CalAIM WCP Pilots and Health Homes Program Transition to Enhanced Care Management and Community Supports Webinar

September 21, 2021

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Slides 1-7	00:00:00 – Susan Phillips	Good morning everyone. My name is Susan Phillips of the Department of Health Care Services. On behalf of the DHCS I want to welcome you to today's webinar and we will be discussing the transition from Health Homes pilots to enhance care management and Community Supports. Both ECM and Community Supports are foundational concepts for the California advancing and innovating Medi-Cal or CalAIM. And, as you know, home person care pilots and Homecare are ending in December. Next year, we are working towards turning the page and really scaling up these community-based care management pilots to eventually form a statewide care management approach. ECM and Community Supports build on the learning and successes of both Whole Person Care pilots and home healthcare programs. Together, and starting in January of 2022, these initiatives are intended to improve the experience of high needs, high cost Medi-Cal members by building on a whole system centered approach to healthcare and centered supports. In implementing ECM and Community Supports, health plans will continue to providers, counties and community-based organizations to really strengthen and streamline the managed care delivery system and ultimately help Medi-Cal members lead to healthcare Managed Care Plans. So we are just a little bit more than three months away from the launch of ECM and Community Supports, and we are focused on preparing for the January go live date. Also we are a couple weeks away from beginning to notify members of the community of the transition for Whole Person Care

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		pilots and Health Home Care programs to ECM and Community Supports. And that will be the focus of today's discussion. On a daily basis there are discussions with organizations to make this transition happen, including counties, health plans and providers. We recognize that this is complex and we are committed to working with all of you on working through the emerging implication issues and really appreciate the extraordinary efforts that you have put into contributing to the launch of ECM and Community Supports. So today we want to pull all those pieces together and give you a clear overview and outline of the process and expectations regarding the transition from whole person pilots and ECM community support. So thank you all for joining today and recommitting to making the launch a success and working with DHCS. Before we officially get started, I do want to share that this is the first in its series of regular public seminars that DHCS will host throughout the fall. And we will use that as an opportunity to share updates and as we work toward a launch of a number of key county initiatives. So please do look out for more from us. So today's agenda, what I will be doing first, is providing a quick update on the rebranding of Community Supports or previously known as In Lieu of Services. Also I have our team here who will be providing a review of the current and future state of Medi-Cal's care management approach. We will be

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		providing a detailed overview of Whole Person Care pilots and home transition to ECM and Community Supports. And finally my healthcare financing colleague will provide a brief update on ECM rates and then we'll have about ten minutes for questions at the end. Okay, you have heard me say this term now "community support." So please be assured that DHCS will be working over the next few weeks to rebrand CalAIM In Lieu of Services or ILOS to Community Supports. As you know, Community Supports are more initiated under CalAIM and will play a fundamental role in supporting our efforts to really meet Medi-Cal members needs through Whole Person Care approach and really address social drivers of health and social determinants of health and to improve health equity statewide. There are a few reasons that we were making this name change. Our goal is really to make a term that's more user-friendly, more member friendly, and to really provide a better, more descriptive name for home and community based services and other services that address home health. We also want to provide more effective and successful ways to communicate the values of the services to Medi-Cal and other stakeholders. So with that, I want to turn this over to Bambi Cisneros. She is the assistant deputy director for managed care systems. Bambi?
Slides 8-10	00:05:41 – Bambi Cisneros	Good morning everyone. Thank you for joining us on this webinar. So on this slide here, we will review the current state and so as you see here in today's environment we currently have two 1115 waiver programs that are the Whole Person Care pilots was implemented in 2015 and was really aimed to

