CalAIM Population Health Management and Children & Youth Advisory Groups

Monday, April 29, 2024

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Continuous Coverage Unwinding

- **The continuous coverage requirement ended on March 31, 2023.**
- **Medi-Cal redeterminations began on April 1, 2023, and will continue for all Medi-Cal members through May 2024 based on the individuals established renewal date.**
- **Top Goal of DHCS**: Minimize member burden and promote continuity of coverage.
  - DHCS implemented several federal flexibilities to make the renewal process simpler during the continuous coverage unwinding.
- **How you can help**:
  - Become a **DHCS Coverage Ambassador**
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available
  - Check out the Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan (Updated March 7, 2023)

Continuous Coverage Unwinding Communications Strategy

- On February 8, 2023, DHCS launched the Medi-Cal renewal campaign, a broad and targeted public information, education, and outreach campaign to raise awareness among Medi-Cal members about the return of Medi-Cal redeterminations when the continuous coverage requirement ended March 31, 2023. The campaign will complement the efforts of the **DHCS Coverage Ambassadors** that was launched in April 2022.
- **DHCS launched the Keep Your Community Covered Resources Hub** which includes resources in all 19 threshold languages.
- **DHCS released the new, interactive Medi-Cal Continuous Coverage Unwinding Dashboard** that will allow you to gain demographic and geographic insights to enrollment and renewal data.
- **Direct Medi-Cal members to KeepMediCalCoverage.org or MantengaSuMedical.org**, which includes resources for members to update their information and find their local county offices. It will also allow them to sign up to receive email or text updates from DHCS.

Agenda

- **Welcome, DHCS PHE Notice, & Agenda** (1:00 – 1:05 PM)
- **ECM**:
  - **Q3 2023 Children & Youth ECM Utilization: a look at the Data** (1:05 – 1:35 PM)
  - **Streamlining Access to ECM: planned introduction of new Referral & Authorizations Standards** (1:35 – 2:05 PM)
- **Equity & Practice Transformation (EPT) Payment: Provider Directed Payment Program** (2:05 – 2:25 PM)
- **Upcoming Meetings, Thank You, & Conclusion** (2:25 – 2:30 PM)

Member Story

Sarah Christensen, RNCM

Inland Empire Health Plan

IEHP Member Story: Impact of ECM

Sarah's story: A two-year old child with autism and SDOH needs enrolled in ECM in Spring 2024

Outreach and Engagement

Upon ECM enrollment, Sarah's ECM Care Manager (an RNCM) attempts outreach to Sarah's mother via phone, text, and home visit.

- The RNCM first meets Sarah's mother in the parking lot of the family's apartment, where they provide Sarah's mother with an ECM brochure and contact information.
- At a subsequent meeting, Sarah's mother shares concerns with the RNCM about Sarah's recent autism diagnosis, abuse from a local licensed day care, and difficulties keeping up with rent for their apartment.

Coordination Across ECM and Other Programs

Sarah's RNCM connected Sarah and her mother to the following resources:

- Referred Sarah's mother to Community Supports *(Housing Tenancy and Sustaining Services)* and coordinated assistance from housing authority to move to a different apartment that better met the family's needs.
- Connected Sarah's mother to food pantry services.
- Referred Sarah to ABA therapy, and helped redirect the ABA therapy referral to a new specialist when the original specialist was unavailable.

