

CalAIM ECM and CS Office Hours: Data Sharing and Billing for ECM & CS

December 1, 2022

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Emma Petievich – 00:00:14	Hello and welcome. My name is Emma and I'll be in the background to ensure tech runs smoothly today. We encourage you to submit written questions at any time using the Q&A. The chat panel is also enabled for comments and feedback. Live close captioning will be available in English and Spanish. You can find the link in the chat field. With that, I'd like to introduce Juliette Mullin, senior manager at Manatt.
Slide 1	Juliette Mullin – 00:00:38	Thank you, Emma and welcome everyone today to today's CalAIM enhanced Care Management and Community Supports Office Hours. The topic of our conversation today will be data sharing and billing for enhanced care management and Community Supports. We're going to dive in in just a moment and provide a bit of an overview of the topic and have a wonderful conversation with our panel today. But before we do that, we'd like to share a few key announcements from the DHCS team. I'm going to introduce Aita Romain from the Quality and Population Health Management Group at DHCS. Aita.
Slides 2-3	Aita Romain – 00:01:11	Thanks, Juliette. Next slide please. So we have gone through this many times, but I want to remind everyone that the end of the COVID-19 Public Health Emergency and the Medi-Cal continuous coverage requirements necessitates a coordinated phase communication campaign to reach beneficiaries with messages across multiple channels using trusted partners called DHCS coverage ambassadors. The PHE has been officially extended until mid-January 2023, and HHS has said that it would provide a 60-day notice before terminating the PHE. And at this time, no notice has been provided. Next slide please. Next slide. So the PHE Unwind Communication Outreach campaign is currently rolling out in two phases to prioritize and sequence strategies, tactic and messages across the state to prepare for the resumption of normal eligibility operations. And we ask you to join us with that. Next slide please. Back to you Juliette?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 4	Juliette Mullin – 00:02:23	<p>Fantastic, thank you Aita. So today's session is an Office Hour session. For folks who are joining a DHCS Office Hours for the first time, I will give a little brief orientation of what this session is going to look like and how we're going to have this conversation today. So an Office Hour session is a Q & A conversation with DHCS leaders and stakeholders who are implementing CalAIM across the state. Each Office Hour focuses on a very specific implementation topic and generally comes in follow up to kind of a longer form webinar done previously by DHCS. Today's topic is a follow up to a webinar that DHCS hosted in early November on data sharing and billing for ECM & Community Supports. I'm going to kick us off first and foremost with some introductions in just a moment and give everyone here an opportunity to meet all of the panelists we have joining us today.</p>
Slide 4	Juliette Mullin – 00:03:20	<p>I will also walk this entire group through how to ask questions throughout the session today. We have a few different options for how you can participate as an attendee. I will then hand it over to the DHCS team to give us an overview of CalAIM, ECM and Community Supports just to ensure that everyone has kind of the core background knowledge needed for our conversation today. And today we'll also give a brief overview of DHCS data guidance related to these programs. Once we cover all of those overview pieces, we're going to dive into some Q & A. So we have some questions prepared for the panelists today based on questions that we received in the previous webinar, questions we've received from stakeholders and then we'll take questions from the audience as well throughout the session.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Juliette Mullin – 00:04:10	So to begin with introductions, I'm thrilled to introduce our DHCS leaders who are joining us today to answer questions and provide an overview of ECM and Community Supports. From the managed care quality and monitoring division, we have Michelle Wong and Tyler Brennan who are going to be here to give us an overview and answer questions relating to Community Supports. And from the quality and population health management division, we have Aita Romain and Dr. Shaw Natsui who are here to answer questions related to ECM.
Slide 6	Juliette Mullin – 00:04:42	We also have a wonderful panel of CalAIM providers. These are three different organizations who are implementing CalAIM in different parts of the state. From the Alameda County Healthcare Services Agency, we have Bridget Nolan Satchwell and Jennifer Martinez from Welbrook Partners, consultants that work with Alameda on their data work. As well as Jeanette Rodriguez from the Housing Services Director at Alameda County. From Bay Area Community Services, we have Jamie Almanza, the CEO. Renee Tripp, the director of finance and administration. And Shamima Abdullah, the ECM program manager for Bay Area Community Services, a provider of ECM and Community Supports in the Bay Area.
Slide 6	Juliette Mullin – 00:05:26	And finally, from Ceres Community Project, we have Brenda Paulucci-Whiting, the Chief program manager. And Karin Pimentel, the contracts manager at Ceres Community Project, which is a provider of medically tailored meals in Marin, Sonoma and Yolo county. All three of these organizations joined us on November 10th to give us an overview of their workflows that they've established for data sharing and billing and invoicing for ECM and Community Supports. Today we're going to do a little bit of a recap of those presentations briefly and then we'll take time to answer any questions from the audience today about how they implemented their workflows, any tips that they have for organizations that are getting started or trying to work through any challenges that you're facing.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Juliette Mullin – 00:06:17	So how can you participate? How can you ask those questions? So as I noted, a lot of the questions that I will be asking today are sourced from previous webinars. There are two core ways that you as a participant today are welcome and invited to participate in the session. The first is to use the meeting chat. We have an open chat today and you're able to just drop any questions that you have in there throughout the session. We may answer some of them directly in the chat, but we'll probably take a lot of them and ask them out loud so that we can kind of build those and weave them directly into the conversation as we're seeing them.
Slides 7-8	Juliette Mullin – 00:06:52	You're also welcome to share any of your own experiences or responses to some of the questions we talk through today in the chat. In addition to using the meeting chat, we will provide an opportunity for folks to actually ask a question out loud and you'll be able to do this by getting in quote unquote "line" to ask a question using the hand raise functionality in Zoom. And I'm going to invite my colleague, Emma, to give us a brief overview of how you can raise your hand, especially if you've joined us via phone only today.
Slide 8	Emma Petievich – 00:07:22	Participants must raise their hand for Zoom facilitators to unmute them to share comments. The facilitator will notify participants when we will take questions from the line. So if you logged on via phone only, press star nine on your phone to raise your hand, listen for your phone number to be called by the moderator, and if selected to share your comment, please ensure you are unmuted by pressing star six. If you logged in via the Zoom interface, press raise hand in the reactions area and if selected to share your comment, you'll receive a request to unmute. Please ensure you accept before speaking.
Slide 9	Juliette Mullin – 00:07:55	Thank you Emma. So with that, before we get into a conversation with all of our panels today, we'll do a little bit of overview as I noted, and I'm going to hand back to Aita to provide an overview of CalAIM, ECM and Community Support. Aita.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Aita Romain – 00:08:10	Thank you. Next slide please. So as many of you know, CalAIM or California Advancing and Innovating Medi-Cal is a bold medical transformation that expands on the traditional notion of the healthcare system. It's much more than a doctor's office or hospital, it also includes community-based organizations and non-traditional providers that together can deliver equitable whole person care. It requires the commitment and hard work of many partners, asking each to move beyond traditional roles and embracing new and more collaborative role in providing care and services. This is a multi-year transformation and as with many transformations on this scale, there will be challenges and we will adapt and evolve as we go.
Slides 11-12	Aita Romain – 00:08:52	Next slide please. In January of this year, DHCS launched the two key components of CalAIM that we will be discussing today. Enhanced care management or ECM and Community Supports. Next slide please. Enhanced care management or ECM is the new Medi-Cal benefit intended to support comprehensive care management for Medicare Plan enrollees. This benefit is designed to address the clinical and nonclinical needs of the highest need enrollees through intensive coordination of health and health related services. Enhanced care management is provided to enrollees wherever they are, whether that is at home, on the street, or at their doctor's office. This is a core component of enhanced care management. The seven core services of enhanced care management are; outreach and engagement, comprehensive assessment and care management plan, enhanced care coordination, coordination of and referral to community and social support services, member and family supports, health promotion and comprehensive transitional care. Enhanced care management is part of the broader CalAIM population health management system designed through which managed care plans will offer care management and interventions at different levels of intensity based on member need with ECM as the highest intensity level.