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		coordinate physical behavioral and social services to and we have the Health Homes Program in 2018. The DHCS launched the Health Homes Program. The HHP serves eligible Medi-Cal managed care plan members with complex medical needs and chronic conditions who may benefit from the intensive care management and coordination. On this slide here we show the counties that offer home health person care. Whole Person Care is in purple and the home healthcare's program is in dark blue and counties that offer both Whole Person Care and home health home is depicted in lighter blue. You can see where the pockets of the programs are, and you see it's not statewide which is one of the reasons why we are doing ECM and community support. Both WPC and HHP evaluations have shown improvements in health outcomes already in early results. ED visits and inpatient utilization have decreased for both programs. Justice-involved individuals experienced an increase in blood pressure control. There was an increase in engagement in alcohol and drug abuse treatment. This is why we are moving to make these changes statewide. I will turn it over to Dana and the managed care quality monitoring division to look at the next few slides.
Slides 11-18	00:08:23 – Dana Durham	Thank you, Bambi. I want to talk about our vision for ECM and Community Supports. Both really build on the design and the learning that we've had from Whole Person Care and Home Health Programs and move beyond County pilots to really standardize statewide implementation of community-based care

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		management and coordination spanning across physical health, mental health and social services. And the idea is to integrate the work into the Medi-Cal managed care delivery systems. So we want to keep the interventions community-based and we are doing that by sending requirements on plans to contract with community-based providers and community-based organizations for both ECM and Community Supports. Next slide, please. So just talking a little bit about what will actually transition. As we said, ECM and Community Supports will replace both Whole Persons Care and home health beginning January 12, 2022. The initiatives will scale up to eventually form a statewide care management approach. So I'll talk a little bit about what each is. Enhanced Care Management, which will often be referred to as ECM, is a Medi-Cal managed benefit that will address the clinical and nonclinical needs of high need, high cost individuals through the coordination of services and comprehensive care management. Community Supports, on the other hand, and as we've said long-term, we refer to Community Supports and services but we really, really feel like this is more descriptive of what's going on in this area and easier to understand as a beneficiary. So those are services that Medi-Cal managed care plans are strongly encouraged, but not required to provide. And they're medically appropriate and cost-effective alternatives to utilization of other services, other settings such as hospital or skilled nursing facility admissions. Next slide, please. So if you look at the current state - in the future state - what we have with Whole Person Care is it's a

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		limited pilot program that is supported across all the delivery systems. Managed care, the for-free service are Medi-Cal eligible. And it was administered by usually County -based local entities. Then we have Home Health which was a benefit and is a benefit in selected counties only. And Medi-Cal managed care members were the only ones who could participate. Additionally, the health plan administered the home health program with care management, contracted out to the providers. So that's what we have currently. And what we are moving towards ILOS, as I said, ECM being the benefit that replaces the care management that was happening in Home Health and then home healthcare. Again that's for home health managed care plan members. And the health plan home managers delivered it to community providers. So ECM is really community-based. And there were several things done with home care and home health programs that are not necessarily about care coordination or care management and so we are replacing those with community-based supports. As we said, community-based supports are optional, but really strongly encouraged. Again available to managed care plan members only. And the health plan administers the Community Supports through community providers and often it complements ECM but it is not necessary that you have ECM to be able to qualify for Community Supports. Next slide, please. So once again, let's talk a little bit more in depth about Enhanced Care Management or ECM. It's a whole person approach to comprehensive care

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		management that addresses the clinical and nonclinical needs of high need, high cost Medi-Cal managed care members. ECM will be interdisciplinary, high touch, person centered and provided primarily through in-person interactions. So the goal is to seek members where they live and help them seek care or help them access services as they might have trouble navigating the system. Our vision for ECM is to coordinate all care for eligible members, including across the physical and behavioral health delivery systems. So the goal is that the person has one care manager who helps them navigate across the spectrum. Every Medi-Cal managed care member enrolled in ECM will have a dedicated care manager. And ECM is available to Medi-Cal managed care members who meet the ECM population of focus definitions. And members may opt out at any time. Additionally, before we go to the next slide, if a member is currently receiving support in Whole Person Care for home health, they will transition to ECM if they are receiving coordinating systems. As far as populations of focus, you will see here that this is our go live for the different populations of focus, as you probably are aware, we have seven different populations of focus. They are individuals and families experiencing homelessness, and adults with serious mental illness and substance use disorder. And those populations go live in January, 2022. For Whole Person Care, health homes counties in July 2022 for all counties. I will note with this that a population is currently being served in Whole Person Care that they start in January, 2022. Just wanted to make sure you were aware of that.

