CalAIM All Comer Webinar: ECM After One Year

August 14, 2023

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Emma Petievich – 00:00:33	Hello and welcome. My name is Emma and I'll be in the background answering any Zoom technical questions. If you experience difficulties during the session, please type your question into the Q & A field, which is located on the Zoom panel at the bottom of your screen. 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 close captioning will be available in English and Spanish. You can find the link in the chat field. And with that, I'd like to introduce Palav Babaria, deputy director and chief quality and medical officer with the quality and population health management division.
Slides 1-2	Palav Babaria – 00:01:11	Hi everyone. Thank you so much for joining us today as we walk through our recently released implementation report on enhanced care management. As well as talking through some of the really necessary and exciting changes that we are bringing to the ECM program to make sure that it is reaching as many eligible members as possible. We will go through the slides and then obviously try to leave enough time for robust question and answer at the end. We can go to the next slide. So, hopefully this is not news to anyone at this point, but a reminder that we are in the continuous coverage unwinding process right now given that the public health emergency in the continuous coverage requirement ended in March.

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Slide 2	Palav Babaria – 00:01:54	And so, Medi-Cal redeterminations have resumed effective April 1st. This is the first time in three years that we are doing this process and for some Medi-Cal members, this is the first time they've ever had to go through a redetermination. Our explicit goal in this process is to minimize member burden and promote continuity of coverage. We know that there will be thousands, if not up to a few million people who are no longer eligible for Medi-Cal coverage. And we want to make sure that those individuals are redirected to other forms of coverage and that for those who are still eligible for Medi-Cal, that we are keeping them on Medi-Cal without any disruptions to their care.
Slides 2-3	Palav Babaria – 00:02:33	So, we do need all of your help in getting the word out. If you haven't already, please join to become a DHCS coverage ambassador. You can get on our mailing list and get access to toolkits that will help you communicate what is happening to members and other community partners who are helping to get the word out. We can go to the next slide. I will also lift up that there's a number of resource hubs that include materials in all 19 threshold languages. And there's a new interactive dashboard which has really relevant data down to the managed care plan and county level that show what is happening with redetermination and disenrollments across the state.
Slides 3-4	Palav Babaria – 00:03:10	And we also have a Medi-Cal member facing website keepmedicalcoverage.org, which can help members navigate what they need to do during the redetermination period to keep their coverage. So, please, please help us get the word out. You can go to the next slide. So, today we have a jam-packed agenda, we're going to start with walking through the recently released report from DHCS looking at ECM uptake and delivery in 2022. And then go through and spend the bulk of our time talking about policy refinements for ECM that have recently been changed and or will be rolling out in the weeks and months to come and then leave some time for discussion. We can go to the next slide.

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Slide 5	Palav Babaria – 00:03:56	So, just a reminder, especially if anyone on this call, I doubt any of you exist at this point, but if you do and you have not heard about Enhanced Care Management. ECM is our statewide Medi-Cal managed care benefit, which really supports comprehensive care management for members with complex needs. So, a reminder on the right, you'll see what our care management continuum is. ECM really born out of our Whole Person Care and Health Homes Pilots is designed to be a comprehensive Whole Person Care care management program that focuses not just on physical health needs, but also behavioral social health related needs. Dental health and other delivery system care coordination and case management needs, and is really designed to support care management for the most complex Medi-Cal members, the top 3% to 5% of our Medi-Cal population with really complex needs across all of those different delivery systems.
Slide 5	Palav Babaria – 00:04:53	We then anticipate that the complex care management programs that all of our managed care plans are required to have as a part of their NCQA accreditation. As well as DHCS population health management program requirements will really help support those members who are higher and medium rising risk, but don't meet eligibility criteria for ECM. And then basic population health management obviously supports all of our members in promoting health and wellness. And then each of the members served in these three buckets also will have access to transitional care services. ECM is also designed to be face-to-face, high touch and in-person interactions. We can go to the next slide.

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Slides 6-7	Palav Babaria – 00:05:32	So, also a reminder, I don't think it's needed for this group, but ECM is administered by our managed care plans and is delivered outside of the plan. So, unlike complex care management, which for the most part is administered by the Medi-Cal managed care plans, all of ECM is designed to be contracted out. And community-based providers, whether those are community-based organizations, medical providers, behavioral health providers are the ones who are providing ECM services in the community. We can go to the next slide. So, in terms of who is eligible for ECM, we have nine unique populations of focus. Most of them cover both adults and children and youth but you'll see some such as our long-term care population, a focus which is for adults and some such as those who are CCS or whole child model involved or child welfare involved are just for children and youth.
Slides 7-9	Palav Babaria – 00:06:26	And then the birth equity populations of focus and our Justice-Involved statewide population of focus have not yet gone live and we'll be going live in January of 2024. All other populations of focus listed here have gone live as of July, which is really exciting, yes. We can go to the next slide. So, hopefully that was a whirlwind recap. We want to dig into the details so let's go one more slide. So, if you have not read it, I highly, highly, highly encourage you to click on the link that is in these slides and access our 2022 implementation report. We released this to really provide much more detailed comprehensive data on both enhanced care management and community supports based off of the first full year of this program, which was calendar year 2022.