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Slide 13	Aita Romain – 00:10:14	Next slide please. Enhanced care management is now live statewide for all the listed populations. And then on this slide, we also outlined some of the populations going live in 2023, including our children and youth population of focus, which will go live in July 2023.
Slide 14	Aita Romain – 00:10:36	Next slide please. Community supports are services that Medi-Cal managed care plans are strongly encouraged to, but not required to provide as medically appropriate and cost effective alternatives to the utilization of other services or settings such as hospital or skilled nursing facility admissions. Community supports are designed to address social drivers of health, and these are factors in people's lives that influence their health. And addressing these social drivers of health is key to advancing health equity and helping people with high healthcare and social needs. There are 14 pre-approved Community Supports that managed care plans may offer to members. Those are listed right here. Different managed care plans offer different combinations of Community Supports. A list of elections by a managed care plan and county can be found on the DHCS website. And managed care plans must follow the DHCS standard's community support service definitions in the policy guide, but they may make their own decisions about when it is cost effective and medically appropriate.
Slide 15	Aita Romain – 00:11:42	Next slide please. And I believe I'm handing it over to Tyler Brennan.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Tyler Brennan – 00:11:51	<p>Hi. Good afternoon everyone. My name's Tyler Brennan, I'm with the Department of Healthcare Services and I'll be walking us through these Next slides. All right, so the big picture. The sharing of information is critical to the successful implementation of ECM and Community Supports. Specifically, it's expected that information is shared among providers, managed care plans, counties, community-based organizations and with DHCS. DHCS has released guidance to standardized information exchange to increase efficiency and to reduce administrative burden. Today we'll explain the member level information sharing as well as billing and invoicing needed for ECM and Community Supports. In so doing, we will spotlight how providers have worked with their managed care plan partners to implement DHCS guidance and enable a better data exchange. For participants who are looking for a deep dive into each guidance document that we'll cover today, our team's going to drop a link ... actually potentially several links in the chat below, including a link to our August webinar on this topic.</p>
Slide 17	Tyler Brennan – 00:12:46	<p>Next slide please. Okay, so before we look at the specific data flows, I want to highlight that there are several data sharing and reporting guidance documents all available on the DHCS website to support organizations in implementing data for ECM and Community Supports. Our team, again will provide links to each document in the chat as we proceed through these Next slides. First, the ECM member level information sharing guidance provides standards for data exchange between managed care plans and ECM providers. Second, the ECM and Community Supports coding options provides guidance outlining, updating HCPCS codes and modifiers for both ECM and community support services.</p>

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Slide 18	Tyler Brennan – 00:13:26	Next slide please. All right, third, we have the billing and invoicing guidance, which provides standard minimum necessary data elements, which managed care plans need to collect from ECM and Community Supports providers if they are not able to submit claims to their managed care plan partners. Fourth, the National Provider Identifier Application Guidance, NPI application guidance instructs ECM and Community Supports providers of non-traditional healthcare services on how to obtain a national provider identifier.
Slide 19	Tyler Brennan – 00:13:57	And Next slide please. Next, we have the social determinants of Health or SDOH coding guidance, which contains a list of DHCS priority SDOH codes for managed care plans and providers to utilize one coding for SDOH to ensure correct coding and capture of reliable data. Finally, number six, the quarterly implementation monitoring report, supports quarterly managed care plan reporting requirements and provides an Excel template related to ECM and Community Supports implementation.
Slide 20	Tyler Brennan – 00:14:26	Next slide please. These six guidance documents support the implementation of the key data flows that we've outlined here. This visual on the slide provides an overview of the key data flows, which support ECM and Community Supports implementation. At a high level, you can see here that information about ECM is shared back and forth between the managed care plan and with ECM providers to support the delivery of ECM to eligible members. Community Supports and ECM providers also send claims or invoices to managed care plans for the services they provide. And finally, managed care plans share data on implementation progress, encounters and outreach with DHCS. And with that, I believe I'm passing things over to Juliette.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Juliette Mullin – 00:15:09	<p>Thank you Tyler. Thank you Tyler and Aita for that overview of the programs and the core data flows and data guidance documents that help providers build the workflows needed to support the data sharing needed for ECM and community support. As I noted at the top of our call today or at the top of our session today, this session is a follow up to a webinar that DHCS hosted on November 10th with all of the organizations who are present today. And we're really excited to get an opportunity to ask some follow up questions of all of these organizations. They shared a lot of great information about how they established data sharing workflows for ECM and Community Supports, and then how they built billing and invoicing infrastructures needed specifically and especially in the community support space was a big focus of our session on the 10th.</p>
Slide 20	Juliette Mullin – 00:16:03	<p>Before we started to go into the Q & A with all of our panelists, I did want to just take a second, with my colleagues, we've had a chance to reflect a little bit on what we learned in that session on the 10th and really what our big takeaways were from listening to all of the presenters share their experiences. And I wanted to invite Lori Houston-Floyd and Kevin McAvey to share some of our core takeaways and some of the big pieces that we walked away from that presentation with. And I'm actually happy to go first. I think one of the big things and one of the big themes we heard across all three organizations was really the critical importance of partnership with the managed care plan, across Ceres, Alameda and Bay Area Community Services, all three organizations really talked us through how they worked hand in hand with their managed care plan partners to work out how they were going to establish these workflows and then turn them into a reality. So that was a big takeaway for me. Lori, I'm curious, what was your big takeaway that you'd share with the group?</p>

