Northwest Collaborative Planning & Implementation Group

Date:
Wednesday, August 22, 2023

Start/End Time: 1:00PM – 2:30 PM PT

Location:
Northwest Zoom Link
Total Number of Attendees: 38

Facilitator Organization:
Population Health Innovation Lab (PHIL),
Public Health Institute

Meeting Objectives:

1. Learn about **Partnership HealthPlan's improvements** and resources.
2. Increase knowledge of **practical solutions** to common Enhanced Care Management and Community Supports pain points and implementation challenges.
3. **Elevate the existing expertise** of local CPI participants to **learn best practices** for pre- and post-contracting challenges of implementation.
4. Gain practice using **evidence-based tools** for improved business planning modeling towards organizational success in implementation.

- **Leave with an action plan** to progress along the Readiness Roadmap.

High Level Agenda

No.	Topic	Key Questions
1.	Welcome, Community Inclusivity	-
2.	PHC Updates	• What questions do you have for PHC after attending the ECM Billing session on 8/22? • What are your clarifying questions about the ECM/CS Billing and Authorization Tips tools?
3.	Growing a Business Mindset: Tips and Tools from the Field for Successful ECM and CS Planning and Implementation	• How has your agency adapted organizational planning to weave Enhanced Care Management (ECM) and/or Community Supports into existing operations at each layer of the organization? • How have organizations in your community navigated pre- and post-contract barriers? • What tools used to evaluate the added value contracting would bring to their organizations and populations of focus?
4.	Solutioning Breakouts • *Contracted Providers Layered Solutions Breakout* • *Pre-Contracted Providers Solutions Breakout*	• At which point of the pre- or post-contract process is your organization experiencing inefficiencies in workflows or contracting? • Can you identify which of the tools provided will best help progress your organization along on the Readiness Roadmap to successful implementation?
5.	Shared Learning from Breakouts	-
6.	Wrap Up and Next Steps	-

Notes/Meeting Summary

Key Takeaways & Discussion Themes by Agenda Topic

Topic	Discussion Themes/Key Takeaways	Actions Taken/Next Steps	Best Practices/Lessons Learned
Welcome, Community Inclusivity	**Challenge for the meeting:** Reflect on your role in this health delivery system that has historically underserved populations. *Frame your thoughts and creativity for action steps through the end of this meeting to be person-centered, trauma-informed, and anti-racist.* **Check-in:** Do you have any "wins" you'd like to share? ○ Arcata House shared a client win that one of their ECM participants who had 500 ED visits last year, has had zero ED visits since the lead care manager helped him with housing.	Follow-up with Arcata House Partnership to learn about their internal referral process. ○ Share process with the Collaboratives.	• With new registrants participating in the monthly convenings, it is helpful to have a brief introduction to CPI and our role as facilitators. • Setting intentions at the start of the meeting can help form action-driven outcomes. • ECM and Community Supports providers are getting more creative in conducting outreach.
PHC Updates	**ECM updates:** ○ **ECM Authorizations:** TARS will be approved for 12 months for new enrollees. ○ **Care Plans**: Are no longer required to be submitted with the initial TAR. ○ **ECM Portal with Point Click Care/Collective Medical:** New features in development. **Upcoming event schedule:** https://bit.ly/45AR7ST	**Participate in the upcoming events hosted by PHC:** https://bit.ly/45AR7ST Review cheat sheets and share widely with collaboratives: ○ ECM/CS Billing Tips: https://bit.ly/45xxomR ○ ECM/CS eTAR Tips: https://bit.ly/3qsg7gh	• Pre-contract and Post-contract ECM and Community Supports organizations should participate in PHC's Roundtables and other communication channels to learn more about programmatic updates reflecting policy updates from the Department of Healthcare Services (DHCS). • Questions asked to clarify the reason for non-payment of outreach without enrolment. Ashley explained.
Growing a Business Mindset: Tips and Tools from the Field for Successful	**Readiness Roadmap Poll:** An implementation progress check-in was shared to learn where people are at on the Readiness Roadmap. **Journey Mapping Overview:**	**Readiness Roadmap Poll:** See Appendix A for the poll results • PHIL will reach out directly to the organizations who	• Most ECM and Community Supports providers have a business plan – PATH support is not just a new benefit, they are a shift in

ECM and CS Planning and Implementation	○ Process ○ Perspective ○ Layers **Business Planning for your future *PATH:*** ○ **PATH Initiative:** CITED, CPI, JI, TAM ○ **Business Planning:** People, Process, Technology, Cash Flow **Elevating the Expertise of Local Partners:** Hear from local providers around their approach to pain points and solutions in the ECM and CS implementation journey. ○ *Arcata House* ○ *North Coast Community Clinics*	are showing great progress and showing slow process to learn more about their implementation successes and challenges. **Continue developing a "Business Mindset":** PHIL will continue to provide opportunities and tools to develop sustainability and scaling efforts among pre-contract and post-contract organizations.	the delivery system. It means looking at the organizational plan as a whole and figuring out how to weave this into existing operations at every layer of the organization.
Solutioning Breakouts	**Contracted Providers Layered Solutions Breakout:** Post-contract Process, Tools, and Solutions_NW ○ Review process, pain point and layering in slide deck. ○ Identify organizational pain points and on the process map. ○ Leave in action: All participants will leave with a tool and action steps for their point in the ECM/CS implementation process. **Pre-Contracted Providers Solutions Breakout:** