

# CalAIM Overview of Data Exchange and Reporting Requirements for Enhanced Care Management & Community Supports

August 4, 2022

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 1	Julian – 00:00:18	<p>Thank you for joining, we will begin shortly. Hello, and welcome. My name is Julian, and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the Q&amp;A field, which is located on the Zoom panel at the bottom of your screen. We encourage you to submit written questions at any time using the Q&amp;A. The chat panel will also be available for comments and feedback. Finally, during today's event, live closed captioning will be available in English and Spanish. You can find the link in the chat field. With that, I'd like to introduce Dana Durham, Managed Care Quality and Monitoring Division Chief at DHCS. Dana, you now have the floor.</p>
Slide 2	Dana Durham – 00:01:34	<p>Thank you so much, Julian, and we welcome you to this webinar today. We're going to talk about data exchange and reporting requirements. But before we do, let's talk a little bit about the public health emergency unwinding. I am anticipating, and we're looking forward to, the public health emergency ending, but there's a risk involved in that. And the risk that we're concerned about is millions of beneficiaries may lose their coverage. So our goal is to minimize beneficiary burden and really promote the continuity of coverage that beneficiaries deserve. And we're asking everyone to help. It's kind of an all hands on deck thing. So how can you help? Well, we want you to become a DHCS coverage ambassador, and that would involve a few things. One is downloading the outreach toolkit on the ambassador webpage, and then also joining our ambassador mailing list. We do want you to be up to date because we feel like the more information we can get out there, the better it will be.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 3	Dana Durham – 00:02:41	<p>Next slide, please. So there are really two phases to the unwinding of the public health emergency. The first phase, happening now, let's encourage beneficiaries to update their contact information. Many people have moved or had change in life circumstances. So as much as you can encourage people to update their contact information with their county office, do. And that includes like putting up flyers, using social media. Anytime you get a chance to interact with the beneficiary, or if you are a beneficiary, just make sure that you note and tell people that information needs to be correct. The second phase will launch 60 days prior to the end of the public health emergency termination. And in that phase, we just want everyone to remind beneficiaries that they'll get a renewal packet in the mail. And once again, update that information if they've not done so yet. Next slide, please.</p>
Slides 4-6	Dana Durham – 00:03:44	<p>So with that, I do want to get to our agenda. We're going to talk a little bit about CalAIM, just to make sure that everyone is on the same page about what CalAIM is, and then we'll talk about data and that'll be enabling the ECM and community supports through data. And then how the data flow works between managed care plans and ECM and community support providers, as well as managed care reporting requirements to the department and the department's expectations and supports for implementing data and reporting requirements. Throughout, we'll have some question and answer time. So we do want to hear your thoughts and any questions you have as we go. Next slide, please. So we'll start with an overview of CalAIM. So I know many of you have heard this, but it's just really important as far as where we are with things.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Dana Durham – 00:04:44	<p>CalAIM is California Advancing and Innovating Medi-Cal. It really is a long term commitment to transforming and strengthening Medi-Cal, offering Californian's a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. So the idea is transforming Medi-Cal in a way that really makes it more beneficiary friendly. And really three of the things we're focusing on are implementing that whole person care approach, and that includes addressing the social drivers of health because our health is impacted by where we are. Our goal is to improve quality outcomes, reduce disparities, and drive really delivery system transformation. And finally, we want to create an efficient and effective as well as seamless medical health system, whereas if you're in one part of the state, it looks the same as if you're in another part of the state, and that there is less confusion and more consistency throughout. Next slide, please.</p>
Slide 7	Dana Durham – 00:05:54	<p>So the big picture, on January 1st of this year, we launched the first components of CalAIM and their Enhanced Care Management and Community Support. Many of you know this, but Enhanced Care Management is a benefit in Medi-Cal that addresses the clinical and nonclinical needs of the high need high, cost individuals through really coordinating services and comprehensive care management. So this is a service or benefit that will have someone really travel with a beneficiary and help coordinate their care as they're at a place where they have pretty high needs and have a lot of touch points. And to make sure those touchpoints are coordinated in a fashion where a beneficiary has less confusion is the goal. Community Supports are services that are optional by a managed care plan and they're medically appropriate and cost effective alternatives to using other services or other settings such as hospitals or skilled nursing facilities. And the goal of Community Supports is to really enable an individual to stay in and get services through their community instead of having to go into a specialized setting if that individual wishes to. Next slide, please.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 8	Dana Durham – 00:07:22	<p>So where is ECM live today? Well, as you see on the map, we went live on January 1st in 25 counties. And those 25 counties have either had Whole Person Care or Health Home. And we started with about 95,000 Medi-Cal members who were eligible for, and automatically transitioned into ECM from the previous program. But since January, we've been able to get new members in ECM. And the populations that have been served are the high utilizers, individuals and families experiencing homelessness, adults with SMI or SUD or other programs that were consistent with what was being offered in Whole Person Care, and we wanted to keep going until the CalAIM could come fully into effect. So there could be some populations and some areas, there are some populations and some areas, that are wider than this. But just wanted to note that those are the general buckets of populations. Next slide, please.</p>
Slide 9	Dana Durham – 00:08:39	<p>We're really excited that as of July 1st, ECM is live statewide, which is great. We really feel like we're going to be able to make a huge difference in people's lives. And so those three populations of focus that I've talked to before are live statewide. They're the individuals and families experiencing homelessness, the high utilizer adults, and the adults with SMI or SUD. Starting on January 1st, 2023, ECM will extend statewide for individuals at risk for long term institutionalization and eligible for long term care and nursing facility residents transitioning to the community. And then starting on July 1st, ECM will extend statewide to the children in youth population at focus. We're really excited about these upcoming implementations and their work groups that are focused on each of them, so please go to the website and learn more about those work groups. Or if you have any questions, please email the CalAIM inbox. But we really are excited and working diligently as we look forward to launching those populations of focus. Next slide, please. So where are Community Supports today? Well, I'm happy to say that Community Supports are 97% of all California counties.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slides 10-12	Dana Durham – 00:10:14	Well, it's live in all counties throughout California. But in 97% of the counties, they're offering at least six Community Supports and Riverside, Sacramento, and San Diego is offering all 14 community supports. Now, as I said before, managed care plans can opt in to community support or not, but another thing I want to point out is the uptake of Community Supports is on a six month basis. So you have different Community Supports starting in January or July, and on our website, there is a listing of all the different dates in which Community Supports will be launched. Next slide, please. Now, we're going to talk about enabling ECM and Community Supports through data. Well, why is data so important? Well, it's important for a lot of reasons. It helps facilitate care, and it also really helps us to look at what's happening to see where we can refine the program or what we can learn. Without data, we don't have as much information and can't really make good informed policy decisions. So to that end, one of the things that we've done is we've released data to standardize information exchange, increase efficiency, and reduce administrative burdens.