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Slide 20	Lori Houston-Floyd – 00:17:08	<p>Yeah, thanks Juliette. I think for me it was just striking how we were speaking with three pretty different organizations. On the one hand, we were speaking with Bay Area, their longstanding organization with a deep history in the communities they serve. And they came to this work with a lot of data infrastructure and they were a pretty savvy data organization, but they really talked about how essential the department's standardized data sharing guidance was for them in shaping their journey and helping CalAIM to be a success for them in the initial year of implementation. And I think Alameda County, very similar story on that front, a long legacy of infrastructure building with their participation in the Whole Person Care pilot. But then really interestingly on the flip side, we had Ceres CBO that really had to stand up their infrastructure in really short order and they too really just emphasized the importance of having standards out and available to help shape and inform this important work. So that was a key takeaway for me. Kevin, so curious to hear your thoughts.</p>
NO SLIDE	Kevin McAvey – 00:18:15	<p>Yeah, so one of the things, so just kind of reflecting back on where we started this journey working with plans and providers a year or so ago to develop these standards is wanting to develop standards that are also flexible. Really thinking about what are the baseline minimum requirements of information that needs to be exchanged between managed care plans and ECM providers. For example, the sequence to make it administratively as simple as possible to receive and interpret the transaction, but also allow a certain amount of flexibility based upon existing arrangements, managed care plans might have with providers and allow a little bit of creativity between some of these new arrangements that are established. That was reflected I think in some of the conversation about the transaction methods for these files, whether it's through web-based portals, SFTP transmission or secure email, and also the format of the files themselves.</p>

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NO SLIDE	Kevin McAvey – 00:19:12	<p>For example, in the member information file, I think as we were envisioning it, one way to do this would be to have an Excel workbook where a certain number of columns are completed by the managed care plan and transmitted downstream and then a certain number of columns for each of those member records are left blank, but then populated by the provider and boomeranged back up to the plan. But other managed care plans and providers have thought about new creative ways to do that and implement those standards in portal format for example, that still allows it to be really efficient and effective. So setting minimum standards seems to be working and thanks to the survey we did, we know is well appreciated in the field. We're always looking to continue to refine this guidance. So any additional comments are always welcome on at the DHCS email address, but knowing that standardization with flexibility is working is always gratifying to hear.</p>
NO SLIDE	Juliette Mullin – 00:20:13	<p>Okay, thank you both so much for sharing and I think that sort of provides our audience here today a little bit of a recap from what we really heard from these three organizations when we spoke with them a few weeks back, acknowledging that for folks that were in that webinar, it was a few weeks ago now and then we may have some people today who maybe did not have an opportunity to maybe see that webinar. And we will be posting that on the DHCS website shortly and you'll be able to access that link to the webinar on the ECM ILOS webpage, which we've dropped in the chat earlier today.</p>

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NO SLIDE	Juliette Mullin – 00:20:48	<p>So with that, we're going to dive into some Q & A and I'm going to have my eye on the chat and pull some questions into the conversation as we proceed. I'd love to kick it off with Alameda County and we'll start kind of high level to give people a good orientation to your work and how you're structured for ECM and Community Supports. So as you shared in early November, Alameda has a unique model for supporting data exchange and billing in which the county serves as kind of an intermediary for CBOs conducting the data exchange and billing with NCPs on their behalf. Can you tell us a little bit about that model, how you created it and how it works?</p>
NO SLIDE	Jeanette Rodriguez – 00:21:32	<p>I can get us started and pivot to Bridget and Jennifer. I'm Jeanette Rodriguez from Alameda County, Office of Homeless Care and Coordination. It's definitely been an iterative process in planning and in creation of our data exchange. What we had modeled in our previous conversation in November was the use of our Homeless Management Information System, so HMIS coupled with our Social Health Information Exchange, so our SHIE to really extract and do data bumps with our information. When we use our HMIS system, what has been helpful is that the community-based organizations that we work with, because in our model healthcare services agency with Alameda County serves as an intermediary between the managed care plans and the community-based organizations providing Community Supports. What we really honed in on was the agency's familiarity with using our HMIS system. They'd been doing data entry and service coordination in HMIS for multiple years.</p>

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NO SLIDE	Jeanette Rodriguez – 00:22:33	What we had pivoted to with the use of Community Supports is an extraction in a monthly cadence where we're extracting the data from HMIS and bumping it with our SHIE information and sending that information to the managed care plans. So it's been a really iterative process with this monthly cadence of data that's being extracted, bumped maps together and we're using that for our request for authorizations, for our billing and claiming, we're also using it for our services entry for housing deposits. And then I'll pivot to Jennifer and Bridget to share a little bit more about the mechanisms.
NO SLIDE	Bridget Nolan Satchwell – 00:23:12	Yeah, I can take that one. And Rajib Ghosh from our team is also on the line from Health Roads and he led the team that really made this technical piece happen. But like Jeanette said, we really wanted the providers to be able to use a system they were already using. And so as they enter an enrollment into HMIS, Rajib's team has it set up that it sort of pings into a dashboard that we have for Jeanette and her team that lets them know this person needs an authorization. Then they're able to pull that information down already bumped on the back end.
NO SLIDE	Bridget Nolan Satchwell – 00:23:47	Again, thanks to this technical piece where the behind the scenes that HMIS data comes in and gets bumped with the data we get from the health plans on who their members are. And so if Bridget Satchwell, a service is entered for me in HMIS, then I come in, oh, I might ping as being with Alameda Alliance. So then Jeanette's team knows who to send the authorization request to. And the provider on the front end doesn't have to worry about any of that. They can just provide the person the services regardless of which health plan they're with, which was a really great piece there.

