CalAIM ECM Office Hours: Overview of Data Exchange and Reporting Requirements for ECM and Community Supports

August 11, 2022

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Juliette Mullin – 00:03	Thank you, Julian and welcome. Thank you for joining us today for our second office hours event in our series of technical assistance events for enhanced care management and Community Supports.
Slide 2	Juliette Mullin – 00:14	My name is Juliette Mullin. I am a senior manager at Manatt Health, and I will be helping to host and facilitate this question and answer session today.
Slide 2	Juliette Mullin – 00:23	To kick us off, I'm going to introduce Neha Shergill with the Community Supports and optional program section at DHCS to give us a reminder about the public health emergency. Neha.
Slide 2	Neha Shergill – 00:36	Thanks so much Juliette. So as many of you already know, just wanting to share that the COVID 19 public health emergency will end soon and millions of Medi-Cal beneficiaries may lose their coverage. So just to reiterate, the top goal of the department is to minimize beneficiary burden and promote continuity of coverage for beneficiaries. And as a reminder to how you can help is by becoming a DHCS coverage ambassador, is also by downloading the outreach toolkit on the DHCS coverage ambassador webpage, and by joining the DHCS coverage ambassador mailing list to receive the most updated toolkits as they become available. Next slide.
Slide 3	Neha Shergill – 01:12	And then we do have a two phased approach with the communications strategy. Phase one is designed to encourage beneficiaries to provide updated contact information in order to be able to contact beneficiaries with important information about keeping their Medi-Cal coverage. This phase is also underway.
Slide 3	Neha Shergill – 01:28	Phase two is designed to encourage beneficiaries to continue to update contact information, report any change in circumstances, as well as check for upcoming renewal packets. Phase two will begin 60 days prior to the end of the public health emergency and an outreach toolkit will be released in the future. And with that, I'll hand it back over to Juliette.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 4	Juliette Mullin – 01:49	Thank you, Neha. So, as I said, this is the second in our series of Office Hours sessions that we will be hosting throughout the year. The Office Hours concept is a Q&A discussion with DHCS leaders and stakeholders who are implementing Cal-AIM. Each Office Hour session focuses on a specific implementation topic. These sessions largely, but not always, serve as a follow up to a longer webinar that was held prior to the session.
Slide 4	Juliette Mullin – 02:19	In this case, our topic is on data exchange and reporting requirements for ECM and Community Supports. And that's in follow up to a webinar hosted last week by many of the folks that you're going to see here today. And we will be diving into many of the questions that we received in that webinar, in the chat, via email, after the webinar, and as you registered for this event. So what we're going to do today is I will kick us off with some introductions of all of the great panelists who are going to be answering questions for us today.
Slides 4-5	Juliette Mullin – 02:51	I will give you an overview of how to ask questions throughout this session. And then we're going to dive into some Q&A discussion. Our Q&A discussion will follow three core categories. We will talk first about data flows from managed care plans to enhanced care management providers. We will then transition into a conversation about data flows from enhanced care management and Community Supports providers to managed care plans. And then we will wrap with a conversation about data flows for managed care plans to DHCS. And so with that, let's go to the next slide and take a look at who will be answering our questions today.
Slide 5	Juliette Mullin – 03:29	On our panel, we have four leaders from DHCS who have joined us to answer our questions. Dana Durham, with the Managed Care Quality and Monitoring Division. Neha Shergill, who you've already met today with the Community Supports and Optional Program Section. She is joined by her colleagues in that section, Michelle Wong and Tyler Brennan.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Juliette Mullin – 03:50	Throughout the session, they will all be answering questions about data reporting and data exchange in enhanced care management and Community Supports. We are also joined by two Manatt Health experts on data requirements and data exchange in ECM and Community Supports. Kevin McAvey, director at Manatt Health and Lori Houston-Floyd manager at Manatt Health. We'll be helping to answer some of the core questions as we move through this session today and help us all get a better understanding of data exchange and data reporting for ECM and community. We go to the next slide.
Slide 6	Juliette Mullin – 04:30	Today's session is based on questions that we've received from previous webinar Q&As, as well as any questions that you've submitted via email, or when you registered for the session today. So we have already had an opportunity to go through all of those questions and really pull together a comprehensive program that's structured around all of your questions. However, we very much invite you to ask questions throughout the session today, and we will be incorporating them throughout the Q&A. The process for doing that is very simple. We have an open chat for this meeting and you can ask your questions in that chat. We will be monitoring it throughout the session and asking those questions of the panelists throughout the session.
Slide 6	Juliette Mullin – 05:10	Please also feel free to use the chat to share your own experiences. As we start to talk through the implementation and the use of these tools, it is a forum for you to share your experiences and your learnings as well. So with that, let's go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Juliette Mullin – 05:28	I mentioned that we were going to have three distinct categories today, and we're going to walk through those one by one to keep us organized. Our first category is going to look at managed care plans and the information that they send to ECM providers. And that really is going to be a deep dive on the member information file. So we'll spend some time there and ask some questions there. We will then transition into a conversation as I mentioned previously, about the data flows from the providers to the managed care plans. And there are several different documents that we will walk through and answer questions on in that category.
Slides 7-9	Juliette Mullin – 06:06	And finally, we will close with the quarterly implementation monitoring report from managed care plans to DHCF. Before we dive into all of this, however, we would like to give you an overview of the ECM and Community Supports programs. And I'm going to hand it back to Neha to give us that walkthrough. Neha.
Slide 9	Neha Shergill – 06:26	Yep. So for CalAIM, just wanting to talk about, it is a long term commitment to transform and strengthen Medi-Cal, offering Californian's a more equitable, coordinated, and person-centered approach to really maximizing their health and life trajectory. And the main goals of CalAIM include implementing a whole person care approach and addressing the social drivers of health, improving quality outcomes, reduce health disparities, and drive delivery system transformation, and to really create a consistent, efficient and seamless Medi-Cal system.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Neha Shergill – 06:58	And then diving deeper into what is ECM. So ECM stands for enhanced care management, which is a new Medi-Cal benefit to support comprehensive care management for enrollees with complex needs that must often engage in several delivery care systems to access care. This includes primary and specialty care, dental, mental health, substance use disorder and long-term services and supports. So ECM is really designed to address both the clinical and non-clinical needs of the highest need enrollees through intensive care coordination of health and health related services. Meeting enrollees wherever they are, so settings such as on the street, in a shelter, in their doctor's office or at home. And ECM is a part of a broader CalAIM population health management system designed through which MCPs will offer care management interventions at different levels of intensity based on member need with ECM as the highest intensity level. Next slide please.
