CalAIM Population Health Management Advisory Group Meeting

July 12, 2023

Transcript

Contents

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Transcript

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July 12, 2023

Transcript

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Transcript

Transcript

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Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Ethan – 00:00:30	Hello and welcome. My name is Ethan 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 written questions at any time using the Q&A. The chat panel will also be available for comments and feedback. During today's event, live closed captioning will be available in English and Spanish. You can find the link in the chat field. With that, I'd like to introduce Dr. Palav Babaria, Deputy Director of the Quality and Population Health Management Division. And Chief Quality and Medical Officer, Susan Philip, Deputy Director of Healthcare Delivery Systems Division at DHCS.
Slide 2	Palav Babaria – 00:01:10	Thank you so much, and thank you all for joining us for this month's meeting of the CalAIM Population Health Management Advisory Group. We can go to the next slide. So before kicking off, just a reminder, I think everyone has been tracking, but as of April, the department in partnership with our counties has resumed Medi-Cal redeterminations. As everyone is aware, these had been suspended during the public health emergency. What this means is that there are millions of Medi-Cal members who haven't had to go through this process for the last few years who do need to go through the redetermination process in order to stay on their Medi-Cal coverage. We want to make sure that we really minimize the burden of this process and keep everyone covered, whether that is through renewal of their Medi-Cal coverage or helping them transition to an alternate form of health insurance coverage such as through Covered California.

