

**(DHCS) CalAIM: ECM & Community Supports Program Data Exchange
Overview (English CART)**

12/7/2021

Transcript

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Slides 1 - 4	00:00:00 – Dana Durham	Hello Everyone. I'm excited to have you here as we are going over data exchange and reporting requirements. We're looking forward to kicking off CalAIM and know that there have been so many different sources of information we've been able to discuss. But today, we're really going to focus on how data gets between the managed care plans and community support providers. And then also what the managed care plans are required to report to DHCS. And really the idea behind that is just to give you the big idea of what we're doing in these areas. Just want to note a couple things. The slides will be available in the next couple weeks. And as well, there is a recording, and that will also be available in the next couple weeks. Next slide please. And to this end, I will be turning it over to Michael Huizar who will be going over the big picture.
Slides 4 - 6	00:01:04 – Michel Huizar	All right. Can everybody hear me okay? All right. So good afternoon everyone. Thank you for joining us for today's webinar. So, a little bit about the big picture of the Enhanced Care Management and Community Supports. As some of you may know, ECM and Community Supports will be replacing both whole person care and health care programs as those two programs will be sun setting at the end of this year, at the end of this calendar year. And the proposals for ECM and community supports will be commencing on January 1, 2022, with the initiative scaling up to eventually form a state-wide approach. So really looking at a little bit more at two programs or the initiatives. ECM is a medical managed care benefit that will address the clinical and non-clinical needs of high need, high cost individuals through the coordination of services and comprehensive care management. And then on the other side of the slide here, and really as a program that works in some instances in parallel but can also function independently is the Community Supports optional program, which provides services, provides services through the managed care plans that they can elect to provide. It's strongly encouraged. But they are

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		<p>not required. And they are medically appropriate and cost-effective alternative or substitutes to other services or settings such as hospital or skilled nursing facility admissions. It's important to note that for the community supports as they are optional to provide, they're also optional for members to receive. So again, just sort of fleshing out the big picture a little bit more. So as you know, I think as ECM and Community Supports works to, you know, works to provide data to the department and to interface amongst the providers, the information sharing between the providers plans counties and community base organizations and DHCS is enormously critical to the success of the program, of both initiatives, the ECM benefits and the community supports optional program. So, we have developed information sharing guidance to standardize information exchange, increase efficiency, and reduce administrative burden between the plans and the enhanced care management and community support providers. We received a host of comments from a variety of partners. And those were reviewed during the public comment period in September. So if we want to call out what the managed care plans will be, we will report to DHCS on the various dimensions or aspects of the new enhanced care management benefit and community support program, which will allow the department to monitor the implementation more closely. And just as some additional information, over 60 comments were received from plans and associations during the stakeholder review of the reporting framework. So, a lot of--a lot of good information that we hope, that we enveloped into the guidance documents. So, as we--as we progress into the next slides, we'll be describing--today we'll be describing the finalized information sharing and reporting guides documents and then taking some questions at the end. So please hang tight or ask questions in the chat or Q&A as you need. We can go to the next slide, and I will be handing this off.</p>

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<p>Slides 6 - 8</p>	<p>00:04:37 – Oksana Meyer</p>	<p>Great. Thank you. So as has been mentioned earlier, much of the following guidance that we will be discussing during this hour stems from a lot of stakeholder feedback as well as our experience in health homes and whole person care. And so, we heard a lot of sort of requests and desire for the department to release guidance or a standardized approach for data and information sharing that can be used as we transition into ECM and community supports in 2022. So DHCS, with the help of our health partners, we developed key pieces of guidance to help facilitate bidirectional information sharing between plans and providers. We recently released several guidance documents, which will be discussed in great detail during today's Webinar.</p> <p>One of the guidance documents that we will be discussing is the billing and invoicing guidance. You'll see on your left-hand side there, which contains the minimum set of necessary data elements in order to standardize the invoicing process for providers who may not be able to accept or submit industry-standard 837 files for claims. So really, a lot of these efforts were geared toward helping providers participate successfully in ECM and Community Supports. Similarly, we also provided an approach for member specific information. This guidance is really geared towards ECM providers who may not have the technical capabilities to process 834 or 837 industry-standard files. The member level information guidance includes standardized sets of data elements that reflect member level information such as name, date of birth, contact information, select health educators, and several other helpful member-specific data elements that we believe will be instrumental in the data exchange of member information between the plans and the providers.</p> <p>So, to note, DHCS is placing reporting requirements on the managed care plans. You'll see on sort of</p>