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NO SLIDE	Bridget Nolan Satchwell – 00:24:21	<p>And then later at the end of each month, we're able to pull the full month of service that's taken place for clients, see which health plan they're with, see if people have had health plan changes, and make sure that the right managed care plan gets billed for the right individuals. And it also means that providers only need to give us the critical information that we can't get anywhere else. A lot of the information we can auto-populate into the templates that the managed care plans need because it doesn't change month to month. So really everything is set up to do as much as possible to reduce the burden on that front end CBO provider to really free them up to do the good work that they do and let this backend piece worry about a lot of the details and administrative lift.</p>
NO SLIDE	Juliette Mullin – 00:25:16	<p>Great. Thank you for providing that overview and kind of elaborating on what you had shared earlier in the earlier webinar. So you've spoken a little bit to the model itself and some of the elements of how you set that up. Could you walk us through a little bit how you partnered with your managed care plan to build all of those systems and what that partnership looks like and any recommendations you have for organizations that are starting to do this on how to work with a managed care plan?</p>
NO SLIDE	Jennifer Martinez – 00:25:48	<p>I can jump in there just a little bit on the data side of things, especially where we were coming into the CalAIM space and then sort of developing the program work together, Jeanette would love to pass that to you. Just with the Social Health Information Exchange that we stood up through the course of Whole Person Care leading up to CalAIM, we had developed a process already that we're receiving both membership and claims from both of the two managed care plans that we have in Alameda County and then also a regular data feed from HMIS. So that was kind of among many other data feeds we had already gotten practice in receiving, understanding the nuances of that information, being able to match that well between records and doing some really complicated kind of deducing when they're near matches so that then when we were well poised to add on these components of authorization and claiming as well.</p>

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VISUAL	SPEAKER – TIME	AUDIO
NO SLIDE	Jennifer Martinez – 00:26:40	So we did that initial work, but then when we got to the CalAIM space, needing to kind of develop and strategize together about how we manage this new kind of claiming structure that kind of took on a new flavor that the OHCC program team led. Jeanette, do you want to go from there?
NO SLIDE	Jeanette Rodriguez – 00:27:00	Sure. We've had a lot of conversations with our managed care team plans and development of the HMIS system. What we utilize, as Bridget mentioned earlier, is the use of projects in HMIS, so enrollments and exits and we're also in development with the plans on doing a lot of technical assistance in QA processes with the agencies. I want to make sure I answer the question. What was the last outstanding piece?
NO SLIDE	Juliette Mullin – 00:27:39	I think that the last outstanding piece is really as we have organizations in the chat today that maybe are starting ... are much earlier in the process or just beginning to set up these workflows and work with a managed care plan partner, what advice would you have for them?
NO SLIDE	Jeanette Rodriguez – 00:27:57	I think a lot of the communication and importance is recognition. I think somebody else had brought it up earlier as well is that we're working with community-based providers that are new to the managed care front. So where we can focus in and hone on database systems that currently work in terms of how we're already collecting information, how we're already supporting individuals and how we can really enhance the system of care and the system of services, that's important. It's also important I think with our communication with the managed care plans that the HMIS system may be something that's unfamiliar to them and what availability there is in our HMIS systems, what reporting availability there is. It seems like where we continue to broaden our own horizons is to bridge what database systems exist, which are in different systems of care and where there are ways that there's intersectionality.

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NO SLIDE	Juliette Mullin – 00:28:53	Great, thank you. I'm going to transition in a moment to ask some questions of Bay Area Community Services, but before I do that I want to acknowledge we're getting a good number of questions in the chat and I want to pause and answer a few of them or address a few of them right now. We will do our best to answer as many of them in the chat as possible, but I'll also ask if Carley Clemons on the Manatt team could actually drop the email, the ECM ILOS inbox information in the chat for any questions you have that are about detailed DHCS guidance that we don't get to today. We really do invite you to email us there so that we can respond to it via email because we have a good number of detailed questions coming through in the chat and we may not have time to get to all of them today.
NO SLIDE	Juliette Mullin – 00:29:42	One question I'd love to touch on, and Tyler I'm hoping maybe you could answer this one for us is a question about NPI. So we do have a question in the chat if you could elaborate on what getting an NPI looks like for a non ... for, I'm going to use the term in the chat, non-healthcare provider. What are the criteria that a social services provider would have to take to get that?
NO SLIDE	Tyler Brennan – 00:30:10	Sure. And this is actually the exact reason we created and put out that guidance on our website. So we would highly encourage you to visit the link that we dropped in the chat. We talk about in that document, what is an NPI, who must have one, and all ECM and Community Supports providers must have an NPI. We also lay out the process detailing how an organization can apply and what it looks like to actually receive an NPI and utilize it on the day-to-day. And finally, we actually do go through and give a step-by-step NPI application process walkthrough in that guidance. So happy to answer any more specific questions if needed.