CalAIM Population Health Management Advisory Group Meeting

July 12, 2023

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 2	Palav Babaria – 00:02:08	We also know that during the pandemic, many of our members moved and the current addresses and contact information that we have for them are outdated, which means that we do not always have the best way of reaching these members. So we really need each and every single one of you and your organizations to help us. You can follow the links on these slides to become a DHCS Coverage Ambassador, where you can get updates on what the progress is with redetermination as well as communication strategies to share. Go to the next slide.
Slides 3-4	Palav Babaria – 00:02:41	So we currently are in phase two, so on this slide you will have links where you can download toolkits, social media messaging, other communications efforts to get the word out. And then please, for each and every single one of you who interact with anyone who is on Medi-Cal, we can also direct Medi-Cal members directly to keepmedicalcoverage.org, which has resources to help Medi-Cal members navigate the redetermination process and make sure that they can keep this really critical coverage. Thank you. We can go to the next slide. So really excited, as I was introduced, I'm Palav Babaria. I'm the Chief Quality Medical Officer and Deputy Director for Quality and Pop Health here at DHCS. We are really going to devote the entirety of our meeting today to talk about ECM and Community Supports. In the spirit of continuous quality improvement, we know that launching ECM and Community Supports, which are a critical part of CalAIM, it is a journey. It is not a single go-live date, where all of a sudden we are done and everything is perfectly implemented.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 4-5	Palav Babaria – 00:03:44	We're currently 18 months into this experiment. There's a lot that we have learned. So we'll be sharing data about what's been happening in the first year and a half of this program. And then most importantly, we at DHCS in partnership with our managed care plans providers, and many of you have been hearing directly from the field, what's working, what's not working as we intended and needs to be refined. So we are also going to be reviewing a series of policy refinements for both ECM and Community Support that we hope will take this program to the next level. And I can promise you this won't be the last set of changes we want to continuously improve on this program and make sure that it is reaching each and every single member across the state that could benefit from it. We can go to the next slide. So as all of you know, who've joined us at these meetings before, we really want to make sure that we are grounding our work and our journey in Medi-Cal member stories. So just wanted to share a story that came up at a summit that we held recently. Last month, we, DHCS met with each and every single one of our managed care plans who are providing ECM and Community Supports and had a provider panel that really shared what they're seeing and experiencing both good and bad on the front lines in the field. So MedZed is one of our ECM providers here in California, and they shared a story of one of their members who had unfortunately multiple clinical and behavioral health conditions and had been cycling in and out of the ED. They were assigned this member by the managed care plan with whom they're contracted for ECM, and they went out in the field and really couldn't find the member anywhere in local neighborhood hangouts or places and addresses that were on the record.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Palav Babaria – 00:05:26	But fortunately, the community health navigator was able to connect with the member's sister who is listed as their family contact and explained what the program is all about, and that ECM and this MedZed community health navigator was there to help in any way that was needed. So weeks later, after being unable to reach this member, the member was visiting her sister and she actually called the community health navigator because there was an escalation and a heated argument, and she needed help and knew that MedZed was there as the ECM provider to help in the situation. So the community health navigator showed up to the sister's house, helped defuse the situation, and then also got the members' consent for services. Through partnership with the community health navigator and MedZed, the member was able to secure temporary housing, received care coordination for high priority medical concerns, and then also apply for SSI and CalFresh to really address some critical deficits in their social needs.
Slide 5	Palav Babaria – 00:06:25	They also were able to get scheduled for and complete a behavioral health assessment and were enrolled in a substance use disorder program. So as of today, as a result of that direct engagement and getting out of health care's four walls and into the field, that member has been able to keep all of their medical and behavioral health appointments, take all of their medications, and has a spot in a residential rehab program, which has been a pivotal moment in this member's life. So just want to give a huge shout-out, not just to MedZed, but each and every single one of our ECM and Community Supports providers who have hundreds, if not thousands of these stories at this point, which are really a testament to the power of this transformation in CalAIM. We can go to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Palav Babaria – 00:07:13	So before we dig into sort of the meat of our substance here, I just wanted to review some of the data that we are seeing at the state level. So this data is from January to September of 2022, and we get lots of questions about why isn't the department releasing more data faster. I will remind everyone that we get data every quarter after the quarter is closed, we do have to compile that data and analyze it. So there's always going to be a several month lag, but we are excited to increase the sort of transparency and granularity of this data, and we'll be releasing a public facing report that has the entirety of 2022 data by county by plan, and in more detail of the populations of focus later this month. So more to come, but in this preview you'll see on the map, the dark blue shaded counties are ones that previously had Whole Person Care or Health Homes Pilots. Then in July of 2022, we launched to all of the lighter blue counties, which hadn't previously participated in those pilots for adult populations of focus.
Slide 6	Palav Babaria – 00:08:16	So this data here represents about nine months of go-live for the counties in dark blue, and then about three months of go-live for the counties in lighter blue. And you'll see that quarter upon quarter, we are enrolling more members every single quarter in ECM, and these are members who at any point in time had ECM services. And you'll also see below the actual number of ECM providers has also been steadily increasing as all of our plans are working with community-based organizations, non-traditional providers to bring them on. I will say from the DHCS perspective, while these numbers are great, we know there are thousands more members who are eligible for these services who are not receiving them. And so a big focus of our presentation today is what are those barriers to getting those additional members enrolled in ECM and how do we improve and streamline our program so that the reach and the scale of the program can be much higher than what it is today? We can go to the next slide.
Slide 7	Palav Babaria – 00:09:19	Susan, I think I'm passing this one to you.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Susan Philip – 00:09:22	Great. Thanks, Paula. First of all, great to see everybody and really happy to be here to walk through these updates today. So when it comes to community support, similarly we're looking at data between January and September of 2022. And you see on this map that this shows the availability of community supports by county. So there really is quite wide take up or offering of community support services statewide. And so this has really been good progress of managed care plans offering Community Supports. Now on the right-hand side, you'll see tables that really show the utilization of Community Supports. So you'll see that about 27,000 members were served by at least one Community Support through last September. And really a bulk of that was through the housing suite of Community Support. So Housing Tenancy and Sustaining, Housing Navigation was really where a bulk of that utilization was.
Slide 7	Susan Philip – 00:10:28	And a lot of that was with work that were being done with counties that were transitioning from previous Whole Person Care work into Community Supports. Like ECM, we're definitely seeing encouraging uptakes in the data for the period that was beyond the period that's reflected here. But we are saying that there are barriers for connecting people with Community Supports even when the managed care plan is offering to elect them. So there's really that gap between the managed care plans decision to offer the service and the actual use of the service. So really addressing that gap is really what we want to talk about in a little bit more detail today and how we are adjusting policies to really help drive up appropriate utilization. We can go to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 8	Susan Philip – 00:11:20	So just wanted to step back a little bit and just share, it's really been a top priority of the department to engage with stakeholders and really gather insights. As Julia pointed out at the beginning, these efforts have been live for 12 to 18 months. So we've had 18 months for community supports and the transitioning populations from Whole Person Care and Health Homes, and now then for certain populations of focus statewide. It's only been wide for a little over 12 months. So lots of lessons learned. We really are looking to hear from our stakeholders to gather insights and recommendations, and we really did this a number of ways throughout 2022 and even into this year. This includes listening tours. We've been throughout this state with our DHCS leadership and CalAIM and ECM Community Supports is top of the agenda in those conversations. And we've really been hearing from the managed care plans and their provider partners during these meetings to really hear how it's going on the ground.
Slides 8-9	Susan Philip – 00:12:25	There has been surveys that have been shared to obtain input for managed care plans and providers, deep dive interviews with providers as well. And of course the data that's been submitted by the managed care plans. So coupled with all this information, we really are working to inform our thinking about improvements. We can move to the next slide. So at this point in the program implementation, we have provided some updates and previewed some updates to certain audiences, managed care plans. We've shared information with plan CEOs and CFOs back in May. And then in June we had an in-person summit, which included all our managed care plans, and it was an in-person summit and a really good opportunity for us to spend the day together to really hear and work out some of the policy discussions. So we have heard consistent feedback from providers and CBOs as well as MCPs that increased standardization of the program design is really needed.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide	Susan Philip – 00:13:37	It's really important from a provider perspective, from a CBO perspective to really minimize that administrative burden. So to the extent that the policies can provide more guidance on how to really streamline certain processes that will help minimize those burdens. So DHCS developed a set of ECM and Community Supports policy to updates. Again, as I mentioned, introduced in May and shared also in June. And we are releasing the updated ECM Community Supports policy guide this month and with an attestation form that managed care plans will be required to sign and that will be due in early September. So we'll be walking through a lot of those updates in this discussion today. Thanks. So Paula, I will turn it back over to you.
Slides 10-11	Palav Babaria – 00:14:36	Great, thank you, Susan. We can go to the next slide. So now we're going to walk through all of those policy refinements that are forthcoming. That plans will be digesting the revised policy guide. We'll also be updating our websites with that information and then submitting the attestation like Susan talked about. We can go to the next slide. So as mentioned, we've already reviewed this with the plans, but through all of the stakeholder engagements that Susan described, we really saw five consistent themes of what the issues were that are outlined here. And so we're going to be going through each of those five themes one by one with the policy changes that we are making to address the feedback and concerns that we've been hearing. And then the ultimate goal for all of them is we really want to increase both the availability access and uptake of ECM and Community Supports from Medi-Cal members who need these services and are eligible for them. We know that, again, we are only scratching the surface right now in terms of reaching and providing these services to members who could be using them.
Slide 12	Palav Babaria – 00:15:43	We can go to the next slide. So the first bucket of themes that we heard, as Susan alluded to is really standardizing eligibility. That having different examples and variation from plan to plan or implementation to implementation is really problematic. You can go to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:16:04	So we heard that especially for CBOs and for providers, that when MCPS apply different criteria for the ECM population of focus, that is very confusing for providers serving these members. It is equally confusing for providers and others who are trying to refer these members, and especially for providers that span multiple counties or multiple plans, it was becoming an increasing barrier. And so this is not new policy, but a reinforcement of existing expectations. So ECM as everyone is tracking is a statewide benefit. So it must be implemented in a consistent way. It is not a sort of waiver or experimental benefit across all of the populations of focus. And the criteria as written in the policy guide need to be implemented and MCPs cannot impose additional requirements to authorize ECM services. So if the ECM population of focus, for example, is our homeless population of focus, there cannot be additional factors added beyond what is written in the policy guide in order to have members qualify.
Slide 13	Palav Babaria – 00:17:10	An MCP also cannot require that a provider has to reach the member a certain number of times or have a certain number of contacts as a condition of authorization. We'll get to payment a little bit later in this presentation. But for authorization, anyone who meets the eligibility criteria independent of the number of contacts or outreach should be authorized for this service. The one exception around changing the population of focus is, again, no population of focus eligibility criteria can be made more stringent or more narrow, but we have gotten feedback that for the individuals at risk for avoidable hospital or ED utilization population of focus, specifically that the current number of ED visits or hospitalizations in a six-month period for which a member is eligible is a pretty high bar. And that there's a lot of individuals who maybe are just one or two visits shy of that, but would really benefit for the enhanced care management benefit.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:18:11	And so for that population of focus, only managed care plans are allowed to broaden their eligibility, i.e., include people who may be a little bit shy of that cutoff and serve a larger population. We can go to the next slide.
Slide 14	Susan Philip – 00:18:31	Great. So for community supports, the variation that we're seeing and how Community Supports is applied is really even more pronounced. We're seeing a really big difference between the service definitions that are outlined in the Community Supports policy guide and how Eligibility's actually being set up by the managed care plans. And some of that was expected because of the initial policy for Community Supports. It was different than enhanced care management, right? Community Supports is not yet a statewide benefit. So at the launch of Community Supports, we did have managed care plans, were permitted to have some variation, had to seek approval from DHCS if they were looking to adopt more narrowly defined eligible populations or restrict the service definition for the elected Community Supports that they offer. They needed to make sure they were sharing that information with DHCS.
Slide 14	Susan Philip – 00:19:30	Describe their plan for how they then restrict that at the beginning, but then how they plan to expand access to meet the full service definition over time. And we had at that point expected a longer ramp up, but just given what we are hearing the last year and in terms of the overly restricted eligibility criteria that plans in some cases have adopted, we are going to move out of that ramp up period. And we're looking for much fuller fidelity to the service definitions. So managed care plans must remove any previously approved restrictions or limitations and adhere with the full Community Support definitions by January 1st, 2024. So that is a change and that is something that we're messaging and that we're also going to be clear in the Community Support policy guide that we're releasing.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 14-15	Susan Philip – 00:20:28	So I also did want to mention in the second half of 2023 and also continuously, we are looking to refine and clarify the Community support Service definitions. We do know that there is potential for improvement where we are, as mentioned, looking for ways to improve and feedback as well. So in the second half of 2023, we'll be working with managed care plans to consider input and potentially further refinements down the road. We can go to the next slide. Thank you. So I also did want to take a minute to talk about cost-effectiveness. So I think DHCS, we've heard some plans might be feeling trepidatious about making these long-term investments and community supports due to the uncertainty and how cost-effectiveness for community supports will be evaluated and how the services will be funded moving forward. I think prior to CalAIM launching DHCS assess the cost-effectiveness and medical appropriateness of each community supports based on experience, with our prior pilots, with Whole Person Care Pilots, with the Home and Community Based Services waiver. We did a lot of stakeholder engagement, thorough lit review of each of the different Community Supports and the impact of those Community Supports on healthcare utilization and outcomes, right? So really is linking to health, healthcare needs and healthcare use.
Slide 15	Susan Philip – 00:22:10	So really just by virtue of being one of the 14 Community Supports that made it to the pre-approved list, these services are considered cost-effective and appropriate. And additionally, in recent guidance from CMS, they really emphasize that states should look at in lieu of services and cost-effectiveness in the aggregate and not necessarily in the individual member level or plan level. And the same principle applies under 1115 and health related social needs services. So that's guidance that CMS released earlier this year. And so moving forward, Community Support services really are deemed to be cost-effective by DHCS. It delivered according to the DHCS service definition. So if you're sticking to the Community Supports policy guide and the clear definitions, it would be...