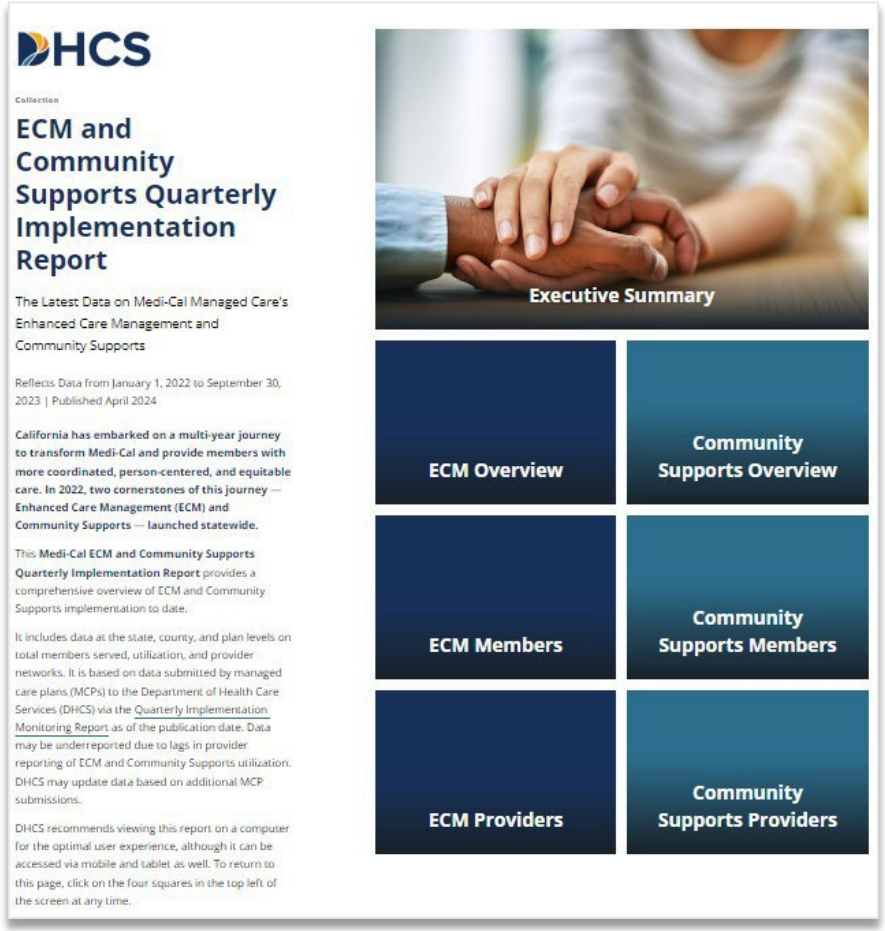
ECM Core Services

Outreach and Engagement | Assessment & Care Plan | Enhanced Care Coordination | Health Promotion | Comprehensive Transitional Care | Member & Family Supports | Coordination & Referral to CS

ECM Q3 2023
Children & Youth Data Update

Just Released: First Public Data on ECM for Children & Youth Populations of Focus

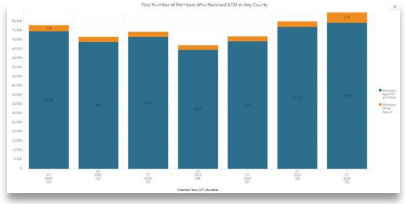
- On April 4, DHCS published the latest **ECM and Community Supports Quarterly Implementation Report** with data through Q3 2023 – the first public release of Children & Youth POF data.
- This report includes data on **total members** and stratifies by **members under age 21**.
- DHCS will continue to release regular updates to this report, with the **Q4 2023 data release planned for June 2024**.



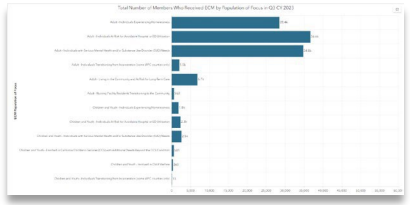
Children & Youth-Specific Data Included in the Public Data Report

Starting with the Quarterly Implementation Report published April 2024, DHCS is releasing the following data on the Children and Youth POFs each quarter:

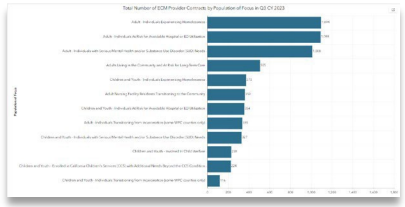
Statewide Data



Total ECM members under age 21

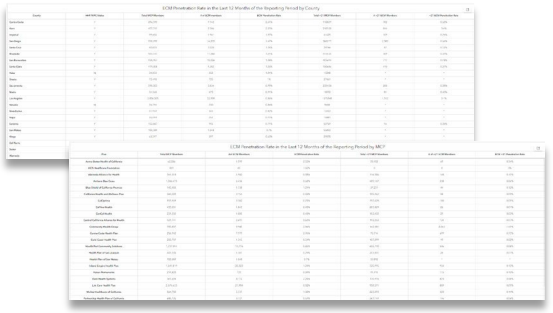


Total ECM members by POF



Total provider contracts by POF

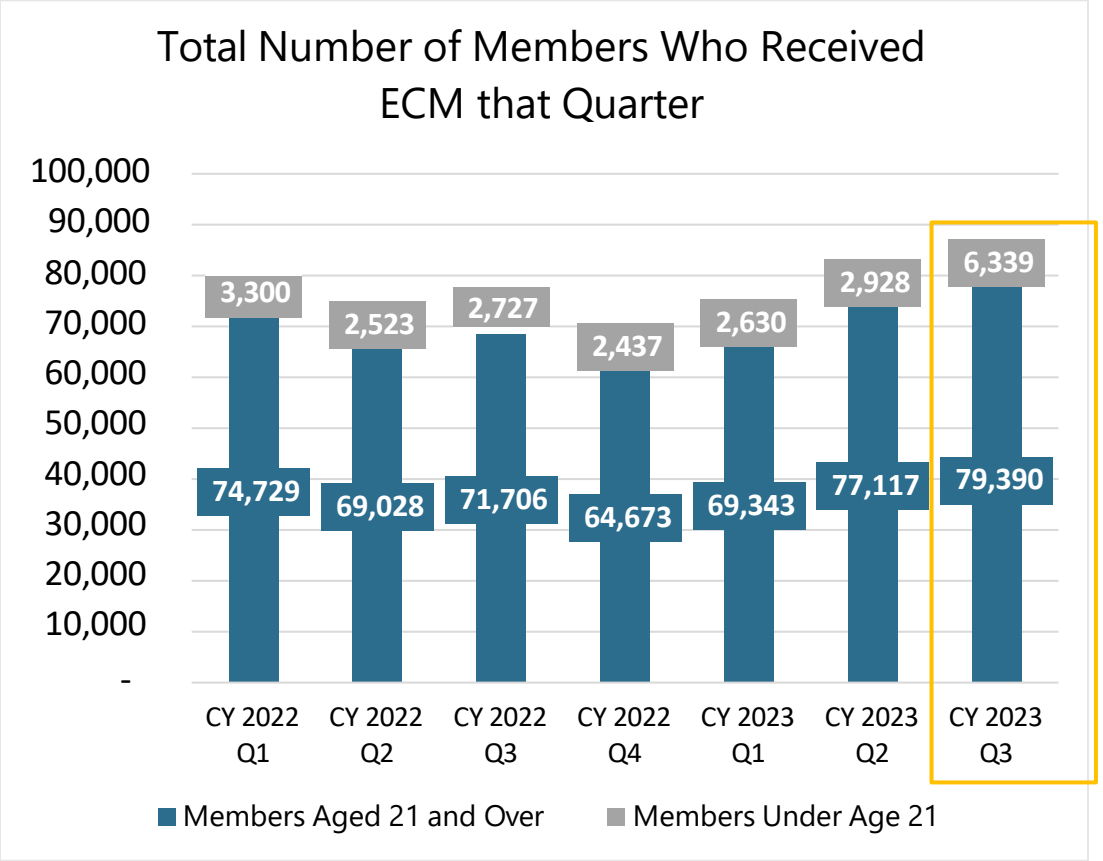
MCP- and County-Level Data



- ECM members under age 21
- ECM penetration rates for members under 21

MCP- and County-Level Data

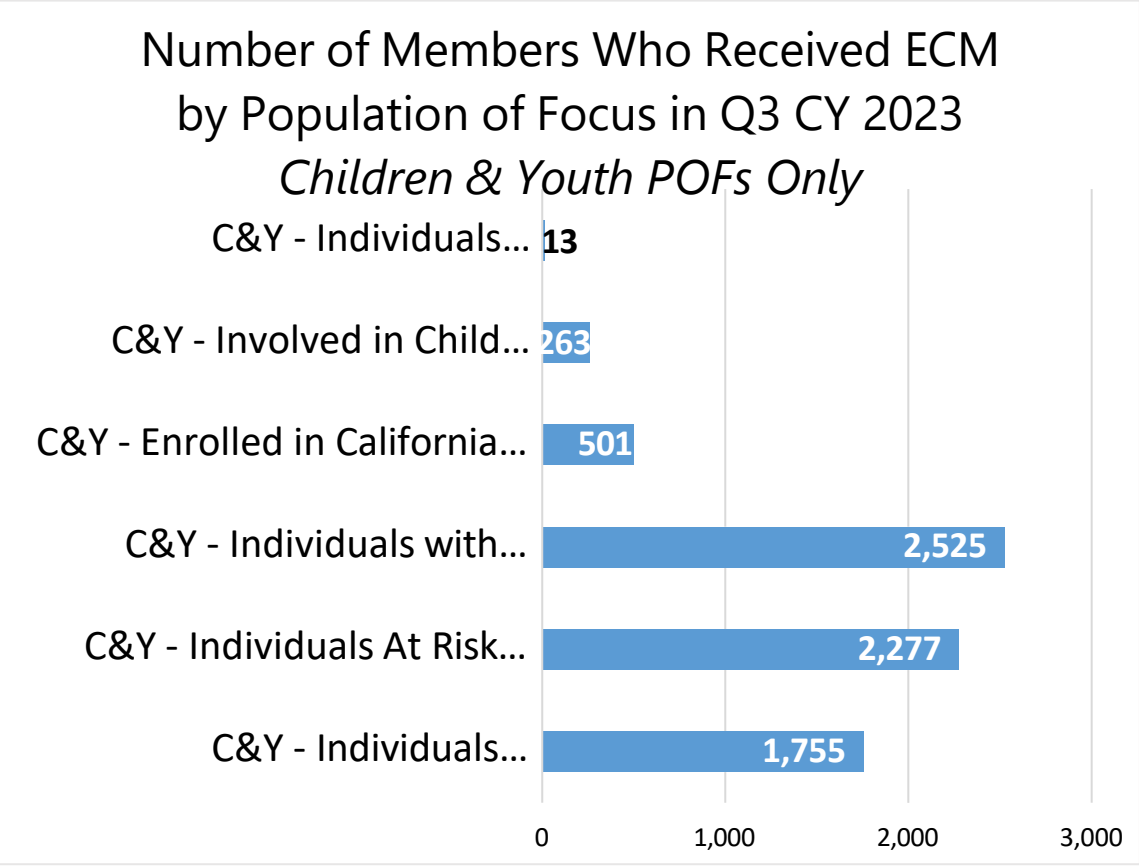
Q3 2023 Data: ECM Members Stratified by Age



Source: ECM and Community Supports Quarterly Implementation Report for Q3 2023

- Prior to Q3 2023, a limited number of Medi-Cal MCP members under age 21 were eligible to receive ECM via an adult POF (i.e., children in families experiencing homelessness; children & youth transitioning from HHP/WPC to ECM).
- From Q2 to Q3 2023, the number of total **members under age 21 enrolled in ECM increased by 115%**, largely due to the Children & Youth POFs going live.
- DHCS anticipates growth in Children & Youth ECM uptake as the program ramps up. Preliminary data shows **enrollment in these POFs has significantly increased** between Q3 and Q4 2023.

