Questions & Answers:
PHC Presents: CalAIM ECM & ILOS June 24, 2021

ILOS - Medical Respite:

Q: Respite services would be in lieu of what current benefit?
Instead of other alternative levels of care such as skilled nursing facility, board and care facility, or acute hospitalization.

Q: What about adult residential or residential care facilities for the elderly-RCFE (ARF)?
The type of services must fit into one of the definitions for ILOS – and be one that is being offered initially or at the time.

Q: I am still unclear about the difference between "short-term post-hospitalization housing" and recuperative care. Can you explain further?
The definitions are close, the biggest difference is Short Term Post Hospitalization is offered with housing transition for members coming from places such as sobering centers short term, it's looked at more like a bridge, where recuperative care is members coming from hospitals based on their medical needs.

Q: Can individuals who receive In-Home Supportive Services (IHSS) also qualify for Personal Care/Homemaker Services, Respite Services, and Medically Tailored Meals and Supportive Foods?
Yes, as long as it is not duplicative, and has to be medically necessary. It cannot mirror any services they are already receiving.

Q: Could you say more about ILOS medical respite for homeless individuals? If there is no SNF available, would they be eligible for ILOS medical respite?
Yes, ILOS provides different services like board and care or room and board centers.

Q: In case of family/caregiver burnout, how long can a patient stay in Respite?
There is a total number of hours per week that can be worked for Respite. Patient cannot receive more than 24 hours per day of care or 336 per year.

Q: If a county were interested in setting up a Sobering Center, would PHC consider including that as an ILOS?
There are the 8 initial services we are launching, but we can add more every 6 months.

Homelessness:

Q: Also, would Street Medicine Programs qualify for ILOS?

This is an opportunity for ECM, if there is an organization that is interested; please reach out to the CalAIM@partnershiphp.org inbox. We want to ensure there is engagement and collaboration with the community health facilities.

Q: As a homeless service provider, would case management services for housing tenancy and sustaining services be reimbursable and if so, is there a standard reimbursement rate?
If the member was medically compromised then yes. PHC has received draft ECM rates from DHCS and we are working on developing rates for tiered severity and expected caseload. As these are draft rates, nothing is final until PHC receives final rates from DHCS in the fall.

Q: For our homeless population, after the respite stay/placement, do we have any program that helps patients get back to their feet like helping to look for employment and such? Or will that all be dependent on the patient?
Please send us a list of current services available in your county, so that we can weigh if that will meet the requirements for this type of service.
Send us an email and we can connect to services needed, this can also fall under ILOS under housing transition and other providers that we can work with.

Q: If a homeless person is leaving the hospital and no SNF is available how do you determine that medical respite is eligible if there is no SNF available to be in lieu of?
It can be a respite center where home health comes in, as long as they can care for themselves. If they cannot, then we would look for a congregate living.

Q: Are there any ILOS for homeless safe parking, tiny homes, and managed encampment program?
It has to be in lieu of something, and we have to be able to link it to their health care and medical needs.

Q: What are the requirements to prove an ILOS is "cost-effective"?
We are still learning those specifics at this time. We know we must show that the In Lieu of Service prevented a covered benefit that would have been more costly.

Q: Will the ILOS be available to those with Medicare and Partnership?
Yes. Medi-Medi members, those who have Medicare as primary and Partnership as secondary, will be eligible.

Q: Will board and care (B&C) facilities be vetted to ensure they are providing optimal care in a safe and clean environment?
We are currently working on that process, whereas in SNF there are state requirements listed on the website. The B&C does not have the same requirements, so we are also looking at congregate living as an option as well.

Contracting:

Q: What is the timeline for contracting with new providers? When do you predict contracting commencement?
Reach out to the CalAIM@partnershiphp.org inbox to receive the Readiness Questionnaire. We are currently working on contracts with Providers.

Q: Please clarify: For hospitals that may be looking to collaborate with counties to provide ECM or ILOS, I am assuming licensing fees are not covered by PHC, as hospitals are required to implement as part of HQIP?
Hospital QIP will be expected to pay on its own and to have a separate set of responsibilities.

Q: We have a hospital-based complex care program, and would like to participate in ECM to support our community; do you anticipate this to be an issue, as we are not located in primary care?
We are interested in contracting with whomever, and the state has an understanding that the infrastructure is not complete but open to new opportunities for filling gaps.
If interested reach out to the CalAIM@partnershiphp.org inbox and fill out the Readiness Questionnaire, you can also review the questionnaire to get a better understanding of how the organization will fit into the services that we provide.

Q: If we are already a Whole Person Care non-profit provider, how will we be able to apply to be a part of this program? Will it go through the county or direct with us through Partnership?
If currently contracted with a WPC Lead entity reach out to the County and establish where they see your role. If you are a current IOPCM with PHC, we are actively working with those entities and sites so that they will transition into ECM.

Q: Will PHC be seeking out congregate living options in the Bay Area? As we only have Southern California options currently.
Yes, we are hoping they will build some, there are a few that are interested in establishing these facilities.

Q: Does the ECM provider also have to be the primary care provider?
To be an ECM provider you do not have to be the primary care provider, you just have to be able to provide the services. TBD depending on agreements with the counties, if through PHC you will contact PHC for billing.

Collective Medical/EDIE:

Q: Will Collective Medical cost be subsidized by Partnership or DHCS?
Yes, PHC will cover the licensing for Collective Medical Technology.