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		<p>Item 3 on this slide, where we'll also discuss a little bit more of what that looks like later on in the presentation, but we are placing a requirement on the health plans just to collect and submit data to the department on a quarterly basis. And much of this data will of course be generated by the providers along with the plans.</p> <p>So DHCS will use this data to conduct ongoing oversight and monitoring of implementation activities for ECM and Community Supports. This data will help us ensure that members in health homes and whole person care have transitioned well and are continuing to receive the necessary services and new members are also being engaged and are also successfully receiving the services that they need. The other data element that we will be collecting, which is not included in this presentation, but it is an important element, is that we are going to be collecting member grievance and appeals data related to ECM and community supports, and this information will be sent to the department by the plans using an existing automated process that is already in place for the collection of group grievance and appeals data. So, I do want to mention that.</p> <p>Additionally, the department has an annual public reporting mandate for AB133, where much of the data gathered from our monitoring efforts will be used to fulfill the department's reporting requirement. So, we really do come full circle with all of the data collection processes that are being put in place. And finally, I want to mention that we also developed coding guidance for ECM and community supports, and this coding guidance is available on our website, and our ultimate goal is to shift over away from sort of the manual data collection process, sort of Item 3, this quarterly monitoring reports and to motivate standardized and counter data process as we shift, you know, a number of years into the future. So, all these documents are available on our website now.</p>

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		<p>So, if folks are interested, you're able to view those. And with that, I will turn it over to our health partners to walk through some of the details that are contained in these documents. Kevin has been instrumental in working with us in many stakeholders to build out this guidance. So, Kevin, I will hand it over to you. Thank you.</p>
<p>Slides 9 - 37</p>	<p>00:09:25 – Kevin McAvey</p>	<p>Thank you so much. And can you guys hear me okay? Okay. Terrific. Well thank you all for taking the time to join us today to learn more about these new data exchange standards that we're developing as Oksana mentioned to address an information exchange barrier that was raised, a barrier that was raised by both managed care plans and providers and really necessary to be mitigated to the support the success of our ECM and community supports programs. It would not have been possible to develop this guidance without our county and plan and provider partners, all of whom provided feedback from guidance inception to finalization, at least this first round, through work groups, working session presentations, and through our several public comment periods which Michael and Oksana mentioned. We really hope the standards put forth will provide a solid starting point to support effective data exchange between ECM and community supports providers. Oksana mentioned the website, and I'll put it in the chat right here. We're going to be talking through a number of pieces of guidance over the course of the next 25 minutes or so. Hopefully my voice holds out. I promise. And all of them, if I miss some kind of an opportunity to put a link in the chat, can be found on I think, most all of them can be found on this page. So, to take a step back, looking at this slide here, I just want to orient everyone to what we're looking at. Because it can be a little bit flummoxing if that's a word. On the left, we have ECM providers and community support providers and this dark purple managed care plans a little bit further to the right in DHCS all the way on the right. So if you think about data for our purposes and our</p>

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		<p>conversation today flowing downstream, we're going to be talking about the standardized alternative methods of sharing care plans in the middle, and over on the left, ECM providers as part of this member information sharing guidance. And there are four different components of that guidance, which I'll take us through, and we'll spend a couple minutes each on, but we'll get to that in a moment. Below that, for managed care plans to--so we have this data flowing between managed care plans and ECM providers and back, and this member information sharing guidance. This information is going to be all ingested and consumed at managed care plans by these standardized methods, and then some of which will get translated on the billing side into the encounter data for standardized submission up to DHCS and for the quarterly implementation reporting that Oksana mentioned and that we'll be touching on towards the end of this presentation. I'll also acknowledge in the lower right-hand corner we have the 274 provider files and ECM outreach data, via the SDR process. Both could potentially be informed by this upstream data that we're going to be speaking to today. We won't speak to them today explicitly beyond that call out.</p> <p>So, we're going to start with a conversation about our member level information sharing guidance, which if you remember from the last slide, includes four different components. It includes the managed care plan member information file. This is data flowing downstream. And then we're going to speak to briefly three files that might flow upstream from the ECM provider to the managed care plan. The ECM provider return transmission file, the ECM provider initial outreach tracker file, and the potential ECM member referral file. The genesis of the development here, which I think it's worth taking a pause on and Oksana mentioned very briefly is that we as a community were trying to effectively exchange information with management providers</p>