Slide 12	Dana Durham – 00:11:44	So instead of there being a lot of differences in the way data is exchanged, we've kind of honed in on that a little bit. Managed care plans are required to report to DHCS on the various dimensions of ECM and Community Supports, and that lets the department look at how we're doing on implementation. Are there things we can refine? We get the information in anecdotally, but also having it supported by data helps us know what's working and ways that we can look at ECM and Community Supports to make it better. So to that end, we'll provide an overview of the data sharing and reporting guidance documents and take questions. But we wanted to provide a refresher of this content because we do think there are some new providers in counties that have recently launched, as well as managed care plans and others who may have questions about data and really want to make sure that you understand all the information that's out there and where to find it. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 13-14	Dana Durham – 00:12:57	<p>So some of the documents that we have are we do have ECM member level information sharing guidance. And that really is standards for what is expected from the managed care plan to give to the ECM provider and backwards. We also have coding options for ECMs and Community Supports. So we've used HCPCS codes and modifiers for ECM and Community Supports, and that helps us know how the actual ECM and Community Support is being delivered. So we'll use those codes to understand what's happening on the ground. Next slide, please. Then we had billing and invoicing guidance. When we looked at doing the billing and invoicing guidance, we were aware that we're having new providers, and some of you may be new providers, who are looking at information in a different way. And because of that, we do think there's a little bit of a learning curve.</p>
Slide 14	Dana Durham – 00:14:08	<p>So if we've done what we can to standardize the minimum necessary data elements that the managed care plans will need to collect that will help us submit claims appropriately to the managed care plans, and thus allow us to monitor. So we'll be going through that, but wanting to let you know what that is. Also, we've written a guidance on how to apply for an NPI. An NPI is a National Provider Identifier. And to be able to deliver these services, you need to have a National Provider Identifier, an NPI. Because that may not be familiar to some people, we've created this guidance. So if you yourself aren't familiar with how to apply for an NPI or someone's asking, we've got just a guidance document that will walk you through from beginning to end of how to apply for that NPI. Next slide, please.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Dana Durham – 00:15:11	<p>Then we have the social determinants of health coding guidance. Social determinants of health are really the social drivers of health that I spoke to before, and they really help us know other things that influence where a person can be impacted by things that are going in on in their life that aren't necessarily totally related to their health, but they influence health. To that end, there's a list of about 100 different what are called Z codes. So we've taken that list of Z codes and have prioritized them down to about 25. And we've done that because I don't know about you, but when I am working with something new, I like to put it on my cubicle or next to me where I can just look at it and look at the numbers and use them, and so that's why we've got those social determinants of health. They help us know what's going on with individuals, how we're targeting, working with the individuals who have different social drivers of health impacting them, and are there different ways that we see things happening in those populations?</p>
Slides 15-16	Dana Durham – 00:16:24	<p>And if there are, how do we make sure we speak to them? So right now, that's not mandatory. But at some point, we will be looking towards doing more with those social determinants of health and using them really does help us know what's going on with individuals. And then we finally have a quarterly implementation report. And part of the reason we've included this here is this is a report that the managed care plans submit to the department, and it helps you know what is expected. So if the managed care plan's asking you for something or saying they need something, most of the time, it's going to have to do with something on this document that they have to report to the document. So we think it's important that you see that report so you can understand what is required. Next slide, please. And I am going introduce Kevin McAvey and Lori Houston-Floyd who will help us with data flows between managed care plans and ECM, Community Support providers.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Kevin McAvey – 00:17:39	<p>Thank you, Dana. And it's really nice to see so many of you today. Dana or Lori, can you give me a thumbs up if you can hear me okay? Perfect, okay. It's a pleasure to see so many of you, some of whom who have been on some of our data webinars in the past, might be here for a bit of a refresher, and so many new names and faces. I'm going to try to break down... Oh, the slides up. So there's a lot here, but don't panic. Don't worry. We're going to unpack it all one data flow at a time. And as Dana mentioned, there is extensive guidance posted on the website. After today's call, if you want to see it, I'm going to throw the link in the chat. Almost every piece of guidance that we're talking about here can be found at the site. Also, if you notice on Dan's previous slides, there were individual links to each piece of guidance.</p>
Slide 17	Kevin McAvey – 00:18:38	<p>I reference those and I think there might be some of the most reference documents on the DHCS website. So always feel free to go and check them out for additional information after today's call. So to take a step back, I like to think about data as information. And information is so critical to be shared between actors in a program ecosystem because, in our case, it helps to facilitate care, what care is needed, when it's needed, ensuring that it happens. It helps, as Dana mentioned, for program and operational improvement, knowing how the program is operating and whether it's operating well, or whether we need to make tweaks to it. And most importantly, for all of us, it allows for payment to be rendered. And on this slide, and we're going to be returning to this at several points in today's conversation, I want to just orient you to what's here and which actors that we're going to be talking about that are exchanging information on a regular basis as part of CalAIM.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Kevin McAvey – 00:19:51	<p>So all the way on the right side of the side, you'll see it's in a dark purple box, DHCS. A little bit more to the left, you'll see the managed care plans. And then all the way on the left hand side, you'll see ECM providers and Community Supports providers. Everything in between is the information that's being exchanged, transmitted, in order to support one of those functions, facilitating care supporting program and operational improvement to have payment be rendered. And we're going to break down each of these boxes and talk about what typically happens in an ecosystem between managed care plans and providers and how we may try to make it easier knowing some of the new providers who are going to be brought into the Medicaid program through CalAIM, but who may not immediately have the capacity, the systems, the operations, the tactical knowledge to participate in some of these data exchanges.</p>
Slide 17	Kevin McAvey – 00:20:57	<p>New data guidance to reflect the new types of services that are covered through CalAIM, but that might not necessarily have had standard codes that represent those services. And as these new initiatives are implemented, new reporting that often needs to take place, in the short term at least, to monitor the efficacy and impact of these initiatives. So one thing I just want to say before we start digging into some of these exchanges is there are different ways that different states and markets exchange data. Sometimes it's very market driven where participants in the market say, "We have longstanding relationships and arrangements of exchanging information with our providers, and we have it covered. We don't need any additional guidance."</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Kevin McAvey – 00:21:58	Well, what's really interesting as we were embarking in the CalAIM program design is we heard from participants across the market, as we start thinking about these new transmissions of information, how important it was and would be for a standardization. We heard from managed care plans that, for example, receiving a consistent set of invoice information from ECM and Community Supports providers, as opposed to 1,000 different submissions of different methods and formats, would allow them to process and translate those invoices into claims more easily and efficiently. It would also improve the data quality of the information that they receive upstream. We also heard from perspective ECM and Community Supports providers that when they're working with, especially more than one managed care plan in their region, the ability to provide invoice information in a consistent way, knowing what pieces of data-
Slide 17	Kevin McAvey – 00:23:00	...in a consistent way. Knowing what pieces of data that they would need to put into a particular form, regardless of the plan, was going to be essential for them to be able to participate in the program and would greatly reduce their administrative burden. And for the state, making sure that ECM providers, community supports providers, managed care plans, all are able to exchange information efficiently, will ultimately allow DHCS to get the information it needs in the most accurate and timely way possible to understand how the program is operating, better understand the health needs and the health determining needs of its population, and we'll talk about that a little bit more, and assess the program's operation.
Slides 17-18	Kevin McAvey – 00:23:49	So with that, I'd like to dig into this first box of the member information sharing guidance. If we go to the next slide, it's a big file. And I'm going to throw the link back in the chat here for ongoing reference for everyone as I go through it. And if you have me up on your screen, I'm sorry. But other than that, you could also go click on the link and bring up the actual document just to follow along.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Kevin McAvey – 00:24:19	I also want to take moment and make a plug for two opportunities to ask additional questions. One, at any time you could always send questions about this guidance to the email address I put in the chat. And two, whether you have a question at any time or particularly over the next week, I believe we have office hours next week on this topic. Lori, what's the date and time of that?