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		So then we'll move to the second for -- I mean second three -- populations of focus which go live in January, 2023 for all health plans. And those are the incarcerated and transitioning to the community. Those who are at risk for institutionalization and eligible for long-term care. And nursing facility residents transitioning to the community. And then our final population of focus is scheduled for July, 2023 for all health plans. And that's children and youth. And we just want to make sure that we are careful as we implement this population of focus and we are intentional in the way we carry it out. So that gives you the timeline for when the different populations of focus will go live. Next slide, please. So Community Supports as we have said previously, used to be known as alternative services. But they are medically appropriate and cost-effective alternatives to settings copied under the state plan. DHCS has selected 14 preapproved Community Supports that it determined are medically necessary or covered under the state plan. I do want to note that Community Supports are optional for health plans to provide and also optional for managed care plan members to receive. So if a member prefers to have the state plan benefit and then qualify for the state plan benefit, of course they can opt for that. Health plans are strongly encouraged to offer all preapproved Community Supports to address the needs of members in a comprehensive way. And health plans must evaluate the medical appropriateness and cost-effectiveness of a particular community support services as an alternative for state plan service when determining whether to authorize that service for their members.

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		This is the list preapproved Community Supports. We'll see several of them focus on housing. Many of them focus on a transition such as going to recuperative care, day habilitation programs. Nursing facility transition to substantive living. Some are about really working to make sure that a person can stay in their home such as personal care and homemaker services and environmental accessibility adaptations, and medically tailored meals. And those are really geared towards making a home where an individual can continue within the community. It's one of the reasons we chose the term Community Supports. Next slide, please. With that, I will hand it over to Michael, who is chief within managed care and monitoring, and I'm really happy to have him present.
Slides 19-25	00:18:42 – Michel Huizar	Okay. Thank you so much Dana. Welcome everyone. The next few slides we'll be focusing our home healthcare programs transitioning to our Community Supports. But starting with the big picture here, most, but not all services offered through the WPC pilots starting January, 21, 2022. In the beginning of the year, the enhanced supports will be available only to Medi-Cal management members as part of a standardized simplified set of services under the California advance Medi-Cal initiative. So most home person care enrollees are Medi-Cal managed members and will automatically transition to care management Community Supports or a combination. Some enrollees in the whole person pilot will not transition to receive the support but most Whole Person Care services are equivalent to ECM and

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		Community Supports and will continue. So even if the Whole Person Care services end, it will be available to transitioning members. Next slide, please.
		Okay. For this slide DHCS WPC transition to ECM health plans must automatically authorize ECM for all their members enrolled in a Whole Person Care pilots who are identified as receiving care coordination services in the WPC pilot.
		The department for DHCS' Whole Person Care transmuting support expectation under community support, as we said, formally participating whole person counties are strongly encouraged to offer all Community Supports that correspond to Whole Person Care services. Health plans have already begun to provide information with the departments on their intentions for offering their Community Supports through their model of care and we are monitoring those decisions closely. Medi-Cal managed care members who were identified by the pilot lead entities as receiving the pilot services that correspond to Community Supports will be eligible to receive those Community Supports provided they are offered by their health plans.
		So for this one here regarding notification for whole person care enrollees and community partners about the transition. For the pilot programs they are expected to notify all of their Whole Person Care or enrollees about the transition we gathered of whether they're transitioning into the new services or not. So the lead edge program can often opt for a partner within the County health plan or managed care plan to develop noticed joint notices for