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Slide 9	Palav Babaria – 00:07:17	Quick disclaimer and reminder is that for calendar year 2022, our long-term care population of focus as well as our children and youth population of focus had not gone live yet. So, you will not see detailed reports and numbers about those populations of focus unless they were grandfathered in from Whole Person Care and Health Homes pilots in this report. But I do think the report is really an exciting transparent step forward to share both state level data on utilization and provider networks as well as stratified data of who the users are of these benefits and services by race, by ethnicity, by primary language spoken and by geography. As well as county level data on utilization and cited data by county and MCP level data on utilization.
Slides 9-10	Palav Babaria – 00:08:05	You can slice and dice the report in different ways and I will say as a data and data transparency nerd, I am personally super excited about our ArcGIS format, which is a far cry from some of the PDFs that we've had and really bulky reports in previous years. And so, we hope that you all appreciate the format and the interface and usability of this report as well. We can go to the next slide. So, what did we see that we've outlined in this report? So, as we all know, three ECM populations of focus went live statewide in 2022. In the 25 counties where we previously had Health Homes Programs and Whole Person Care, those are the counties over here in dark blue. It was adults who were at risk of avoidable utilization. So, those would frequent avoidable ED utilization or hospitalization.
Slide 10	Palav Babaria – 00:08:58	Adults experiencing homelessness and adults with serious mental health or substance use disorder needs who had other additional needs as well. So, those three populations of focus went live in January for all of these dark blue shaded counties who had previous pilots. And then the entire state went live with expansion to the additional counties that are represented here in the light blue in July. I will call out, and those of you who've read the report know this. We recognize that in those counties that launched in July, they have far less infrastructure. They did not come off of five years of Whole Person Care and Health Homes pilots to build upon.

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Slide 10	Palav Babaria – 00:09:35	And so, throughout the report we really try to call out the trajectory of utilization and provider growth in these two counties in two separate buckets. Because we recognize that the infrastructure in those counties that went live in January looks very different than the infrastructure for those counties that went live in July. And then you'll also see in the report there are Justice-Involved individuals who are being served, who are captured in this report, but those are ones who again had been grandfathered in Whole Person Care counties that had a Justice-Involved component. And we look forward in January of 2024 to expanding that statewide with the Justice-Involved ECM launch.
Slide 11	Palav Babaria – 00:10:15	We can go to the next slide. So, really exciting. We served 109,000 Medi-Cal members in ECM in calendar year 2022. And I've recognized that when you know that Medi-Cal serves 14 to 15 million people, 109,000 does not necessarily seem like a huge number. And I encourage you all linked in our report, there is a video of Colleen's story and those of you who have joined us in our population health management public advisory group have heard Colleen's story before. But when you recognize the sheer complexity of each and every single one of these cases, individuals who are homeless, who are struggling with not one, not two, but often four, five, six medical conditions who are in and out of emergency rooms and hospitals who literally cannot afford food that is healthy, that would keep them out of the ED.

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Slide 11	Palav Babaria – 00:11:11	When you think about just the sheer magnitude of need and services across 109,000 members, it really is staggering. And so, I hope we all take a moment to really celebrate that success. You will see also really excitingly over the course of 2022, there was steady quarter upon quarter increases in the number of individuals that were being served. And so, this is even as individuals are graduating from the program transitioning off of the program, we are still not only filling their slots but adding new members over time. And you'll see here the largest population of focus served far and away was those who were at risk of avoidable hospital or ED utilization followed by those with serious mental health or SUD needs followed by those experiencing homelessness.
Slides 11-12	Palav Babaria – 00:11:59	And then fourth was those involved in the Justice-Involved system. But again, that last population was only present in a few specific counties. We can go to the next slide. So, this really breaks down as we mentioned, what member engagement looks like in the 25 counties with Whole Person Care or Health Homes pilots. You'll see that there were members who transitioned and rolled over from the Health Homes pilot represented here in yellow as well as those who were in Whole Person Care represented in the blue. And not surprisingly, over time we saw those who had been rolling over that population shrank as those members graduated from the program or didn't need those services anymore.
Slides 12-13	Palav Babaria – 00:12:44	But the really exciting thing to me is when you look at newly engaged members, so these are brand new, not individuals who are grandfathered in. That orange bar went from 7,000 to 27,000 over the course of the year and suggesting that we are building upon the networks that we have and growing capacity throughout those 25 counties for additional members. Yes, definitely reasons to celebrate. We can go to the next slide. So, then as mentioned before, we know the landscape and infrastructure looks really different in those 33 counties who didn't have Whole Person Care or Health Homes pilots.

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Slide 13	Palav Babaria – 00:13:21	And so, the uptake and the pace of growth is definitely slower within those counties. So, at this point, we only have two quarters of publicly available data and we see that there were 600 members being served in quarter three and then that jumped up to 1.9 or 1,900 members by the end of quarter four. And we anticipate that quarter upon quarter we are going to see increases in growth. And we are looking to learn from the lessons learned from this data and feedback from our path and cited communities about what additional infrastructure and capacity building needs these counties have so that we can really accelerate this trajectory. We can go to the next slide.
Slide 14	Palav Babaria – 00:14:04	So, we have gotten a lot of questions about who is providing ECM services throughout the state. So, also not surprisingly, the largest provider by far and away is our federally qualified health centers across the state. Many of them had been involved previously in Whole Person Care pilots and given the models of integrated primary care they provide, are really expanding that access to most of the populations of focus. We also have seen a lot of other medical types of providers, whether that is physician groups or hospitals or community health centers providing services. As you'll see on the top end of the spectrum, we have a few early adopter local health departments and rural health centers and counties, but not as many of those traditional medical providers. And we'll get to that in the next section of this, what we want to do to really change the mix of providers that we have.

