00:41:07	And I know that child welfare agency will be very shocked when I tell them it's zero, but I told them

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		263 is low enough, but zero in LA is pretty bad. And there's more contracted providers that you mentioned 357 contracts, there's only 263 enrolled. So that also makes me think what's happening there. So I'm just wondering if we can be really specific with these populations of focus and say we expect youth plans to do this and this as opposed to, we hope you do this.
Slide 16	Palav Babaria – 00:41:41	Thank you, Kim, so much for bringing up some of those obvious conclusions from the data. The short answer is we completely agree. The longer answer, which we can get into more offline in the interest of time, is that one, all of you who know me know I wish we were at capacity and at the numbers we want to see yesterday, but this really is going to take some time to build out those relationships. So a few levers which I think will help us get there faster is as of the 2024 contracts, the MOUs are being executed. We know that in some areas, the MOUs between counties and child welfare departments have not yet been signed or are still in the negotiation process. But that relationship and that MOU is critical for both those entities to start sharing data, collaborating, especially because we know especially foster youth, we need to build trust and we need to earn that trust.
Slide 16	Palav Babaria – 00:42:35	And often, the partnership with the child welfare agency and case managers that already have that relationship are so critical to having that child and their caregiver accept the ECM benefit. So we know that the rates of denials are higher for some of these populations, and we need to get that in place. Secondly, we also know that as a part of the new managed care contracts, all the plans will be required to have a child welfare-involved liaison position. That is still also building up, but that is another critical tool in our toolbox to help connect more deeply with both the county and service

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		providers in this space and be a point of expertise and contact on the managed care plan side.
Slide 16	Palav Babaria – 00:43:15	And I think that either the draft or final APL is coming out soon and there is absolutely ECM language in there. And then thirdly, I think all of you know, either director boss is really committed to this population and has already done individual outreach to all of the CEOs based off of that quarter three of data. So there's a lot of high-level attention focused specifically on that subpopulation. But all of those things I think in concert, we should hopefully be seeing the fruits of some of those interventions soon. Phoebe, go ahead.
Slide 16	Phoebe Bell – 00:43:47	Yeah. I mean, I think one of the things to think about, there's a few different ways to think about the uptake. And to me, in our county, we, the behavioral health department are an ECM provider for a number of adult populations. And the place where it's made sense for us, marginally at least, is places where we have a harder time building the specialty mental health system. And so our outreach work and our engagement work with our unhoused residents, things like that, that's where it's been the closest to a fit. We spent quite a lot of time trying on for size becoming a children's ECM provider, working with our providers around should they become a children's ECM provider, how does it fit together with the specialty mental health or behavioral health system? And honestly, I think it's a more powerful mechanism in places where there's not already the ability to provide case management.
Slide 16	Phoebe Bell – 00:44:40	If you can provide case management in the specialty mental health system, it's a more comprehensive and better way to go. And so it's helped us dig deeper into the case management work we're doing but not needing to bring a new way of doing that on board, and that's where our providers landed as

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		well. If you're a physical healthcare provider that didn't have a lot of case management capacity before, it might make more sense or other entities that aren't doing that work. But I don't know, I think to some degree it's the lack of uptake in some places reflecting that there's already capacity there that can be maybe strengthened and bolstered certainly, but isn't from a lack of people wanting to do that care coordination, it's just being done differently.
Slide 16	Palav Babaria – 00:45:27	Really great points, Phoebe. Thank you for lifting up. And I would say all of us collectively, it will be helpful to understand how much of that existing case management truly is Whole Person Care, which clearly from the stories we heard is what our members need versus maybe focused on a more narrow subset of conditions for services. Chris, I see you're next.
Slide 16	Chris Stoner-Mertz – 00:45:52	Thanks, Palav. Just trying to maybe put a little finer point on Kim Lewis' comments. When we talk about MOUs and the plans having requirements, my question is how bi-directional is that when it does come to child welfare or other systems? Because I don't see anything, for example, coming out from CDSS around how the departments can be working with the plans. And so I do think, I'm curious at the state level how much the departments are working together around this. I think it's so critical that that support and relationship you talked about Palav and trust building, and that takes time between these different organizations that have not worked together before. But we're certainly seeing it on the ground, and I see Camille made a comment on who runs our full circle health network. It's really challenging to get that kind of information flowing across agencies and plans.