Slide 18	Lori Houston-Floyd – 00:24:47	Yep, Kevin. So that's next Thursday and it's at this same time. So we're going to come back to the table to discuss any and all questions that we might not get to today, or as folks think about this guidance over the coming couple of days, if you've other questions we'll be able to address them there too.
Slide 18	Kevin McAvey – 00:25:06	Yeah. Thank you, Lori. I'm sorry to put you on the spot. So as we're going through the rest of today's presentation, as you have questions, please feel free to throw them in the chat or send them to the email address. And I think we might have a little bit of time today at the end of the call to answer some of those questions, and at the end of each section, I think. And then certainly next week we'll come back to some of the more common questions that we've heard. So the member information file guidance really defines a standard set of minimum necessary data elements, standard file formats, transmission methods, transition frequencies that will support information exchange about members between the managed care plan and the ECM providers and back. It's a bidirectional exchange. And we'll be unpacking each of those exchanges one at a time.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Kevin McAvey – 00:26:04	The first transmission we'll be talking about is the member information file itself, the transmission that comes from the managed care plan to the ECM provider providing a baseline set of information about the member. And then we'll be talking about the ECM provider return transmission file, which is, and I like to think of it this way, it's like what the ECM provider adds to that file about those members that can then be resent with this new information back upstream to the managed care plan to make that transaction as efficient as possible. I'll pass it over to Lori Houston-Floyd in a little bit to talk about the ECM provider initial outreach tracker file and then the potential ECM member referral file.
Slides 18-19	Kevin McAvey – 00:26:53	But let's get started with the first one. So to perform whole person care management, DHCS is just very aware ECM providers need to be equipped with data beyond their four walls that reflect the total clinical and non-clinical picture for each member in enhanced care management, including behavioral health data and pharmacy data received by DHCS, other vendors, and other information that managed care plans might have available to us.
Slide 19	Kevin McAvey – 00:27:25	So in a traditional provider managed care plan arrangement, as many of you know, what would usually happen is a managed care plan would send over the 834 and 837 files, which can be very large member information and claim files that would allow a provider to analyze them and extract important clinical information and member information that could then direct their care, know who they're serving, and how best to serve them.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Kevin McAvey – 00:28:03	<p>What we are very aware of is not all ECM providers are coming with that same technical capacity, again, like the systems in place, the operations in place to intake, digest, analyze those files and the technical know-how to often do so. So the thing that we asked stakeholders at the beginning of the design process is, " What are the key pieces of information that you would need in order to best do the job set out for you?" And that's where the member information file came from. It's an alternative way for providers who cannot accept 834 and 837 files to get the information they need. Managed care plans are required to create these files and share them with all contracted ECM providers. The files must include consolidated demographic, utilization, and other information about provider assigned ECM members in a way that those ECM providers can digest.</p>
Slide 20	Kevin McAvey – 00:29:08	<p>And so let's dig into this first file a little bit more. If you go to the next slide. So the actual member information file, we're going to talk through a number of the different contents or cables that ECM providers can expect to receive from managed care plans. But, again, big picture, this is meant to provide information on the individual members assigned to the ECM provider about their clinical and nonclinical needs. We recommend it's shared in an Excel based workbook or another mutually agreed to file format.</p>
Slide 20	Kevin McAvey – 00:29:44	<p>And I think you'll see a common theme throughout all of our guidance discussion today. For most of these pieces of guidance, this is what's at minimum expected, or the default expected, for an exchange between managed care plans and ECM or community supports providers. If mutually agreed to between the ECM or community support provider and the managed care plan, additional information could be collected. It could be exchanged in a different way. The point of all of this guidance and standardization is to make these exchanges as efficient as possible and so we offer that flexibility.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Kevin McAvey – 00:30:28	In some of this guidance, the guidance actually comes with a template, which we'll talk about a little bit later, that's expected to be shared and used. Other guidance, like the member information file, it's a description of what information must be comprised in any template that's ultimately developed by a managed care plan, but should provide, again, that minimum baseline expectation of what information should be exchanged.
Slides 20-21	Kevin McAvey – 00:30:53	Through the member information file we would expect that all the ECM providers would get their member engagement elements within 10 days of member assignment and then at least monthly thereafter. So, not to the bury the lead too much, but let's talk about what actually would be in that file that we've received. And the next slide, please. So there are like four tables that we are going to briefly tick through. And I am going to save you, and I'm not going to tick through all of the different elements that are in here. But I'll call out a few that might be of particular interest to you and where we've received a number of questions in the past.
Slide 21	Kevin McAvey – 00:31:33	So table one of the member engagement file provides demographic information for the members that are assigned to the ECM provider. So you have your names, your contact information, residential mailing, date of birth, other demographic characteristics. But a couple of pieces, I'm going to dive into the homeless indicator and ECM population to talk about what you could expect, if you're an ECM provider, to see in those fields.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Kevin McAvey – 00:32:06	<p>But one thing that I want to emphasize, if you have the document up, and, again, I would encourage all of you to take a look at it because there's so much in here that we're not otherwise going to cover today. And in particular, one thing that you will note that's in that document that's not on this slide is that there are a heck of a lot of footnotes at the end that each of these data elements. And those footnotes actually can set you up to understand, if you're a managed care plan, what you should be expecting to kind of program into these files that are going to be produced and sent down to ECM providers, and if you're an ECM provider, what you should be expecting. They're not exhaustive. And that's where your questions come in, as we think about improving these files through the years ahead, understanding how you're engaging with them, what information will be useful, is important for us to know. So, again, always feel free to volunteer your questions.</p>
Slide 21	Kevin McAvey – 00:33:04	<p>So the homelessness indicator. So if you look at probably about halfway down or so, the homeless indicator will be an identifier for if the member does not have an address and is experiencing homelessness as known by the managed care plan and as defined by our ECM policy guidance. If the member was identified as homeless, you could expect to see a one there. If the member was not or it's unknown, that field will be blank. And then similarly for the ECM populations of focus, for each of the populations of focus that that member was identified for, you'll have a one indicated for those fields. Where the member has not been identified, where it's a clear no or just not enough information, you will get indicators of zero.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Kevin McAvey – 00:34:02	Next slide, please. Perfect. So on the second table, this actually gets beyond the basic member information, who the member is, to what the member's health needs are. So you have a number of flags for health indicators, clinical, chronic conditions, many of the typical ones. And I think this was informed by some of our leading whole person care pilot information exchanges that we saw. Has well, bipolar disorder, diabetes, hypertension, substance use disorder, SMI, to help, again, a provider get oriented really quickly to what an individual's health needs are. For each of these, they might be populated with a Y for a known condition, an X where the condition is either not known or known to not be occurring.
Slide 22	Kevin McAvey – 00:35:02	But for the chronic conditions, for those more technical folks on the line, and, again, this is in one of the footnotes in the guidance, this indicates that at least two separate services on different dates had relevant diagnosis codes for the specified conditions on each claim. And that's within the past two years with the exception of the SMI, SUD, SED flag, which may be identified within the previous one year or 12 months.