Documentation:

Q: I heard the term "medical necessity." Does this mean that case managers and /or providers have to have specific qualifications/experiences to provide services? Also, will providers go through Utilization Reviews and be subject to recoupment if audits and URs find deficiencies? What kind of documentation/notes, client plans, and assessments would be required for either ECM or ILOS?
It will depend on the situation, but validation will need to be submitted with the request of service. The phone number to call will be announced at a later date.

Q: How do we send referrals to ILOS? Do we fill out a form? Is it by fax/email or is there a specific contact per county?
For PHC, we are building TAR requirements, at this moment, it will probably start with a phone call or referral of a TAR. If the referral is to the county entity, then it will be run by the county.

Q: Would you also submit a TAR for something like shoe inserts for someone who has foot drop?
TAR from a vendor is required as this may be a covered benefit and will be reviewed for medical necessity.

Q: What kind of documentation is required? What qualifications are needed/required for case managers or staff?
In the current drafted language today they point to both non-clinical and clinical roles. The state has left it a little flexible to manage the approach, the Care Plans will have appropriate clinical oversight. The clinician will serve as the ECM Care Manager. We are looking to leverage the key expertise that is available in the counties and communities.

Q: Will WPC programs in counties monitor the clinical oversight of the billing/documentation or would contracting entities working with WPC counties be responsible for their clinical oversight?
We are still exploring this, at a minimum if there is a community-based entity that has almost all requirements, PHC can provide any oversight to assist. We are working with DHCS to see what those contracts will require.

Q: How long are you expecting the TAR process to take? Will it be M-F 9-5?
Yes M-F 9-5, we have a 5 business day turnaround time and we want to maintain that with the ILOS Program. There are no specific criteria; we are putting together our TAR process.

Q: What type of documentation is required, and do we bill through WPC county Medi-Cal systems?
The state is requiring a lot of documentation of any approved services and we will have to show what services this is in lieu of and cost savings.

Rates, Incentives, Billing, and Claims:

Q: How are participating providers compensated/paid for providing personal care and respite services? How long does it take to pay the Provider? How many hours are covered for a client at one time for respite or personal care? How are clients referred to the Provider?
The first step is filling out the Readiness Questionnaire we have developed. Please send an email to the CalAIM@partnershiphp.org mailbox. Claims for services sent to our Claims department is the preferred route. PHC is required to send the payment within 45 days, but we try to complete it within 30 days. We are looking into invoices for providers that do not currently have an electronic process in place, but electronic is our preferred method.

Q: Is there incentive/infrastructure funding to support counties/communities to develop these services?
There is incentive funding for counties/communities to develop these services.

Q: Since Lake County has almost nothing for services, how can we find providers?
There are incentive dollars and the opportunity for the counties to grow the number of services provided in the counties. With the lack of services provided in Lake County, the members are allowed to seek care outside of the county, and the funding will be determined by DHCS and the state.

Q: Will the state incentive dollars flow through Partnership or can the counties go directly to the state?
The amount of funding is still being discussed but the dollars will flow to the health plan and then to the county.

Q: FQHCs providing IOPCM services were paid on a per member per month basis, will this continue? Also, there was a 12-month limit on keeping clients enrolled in the program, will there be a limit on how long a client can receive ECM services?
PMPM the details are still being worked out.

Q: IOPCM already has a PMPM rate developed for the homeless, do we know how ECM PMPM will compare?
PMPM the details are still being worked out.

Q: Can you speak to how ECM and ILOS will integrate with county-funded programs and services?
For some populations, ECM will service through wrap services. We are working with the five counties to identify which services can be classified as ECM that is different from TCM.

Member Referrals and Assignments:

Q: How will the initial eligible ECM target population be identified and will those members be shared via a TEL to the ECM providers, similar to HHP?
Members can self-refer, providers can refer, and PHC can use any data available on hand to identify any person that may be a candidate for ECM such as claims data, transportation assistance, etc.

Q: If there are multiple FQHCs in a county and not all are contracted as ECM providers, is it conceivable that a contracted EMC-FQHC would receive eligible members who are connected to a non-ECM contracted FQHC?
We want to make sure we can keep the member at their established site as long as it is an ECM provider. We understand we may need to send them to a different site, but we will leverage non-contracted sites to join if we can. If we identify someone on the targeted list, and that person is assigned to a clinic but seek care at clinic B consistently, we want to connect with that clinic and see if we can work something out. Regarding beneficiary choice and qualifying for services, if we see that these patients can benefit from ECM we want to connect with these providers with changing to a new PCP.

Q: If a member's needs of service cannot be provided in their residential county; can other Partnership counties provide services?

The services will only be available to those members in the first 5 counties involved in Phase One. If we need to, we can tap into services outside the county line, but for the go-live, the member needs to be residentially located in the first 5 counties.

Q: What happens if a county does not currently have these facilities or services? I.e. IHHS works in rural areas. Will there be available housing?

As long as the member is residentially located in the five WPC Counties for the Go-Live 1/2022, they have the option to receive services outside of the county lines. There are state plans that will be coming from the governor's office.

Training:

Q: Will PHC also facilitate training on CalAIM Proposal Appendix I (ECM) and Appendix J (ILOS) that help summarize the requirements in layperson's terms, as the Appendices are quite dense, yet very important for anyone wishing to provide these services?

The description for ILOS is 81 pages long; we are working on this document to make it easier and clearer for everyone to understand. We will be creating documents that break down the requirements for each section.