Q3 2023 Data: ECM Children & Youth Members by Population of Focus

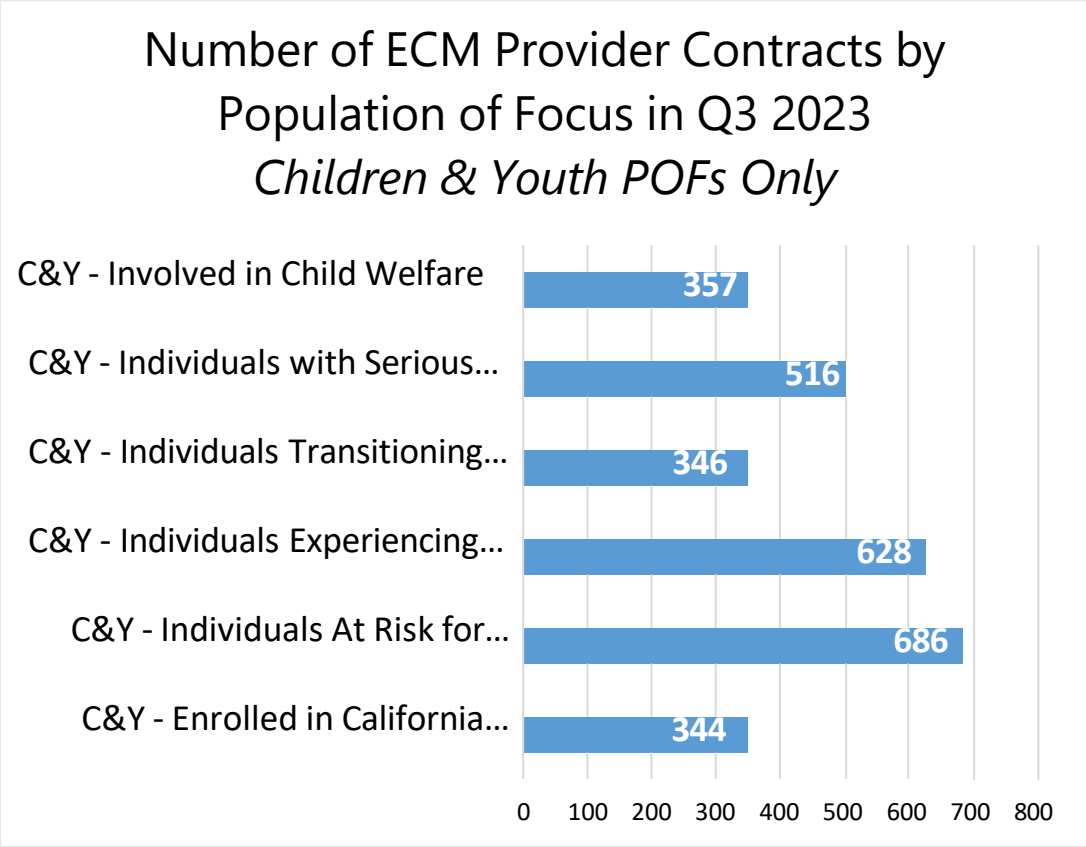


Source: ECM and Community Supports Quarterly Implementation Report for Q3 2023

- Initial ECM uptake among the Children & Youth POF shows more utilization among POFs with diagnostic or health care utilization eligibility criteria and with adult POF counterparts.
- As MCPs continue to establish referral pipelines and provider networks for members who are eligible for the CCS and Child Welfare POFs, DHCS anticipates continued growth for these populations.

Note: **In this chart, many members qualify for multiple POFs and are counted in each POF they qualify for.**

Q3 2023 Data: ECM Providers by Children & Youth Population of Focus



Source: ECM and Community Supports Quarterly Implementation Report for Q3 2023

- In addition to member utilization, MCPs report provider networks by POFs.
- The most common provider types serving Children & Youth are "Other qualified provider or entity" and Federally Qualified Health Centers.

Note: **"Provider Contract" is defined as each unique combination of NPI, provider type, MCP, and county. For example, a CBO that contracted with three MCPs is counted three times for this measure.**

Member Story

Patricia Washington-Gordon, RN, MBA, MSN, CCM

Molina Health Plan

Molina Member Story: Impact of ECM

A family experiencing homelessness enrolled in ECM and connected to Community Supports

Coordination Across ECM and Other Programs

After Mary and her four children were enrolled in ECM, their Lead Care Manager (LCM) connected the family with services tailored to meet their health and social needs:

- Created a roadmap towards matching the family with sustainable housing.
- Enrolled Mary in Community Supports *(Housing Transition Navigation Services and Housing Deposits)*.
- Coordinated assistance in searching for and securing housing that met the family's need.
- Provided housing deposit assistance and supported Mary in locating essential household furniture.