Slide 22	Kevin McAvey – 00:35:34	One other flag or indicator I want to know here is the FDOH indicator. So it's at the bottom of the health indicators box, the social determinants of health indicators for claims based. So this is where you're going to start to see the utilization. We're very much hoping for the utilization and reporting of these ICD-10 Z-codes, the 55 to 65, that they indicate a means that extend beyond, which we would traditionally think of as health and clinical indicators.
Slide 22	Kevin McAvey – 00:36:04	And as Dana mentioned before, a lot of these SDOH codes that we're hoping managed care plans and providers prioritize, can be found in the L plan letter 21009. So I'd encourage you to, again, print it out. I think I have it printed in my office desk and, of course, Lori's desk next to mine. And I know for sure Dana does, but it's just really out of all of those, those are the ones we should be thinking about most often and how can we be interpreting them and incorporating them into our workflows and what should we ultimately be reporting up upstream.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Kevin McAvey – 00:36:42	<p>And then one of the other indicators here that I wanted to talk about was the drug listing. So towards the bottom of this table, after the health system utilization indicator, if you'll look at the emergency department use, in patient service use, you'll get a listing of the drugs that the member might have recently gotten fulfilled. The list would comprise the national drug code, the NDC code, the prescription date, and the indicator for prescribed, but not yet received in medications. These will be sent to you most likely, unless the managed care plan has a slightly different arrangement with you as a text string. You might have to pull them apart, but it's always critical information to have as you're thinking about making sure that a member is adhering to their medication plan and you're setting them up for healthy outcomes.</p>
Slides 23-24	Kevin McAvey – 00:37:50	<p>Next slide, please. And I'll go through the next two fairly quickly, because I'm sure I'm inevitably behind where I should be. But we have also within this file the ECM providers can expect to receive primary care provider information, clinic information, again, key and critical contact information for ECM providers and table for administrative and plan information. This is really to make sure, on the next slide, that the ECM provider is getting all the information it needs about the member and the plan's relationship to the member, which will then be shared back, used to inform upstream information exchanges from the ECM provider to the managed care plan.</p>
Slide 25	Kevin McAvey – 00:38:42	<p>Yeah, okay. I'm going to take a breath and we're going to all turn to the next slide where we have now covered our first information exchange between the managed care plan and the ECM provider. Now we're going to take the round trip.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Kevin McAvey – 00:38:59	So, again, the way that I like to think about it as we designed this standard file format, or at least one option for the default file format, is you have this information, let's just say, in an Excel workbook and it comes downstream and it comprises rows A through L of all this information. I'm sure there's a lot more than that. But then they'll have fields for M through Q that might be blank, that the ECM provider can actually fill out about the members and then send back to the managed care plan to add information that the managed care plan would otherwise be sending ad hoc requests about.
Slides 25-26	Kevin McAvey – 00:39:41	And that's the heart of what the return transmission file is. ECM providers hold the primary relationship with the members and accordingly know best, have the best access, to who these members are, what their needs are. And the more that can be shared upstream to the managed care plan, the more the managed care plan can better do its job and ultimately provide the information that a ECM provider, in this instance, might need. So the purpose of the ECM provider return transmission file is to, again, standardize and streamline key information that the managed care plan might most commonly require about members from ECM providers beyond information contained in the billing and invoicing guidance. Next slide please. So before similarly digging into the contents, let's talk about what the file will actually look like. It could look like, as I just described, an appended field for an Excel workbook, it could be its own separate workbook, depending upon the relationship with the managed care plan, but it should have all the data elements that we're going to be talking about and, I think, in the sequence that we're going to be talking about as well. It'll be a transmission frequency as mutually agreed to by the managed care plan and the ECM providers. And managed care plans may choose to align reporting due dates from ECM providers with DHCS's timeline for managed care plans to submit the quarterly implementation plan report.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 26	Kevin McAvey – 00:41:22	<p>Because, and this is really important to make, as Dena mentioned, why we're going to be talking a little bit about some of the reporting that managed care plans are expected to provide to DHCS because instead of having, again, separate ad hoc requests from the ECM providers, the managed care plan, so they have that information to provide DHCS, we're trying to package it all together as efficiently as possible. So the provider return transmission file will be used by managed care plans to support their submission of PCM and community supports quarterly implementation report to DHCS. And, again, hoping that through the standardization, it makes information exchanges throughout the ecosystem that much more efficient.</p>
Slide 27	Kevin McAvey – 00:42:07	<p>Next slide, please. So thinking about that workbook and columns A through L provided downstream from the managed care plan to the provider as the ECM provider is passing information back upstream in columns N through Q, some of these fields might be present and ECM providers may have new information that they wish to share with the managed care plan for the managed care plan to update its records. This, again, includes information about whether, to the ECM provider, the member appears homeless, additional new information about the member's residential address and contact information, as well as ECM benefit start date, benefit end date, lead care manager name. And, again, this is all to prevent sometimes ad hoc reporting that the managed care plan might require of an ECM provider.</p>
Slide 27	Kevin McAvey – 00:43:10	<p>Two fields I want to call out here just for your awareness. And we received some questions before, the status of the member engagement. These are the reason codes that are received, that are expected to be produced by the ECM provider for the managed care plan. So that one would be pending outreach. Two, currently in outreach. Three, the member is in enrolled. Four, the member is declined. And five, the member is excluded.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 27	Kevin McAvey – 00:43:41	The other field I'd like to call out here is the discontinuation reason code. One reason code will be supplied for each member. And those reasons codes could include the member has met all care plan goals. The member is ready to transition to a lower level of care. The member no longer wishes to receive ECM services. The ECM provider has not been able to connect with the member after multiple attempts. Again, this is a way to communicate upstream with the managed care plan about member outreach and engagement or discontinuation as appropriate.
Slide 28	Kevin McAvey – 00:44:21	Next slide, please. And I think this is the last slide for this kind of go around exchange with the provider return transmission file, where ECM providers will be expected to note, or have the option of noting, the number of in person and telephonic video encounters that the provider has engaged with the member during the reporting period, as well as some more administrative information, just to make sure that the managed care plan is tracking who these members are and what period we're talking about.
Slide 28	Kevin McAvey – 00:45:11	Terrific. So one other point before I turn it over to Lori Houston-Floyd, is I think we received a question about Z-codes and how the managed care plan might already have Z-codes available. The managed care plan might have Z-codes available through several different methods. So through previous ECM provider transmissions that they might receive or other Z-codes might have otherwise been identified on claims through the normal practice and delivery of healthcare services. Through those claims, Z-codes are increasingly being used and managed care plans are increasingly building up capacity to aggregate and flag that information about members to better deliver care. So with that, I'll pass it over to Lori Houston-Floyd.
Slide 28	Kevin McAvey – 00:46:00	And I think we'll go through the other two files and the member information file, and then we will circle back and have a short opportunity for questions now.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Lori Houston-Floyd – 00:46:14	Thanks so much, Kevin, and nice to be with you all today. I'm Lori Houston-Floyd. I'm a manager with Manatt Health, and I've been working very closely with the department with Kevin on the design and implementation of ECM community supports and the population health management program. So as Kevin noted, I'm going to take us through the final two components of the member information sharing guidance.