Slide 11	Neha Shergill – 07:55	So as you can see presented on this map, we see the launch and expansion of ECM. Those that you see in pink began implementing ECM in July of this year, making ECM now statewide. Currently the live populations of focus are high utilizer adults, individuals and family families experiencing homelessness, adults with SMI and, or SUD and starting on January first of next year, ECM will extend statewide to individuals at risk for institutionalization and eligible for long term care, nursing facility residents transitioning to the community. Next slide please.
Slide 12	Neha Shergill – 08:36	So what are Community Supports? Community Supports are services that Medi-Cal managed care plans are strongly encouraged, but not required to provide as substitutes for utilization for other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. And Community Supports are really designed as cost effective alternatives to traditional medical settings for services. They are designed to address the social drivers of health. And next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Neha Shergill – 09:07	So currently the department has preapproved... We have 14 Community Supports plans we can offer ranging from housing related services, recuperative care services, transition and diversion services from skilled nursing facilities to medically tailored meals, asthma remediation and sobering centers. So I won't just go into all the services in detail, but just providing a high level overview of a few. The housing related services include housing navigation to help locate and apply for housing, housing deposits that assist with set up costs and housing tendency and sustaining services, which helps those who have found housing stay housed.
Slide 13	Neha Shergill – 09:44	The transition and diversion Community Supports both provide assistance with keeping members who would otherwise be placed in skilled nursing facilities in the community. And medically tailored meals that provide medically appropriate meals or groceries to members who have chronic conditions or who have been recently discharged from the hospital. The benefits include improved member health outcomes, and lower hospital readmission rates. And plans may also submit proposals to offer new Community Supports outside of these 14 preapproved supports subject to the department's approval. Next slide please.
Slide 14	Neha Shergill – 10:19	And then just talking more about who's eligible for Community Supports. So each Community Support has specific eligibility criteria linked to each service. Enrollees in Medi-Cal managed care may be eligible for Community Supports, which are voluntary to the enrollee. And given Community Supports are optional to the plans, there is a mix of how and what Community Supports are available with each plan and each community. And with that, I will hand it over to Tyler to talk more about the big picture, enabling ECM and Community Supports through data. Thanks.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Tyler Brennan – 10:49	Hi, thank you, Neha and good afternoon everybody. My name is Tyler Brennan and I'm with the Department of Healthcare. We're going to be looking at the big picture really here in enabling ECM and Community Supports through the data that we're talking about here today. So information sharing among providers, managed care plans, counties, community based organizations, and DHCS is critical to ensuring the successful implementation of the ECM benefit and of Community Supports. As such DHCS developed guidance to standardized information exchange, increase efficiency and reduce administrative burden between the state managed care plans and ECM and Community Supports providers. Managed care plans were required to report to DHCS on various dimensions of the new ECM benefit and Community Supports, which allows the department to monitor ongoing implementation. Today we're providing an overview of the data sharing and reporting guidance documents, and will be taking questions and responding to the best of our ability. DHCS wanted to provide a refresher of this content and provide an opportunity for managed care plans and providers in counties where ACM launched in July of 2022. Next slide please.
Slide 16	Tyler Brennan – 11:52	So here on this slide, we really do see the big picture in all of the different files and documents that we're talking about. The ECM and Community Supports implementation are supported by these key data flows. And we'll be going into each one of these boxes in future slides. And with that, I believe I'll be handing things back over to Juliette to lead us through the next slide.
Slides 17-18	Juliette Mullin – 12:14	That's right. Thank you, Tyler. Thank you Tyler and Neha for that overview of ECM and Community Supports. And so without further ado, let's dive into data exchange and data requirements for the programs. So we begin with the member information file, which is a file that passes from the managed care plan to the enhanced care management provider. And if we go to the next slide, you'll see that file particularly highlighted here.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 18-19	Juliette Mullin – 12:43	So you can see, this is one of the tools that passed between the MCP and the ECM provider, the member information file. And if we go to the next slide, we'll explain a little bit about what it covers. So this tool is really designed to enable MCP to provide the information that ECM providers need about members' clinical and nonclinical needs. And it's going to be an essential tool for the enhanced care management providers to do outreach and to begin enrolling members.
Slide 19	Juliette Mullin – 13:16	And with that brief overview of the file, I'm going to begin to dig into some of the questions that we have gotten from many of you in previous webinars and previous sessions. So this first question is for Kevin McAvey. Kevin, we've gotten a number of questions about being able to include additional data elements in this file. Specifically, we've received the question of, "If I'm a managed care plan organization, and I identify other data elements that I would like to include in the file from ECM providers, can I add them to the member information file?"
Slide 19	Kevin McAvey – 13:55	Thank you so much, Juliette. It's a really great question. And one that we've received quite frequently. So no you can't be required to actually supply that data element unless it's mutually agreed to with the managed care plan and the ECM provider. There's a stipulation that comes with the actual guidance itself and I will include this here. Managed` care plans may not impose additional reporting requirements on ECM providers that exceed those as required in mandatory elements as listed in this guidance, again, unless mutually agree to between the ECM provider and the managed care plan. It's a really good question.
Slide 19	Kevin McAvey – 14:42	For those who are following along. I would encourage you, as we're thinking through and talking through these questions and new questions might come to mind, please feel free to put them in the Q&A, and if we don't get a chance to answer them all today, or honestly, if we don't have an answer to some of them today, we'll use those questions to inform our future guidance and communications that are put out to the market.