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		<p>who might not have the technical capacity to analyze bigger complex data sets, which are kind of the life blood and like the standardized exchanges that many of us engage with on a daily basis. And then, thinking upstream - how your ECM providers reliably report back to managed care plans about the members that they exchange with on a daily basis and their engagement with those members. And similar information is being requested in slightly different ways from each managed care plan by slightly different files, field specifications, different file formats and transmission methods. And so what we did is we through this guidance, we put forth an alternative standardized pathway for member information exchange. For providers that might not otherwise have the standard EVI methods, and our hope is that these standards will maximize the comprehensiveness of information flowing to ECM providers to support care and management, will prioritize key information that should flow back up stream to manage care plans, and both reduce manage care plan and provider burden associated through such reporting. For each of the files that we'll discuss, the guidance defines standard minimal data elements as well as standard file forms transmission methods and suggested and sometimes required transmission frequencies to support the goals of each transmission. Again, the downstream and upstream standardized communication allows for a bidirectional information exchange where one might not have previously existed or might have been very difficult and burdensome for both actors to engage in. The guidance that we'll be speaking to can be found on the website - and I would encourage you as we're going through to pull that up on your screen. Just two screens, especially. And put any questions you have in the chat now, and I do think we have an e-mail address towards the end of this presentation, and you're welcome to e-mail us with questions at any time. We also have a frequently asked</p>

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		<p>questions document that gets regularly updated with questions we receive. So, I'll refer you there for any additional guidance.</p> <p>So, each file that we're going to talk to, member information file, transmission file, initial outreach file, referral file, has its own purpose and requirements. So, let's step through each and move to slide 11. I'll start with the first one, which we started in the design process as well, information that flows downstream, again, between managed care provider and the ECM provider. So, to just kind of ground this in an actual meaning, I want to take a step back and really beyond this slide and really think about a gentleman named Frank, who's a medical managed care member recently assigned to an ECM provider. Frank might have a history of schizophrenia and diabetes and might have recently suffered some complications related to COVID-19. He's assigned an ECM provider, whatever entity type it might be, which while well equipped to support him clinically and make the connections to support his long-term health may not have the technical and data systems immediately in place to ingest sizeable claims and encounter history files or to immediately identify and respond to his clinical needs and support his known service history. So to make sure that Frank gets this, the member guidance was developed ensuring the ECM provider has access to as much of this information in as timely a manner and as distilled a way as possible to allow that ECM provider, upon outreach or soon thereafter, to know what are some of the key clinical indicators that provider might need to know and where to support that individual's immediate engagement and long-term care management planning. The member information file includes information about members' clinical and non-clinical needs. The file itself must include consolidated demographic, utilization, and in accordance with the specifications outlined in the link I just shared and to the greatest extent that managed</p>

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		<p>care plans have this data available. It is obvious. As you'll read through it, it's very claims and encounter data dependent. Managed care plans might also leverage any other information they receive from DHCS via the plan data feed or other data sources to which the managed care plans might have unique access. We'll walk through these data requirements and talk at a high level about their contents and how often they're expected to be exchanged.</p> <p>But I want to just kind of also note beyond the contents that we'll talk through; we are putting forth a standardized file format and transmission frequency. The format is expected to be an Excel-based workbook or other agreed to format between the providers. A common theme we'll talk to during each of the pieces of guidance, if managed care plans and their respective information trading partners agree to an alternative format or transmission method, it may certainly engage in that beyond what is outlined in the guidance.</p> <p>And then for the transmission frequency, there are two tables-tables one and Table 4 that are expected to be shared within 10 days of member assignment. And tables 2 and 3, which get into some more detailed clinical and non-clinical information is expected to be shared at least monthly. And I'll enumerate that. The first table, and you'll also see this, again, I'll refer you to the link in the chat, towards the bottom of page 3, the first table is our member engagement information table. This includes basic information about the member, his or her date of birth, some core demographic information, as well as a really key piece of information. The ECM populations of focus that enhanced care management providers will need to-- will benefit from having to support both their outreach and their care planning. Again, this can extend from adults experiencing homelessness down to children and youth high utilizer. And I</p>

