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ECM Provider Roundtable Collaboration Meeting

Thursday, April 28, 2022
1:00 p.m. – 3:00 p.m.

Roundtable Agenda

- CalAIM Overview
- Population Focus & Member Identification
- Authorization (Outreach & Service)
- Assessment & Care Plan
- Service Components
- Data Sharing
- Billing
- Open Conversations

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What is CalAIM?

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year set of initiatives developed by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of the Medicaid population in California by implementing a broad delivery system as well as program and payment reform.

One of the first CalAIM initiatives is Enhanced Care Management (ECM) which is a whole person, interdisciplinary approach to comprehensive care management. This new benefit will address the clinical and non-clinical needs of high-cost, high-need managed care members through a systematic coordination of services.

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ECM Populations of Focus

CenCal Health will launch the first three (3) Populations of Focus on July 1, 2022.

- Individuals Experiencing Homelessness
- Adult High Utilizers
- Adults with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD)

Populations of Focus launching January 1, 2023

- Individuals Transitioning from Incarceration
- Members Eligible for Long Term Care (LTC)
- Nursing Home Residents Transitioning to the Community

Populations of Focus launching July 1, 2023

- All Other Children and Youth

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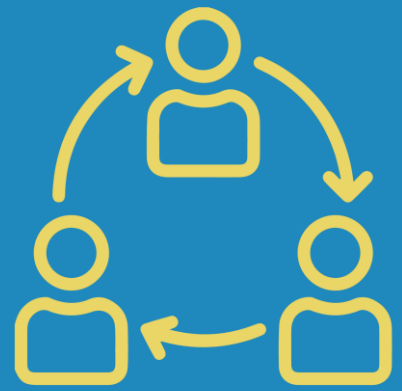
POF Member Identification



Member Identification can happen in three (3) ways:

1) CenCal Health will use claims and/or other data available to identify members presumed eligible for ECM.

2) Providers can identify and refer a potential ECM member.

3) The member or the member's representative can refer them(selves) to the program.

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ECM Member Assignment

- ECM presumed eligible members will be assigned to an ECM provider who has the expertise to serve the various populations of focus.
- An ECM Provider will receive a monthly list of members that will require outreach and engagement to initiate enrollment in ECM services.
- The ECM Provider will need to create a risk stratification plan to determine which members they will outreach to first.

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Authorization (Outreach & Service)

ECM Providers will submit an authorization request to begin outreach to their assigned members, and the Authorization Request will be auto-approved for six (6) weeks.

Outreach Needs:

- Conduct screenings to assess the member's willingness to participate in the program
- Determine if the member is receiving services through another case management program that would be considered a duplication of services or if the member's situation has changed.
  - *Members have the right to stay in their current Case Management program or can elect not to participate in ECM.*

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Assessment & Care Plan

ECM Providers will complete a Comprehensive Assessment of members who agree to participate in ECM services.

A specific Care Plan will be created based on:

- Member's goals
- Health status needs
- Preferences regarding physical health, mental health, disabilities, substance use, and oral health
- Community-based long-term services and supports to manage serious illness, trauma-informed care needs and social services

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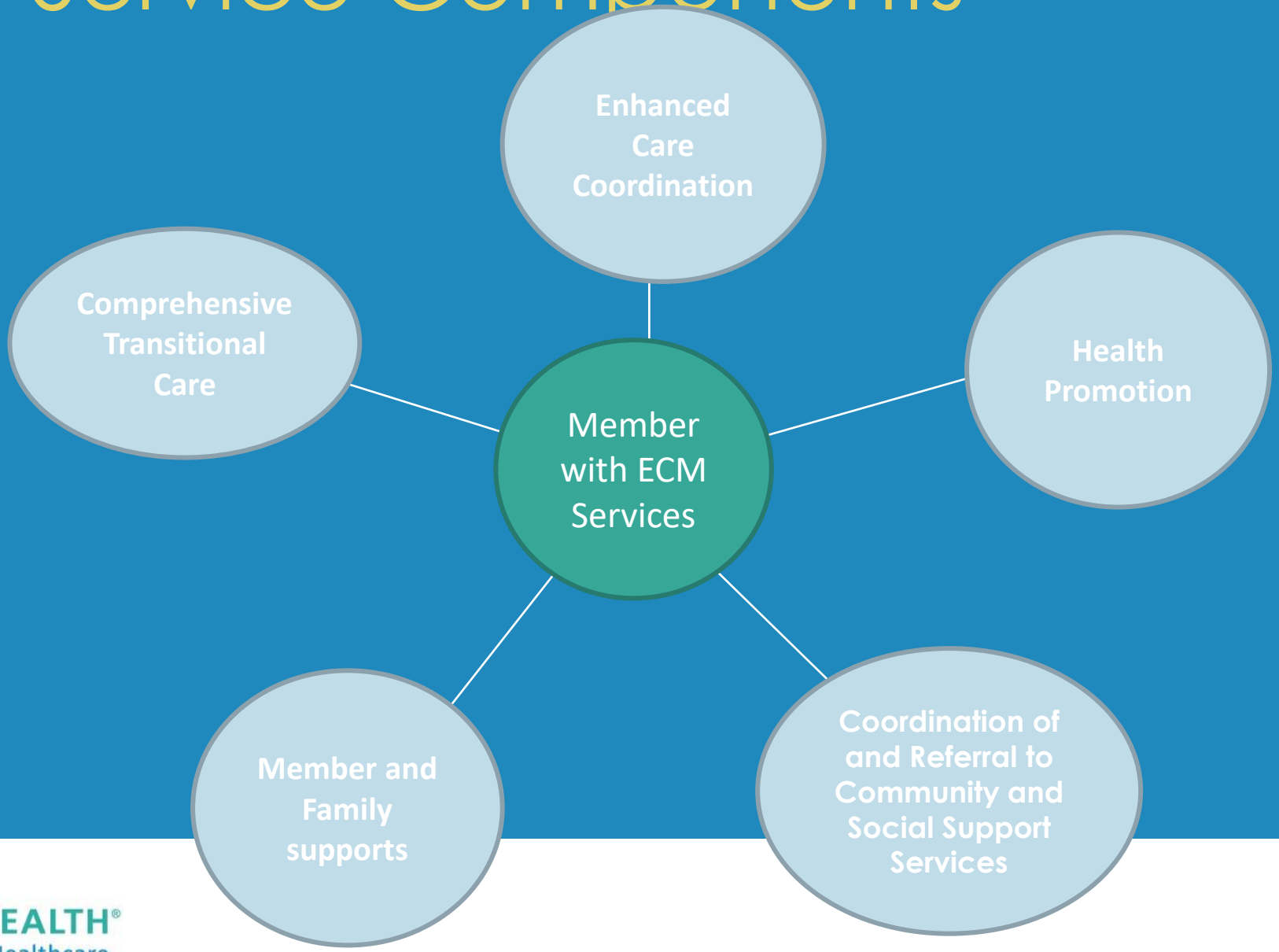
Core Service Components



