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Session 8: Process for Receiving & Approving Referrals for ECM and ILOS Services

August 9, 2021

Meeting Summary

Discussion Takeaways:

- Plans indicated they will use their current UM authorization process for ECM referrals.
    - One plan noted that they will not have a separate authorization process; ECM referrals would come in through the normal intake process and be routed to a specialized ECM team.
    - Another plan indicated they are using their UM structure as a framework, but a special ECM team would serve as adjudicators and processors.
    - Another noted they will also use their current authorization process for ECM referrals. Nurses and coordinators who manage specialty referrals will also review ECM referrals. An ECM team member in the care coordination department would be available to assist with eligibility or other questions, but the plan anticipates most will be preauthorized before they reach the coordinator.
- Several plans noted that typical UM authorization processes will be used for ECM services that are denied (i.e., cases will be directed to and reviewed by a medical director who will make the final determination).
- If a member calls into the plan indicating interest in ECM services, one plan stated they would connect the member to a care extender within the plan who would determine whether the individual is likely eligible for the ECM service. If the member appears eligible, s/he will be connected to the ECM care team who would confirm eligibility. If the member is not eligible, s/he will be directed to other resources to address the need.

- One plan shared that members who call in would be directed to an ECM provider so that the provider can thoroughly document the assessment process.

- Plans are using multiple strategies to identify members who meet target population criteria and may need automatic authorization for services. Strategies range from health plan data, members in case management and concurrent review.
    - Plans are using their own data to identify members who are high utilizers or may meet target population criteria. ECM providers could be provided data as appropriate and reach out to members; however, providers would still need to submit a referral for services.
    - Plans are also utilizing predictive eligibility tools to help identify members who may be eligible for ECM services. Results are given to the ECM team for follow-up (unless the member is already linked to an ECM provider).
    - One plan discussed development of a daily report to identify members who may need ECM services. Customer Service will serve as triage to identify member interest in ECM services. Plan staff (clinical or other staff, as appropriate) will check eligibility and if the member is eligible, a warm handoff would be made to an ECM provider. If the member is not eligible, s/he will be informed about other available resources and plan staff will work with providers to validate any secondary information that might indicate eligibility. At this point, if the member is still not eligible, a Notice of Action letter will be sent to the member.
    - DHCS data on members who may be eligible for ECM based on their participation in a Whole Person Care (WPC) program and/or data directly from WPC programs are also being used to help identify members who need ECM services.

- Plans are developing varying approaches to authorization time frames and for reassessing member needs within DHCS requirements, including:
    - Six-month ongoing authorizations
    - Twelve-month authorizations for new ECM enrollees
    - Six-month authorizations, but depending on the individual member's needs for ECM services or other services/resources, eligibility criteria may be adjusted at six months
    - Twelve-month operational authorization with a "mini-assessment" of the member's needs at six months to help track, trend and monitor progress and his/her need for additional assistance or resources
    - Six months for HHP and WPC rolling authorizations and 12 months for ongoing new services

- Regarding matching members to ECM providers, one plan uses a hierarchical logic that first prioritizes a member's relationship with their DBH partners, secondly by PCP and subsequently by geographically placed care teams.

- When plan data identifies a potential eligible, one plan noted that the information is sent to the ECM team to follow up and sort through the eligibility process. Another plan noted that they send the information to the ECM provider to conduct an eligibility checklist. If the provider finds the member eligible based on the checklist, they should start providing services; if the plan finds the member ineligible, the plan would still reimburse for that month.

- Referrals for ILOS services will be processed differently than for ECM services. Recognizing that these referrals could come in through multiple points of entry, plans want to centralize requests. Some plans will follow their usual UM authorization processes for ILOS services, including turnaround times for processing authorizations.

- Given member needs and the diversity in types of ILOS services — some of which may not fit into a typical authorization process — plans are likely to have or need to develop varying criteria for approval.

Next Meeting:

The next session is scheduled for Aug. 23 and will focus on the Model of Care Part 2 submission.