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Susan Philip – 00:23:03	... supports policy guide and the clear definitions, it would be considered cost-effective. So I did want to clarify that, obviously at individual level, the policy guide makes really clear what service definitions are applicable. So to the extent that plans are using that, they're considered cost-effective. So we can go to the next slide.
Slide 16	Susan Philip – 00:23:27	Okay. So I think we're going to pause for discussion here and see if folks had questions.
Slide 16	Tangerine Brigham – 00:23:36	This is Tangerine, Susan. Can you hear me?
Slide 16	Susan Philip – 00:23:40	Yes, I can hear you.
Slide 16	Tangerine Brigham – 00:23:41	Great. On the last issue, I've heard not only for community supports the cost-effectiveness concern, but I think because it's not community supports are not benefits the way ECM is. I think there's also perhaps some trepidation about getting too far into the provision of a community support, no guaranteeing that. After the waiver, that particular service will be funded in some way by the feds. Did you hear that as a concern? Because I've certainly heard it as a concern.
Slide 16	Susan Philip – 00:24:24	Yeah, I think that was raised as a concern. But I think we should just share upfront, we are really looking to move community supports into benefits. That is the vision. After this waiver, that is the vision. And just in terms of the housing suite of services, we are seeing wide uptake. There's definitely capacity in the delivery system for that. So when we look at thinking about how can community supports even become a benefit, we need to look at whether the delivery system has capacity. And with our path initiatives and with the current even offering of community supports and the providers that are participating, there is a good robust uptake for some of the community support. So we're really committed to making sure that we are, again, our long-term vision of transforming the community supports from IOLS to actual Medi-Cal covered benefits and we think we can really achieve that, maybe even faster for some of the housing support services. But definitely that is the longer term vision after the waiver.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Tangerine Brigham – 00:25:38	Thank you.
Slide 16	Susan Philip – 00:25:43	Okay. Kim, do you want to go next?
Slide 16	Kim Lewis – 00:25:45	Thanks Susan. Hi everyone. Kim Lewis from the National Health Program. One of the questions, I'm glad you touched on it, Susan, about what we've been hearing, which is various plans having restrictive requirements as to who can get community support services, and for example, when plan requires 12-month continuous enrollment, which to me that means you wouldn't even be able to get it, I don't know when the 12 starts, but that seems pretty restrictive to have to be in the plan for 12 months to get that. And also another one that says certain populations like dual eligibles was Medicare Part A can't get community services.
Slide 16	Kim Lewis – 00:26:26	So I'm wondering, it sounds like you are saying two things. One is it sounds like in 2024 you're going to try to stop this variation of restrictiveness, some of which is not even publicly available to know by the plans either on their website or on benefits materials, which is I understand part of the terms and conditions and the waiver to have to do that. So I'm trying to figure out where will this variation end and how will beneficiaries know when this stops and what's right and what's wrong in terms of these limitations?
Slide 16	Susan Philip – 00:27:01	Right. That's a great question. Yeah, so the expectation is January 1st, 2024 that there will be again, full fidelity to the service definitions and to adhere to the eligibility criteria that we at DHCS has laid out and not have it be more restrictive. So that's policy come January 1st, 2024.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Susan Philip – 00:27:25	In terms of how members will know, that's a good question, and certainly in our policy guide, that information is clear, certainly the information we want to get out to our provider. The providers are partnered with the managed care plan. So certainly that's information that we need to make sure that the providers are aware and trained. One of the requirements under various initiatives, including our IPP program is to ensure our managed care plans are really educating the provider partners about community supports, ECM, and the way in which members can actually access these services. So that's actually also another requirement that is, and I'll talk a little bit more about that when we get to the awareness discussion later.
Slide 16	Kim Lewis – 00:28:15	Thanks.
Slide 16	Susan Philip – 00:28:19	Phebe.
Slide 16	Phebe Bell – 00:28:22	Hi. Thanks. I'm Phebe Bell, the Behavioral Health Director for Nevada County, and we are actually an ECM provider ourselves. And we chose to focus on people with serious mental illness or substance use disorder who are also experiencing chronic homelessness and who are not well-engaged in our services and sort of using it as a different way to try to engage people and to provide support to them addressing whatever it is of interest to them, even if that's not engagement and treatment, which has been great in many ways.
Slide 16	Phebe Bell – 00:28:53	And I have a million things to say about ECM, but I think the thing I'm most struggling with right now is trying to better understand the intention of the service. We've been super struggling, the population we're trying to serve needs high intensity, high touch, so per member per month is really not working very well because our caseloads are supposed to be 50 people per staff person and you can't work with the population we're trying to serve at that volume with any kind of success.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Phebe Bell – 00:29:19	And so we were in conversation with some of the plans recently where they basically said no, you're not supposed to really be doing case management, its care coordination, it's phone calls to set up doctor's appointments type of stuff. And that is really meant to be done in conjunction with other case management, not kind of fill in gaps for people who aren't effectively receiving sort of case management, for lack of a better word.
Slide 16	Phebe Bell – 00:29:41	I'm wondering if you guys can speak to that a little bit, both in terms of how the finances are structured but also the philosophical vision of where ECM fits into the picture.
Slide 16	Palav Babaria – 00:29:52	Yeah, I can take that on. So I think the vision, which I think we've said before and is articulated in more detail in our policy guide is that ECM really is a comprehensive, whole person care management program. And there's six different buckets of activities and yes, care coordination is one of them. So the ECM, the lead care manager should be helping to facilitate and reduce barriers to accessing medical, behavioral health services, making appointments, et cetera.
Slide 16	Palav Babaria – 00:30:18	But that is only one piece of the puzzle. And the vision is that the ECM lead care manager is also addressing all of those other needs. Like you said that client's primary issue may not be wanting to go see the doctor. It may be housing, it may be having stability, it may be getting treatment for longstanding trauma. There's a lot of different issues going on and the expectation is absolutely that the ECM program is addressing all of those needs, meeting members where they're at. Addressing whatever of their whole person care elements is that entry point to building trust in a relationship with the provider and then yes, also getting eventually, to all of the medical and clinical outcomes and needs that we have. And so I think the program that you described is absolutely in alignment with the department's vision for ECM.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Palav Babaria – 00:31:08	In terms of payment, I think we'll get to some of this later in the presentation, but there is flexibility. The plans have flexibility to negotiate rates. And we've also communicated with the plans that the department's expectation is not that there is a one-size-fits-all approach to ECM for each and every population. We recognize the rates are different depending on the intensity of the population you're serving and serving a highly complex SMI SUD population is going to be different than serving a child who's enrolled in the CCS program. And there is room for negotiation depending on what that mix looks like for the ECM, both in terms of what the caseload is, but as well as payment to reflect that.
Slide 16	Phebe Bell – 00:31:52	Yeah, I appreciate... I mean that's how I understood the program from the get-go and it's why we sort of jumped in with the group that we are trying to reach, and we're just seeing such a mismatch between how the managed care plans understand the program and are paying for the program and what the experience of who we're trying to serve is. And yeah, I don't know how we bridge that divide, but...
Slide 16	Palav Babaria – 00:32:14	Yeah. And then the last thing I'll say around duplication is definitely the vision of ECM is not to displace or duplicate programs that already exist, but if a client is not in those programs or is not receiving services, that there's less concern about that displacement or duplication. But appreciate you bringing those really critical pieces up, Phoebe, and I think we'll get to some of those in more detail later in this presentation.
Slide 17	Palav Babaria – 00:32:39	So I'm going to keep us moving and we'll go to the next section because there's a lot more to get through and I see a lot of comments in the chat also around referrals and how members are identified. So we'll be getting into some of that as well.
Slide 17	Palav Babaria – 00:32:53	So the next bucket of issues is really around how the referral and authorization process works, and both streamlining and standardizing that. So we can go to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Palav Babaria – 00:33:09	So I think one of the consistent pieces of feedback that we've heard is that managed care plans often have different time frames for what period of time ECM is authorized for, when it is reauthorized, and also when assessments and reassessments have to happen. So this obviously for providers that are working with multiple plans in a single county or across county lines, having workflows and systems that can accommodate all of these different timelines is very challenging. And we've heard a consistent plea to standardize those pieces to really reduce the administrative burden on providers.