ECM Core Services

MCP Discussion: How Plans Are Implementing ECM for Children & Youth

1. How did you approach the implementation of ECM for Children and Youth? Did you start by focusing on specific POFs or subgroups?
2. How have you built a network of contracted providers specialized in support for Children & Youth?
3. How have you implemented a model for ECM that meetings the unique needs of Children & Youth (i.e., not a “one-size-fits-all model”)?
4. How did you identify and establish referral pathways for Children & Youth members eligible for ECM?

Advisory Group Discussion

Pulse Check on ECM for Children & Youth Nine Months After the Launch

Identification and Referral Pipeline to ECM for Children/Youth

Provider Networks to Serve the Diverse Needs of Children/Youth

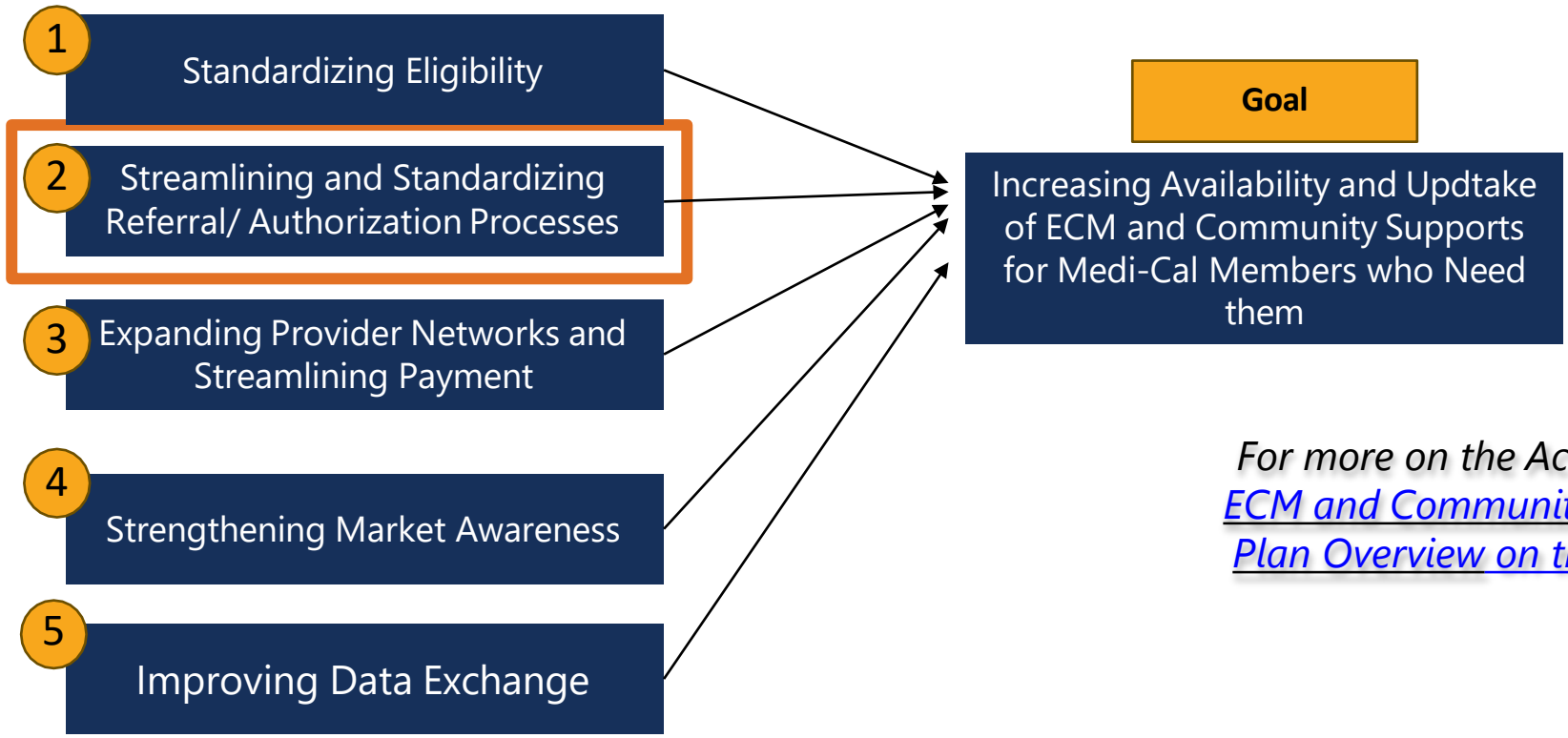
Overlaps with Existing Programs Serving Children/Youth

1. Is it easy or difficult to refer a child or youth to ECM in your local area? Why?
2. What local strategies have been successful in building up referrals?
3. CBOs which serve children are typically public information, including via MHPs' provider directories. Yet DHCS understands that MCPs and providers serving children and youth are still not developing contracts. Why?
4. What strategies have been successful in building up these networks?
5. Are ECM Providers or would-be ECM Providers worried about duplication with existing programs?
6. What can be done to mitigate this concern beyond existing DHCS policy guidance?