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Slide 19	Kevin McAvey – 15:07	I also want to note for those who weren't able to join us last week, we did a full presentation on these guidance elements and that deck will be available in the coming weeks online after it goes through ADA compliance. So the answer to your question is no, unless we truly agree to, but Juliette, we have another.
Slide 19	Juliette Mullin – 15:30	Yes. And so there's kind of a follow up and related question here, is if it can go the other way? So can the managed care plan decide to add information into the member information file that it sends to ECM provider?
Slide 19	Kevin McAvey – 15:44	Yes. Another good question. Equally good. No, not unless it's mutually agreed to between the ECM provider and the managed care plan. And this goes for all of the guidance shared in the document. So if you have it up on your screen right now, and you're going through looking at the member information file, and then we'll get to this a little bit later on, the provider return transmission file, not to scoop us here... But each of the tables and all of the data elements they contain and table one, the member engagement information as transmitted from the managed care plan to the ECM and Community Supports provider, additional information about the members' clinical information, the clinical chronic conditions that... An example, we pull out a number of clinical chronic condition indicators ranging from asthma to TBI. If the ECM provider would like additional clinical indicators, it is also more than welcome to use additional transmissions it may receive from the managed care plan, including an analysis of the A37 file.
Slide 19	Kevin McAvey – 17:04	But otherwise we need to reach mutual agreement with the managed care plan for those indicators to be included in the file. For a lot of these data fields that are included in the member information file guidance, I would encourage two things one, read all of the footnotes. And then two, if you have any additional questions about the data that is coming to you or should be coming to you or could be coming to you, I would encourage you to work really closely with your managed care plans to really figure out a data exchange that works for both of you.

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Slide 19	Juliette Mullin – 17:42	Great. Thank you, Kevin. That's really helpful. My next question is for Lori, we get a lot of questions about the frequency of this file. I'm wondering if you could give us an overview of how often managed care plans are required to share member information files with ECM providers.
Slide 19	Lori Houston-Floyd – 17:59	Of course, thanks Juliette. This comes up a lot. I think it actually really speaks to the member assignment process for ECM. So just as a reminder there, whenever a plan authorizes a member for ECM, they have to assign that member to an ECM provider within 10 days. And along with that, share some of the member engagement elements that are contained within this data guidance document. So specifically tables one and four.
Slide 19	Lori Houston-Floyd – 18:25	There's kind of a part two to this answer though. And that is when a member, on an ongoing basis, plans also have to share updated data, at least on a monthly cadence, either for members who are brand new to the benefit, or who have been in the benefit for a while. And so that's comprehensive sort of completed updated information, that's tables one, two, three, and four from this guidance.
Slide 19	Lori Houston-Floyd – 18:54	Yeah. And I think one other comment, I'm going to just pivot a little bit... Cause I'm looking at the chat and I want to respond to Megan West, who's highlighting a little bit of variation in sort of the data sharing formats. And I want to just call attention to this because there may be a little bit of non-standardization here. The file format itself could be an Excel based workbook or in another mutually agreed upon file format with the plan. So I think that's an area where there's not total standardization across the board. DHCS did not create a template for this specific file. So just wanted to acknowledge that as well.
Slide 19	Juliette Mullin – 19:41	And I think that segues really nicely into my next question actually, Lori, which is, what are the acceptable ways of transmitting this file to the ECM provider. And the step down from that even further is, how could I go about setting up a transmission process with an MCP that I'm partnering with if I'm an ECM provider.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Lori Houston-Floyd – 20:01	Yeah, thanks Julia. I think, again, this sort of speaks to the collaborative encouragement that these data guidance documents were really designed to achieve, and that is collaboration between the MCP and the ECM providers. So there are a couple of possible methods for transmitting this data, web based portals, SFTP, secure email, if no other option exists, or if there are other methods that are again, mutually agreed upon by the ECM provider and their plan partners. But again, this is really meant to be decided upon in a sort of collaborative nature.
Slide 19	Juliette Mullin – 20:46	Great. Thank you, Lori. So moving a little bit into the Z codes that are involved in the member information file. Dana, I'm wondering if you could speak a little bit to how managed care plans can go about getting Z codes and setting up that process for themselves.
Slide 19	Dana Durham – 21:10	So the Z codes are actually what are called ICD10 clinical modification codes. And the point of them is really to track information about members or clients, beneficiaries. And the information that you're tracking through them is actually social drivers of health. I'm not sure... I just want to explain a little bit about social drivers of health and those social drivers of health really help us know circumstances that one has going on in their life and help us know a little bit more about really what's happening.
Slide 19	Dana Durham – 22:01	The codes themselves are available through an ECM provider and they're on the ICD10 list. And they're also part of an all plan letter. The all plan letter is 21-009, and that outlines some codes that we think will be useful for you to use. Z codes really do help us know what's going on with the person and address those drivers that really impact health and the goal of collecting them is helping us to give a more informed care to a beneficiary, as well as addressing those disparities and knowing what they are as we go into working with someone.
Slide 19	Dana Durham – 22:50	So I think that answered the question you were asking Juliette, but happy to have a follow up if you have one.

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Slide 19	Juliette Mullin – 22:57	No, it does answer it. Thank you, Dana. I think my last question for this file is going to be for Kevin and specific to some of the fields that we're asked to report in this category for this document. So for the gender, race and ethnicity codes, what are the appropriate options for this category? Could you walk us through that?
Slide 19	Kevin McAvey – 23:19	Yeah, so that's actually a good question. And I want to just kind of return to the one that Dana got cause I'm jealous. So one of the one of the things that we're trying to do here and the departments putting out these Z codes is to start to build a culture around use. So as we think about whole person care, we are actually collecting data that can be shared in the bloodstream of our health system, on claims and encounters that can help to flag non-clinical indicators of health that others can use to provide support to individuals. And I think that just goes to everything that Dana said and the importance of starting to use those codes. And I threw the link in the chat, if you can scroll up and find the APL that I was referencing.
Slide 19	Kevin McAvey – 24:13	For gender, race, ethnicity codes... For all codes that are not otherwise specified in any of our guidance, always feel free to ask a question and email DHCS, and we will get back to you with an answer. But if there is no guidance, it's usually because we're defaulting to the codes that managed care plans are required to submit to DHCS. And those are in the chat.
Slide 19	Kevin McAvey – 24:44	One point I do want to make about a lot of these claims and encounter codes for both the A34 and the A37 files that manage care plans must submit to DHCS against standard requirements, is that a lot of times, or most of the time, those requirements aren't necessarily made up by California. Those are requirements that California needs to follow in order to submit their data up to CMS.

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Slide 19	Kevin McAvey – 25:12	So if you do see race and ethnicity fields profiled in a way that's a little bit different than you're used to, or have a question about them, some of those fields are in DHCS's control, but some of them are not. And the reason managed care plans are collecting them in that way is because they are required to submit data by that format up to DHCS as DHCS is required to submit up to CMS. But Dana, anything else that you want to mention on either of those two?
Slide 19	Dana Durham – 25:46	No, I really can't think of anything. And Kevin, maybe you should have gotten the question because you did a great job kind of explaining.
Slide 19	Kevin McAvey – 25:52	I got jealous, sorry.
Slide 19	Dana Durham – 25:53	No, I'm jealous of your answer. So it's all good.
Slide 19	Juliette Mullin – 25:57	If I'd known his passion for Z codes, I would've asked.
Slide 19	Juliette Mullin – 26:04	All right, wonderful. So that brings us close to the end of our conversation about the member information file. I just want to acknowledge that we are seeing a lot of questions coming into the chat and we're kind of organizing those in real time to match up with certain components of our discussion today. So I've seen some questions about billing. We're noting them and we'll bring them up when we get to billing. Similarly some questions about the implementation report, we are absolutely tracking those. So please keep dropping them in the Q&A, that's very helpful.
Slide 20	Juliette Mullin – 26:39	So with that, if we can go to the next slide, we're going to transition into our middle category, which is our biggest in terms of the number of documents we want to review with you today. And this is the category of data flows from ECM and Community Supports providers to the managed care plan.
Slides 20-21	Juliette Mullin – 26:57	So we will begin with the return transition file. And if we go to the next slide, we're again bringing back that visual that shows you where the return transmission file fits in the ecosystem of data exchange documents here. So it is a file that goes from the ECM provider to the managed care plan. And if we go to the next slide, wonderful.