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Slides 14-15	Palav Babaria – 00:14:58	Because we know that for many members their medical providers are the best person to provide ECM services, but for some of the populations of focus they're not. And we want to make sure that we have a really broad diverse network so that we can meet the unique needs of each and every single member in ECM. We can go to the next slide. You'll see here we have two different lines, the bottom one is the number of provider contracts and then the, sorry, orange one is the number of provider contracts and then the blue line is individual ECM providers as measured by a unique NPI. And so, for both of these you'll see there's an upward trajectory. So, there have been growth in the number of contracted providers as well as the number of unique providers for ECM over 2022, but the gains have been modest. We can go to the next slide.
Slide 16	Palav Babaria – 00:15:55	So, I'm going to pause there and maybe we can just see if there are any questions specifically on the data before we go into the actual policy revisions that we will be rolling out.
Slide 16	Lori Houston-Floyd – 00:16:16	Hi all. This is Lori Houston-Floyd, I'm a senior manager with Manatt and I support the department on all things ECM and community supports. I think Palav, the only question I'm really seeing here related to data is if the department can share about how many total teams by the 51 counties are reflected in the data. I wonder if you want to speak to just the provider data in a bit more detail there.
Slide 16	Palav Babaria – 00:16:40	Yeah. And I do think we have some of this breakdown internally, it was not published in the public facing report. So, we can definitely take that one back to see what else we can share publicly, whether it's in our next fact sheet or future reports, but great call out. Great, and then I also see one more data question in the chat from Richard. So, I think one of the challenges in terms of getting data closer to real time is we get a quarterly implementation monitoring report submitted to us from plans which is submitted about a month or two after the end of the quarter. And we do have to do a fair amount of cleanup sometimes on some of that data internally and then package it.

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Slides 15	Palav Babaria – 00:17:22	So, we are looking to see how we can make that process smoother. We're doing some data refinements which we'll cover in this next set of the sections too. But there is always going to be some lag in terms of when services are rendered and when that data, whether it is by claims or these monitoring reports gets to the state. So, we also encourage you locally to have those conversations because we know many of our local partners have much more real-time data than we have accessible to us at the state.
Slide 14	Lori Houston-Floyd – 00:17:52	Palav, another question from you. Two slides ago, there was types of organizations and the ECM contracts that they currently have. What would you and the department like this distribution to look like in the coming year and why?
Slide 17	Palav Babaria – 00:18:08	Great question. I'm going to have whoever asked that question, hold it and let's go to the policy refinements and I think your question will be answered, but if it's not, please do ask it again.
Slide 17	Lori Houston-Floyd – 00:18:18	It's a great segue to the next section.
Slide 17	Palav Babaria – 00:18:19	Yes, it's like we planted that question. So, we recognized this is an amazing start as I mentioned to our program and we also know that 2022 was just the start of this journey. I think all of us recognize that there are lots of individuals out there who are eligible for ECM and community support services who are not receiving them for a whole host of reasons. And our explicit goal throughout the remainder of 2023 and throughout 2024 is to ramp up, increase provider capacity, increase identification of these members and enrollment into ECM and to really make sure that anyone who could benefit from this program has access to it and has offered these services.

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Slide 17	Palav Babaria – 00:19:03	So, as we look forward throughout the rest of this year, as mentioned, we already launched our long-term care population of focus in January. Children and youth went live a little bit over a month ago and then we look forward to January of 2024 when our birth equity and Justice-Involved populations of focus will be going live. And I often get comments from the field, please stop adding more populations of focus. So, I can say as of this point in time, there are no more populations of focus planned after January 2024. Don't hold me to that forever, but for the foreseeable future, once we get through these, we can really focus on expansion and refinement of the program.
Slide 17	Palav Babaria – 00:19:43	We also want to continue supporting ECM providers through the PATH program and cited grants to really again build that capacity, especially along non-traditional providers. And then we really want to make sure that we're incentivizing MCPs who have the incentive payment program to also continue to expand capacity and improve ECM uptake. And then the focus of today's webinar is really on this last bullet point is that we have heard loud and clear from all of you from our partners across the state from listening tours that our director's office has done, that there are barriers. And we know that 2022 was our first year and we really appreciate all of the feedback that we've received because it helps us refine our policy, make improvements and really break down those barriers. We can go to the next slide.

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Slides 18-19	Palav Babaria – 00:20:35	So, these are all of the ways in which we get data about what is working and not working. There's advisory groups, there's the listening tours that our director, director, boss, and state Medicaid director Jacey Cooper have been doing across the state. We have done numerous surveys with our managed care plans and other entities. We have our quarterly report that we get submitted from MCPS as well as interviews that we perform with the department and our consultants to meet with groups of people to understand what is and is not working. We can go to the next slide. And so, in that spirit, I'm not the chief quality officer for nothing. We are committed to a culture of continuous improvement and want to forever make improvements and make this program as good as it can be.
Slide 19	Palav Babaria – 00:21:18	And so, when we launched the program in 2022, there were some parts of ECM that were very prescriptive and standardized. Whereas, there were other parts where managed care plans had flexibility and could define what their model was through the model of care process. Now, a year and a half into the program, we have heard consistent feedback from providers and CBOs as well as some MCPs that they really need increased standardization. And this is particularly true of providers and CBOs that either have multiple managed care plans operating in their county or those that span county borders and are having to contract with multiple MCPs across multiple regions.

Slide 19	Palav Babaria – 00:22:00	As you can imagine, if each MCP has their own separate requirements around what the ECM model of care is to look like, what reporting has to look like, what authorization has to look like, that can add a lot of administrative complexity and burden on our providers. And then specifically CBOs and providers really are saying that that administrative burden is taking away from member care and leading to a lot of problem scaling and serving more members. And so, we released a set of ECM policy refinements in areas of reinforcement. All of this is now publicly available in the ECM policy guide, we can drop that link into the chat if that is helpful. And then we've also identified areas for future design work that aren't yet included in this policy guide that we are working through in the weeks and months to come, which we're going to discuss today.
Slide 20	Palav Babaria – 00:22:53	We can go to the next slide. So, this is the five buckets of work. So, the ultimate goal very explicitly is increasing availability and uptake of ECM. We don't want this to be one of those things that we put in a lot of barriers to getting this service. We truly do want everyone who could benefit from this service and is eligible to receive it. And we recognize that standardizing eligibility, streamlining and standardizing referral, authorization processes, expanding provider networks and streamlining some of the payments, strengthening market awareness. A lot of people including members still don't know that ECM is out there or what it is.
Slides 20-22	Palav Babaria – 00:23:32	And then also improving data exchange have all been identified as major themes that if we can fix these problems will result in more members getting these services. We can go to the next slide. We can go one more. So, a few things that we have done. So, in current state there is variation we have heard from providers who are providing ECM services in terms of the eligibility criteria for the ECM populations of focus. And so, this is not new policy, this is us reinforcing existing policy. ECM is a statewide benefit and like all benefits plans must offer the benefit and they have to adhere to the existing eligibility criteria.