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		<p>apologize. I misspoke – it is on page 6 going into page 7. So, this Table 1, member contact information, demographic information, information on the individual's population or populations of focus as well as whether this individual is transitioning from a health home program or a whole person care pilot. For individuals where this is applicable, it will also contain information on member's guardian or conservator. Next slide please.</p> <p>The second table which does have more detail and is expected to have more clinical information on the member, is expected to be shared at least monthly downstream from managed care plans to ECM providers for all of the individuals assigned to that assigned to that provider from the managed care plan. This will include a set of health indicators as listed here and specifications on what those indicators would look like are included in the document I shared in the chat including indicators for conditions such as asthma, bipolar disorder, dementia, diabetes, hypertension. And as you'll see in the specifications, we're looking for those services as recommended to us by some workgroup plan and provider partners and documented in the guidance to occur on at least two separate services on different dates with relevant diagnosis codes for the specified condition on each claim within the previous 2 years. The exception to that are the SMI, SUD, SED-related indicators where we're looking for an indicator to flag condition if experienced by those specifications within the previous 12 months. For the social determinants of health indicators, these are claims based, we're looking for ICD-10 available that identified ICD-10 Z codes in that 50 to 65 range identified within the previous 12 months. DHCS has also released guidance on priority social determinants of health ICD-10 Z codes which are going to go and drop right in the chat. So, we all have it. So, we can start using it. These helps, again, to identify key Z codes commonly used and</p>

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		<p>expected indicators of social needs. And the identified SDOH diagnosis codes are expected to be listed with a code in the code descriptor in the field with multiple codes should they exist and be separated by semicolons. We're also expecting pharmaceutical drug information and related indicators to be included in this table. That will be a really robust one, but hopefully it's formatted and transmitted in a way that is really ultimately easily digestible for ECM providers to immediately get a sense for the clinical needs of the members assigned to them and respond accordingly. In Table 3, the managed care plan is expected to share on a monthly basis. Again, we're at tables 1 and 4 within 10 days of assignments, 2 and 3 and 1 and 4 refreshed at least on a monthly basis.</p> <p>In Table 3, managed care plans are expected to fill out important information about primary care provider and clinic information to support regular outreach. So again, within 10 days of member assignment, in addition to that baseline contact information concluded The Bold and the Beautiful member in Table 1, Table 4 is expected to be shared with some basic administrative and plan information downstream to the ECM provider. Again, this should be shared at least monthly. If anyone has any questions about these files, again, I encourage you to please reach out to us with questions. Put questions in the chat. We'll have time for Q&A towards the end of this conversation. And again, I'd encourage everyone to look at the member level information sharing file and documents that's linked to in the chat. Okay. So, we have information. It just flowed downstream for managed care plans to ECM providers and member information file. As ECM providers will generally hold the primary relationship with managed care plans receiving enhanced care management, DHCS very much recognized that certain information will need to flow regularly back upstream from ECM providers,</p>

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		<p>separate and apart from claims and invoices. The purpose of the ECM provider return transmission file--and we can go to the next slide--is to standardize and streamline key information that manage care plans most commonly require about members from ECM providers beyond information contained in claims or anchor encounters. I'll talk a little bit more about some of the information in the return transmission file tables. But just to note here, like the information being shared downstream purposely in the member information file, the return transmission file is expected to be in an Excel-based format. One model which I want to call out here that really stood out in the development process, there's actually a few managed care plans that use this in the health program is to have an Excel-based work book with a member panel or roster, a key set of member information for all of those members that are going to be shared downstream in this Excel-based work book, columns A through, I don't know, P with information filled with all of what we previously described. And then columns QRS T UV left blank. And then what providers were able to do previously is take that file, readily assess on that member record level, the key indicators that they needed to do the work that they were assigned to do, and then for that member record, fill in those blank columns. So just putting that out there as one emerging practice that we've seen in the field that has been effective, and that would meet all the requirements put forth in this guidance. The transmission methods put forth for standardized exchange can include web-based portals, S FTP transmission, and if no other option is available, secure e-mail though we would caution and advise that data should be shared in alignment with federal, state, and contractual data conditional requirements. For transmission frequency, the frequency of transmission will be mutually agreed to by both the manage care plan and ECM provider. We'll leave it up to you as</p>