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NO SLIDE	Juliette Mullin – 00:30:45	Great. Thank you, Tyler. And just to reiterate, I know you noted this, but the link to that guidance document is in the chat for folks. I'm seeing a few questions about congregate living health facilities. I know these were actually raised in a recent webinar, a recent Office Hours that we held. And so I just want to note that that is a question that we have taken back, and the department has taken back. So we will provide an update on that when we have one. At this time we do not, but thank you for continuing to raise the issue and it's something we are looking at.
NO SLIDE	Juliette Mullin – 00:31:20	Let's take a look here. I do see there is a request in the chat, but I'll just sort of open up to all the participants today. We have a lot of people on the line today and we have an organization requesting if there are any HMIS providers who would be willing to speak with the COC that's posting the question in the chat about how they have set up and opened up their HMIS system. Any organizations that have joined us today, please feel free to respond and reach out if you would be willing to connect.
NO SLIDE	Juliette Mullin – 00:31:50	Continuing on, I think what we'll do from here is we'll just keep going and we'll start to ask some questions to Bay Area, but please continue to drop your questions in the chat as we go. So would love to move to Bay Area Community Services and it would be great if we could start just with a brief overview of your ECM and Community Supports programs at Bay Area Community Services.
NO SLIDE	Jamie Almanza – 00:32:20	Yeah, hi there everybody I can start and I have my colleagues here, Shamima and Renee, so definitely feel free to jump in. But we started in Alameda County contracting with the local health plan, the alliance to bill ECM services and Shamima is our program manager who can talk about what those services are. Then Renee certainly can talk about the administrative implementation of those services.

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VISUAL	SPEAKER – TIME	AUDIO
NO SLIDE	Shamima Abdullah – 00:32:47	Good afternoon everybody. Excuse me. I'm glad to be here and be able to speak on regarding ECM services and support that we give. I think earlier someone mentioned that we serve individuals from a high range of need to someone with mild needs. The support that we have been giving in the community lately has been a triage to try to figure out what services an individual is connected to, what service an individual is not connected to. If they have a disconnection, how do we reconnect them? How do we become a liaison in between a provider and the member being able to bring them a service that they need, whether it's social services, medical, any goal that will reach them to their independence and self-sufficiency and be able to sustain in the community. Our goal is to just provide whole person care and a quality of healthcare, more preventative healthcare and less emergency room visits and emergency services to our population.
NO SLIDE	Renee Tripp – 00:33:48	Awesome, thanks Shamima.
NO SLIDE	Juliette Mullin – 00:33:51	Go ahead Renee.
NO SLIDE	Renee Tripp – 00:33:51	I'll just jump in really briefly with our setup and exchange. We worked very closely with our managed care plan. We had previously done the health homes program, so Alameda Alliance and BACS worked together to really hone the systems that we needed to present the data and back and forth to them. We streamlined then from the health homes program into ECM, making sure that we could eliminate as many of the barriers to getting reporting data and billing data to them and sort of lower the threshold of work that we were doing from the health homes program. And then we also used our QIA and data analyst teams to take data from our existing programs, cross reference with our existing folks so we could make sure that if we had an existing connection to somebody that was on our eligibility list that we could reach out to them efficiently and a lot of back and forth with the managed care plan to ensure that we were fully operationalizing the program.

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VISUAL	SPEAKER – TIME	AUDIO
NO SLIDE	Juliette Mullin – 00:35:13	That's great, thank you for sharing that. So in the webinar in November you walked us through how you built specifically your data workflows and the work that you did in partnership with your managed care plan around that piece of building up the infrastructure that you need for ECM and Community Supports. Can you walk us through a little bit of what that experience was like and similarly to Alameda, any recommendations or advice you would give to an organization that is starting this process?
NO SLIDE	Renee Tripp – 00:35:43	Yeah. So we developed on our Microsoft Teams, a private channel that we could communicate and make sure that our data files were all in a location that can be accessed by all our different staff and people that need to access that data. So really making sure that you have a single source of truth for information that then staff and managers and so forth can access and update and then that taken and given to the providers on a regular basis. Alameda Alliance, our managed care plan is very good about setting up the technology, the FTP sites that we upload documentation and billing sheets too. And then they also give us feedback if something's not correct, if there's data that's missing. And then they will also let us know if any claims have been rejected and so we can then go back and look at why they were rejected and refile those claims if needed.
NO SLIDE	Juliette Mullin – 00:36:58	Great. Thank you, Renee. Just looking at the clock, I'm going to move us along to Ceres for a moment and ask a few questions to Ceres as well. So Ceres as I noted a little bit earlier in today's session, Ceres is the community-based organization focused on providing medically supportive foods. So I know Karin, you and your team, you had to build a lot of new processes and infrastructure to be able to do the data sharing and the billing needed for Community Supports. Can you walk us through kind of first how you became a Community Supports provider, how you kind of started to work with Partnership Health Plan to become a Community Supports provider and then how you worked with them to build the data workflows that you needed.

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VISUAL	SPEAKER – TIME	AUDIO
NO SLIDE	Brenda Paulucci-Whiting – 00:37:48	Hi, I'll start and then Karin can jump in on the workflows part. I'm Brenda Paulucci-Whiting, Chief program officer with Ceres. And we began working with Partnership Health Plan of California, they are our managed care plan here in late 2017 and early 2018. And specifically when the state authorized funding for a statewide pilot of medically tailored meals in which we were involved. And then strategically we started to build this partnership. We began attending many of the CalAIM stakeholder meetings. We had support from the California Food Is Medicine Coalition, CalFIMC to begin building awareness and relationships with health plans. And then we started engaging with health centers as referral partners and deepened those partnerships by working together on demonstration pilots.
NO SLIDE	Brenda Paulucci-Whiting – 00:38:37	So for instance, we would provide medically tailored meals to patients with hypertension or seniors with depression and at least one chronic illness. We had a pilot for pregnant women with gestational diabetes and then we participated in a large randomized control trial with Kaiser for medically tailored meals. And along the way we kept sharing this information with Partnership Health Plan, sharing the research findings, intervention designs and the eligibility frameworks and to keep an open dialogue with them.