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Slide 22	Palav Babaria – 00:24:16	And so, we have reinforced this in our policy guide, but for example, if there is a specific population of focus that is outlined in the ECM policy guide, plans cannot add additional requirements such as specific clinical or social factors that are required to be met to meet that eligibility threshold. And so, for those of you who are providers on this call, if your member or if the patient meets the eligibility criteria as identified in the policy guide, they should have access to ECM services. We also clarified that an MCP can't require ECM providers to have a certain number of contacts with a member as a condition of authorization. This was another thing we heard consistently from the field that some plans, three contacts had to happen with a member before they could be authorized for ECM.
Slides 22-24	Palav Babaria – 00:25:06	So, the only contingency for authorization is that the member meets the eligibility criteria. We did get feedback that the current population of focus around individuals at risk for avoidable hospital or ED utilization is a really high bar to meet. Because currently you have to have six ED or a certain number of ED visits in six months. And so, we are providing some flexibility to the plans that if they want to lower that bar a little bit, i.e. not have as many ED visits or hospitalizations to meet the eligibility criteria, the MCPs have the ability to do that. We can go to the next slide and go one more. So, the second issue was really around referrals and authorizations. And so, we also heard consistent feedback that the time period for initial authorizations as well as subsequent authorization periods for ECM services were widely variable.

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Slide 24	Palav Babaria – 00:26:05	And so, a single provider for one plan, they could maybe get 12 months of an authorization, another one would be three months, another one would be six months. And then keeping track obviously of all of those differing authorization timelines is really challenging. So, effective July one of this past summer for all ECM authorized members, the initial authorization period must be 12 months and then reauthorization periods thereafter are in every six-month chunks to really standardize what this looks like statewide and simplify it for providers. We also heard a lot of feedback from the field that there were very specific reassessment timeframes that were being applied to determine whether or not a member should continue receiving ECM or whether they had met the intent of their care plan.
Slides 24-25	Palav Babaria – 00:26:52	And so, we have modified the approach for how this should be done. And so, the ECM provider should be reassessing care plan goals obviously throughout the interaction with that member and throughout the 12-month authorization period. Plans may still perform periodic review, but this should be done as a part of their monitoring and oversight activities and not necessarily as a part of the authorization process or reassessment process. We can go to the next slide. And I'm going through these a little quickly so that we have enough time for discussion. The other big piece of feedback that we heard from all of you in the field is that we know the best way to serve a member is by linking them to these services when they're open to them, when they're identified at the point of care.

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Slide 25	Palav Babaria – 00:27:42	And if an authorization has to be made and then however many days later that authorization is approved and then you have to go find that member who is no longer in the emergency room or no longer in the hospital. It can be really challenging and we may have missed the opportunity when someone was open to receiving services to engage them. And so, in response to this feedback, which we totally agree with, we DHCS strongly encourage MCPs to implement presumptive authorization. And so, we had some great examples of this that have been lifted up that we've spotlighted in meetings. But if you are a trusted provider working with an MCP, please work with them to figure out how you can start implementing presumptive authorization and serving that member in real time in the moment.
Slides 25-26	Palav Babaria – 00:28:28	While on the backend that authorization process is continuing so that we can really close that gap between identifying members and getting them the services that they need. And then just a flag not live yet, but for the justice involved ECM population of focus, we will be requiring presumptive authorization on the day of release. Again, because that is such a critical time and we need them to be enrolled and have access to these services from the second they leave that correctional facility. We can go to the next slide. So, we also have heard and this is one that is not live yet but is coming that the forms processes for referrals and authorizations across MCPs really add a lot of administrative burden.

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Slide 26	Palav Babaria – 00:29:16	And so, we are going to be working to develop a statewide standard for referrals in the fall of this year and then rolling that out in the future. I will also take this opportunity to lift up, we know, and it's not bad, but in current state, many if not most of the referrals are coming from data mining. From looking at claims and encounters and other data and identifying individuals who would meet eligibility criteria for ECM. I think from the department's perspective, the two problems with that is that one we know, and I'll give a shout-out to the CHCF report that spotlighted this recently. Is that claims data inherently has biases, especially racial and ethnic biases based off of disparate rates of utilization across certain racial and ethnic groups across the state.
Slide 26	Palav Babaria – 00:30:04	So, if you are only using claims data or only using data mining, we stand at risk of perpetuating biases and health disparities within the ECM program. Additionally, again, we know not all members want this service and a member being both identified and receptive to being enrolled in ECM is going to go over a lot better if there is someone trusted in their lives. Whether that is a teacher at school or a social worker or a primary care provider that they already know who recommends that program to them and makes the referral, then if they are receiving a cold call, whether that cold call is from an ECM provider or from a managed care plan.
Slide 26	Palav Babaria – 00:30:45	And so, our future vision is that the majority of referrals should be coming from the community and that someone who knows that member and is already engaged in that care is having that conversation and recommending this program to the member. So, more to come on these statewide standards, all MCPs and ECM providers will absolutely be engaged in that design work and then we hope to launch these sometime in 2024. And then also we'll flag the connection to IPP that there are IPP measures that incentivize MCPs to provide training and TA on ECM and community supports to all of their contracted providers.