Slide 18	Palav Babaria – 00:33:45	So with the new policy guide, DHCS is standardizing authorization and reauthorization timeframes for enhanced care management. So effective July 1st, 12 days ago, all members who are authorized to receive ECM will have an initial authorization period for 12 months. For anyone who is eligible for ECM, they're authorized for 12 months.
Slide 18	Palav Babaria – 00:34:06	Reauthorization, so we know that some people will graduate in that time or not need further ECM services beyond 12 months, but for those that do, reauthorization periods thereafter will be in six month increments.
Slide 18	Palav Babaria – 00:34:19	We are also modifying the approach for how members can be reassessed. And so we have in our policy guide updated that MCPs cannot just have sort of blanket reassessment timeframes, i.e. that an ECM provider has to reassess a member every month or every two months, but that really, reassessment should be driven by the care plan and the goals that are established between the ECM care manager and that member throughout the 12-month authorization period based off the member's needs. So depending on what the member's goals are and what sorts of activities they're focused on, and I think Phoebe's comments about really centering the member in this care planning process are really apt here, that reassessment needs to be done based off of clinical goals and the care plan. Plans may still perform periodic chart reviews to maintain program integrity, but that assessment process cannot be used for that purpose. We can go to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Susan Philip – 00:35:20	Okay. Yeah. So similarly for community supports, we have seen issues related to authorization, reauthorization timeframes. We've seen that managed care plans do have just disparate timeframes for the initial community support authorization and then the reauthorization decision. And this does create administrative burden for providers, especially those that are providing with multiple plans in one area. And so that lack of standardization really is an issue for providers.
Slide 19	Susan Philip – 00:35:54	So we are working to develop some standardization. We have a few areas that we're considering, and in the second half of 2023 we are going to be working to develop that. We'll bring that for vetting with this group and others, and that will be for implementation later in 2024. So more to come on that. We can go to the next slide.
Slide 20	Palav Babaria – 00:36:25	So I saw a question in the chat earlier that was about this exact topic of when are services authorized and is it before or after the contact is initiated between ECM provider and the member? And so we strongly encourage each and every plan to adopt presumptive authorization arrangements with trusted providers to help streamline access, i.e. if there is an ECM provider who knows about a member or is serving a member in another capacity or has a relationship with that member and they identify that that member is eligible for ECM based off of the published criteria, that they can start providing ECM services with presumptive authorization without having necessarily to go through the entire process and waiting for authorization for providing services.
Slide 20	Palav Babaria – 00:37:15	We've had great examples from some of our managed care plans who have implemented this process and it really reduces barriers for that member, and means that services can get to the member as soon as someone identifies eligibility as opposed to telling the member we're going to put in an authorization and we'll be in touch, especially for members that are hard to reach or hard to contact after that date.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Palav Babaria – 00:37:37	And then just flagging that when the justice involved ECM population of focus goes live, we will require presumptive authorization for ECM services on the day of release to prevent any interruptions in care between pre-release services and ECM for the justice involved population.
Slide 20	Susan Philip – 00:37:57	Great. And then for community supports, there are some scenarios where it just doesn't work to wait on authorization. We're really talking about time-sensitive community support services such as recuperative care or [inaudible 00:38:12] post-hospitalization, and it just doesn't make sense to wait a really long time for that authorization because that is the difference between whether the individual is placed and whether that placement works out or not.
Slide 20	Susan Philip – 00:38:24	So based on the feedback we're hearing, we have learned, for example, for recruiter care, that the eventual authorization of those services is close to a hundred percent, which is really good. So in those types of situations, we're really encouraging plans to consider presumptive authorization arrangements to really assess based on your data, based on what percentage of authorizations are eventually provided, can some of those really move to a presumptive authorization to minimize that burden. Can move to the next slide.
Slide 21	Palav Babaria – 00:39:06	Great. So another area that falls into this bucket is that we've heard consistent feedback about all of the disparate input forms and processes for both referrals and authorizations across MCPs, which creates a high administrative burden for providers, especially those obviously working with multiple plans.
Slide 21	Palav Babaria – 00:39:26	So a few things on this. We are moving in the direction of having statewide referral standards that we will start designing in quarter three of 2023. There will be more engagement with our plans, ECM and community supports providers and this group as we embark on that design work. And we anticipate rolling out that future statewide referral standard sometime in 2024.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Palav Babaria – 00:39:51	The other piece that I'll flag here, which I saw a few chat comments about as well, is that in current state, what we've discovered from our plans is that most of the referrals for both community supports and ECM are coming from data mining, i.e. plans, running rosters of members that meet eligibility criteria. While that is definitely one of the strategies we want plans to employ, I think we as a department recognize that only using utilization data is neither effective, because we know that referrals coming from a trusted source for that member are much more likely to be accepted than doing cold calls off of rosters from a random entity that does not have a relationship with that member.
Slide 21	Palav Babaria – 00:40:34	We also know that using data mining, and I'll give a shout-out to that. There was a great CHCF brief on this recently that using utilization data is also prone to introducing disparities, especially racial and ethnic disparities that are tied to under-utilization. So we know there are lots of members out there who are eligible for ECM and community supports, need those services, and don't show up in utilization data because of longstanding barriers and distrust of the healthcare system as it stands today.
Slide 21	Palav Babaria – 00:41:04	So DHCS's explicit vision and goal is that the vast majority, if not all of ECM and community supports referrals come from outside the plan, from community-based settings, from schools, from social services entities who are already serving these clients, from providers, from ECM and community supports providers themselves. We recognize that today that is not the case. And so we also have our IPP program, which has measures to incentivize MCPs to provide training to all of their contracted providers about these benefits and how to refer and how to set up successful, streamlined low-barrier referral pathways.
Slide 21	Palav Babaria – 00:41:44	I'll also lift up that the existing policy allows for self-referral as well from Medi-Cal members and the family members and others involved in their care. And we really encourage anyone and everyone who identifies members that could benefit from these services to make the referral. Susan, anything to add there?
Slide 21	Susan Philip – 00:42:05	No, I think you covered it.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Palav Babaria – 00:42:08	Great. So I think we'll pause now for discussion and feedback on referrals and authorizations.
Slide 22	Juliette Mullin – 00:42:12	And it looks like Mike Odeh has raised his hand. Mike, would you like to ask your question?
Slide 22	Mike Odeh – 00:42:44	Hi Paul and Susan, thanks for the presentation. I'm wondering, is there an expectation for how long before referrals are acted upon, whether it's a self-referral from a member or a referral from a provider or identified by the plan? How long before a member gets matched up with or sort of determined to get services? And I know you talked about some of the presumptive piece, but just trying to think through the different pathways of how someone gets to ECM and how it sort of operationally works. Thanks.
Slide 22	Palav Babaria – 00:43:21	Great question. And I'm going to phone a friend, if any of my team members are on the call. We do have guidelines for when authorization needs to be issued. And then Susan, I don't know if you want to comment on some of the expedited timelines for some of the community supports.
Slide 22	Susan Philip – 00:43:36	Yeah. So for the time-sensitive community supports, we are saying you've got to do it within 72 hours. So that was actually an update we made earlier. That's for authorization. The piece that we talked about earlier is really even for those where there's a consistent approval, can you even do it even earlier to reduce those barriers and have it been a presumptive authorization? So just a slight nuance there. But that's an example of where we're laid down some guidelines for where there is a time-sensitive community support.
Slide 22	Jules Vigorito – 00:44:22	Seeing that Caroline Sanders has a hand up. Caroline, would you like to ask a question?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Caroline Sanders – 00:44:27	Hi, yes, thanks. And actually, I think someone else had raised this in the Q&A, and I guess I just want to understand a little bit better. I realize some plans are data mining in order to determine who might be eligible for community supports and ECM. For the providers that are available and stand ready to provide the services, how are they getting these referrals? Are they able to reach out to some of the members? How do they know that the folks that they are working with and providing services to our plan members? And we are not a provider, so just looking at this from the outside, what tools and resources are available to providers to make sure that they're really reaching these populations and connecting them to the plans and that the communication is bidirectional too?