Slide 30	Lori Houston-Floyd – 00:46:36	Next slide please. So this ECM provider initial outreach tracker is an attempt to standardize how providers, ECM providers, are documenting the outreach efforts that are required to enroll members in the benefit. And the reason why this exists at all is actually because the ECM benefit is defined as including outreach. And so there's a component of the capitation payment rate that's going to the managed care plans to cover those outreach efforts. And so the state really wants to understand what's really required here. What is the level of effort that it takes in terms of number of outreach attempts to get a member enrolled into the benefit?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 30	Lori Houston-Floyd – 00:47:24	<p>So this guidance attempts to standardize how the providers share that information with the plans. And essentially there are two ways that this can happen. The first is through the use of standardized HCPCS codes, which we'll actually show and talk more about in a few moments. But there are a couple of G codes that the state has identified with some U modifiers that initially allow providers to code those outreach efforts. So that's one way. And actually specifically, if a provider organization is using those HCPCS codes, they're likely going to be able to generate a report using their system and then report it up to the managed care plan that way. The other method, of course, if HCPCS are not being used, or the providers are not able to create encounters, then ECM providers would be able to populate this data in a manual sort of way. So those are the two methods. The state has not provided a standardized template here, but really has provided standardized data elements. And before we look at those, I want to talk about the two ways in which this information is then used by the managed care plans and reported up to the state. So there's a quarterly implementation monitoring report that Dana talked about, that we're going to go into more detail on. So that's one area where there's a dimension that looks at outreach efforts. So this reporting from the providers is going to directly feed into that. And then there's a separate process. There's a question about this in the chat too. What is the SDR reporting process? This is something that's defined as the supplemental data request process, and it's from the capitated rates division. So at some point throughout the course of this year, they will call up on the plans to share additional information about outreach data. So those are the two ways in which the MCPs are going to be actually using this data.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 31	Lori Houston-Floyd – 00:49:36	<p>And then the next slide, if we can flip there, really talks about the standardized way in which ECM providers are meant to be documenting these outreach efforts. So it's pretty simple, but it is exhaustive. So it's for every outreach attempt that happens at an individual member level and it's before members have been enrolled into the ECM benefit. And just to clarify, an outreach attempt in this case is either an in-person or electronic or telephonic individualized attempt meant to engage a member and try to prompt them to enroll in the benefit. And in terms of... Sorry, one last thing. And if you could actually go back one more slide, Julian, thank you. The frequency here in terms of reporting is really agreed upon by the managed care plan and the ECM providers, though, recognizing that the plans are going to report on this data at a minimum and a quarterly basis. The managed care plans may want to keep that in mind when they're defining and establishing that cadence with their ECM provider network.</p>
Slides 32-33	Lori Houston-Floyd – 00:50:53	<p>Okay. So then moving along to the final component of the member information sharing guidance. This is what we're calling the potential ECM member referral file. And this is the only optional, totally optional, component of the guidance. And if you go to the next slide, please. This articulates the use case for this optional file. And that is, there may be instances, there should be instances, where ECM providers in their day to day work and other providers actually, are identifying members that may belong to ECM and are good candidates for ECM. And so this file, and this guidance really attempts to standardize the minimum set of data elements that providers share with MCPs to refer the members into the benefit.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slides 33-34	Lori Houston-Floyd – 00:51:51	Again, here there's a, the frequency for this type of data exchange is agreed upon between the managed care plans and the ECM providers. There's no standardized template for this either, but if you go to the next slide, you can see the minimum set of data elements that providers should be sharing with managed care plans to refer members who may be potentially eligible for ECM. And again, this is entirely optional. So with that, I'm actually going to pass it back to Dana and Kevin to go through some of the specifics with the billing and invoicing guidance.
Slide 36	Kevin McAvey – 00:52:44	Dana, would you like to kick us off? Or would you like me?
Slide 36	Dana Durham – 00:52:51	If you don't mind kicking us off and I'll go after you go, if you don't mind.
Slide 36	Kevin McAvey – 00:52:55	Not at all, not at all. So the billing and invoicing guidance, I'm going to similarly share this in the chat. As with the rationale for developing the member information sharing guidance, where ECM providers typically might not have the capacity to ingest, consume, analyze large data sets to get the needed clinical information that they need right away, ECM providers and community supports providers might not have systems in place to be able to share standardized claims, the 37-P's or I's upstream, to managed care plans.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Kevin McAvey – 00:53:42	So what's the best way, like we were asking the markets to make sure that ECM providers and community support providers had capacity and could fulfill the sharing of billing information upstream to the managed care plans, getting managed care plans the information they need to ultimately fulfill their requirements of translating this information into an account that can be passed back up to DHCS to fulfill their contractual requirements. And that's borne out of that need from both ECM providers and community support providers, as well as managed care plans was this alternative of billing arrangement. So we'll talk a little bit about the HCPCS that are going to be underlying and used and either the standard of claims based transactions that might move from the community supports provider or ECM provider to a managed care plan. But this is an alternative for those providers that might not have it, have that capacity available. So if you [inaudible 00:54:46]-
Slide 36	Dana Durham – 00:54:46	And Kevin, I'll just-
Slide 36	Kevin McAvey – 00:54:48	Yep.
Slide 36	Dana Durham – 00:54:48	... Just say on top of that I'm not as familiar with data as you are. So just to kind of level set a little bit for those of us who are a little bit more data illiterate. To actually be able to track this stuff and monitor, we have to have certain information and codes. And so that's why this information is important because for what's called an encounter data, it tells us exactly what happened at the time and who did the service, what the service was and what happened in the service. And so that stuff, that information must be on the files for the managed care plans to be able to complete things. So that's why this information is so important. Sorry, it took me a while to learn that so I thought it was important to kind of just back up a little bit.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Kevin McAvey – 00:55:46	<p>Absolutely. And I think that this is a real reminder. I mean, it's easy, at least for me and others to be when you hear data, I don't know about you, but my heartbeat goes up in all good ways, mostly. But really it's about information and making sure information is appropriately being shared throughout the system to support care for individuals, to help everyone understand whether programs are working and how to improve them. And particularly in this instance, to remit payment. But even on a claim that goes upstream, there is really important diagnosis information and information about a member that could then be harvested and used to support the member moving forward. So in lieu of a standardized claim transaction, this is an alternative that was developed.</p>
Slide 37	Kevin McAvey – 00:56:39	<p>And if we can go to the next slide, we'll get into what this alternative actually looks like. So ECM and community support providers, again, are expected to submit claims to manage care plans, to the greatest extent possible. But for those who are unable to submit compliant claims, they may use this standard invoice template or guidance to submit invoices to the managed care plan that provide necessary information. If again, similar to the member information file, if a managed care plan and an ECM or community supports provider mutually agree to share this information in a different format by a different standard or transaction method than what's described in the billing and invoice guidance, everyone may certainly do so.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slides 38-39	Kevin McAvey – 00:57:37	<p>Next slide please. So I'm going to, and unlike... I swear this is not going to have like four different parts or files we're going to go through, but it does have four different tables and we'll tick through each of them just to kind of express what information is going to be expected to be shared from an ECM and community support provider to a managed care plan to bill for a service. Let's go to the first one. So actually before we go into the contents and the guts, the file format, similar to the member information file. It might be an Excel based workbook. A managed care plan might also have a web-based form or portal that would have all of this information requested presented in a common sequence. There is no standard template, but all the requirements for reporting should look remarkably similar among plans. Providers should submit in service invoices as specified in the standard terms and conditions, and in alignment with the managed care plan contractual requirements at DHS. Please talk to your managed care plans to understand those current requirements.</p>
Slide 39	Kevin McAvey – 00:58:54	<p>Dana, anything else that you want to add on the overall file? Structure, transmission frequency, importance of the file before we get into the content?</p>
Slide 39	Dana Durham – 00:59:02	<p>No, I mean, it's something we usually don't get involved in as far as format or anything like that, but we do... I'm going to make a plug here for that we do have the path collaboratives, and if there are concerns about in your community, the way that's happening, that might be a good place to discuss it. So just wanted to put in that plug there. Thanks, Kevin.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Kevin McAvey – 00:59:30	No worries. Okay. Next slide please. So the first set of information that'll be expected to be shared upstream from an ECM provider and a community support provider to a managed care plan will be provider information. So providers should bill using their NPI. If you do not have an NPI, as Dana mentioned, there is an opportunity and there's guidance for that, how to get one. And I'm going to throw that into the chat right now. Okay. And then this table should include information from the provider about its location, NPI and TIN, the rendering provider name, which might be different than the billing provider name and related contact information. [inaudible 01:00:25]-
Slide 40	Dana Durham – 01:00:24	And Kevin, why is this stuff important?