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		applicable managed care plan members. And in addition pilots must also notify providers of the inclusion of the program. For the health plans, it's expected that the plans notify their respective enrollees who are transitioning into the services prior to the January 1st, 2022. And they can also opt to work within County Whole Person Care identities on joint letters to each member or send separate notices to their members after counties have completed their noticing. And then just lastly here to round out the slide, so for the departments through this process we are or have provided standardized member noticing to the pilot and health plans to tailor themselves and put their brand on and use. And we are providing ongoing guidance to WPC's pilots. The pilots should be integrating their noticing during the course whenever possible. And this has to be done by December 1st, 2021. The department is strongly encouraging or requiring pilots to share their notification in person during the regular in person counter prior to December 1. The written notification would be passed or should be passed by hand by the provider with an opportunity to discuss and answer questions. And lastly, a strongly encouraged approach or method was asking that providers document the notification that was shared during the in person encounter to a list or roster documented with notice. So alternatively, Whole Person Care and really are not noticed in person, then WPC must do both, which is to send the notice to each enrollee's last known address and call the enrollee up to five times or until successfully reaching them. So this slide covers the transition time limit at a really high level. So beginning at the top, as I said, we

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		noticed we released the finalized noticing templates early this month to the end of November. The pilot entities will be commencing noticing by mid-October. It should have that completed by December 1st as I said on an earlier slide and, lastly, for the health plan they should complete noticing a joint notice with the plan by December 1st and complete this by January 1 or within 14 days of being notified of a transition member. All right. I think that does it for my slide. We can move to the next one. I will hand it over to Oksana.
Slides 26-30	00:25:23 – Oksana Meyer	All right, Michael, I will run through some of our key points on the transition of health homes. So I will start off with the big picture and then go through some of the key elements. As far as health homes and the transition to ECM, as many of you may be aware, the department went through a multiphase process to home health homes so there's a lot of knowledge and expertise and infrastructure that was developed by the health plans implemented by health homes. So we began to dig through the development ECM. We really leveraged a lot of the work that was done for health homes. And what you will notice is much of the ECM core services are also based on the core services and health homes. We felt pretty good about the work that was done with health homes and emerging and transitioning health homes into the new ECM benefit statewide. So as far as the big picture for health homes, all the current health home enrollees will be grandfathered into ECM effective January 1st. And so that was something that we think will be very seamless for our beneficiaries. We also will request that a reassessment of all transitioning members from health homes into ECM occurs at about six months after they transition to ECM to ensure that the

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		benefits are still for the right fit for members who transition into ECM from health homes. We also are working closely with the plan to ensure that all eligible Home health members transitioning will have access to a couple of Community Supports that the plans elects to offer within their service areas. And so also just a note that we have strongly encouraged all of our health plans, starting ECM in January, to really offer as many of the Community Supports as they are able to and especially ones that correspond to some of the health home services that are transitioning into that community services category. Next slide, please. Again this is just to iterate that. We believe the health homes transition to ECM will be very seamless and smooth from the perspective of the members just because we do expect to grandfather in all current health members into ECM. Next line, please. Our expectations around the Community Supports, again, as I mentioned we are working very closely with the plans to encourage all of the plans implementing in January to offer the full menu of community support services, but especially the ones that correspond some of the services members receiving the home health programs, specifically some of the housing support services. And as Michael mentioned right before me, we do have a preliminary selection of some of the community support that we are considering, and we are very pleased to see what the selection looks like. So we feel pretty comfortable and confident that members will continue to receive all the necessary services