Slide 22	Palav Babaria – 00:45:44	Great question. So maybe Susan, I'll start for ECM and then feel free to pile on for community supports. But I think what we have seen most commonly is that independent of where the referral comes from, whether it is from some outside provider entity or data mining, the plan then compiles that list of eligible-
Slide 22	Palav Babaria – 00:46:03	Then compiles that list of eligible members for whom they've authorized services. And then we'll often send that list or roster to the contracted ECM or Community Supports Provider to say, "Hey, here's the list of members that are eligible and authorize, go forth and provide them services." And then those ECM providers will go outreach to make contact similar to the member story that we shared, often going out into the field to find the member depending on what their situation is or if they can't be reached through other means. I think what we heard at our summit from providers is... So that's the standard model that I would say is pretty common across all of our plans right now. I think the cutting edge and future state relationships that we've seen that we hope to support scaling across the state, one of the panelists that provides ECM services, they started going broader.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Palav Babaria – 00:46:50	They work on the LTC population of focus and so in sniffs, have just been assessing broadly anyone on Medi-Cal for eligibility and then proactively identifying people in the field, "Hey these people are eligible." And then working with the plan to make sure that that member, depending on what plan they're enrolled in, can be authorized for services and then starting to serve them. I think that is the future state vision, where we're not just waiting for rosters, but that the vast majority of Medi-Cal members are being served by someone somewhere in our state, whether that is in a healthcare setting, an educational setting, a social services setting. And so how can we capitalize on those people who are already serving members, already have a relationship to help identify and link those members to ECM or Community Supports? Is the vision that we need to get to.
Slide 22	Susan Philip – 00:47:39	Yeah. I'd agree with that. And I just want to emphasize that, we haven't seen as much referrals in all the different pathways that is possible. And so we do want to... The standard process in terms of the plans, developing a list, getting to the providers, which is one way, but again, we've got Community Support Providers, for example, who understand their population, understand that this individual is definitely eligible for housing navigation. And making sure that that bidirectional feedback is provided to the plans and the authorizations are provided in a streamlined fashion. Basically, a no wrong door for referral processes, is what we're trying to drive towards.
Slide 22	Caroline Sanders – 00:48:28	Thank you. And I guess just on a related note or just a quick follow up, it seems as though, at least one of the comments that I saw is that the standard model that some providers are not even getting the referral lists. And so, just curious what you've heard about that. And you did mention that some of the different pathways, there's not as much referral going on right now. I like the broad vision of, "Let's just serve everyone." And I'm glad that you're moving in that direction, but also just wondering, for this time now, what is happening there and how can we potentially improve that or strengthen those pathways so that providers are getting those lists and getting the information?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Palav Babaria – 00:49:27	And I would say one consistent piece of feedback we've heard Caroline, is not that the providers are not getting the list at all, but that the numbers they're getting are much lower than what was anticipated. I think it goes to this broader issue of, as we build out capacity, we know theoretically there's a lot of demand out there, but we're not necessarily finding that demand specifically. And again, data mining only goes so far. And so how do we catch all of those other people so that the capacity that has been built is effectively being utilized? And we also looked up, [inaudible 00:49:58], comment in the chat that I think, yes, the goal is really to have not an either or but both and approach. But just recognizing that the community based referrals is very nascent and non-existent in a lot of places and that's where a lot of work needs to happen. Maybe Kim, let's take your last question and then I'll keep us moving on to the next section.
Slide 22	Kim Lewis – 00:50:18	Sure. This is the comment and follow up to what Carrie just raised around, I think outreach. I'm glad to have you emphasize the, and in that last comment. Because I think a lot of ways that you're going to identify folks is through trusted partners as you said, or existing providers who they trust, whether it's specialists in the special mental health system, whether it's a community health worker or a peer support specialist, somebody that they have a connection with or they trust that will talk to them about, I think the importance of the service and why it's helpful for them to have it. And that seems like the best. Not just people they don't know that are ECMs that they haven't yet met, but actual people they do know. I'm thinking that, really should be including primary care offices as the way to educate where they're going to be touching regularly, those folks, at least, we'd hope or their specialists, if they're having their specialists be their primary care contact, then it seems like that's the real opportunity to link them to the service right away, even if it may happen in different sequence.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Palav Babaria – 00:51:25	Yeah. And I would just piggyback to that, that I think it's not just about the referral getting made, but it's also about the member accepting these services. And we know from lots of data points that, if someone that the member trust tells them, "Hey, I recommend this program, someone's going to call you pick up the phone," they're much more likely to do so than a random outreach that they're not expecting. Thanks for lifting that up Kim. We're going to go over to the next section, but Mike, my, [inaudible 00:51:49], friend came in, and it's in the policy guide and the APL, but authorizations must occur within five working days for routine authorizations and within 72 hours for expedited requests. So that is the authorization is either approved or denied with whatever the justification is, but those are the timelines.
Slides 23-24	Palav Babaria – 00:52:12	Okay. Let's go on to the next bucket of issues. We talked a little bit about referrals and authorization, how members get there and get in through the door. The other piece is really around the provider networks and streamlining payments so that we can have more providers participating in both our ECM and Community Supports program. We can go to the next slide. For ECM, and I saw some questions in the chat earlier where people were asking about data that we have about different types of ECM providers, so I will say the vast majority of our ECM providers across the state in all regions and all plans are traditional Medi-Cal providers, who are already providing Medi-Cal services. And so what we have seen, is that often MCPs are relying on clinic-based providers and resulting in a one size fits all for the ECM program.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Palav Babaria – 00:53:06	And this is not to say that we don't need clinic providers, there are amazing models of primary care embedded ECM that we've seen across the state with our federally qualified health centers and other providers. I think the issue is, is that we know that model does not work for everyone. If someone never goes to primary care and doesn't have a relationship with primary care, that is probably not going to be the best ECM model for them. If an individual is in a long-term care setting and again doesn't go to their PCPs office outside of that setting, probably not the best ECM provider. For children and youth specifically, we know that there are some children and youth where the primary care provider's office is well situated for their ECM provider, but there are many, whether they are child welfare involved, justice involved, et cetera, where that is not where the nexus of their needs and their care are.
Slide 24	Palav Babaria – 00:53:55	And the vision for ECM is that we really have a broad network that the best ECM provider for that individual member based off of what their needs are, where they have trusted relationships, is who is providing them services. We have new policies that we're going to be rolling out that requires partnerships for Managed Care Plans with specific provider types and we will be requiring that MCPs prioritize contracting with ECM providers that specialize in some of these specific populations of focus. We also want to encourage our MCPs to really think about how they're engaging with both their ECM and Community Supports Providers for the new CHW benefit and really building out that continuum of care, so that as members step down from ECM or maybe are not eligible for ECM, that CHW benefits can be provided, because many of those providers have CHWs on their staff.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 24-25	Palav Babaria – 00:54:53	We also will be issuing a requirement that will go live in January, that all of the MCPs network directories that are on their website and publicly available and that the department is monitoring and auditing on a regular basis indicate which specific populations of focus each ECM provider is equipped to serve. We can go to the next slide. This is just an example. These are not designed to be exhaustive provider types, but some of the nuance that we're trying to bring to specific populations of focus. For example, as Phoebe Bell on our Advisory Group lifted up earlier, for adults with serious mental health and SUD needs, often that population doesn't make it to their primary care provider. And having PCP based ECM may not be the best option for that member. Conversely, many of them are engaged with county behavioral health and if county behavioral health can be assigned to that ECM as the ECM provider, there's really that ability to build out a continuum of care and build on a trusted relationship with that member.