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Slide 16	Palav Babaria – 00:47:11	Thank you so much, Chris, for lifting that up. We agree and so all of our state partners, other departments have absolutely been involved in the MOU creation process, they have all reviewed the specific MOUs. Obviously, DHCS' authority really is on the managed care plan oversight, but other state departments have looked at the language and informed and weighed in for the pieces that are outside of our purview and jurisdiction. That being said, the same silos that exist locally exist at the state level, too. And we're continuing to partner with them, not just on the language, but how we roll this out and support both of the entities from our various perspectives and set them up for success. Alex, let's go to you.
Slide 16	Alexandra Parma – 00:47:58	Hi, everybody. Hi, Palav. I'm Alexandra Parma with the First 5 Association and First 5 Center. And my comment is regarding the building up of networks of providers for ECM and for some of our First 5 members who have been interested in becoming Medi-Cal providers or supporting their child-serving partners and in doing so, they've really found the community health worker benefit to be a more natural place to start, less overwhelming because community health workers are a provider type that really fits in with the workforce of many of their programs and it's just less complicated than ECM.
Slide 16	Alexandra Parma – 00:48:31	But for those who have made it through that process, now they're thinking about ECM. So I just wanted to lift up the fact that that's happening, that there's a provider pathway to start with community health worker and then move into ECM. And then one of the challenges for others to follow in this path I think is that there's just fewer TA dollars and capacity building supports to start there at community health worker services than there are for ECM and Community Supports through PATH or IPP. So I just wanted to lift that up as an opportunity

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		to build a pipeline and some of the First 5's finding community health worker as a natural place to start.
Slide 16	Palav Babaria – 00:49:06	Thank you so much. And I will remind everyone, we did add community health worker uptake into some of our state-level IPP measures and so plans are looking at how to incorporate that into their IPP programs as well. Mary, let's go to you.
Slide 16	Mary Giammona – 00:49:23	Thank you so much. Thank you so much, Palav, and everybody who's shared. I think a couple of experiences we've had, and Neeta has mentioned that, and I think we've seen it in the stories as well. It's so multi-leveled to implement something this important and this broad, first of all, to find the community partners that are able to go ahead and focus on so many different levels of what children need. I think when you look at the adult population, there are many of the similar kinds of things that adults have that children have. But with children, you have the additional layer of family, you have their clinical problems that can be quite different than what adults have. And we have a lot of different case management programs that are already working. I thought it was very telling in the IEHP story that the mom had said, "Yeah, I got your messages, but I'm so busy" she didn't answer.
Slide 16	Mary Giammona – 00:50:36	And yet, she found out so many of the rich resources that this program had. So that what we have found, and I think that maybe might not have come through as clearly in our story from Molina, is that finding these trusted resources that are already there and having them become ECM providers has made a big difference. One of the programs we've worked with, for example, is CHLA as well as RADI. And so for our CCS population for example, they really have made a difference because they're identifying youth and kids that they say they need this on top of their CCS program because of their

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		social determinants of health. And then while they're seeing a kid in clinic, they can say, "Look, we have this. What about it?" And the persons were already there. What they're busy with is what's already happening, for example, at CHLA, and they pick it up. And that's an outreach that doesn't have to wait for someone to catch them in a parking lot, you know what I mean?
Slide 16	Mary Giammona – 00:51:43	So I think identifying as providers for children, having the providers that already are working with the kids has made a big difference. And that's what we're encouraging folks to try to do, in mental health and certainly in foster care as well. There's still so much more to do, but that's been a big difference that we have seen in getting more kids enrolled in ECM because you've already got them in their networks and I think that was one of your visions, Palav. So that's one thing that I would say. As far as worrying about duplication, not really if you're offering additional services from what you're generally providing.
Slide 16	Palav Babaria – 00:52:26	Thank you so much, Mary, and really great points. Clearly, this is a very hot topic. So we're going to take everyone whose hand is already raised and then Michelle, you'll be the last commenter so we can move on to the next portion of the agenda since we are running behind. So Caroline Sanders, you're next.
Slide 16	Caroline Sanders – 00:52:43	Thanks, Palav. Cary Sanders with CPEHN. Just a couple thoughts. I think on the question of CBOs not developing contracts with MCPs, I think part of what we have seen as we've monitored the PATH TA Marketplace and the infrastructure funds is that it's really difficult, it's been really difficult for partners to access those funds. And if you're providing preventative CHW services, I mean, there's no infrastructure or funding or support to contract with