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		<p>information trading partners to mutually agree the cadence in which this information should be.</p> <p>Next slide. So, within the provider transmission of file, there are--there are several tables of information I want to walk through very quickly. The first are ECM member engagement information. This includes information, again, coming back upstream from the ECM provider to the managed care plan, information confirming the many, many changes to the members contact information, ECM benefit, start date, the status of member engagement, ECM benefit end date, and information about the ECM's lead care manager, the individual itself. It may also include recommendation for discontinuation, a discontinuation reason code, and discontinuation date. Some of these data elements, which are now flowing back upstream from the ECM provider to the managed care plan, are going to be useful as we engage in, like, our conversation in a couple of minutes about the quarterly reporting between managed care plans and DHCS. This will be a key data source for managed care plans use. And Table 6 and seven include information on ECM service and the ECM provider itself. Number of ECM encounters during the reporting period in person or telephonic and video, and then some basic baseline administration information, when was the file produced, the period it covered, and some basic information about the transmitting provider itself. Okay. So, member information file exchanging member, member information just for outreach and some baseline clinical information flowing downstream, return transmission file flowing downstream between ECM providers and managed care plans.</p> <p>I wanted it to talk briefly too. Next is the ECM provider initial outreach tracker file. Initial outreach to managed care plan members is identified as eligible for enhanced care management is</p>

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		<p>considered, in assumptions about the cost which are included in the payments paid to managed care plans. To equip managed care plans with adequate information about outreach occurring, we have standardized across ECM providers and managed care plans. ECM providers may report and require information that we'll speak to in the initial outreach tracker either by using claims that they have internally and are reporting on a regular basis to managed care plans using the hit picks codes that document the type of outreach that the, and services that are delivered. So, you may use this data to repurpose this data to produce this report, or if ECM providers are not creating encounters and automation is not possible, they may populate these data elements manually. We proposed a standard of an excel-based workbook or other mutually agreed to file format to support this change. Like the previous files that we discussed here, DHCS is not providing a standard template. We're expecting this- the ECM provider initial outreach tracker is reported on a frequency agreed to between the managed care plan and the ECM provider, though we want to point out and note that managed care plans may wish to align reporting due dates from ECM providers with their own reporting due dates to submit the quarterly implementation report back upstream. Include some baseline information about the member, mainly the members CIN, the provider type, the date of outreach attempt, and the outreach attempt method. ECM providers are required to capture each outreach attempt for every member that has been identified for enhanced care management. Okay. So, we're almost done with member information sharing guidance. Things are going to get fun with billing and invoicing. For our file, the potential ECM member referral file, let's roll on to the next slide. Thank you.</p> <p>So, ECM providers are encouraged to identify their patients and clients who may belong to ECM</p>

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		<p>population of focus, and that may benefit from enhanced care management that we're doing here. Managed care plans may request the potential ECM member referral file. I apologize for all the names, from ECM providers with data elements which we'll speak to in a minute. The file was designed to provide a standardized format method from ECM providers for consideration for a moment to handle secure management. If a reporting is agreed to by the ECM provider, managed care plans must require ECM providers to report these files in either an Excel-based work book, which is the default standard, or another file format mutually agreed to with the ECM provider for transmission methods, again, web-based portals, SFTP are strongly recommended if possible. And for frequency, managed plans may request the file from ECM providers at a mutually agreed frequency. Again, this was optional and was meant to make transmission more efficient for all trading partners involved. Perfect. So again, this is standardized information about the member meant to keep the information burden of reporting as low as possible. It includes some basic member information, member first name, last name, date of birth, as well as the potential ECM populations of focus for the member. More than one of these populations can be selected, and we have a free text field for explanation for why they were identified. This, again, is an optional file for ECM providers to share with managed care plans. Okay. So, member information sharing guidance is done. We can check that off.</p> <p>And now let's move onto the ECM and community support billing and invoicing guidance. I'm going to put the full file, which we can download and look at yourself, in the chat, and I encourage you to please read it, review, think about it, and share any questions you might have. Essentially, enhanced care management and community support providers are going to be expected to submit claims to</p>