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Slide 22	Juliette Mullin – 27:22	So the return transmission file. Generally speaking, we know that ECM providers are holding the primary relationships with members who are receiving ECM. And so with this in mind, we have developed some guidance and some standards around how ECM providers can share information back to MCP. So with that, I will ask Lori, if she'll give us a little bit of an overview about this document and kind of the longevity of this document when it's used, its duration, et cetera.
Slide 22	Lori Houston-Floyd – 27:58	Yeah, of course. So this is really intended to be a way for providers to share all of the robust information that they're getting from their work day to day and managing patients. The frequency of this data should really be shared at a cadence that is agreed upon between the ECM provider and the MCP though I will note here, and we'll talk about this in a bit, that there are separate reporting requirements that the MCPs must adhere to you, and that happens on a quarterly cadence. And so the MCP may wish to align how they're getting this information about member specific details to help them feed that separate reporting requirement. And the data here ranges from information about the types of services that they've been receiving for ECM, clinical data, information about the provider themselves... So that's kind of the range of data elements there just summarizing at a very high level. And this is expected to be sort of in use sort of for the longevity of the benefit. Really essential in terms of getting that information to the plans.
Slide 22	Juliette Mullin – 29:12	Great. Thank you, Lori. And I think you covered it a little bit in what you just spoke to there, but I'm curious, Dana, a question that we get a lot about this file and kind of more broadly is the why. It'd be great if you could walk us through the rationale for why DHCS is asking for these data elements to be shared through the return transmission file.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Dana Durham – 29:33	Yeah. And that's a really good kind of... And thanks for teeing up that question. It's a really important way that we expect the providers and managed care plans to communicate. With that communication it gives more insight into what's actually happening with the beneficiary. And that's really important because the managed care plan can know what is currently being provided to the beneficiary and look at that and see what other opportunities may be there to make sure that individual is given care as well as track what's going on with that individual to really assure that all care coordination is being done appropriately.
Slide 22	Dana Durham – 30:19	And part of it is that the information is part of what the plans must report up to DHCS. But I think the bigger impetus behind that sharing is because the communication should flow both ways. What's happening with the beneficiary, the provider should know, and also the plan should know and that loop really helps for visibility. That enables us to have a better visualization of what's going on with an individual and be able to monitor in a way that can ensure someone's getting the appropriate care that they need at the right time and in the right way.
Slide 22	Juliette Mullin – 30:59	Great, thank you, Dana. That's really helpful. Kevin, this is kind of a variation on a theme of a question I've already asked you, but can an MCP impose additional data sharing requirements beyond the mandatory elements included in this data guidance?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Kevin McAvey – 31:17	That's a great question. And so I'm going to answer it in the same way, but an opposite way. So yes, if it's mutually agreed to between the managed care plan and the ECM provider. No, they cannot unilaterally make that decision. So again, part of the rationale for introducing standards is to make these exchanges more efficient, make sure that ECM providers know the type of information they need to be sharing upstream with managed care plan. And for managed care plan, the type of information they are responsible for sharing downstream. All of this guidance was requested by managed care plans and prospective ECM providers to support those exchanges. So breaking that standardization being it adding additional elements. It could be incredibly valuable, but we do leave it to the managed care plan, the ECM providers to individually make that assessment and support those changes.
Slide 22	Juliette Mullin – 32:14	Great. That's really helpful. And I have a kind of a sub question from that one, for those of us who summarized all the table numbers in the return transmission file, in table six of the return transmission file, we identify some optional reporting elements for ECM encounters, either for in person or telephonic video encounters. Could you tell us a little bit about why this reporting element is optional?
Slide 22	Kevin McAvey – 32:41	Yeah, and I mean, it's another good question. So for table six, for those following along at home, this is on page sixteen of the member level information sharing guidance focused on return transmission file. Sorry, title and a half. The number, it describes that it asks for the number of ECM encounters during the reporting period broken out by in person or telephonic and video. And it notes that this requirement is optional.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Kevin McAvey – 33:13	So why is this reporting optional? Because ECM providers are required to submit claims or encounters as established, according to the DHCS billing and invoicing guidance, which we're going to cover in a couple minutes and as such, ECM providers are already submitting this data elsewhere. If there are, and I can think of a number of reasons why managed care plans that we see and providers may want this information to be transmitted on a require basis, including data timeliness, but we'll leave that up to managed care plans and ECM providers to determine.
Slide 22	Juliette Mullin – 33:56	Great. Thank you, Kevin. And I have a final question around this piece for Lori. We've discussed in the past that we there's no requirement for reporting back care plans. Could you tell us a little bit about whether or not, given that there's no reporting requirement, what are the implications and does it matter from a DHCS compliance perspective to have a care plan if it's not a reporting requirement?
Slide 22	Lori Houston-Floyd – 34:19	Yeah, it's a great question. And the answer is yes, care plans are essential. They're a core part of the ECM benefit. They're a core part of care management. And so even though the state is not formally asking to see individual care plans at the individual member level, data elements that are captured on the care plans often will feed into this reporting. And really it's just the central point of guidance for interacting at that member level between the ECM provider and the individual member. So, yep. They're very much required. Dana, anything to add on that?
Slide 22	Dana Durham – 35:00	I think the only thing I might say is, they are subject to DHCS oversight too. As our audits and investigations team goes out and audits providers, they are a required part of what must be provided for the ECM benefits. And it really helps where you're headed and where you're going with an individual. And we always need to have a plan. What are we doing and why are we doing it? So, there's some requirements, but it also it just makes sense to have them.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 22-24	Juliette Mullin – 35:37	That's really helpful. All right. So I think that brings us to a close on the return transmission file, and we can move into our next file that flows from an ECM provider to a managed care plan. And that is the provider initial outreach. Go to the next slide. Give you a little bit of an overview of what this is.
Slide 24	Juliette Mullin – 36:02	So this file is really intended to help identify members for initial outreach and track the initial outreach that's being done. It goes from the ECM provider to the managed care plan. So the ECM provider is reporting to the managed care plan on the outreach that it's conducting for ECM members. Lori, I will turn to you and see if there's any additional, high level summary contacts that the group should be aware of about this before we dive into questions.
Slide 24	Lori Houston-Floyd – 36:32	Yeah. Thanks so much, Juliette. I think the key thing here is just always going back to the why. Why does this exist? Because we do know that the level that's involved of effort that's involved to capture this can be intense. The reason is because the ECM benefit is defined as including outreach. And in fact, the managed care plans are getting a component of the capitation payment for this particular activity. And so the state is deeply interested in understanding what is the level of effort that's required to enroll a new member into the ECM benefit. And I think this reporting likely won't be around forever, but I think for especially the first year, couple of years, the state is very keen to understand whether or not the existing payment is really matching up with the level of effort that's required out in the field. So we'll answer a lot of questions. There's a lot of questions always with this particular tracker. And I know Juliette back over to you to kind of lead us through some of those questions.
Slide 24	Juliette Mullin – 37:34	Yeah. Let's dive right in. Because we do have a long list from our previous sessions. So Kevin, this first question is for you. Is the data reported on the ECM provider initial outreach tracker only capturing ECM outreach service and no other ECM services? Can you clarify that?