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		plans as we know. So what is available is it's incredibly complicated to apply for funding or for technical assistance. And as a result, a lot of our partners who've tried to access funds just say that they haven't been able to because of how troublesome it is.
Slide 16	Caroline Sanders – 00:53:53	And so I think mainly it may be working for some of the larger nonprofits, but for smaller nonprofits, it's still very, very difficult. And I think as a result, we're not getting the reach that would be helpful to see. And that's also extending to certain populations, like we know for native and indigenous populations, there's been a lower uptake in terms of contracting and the TA and infrastructure funds as well. So yeah, just focusing in on that TA piece because I think what is available is only available to folks in the ECM, Community Supports and it's an extremely high bar even there. And then forget about preventative services, there's absolutely nothing to help with contracting. Thanks.
Slide 16	Palav Babaria – 00:54:54	Thank you so much for that feedback, and we will take that back. And I do know the department has been really looking at how we can leverage hubs more successfully in this space, and many of them were funded through some of the previous PATH CITED rounds. So lots more to come on that. And I also want to lift up one comment from the chat because of your comment about some of those health disparities is that the data explicitly shows that ECM and Community Supports uptake for non-English speaking individuals, especially our Hispanic and Latinx population and Spanish speakers, is significantly lower than those enrolled in Medi-Cal. And that is a known disparity, which we are talking about internally with our plans and through the learning collaboratives that we need to all

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		collectively address. So just wanted to put that out there. Laurie, let's go to you next.
Slide 16	Laurie Soman – 00:55:41	Thanks, Palav. I actually have two questions, the first one is really building on some of the stuff that's been said about PATH. What do we know about the current ECM vendors for children and youth? I mean, you know I'm continuing to survey statewide the county CCS folks, and what I'm still hearing, and it's still early times, what I'm still hearing is that the majority of vendors that they're aware of and "available" to serve kids in CCS do not have expertise in CCS and in fact are really adult-focused vendors. So I'm really interested in knowing more about that vendor network. The number of contracts looks good, but if they're not suited for children in general and for the populations of focus, then not so much. So that's my first question. Do we have information on what the vendors actually look like? And is that going to be shared publicly? And I'll wait, and then I am going to ask a second question quickly.
Slide 16	Palav Babaria – 00:56:45	I'm trying to get your full maximum impact, Laurie. I wouldn't expect anything less. I will say we have qualitative information from all of the model of care submissions that the plan submitted to us that did ask specific questions about what types of providers they were contracting with, what prior expertise and experience they had serving some of the unique populations of focus. That being said, we know that this, again, this benefit and the network is growing and evolving, and some programs have lots of expertise, like we just joined a Family Voices of California conference last week and one of our children's hospitals was presenting.
Slide 16	Palav Babaria – 00:57:24	They obviously have tons of experience with the CCS population of focus and yet, even they were trying to figure out how do you make this model of

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		care work? What is it that they need? How do you structure the care team? So even where there is expertise, there isn't necessarily a fully fleshed out program that is a seamless experience for our members yet. And so we need a lot more information, so this is not a one-and-done model of care submission review. And we are also starting to look increasingly at some of the quality outcomes and member experience and other pieces to better understand how ECM is working across all populations of focus, so lots more to come.
Slide 16	Laurie Soman – 00:58:01	Okay, and I'll look forward to hearing about that because obviously, that's critical and we all agree on that. So my second question is really about how can we use the data on enrollment to determine who we should be focusing on and how to focus on them. So I'm wondering, for example, are the plans being asked now to focus on, for example, two very low enrollment populations where they're easily identifiable, kids in foster care, kids in CCS? And it seems obvious that every child in foster care should be eligible for ECM just on the face of it. They probably tick off almost all of those boxes.
Slide 16	Laurie Soman – 00:58:41	And at Family Voices, Palav, I believe that was where you mentioned that you thought probably 50% of CCS kids would be eligible. So obviously, 500 kids so far in CCS out of a potential hundred thousand, we have a lot of movement. So how are you planning to work with the plans to get them focused perhaps as a start on these really identifiable populations and bringing kids in? And can we address the issue of more presumptive eligibility for populations like that where we're pretty confident these kids are reachable and eligible?
Slide 16	Palav Babaria – 00:59:19	The short answer is we've already started those conversations with plans. Linnea, you're up next, so maybe you can also comment on this a little bit.