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		<p>managed care plans using national standards to the greatest extent possible. For providers who are unable to submit compliant claims may instead submit these standardized invoices to managed care plans with the required minimal necessary data elements as defined in this guidance. Perfect. ECM and community support providers are expected to stick to this standard unless there is an alternative mutually agreed to format. This is of critical importance to managed care plans who will be held responsible for, you know, paying ECM and community supports providers. And this should be-- these files should be exchanged even if the ECM or community support providers are covered under a capitated arrangement. And second, managed care plans are still going to be expected to translate these claims or standardized invoices into compliant encounters for submission to DHCS. Again, this standardization had meant to help both ECM and community support providers as well as the managed care plans. If managed care plans and ECM support providers mutually agree to share this information using a different format--God bless-- same with standard or transmission method, they may certainly do so. Again, this guidance is meant to facilitate standardized exchange, certainly not to get in the way of it. DHCS has defined minimum data elements providers will need to cement. These will include, these are tables, not different files. These include provider information, information about the billing provider, information about the member, service and billing information, and just some basic administrative information. Let's just dig right in. I think we've covered most of this. But I do want to mention the invoice templates, again, are expected to be very user-friendly given their purpose: Sharing clear instruction for submission, ideally having locked fields, to minimize submission errors. We want this to be as seamless a process as possible to the extent managed care plans can create data fields which all auto populate based</p>

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		<p>upon previous submissions and automatic error checks to minimize requirements for resubmission. Those are all strongly encouraged. And we are expected that invoices are not only comprised all of the fields as described as required in the guidance I put in the chat but also in the same sequence and ideally using the same language as presented to make an ECM provider really understand what is being asked regardless of asked for or the managed care plan, interpret the data that's being received, regardless of whom it comes from and where it goes. The invoices, the invoice standards as proposed here, allow for multiple services rendered on a single day by a single provider for a single member to be in the same template. And that template is, ideally would be either an Excel-based workbook or a web-based portal. These standards may be found in the link in the document. Again, if there are alternative methods that work well for both the ECM community support providers and managed care plans, those certainly may be pursued. Managed care plans must require ECM and community support providers and submit service invoices in alignment with standard terms and conditions and other contractual requirements. Next slide please.</p> <p>Okay. So, billing invoicing guidance. This says member information for Table 1, but it's a trick. It's actually provider information. I'm sorry about that. So for provider information, which is represented in the actual document itself as Table 1, requests specific information about the billing provider and the rendering provider. It also asks for information about the provider's NPI. And I want to just flag that the department put out guidance about receiving an NPI and expectations for receipt a couple of weeks ago. I'm going to flag it here. We don't unfortunately have time to talk through it all. But I would encourage you all to read it, review it, and make sure that you and</p>

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		<p>your trading partners are in alignment with it. Next slide please.</p> <p>Provider information. This is actually member information. This provides information about the members CIN, first name, last name, and basic address information and date of birth. Service and billing information. Table 3. So this includes, and this is, again, where multiple procedure codes may be submitted by care management, our community support providers, rendered to a single member by a single provider, and the managed care plan should support that flexibility for multiple entries. This includes information not only about the procedure codes and modifiers, and includes information of a start date, end date of the service, optional requirement for a service name, service unit counts, place of service diagnoses codes, unit cost, charge amounts, and invoice amounts. And those fields should be completed regardless, again, of whether the provider's covered under a capitated arrangement. A couple of notes that I want to put out here. We've mentioned at several points the HCPCS codes, and just coming back to what Oksana said, I would refer you all to the latest ECM and community support codes in the document in the chat. If you have questions about any of those, again, feel free to share. I will also put that in the diagnose, the Z code, preferred Z code for social determinants of health data in the chat as well as both will be useful for completing both the procedure codes and procedure code modifiers as well as the diagnoses codes.</p> <p>Managed care plans will also be expected to communicate with relevant member diagnosis information to ECM and community support providers on referrals or authorization to guide to treatment or services through the member level information sharing process. That whole thing we talked about before, and this information will then be</p>