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Slide 28	Palav Babaria – 00:31:23	We can go to the next slide. Great, so I think when it comes to provider network and payments, so we know as I mentioned earlier that there are a lot of wonderful providers, especially all of those FQHC who have contracted who really are doing a great job providing ECM services to our members. And yet we also know that we have a really diverse membership across the state and especially for some of the newer populations of focus such as those who are in a long-term care facility or children and youth who are welfare involved. Their primary care provider or their FQHC may not actually be the best person to provide ECM to them depending on what the member's engagement is with primary care and with their health center.
Slide 28	Palav Babaria – 00:32:12	And so, we want to make sure that we are really expanding ECM and that we have a broad network of providers who specialize in each specific population of focus. ECM was never envisioned as a one size fits all approach and we need a diverse network that really reflects the diversity of needs and experiences of our members. And so, in the new revised policy guide, there is very specific language for each of the populations of focus for who we envision outside of the traditional clinical providers may be good ECM providers within that space. And we are encouraging MCPs to really think creatively about how they help build out that continuum. So, that providers who are providing ECM also potentially can start providing the new community health worker benefit, help step members up or down to services as they graduate from the program.

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Slides 28-29	Palav Babaria – 00:33:03	And then moving forward, our MCP network directories are also going to have to indicate which specific population of focus each ECM provider is equipped to serve. So, that is very clear, "Hey, this individual specializes in that long-term care population of focus. This ECM provider does a great job with child welfare involved youth." And so, that is very clear how collectively that network is really meeting the needs of the population. Also flag another connection to IPP. We are monitoring and incentivizing uptake of the CHW benefit in '23 and '24. We can go to the next slide. So, this is what is referenced here, this is now I believe in our policy guide. So, this is not exhaustive, this is starting point, not the endpoint, but we really want to call out who in the current space is already serving these specific members, right?
Slides 29-30	Palav Babaria – 00:33:55	The goal of ECM is to not add another cook to the kitchen but really provide comprehensive care management ideally leveraging relationships that exist with the member already. And so, I'm not going to read all of these out, but you'll see some of the facilities and partners at the local level and at the state level that we really see as being experts in some of these populations of focus. We'll go to the next slide. And we have a similar list going especially for children and youth. And I will also flag there is some sorting required here and it is going to be hard to identify for an individual member who's eligible for ECM. Who's already taking care of them? Are they enrolled in a school-based clinic where maybe that is the best ECM provider? Or are they followed by a CCS case manager where maybe that program can expand and provide additional services?

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Slides 30-31	Palav Babaria – 00:34:46	And locally really figuring out how are you not just getting lists of individuals to enroll but really getting those individuals to the right ECM provider based off of preexisting relationships and meeting their needs is going to be critical. We can go to the next slide. The last, I think this is the last slide, but the last other provider network and payment issue is really around the HCPCS code sets. And so, we have also heard consistent feedback. There's different criteria and that some plans have required additional code sets or different code sets on top of the ones that DHCS has required. And so, we will be reissuing the HCPCS coding requirements with clarification that for ECM, these codes have to be used as is without additional codes or modifiers. And again, that is to streamline this so that those providers who are contracted with multiple plans don't have to set up different coding and billing systems for each of the different contracts.
Slide 32	Palav Babaria – 00:35:46	We can go to the next slide. We also have heard that there have been a lot of issues with timely payment or Deloitte invoice payments and especially for CBOs that are new to billing Medi-Cal, we recognize you are small, you don't always have large margins and not getting paid on time can be really financially disastrous to you. And so, we are reinforcing existing timely provider payment requirements. So, what is listed here, this is not new policy. There is a new APL that's clarified this, but this is existing old policy and so everyone should be abiding by this. And so, in current state, MCPs are required to pay 90% of all claim claims within 30 days of receipt and 99% of all claim claims within 90 days.

Slide 32	Palav Babaria – 00:36:33	And then MCPs must also reimburse claims or any portion of a claim as soon as practical as listed in our California Health and Safety section code 1371 but no later than 30 working days after receive of the claim. And we also recognize that for some of the newer Medi-Cal providers, CBOs, those who aren't used to billing Medi-Cal, there may be issues with submitting a clean claim and what that means and how to do that effectively. So, MCPs are also required to train all of their ECM providers on how to submit a clean claim so that you can get to that threshold and then get paid. So, there are reinforced clarifying guidance that has been released to this end recently. We can keep going.
Slide 33	Palav Babaria – 00:37:18	We also have heard issues about providers not being consistently reimbursed for ECM outreach. I think we recognize that depending on the population of focus, if you are serving the homeless population, it's going to take a lot of outreach. This is not you make one phone call and someone says yes and they're enrolled in your program. And so, MCPs are expected to be reimbursing ECM providers for outreach including for unsuccessful outreach that didn't result in the number enrolling into ECM for whatever reason. And so, the rates that we DHCS pay MCPs already include assumptions about the cost of outreach. We continue to refine our assumptions and improve those rates over time.