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		even though some of the home health services will be provided now through the Community Supports option. Next slide, please. To wrap up what we are doing in health homes. The big transition milestones is in September. We released member template notices for plans to sort of begin putting their own logos and so forth. But that can be used to notify members of this transition and really the member notices sort of provide information that folks are getting grandfathered in. There really shouldn't be a lot of destruction in their care. And that this is happening effective January 1st. In October, just a few weeks from today, we are expecting to receive the first pass of the health plan network development process. So we're looking forward to receiving that information. And then the next milestone is in December where we expect some of the first mailings to go out to members to notify them of this transition. We also know that healthcare providers are also working with our members to help them know that this change may be coming in to answer any questions. And then the next grand milestone is the transition and the effectuation of the ECM and community services, January 1 of 2022. I think that's it for me as far as health homes transition information.
Slides 31-36	00:30:48 – Dana Durham	Thank you. I'm really excited about some of the work requirements that we have for the health plans. As far as contracting with providers in the community, the health plans are required to develop networks of ECM and Community Supports in ways that preserve the critical infrastructure developed under Whole Person Care and health homes.

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		Just from a conceptual level, ECM and Community Supports our community-based services. Medi-Cal managed care plans receiving these services will have primarily in-person encounters with community-based providers rather than encounters over the telephone. So the health plans must establish contracts with providers and community-based organizations to provide both ECM and Community Supports starting with transitioning populations in January, 2022. The networks really are expected to go over a time and we are doing everything we can to support their growth of those networks. One of the key things that we really feel is important is preserving the infrastructure that's been built in health homes and home person care. For that reason plans are specifically required to work towards contracts with the Whole Person Care lead entities. So often counties and the case of Sacramento, the city, and community-based care management entities as ECM and community support dividers. We feel like they've done a really good job and this concept is built on what was embedded in health homes and home person care so as much as we can transition these providers. Well, that is the goal. Next line, please. So just to give you an idea of ECM provider requirements. ECM providers really are community-based entities with experience and expertise providing intensive, in person care management services to individuals and one or more of the populations of focus. And they are primarily responsible for coordinating care across multiple

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		medical, behavioral and social service systems. So if a beneficiary has a need that has been identified in whatever area, including even dental, that care manager is responsible for coordinating that need. There must be a lead designated care manager for each member receiving ECM. In the contract with health plans, the ECM providers must meet specific contractual requirements and demonstrate the capability related to care models, billing, and data sharing. And it's really important that we can have ECM providers who can help with the care model making sure they can bill and that they can share data back so there is that vision of what is happening with an individual across the spectrum. Next slide, please. Just to give you an example and just note this list is not intended to be exhaustive. So I'm sure we're missing some, but just examples of ECM providers really are County agencies, federally qualified health centers or FQH as they are often referred to. Primary care providers, behavioral health entities, community and rural health clinics, community mental health centers or organizations serving individuals expressing homelessness or justice-involved individuals. As I said, this is not an exhaustive list. Next line, please. So as we have talked about ECM providers, let's also talk about community support providers. Community support providers are to deliver critical medical and social services such as housing navigation, recuperative care, medically tailored meals, those things that are typically funded in Medi-Cal. It's that list of 14 player groups services. Community support providers contract with health

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		plans as being primarily responsible for delivering select medically appropriate alternatives to more costly state plan services. They can subcontract with other entities as it is appropriate. Once again, they must meet certain contractual requirements such as those related to care models, billing, and data sharing. Next slide, please. So these are a list of potential community support providers. Of course, once again, this list is not exhaustive. It just gives you an idea of who those providers may be. It could be social service agencies, life skills training and education providers, home health or respite agencies, home health delivered meals providers, affordable housing and supportive housing providers and then sobering centers. Next line, please. With that, I'm going to turn that over to David Bishop who was one of the branch chiefs in our capitation rates development division.
Slides 37-39	00:36:40 – David Bishop	Thanks, Dana, I appreciate it. Just to give everybody a heads up, or an update on 2022 ECM rates. I just wanted everyone to know on the call that the final plans specific for ECM rates for calendar year 2022 along with high-level rate assumptions were shared with all healthcare plans on September 8, 2021. Were happy to announce that that big huge milestone was met a little bit earlier than had anticipated because the department did hear from the community not only just the plans but the providers as well. That they were really looking forward to getting those final rates out. So the department did reach that goal a little bit ahead of time. So we were really happy to have achieved that milestone. Additionally, just final notes on those