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		And then I think the critical next steps are going to be both referrals and presumptive eligibility, which is our next agenda topic which we will get to right after Michelle. So Linnea, I will turn it over to you.
Slide 16	Linnea Koopmans – 00:59:39	Thank you. Yeah, Linnea Koopmans with LHPC. And I think just a couple of comments about the Q3 data and what to expect going forward, and maybe some considerations for some of the special populations we've been talking about. And as others have said, and I think Palav, you even said this yourself, it's the first quarter of data I think we expected, as with other populations of focus going live, that it's a slow buildup, but that every quarter we see progress. And I think that's exactly what we would expect for the next quarter of data. And then specifically thinking through and top of mind is foster youth because of the conversation we were having here and the conversations that are happening internally within the plans about how do we increase enrollment specifically among that subpopulation. We're having conversations about not only where are their successes and why is that, or what are those plans and their partners doing, but also are there unique challenges or barriers and what are those if they're different from other populations of focus?
Slide 16	Linnea Koopmans – 01:00:50	I mean, we all know the challenge of bringing CBOs into the network, that that is really important work, but it takes time. And that's been diligently a part of CalAIM for the past couple of years, but are there unique considerations? And I think maybe a couple, particularly for foster youth, is I think it's not even just a matter of ensuring that they're presumptively eligible, but that they're being linked to the right ECM provider. I mean, this is a population that is connected with so many other individuals and resources as a part of their care team, but I think having the right ECM provider is really important.

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		And that may not always completely align with just, a quick uptake in the numbers is making sure that you have the right local partners to serve that population. And in many cases, maybe that's the county, maybe it's another provider serving that population, but I just wanted to make that point in addition to just the volume issue, which yes, we want the numbers to be higher too. Absolutely.
Slide 16	Linnea Koopmans – 01:01:55	And then I think a couple of other considerations is one, and trying to dig in more to what the questions are that are coming up here, but is around the issue of consent. That looks different for foster youth than for other populations, as well as this issue of duplication. And I think we realize, and those that are a part of this advisory group have been talking about this for a long time, but that yes, ECM can absolutely be additive but there isn't, it just continues to be one of those issues that comes up and comes up and comes up.
Slide 16	Linnea Koopmans – 01:02:29	And I really feel like if the counties in particular are one of the primary places where these kids are getting served today and could potentially be the best ECM provider, if that's a barrier, I think it probably warrants coming back to and looking at is there additional guidance that could be provided to clarify and minimize that barrier? If it's audit risk and concern, if there's just more detail that needs to be provided so that that's not the thing keeping providers from contracting with plans who are serving these kids and should be serving them under ECM.
Slide 16	Palav Babaria – 01:03:06	Thank you, Linnea, so much. All fantastic points. And I think it goes back to there were so many unknowns with all of these subpopulations of focus and details that we are all still collectively working through. And I think as any and all of you on this call are coming up against some of those challenges

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		or issues, please have a low threshold to email DHCS or ECM and Community Supports' inbox because I do think where there are clear answers, we DHCS issuing at least FAQs, if not more formal guidance as soon as possible will likely help everyone across the state who's struggling with the same questions and issues. Michelle, let's go to you.
Slide 16	Michelle Cabrera – 01:03:46	Thanks, and it really builds off of the last couple of comments so I'm happy to go last here. And really something that Alex Briscoe put in the chat, to underscore Phoebe's earlier point, I think part of what county behavioral health is asking at least is how is ECM going to allow us to do stuff that we can't already do under ICC, for example? Right? And where you have these systems that are very heavily case management-anchored, whether it's CCS or county behavioral health, especially as it relates to foster youth, right? We do need to do a better job I think of emphasizing what the value proposition is. And so I think what you just mentioned, Palav, about providing more information, more guidance, getting more into the weeds on the value proposition would be helpful given how specialized and narrow the target populations are here and the generous array of case management-related services we have.
Slide 16	Michelle Cabrera – 01:04:57	We really are doing Whole Person Care to a large degree for the populations that are already eligible for our services, right? And those populations overlap by definition with the groups that you're trying to target. The other question I have, and this is just a more broad general question, is again, foster youth CCS kids we're talking relatively lower numbers, but how are managed care plans working with their broader networks of children serving primary care for example, children's hospitals, I've heard Rady mentioned, a few others earlier to make sure that those systems that may be higher touch