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Slide 24	Kevin McAvey – 37:52	Yeah, I can. So, that's correct. The data elements and the initial outreach tracker include the member client index number, the provider type, the date of outreach attempt and outreach attempt method. I just put the link in the chat. On page 19, you'll see a table. Table eight, that can provide more information on this question if useful.
Slide 24	Juliette Mullin – 38:18	Great. Thank you. And this is a question we get a lot relating to this one. Billing data will also document outreach attempts. Can you explain to us what the reason is for having a duplicate file that is needed to submit the same data that you're getting in the billing data?
Slide 24	Kevin McAvey – 38:38	Yeah. I will say the billing data should reflect exactly everything that would be reported via this reporting method. But from all of our claims and encounter data experience, especially when you're setting up a new program, the practical reality is there probably won't be a one to one relationship. If there is, that's amazing and you're doing a really wonderful job with your coding and you can actually...
Slide 24	Kevin McAvey – 39:09	Providers creating compliant encounters for outreach, using the HCPCS codes, which is preferred, but not required. You may be able to run reports on the data that you have to actually produce the data for the outreach tracker. Again, as Lori mentioned, this is a requirement in place today. I defer to the department whether in the future year where we're getting all this data via encounters, whether this would still be needed, but until we get to that day, that is why this is being requested.
Slide 24	Juliette Mullin – 39:46	Great. That's helpful. One of the required data elements for this reporting is to indicate the provider type using a code that reflects the provider type as either one, outreach by clinical staff or two, outreach performed by nonclinical staff. Could you explain to the group why that was included in the document?
Slide 24	Kevin McAvey – 40:06	Yeah. There are rate differences and implications, depending upon if the outreach was performed by clinical or nonclinical staff. So that's the rational of those elements.

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Slide 24	Juliette Mullin – 40:20	Makes sense. All right. Lori, this question is going to be for you. So are ECM providers required to submit all outreach attempts regardless of whether they were successful in making contact with a member?
Slide 24	Lori Houston-Floyd – 40:31	Yeah. So the answer to that is yes. The department is looking for exhaustive outreach efforts before a member was enrolled into the benefit, whether or not they successfully made contact with that member.
Slide 24	Juliette Mullin – 40:45	Got it. And what about a robo call campaign? Would a robo call outreach reminder from a robo call campaign be counted as an outreach here?
Slide 24	Lori Houston-Floyd – 40:54	This is a good question. We get it a lot. I think the most important thing to think about here is the actual definition of how an outreach attempt is defined. So you can find that too. I know Kevin chatted this document in the chat. It's on page 19. So an individual outreach attempt is... The key thing here is it's an individualized outreach attempt. It can be telephonic, in person, electronic, but it cannot be sort of a generic email blast. It has to be individualized. So in this case, the robo call campaign should not be documented and included in this reporting.
Slide 24	Juliette Mullin – 41:35	Got it. Great. So that brings us to a close on our questions that we had pulled together from previous sessions on the initial outreach tracker. And I'm keeping an eye on the chat and I'm not seeing questions specific to this tracker there. I'll pause to see if, Lori or Kevin there's anything that you've seen come through that we'd want to cover here. I think we can probably move to the next file. Great.
Slide 24	Lori Houston-Floyd – 42:08	Sorry. I do want to respond to Chris Dodson's comment. And that is that this reporting that's been outlined about outreach from the department is standardized. And so again, any sort of additional requirements that the plans may be asking for above and beyond this standardized set, that should not be necessarily happening in the field. So just wanted to kind of remind that this baseline reporting exists for a reason. So just want to flag that.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 24-25	Juliette Mullin – 42:44	Great. Thank you, Lori. All right. Let's move along. I'm realizing that we're having a lot of fun talking about data and we're actually coming into our last 15 minutes here. So this is our last file that moves from the ECM provider to the managed care plan in the member information sharing guidance section. We are going to talk about the ECM member referral file. So let's go to the next slide here.
Slide 26	Juliette Mullin – 43:16	So this file provides a standardized format and method for the MCP to collect referrals from new ECM enrollees from ECM providers. So ECM providers are sending information about new ECM enrollees to the managed care plan. Lori, I'm going to start with a question to you related to this file. Would a PCP be able to refer and by PCP, I mean a primary care physician or a provider, be able to refer a patient directly to the ECM provider or do they have to go through the health plan first?
Slide 26	Lori Houston-Floyd – 43:55	Yeah, this question also came up or a variation of it came up last week. So I think the important thing to remember is that authorizations happen at the MCP level. So this particular provider in question could refer directly to the MCP or they could also, if they have a really good relationship with a group of ECM providers, they could refer directly to the ECM providers, but just know that the ECM provider is going to then turn around and send that referral up to the managed care plan.
Slide 26	Juliette Mullin – 44:23	Oh, and if I want to refer a beneficiary who I think is potentially eligible for ECM to the managed care plan, are there guidelines for how I can make that referral?
Slide 26	Lori Houston-Floyd – 44:34	Yeah, there are. And in fact, that's exactly what this particular tracker, this file endeavors to lay out. A standard set of data elements to support the referral. So, this is... Can add it into the chat really quickly. Page 21. Specifically, if you want to look at table nine. And again, same principle applies, managed care plans really should not be asking for additional data elements above and beyond the minimum sets that are defined here in this guidance.