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		rates, the PM rates are different across plans and counties. As you all may be aware they set rates across different plans and counties so they're very unique to those specific plans and counties in which they are operating in. Additionally, the ECM provider reimbursements, ultimately those rates that the plans will pay their providers will depend on the plan and provider negotiations. We want to make sure that you are all aware that the DHCS does not direct health plans on how or why in developing and compensating the ECM providers for providing the care. DHCS does not give direct guidance on how to do that. It really is up to the plans of the providers to make that ultimate negotiation. Additionally, just adhering to our DHCS's normal process, the ECM component of the total health plan rates will not be posted on the website. Really wanted to make sure that the provider community and the general audience does know, DHCS does post the managed-care rate ranges on our website on an annual basis. So we do have historical rates that are available on the DHCS website. Not saying that they're not available, just not this specific ECM, PMPM's are not posted and for calendar year '22, just so everyone is aware, as soon as the departments submit for review and approval to CMS, we will be posting the additional rate ranges for calendar year 2022. And sometime in the first of the year of '22. So between January and March, by the end of March, we will have the calendar year '22 rate ranges for the plans posted on a website. Additionally we do expect the providers and health plans are finalizing the discussion. So those model of care part three submissions can be submitted no later than October 1st of this year. Next line, please.

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		We did want to make sure this was communicated. I think we've been having this conversation, but really wanted to have it hit home as well that the health plans are not required to make whole person care pilots whole financially. So this is one thing that has been really a topic of conversation. We really wanted to reiterate that it is very key that the health plans will be working with the established community, the providers that will provide ECM. And that's how they will be disseminating the negotiated rates between the providers in the plans. There will not be a one-on-one from coming over from the Whole Person Care pilots into the ECM PMPM's. Additionally there are some other avenues that we really wanted to highlight that the department is doing. We are investing in community or capacity building as well as infrastructure to facilitate this transition from Whole Person Care as well as outcomes into ECM and Community Supports also known as ILOS In Lieu of Services. Additionally, for calendar year 22, you all may have been aware as well we are rolling out an incentive program which will assist in the implementation of ECM and Community Supports. That goes live January 1st of 2022. And that incentive program is carrying over three program years which is additionally from January of 2022 all the way through June of 2024. Additionally, the department is pending formal approval for funding of the CalAIM 1115 waiver to support the delivery system reform through an initiative known as providing access and transforming health supports. We are actively involved in conversations with CMS. We discuss with

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		them and are really working towards finalizing our discussions over the next quarter or so that we are hopefully going to be on a path to get formal CMS approval by the end of the year. We are crossing our fingers. Once again we can't make any commitments but we are actively working with our CMS colleagues to work on that as well and forming a path to implement the ECM and Community Supports. Additionally, I also want to incorporate the shared risk savings models which will incentivize the health plans to fully engage in ECM and Community Supports as well as to support a statewide carbon of long-term care in future years. This is something that will be incorporated into the future years, calendar year 23 and forward. But I just wanted to let everyone in the community know that the department is dedicated to providing as much support as possible to ensure that we have a successful implementation of ECM and Community Supports. Next slide, please. So I just wanted to also provide additional resources that are available. The DHCS, ECM and Community Supports website. Very valuable website. That's updated on a frequent basis if any of the latest documentation. It has the contract updates, FAQs, it has some prior webinars that we've discussed and information on the Halle incentive programs as well as the model of care. It is a useful website that the department is actively updating it as often as possible. Additionally, if you have additional questions that you have that you would like to send to the department, please send it to this e-mail address listed on the