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Core Service Components

Once the Assessment and Care Plan is completed, ECM Providers will submit a Treatment Authorization Request (TAR) for review and approval for services in six (6) month intervals via CenCal Health's Provider Portal with the following Core Service Components:

1. **Enhanced Coordination of Care**

Intensive, primarily in-person contact with the Member and their family member(s), guardian, AR, caregiver and/or authorized support person

2. **Health Promotion**

Health promotion includes services to encourage and support members receiving ECM to make lifestyle choices based on healthy behavior, with the goal of motivating Members to successfully monitor and manage their health.

3. **Comprehensive Transitional Care**

Services intended to support ECM Members and their families and/or support networks during discharge from hospital and institutional settings.

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Core Service Components (continued)

4. **Member and Family Supports**
Member and Family Supports include activities that ensure ECM Member and family/support are knowledgeable about the Member's conditions, with the overall goal of improving their adherence to treatment and medication management.

5. **Coordination of and Referral to Community and Social Support Services**
Determining and coordinating appropriate services to meet the needs of Members, including services that address social determinants of health needs including housing, and services being offered

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Data Sharing Requirements

MCP Member Information File:
To equip ECM Providers with data beyond their four walls that reflects the total clinical and non-clinical picture for each Member in ECM to include the following information:

- Member assignment files defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider,
- Encounter and/or claims data, and
- Physical, behavioral, administrative and SDOH data for all assigned members.

ECM Return Transmission File:
To standardize and streamline key information that CenCal Health will most commonly require about Members from ECM Providers beyond information contained in billing and invoicing.

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Data Sharing Requirements (continued)

ECM Provider Initial Outreach Tracker File:
To standardize provider outreach reporting of the total number of both successful and unsuccessful initial outreaches to Members occurring by ECM Providers.

ECM Member Referral File:
A standardized format and method to collect referral information from ECM Providers for consideration for enrollment into ECM as ECM Providers are encouraged to identify their patients and clients who may belong to an ECM Population of Focus and thus may benefit from ECM.

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Data Sharing & Frequency

File Name	Required?	Responsibility	Frequency
MCP Member Information File	Yes	Plan to ECM Provider	1st business day of month; weekly if new assignments posted
ECM Provider Return Transmission File	Yes	ECM Provider to Plan	Monthly Last business day of month
ECM Provider Initial Outreach Tracker File	Yes	ECM Provider to Plan	Monthly Last business day of month
ECM Member Referral File	No	ECM Provider to Plan	As needed

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Billing: Claims vs. Invoices

- ECM Providers will be expected to submit claims to CenCal Health using national standards to the greatest extent possible, e.g., ANSI ASC x12N 837P or via the CenCal Health's Provider Portal.
- ECM Providers who are unable to submit compliant claims may instead submit invoices with minimum necessary data elements as defined by DHCS to standardize invoicing to mitigate provider burden and promote data quality.
- CenCal Health will use the standardized billing and invoice data for two (2) purposes:
  1. To pay ECM Providers for ECM services rendered.
  2. To submit compliant encounters for submission to DHCS.

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Billing: Payment Structure

- Outreach & Comprehensive Assessment
  - Fee for Service (FFS)
  - Frequency Limitations Apply
- Enhanced Care Management Services
  - Case Rate
  - Minimum Threshold Applies
  - Rolling 30 Day Calculation

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Initial Outreach/Engagement FFS

Code	Description	Modifier	Rate (per 15 minutes)	FFS Frequency Limitation
G9008	ECM Outreach In-Person: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	U8	$15.54	22 Units (5.5 hours)
G9008	ECM Outreach Telephonic/Electronic: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	U8, GQ	$11.65	14 Units (3.5 hours)
G9012	ECM Outreach In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U8	$11.65	22 Units (5.5 hours)
G9012	ECM Outreach Telephonic/Electronic: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U8, GQ	$8.74	14 Units (3.5 hours)

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ECM Services – Care Management Plan

Code	Description	Modifier	Case Rate
G9008	ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1	$469.10*
G9008	ECM Phone/Telehealth: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1, GQ	
G9012	ECM In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2	
G9012	ECM Phone/Telehealth: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2, GQ	

*ECM Case Rate is the total amount reimbursed for any combination of ECM codes and modifiers at or above 12 units of 15 minutes (3 hours) per rolling 30 calendar days

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What questions or concerns do you have?

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