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Slides 33-35	Palav Babaria – 00:37:58	And we also have a survey underway, supplemental data requests to better understand the rates that ECM providers are being paid including for outreach. And so, we are working on guidance to really standardize the thresholds that should trigger payment because we recognize that in current state each plan when payment kicks in is at a different point in time. So, this is an area of future policy guidance. Okay, we can go to the next slide. So, strengthening market awareness. So, I will say there is generally low awareness about ECM and how to access the benefit. And I will say those of you who know me, I am still a practicing primary care provider and in my very own clinic where I practice every Friday morning, most of the people around me have never heard of ECM and have no idea what the benefit is or how to refer for it outside of our healthcare system.
Slide 35	Palav Babaria – 00:38:54	And so, I think this is a major area where we really want to reinforce existing guidance and make sure that collectively the MCPs. But also, all of us are making sure all of the contracted networks of providers are aware about the ECM benefit, that they understand the eligibility criteria and that they're really identifying these individuals and referring them for ECM. And this links back to what is the source of the referrals, right? If the network doesn't even know about this benefit, we are not going to get to a point of having a majority of community-based referrals for this program from trusted voices. And then also really making sure that we're using all opportunities, whether that is in call centers, transitional care services requirements to identify individuals who are eligible and make those referrals.

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Slides 35-36	Palav Babaria – 00:39:41	And then there are IPP measures very specifically tied to this to work on education and engagement. We can go into the next slide. We also know that there's low awareness in the community in addition to providers. And so, really making sure that the public facing websites member handbooks and provider directories are really up-to-date and that everyone knows about the benefit and that how they can be eligible. And so, we have already been monitoring websites, but we will be continuing to do this on a regular basis as well as handbooks so that we can flag and follow up with MCPs where there are gaps that we are finding.
Slides 36-37	Palav Babaria – 00:40:20	If any of you on this call have suggestions or ideas of how we get the word out, I am biased because my team oversees the ECM program. I'm not going to pretend that I'm not, but I do think this is one of the most potentially transformational parts of Cali. And the more we can do to really spread the word, the better it will be for all of our members. We can go to the next slide. The last thing that we'll call out is we also recognize that path is a really underutilized part of the overall Cali transformation. And so, for those of you who may not be tracking, PATH is actually comprised of four separate but interrelated initiatives.
Slide 37	Palav Babaria – 00:40:59	So, the collaborative planning and implementation initiative is really to provide local collaborative planning and implementation groups where people can come together. There's expert facilitators who partner with the department to run these groups and it's really to work through what is happening locally. How do we support standardization, public communications, how do we help support new interested providers or plans? We're struggling with various issues and getting the word out and working through them. And so, we really encourage that all of you who are interested in this program attend and participate in your local initiative. We can go to the next one.

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Slide 38	Palav Babaria – 00:41:36	The next bucket, which I think many of you're probably more familiar with because there's funding tied to it is cited, which is grant funding to enable those who are transitioning, expanding or developing ECM capacity and community supports capacity. We already awarded $200 million in rounds 1A and 1B and then applications to round two closed a few months ago and we'll continue to release information on future rounds of cited. And as mentioned, we are really looking at the data we are receiving and the gaps that have been identified both in that data but also from stakeholder engagement to see how we need to potentially tweak some of these cited awards moving forward to really meet the needs of our state in aggregate. We can go to the next slide.
Slides 39-41	Palav Babaria – 00:42:23	The technical assistance marketplace is also live. And so, anyone who is either contracted or a prospective ECM or community supports provider, we encourage you to shop for technical assistance. It is really an amazing opportunity to learn and scale based off of the experience of people who are already doing this in the field and have already worked their way through a lot of these questions. We can go to the next slide. And then the last bucket really is very specifically focused on the Justice-Involved initiative given the complexity of this effort. We can go to the next slide. Lots more information about PATH located here, please visit the website and we welcome all feedback that you all have on these services and how we can improve them over time.

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Slide 43	Palav Babaria – 00:43:06	We can go to the next slide, and go one more. So, I think the last part around improving data exchange, also a lot of feedback that there is variation across the state and that especially for some providers and CBOs, they're being required to document a lot of very specific detail in plan specific IT portals. Which is resulting in a lot of duplicate data entry, which again comes with its own time and administrative burden. And so, we are clarifying our current policy and reinforcing it, which is that MCPs cannot require ECM or community supports providers to use an MCP specific portal for day-to-day documentation of services.
Slides 43-44	Palav Babaria – 00:43:48	So, this is like writing outreach notes, the day-to-day documentation does not have to be done and that can be done in the native local systems that people have. MCPs may use their own portals to exchange member engagement list and authorization information. So, that part is not changing and MCPS can continue to require providers to use the portal for those specific limited functions. And then data sharing guidance documents, we recognize this continues to be an area obviously if we're going to do this right, sharing data all being on the same page about the data is going to be really critical.
Slides 44-46	Palav Babaria – 00:44:29	And so, the goal is to really standardize as much as possible so that we can promote efficiency and reduce administrative burden. So, just pointing out that in April 2023 we released new and updated data sharing guidance documents. All of these are available on our website that really provides more detail that is standardized, streamlined and structured for all of the pieces here. And then the one that has not come out yet is the updated HCPCS coding guidance document, which will be coming out this fall. We can go to the next slide, one more. Okay, and I promise we're almost at Q & A because I already see all the questions coming in through the chat. So, all of the stuff that we've described today, unless we specifically said this is still in development and this is coming later, all managed care plans and ECM providers are expected to adhere to the policy refinements that we described.

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Slide 46	Palav Babaria – 00:45:32	So, all of this went out in July of 2023. Plans are completing an attestation form that they'll be submitting back to the department by September 8th, documenting that they are in compliance and adhering to all of these updated policies. We've also developed a cheat sheet, which we can drop the link in the chat and it's also linked in these PowerPoint slides so that providers and other stakeholders who don't want to read our multi-page ECM policy guide, which we recognize is really dense at this point. It's a higher-level summarized version of that so that you can really use that as a reference point, share that with your communities and networks and stay on top of the policy developments as well.
Slides 46-47	Palav Babaria – 00:46:13	And then more policy development, especially around the coding options and guidance and some of those standardized referral templates will be forthcoming later this year. We can go to the next slide. So, you made it through a lot of information and Lor, first I'm going to say did I miss anything? And if yes, feel free to fill it in and then we can go to Q & A.
Slide 47	Lori Houston-Floyd – 00:46:39	No, Palav, you covered so much ground and I think where we'll go with the Q & A, it's a robust discussion happening across a couple of different forum. So, I've aggregated some questions here and let's just step through them. I think it might be good to even repeat some of the key things that you covered. Let's start with foundational ECM eligibility. A question that came up that is particularly salient just given the recent launch of the children and youth populations of focus. Someone has asked, many patients may remain just in straight Medi-Cal and they want to confirm that therefore they would not be eligible for ECM. Is that correct? So, this would particularly include some children who are in foster and child welfare as well as CCS high risk.