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VISUAL	SPEAKER – TIME	AUDIO
NO SLIDE	Brenda Paulucci-Whiting – 00:39:09	<p>And then operationally we began participating in a Ceres of CalFIMC trainings on claims billing, data and IT security and contracting with healthcare. We went through the process of obtaining our national provider identifier. We had a registered dietician that we already had on staff and then we began this process of deliberately garnering board support so that we could begin investing in the resources. And some of those initial investments included hiring me and my role and Karin as contracts manager and we both have backgrounds in healthcare and revenue cycle management. We contracted with an organization to perform an S2 audit of our HIPAA policies and practices and we've been continually meeting monthly for oversight and continual improvement there. And then we participated in a lot of cross exchange and resource sharing with organizations on the same path and all of that led up to us signing a contract with partnership in late 2021 to launch the benefit. And then Karin can talk about some of the workflows.</p>
NO SLIDE	Karin Pimentel – 00:40:14	<p>Sure. Thanks, Brenda. So there's really like two parts the way I see it to creating a workflow and the first part is actually building out the technology and the systems that you need. And then there's training once you have all of the systems in place and everything built, how do you actually roll it out and who on your team is going to be using this new technology? And so we had to first build, so we had to build a standardized medical referral form for healthcare providers so we could collect more accurate diagnosis in substantiating lab data as justification for the Community Supports benefit. We also needed to have this information drop into our CRM, which is Salesforce in a manner that's HIPAA compliant. So we had to research the right solution and we landed on Jotform, which is a really affordable solution and integrates a Salesforce. And then we needed to reconfigure Salesforce so that the medical referral and the new information could map into our system properly. So that was part of the build phase.</p>

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NO SLIDE	Karin Pimentel – 00:41:28	Then we needed to train our client care coordinators on how to collect insurance information in a way that minimized errors leading to claim denials. And we had to incorporate the Medi-Cal verification part into the intake flow and train staff on how to properly verify if a client has Medi-Cal. And then we had to change our intake workflow so we could gather this information upfront and determine eligibility for the benefit and then expedite our ability to put our clients onto the program. So now we're exploring ways to automate eligibility assignments. It's a manual process for now. So I review intakes daily and assign them their eligibility and we're working on training our care coordinators on how to identify qualifying clients and I work with a data analyst and we hold the entire claims billing process including the treatment authorizations. So next we're going to look at how we can seat that within our client and nutrition care staff and where we might need additional capacity. So that was the building and then the rollout of how we implemented new workflows.
NO SLIDE	Juliette Mullin – 00:42:50	Great, thank you so much Brenda and Karin for that. I'm actually just going to take a question from the chat right now that's directly ... it's a direct question to what you just spoke to, Karin. Could you share the name of the platform that you used the integrated Salesforce?
NO SLIDE	Karin Pimentel – 00:43:03	Jotform. J-O-T-F-O-R-M.
NO SLIDE	Juliette Mullin – 00:43:06	Jotform.
NO SLIDE	Karin Pimentel – 00:43:06	Yeah, Jotform.
NO SLIDE	Brenda Paulucci-Whiting – 00:43:09	It's really affordable. We were looking at something that was like \$23,000 to integrate with Salesforce. Jotform is \$247 annually and you can pay more if you expand licensing and branding, but it works for our needs, especially as just a small growing nonprofit.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Juliette Mullin – 00:43:34	Great, thank you. I do want to at this stage invite folks in who are participating today to raise their hand. If you would like to ask a question kind of out loud to the participants, to the panelists that we have today and hear from Bay Area or Ceres or Alameda County, how they have implemented something or how they've addressed a challenge maybe that you are facing. The folks on our panel today would be happy to share their wisdom and their experience on that. I will just note as people are thinking about their questions, if you have a very detailed question about guidance, like a specific code or anything like that, we do recommend sending it to the inbox because those can be tricky to answer live in a webinar. But we will do our best. And I see a first-hand raised.
Slide 22	Emma Petievich – 00:44:32	Carol West you should be able to unmute.
Slide 22	Carol West – 00:44:36	Yeah. It sounds like you're doing a lot of work to try and reduce the amount of work that each person has to do for the billing process. And I am a community health worker and interested in whether you have as part of your workflow with your care coordinators, if they have electronic handheld devices that link into your electronic records or your billing workflow or whether that is a paper process that has to be done when they get back to the office?
Slide 22	Juliette Mullin – 00:45:09	Great. I'm wondering Ceres if you maybe want to take a first pass at that question.
Slide 22	Karin Pimentel – 00:45:19	I don't know. If I'm understanding your question correctly, we don't have people out in the field if that's what you mean, where you need something if you're not in your office to electronically put that information in. Is that what you're referring to?
Slide 22	Carol West – 00:45:39	I guess it's really about how do you document the services provided or is that all happening in your office? Is that all office based?
Slide 22	Brenda Paulucci-Whiting – 00:45:52	Oh I see.
Slide 22	Carol West – 00:45:52	I guess I don't really understand your model. I assumed that you had people out in the field delivering meals.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Brenda Paulucci-Whiting – 00:45:59	We do and we have volunteers, we call them delivery angels that deliver all of our meals and we use Salesforce to track all of our culinary, our client care and our volunteer operations. And so we have volunteer schedules that populate like six months out and we take attendance essentially and then we track all of our meal production in the system. And so every meal that's made runs through Salesforce and tracks and stamps to each client and then we track funding sources against those different services. And similarly with registered dietician like nutrition consultations we track the same way. So it's all done electronically and some automated and some manual processes.
Slide 22	Carol West – 00:46:54	Okay, thank you.
Slide 22	Juliette Mullin – 00:46:56	Well and I'm wondering Carol if maybe your question is more geared toward an ECM provider. I'm wondering if Shamima or Renee or Jamie you want to weigh in on how Bay Area approaches this?
Slide 22	Shamima Abdullah – 00:47:08	Sure, I will. The way we work with our partners in outreach, I actually coordinate all the outreach. I make contact with just about every single individual that's on our outreach list. I conduct a team decision making, we call them TDMs where I set up a meeting with if there's care providers that I can identify in CHR or any of our database systems or where the referral comes from. We gather a lot of our information from there before we meet with the partner, their age, if there's any important information that the case managers want to pass down, treatments.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Shamima Abdullah – 00:47:41	Since we are community based, our staff do have laptops. So as long as they're in a secure area, we have offices throughout our Bay Area that once they get done with their individuals for the day, they can report back to the office where they can document their notes or their engagement with the individual. And weekly they send that or we look at their spreadsheet and we implement the dates into the database system that we send over to Alameda Alliance. So our work is really field-based. We are on the go all the time and we have our laptops, we work wherever we are at and wherever it's safe for us to work, with the also confidentiality of people's records and making sure those things are not exposed as well.
Slide 22	Juliette Mullin – 00:48:21	Great, thank you for that. And I see another hand raised.
Slide 22	Emma Petievich – 00:48:33	Great. Vera L you should be able to unmute.
Slide 22	Vera Lee – 00:48:37	Sure. Hi this is Vera. I have a question. So we are applying to be a ECM provider with our partnership in our region. So just a question on any tips about if we do have a small caseload like 45, caseload provide like a community base ECM, what's your recommendation of what to prepare and also especially billing and claim, do you see the benefit to have a billing vendor or is it very doable because it's internally give to MCP to do it? Or you recommend have a billing expert to facilitate the process?
Slide 22	Juliette Mullin – 00:49:19	Thank you for that question. I'm wondering if the Bay Area C is willing to take that one. Great.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Renee Tripp – 00:49:24	Yeah, I can speak to that a little bit. I think that as long as you have a dedicated person who is your expert in the billing, that can really work hand in hand with the managed care plan to develop the spreadsheet. The billing has really been simplified compared to previous programs and need for forms for each encounter and all sorts of different things. So it's pretty simple. You just have to keep track of your encounters for each client and your outreach activities. So you do have to be methodical about entering that into some sort of spreadsheet. Like I said, we use Microsoft Teams so that all the team members have access to the same spreadsheets and then we do have a QIA that populates those sort of repetitive fields that need to be populated and then submitting that via a secured source. So it's not overly complicated, but it does take time and dedication. So you have to make sure you have somebody who's your key person who's responsible for that, for sure.
Slide 22	Vera Lee – 00:50:34	Thank you, Renee. Just a quick follow-up question, so the reimbursement, if we are new, if looking for reimbursement will be on tier or to support the salary or what's the expectation or timeframe?
Slide 22	Renee Tripp – 00:50:47	Okay. I just want to say that billing is ... I mean receiving the funds and how they decide what rate it's paid at and what encounters will be paid is the most difficult process to communicate with the managed care plans. It's very different for us anyways because we weren't billing like this previously. So you really have to be very particular and clear with the managed care plan as to what reporting. And for housing and Community Supports, I believe it's much more specific as to what is your option for billing. But in ECM you have a variety of levels of billing.