Slide 25	Palav Babaria – 00:55:57	Same with community-based behavioral health and medication- assisted treatment programs and other providers who provide specialty mental health or DMCODS services. Similarly, for those members who are experiencing homelessness, how do we prioritize assignment of street medicine providers, homeless navigation centers or transitional housing for those members? For those who are in nursing facilities, really leveraging California Community Transitions Lead Organizations, affordable housing communities, the Alzheimer's Association, memory care, et cetera. And then similarly for those who are at risk for LTC institutionalization, we have many amazing programs like our, [inaudible 00:56:36], centers, area agencies on aging, other home health agencies who are really well positioned to serve these members.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 25-26	Palav Babaria – 00:56:42	You'll see the common thread; it does require a sorting exercise. You can't just generate a random list of names and send it off to an ECM provider. It requires some understanding of, where are these members being served? Where are their existing relationships that we can build upon and how do we get the right member to the right ECM provider to meet their needs? We can go to the next slide. And I'll underscore that this sorting exercise is really, really critical for our children and youth ECM population of focus that just went live, because many, if not most of these youths will have other types of services, care managers and programs that are already working with them. And the vision is not to have duplication and too many cooks in the kitchen, but to really build upon trusted relationships and enhance and expand the services that these children and youth need.
Slide 26	Palav Babaria – 00:57:35	For children with serious mental health or SUD needs, and this includes, they will flag that with the new specialty mental health criteria that launched as a part of CalAIM, any children with an ACEs score of four or more is eligible for county behavioral health services and thereby is eligible for ECM. This is an incredible opportunity to really address and support the needs of complex children and youth and intervene early leveraging enhanced care management. But we anticipate that for some of those should children and youth, school-based clinics, behavioral health providers, public health and social service programs and CBOs that are serving children and families with special needs, will be really well positioned to take care of these children and youth.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 26	Palav Babaria – 00:58:20	For CCS similarly, CCS programs and Michelle Gibbons, thank you for your comment in the chat, which is a typo and oversight. But CCS programs based at the counties as well as CCS paneled providers including specialty care centers, acute care hospitals, et cetera, will also be a key part of the contracting. And CCS programs have been historically called out in our policy guide already as an entity that plan should be trying to contract with, but we're expanding that to include the rest of this list. Same with children and youth at risk for avoidable hospital or ED use, how do we leverage school-based clinics, medical providers and the underlying reasons for that ED utilization? And then for those involved in child welfare, we recognize that there are a lot of programs that span a lot of different entities, and I think having those CBOs, public health programs, First Five, Black Infant Health, et cetera, who are already in the space, already serving these children and youth is the preferred approach for this population. We can go to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 27-28	Susan Philip – 00:59:26	Great. And for Community Supports, just reemphasizing that our policies are requiring partnerships with specific provider types, again, that have experience with individuals that have the specialized needs. It's again, we're talking about engaging with trusted partners, ensuring that our Managed Care Plans are contracting with Community Support Providers that have the experience. And also then, to the point made earlier, including provider types such as skilled nursing facilities, especially as we're thinking about transitional care services, really being able to identify individuals that could, for example, transition to home or community-based care, how to engage those providers that know and understand those populations. Those are policies that we'll be releasing shortly. Okay. I want to go to the next slide here. This is switching gears a little bit to talk about coding guidance. There's been some feedback that we have heard that ECM and Community Supports, HCPCS codes, which are being used to code for claims, encounter data and being used as part of the invoicing process that are then provided to the health plans, that there are lots of variation and that it's really leading to that increased administrative burden for providers. There's a HCPCS code set, it's being applied differently by Managed Care Plans. And again that some of those additional codes that are being required by plans is just above and beyond the coding guidance that DHCS has provided.
Slide 28	Susan Philip – 01:01:23	We have already issued guidance that Managed Care Plans really need to stick to the HCPCS coding options for Community Supports as defined by DHCS, really to ensure that, especially you think about a provider that's contracting with multiple managed care clients, that there is that standardization for the code sets that they are applying when they're talking about the same set of services. That has already been issued in guidance and that's already available to folks to take a look at. But that is a change in the policy guide that was made earlier. We can move to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Palav Babaria – 01:02:04	This one is, we've heard widespread reports of either non-payment or delayed invoice payments by Managed Care Plans, especially to CBOs that are new to billing Medi-Cal. And we recognize that, especially for smaller organizations and CBOs, these types of delays are non-payment can be really catastrophic to that organization and preclude their participation in this program. We are reinforcing existing timely provider payment requirements, so both ECM and Community Supports are subject to standard reimbursement timelines, where in our boilerplate contracts, MCPs must pay 90% of all clean claims within 30 days of the data receipt and 99% within 90 days. And then there's also California Health and Safety Code that reinforces some of these requirements in terms of reimbursing no later than 30 working days after the receipt of the claim. These requirements pertain to both claims and in invoices.
Slide 29	Palav Babaria – 01:03:00	We also recognize that some of the issues may be that some of these newer providers who are not used to billing Medi-Cal may be struggling to submit clean claims. And so MCPs are also required, and this is not a new requirement, to train their contracted network of ECM and Community Supports Providers on how to submit a clean claim and work with them if they're struggling to do so, and personnel must be available to help troubleshoot those issues. And then just flagging that an APL will be issued offering clarifying guidance on this. That will be forthcoming later this year.
Slide 30	Palav Babaria – 01:03:37	We can go to the next slide. The other consistent piece of feedback around provider payment that we've been hearing is that providers are not consistently reimbursed for ECM outreach, so this is publicly reminding everyone that MCPs are expected to reimburse ECM providers for outreach, including for unsuccessful outreach, where maybe multiple attempts have been made but the member has not decided to not enroll in ECM or was unable to be reached. What we, at DHCS, pay the MCPs, already includes assumptions about the cost of outreach and that money is being paid to plans today and we expect them to in turn transmit that payment to providers. And then we'll also cover this later in the rate session.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 30	Palav Babaria – 01:04:29	And then we also are currently launching a supplemental data request for all of our plans to better understand the rates and how they're paying ECM providers. And then I had also seen a question from Tangerine. I will remind everyone that we cannot currently as is, in the ECM policy guide, if someone is enrolled in ECM, the CHW benefit cannot be also billed. And Tangerine's question, I think was around transitional care services. The expectation is, for something like transitional care services, if a member is in ECM, the ECM lead care manager entity is responsible for providing all of those services and you cannot double bill using CHW services.
Slide 30	Palav Babaria – 01:05:10	That being said, prior to an individual being enrolled in ECM or after discharge from the ECM program, if they've graduated or are not interested in being in the program, CHW services can be used including for things like outreach and engagement. And we'll be further standardizing some of these thresholds that should trigger payment for ECM providers in future guidance. Because we've also heard, similar to the previous conversation we had, where there's differences in how many touches a plan requires for authorization, which we have revised. There's also differences we've heard in how many touches plans require before a provider will get paid. So more guidance will be forthcoming on that. We can go to the next slide. We're going to pause for discussion on all things related to network and payment.
Slide 31	Jules Vigorito – 01:06:17	[inaudible 01:06:16], not seeing any hand raised. We can take a question from the chat if that's okay. We have question from Chris Dobson asking, "What's being done to standardize required enrollment outreach expectations and engagement after enrollment, seeing we have a two plan ECM, CS provider and it's like we are running two programs due to the varied requirements?"