Slide 47	Palav Babaria – 00:47:23	That is correct. And so right now, ECM is a managed care benefit only. I think as all of you are tracking, by 2024, we anticipate that 99% of all Medi-Cal members will be enrolled in a managed care plan. So, that is by far and away our predominant delivery system. And then we also know that for some of those populations that you mentioned, encourage you all to take that into consideration. We have heard reports and stories, especially for some of the foster involved youth where they are in managed care and then locally for a variety of reasons, longstanding practice has been to switch them to fee for service. And so, I think those are areas where we will want to partner with you to figure out given these new benefits structures, does that make sense? Are there other solutions we can work through? But yes, it is only available to manage care members.
Slide 47	Lori Houston-Floyd – 00:48:13	Thanks for that Palav. And just another key question that came up in the data section that I think it's just worth answering this one and almost to advertise the data once again. Is the county specific enroll that data available in this report and is it also broken down by the health plan and county level?
Slide 47	Palav Babaria – 00:48:31	Yes, and yes. And all of that is in there. We really want it to be publicly transparent and I will say just a huge kudos also to our plan partners. This data is not designed to shame anyone, but it’s really data is power. And I think the more we can understand what is happening in each of our counties and regions, we can start to partner together to really close those gaps, reduce the barriers and get this benefit out.
Slide 47	Lori Houston-Floyd – 00:48:57	Okay, great. So, let's now shift into some of the policy updates that you just talked about. I'm going to spend a moment on ECM referrals and authorizations. And so, can you just remind the group, Palav, is there right now a standardized way that a medical provider can refer a patient for ECM?

Slide 47	Palav Babaria – 00:49:16	There is no standardized referral form. So, all managed care plans in current state are required to have information about ECM and ECM referrals on their websites and we are monitoring for that. And so, often that is if you are on here and you're trying to figure out how do I figure out where to send someone, the plan website is often a very good place to start. But we have heard from the field that beyond that what is required in the referral, the degree of information, the degree of verification about eligibility does vary from plan to plan. And that is what we are hoping to standardize later this year.
Slide 47	Lori Houston-Floyd – 00:49:50	Thank you for that clarification. And now turning to the standardized authorization timeframes. There's some questions and comments about, basically the gestalt of the questions is, has the department further standardized the operational processes beyond the timeframes for ECM? Can you comment on that? And so, the context here is do providers have to complete reassessments at certain points or are providers required to update care plans at the six-month mark? Can you opine on the department's role in standardizing at this level at this point?
Slide 47	Palav Babaria – 00:50:29	Great question. So, at this point, the hard and fast standardization timeline is around those authorization timelines as mentioned, 12 months for the initial period of authorization and then six months thereafter. And I will say that that doesn't mean that member in ECM is going to be in the program for 12 months. That is contingent upon the individual member's needs, what their care plan is when they have been ready to graduate or transition out of the program. So, that is really just about the authorization period and not the care plan. I do think we heard loud and clear that many individuals required to do reassessments at various periods and we have reaffirmed in our policy guidance that plans should not just have a blanket requirement, "Hey, every two months, go reassess every member."

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Slide 47	Palav Babaria – 00:51:11	The reassessments really need to be driven by the individual care plan that is developed. And so, that is very clarified, but beyond that, we have not made more prescriptive requirements around the reassessments or the operations of the care management model. So, I hope that answers that bucket of questions.
Slide 47	Lori Houston-Floyd – 00:51:30	Yes, so helpful, Palav. Thank you. Pivoting now in this rapid-fire round, a couple of questions about ECM providers specifically. So, one question is, are there criteria that DHCS is currently using or will use to identify whether a provider is equipped to provide ECM to a specific population of focus?
Slide 47	Palav Babaria – 00:51:52	So, I think at this point, the specific model of care that is listed in the ECM policy guide around the buckets of services that have to be provided is as prescriptive as we have gotten. So, each plan is assessing and vetting ECM providers obviously that they're looking to contract with. We are internally looking at our data and trying to better understand the models that exist across the state so that we can better lift up best practices of "Hey, these are the types of providers, the types of models that we are seeing that are the most effective for each population of focus." But I think it's fair to say, especially for some of the newer populations of focus like children and youth who were not as well represented in our whole person care and health homes pilots for whom we have a formal evaluation and findings, we're definitely going to need more data before we can lift up any of those types of best practices.
Slide 47	Lori Houston-Floyd – 00:52:45	Great, thank you Palav. And also, a small dialogue happening around the ratio of number of members to a specific ECM provider. Can you just talk a little bit about DHCS's current policy on if there is a ratio or not and what the department may be looking at here for future design?
Slide 47	Palav Babaria – 00:53:06	I'm going to phone a friend and have someone remind me. I don't think we have concrete ratios written in the policy guide, but Lori please confirm that understanding.