Slide 40	Kevin McAvey – 01:00:27	Yeah.
Slide 40	Dana Durham – 01:00:28	Why is this stuff important? Yeah.
Slide 40	Kevin McAvey – 01:00:31	That's a great question. So this is important for the managed care plan to make sure that they are remitting payments to an eligible provider, and they understand who is providing services to the member for both operational performance tracking purposes, as well as to just understand how the member is in interacting with the healthcare system. Is there anything else that you'd want to want to add on that one?
Slide 40	Dana Durham – 01:00:54	No, no. I mean, I think it's self-explanatory. But really the plans are required to have this information because they do need to oversee their providers. They have to know all this information about a particular provider, those areas that are mandatory. Thank you.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 40-42	Kevin McAvey – 01:01:16	<p>Yeah, no worries. And I think that's just another great point. So as you're thinking through this information and why some of these fields might need to be shared upstream, remember that it's not always for the managed care plan's exclusive use. A managed care plan needs to translate all of this information into compliant encounters that they submit to DHCS. And so sometimes the DHCS as its thinking about its overall responsibilities for program oversight and management, might need information of the managed care plan might not necessarily. And so if you ever have a question on why a field is needed, that could be a potential answer. Next slide please. So for services provided to a member, it's important to have member information. This includes the member client CIN, the client identification number, any member record number from the plan. Member first name, last name, again, the homelessness indicator, contact information. This is all pretty good of standard information that will be included in the claim. Next slide, please. Further service and billing information. What services were actually provided. And Tyler, I think after we pause for questions after we get through this piece of guidance, will be providing more information on some of the new procedure codes that you might run into. But what service was provided, providing the appropriate code and modifier, when was the service provided, what was the service's name? This is optional, but maybe to be determined between the managed care plan and the ECM or community support provider to the mandatory. It also serves as an... I don't know about you, but for those who been involved in submitting claims, it's a good check. Both for you and managed care plan that we're confirming that was the service, that the code matches the service name. [inaudible 01:03:21]-</p>
Slide 42	Dana Durham – 01:03:20	<p>Well, and I'm sure no one else does this Kevin, but sometimes I might fat finger something. And it's a good check against that. If something's thrown back always to kind of have the service name. Yeah.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 42	Kevin McAvey – 01:03:37	It totally is the fat finger check. And also when you're looking at the tables, the end of the day, and your eyes are getting worse by the day and things happen. So it's always a good check.
Slides 42-43	Kevin McAvey – 01:03:50	Member diagnosis code. And it was a question before, and I think I was remiss, or maybe I just went by too quickly about what the SDOH, the priority SDOH codes were. I'm putting it back in the chat now. And again, I'd love to see increased utilization of these codes as we identify health determining factors for our members. And then like other important things like the service charge amount or the invoice amount are critical to make sure you get paid for the services that are rendered. And next slide, please. And then finally, we'll close up as of all this guidance, there's an administrative information table that just provides some standard information, so that plans and others can track these more manual claims that are produced. And I think I'm turning it... Dana, anything else that you'd add before we turn it over to Tyler?
Slide 43	Dana Durham – 01:04:58	No, but you've been talking for a while. Kevin, which is great. Thank you.
Slide 44	Kevin McAvey – 01:05:03	No worries. No worries. Then I'll happily pass it over to Tyler. And then I think we will have a little bit of a break for Q and A and water. And look forward to your question.
Slide 44	Tyler Brennan – 01:05:14	Thanks, Kevin. I appreciate it. Good afternoon, everybody. My name is Tyler Brennan I'm with the Department of Healthcare Services, and I'm going to talk a little bit about the ECM and community supports coding options document. The link I just put actually in the chat. So feel free to reference that as we go through. But as we've mentioned, DHCS requires to submit encounter data in accordance with requirements in the MCP contract and APL 14019. For ECM and CS MCPs are required to submit encounter data through the existing encounter data reporting mechanisms for all the delivered services.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Tyler Brennan – 01:05:45	So in line with that, MCPs must use the HCPCS and HCPCS stands for healthcare common procedure coding system. These are level two codes that we have given this document to report both ECM and community support services. The HCPCS codes, and the modifier combined define the service as ECM, or as a community support.
Slide 44	Tyler Brennan – 01:06:03	If any services are provided through telehealth and additional GQ modifier must also be used. All telehealth services must be provided in accordance with DHCS policies. And a quick note on payments to reaffirm and reinforce what's already been presented on previous slides, MCPs may utilize alternative payment approaches with community support providers, but must use the HCPCS codes and modifiers provided by DHCS for reporting applicable encounters to DHCS.
Slide 44	Tyler Brennan – 01:06:29	For example, an MC might opt to pay a provider for housing transition and navigation services as per member per month, as a per member per month payment or PMPM. That MCP must still reporters to DHCS as a per diem for every service render by that provider using HCPCS codes and modifiers in this document. Finally, MCPs may use either the per diem or per 15 minutes HCPCS codes for community support services that have both options available. So there's some flexibility built in there. And with that, I'll now pass things back over to Lori Houston-Floyd who will lead us through the next slide. Lori?

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## Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Lori Houston-Floyd – 01:07:06	Thank you, Tyler. So we're going to actually take a moment and acknowledge and start to go through some of the questions that have been coming through the chat. So we might not get to everything today. We might have to take a few things back. So, as we mentioned, we'll try to address more questions next week. But the first thing that I want to talk about comes from Samuel Taylor, who asked, are ECM and community supports and MCPs required to share care plans in addition to encounter data? And I'm happy to start this and Dana and others, please feel free to add on. So I think let's break down this question a bit because there's no formal reporting requirement for the care plan itself to come up to the department. But there may be instances where the managed care plans are requiring their ECM and community supports providers to share more information about what's going on in their care plans. So that's where there may be an element of reporting that's going on, but there's no formal care plan totally going up to the state.