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 31	Palav Babaria – 01:06:33	I think that's an area as we dive deeper into some of these payment requirements and referral requirements where we do hope to go deeper. So Chris, welcome, any written feedback you want to provide us either in the chat or to the mailbox after this meeting to better understand the specific barriers. But it is a consistent concern that we have heard and intend to address to the best of our ability. And then I also saw a few questions in the chat just around payment and when those expectations will go into place. And so for the payment piece, those requirements that we said about the 30 days and 90 days, those are already in contracts and already in state statutes. Those requirements are live and plans are already required to support their ECM and Community Supports Providers in submitting clean claims.
Slide 31	Susan Philip – 01:07:21	Yeah. And Palav, just to add to that, we did actually issue an all plan letter for public comment and looking to finalize that over the next few weeks. And that clarifies even further that, when we're talking about invoices right from ECM and Community Support Providers, those were considered claims. That is what is to be used as a basis for plans to translate that to encounter data. But those are the claims that ECM and Community Support Providers are submitting. And that is, so that the APL also clarifies that, helps connect those dots a little bit more clearly.
Slide 31	Palav Babaria – 01:08:05	And also respond to Noah's comment in the chat. We cannot have double billing, so if ECM is paying for outreach, then you cannot also bill for the CHW benefit for the same outreach. We recognize there is variation in how ECM is paid. Some are paid on a capitated basis, some start after outreach is done, some are on a fee for service basis, so I think that the individual answer will depend on what that relationship looks like with the plan. But you cannot get paid twice for the same outreach essentially. Great. Okay, let's keep going, because we have a few more sections to get through.
Slide 32	Susan Philip – 01:08:54	Okay. I will take the next section. And this is really focused on strengthening market awareness and really making sure that we are really optimized.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 32-33	Susan Philip – 01:09:03	And really making sure that we are really optimizing the way folks in the market plans, obviously plans, but providers and members are really aware of the opportunity for ECM and community supports. So the first, as we've touched on before, we can move to the next slide, is really related to enforcing existing guidance for managed care plans to really ensure their contracted networks and providers are aware of the ECM and community support services. Again, what are the eligibility criteria? What are the pathways for submitting referrals? And there's also requirements now for ensuring that call centers are trained on how to refer for ECM and community supports.
Slide 33	Susan Philip – 01:09:52	Ultimately, we're really looking to our plan partners and providers to think of creative ways to really approach education outreach on these benefits and referral processes and just maximize awareness. So, to the extent that managed care plans have their own webinars and road shows and trainings and site visits with their plan provider partners, making sure that, as they're standardizing approaches, that there's clear information on their websites, provider manuals, newsletters, that they're really thinking through all the different avenues by which they disseminate information, and ensure that contracting providers are aware. And then, again just to reiterate, the incentive payment program includes measures to really incentivize that increased awareness and training of providers on ECM and community supports. So there's also that financial incentive there as well.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 34-35	Susan Philip – 01:10:50	So we can move to the next slide. And then just as a reminder, managed care plans really are to ensure that publicly facing websites, especially the member handbooks and provider directories, include the most up-to-date information about ECM and community support. So for example, the provider directories must include who are the ECM and community support providers and how to access them. And so the other point we just wanted to raise up also is that DHCS, our own website contains fact sheets and other language that managed care plans can really just plug and put into their websites and into their collateral so that we can really get the word out and try to streamline that messaging. And I do want to flag that, as part of our ongoing monitoring efforts, we are reviewing managed care plans' websites, handbooks, provider directories to make sure that the information does reflect that most up to date information and ensure compliance. We can move to the next slide. So I did want to switch gears a little bit. The next few slides are really focusing on PATH, which is Providing Access and Transforming Health. This is an initiative that is really multi-year initiative to really build and scale infrastructure and capacity for successful implementation of ECM and community supports. And under PATH, there are four key initiatives. The first I wanted to really highlight is a collaborative planning and implementation initiative. This is an initiative that really provides support for collaborative planning and implementation groups to really come together and promote readiness for E C M and community support. So this launched earlier this year, so about six, seven months in now and we have 25 collaborative groups throughout the state. As of now we have about 600 organizations that are registered and participating in those collaborative groups, and we really encourage entities, managed care plans, providers, counties, other stakeholders that are interested in building capacity for ECM community supports or participating as an ECM provider or community support provider, really engaged with that initiative.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 35	Susan Philip – 01:13:27	I mean they're really intended to be a place where A, you can find partners that you can also engage on implementation concerns. So if you are an existing ECM provider, find other folks that you can reach out to. All our managed care plans should be engaged in their regional collaboratives, so that is something that we are requiring our facilitators that are running these collaboratives to ensure that the managed care plans are coming and engaged in this effort. So please do look out for that and a lot of that information is just on our website. Go and register and find your local collaborative.
Slide 36	Susan Philip – 01:14:15	Okay. We can move to the next slide. Okay. The next key initiative is CITED, long acronym here, Capacity Infrastructure Transition, Expansion, and Development initiative. And this bucket is really providing grant funding to help scale infrastructure and capacity for entities interested in becoming ECM and community support providers. So this launch last year, in the first round one we awarded over $200 million. We have a round that it's closed and we're reviewing the CITED grant application right now. We have a number of organizations that have expressed interest. So if you are interested in future rounds or will be future rounds available, check out our website, make sure that you're going through their process. It is application based so there's a real rigorous process by which you need to submit the application, need to really demonstrate that, fully intend to and will have contracts with a managed care plan to actually provide ECM and community supports by the end of the award. So it is really important that the funding that we're providing through this bucket really builds ECM and community support capacity statewide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 37	Susan Philip – 01:15:40	Okay. So we can move to the next slide here. Okay. So the next bucket here is a Technical Assistance Marketplace initiative. So this is really what it sounds like. The idea is that we have a marketplace, it's live on our website right now. And the idea is we have vendors that have been reviewed, pre-approved by DHCS and there are domains that you can shop essentially and look at off-the-shelf services, look at specific types of support, technical assistance, hands-on consulting services, for example, that an entity looking to scale and build up community support services might need.
Slide 37	Susan Philip – 01:16:27	So for example, if you are a CBO and you're wondering, okay, how do I go about billing managed care plans? Or I don't know the first thing about contracting with a managed care plan. That technical assistance service is available through the marketplace, and the idea is that an entity that's looking to obtain those services could find a vendor, work with a vendor to develop a project, submit an application for that project, and then we, under the TA Marketplace initiative, will pay for that. So there's no cost to the organization looking for that project and looking for that technical assistance support.
Slide 38	Susan Philip – 01:17:10	Moving to the next slide here. So then finally there's a Justice Involved Capacity Building initiative. So this is really specific to our justice involved initiative and that includes pre-release Medi-Cal enrollment and suspension processes and really building up capacity in the pre-release role, as well as delivery of Medi-Cal services 90 days prior to release. So this is very specific to entities that are eligible under the JI initiative. So that includes sheriff's departments, juvenile services. So there's a number of county eligible organizations that are eligible, but it's very specific for justice involved.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 38	Susan Philip – 01:18:02	Okay. And then, so those are the PATH initiatives. I know I went through those quickly. I did also want to mention one other policy change that we wanted to highlight that has to do with really building awareness for community support services and ensuring that we're really optimizing community supports as a service. So, we are aware, before community supports came online, that managed care plans were delivering safe value-added services. So for example, a managed care plan might have been providing medically tailored meals to certain populations but they weren't considered community support services per se.
Slide 38	Susan Philip – 01:18:51	So we are encouraging managed care plans to really look and evaluate those value-added services and see if it would make more sense to really drive that into community support services. And at the end of the day, the reason we're looking to encourage that is we want to take up of community support services so that we can really make it be a statewide benefit going forward. So that's something we're really encouraging managed care plans to take a look at those value-added services and really see if we can drive enrollment into community supports instead. Okay. So I know we're getting close to time and I think we can move to the next slide here and pause for a brief discussion.
Slide 39	Susan Philip – 01:19:54	I don't see any hands up. I do see a question from-
Slide 39	Kim Lewis – 01:19:58	Yeah, my...
Slide 39	Susan Philip – 01:20:00	Oh-
Slide 39	Palav Babaria – 01:20:00	Kim Lewis actually has her hand up.
Slide 39	Susan Philip – 01:20:02	Oh, okay. Just saw that. Okay, great.
Slide 39	Kim Lewis – 01:20:03	Sorry.
Slide 39	Susan Philip – 01:20:03	That's okay.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Kim Lewis – 01:20:08	I should say speak up. Hi. It's not about the PATH specifically and I maybe could have raised this earlier in this conversation around the justice-involved population. I know we just submitted lengthy comments on the guide that was put out for justice involved, a rollout implementation. And one of the things I think we're concerned about, specific to ECM is the potential for too many either handoffs or truncated deliveries of the service while in the 90 day in reach is happening and while they're still not released, as well as the expectation of day one managed care accountability for ECM starting in the community when it's probably not realistic if they're not even members of the plans yet until that potential retroactive date back to the first.
Slide 39	Kim Lewis – 01:21:00	And say they come out on the 20th and we're like, "Okay, well now you're going to be a plan member back to the first of the month," but you shouldn't expect them to turn on a dime to be able to identify those members, know who they're going to be, and then either work with someone who's doing ECM already that isn't in the managed care network or to change potential ECMs, which I know isn't the purpose or the intent. They want to have continuity.
Slide 39	Kim Lewis – 01:21:26	I'm just a little worried about the realistic nature of that transition and whether there's a way to have the plans do more of a reach in obligation or fund those ECMs, some kind of a case rate so they can bridge that transition themselves rather than say you have to be a fee for service provider and you have to be a managed care member to do this. Because I think that's the thinking, but I don't know how many ECMs, like community health workers, are going to sign up to be fee for service providers when it's not a benefit that's designed around fee for service. So, I just wanted to flag that here as well because it's something we've been thinking about.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Susan Philip – 01:22:07	Thanks, Kim. I appreciate that comment. Okay. I think Catherine Sullivan, I see your question there. Please feel free to chime in if you can be off mute. Maybe there's technical issues here, but Catherine, we see your question. I know you have several comments and questions in the chat. I think we can take a review of those. If there's anything specific you wanted to raise now and you don't have technical issues, feel free to raise it right now. I'll give you a minute to.
Slide 39	Palav Babaria – 01:23:04	And maybe Susan, while that's happening, I know we only have a few minutes left and have one more section to get through.
Slide 39	Susan Philip – 01:23:09	Yes, yes, go ahead.
Slide 41	Palav Babaria – 01:23:13	Let's keep going, and then if others have more questions and stuff, please feel free to drop them. So the last common theme that we heard was really around data exchange. We can go to the next slide.
Slide 42	Palav Babaria – 01:23:26	So, a few things in this area. We heard that many providers and CBOs are being required to document the detail of their ECM and community supports delivery, so things like care plans, et cetera, in plan-specific IT portals, which again, if a provider is working across multiple counties, multiple plans can become very administratively burdensome. And so we are clarifying the existing policy, which is that MCPs cannot require ECM or community supports providers to use their MCP- specific portal for day-to-day documentation of services. This is different than any sort of requirements around submitting, billing, and claims, but for documentation purposes, this cannot be a requirement. However, MCPs may use their own portals to exchange member engagement lists and authorization information with contracted providers. We can go to the next slide.
Slide 43	Susan Philip – 01:24:29	Great. And then for community supports, the first year of implementation, we had data standards for information exchange between managed care plans and ECM providers, but not for community support providers. So earlier this year, we released a new community support member information sharing guidance, and that was really intended to standardize community support member information exchange.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 43	Susan Philip – 01:24:57	So, as we had seen in the first year that providers were really exchanging member information, authorization statuses, service delivery, progress information just in all different non-standard ways. And it was creating administrative burden for the providers, especially, again, those ones that might have contracts with multiple managed care plans. So in developing this guide, we really did engage with managed care plans and community support providers really extensively earlier this year to develop these standard data standards for the community support member information. And I think it really does help to address some of the lack of standardization issues that we have been seeing.
Slide 44	Susan Philip – 01:25:45	And the next couple of slides really just points to the timeline. So again, we had, oh, we can go to the next slide. We had provided the community supports member information, sharing guidance in April, and also provided, as Palav alluded to, member level information sharing between managed care plans and ECM providers that have been updated, quarterly implementation monitoring report guidance was also updated. So this is how we can see, again, some of the utilization information that you saw earlier is really based on this. And then ECM and community support billing and invoicing guidance. So this is again how ECM and community supports providers can bill managed care plans and provided some updates there. And as I alluded to earlier, we are updating also some of the HCPC coding guidance for ECM and community supports