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Slide 26	Dana Durham – 45:12	Just let me just make one caveat with that. Just if you are being asked for additional fields, please let us know. I do want to... Through our email box. And the reason... And what I'd like you to do before you let us know, is make sure it's not part of a different agreement you may have. For instance, if you're participating in the incentive payment program, and one of the things you've agreed to is to provide more information, we'd just like you to check that first before you let us know. And if it's not, we certainly will really investigate what's going on so that we can really understand what's being asked and why. And then we'll have a further follow up with you as well as the managed care plan.
Slide 26	Juliette Mullin – 46:06	Great. Thank you, Dana. I think that's very helpful for folks to hear and know. One additional question relating to member referrals kind of more broadly, and this one for you, Lori. Is there, or will there be an expected percentage of new clients overall or by managed care plan who have been identified for ECM who must be enrolled in ECM?
Slide 26	Lori Houston-Floyd – 46:31	Yeah, thanks Juliette. I think there's a couple of ways to respond to or interpret that question. But I think in this context this really has to do with provider capacity and it goes back to the negotiations and the contracts as Dana was referring to that have been established between ECM providers and managed care plans. And so managed care plans have sort of agreed to specific provider capacity thresholds in those contracting negotiations. So would definitely kind of look to those predetermined thresholds to inform enrollment rates.
Slide 26	Juliette Mullin – 47:09	That's really helpful.

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Slide 26	Dana Durham – 47:11	Yeah. I mean, I also want to say I'm not really sure that we've landed on a really expected percentage, but we have landed on really what is expected as far as the population goes. So the populations of focus do need to be part of ECM and we are doing a ramp up for that. And as Lori kind of alluded to, there are some provider capacity issues. Over time, we'll be looking a little bit more about, and I think this is years out, not right now, but about making sure that those who are appropriate for ECM are referred for ECM and Community Supports. But I'm wondering if we'd ever really go with ratios, but more just checking that against people that, as we look at the data, are appropriate for ECM.
Slides 26-27	Juliette Mullin – 48:12	Great. Thank you, Dana. And thank you, Lori, for your responses to that question. With that, I think we can transition into our last file in this category, our last component of this category. So this is the last piece we want to cover to go from ECM providers and Community Supports providers to managed care plan. And this is a piece we've already alluded to a number of times in our conversation today, the billing and invoice guidance. If you go to the next slide.
Slide 28	Juliette Mullin – 48:44	So DHCF has defined the minimum data elements that providers need to submit to mitigate MCP and ECM and Community Supports burden the burden around reporting here. So we have released some guidance around billing and invoicing. I'm going to hand it over to Kevin, maybe to give us just a very high level overview of what that guidance is.

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Slide 28	Kevin McAvey – 49:12	Absolutely. So ECM and Community Supports providers, as if they were a traditional healthcare organization that's been in this ecosystem for a while, would generally be expected to submit claims upstream to the managed care provider using a standard A37 transaction format. But as we know, especially as this program is going... It was just getting going many ECM providers and Community Support providers might not have that native capacity available. So in lieu of sharing standardized electronic transactions upstream to manage care providers for managed care provider delegated entities, we have, at the request of managed care plans and ECM and Community Supports providers created standardized guidance on what an invoice should look like. That all ECM providers and Community Supports providers can agree to share upstream and managed care plans can be prepared to accept, and again, in these common parameters.
Slide 28	Kevin McAvey – 50:21	And so Tyler put in the chat, a link to the billing and invoicing guidance, which covers the data elements that should be included. And to a couple of questions in the chat, that similar to all member information, file guidance, managed care plan data requests may not extend beyond what is required in this guidance unless mutually agreed to between the managed care plan and the ECM provider and managed care plan and the Community Supports provider.
Slide 28	Kevin McAvey – 50:49	If you're a managed care plan on the line, and you would like to kind of suggest additional fields for future iterations, again please feel free to email the inbox for that future consideration. Again, we want this to be useful to the field and that's where it started, and that's where we wanted to continue going. So the billing and invoice and guidance, provider information, it requests information about the member, information about the service actually rendered as well as the billing information and a few administrative elements themselves.