Slide 45	Dana Durham – 01:08:11	Yeah. I mean, I'd agree with you, Lori. There is no formal care plan going up to the state. But a lot of those elements are really important in care coordination and in the various services that need to be given to an individual. So a managed care plan may as part of their contract, say that they need that care plan or have it where it can be easily accessed and or discussed. We have not prohibited that from happening because a lot of it really informs how and what care should be given and when. So just wanted to add that caveat on.
Slide 45	Lori Houston-Floyd – 01:08:52	Thanks so much, Dana. Sharon Lino has asked if we can speak a little bit more to the data exchange process when the ECM provider is a CBO that's contracted-

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VISUAL	SPEAKER – TIME	AUDIO
Slide 47	Lori Houston-Floyd – 01:09:00	<p>When the ECM provider is a CBO that's contracted or subcontracted by the MCP. And I think what we're seeing, and just to go back to the visual, if Julian you could advance one slide, and just one more. Much of this is grayed out, but you can see that there is an exchange of data that's going back and forth between the MCPs and the ECM and community supports providers. And so, we've been trying to step through that data flow a little bit today, where we've taken you all through what's coming from the managed care plans, when for ECM, when they identify members who are eligible for ECM, and sharing that information with the ECM providers. And Kevin walked through that. He also articulated what's required to come back from the ECM providers. For billing and invoicing, which we just talked about, those data elements come back up to the plans from both community supports providers and ECM providers. So hope that helps to answer the question. It's really, there's this ecosystem of data flows that are happening sort of across the program between the plans, the providers, and then ultimately back up in the form of reporting from the plans to the department. Dana, anything else to add on there?</p>
Slide 47	Dana Durham – 01:10:24	<p>I would just say that this is just such an important part of what really is happening with ECM because there is that need for communication. And part of the reason we have an ECM provider is so that care is coordinated. So really the plan having that visibility, as well as the ECM provider having that visibility, is highly important to the individual receiving care. And that data exchange, we kind of feel is really fundamental to the ability for the individual to get the care they need. That's why we've spent this time and why we feel like it's so important.</p>
Slide 47	Lori Houston-Floyd – 01:11:06	<p>Thank you, Dana. Melissa asks if a PCP is able to refer a member to the ECM provider, or if they can refer directly to the plan? Dana, do you want to talk about how referrals work for ECM?</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 47	Dana Durham – 01:11:25	<p>Sure. So anyone may refer through the plan to a, someone for ECM or community supports. That can be the individual themselves. It can be a PCP. It can be an advocate for the individual. It can be the plan. The plan also does some data mining. But the plan would need to be involved in that process. There are some ways that even the ECM provider themselves, once they're aware of an individual, can refer back to the plan to make sure that person is eligible for ECM. But just the plan does have to be involved. So just want to make that clear, but that's not supposed to be a barrier. It's just to make sure that the person is appropriate and that all visibility that needs to be had is there. And Tyler, I might have left something off. So if you have anything to add or anything, please feel free.</p>
Slide 47	Tyler Brennan – 01:12:27	<p>I would just second that and also say that we sort of incorporate a no wrong door approach in both ECM and community support. So really trying to enable people to access both ECM and community supports in any way they're able to</p>
Slide 47	Lori Houston-Floyd – 01:12:41	<p>Super helpful. Thank you both. And I think part of Melissa's potential confusion was when we were looking at the potential ECM member referral file. I think her question was, does the referral, if it comes from another provider, does it have to go through an ECM provider? And so, the answer really is no. All referrals are coming into the plans. And as Tyler noted, it's a no wrong door approach, so to speak. So referrals can be coming in from multiple venues.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 47	Lori Houston-Floyd – 01:13:09	<p>Okay. Kim noted, when we were looking at the member information sharing guidance, that a lot of the clinical codes were clearly adult health indicators. And that's right. And her question is when will the pediatric indicators be available? And so, I think Dana alluded to this earlier, the department is actively sort of, or will later this fall, be kind of taking more formal feedback on the existing data guidance documents. So to foreshadow a little bit, later on in September, the department will be releasing a survey to get more information on the existing data guidance documents. In tandem with those efforts, in terms of updating the existing guidance documents, the department will be adding more specifications for the populations of focus that are going live next year. So the exact timing for when these documents will be released is to be determined. But just to respond to that question, this is an effort that is very much top of mind for the department and actively will be underway.</p>
Slide 47	Lori Houston-Floyd – 01:14:21	<p>I think we might have time for one more question and then we can continue. So Sandy asks a sort of a related question. I'll take this one. Sandy wants to confirm that the managed care plan is required to provide the population of focus indicator to the provider and not the other way around. And that is true. That's actually the current state of the guidance documents. However, we've been hearing some feedback from providers and from plans actually saying that it would be really helpful since ECM providers are the ones that are on the ground, working with the members directly, they might actually learn that a member meets other populations of focus criteria. And so, this might be one of those things that we will be looking at potentially updating down the road. But Sandy, to answer your question, yes. That's the way that currently the guidance is constructed.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 47	Dana Durham – 01:15:17	Well, and that kind of initial, it initiates the reason you're looking at an individual. As you're having that conversation with them as an ECM provider that, or potentially having them in ECM, as you're doing outreach, that's more of a flag to let you know why the plan thinks that they may meet criteria. And that can always be updated in conversation with the plan, kind of as Lori said. So I do think, as you start, there has to be a reason that person is being looked at. That's why they're with the population of focus to begin with. But that population of focus can always kind of change in the conversation. And that should be something that actively the plans and the providers work on together.