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		screen. And on the next slide, we will switch over to the formal Q&A session.
N/A – Q&A	00:44:10 – Edith Stowe	Thank you so much David. My name is Edith. And I am with Minette Health. I'm going to go through some of the very good questions and answers that have arisen in the chat. It's clear from the questions that we have a number of community providers on the line which is wonderful. And I'd like to invite the colleagues to clarify the principles for that audience to assess at this time. Before I do that, we had a number of questions of when can we see the recording. And the answer to that, I think, this is the first webinar that will be recorded and videoed and will be available on the ECM Community Supports DHCS website along with the slides, something like five business days from now. So keep checking the website. We have a cluster of questions. This can go to Dana as being really clear about who is transitioning automatically or grandfathering as we sometimes say from the Whole Person Care program into ECM? And is it only the people who are in the population and focus or is it a different principle? What about persons who might meet focus but do not go live until 2023. So Dana I wish can really clarify how individuals are being identified for this immediate transition.
N/A – Q&A	00:45:48 – Dana Durham	Really appreciate that question. In general, if someone is receiving care coordination and Whole Person Care, it will be transitioned to ECM whether or not they're meeting a population of focus. There are a couple of instances where the Whole Person Care entity may not feel like a group of individuals is receiving intensive enough services to really benefit

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		from ECM. If that's the case, they would be identified for complex case management and transition, but that is the exception and not the rule. I just wanted to make sure I noted that there was that certain small number of people but with that small number they will be transitioned to complex care management and it is the Whole Person Care lead entities who were helping us identify those people who transition. I hope that answers your question.
N/A – Q&A	00:46:57 – Edith Stowe	And then on the health homes side - this is pretty straightforward - but is it everybody that comes in ECM from health home or is anybody being excluded?
N/A – Q&A	00:47:12 – Oksana Meyer	No; I'll quickly say on the health homes side, all health home enrollees will be grandfathered in. And they do have an opportunity to opt out. And that the opt out option is also available for home healthcare as well.
N/A – Q&A	00:47:35 – Edith Stowe	Great. Okay. Another ECM design question. Less about the transition that goes on in 2022, but more about the benefit. What if someone that falls into more than one bucket? Does it matter is how that might affect how they get the benefit?
N/A – Q&A	00:47:58 – Oksana Meyer	I can quickly answer that. It doesn't matter. So if an individual or enrollee meets the requirements of any of the populations of focus that are going live in January, they would be eligible to receive ECM.
N/A – Q&A	00:48:20 – Edith Stowe	Great. Let's tackle some ILOS questions. Actually if we could have the slide back up. And go to the slide that has the list of all the supports. So I am going backwards. There we go. That's the one. We had a couple of questions like can you break it down for us in more real-time. How do these communities supports help people with housing? How did they help people with rent? Can they help people with utilities? Either Dana or maybe Michael?

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N/A – Q&A	00:49:10 – Dana Durham	Yeah, ongoing rent and ongoing utilities cannot be helped through the Community Supports. That is actually a CMS rule. So the ongoing sustainment of kicking someone in their home through paying for rent or utilities cannot happen. However, the housing deposits would cover such things as a deposit to get someone into a house and/or a deposit for utility or something else that could be needed. So it's kind of a two-pronged answer to that question. Yes and no. For the best way to really understand what is included in the community support. I do want to mention that there's a pretty good description of each service in the CalAIM proposal. If you have a particular question after the webinar about a particular one, I really do encourage you to look through that proposal because it may answer your question. But we're still answering questions and are happy to. I just wanted to make sure that you know it's available.
N/A – Q&A	00:50:28 – Edith Stowe	Great. A couple of questions about dual-eligibles. First of all are these new programs available in general and are they available to dual-eligibles in general, and are they eligible to Part B Medicaid members? Dana, do you want to take that one?
N/A – Q&A	00:50:55 – Oksana Meyer	I would quickly say on the ECM side dual members are eligible for ECM unless they're in a fully outlined plan like CCI. Dana, if you want to address … .
N/A – Q&A	00:51:12 – Dana Durham	Sure, as far as in Community Supports, dual-eligibles are eligible for Community Supports as they are -- as the community support is offered and is a community supportive and cost-effective for that individual to get. That service, I will note, however, that there are some Community Supports that are being stood out with limitations. We will be posting those communities supports that are available for