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Slide 22	Shamima Abdullah – 00:51:39	And I would also just add to that, within the first 90 days they allow you to deal ... you can deal within a high tier, meaning four or more services, is considered a high tier. Then we have a low tier, which is one service a month per individual. Everybody that comes into our service, we try to give them a 90 day high tier and come up with a health action plan. So we spend more time with those individuals as well. And so that part's really important to just as much time you can spend within the first 90 days. Alameda Alliance allows us to bill based on just four services, or five services or more, we're billing for a higher tier and anything less than that, we're billing at a lower tier. And if you can get all your partners in and be able to work your individual at a higher tier, you'll see a lot of revenue and coming in.
Slide 22	Shamima Abdullah – 00:52:29	But then at the same time, when it comes down to reimbursements, every probably care plan is a little bit different. Ours is within 30 days and then we should be getting an invoice saying what the breakdowns is and if there's anything missing from it. If we did not get paid, they'll let us know the discrepancy. Sometime people are taken off of the eligibility list without our knowledge, but we go back and we can rectify those within the time and say, this individual is actually on our plan and we could go back and they'll reimburse us for those within the 90 days or so.
Slide 22	Vera Lee – 00:53:00	Thank you very much
Slide 22	Juliette Mullin – 00:53:01	And thank you for your question. I see another hand raised.
Slide 22	Emma Petievich – 00:53:10	Ms. Sandra Alvarez, you should be able to unmute.
Slide 22	Sandra Alvarez – 00:53:14	Hi, I'm calling from WellSpace Health here in Sacramento and I had some questions around the ECM and how you were speaking about the acuities of patients that you see. How do you go about paneling those individuals? Do you have an intensive team that works with the individuals that have higher acuity and then once they're more stabilized they transition to other case managers that might have less experience with an intensive acuity range of individuals? Or how does that work

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Shamima Abdullah – 00:53:49	For Bay Area Community Services, for our ECM program, we do a whole person. So that individual that they're working with, we will train them to our best ability to get them, be able to support that individual. If we cannot support, we outsource and resource to those specialty programs in the community, the resources, there's plenty of services out there. So what we cannot do internally, we look externally to those partners and agencies and we form a relationship and a collaboration with those individuals. And so you're still working with the partner but you're more doing the collaboration. So I may not do the work for them, may not be the actual ... but I will be the connection for them. Whether it's their specialties for healthcare, like speech therapy and those things. We will go to those appointments. We may not do the appointments but we will assist in those areas.
Slide 22	Shamima Abdullah – 00:54:35	And then also making sure that our staff is trained not just in the field of working with individuals that are high risk, but also mental health, understanding healthcare plans, understanding what's the individual's rights to services and what medical services are provided under their healthcare plans so they can also better understand what they qualify for and how we can support them as a collaboration. Just coming into the partnership as a collaboration and when you see someone has a higher need, let's say it's severe mental health, we want to get connected to a community mental health program. That's something that we've been doing more recently is connecting our partners if they're not already connected to community mental health or whatever those specialties are and just walking with them, being with them at that time while the other partners and agencies are working with them collaboratively.
Slide 22	Juliette Mullin – 00:55:33	Thank you for that response and for that question. This time we'll invite anyone else who would like to raise their hand. Oh I see another question. Let's take this hand.
Slide 22	Emma Petievich – 00:55:53	Fernando, you should be able to unmute.