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		<p>used by providers during invoice submission as can the Z codes that DHCS put out and released earlier this year.</p> <p>One other note on this slide. We have received a number of questions about clinical sign off. Clinical sign off is not required on ECM and community support reporting and claims. Enhanced community management and Community supports providers are not required to have a clinically licensed staff member sign off on reporting or claims submitted by a non-licensed staff member such as ECM, the manager, or housing navigator. DHCS considers this to be a burden and would require a significant level of administrator time for a clinical staff member. In addition, many community support providers do not have the clinically licensed staff members to support this requirement since license is not necessary for provision of high-quality community support services. Managed care plans should continue to review claim submissions by both clinical and non-clinical staff according to their oversight and monitoring processes to ensure that clinical consultants are guiding and supporting non-clinical staff members as appropriate. If you have questions about that, please let us know. We want to take a moment to make sure that that was clear in this presentation.</p> <p>And then finally, to end on the softest note probably of this whole presentation I hope, let's go to the next slide, and finally within the invoicing and billing guidance, we're expecting ECM providers, support providers to share a certain administrative information about the invoice itself, back up streaming for ongoing tracking. Next slide please. I'll turn it over to Oksana Meyer to bring us home with the managed care plan reporting requirements to DHCS. I hope this was helpful and look forward to your questions.</p>

(DHCS) CalAIM: ECM & Community Supports Program Data Exchange Overview (English CART)

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Slides 37 - 39	00:48:04 – Oksana Meyer	<p>Kevin, thank you so much. That was incredibly helpful and very detailed. And we appreciate you walking us through the deck. So to help us get to the finish line, so you'll see on this sort of intricate chart here, again, coming full circle where a number of the data elements that Kevin just walked through will be sort of generated, compiled, and then reported up by way of the plans to the department. And as mentioned earlier, we are implementing a quarterly reporting process where reporting templates will be submitted by the health plans to the department on a quarterly basis. Next slide to talk through what they will look like.</p> <p>So again, from our perspective, a lot of this data is going to be incredibly useful for the department as we implement ECM as we transition from care and health homes into ECM and community supports and as the plans begin sort of operationalizing, the data collected and submitted to us will be helpful for us to ensure that members are receiving services, referrals, and that we overall are making sure that implementation is going well. And so as mentioned here on the slide, there will be sort of six dimensions of data that we will be collecting on a regular basis. ECM and community support providers will be responsible for providing a lot of the information that will be compiled and sent over to the department. And so, we hope this, all this data guidance is going to be helpful to help support that effort.</p> <p>I also want to mention that, again, as we transition out of whole person care and health homes, the department is going to be collecting a one-time transition report that will contain member information about folks who have been receiving health home or whole person care services in that and knows who will be transitioning into ECM, and that'll help us ensure that we sort of follow through and sort of</p>

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		<p>monitor people that are transitioning into the new initiatives starting January.</p> <p>Just briefly to go over some of the domains of data that will be collected on a regular basis. The information that we'll be looking for will include, it's bifurcated and will include information and data on ECM on the provision of ECM services as well as community support services. And the data that will be rolled up and submitted to us will include member level information, and it'll track the provision of services for both ECM and community supports. We're going to be looking at data that will help us understand sort of what the outreach efforts look like as far as how many people are receiving it or at least how many people end up rolling overtime, and we'll also be looking for information related to ECM provider capacity as well as community support provider capacity and similarly, sort of domain six on community supports we'll be looking for information and sort of tracking trends related to requests and denials and trying to ensure that members are receiving services as requested.</p> <p>And quickly, the--this information will be coming to the department quarterly, and we expect this to happen for at least the first 3 years as we phase the multiple populations to focus. And I think we're almost at the finish line. So, Michel, I will turn it over to you to help us back. Thank you.</p>
Slides 40 - 43	00:52:02 – Michel Huizar	<p>Thanks, Oksana. Okay. So, expectations and support for implementing - in terms of the timing for the implementation for the data sharing reporting.</p> <p>So, beginning on January 1, 2022, plans and enhanced care management community support providers should begin sharing the data and submitting invoices to the best of your ability as completely as possible. However, we do recognize that configuring these systems does take time. There's going to be some onboarding and some</p>