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Slide 28	Kevin McAvey – 51:29	It has standardized file format, transmission methods, reporting frequency, and secure a transaction of protocols. It even has some guidance as with a claim, if it is not approved, there is a generally a pretty standard process that a managed care plan and a provider will go through to correct the claim and re-adjudicate it. There is some guidance in here for how that re-adjudication and resubmission should go in this instance. So that's, again, a high level overview. I'd encourage you all to review the guidance and the footnotes. And if you have additional questions, always feel free to email us at any time. But I think we have one or two that we've already received. Is that right, Juliette? Juliette?
Slide 28	Juliette Mullin – 52:17	Yeah, there is a question that we got a little while back around billing that I want to bring back. We said we would be tracking questions for when we got to those sections earlier, when we were talking about the basic requirements for reporting, and you were explaining that managed care plans can't require more reporting unless it's mutually agreed upon between the MCP and the ECM provider, does the same thing apply to invoicing requirements?
Slide 28	Kevin McAvey – 52:46	Yes. So even if your organization, whether an ECM provider or Community Support provider does not have the technological capabilities to generate and submit claims, you still must receive an NPI number as a required, invoice data element. But luckily it's actually in... We went through this internally and I think we actually tested it. It's not that hard. And DHCS has incredibly helpful, thanks to a tremendous team there put together this literally step by step guide for providers participating in the ECM and Community Support programs to get an NPI. So please feel free to review that. If you have additional questions, submit it. But we've received some really positive comments from the field about it's the utility of this guide and its ability to make sure you get the NPI that you need.

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Slide 28	Juliette Mullin – 53:46	Great. And I'm glad you mentioned the NPI guidance, because I do have a question about that as well. So if my organization is not generating claims and we're submitting our bills via invoices, do we still need to receive an NPI?
Slide 28	Kevin McAvey – 54:00	Yes, yes you do. And you should. So it's regardless of the payment method, all ECM and Community Support providers should seek and receive and use an NBI in their transmissions. For managed care plans, managed care plans should use the standardized billing and invoicing guidance that invoicing guidance to pay ECM and Community Supports providers, whether it is a payment is rendered on a fee for service basis. In other words, you get an invoice and you pay it, or whether it's just an accounting of the services rendered under a capitated basis. It doesn't matter.
Slide 28	Kevin McAvey – 54:43	Importantly, DHCS is not specifying the payment model between managed care plans and providers for either ECM or Community Supports though DHCS has issued non-binding Community Supports pricing guidance, which I point you to that managed care plans and providers may use as a source of information on potential pricing strategies and amounts. So everyone should get an NBI. And I believe Tyler added some clarification. Put the link back in the chat and suggested and been pointed to the suggested taxonomies included in the information.
Slide	Juliette Mullin – 55:19	You did. And I just want to ask one last question on billing, and then we'll transition into our last report with our last couple minutes. How does the requirement to submit encounter data relate to payments by the MCP to the ECM and Community Supports providers?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Kevin McAvey – 55:38	Yeah, and I think I started covering this a little bit in the last response. Similar to encounters. Even if you are not getting paid, you are expected, for the invoice you submit... It is critical that you completes that invoice as if you are populating all the information required as if your payment dependent upon it. That information that is transmitted upstream to your, whether it's a provider or managed care plan directly and intermediary... And then it ultimately comes up to DHCS. And all of those people in between really depend upon that information to understand how services are being utilized and the health of our populations. So please make sure that even if you're not getting paid on a fee for service basis, you're completing the invoices as thoroughly and accurately as possible.
Slides 28-29, 31	Juliette Mullin – 56:31	Great, thank you, Kevin. And with that, let's transition to our last document with just two minutes left in our session today. So go to the next slide. Our last document is documents that transition from managed care plans to DHCS. This is the quarterly implementation monitoring report. So can we move forward two slides? Here we go. So many, if not all of the folks on this call will have some familiarity with this quarterly implementation monitoring report as we are now in quarter three.
Slide 31	Juliette Mullin – 57:01	Throughout the first several years of this program, DHCS will require managed care plans to submit quarterly implementation monitoring reports, demonstrating and showing data about the implementation of ECM and Community Supports. I'm going to dive straight into a couple core questions that we've gotten here so that we can cover those. One question that we received early on in the session today is whether or not in ongoing quarterly implementation reports, managed care plans should include health HSP or whole person care patients that transitions from those programs into ECM in the reports going forward. And I'm going to ask Lori, if you could maybe speak to that.

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Slide 31	Lori Houston-Floyd – 57:44	Yeah. So for members who have transitioned from whole person care or health home programs, if they are still receiving services, they still need to be reported on. And so they will go into the members and services tab of the report, recognizing that that particular report asks for a population of focus. It's not a perfect solution because the member may not perfectly meet the eligibility criteria, but they're still in the benefit because they've not been discontinued. So go ahead and select the best, most appropriate population of focus that member might align with. That would be the guidance there, but yes, they should absolutely remain in the reporting if they're still receiving services.
Slide 31	Juliette Mullin – 58:27	Great. Thank you, Lori. And my last question will go to Tyler very timely. We are just a few days away from the next implementation report deadline. Tyler, could you walk us through how MCPs can submit that report, please?
Slide 31	Tyler Brennan – 58:41	Surely. So DHCS has developed a standardized template for MCPs to submit the required data elements. Managed care plan should have copies of these templates. And actually within the template itself, we do have an instructions tab on the beginning that walks the managed care plan through that process. If there are any questions about any of the details in the template, please reach out to the ECM and Community Supports mailbox that has already been mentioned on this call. And we just a reminder, we did send out fresh templates and a reminder emails with the most current template to MCPs on August 5th. So just six days ago or so.
Slides 31-33	Juliette Mullin – 59:18	Wonderful. Well, thank you, Tyler. Thank you, Kevin, Lori, Diana, Neha, Michelle, everyone for their participation in this session today. Thank you everyone who joined and asked so many amazing questions in the chat. If we didn't have a chance to get to your question yet, we will definitely be reviewing them and incorporating them into upcoming TA events, technical assistance events. And with that, thank you for joining and have a great rest of your day.

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