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		each plan soon and if there's a limitation on it, it will be noted just so you are aware.
N/A – Q&A	00:51:57 – Oksana Meyer	And folks, if I could put in a plug, we recently posted to policy guides. A policy guide on ECM and a policy guide for ILOS services. So all the exclusions for eligible dual are in those documents and on the DHCS services homepage. Great so I just wanted to refer folks to that for any additional information.
N/A – Q&A	00:52:22 – Edith Stowe	Hi, David, a question about duals. So in the great assumptions of ECM, there are differences of people who are dually eligible for Medicare and Medicaid was the question.
N/A – Q&A	00:53:06 – David Bishop	Yes. So all of the ECM, sorry, as Oksana mentioned, anything that had to do with CMC or fully integrated descent, the rate assumptions do not include those specifically. If they were ML THS, what we call CCI non- duels, those also were incorporated into the Medi-Cal managed care rate development.
N/A – Q&A	00:53:40 – Edith Stowe	It's clear from the questions that are a number of folks from FQHCs – let's tackle some of that. One person the question if I'm an FQHC and I wasn't involved in home person care but would like now to explore becoming an ECM provider or provider community support, can I get involved even though I was in Whole Person Care? And then sort of a related question for providers. If I have primary care signed members, will I automatically have those same members to ECM or not necessarily? I can turn that one to Dana first.
N/A – Q&A	00:54:38 – Dana Durham	Sure. So if you're interested in contracting with a managed care plan for Community Supports or ECM, contact that managed care plan. They're still growing their networks. They'll need to know your ability to service how many people you can work with on ECM and Community Supports. And then they will have some other specific questions. But I know

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		they would love to hear from you. Because they are working really hard to build up their networks. So thank you for being interested!
N/A – Q&A	00:55:18 – Edith Stowe	What's the relationship of the state setting up a relationship between primary care patients and ECM providers, is it necessarily one-to-one or often one-to-one?
N/A – Q&A	00:55:30 – Dana Durham	Yeah, that will be worked out through the managed care plan. And they are looking at one model they're going to offer ECM through. But that will specifically be managed care plan to managed care plan to answer that question. Some really do want the clinical provider to be the ECM provider and in other cases, that really just isn't the route that the managed care plan may be going. This actually really falls a little bit more with Oksana. She probably has more information on it.
N/A – Q&A	00:56:07 – Oksana Meyer	Yes. That's all correct. The only thing I would add is if we have, for example, again it depends on what the MCP sort of moves forward with and their availability of providers in their network. If the plan has a PCP that is also elects to be an ECM provider and has the capacity to do the full spectrum of ECM services, then all identified and eligible ECM members that are also assigned to that PCP would be sort of assigned to that ECM provider/PCP that that member already has just to ensure the continuity. If that's not an option, because we do know there are some very small provider practices and it's just not feasible further provider to sort of build out a full space for ECM, we would then ensure that the member -- whoever the ECM provider -- that's assigned to that member, that ECM provider and the members lead care manager is in close contact with the PCP to ensure that the members

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		health information and so forth is understood and known and is incorporated into the care plan.
N/A – Q&A	00:57:35 – Edith Stowe	We are at the top of the hour. I think we can go to the very last slide that has the mailbox because there are a lot of people who have good questions and they want to follow up with this team. Just share that e-mail address. There we go. It's that second e-mail just there. On the website which is published here, you will see that there are the billing requirements that we're hearing a lot from billing providers that will be coming out in October and finalized billing requirements. So please look for that on the website. We are at the top of the hour. Thank you very much for attending and engaging with us for this transition. We look forward to engaging with you again. Have a great day!