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Slide 22	Fernando Gomez – 00:55:57	Hi. Hello. I guess one of my questions would be in terms ... 'cause I saw it also in the chat, I saw it a lot in the chat was the issues ... and I'm pretty sure other agencies would probably have the same thing with billing in terms of chasing down those denials and then following up and very ... so I guess the thing would be, it's not just with one health plan, you have multiple health plans depending on if your agency has partnered with these. So I guess, what would be the best way to navigate this because I mean even if you have had certain meetings with these health plans, it continues to happen. We're at the end of the year.
Slide 22	Fernando Gomez – 00:56:38	So I guess next year in the coming year because it's going to keep going, will there be something put in place to help alleviate some of these agencies? 'Cause I know it can be very overwhelming for some agencies that are barely getting into this space and providing enhanced care management. They've maybe already provided Community Supports with housing and tenancy, but on the ECM side it can be very overwhelming with billing and...
Slide 22	Juliette Mullin – 00:57:12	Yeah, thank you for sharing that. Maybe what would be a great first response on this question is if we could ask the Alameda team to share a little bit the work that they have done around establishing batch authorization processes with their managed care plan partner and what that's looked like in Alameda.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Bridget Nolan Satchwell – 00:57:37	<p>Yeah, I'm sorry I missed part of the question but just on the batch authorization piece has been really helpful because like you said, it's so overwhelming the amount of data and to have to send one authorization at a time and then get a fax back, it became a lot to manage. And so, one of our health plans has about 80% of our Medi-Cal membership, Alameda Alliance for Health and they were just super understanding of this issue with us. And together the housing program team and Alameda Alliance developed an Excel spreadsheet that we exchange weekly where we send over a spreadsheet of the people that need to be authorized with some key information and then they send that same spreadsheet back to us with the approvals and denials and they also put the authorization number in that Excel spreadsheet for us. So we still get those faxes, the patients still get those faxes and we can always use those for reference. But that's been really helpful in just minimizing the paperwork for us. Excuse me. And then ECM, it works a little bit differently and I'm less familiar with that process.</p>
Slide 22	Shamima Abdullah – 00:58:52	<p>I think I can speak a little bit to the process of ECM. So when we usually get our referrals that come in, if they're not coming directly from Alameda Alliance, usually outside providers will fax over, send over Alameda Alliance a referral for the member. Otherwise, there is a list that's generated called the eligibility list. That list is generated and it's populated to our compliance department, which sends over to me. And then I see an active list of people that's enrolled and individuals that we have to outreach to. One thing Alameda Alliance has done that made it easier on us for consent and being able to work with a partner, we just have to get verbal consent. So while you're out on the phone with them, if you're doing telehealth and you're reaching out, there's three different tiers that you work with an individual on. If it's just a phone call that's a tier within itself or if it's like actual having a video healthcare service, that's another tier you work with individual.</p>

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Slide 22	Shamima Abdullah – 00:59:40	But you can get consent right there. Once you get consent you can enroll the partner and start working with the partner. And I think that when that works, in that aspect of not having to ask for approval for them, we already get our approval list directly from Alameda Alliance with so many individuals that we can work and it comes to us once a month with just a population and I believe we only get that list directly towards us that we could work with. So no other provider gets our list.
Slide 22	Renee Tripp – 01:00:05	And if I could just really quickly say, you do really have to cross-reference all the data you're getting back from the health plan, they will tell you why a claim has been denied. And again, making sure that you have that central source of information so you add that into the line item for that client so you know, okay, this needs to be adjusted and that's why that data analyst segment is important because yes, there's very specific tiers, you can do a lot of work and if you're not documenting it correctly, you won't receive the maximum benefit for that. So it is definitely something, especially for smaller CBOs who are just entering this, I recommend you work very closely with your managed care plans because they do want to support you in this process. Making sure that you're reaching those higher billing levels for each client that you can.
Slide 22	Shamima Abdullah – 01:01:08	And if I can encourage anything, as you are outreaching to your members, as soon as you outreach and you're able to get a consent and enroll, Alameda Alliance has made it for that month, so all outreaches will count as well as the enrollment so they will not miss out on those services. So if you outreached all month and finally at the last month you got an enrollment on them to consent to work with them, you will be able to bill your network the outreach calls or however your outreach attempts as well as the actual enrollment. So you want to move people over from your outreach to your enrollment tab so they can be on both outreach and enrollments with the exact dates that they're ... so you would be able to deal for both areas.
Slide 22	Juliette Mullin – 01:01:52	Great. Thank you. Rajib, I saw you came on camera. Did you have a comment you wanted to add on this one as well?

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Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Rajib Ghosh – 01:02:00	Well, I see that we are over time here, so I guess the process has been quite well explained. And from the Alameda standpoint, we are fortunate to have a pretty robust technology platform at the moment, which we have built and continue to build or adding to it to really track. And I think the question that the gentleman who raised that question, I think the main issue is that when you are dealing with multiple health plans, fortunately for Alameda we are dealing with only two. But if you have more than that and you have denials coming from different directions, how do you even tackle that? And I think that is the key issue. And so again, we have the experience of two health plans and what we are building is that reconciliation process, which is going to be automated. So anytime denials come in, which will automatically, it's all happening over electronic exchange, so nothing ...
Slide 22	Rajib Ghosh – 01:02:58	I mean right now there is a little bit of a manual part there. Very soon we'll go to full automation, which means the health plans and the county will send correspondence to each other all electronically, no manual intervention. And the reconciliation report will automatically throw out what are the reasons which claims got denied, which encounters got denied, and then corrective actions could be taking place. But it's a cumbersome process and I'm not going to underplay that, especially where you are dealing with multiple health plans, three, four, it's not easy.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 22-23	Juliette Mullin – 01:03:39	<p>Thank you so much and thank you to all of the panelists who've shared their wisdom and their insight and their experience implementing ECM and Community Supports today. We are going to close on this question here. I had many more questions that I wanted to ask our panelists today, but we're not going to get ... we are at time because we've had such a good time talking through all of these workflows here today. I want to thank everyone who joined today's session for their great questions. And I also had seen out of the corner of my eye in the chat, not just our panelists responding to questions, but actually participants today also weighing in with their own responses and their own experiences, which we greatly appreciate. We all learn from each other. With that, we want to thank everyone for joining today. Have a great rest of your day.</p>