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		with kids also have good understanding of how they can make direct referrals into whatever ECM providers they may already have available?
Slide 16-17	Palav Babaria – 01:05:54	Great points. And I think you set us up for our referral conversation so lots more to come, Michelle, especially on that last point of learning more about what plans are doing in this space. So let's go on to the next slide deck and I will warn everyone given time, but this is really incredible, useful dialogue. We will be pushing Equity and Practice Transformation Payments to our next meeting, so if you have any burning questions about that, feel free to drop it in the chat. But we will be using our remaining 22 minutes to review the streamlining access to ECM and ECM referral and authorization standards because we are trying to finalize this policy as soon as possible. We can go to the next slide.
Slide 18	Palav Babaria – 01:06:36	So I will remind everyone, I'll try to go through at a high level and leave enough time for discussion. And I will remind everyone that these are draft pre-decisional guidance, so your feedback is very timely and appreciated. If we don't get to everyone's comments today, please feel free to drop additional stuff in the chat or email us directly with additional feedback offline. So this is part of our overall ECM and Community Supports action plan that we've rolled out last July, and we are really focused on this bucket two, streamlining and standardizing referrals and authorization. We can go to the next slide.
Slide 19	Palav Babaria – 01:07:15	So we have heard from plans, providers, members, pretty much everyone that the current referral processes vary from plan to plan. They can sometimes be a barrier to people who are trying to make referrals. Michelle, that explicitly dovetails into your last comment. And really having some streamlined statewide standards would be very

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		helpful, especially in those areas where there are multiple plans that a single referring provider may be working with and that without doing that, we are unlikely to meet the department's goals of having a hundred or as close to 100% as possible of our referrals from the community. Also dovetailing on some of Laurie's previous comments, we also know that for certain key populations of focus and provider types, the presumptive authorization policy is really critical to getting this benefit to eligible members as quickly as possible.
Slide 19	Palav Babaria – 01:08:08	So today, we will review how we are proposing to streamline a common referral standard statewide that all plans would adopt as well as expand the use of presumptive authorization, which we have strongly encouraged plans to do since last summer, but that we are proposing to make required for certain specific groups. Separately, I will also flag that there is a provision in the 2024 managed care plan contracts that goes live in January of 2025 around closed loop referrals. Some of the pieces we are talking about around referrals and authorizations are intimately linked to closed loop referrals, so more to come on that because there are some dependencies here. We can go to the next slide.
Slide 20	Palav Babaria – 01:08:55	So again, we'll go through this pretty quickly, but we know that in current state, differing MCPs have differing documentation requirements for getting ECM approved. DHCS requires a five-day or 72-hour authorization timeline, but we've also heard loud and clear from the field that delays are common. We have encouraged plans to have presumptive authorization but uptake on this has not been as robust or uniform across the state. And we also know in current state to the conversation we were just having, in some cases a specific ECM provider is already serving that individual in another capacity,

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		whether that is for primary care or behavioral health services, and yet that information isn't always visible and so getting the right member assigned to the right ECM provider becomes a sorting issue. You heard from IEHP some creative solutions they're putting in place to make sure that that is reviewed closely and wherever possible continuity is promoted, but that is not explicitly uniform throughout the state right now. We can go to the next slide.
Slide 21	Palav Babaria – 01:10:05	So our explicit goals for streamlining referrals and authorizations is to reduce time from when a member is identified to eligible to when they can actually start getting these services. We know especially for some populations of focus, when you have them in front of you is when you have the opportunity. And if you miss that opportunity, that that member may or may not ever engage in ECM. We want to create a consistent statewide format and process for ECM referrals so that community-based referrals don't have to figure out what the individual requirements are plan by plan, we want to increase awareness of ECM in the community so that most of the referrals come from someone who already knows the child and youth in greater detail.
Slide 21-22	Palav Babaria – 01:10:47	We want to improve the quality of matching like we just talked about, and we also want to standardize what information is needed, which ties back to number one so that there isn't varying amounts of information being collected from plan to plan. I will also tell you we've been working with our plans very closely through this process through a number of focus groups and for the most part, most of our plans are largely aligned. Most of the information is already 90, 95% the same. It is really that five to 10% difference that really is problematic and impactful and burdensome to our provider community and