Streamlining Access to ECM via ECM Referral & Authorizations Standards

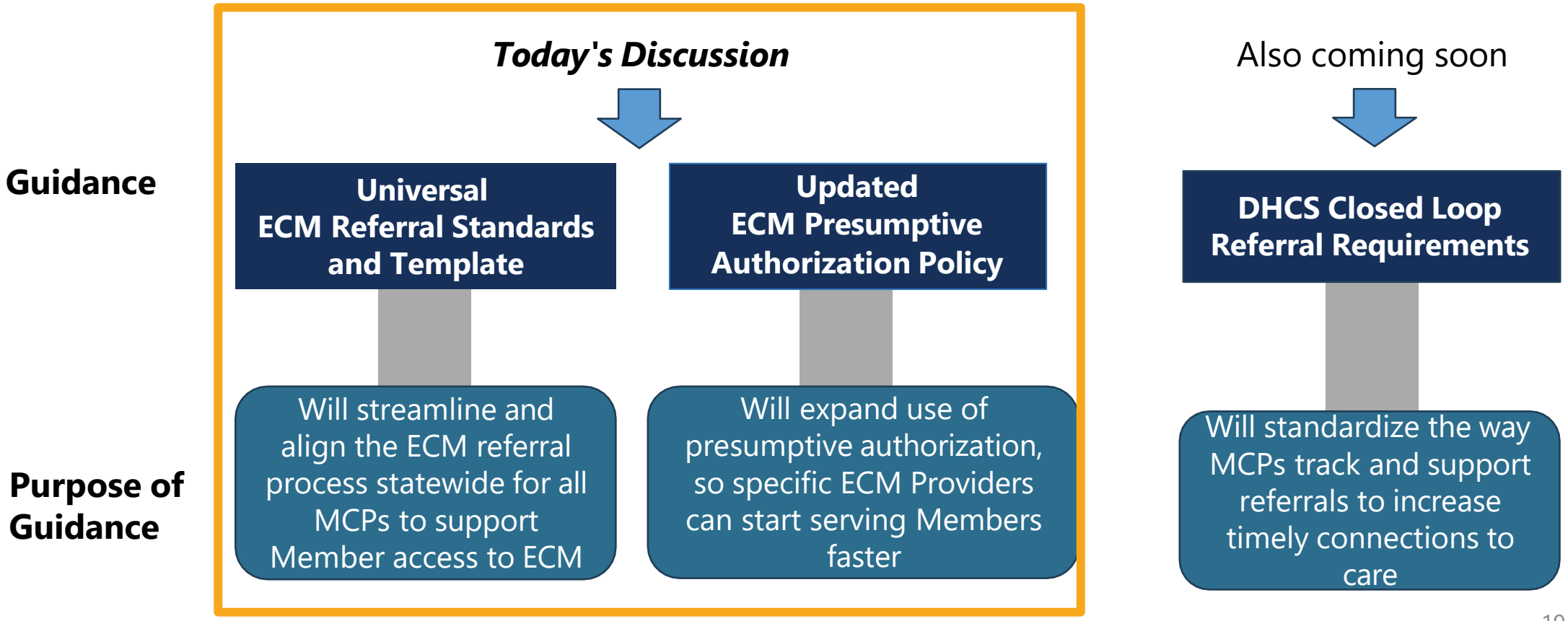
Streamlining Access to ECM

In July 2023, DHCS released an "Action Plan" for improving ECM and Community Supports availability and uptake. This includes a commitment to streamlining referral/authorization.



For more on the Action Plan, see the ECM and Community Supports Action Plan Overview on the DHCS website.

New: Upcoming Guidance on ECM Referrals and Authorizations



Stakeholder Feedback on Current State

While some regions/counties have taken steps to streamline ECM referrals across MCPs, several barriers remain.

- **Referral Documentation**: MCPs have varied documentation requirements (forms, eligibility checklists, TAR forms) – making it hard for referral partners to navigate different processes
- **Authorization Timelines**: Even though DHCS requires 5-day or 72-hour (expedited) authorization for ECM, delays in connecting to ECM are common
- **Presumptive Authorization**: Despite DHCS policies encouraging it, few MCPs are implementing presumptive authorization with ECM Providers
- **ECM Provider Assignment mismatches**: MCPs may assign Members to an ECM Provider without a previous treatment relationship even when an existing relationship exists

DHCS Goals for Streamlining ECM Referrals & Authorizations

- **Reduce time** from when a Member is identified for ECM to when they begin ECM services, so Members are connected to the care they need and aren't lost to contact
- **Create a consistent statewide format and process** for ECM referrals submitted by community partners
- **Build awareness of ECM in the community** as an option for referral
- **Improve quality of matching of Members being referred, with ECM Providers**
- **Standardize what information is needed** for MCPs for ECM eligibility, authorization and Provider assignment

Forthcoming Universal ECM Referral Standards

Upcoming Universal ECM Referral Standards

Purpose of Guidance: Will streamline and standardize the ECM referral process with two solutions:

Universal ECM Referral Standards and Form Template

The **ECM Referral Standards** define the information that MCPs are expected to collect from referring individuals for members being referred to an MCP for ECM (when portal-based, EMR, or other electronic referral forms are being used).