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		<p>possible delays. So as such, we do expect that implementation to adhere to all requirements contained in this standardized provider data sharing files and billing and invoicing by April 1, 2022. And then relatedly, for the reporting, starting at the beginning of January 2022, we will be conducting weekly check in, implementation check in, with managed care plans, separate apart from the, some of the monitoring reports, and these--and these are--these implementation check it's are very similar to other implementation check in that the department has conducted in the past where we'll be asking a series of questions as to ensure that there are no member issues or provider issues and several other areas. So be on the lookout for that starting in the first week of January 2022. Oh. I should say, though, that the first implementation monitoring report and implementation report will be due to DHCS May 15, 2022. Okay. Next slide.</p> <p>So for elements in terms of support for the implementation, you know, we have communicated plans are required to provide technical assistance to providers, and funding will be available for capacity building and training through 2 programs that you may have heard of that are on similar tracks for implementation being that the incentive payment program as well as the providing access and transforming health or path program, incentive payment program is slated to begin January 1, 2022, and the providing access and transforming health program is, while we are still working in conversation with CMS, many of the elements are tentative and subject to CMS approval. But for the incentive payment program, there will be areas where plans can earn funding and support of their providers. So, for those related to electronic change of care [;am information and electronic health information documentation systems and claims and invoicing. So, noting those key areas.</p>

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		<p>And then on the other side for PATH, there are areas where under enhanced care management community supports, technical assistance, resources, available to counties and community-based organizations and others, as well as capacity and infrastructure transition, expansion, and development. But again, noting that the ten have been subject to CMS approval. Anyway, we can move to the next slide, and I think I will hand it over to Lori.</p>
<p>N/A (Q&A)</p>	<p>00:55:28 – Lori Houston-Floyd</p>	<p>Thank you very much. Oh, thanks, Michael so I know we only have a couple of minutes and we've received many great questions in the chat today. I'm going to field a few to the team here. So, this is pretty technical and in the weeds and Kevin I'll look to you for this one, going back to the MCP Member information.</p> <p>There's a question around if the data that the plans are going to be sharing with ECM providers is you referenced a couple of tables that need to go every 10 days Can you clarify if that's 10 days or 10 business days.</p>
	<p>00:56:03 – Kevin McAvey</p>	<p>10 calendar days.</p>
	<p>00:56:23 – Lori Houston Floyd</p>	<p>Ok, great. Next question. On the ECM outreach tracker - is the data reported in the ECM provider initial outreach tracker only capturing ECM outreach attempts or are other ECM services reported there? What is being reported there is it all types of ECM related services or just outreach attempts?</p>
	<p>00:57:14 – Kevin McAvey</p>	<p>Only ECM outreach.</p>
	<p>00:57:23 – Lori Houston-Floyd</p>	<p>Ok great thank you. Here is another good one. Can MCPs require data elements that go above and beyond what have been presented in this presentation today? Can they ask ECM providers to report on other things? Kevin or maybe Oksana, I'll look to you for this.</p>

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	00:57:47 – Oksana Meyer	So, the answer to that is no we really want to maintain sort of this minimal standard of data elements to be required, just to ensure we have a consistent approach. As we implement ECM and been Community support so really nothing, above and beyond what was discussed in it and that is in the guidance documents.
	00:58:06 – Kevin McAvey	The only thing I'll add to that is similar theme, as we were going throughout unless there's mutual agreement between the managed care plan and the ECM and Community sports providers, then you should definitely can definitely do that, but that minimum standard is that minimum standard and we are expecting those
	00:58:29 – Lori Houston-Floyd	Well, thank you so much, and again I know we're right at time here so. Thank you all for your great questions and will continue to follow up with additional FAQs and guidance.
N/A	00:58:40 – Oksana Meyer	Thank you
N/A	00:58:41 – Kevin McAvey	Good to see you all.
N/A	00:58:46 – Julian Ward	Thank you for joining. You may now disconnect.