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Susan Philip – 01:26:50	Okay. And then we can move to the next slide. So we really are looking to ensure that managed care plans are working with their ECM and community support providers to implement these new and updated standards. And this is really the timeline and the expectation for when the guidance is effective. So as I alluded to earlier, in terms of the HCPC codes and using the standard HCPC codes, that really is effective immediately. In terms of updates and changes to the member level information sharing between managed care plans and ECM providers, that guidance, which was effective a few days ago, July 1st, same goes for the billing and invoicing guidance, effective July 1st. And then the April guidance that we had provided will be effective September 1st, 2023. So there's a little bit of a ramp up phase there.
Slide 45	Susan Philip – 01:27:52	And then the next, just as a reminder that for managed care plans, the next quarterly implementation monitoring report, again we provided new updated templates, that information and the templates and the submissions using that new template will be effective on November 14th, 2023.
Slide 46	Susan Philip – 01:28:16	Okay. We can move to the next slide.
Slide 46	Palav Babaria – 01:28:21	So just to give people a preview in terms of the longer term commitment to streamlining reporting burden, I think as many of you know, all of the plans have been required to submit quarterly manual submissions to DHCS, which is where a lot of this data comes from, but the vision and goal is to really automate as much of this reporting as possible. So by the end of this calendar year, we are going to start leveraging encounter data via the ECM and community supports HCPCS codes to really track utilization of these services. Initially, obviously, it took a while to get the coding and the billing set up, so that was not a reliable way to monitor the go live. Now 18 months in, we'll be slowly making that transition.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 46	Palav Babaria – 01:29:01	We also are updating the Provider 274 file and MCPs will be reporting ECM and community supports providers via this file. And I saw some questions in the chat earlier, we agree that it is critical that everyone who is serving Medi-Cal members knows that they're enrolled in ECM and who their ECM care manager is to support care coordination and follow-up activities. And so we are exploring ways that we can leverage that 274 file in the future, especially via our PHM service. And then we also are going to be collecting enrollment information through the JSON file data format, which MCPs are already using for other reporting requirements. This will enable the department to get all of this information in standard formats and then flow into our data systems, which will also enable us to hopefully set up more timely public reporting as well for all of you to be able to see what's happening with these two critical programs and more guidance coming soon.
Slide 48	Palav Babaria – 01:30:02	Let's just jump to slide 48 to just talk about the next steps. So we will be shortly releasing the ECM and community supports policy guides. The website that was dropped in the chat will be updated, so that will be publicly available for this round of the policy updates. And then all of our plans will be submitting attestation forms indicating that they're complying with these new requirements. And then by the end of July, you'll have all these updates on the public-facing website and in August, there'll be two webinars that are really aimed at providers to go over this information from a provider perspective.
Slide 48	Palav Babaria – 01:30:46	Great. Well, I know we are at time, so thank you all so much for joining us today. I know there was a lot of questions and comments in the chat that we couldn't get to, but we promise we'll take all of that back and hope to weave it into things that we address moving forward. Thank you so much.
Slide 48	Susan Philip – 01:31:06	Thanks everyone.