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		referring providers. We can go to the next slide. One more.
Slide 23	Palav Babaria – 01:11:29	So the guidance as I mentioned for the referral standards is really going to take two forms. One, is there going to be standards? What specific elements of information are plans asking providers to complete? And then the second one is going to be a referral form template, which is a template that can be co-branded by multiple MCPs working in the same location or with overlapping provider networks. The referral standards will really get at, I believe Alex Briscoe in the chat asked how can we get to batch referrals? So in current states, some MCPs will accept an Excel file or a batch referral, multiple members being referred by a referring provider.
Slide 23	Palav Babaria – 01:12:12	Other MCPs require a single form to be filled out for every single member, which obviously if you're trying to refer 100 members who are eligible, which some of the CCS or child welfare programs may very well be, that can become very onerous. And so the future state referral standards will both specify what are those elements that have to be included, what are the acceptable batch format forms, as well as a form template for those individual one-off referrals, that also will continue to be submitted. We can go into the next slide.
Slide 24	Palav Babaria – 01:12:48	So as mentioned, we'll have standardized questions for the referring provider or organization to work through about what population of focus they fall into, if there are any additional eligibility requirements, providing detail on that. For example, to Laurie's point about CCS, we anticipate about half of the CCS kids to be eligible because they have social needs. Social needs are not always apparent in claims data or in counter data, and that is really critical information we need from someone who

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		already knows that child or family that you can't data mine for effectively. And so there are pieces like that that are really, we need the community to identify and put in the referral standards.
Slide 24-25	Palav Babaria – 01:13:29	As I mentioned, these have been very heavily vetted and informed by interviews with our managed care plan partners. We also recognize this may require reprogramming some systems and so the guidance will be effective January 1, 2025 so that there's time for any systems updates that need to happen. And once that guidance is in effect, MCPs will not be permitted to ask for additional information. So some ask for additional documentation, electronic health records, CAR forms, et cetera, this will sunset that and will be one-stop shopping for all referrals. What is on that form is sufficient and necessary to authorize that service. We can go to the next slide. One more.
Slide 26	Palav Babaria – 01:14:17	So as mentioned, we recognize that presumptive authorization is an opportunity to really streamline and promote uptake of ECM where some of these populations of focus are very clear-cut and there isn't a lot of additional information that is required. We've already encouraged in our policy guide referenced here on page 98, plans to do this. We know from the data that current uptake of presumptive authorization is happening in many areas across the state, but in really limited pockets and not necessarily at scale statewide. We have also heard loud and clear from the provider community that while they're waiting for authorization, providers are hesitant to start providing services because they don't know if they will ever recruit those costs. And especially for smaller providers and CBOs, they do not have the cash flow and capital to take a risk on that and not get reimbursed. We can go to the next slide.

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Slide 27	Palav Babaria – 01:15:15	So our forthcoming updates, the proposed guidance really aims to expand presumptive authorization for specific ECM provider types as well as specific ECM populations of focus so that essentially they can start providing ECM and they will be guaranteed payment for up to a 30-day timeframe until the MCP either authorizes or denies the ECM prior authorization request. So if the plan ultimately denies it, they can still recoup all of that funding up through 30 days. And then if it's authorized, obviously, that member will have a 12-month authorization on file for that ECM provider to continue serving that member. There would still be a need to submit the referral so that the plan can do the due diligence that they are required to do by DHCS to make sure that referral is appropriate and authorize services. And as mentioned, the provider can still recoup money for 30 days. We could go to the next slide.
Slide 28	Palav Babaria – 01:16:20	So this is the proposed presumptive authorization proposal that we have put forth. On the left, you will see the population of focus that is eligible. And on the right, you will see the provider type that we are proposing falls under this criteria. So for example, if there is a street medicine provider already contracted with that managed care plan for street medicine and they're contracted for ECM, they could start serving adults and children experiencing homelessness under presumptive eligibility and at the same time submit the referral but not have to wait for that authorization to start providing ECM services. So you'll see the combinations all the way out, I'm not going to read them aloud.
Slide 28	Palav Babaria – 01:17:04	We are really trying to identify, again, specific populations of focus that are high risk and specific provider types who already have a contract both for ECM and some other relationship where this would make sense. Your feedback especially on this table