Slide 47	Lori Houston-Floyd – 01:16:09	Thanks so much, Dana. So I think we're handing it back off now to Tyler to take us through some of the reporting requirements for the managed care plan. So Tyler back to you,
Slides 47-49	Tyler Brennan – 01:16:20	Thank you, Lori. And we can stay on this slide. So talking about the MCP reporting requirements to DHCS, DHCS requires that MCPs submit a quarterly implementation monitoring report, in addition to their encounter and 274 provider files. In order to accurately report on the elements included in this report, MCPs must collect data from ECM and community support providers, as detailed by this chart. MCPs should also be leveraging data from the ECM member information and return transmission files to the greatest extent possible. Next slide, please. Throughout the first several years of ECM and community supports, DHCS requires MCPs to submit the quarterly implementation monitoring report to monitor the overall implementation. The MCPs are responsible for this report and use information from the standardized provider data flows described today, in part, to construct the content. DHCS requires MCPs to provide data across six dimensions, which we'll look at and talk about a little bit on the next slide. ECM and community support providers responsible for providing MCPs with the information needed to complete many of the reporting requirements.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 49	Tyler Brennan – 01:17:22	<p>And I see you've already moved to the next slide. So thank you for that. DHCS works with and monitors MCPs' implementation of and compliance with requirements across multiple domains, including membership, service provision, grievances and appeals, provider capacity, and quality. The key reporting dimensions on screen reflect and capture these domains. So we have six tabs as part of the quarterly implementation monitoring report. The first of which is the ECM members and services tab, followed by the ECM request for services and outreach tab, the ECM provider capacity tab, the community supports members and services tab, the community supports provider capacity tab, and finally the community supports requests and denials tab. So DHCS provides a standardized Excel workbook template to MCPs for them to utilize for this reporting. The template includes separated tabs to capture the key data necessary for successful monitoring. Quarterly reporting began on May 15th, 2022 and included data from quarter one this year. So that was January through March of 2022.</p>
Slide 49	Tyler Brennan – 01:18:22	<p>And the next Q2 submission is due to the department by COB on Monday, August 15th, which is coming up. And that's going to be the Q2 data covering April through June. This supplemental reporting is expected to continue for at least three years, and that's due to multiple phases of additional ECM populations of focus, as well as in recognition of the significant transition to encounter reporting that will be occurring for many providers in field, especially community support providers. The supplemental reporting will be discontinued as a separate requirement once DHCS determines that the encounter in 274 provider file information is robust, as evidenced by congruence between that data and the quarterly implementation monitoring report. And now, I'd like to pass things back over to Lori Houston-Floyd again, who will lead us through the next slide. Lori.</p>
Slides 50-51	Lori Houston-Floyd – 01:19:07	<p>Thank you, Tyler. I think, given the long round of Q&amp;A we just did, maybe we can keep going and allow Dana to close this out around expectations for implementing these standards and for reporting.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 52	Dana Durham – 01:19:20	<p>Yeah, thanks Lori. So right now, MCPs and ECM and community supports providers should be exchanging data and submitting invoices as completely as possible. Managed care plans are expected to share ECM, community supports, and information and encounters to DHCS. And that share of information between the ECM providers, community support providers, and the managed care plans allow the managed care plans to report on that report that Tyler just went over. So want to talk about when reports are due to the department. So the first quarterly implementation report, and that includes the managed care plans that went live and that were live in health homes or whole person care counties. And they went live with ECM on January 1st. That first quarterly implementation report was submitted on May 15th. And we're expecting our second quarterly implementation report on August 15th. And then, we're going to expect our third implementation report. And that third quarterly implementation report will also include the plans that went live on July 1st. And that report is due on November 14th. So we're really excited about these reports and that they are helping us know where to concentrate our technical assistance and also telling us about the growth of the ECM and community supports, which is happening in great ways. Next slide please.</p>

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 53	Dana Durham – 01:21:21	<p>So this webinar isn't necessarily intended for this, but it's always important to know what support is available, if you have questions, and if you're kind of going, "Oh, this is not something I know how to do. And I need some additional help." There are two programs that are really to help with funding for capacity building and training, as we get these programs up and going. I'm going to kind of go and reverse order. The first one started already, and it's the incentive payment program. And it is run through the managed care plans. And they participate in our incentive payment program, and they use that incentive payment program to invest in and work with community support and ECM providers. So the way the funds work in that instance is DHCS gives incentives to the managed care plans who are encouraged to share those incentives with the providers. And that really strengthens the network because without providers, there would be no way to do ECM or community support. So that, I've seen through looking at that program, we've been able to see that there's funding for how do you do billing? How do you do some of this data exchange? How can we help make sure you know what you need to do as far as ECM or community support happens? And that's what that program is intended for.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 53	Dana Durham – 01:22:59	<p>The other program is PATH, and that is a similar program but not the exact same program. That program really is more intended to address the gaps that are not addressed through the incentive payment program. But it does want to, as well, support the ECM and community supports infrastructure and capacity. And eligible entities really are... And I know I'm going to leave someone out, so I will do as much as I can. But if I don't mention your particular entity, it doesn't mean you're not eligible. It just means that isn't on the slide, so I didn't include it. The counties, former whole person care lead entities, providers, community based organizations, tribes, others who are giving or supporting in ECM or community supports. MCPs are not permitted to receive PATH funding for the infrastructure capacity or services. And the funds, the flow of funds, just so you understand how this works, it goes from DHCS to our third party administrator, which is PCG or Pacific Consulting Groups. And they will award the funds. There's information on our website about the timeframes for that. And there are starting to be applications for those. They're not all quite up yet, but we're working towards it. But both of those programs are really geared towards helping as you have some questions or need some assistance with getting ECM or community support up and going. Next slide, please. And Laurie, I guess it's back to you.</p>
Slide 54	Lori Houston-Floyd – 01:25:02	<p>Thanks, Dana. I guess it's really back to us to close with a few minutes of Q&amp;A. So I want to respond, I think, most immediately to Shannon's question. With DHCS or managed care plans will be able to share this information with county counterparts, especially interested in provider capacity. Dana, do you want to take that one? I think it's in reference to some of the funding opportunities and sort of the relationship that plans are-</p>
Slide 54	Dana Durham – 01:25:38	<p>Yeah. Can you just repeat the question? I'm sorry.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 54	Lori Houston-Floyd – 01:25:41	Oh, of course. So will the department or managed care plans be able to share the information on the incentive programs with the county counterparts? I wonder if you could just talk a little bit about the efforts that have been underway there?
Slide 54	Dana Durham – 01:25:55	Yeah, I mean, so the opportunities are to be shared with everyone who is eligible to receive who they're contracting with. As far as if you have a question about your local managed care plan, and if they have those opportunities, we certainly would want you to contact them. And if you're having trouble knowing who your managed care plan is, we certainly can facilitate making sure that you know who your local managed care plan is, so you can work with them. As far as all of the details of the program, they are not... It's an incentive program, so we can't direct payments. So we don't really control all the mechanisms of the program as a department. But I have found if you have questions, that the plans have been very forthcoming with answering those questions. And if you are having questions that you're not getting answered, we're happy to work with you to make sure that we facilitate those questions getting answered.
Slide 54	Lori Houston-Floyd – 01:27:07	Thanks so much, Dana, I'm going to try one more question. I don't know if we know the answer to this. I don't know the answer, but Dana and Tyler and others, you might. So Kimberly asks, if you please can confirm that atypical provider identifiers, APIs, are not acceptable in lieu of NPIs? She's noting that some other states do allow the API in lieu of the NPI.
Slide 54	Dana Durham – 01:27:35	Yeah. And we have decided that we are requiring NPIs. So that's why we did the guidance and walk through. If you are having trouble applying for an NPI, we certainly will offer technical assistance and work with someone through it, but we are requiring the specific NPI.

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 55	Lori Houston-Floyd – 01:27:59	Thanks, Dana. Okay. So I think we're almost out of time. I'm going to give a final plug for next Thursday, the office hours, and just want to set the record straight that our office hours is next Thursday at 2:00 PM Pacific. So thank you so much for all of the questions and all the engagement today. We're going to take some of these back. And if you have other questions, over the course of the next several days, please do share them with the email address that's listed on this slide. Kevin also included it in the chat earlier. We would really appreciate the opportunity to hear from you. As you might imagine, some of the specifics with data questions can take a minute to kind of look at it and get answers sort of formulated and prepared. So with as much advanced notice as possible, we would really appreciate advanced questions. That said, if you show up next week, we will be also fielding questions live. So thank you so much. And until next week.
Slide 55	Dana Durham – 01:29:00	Thanks.
Slide 55	Tyler Brennan – 01:29:00	Thank you.
Slide 55	Julian – 01:29:03	Thank you for joining. You may now disconnect.