The **ECM Referral Form Template** is an application of the ECM Referral Standards for when a PDF or hard copy form is used to submit the referral.

What to Expect in the Referral Standards

- The ECM Referral Standards will provide a standardized set of questions for referring individuals to work through, to support Member eligibility for ECM, authorization and ECM Provider assignment.
- The proposed Referral Standards have been heavily informed by interviews with MCPs and by reviewing standard forms currently in use in several regions across multiple MCPs.
- Proposed Guidance: Effective January 1, 2025, **MCPs will not be permitted to impose additional documentation requirements for reviewing a Member's eligibility and authorizing ECM beyond what is included in the ECM Referral Standards**.

Upcoming updates to ECM Presumptive Authorization Policy

ECM Presumptive Authorization: Current State

"MCPs **are encouraged** to work with ECM Providers to define a process and appropriate circumstances for presumptive authorization, whereby select ECM Providers would be able to directly authorize ECM **and be paid for ECM services** for a fixed period of time until the MCP authorizes or denies ECM based on a complete assessment of Member eligibility for ECM consistent with Population of Focus criteria. There may be a subset of high-performing Providers with the MCPs' contracted Network of Providers for whom this capability would make sense." ***(ECM Policy Guide p98)***

Currently, MCP uptake of true presumptive authorization (including payment) is limited.

Proposal: Forthcoming Updates

Purpose of Guidance: Will expand use of presumptive authorization, so **specific ECM Providers** can start serving Members faster

Proposed New ECM Presumptive Authorization Guidance

- **<u>Select</u> ECM Providers will be able to directly authorize ECM for Members and be paid for ECM services for a 30-day timeframe** until the MCP authorizes or denies ECM based on a complete assessment of Member eligibility for ECM.
- ECM Providers under presumptive authorization would still submit an ECM referral to the MCP within the 30-day period.
- In cases where the MCP does <u>not</u> authorize ECM, ECM Providers will be paid for services provided in the presumptive authorization period.

Proposed MCP Implementation Deadline: **January 1, 2025**

ECM Presumptive Authorization Proposal

ECM Population of Focus	ECM Providers Covered by Presumptive Authorization Proposal
1) Adults & Children Experiencing Homelessness	Street Medicine Providers
2) Adults & Children At Risk for Avoidable Hospital or ED Utilization	Primary Care Providers
3) Adults & Children with Serious Mental Health and/or SUD Needs	Specialty Behavioral Health Providers contracted with a County Behavioral Health Agency
4) Adults & Children Transitioning from Incarceration	Providers serving Members who receive pre-release care management
5) Adults Living in the Community and At Risk for LTC Institutionalization	California Community Transitions (CCT) Lead Organizations
6) Adult Nursing Facility Residents Transitioning to the Community	California Community Transitions (CCT) Lead Organizations
7) Children & Youth Enrolled in CCS/CCS WCM	CCS Providers
8) Children & Youth Involved in Child Welfare	Health Care Program for Children in Foster Care (HCPCFC) Providers, County DSS Offices
9) Birth Equity Population of Focus	BIH, PEI, Indian Health Program, AIMSS or Doula Provider, Midwives, OB/GYNs

Discussion
Presumptive Authorization Design

Proposed Providers

» What ECM Provider types would you consider adding or removing to the list of those eligible for presumptive authorization?

Operationalizing

» What are low barrier methods ECM Providers can use to verify a Member is not already receiving ECM from another entity?

Equity & Practice Transformation (EPT) Payment: Provider Directed Payment Program

Overview of EPT

- **Funding**: One-time $700M initiative ($650M for the Provider Directed Payment Program)
- **Goal** is to improve primary care for Medi-Cal recipients by focusing on:
  - Population health
  - Health equity
  - Practice transformation including value-based care
  - Evidenced-based models of care
  - Partnership with Medi-Cal MCPs
- **Aligns with DHCS Comprehensive Quality Strategy** and Bold Goals

What is the Provider Directed Payment Program?

- It **is**:
  - A CMS "Directed Payment Program"
  - A program that pays accepted primary care practices for activities/milestones completed during program, not before
  - Only for Medi-Cal MCP contracted primary care practices
- It is **not**:
  - A grant program (allowable costs and award agreements not relevant)
  - A program that pays for activities/milestones done before the program
  - A program that pays MCP for activities

Cohort 1

- Accepted in **January 2024 for five years**
- **209 practices** with 282 locations of operations
- Selection process prioritized certain high priority populations of focus, tribal health programs, and activities (evidenced-based models of care and integrating behavioral health)
- Potential maximum payments **over 5 years of approximately $380M**
- Types of practices:
  - 119 private practices
  - 74 Health Centers (FQHCs, Look-Alikes)
  - 12 Tribal Health Programs
  - 4 Public and District Hospitals

Cohort 1: Maximum Payment Based on Assigned Medi-Cal Lives (at time of application)

Medi-Cal & D-SNP Assigned Lives Range (at time of application)	Maximum Payment (over all categories)
500–1,000	$375,000
1,001–2,000	$600,000
2,001–5,000	$1,000,000
5,001–10,000	$1,500,000
10,001–20,000	$2,250,000
20,001–40,000	$3,750,000
40,001–60,000	$5,000,000
60,001–80,000	$7,000,000
80,001–100,000	$9,000,000
100,001+	$10,000,000

Funding subject to CMS approval. Changes to assigned lives during cohort do not change maximum potential payments.