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		is really, really appreciated and welcome. So everyone on our advisory groups, please go through it with a fine-tooth comb. Send us all of your ideas and edits about where you think it is too narrow, too broad, something that we missed. That's really the big part of the feedback that we are looking for today. And I see folks are already dropping in the chat, so great. We can go to the next slide.
Slide 29	Palav Babaria – 01:17:45	So I'm going to stop talking now and really open it up to our advisory groups. In terms of the presumptive authorization design, are there any provider types that you think are missing or ones that don't belong on this list that we should remove? And then the other big operational implementation question we have is in current state, an ECM provider does not always know if that member is already enrolled in ECM with another provider. And we do not want to, for obvious reasons, say member receiving ECM from two totally different providers and organizations and so we need everyone's smart thinking here. What are opportunities and methods by which ECM providers can make sure someone isn't already enrolled in ECM before they start providing services through presumptive authorization? Katherine, I saw your hand go up first, so let's start with you.
Slide 29	Katherine Barresi – 01:18:40	Hey. Thanks, Palav and team. Just the first one to touch on was the operationalizing it, as you just hinted on essentially two ECM providers both servicing the same member. I wonder if there's an appetite with regards to presumptive eligibility to ease us into this statewide when we think about data exchange framework and HIE and CIE and specifically closed loop referrals bringing on partners such as non-traditional provider partners and CBOs, some of which are being heavily invested through past cited. I think that this is a nice policy, I think that should be our goalpost. I don't know if we

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		do that today if we're going to get the uptake in capacity that we're expecting.
Slide 29	Palav Babaria – 01:19:22	And Katherine, sorry, I just want to make sure I understand that feedback. So are you saying we shouldn't require that verification to happen before presumptive authorization right now?
Slide 29	Katherine Barresi – 01:19:32	No, I think we should. And I think the challenge is that most systems are not talking to each other and there's different communities investing in different systems doing different things. And partnering with managed care for all of the many different closed loop referrals, ECM is a component of that from a pop health perspective. We need that check and balances until the system start talking.
Slide 29	Palav Babaria – 01:19:54	Yeah, great feedback and totally agree. And yes, long-term vision for a whole state should be that this information is a part of our data exchange framework and available through HIE so that everyone knows who the appropriate care managers are for our members. Tangerine, let's go to you next.
Slide 28-29	Tangerine Brigham – 01:20:11	Yeah, thanks so much, Palav, for this. Going back to your previous slide, I do believe at least in some systems there are a multitude, well, the placement of ECM staff are in primary care clinics irrespective sometimes of the population of focus. And the population of focus, the authorization process seemed to be geared towards the assumption that certain individuals would only be seen by certain types of providers. For example, the adults and children experiencing homelessness. We certainly see them in our mobile clinic, but we also see them in our primary care sites also. And so I do think that there is an opportunity to broaden the overall proposal to really address the multiple places in

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		which we may have ECM staff that are assisting these populations.
Slide 28	Palav Babaria – 01:21:06	Great points, thank you. Heyman, let's go to you next.
Slide 29	Heyman Oo – 01:21:14	Hi. Sorry, let me come on camera. Thanks. So I'm actually in clinic so apologies, but I'm a long-time lurker, infrequent commenter on these advisory calls, but I really do appreciate hearing everything going on. I'm a pediatrician by background at FQHC in Marin County, so that's the background that I'm coming from. And I wanted to comment to your question of how do you ensure additive services not duplicative services and still allowing flexibility to still be patient-centered? So just my clinical experience is when people come into care at different touchpoints, even within our own FQHC system, sometimes they're ready for certain things and they're not ready for other things. Sometimes they're engaged with their ECM provider for a while, they fall out of that, and then they're ready to engage in a different space. And so I don't have a solution, but I just want to elevate for people to keep into consideration.
Slide 29	Heyman Oo – 01:22:07	Obviously, the dream would be easy communication and verification with all people who are involved in the care of our patients. But short of that, some flexibility around if a member or a patient of mine goes to see another provider in my clinic but at a different site doing a different thing, I would want to feel like they are empowered to do what is right by that patient in that moment while they're in front of them. Given that these are generally high needs patients waiting to say, "Hey, let me just call these other people and make sure they're not duplicating these services that I'm offering you", feels like that's not the right thing that we're trying to do if the patient is requesting assistance from us.