Slide 47	Lori Houston-Floyd – 00:53:13	Yeah, that's correct. There's no current ratio.
Slide 47	Palav Babaria – 00:53:16	Yeah. And I've seen the chat and I think someone was throwing around 50 to one. And I will say from our listening tour and meeting with plans and providers, that is definitely a common number that we have heard in the field. But we also recognize, again, this is not one size fits all and if you're serving an entire panel of homeless individuals with complex behavioral and social and health related needs. That ratio is going to need to be different than if you are in primary care-based model only focused on chronic disease management. And so, that is an area absolutely as we get more data and understand what all the different models are across in the state where we hope to lift up common themes and best practices, but we have not issued any strict guidance to date.
Slide 47	Lori Houston-Floyd – 00:54:01	Thank you, Palav. And the flavor of questions of where I'm going to head now is towards the future and things that the department may be looking at in the future, a couple of questions around payment. Can you just share a little bit about the supplemental data requests that the department has issued and how the department will be looking at a couple of different dimensions. So, a few questions here. What is DHCS doing to potentially standardize the number of expected outreaches that a [inaudible 00:54:30] provider needs to attempt for enrollment before excluding a member that they're not able to contact? So, just getting into the process around outreach attempts and payment thresholds for ECM.

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Slide 47	Palav Babaria – 00:54:46	Yeah, so I think just globally obviously we have our own requirements and I'm not the finance person, so I'm paraphrasing what my finance colleagues have told me. In our managed care environment, there are some lines in terms of how prescriptive we can be with plans around payment based that are federally determined. We don't get to decide what those lines are. And so, I think at this point in the survey, if you are one of those individuals who's responding to the survey, it's a fact-finding mission. We want to understand what is the common practice across the state in terms of outreach and engagement in some of those thresholds.
Slide 47	Palav Babaria – 00:55:22	What are maybe some of the outliers that are causing a lot of heartburn and making it really hard to operate and scale. And again, the whole point is to lower barriers so I think once we have that data, we'll be in a better position to say, "Hey, 95% of the state doing one thing and then there's like 5% that's maybe doing something else." Or is it really, how big is that range in practice so that we can definitely come up with some standards that ultimately, we either require or strongly encourage based off of what we're allowed to do.
Slide 47	Lori Houston-Floyd – 00:55:51	Great Palav. And just to note that this likely will involve looking at the PMPM and fee for service payment models as well because there's some questions about that in the chat.
Slide 47	Palav Babaria – 00:56:00	Yup.
Slide 47	Lori Houston-Floyd – 00:56:02	Okay. Going to TA for a moment. There's a question about if there will be any formalized guidelines to standardized or combine technical assistance meetings and workshops. I wonder if you want to speak a little bit more about PATH.

Slide 47	Palav Babaria – 00:56:19	Yeah. So, I think obviously when we first started in January of 2022, our PATH TA marketplace, the cited grants and the PATH learning collaboratives didn't exist yet. And so, I think we've started these webinars and other forms for engagement. But absolutely as we move forward, the whole point of PATH is really to support the statewide development and scale of ECM and community supports. And so, we want to make sure that we are linking back all of the conversations we're having, the needs that individual local entities have, whether that's the plans, the providers to our PATH process. So, if you are familiar with all of those four path work streams, I encourage you to become familiar as rapidly as possible and we will also be doing our best to help bring everything back to those venues.
Slide 47	Palav Babaria – 00:57:09	And then I also just will say, I've seen a lot of back and forth in the chat about can we put this in writing and that writing? And I will say all of the guidance we have issued is public and in writing. And so, for those of you who are providers or trying to figure out, did the department say this or did the department say that in your contract negotiations. If it is not present in our ECM policy guide, it is essentially not a requirement from us. And that's where I think the policy guide and the cheat sheet, I encourage all of you to use it as your sources of truth because all of the guidance we've issued is present in that policy guide and that is what we hold our plans to.

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Slide 47	Lori Houston-Floyd – 00:57:48	Thank you, Palav. One other question, I think just to tout the additional cheat sheet guidance that just was released. Had there been a few questions that does DHCS have a comparison document showing what was updated compared to the previous versions of the policy guide? And I think we can just draw everyone's attention to this was dropped in the chat earlier. There is a cheat sheet that really breaks down what is DHCS's policy, what is plan policy, where there are differences. So, encourage everyone to look at that document. We have two minutes left, I am scanning another question about payment. I don't know the answer to this one Palav because the department has just clarified that providers can bill for unsuccessful outreach. Can those providers retroactively bill their plans if they have not been billing for those unsuccessful outreach attempts to date?
Slide 47	Palav Babaria – 00:59:00	I don't know the official answer, but I would encourage you to contact your plan as soon as possible to have that conversation.
Slide 47	Lori Houston-Floyd – 00:59:20	I think Palav, in the final minute, interesting question here in the chat from Jen. What do you need from a communications messaging perspective to assist and promote on what's going on and what the department is doing to address meeting gaps and needs for the programs?
Slide 47	Palav Babaria – 00:59:40	Great question. So, I would say I think there's two things that we want every single person on this call to walkway with. One, there are a lot of members out there eligible for ECM who don't know about ECM or that they're eligible or haven't been referred. So, anything you can do to spread the word that this thing even exists among providers, schools, anyone who essentially touches a Medi-Cal member in any way, shape or form is really helpful. And then I think the second piece is again, we want to continuously be improving and refining this program. And so, if you are a plan or an ECM provider and you're encountering barriers, we absolutely want to continue hearing about those issues as well as we make these policy refinements.

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Slide 47	Lori Houston-Floyd – 01:00:22	Thank you so much Palav and thank you all for your engagement and for your questions. We will also be doing the same program on Friday for community support. So, I look forward to seeing hopefully some of you there as well. With that, Palav, have any final closing words?
Slide 48	Palav Babaria – 01:00:38	No, we're not at our destination yet. This is definitely going to be a multi-year journey so, thank you all for joining and for your partnership in making this as high impact as possible. Thank you all.