Cohort 2

- **Planning for Cohort 2 is currently underway**. Further details are not available yet.
- Practices in Cohort 1 cannot apply to Cohort 2.

Population Health Learning Center: the "Learning Center"

- The Learning Center is contracted with DHCS to **serve as the Program Office** for the EPT Program, and fulfill the following functions:
  1. **Provide program oversight, design support, and coordination** for EPT across practices, managed care plans/delegated entities, and other key stakeholders
  2. **Design and coordinate the Technical Assistance strategy** for EPT practices, including peer learning through the "Learning Collaborative"
  3. **Facilitate continuous learning and best practice sharing** across all stakeholders in EPT.

Population Health Management Initiative (PHMI)

- Program that **supports 32 Federally Qualified Health Centers' (FQHCs) work on population health management and health equity**
- PHMI has **developed resources to support clinics' transformation efforts**, many of which are being leveraged for EPT:
  - Many EPT activities are designed to be consistent with **PHMI Implementation Guides**, though guides will be rewritten for EPT
  - Recommended data that MCPs share with practices is also aligned with PHMI

Technical Assistance (TA) through "Learning Center"

- Common curriculum across all practices
- Peer learning tracks:
  - Health Centers, Tribal Health Programs, and Public Hospitals
  - Independent/private practices
- Coaching pool (optional and not funded by EPT):
  - Allows pooling of financial resources (variety of potential sources)
  - Increases access to practice coaching that is standardized, aligned with structure of EPT, and lower cost

Children and Youth in EPT

Children and Youth

- Children/youth are **one of the populations of focus** practices can choose in EPT (all practices *must* choose one population)
- **40% of Cohort 1 practices** chose children/youth
- Practices **must work to implement specific activities** with the population of focus

Activities*

1. Care Team Design and Staffing
2. Stratification to Identify Disparities
3. Clinical Guidelines
4. Condition-Specific Registries
5. Proactive Patient Outreach and Engagement (including assigned but not seen members)S
6. Pre-visit Planning and Care Gap Reduction
7. Care Coordination

*Activities are the same across all populations of focus. For additional details, see Attachment 3 – Categories, Activities, and Milestones for Provider Directed Payment Program.

Questions?

» For additional information on the EPT Payments Program, visit the webpage.

Upcoming Meeting & Other Webinars

The next CalAIM Children & Youth Advisory Group meeting will be held on
Thursday, June 27th, 1:00 – 2:30 PM PT

Medi-Cal Children's Health Advisory Panel (MCHAP) Meeting

May 1, 2024

Zoom Link & In-Person Attendance Info Available Here

Stakeholder Advisory Committee (SAC) & Behavioral Health Stakeholder Advisory Committee (BH-SAC) Meeting

May 29, 2024

Zoom Link & In-Person Attendance Info Available Here

Appendix

Overview: Current ECM Referral & Authorization Process

The basic steps of the existing ECM referral and authorization process are outlined below. Currently, MCPs may vary their process slightly and require varied documentation. New DHCS guidance will aim to align MCP processes.

Entity submits a referral to MCP for ECM	MCP confirms eligibility and authorizes ECM	MCP assigns Member to an ECM Provider	ECM Provider outreaches the Member and begins services	ECM Provider bills MCP for ECM services provided
Often, referrals can be submitted via different modalities (i.e. physical form, EMR output, online).	MCPs must make an authorization decision within 5 days for routine requests.	The MCP must assign the Member to an ECM Provider that has appropriate experience, prioritizing trusted Providers.	MCPs must reimburse ECM Providers for outreach, including unsuccessful outreach that did not result in a Member enrolling into ECM.	ECM is subject to the same standard reimbursement timelines as other Medi-Cal services.

What is Presumptive Authorization?

Basics of MCP Authorization Process for ECM *(without presumptive authorization)*

1. ECM Providers submit a Member referral for ECM to the MCP.
2. MCPs evaluate Member eligibility for ECM and authorize* individuals for ECM.
3. Once ECM is authorized by the MCP, ECM Providers can bill the MCP for ECM services provided.

*For all Members authorized to receive ECM, the initial authorization period is 12 months and the reauthorization period is 6 months.

Differences under Presumptive Authorization Policy

- **Select ECM Providers are able to directly authorize ECM for Members and be paid for ECM services for a fixed timeframe** until the MCP authorizes or denies ECM based on a complete assessment of Member eligibility for ECM.
- Select ECM Providers are 'pre-approved' to start ECM services after they review Member eligibility and can bill for services provided prior to the formal MCP authorization.