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Slide 29	Heyman Oo – 01:22:48	And so I don't know all the ins and outs of how the verification happens and how long it takes and the data sharing, but I do want to just elevate as a primary care provider and seeing these patients when they're coming to me and saying, "Hey, I need this", I would love to be able to do that for them or direct them to the person that can do that without having to worry that maybe someone else was working on that, right? Because if the patient's saying they need it, they need it.
Slide 29	Palav Babaria – 01:23:14	Absolutely. And we are still dotting our I's and crossing our T's on this, but definitely I think the double payment first single service where someone provides a service, and they get reimbursed both through ECM and some other reimbursement code is a bigger problem than members get a service multiple times. We know people go to EDs and get 10 CT scans and one could argue maybe not all 10 of those were needed, but definitely we want to make sure our members are getting the services that they need wherever they engage in the system. Sarah, let's go to you next.
Slide 29	Sarah Arnquist – 01:23:49	Yeah, thanks. Sarah Arnquist, independent consultant and I work with Full Circle Health Network. I am putting on my managed care hat and thinking that operationalizing in this will be challenging, and so there's a lot of details to work out. And I guess what I'm offering is while those details around initiating payment right away or authorize, like get figured out, an interim step would be that presumptive eligibility just mean that you don't need a one-by-one case review. So that it still may go to the plan in a bulk flat file submission and the plan bumps that up en masse against its database and then responds and says they're authorized versus doing one-by-one referrals because that one-by-one referral process with a nurse looking at it can take a long time. If you send

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		a hundred, it takes more than 72 hours. It will take... And so if that makes sense, then interim step would be presumptive eligibility equal not doing individualized case reviews one-by-one while you then go figure out whether that's going to tie to payment or not because I imagine that's going to be a bigger conversation.
Slide 29	Palav Babaria – 01:25:16	Thank you, Sarah, so much. You're clearly lifting up the process by which these reviews are happening. And we do know that some of our plans have really automated some of these processes, especially where eligibility is an aid code or something where you can do an automated data match, whereas some of our other plans are still doing that one-by-one case review, which is historically how many prior authorizations have happened. And so definitely an opportunity to scale some of those best practices. Great. Not seeing hands up and knowing we're at time, and I apologize again that we're a little rushed. We are clearly way too ambitious in our agendas in the time we have allotted. I'm going to call on Sarah from our team to see if there's any burning questions that we want to lift up from the chat or Q&A before we close out.
Slide 29	Sarah Allin – 01:26:07	Thanks, Palav. Appreciate it. I think lots of fantastic feedback in the chat. Also, some questions about just the operational components of what presumptive authorization really means and what it means in terms of when a referral does need to be submitted, when it doesn't. And so I think this is a good fly for us that whatever guidance we put out, we should be pretty detailed in explaining what the policy means. And then a few good ideas about ways provider portals may be a good source of information about authorizations that are existing for members. So we will save this chat, we will save

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		the comments. And I think for now, we can wrap things and take this feedback back.
Slide 29-43	Palav Babaria – 01:26:49	Thank you. And two final comments before we wrap up. One, as of right now, we do anticipate a referral still needed 100% of the time because it is critical for tracking and other authorization pieces. And then we've seen a lot of chatter in the chat about outreach and DHCS does pay for outreach and has baked that into its rates, including when outreach is not successful. So plans are getting paid for that. And if you're a provider not getting paid for that, I encourage you to have that conversation with your plan partner. Let's go to the next slide. Sorry, we're going to have to scroll through to the end. And Jeff, so sorry that we kicked EPT to the next meeting. We got lots of really amazing, great work here that we definitely want to dig into next time.
Slide 30-43	Jeff Norris – 01:27:38	All good. Folks can email me if they have particular points of feedback. No worries.
Slide 43	Palav Babaria – 01:27:45	Okay. So last two things to flag in our last 30 seconds is that we will be looking at some of this data and have a really exciting panel with some of our plan partners around children's services in general at the upcoming MCHAP meeting. So encourage all of you interested in children's health and preventative care, especially to log in on May 1st. And then we also have our upcoming Stakeholder Advisory Council and BH-SAC meetings coming up, and then our Children and Youth Advisory Group will reconvene in June. And I can assure everyone this is not the last conversation we will be having around ECM or ECM for children and youth. And all of this will be posted publicly if it is not already on our population health management website. Thank you so much to everyone who joined today, and especially our care managers who shared

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		our member stories. It is the gold standard, which we all aspire to. Thank you.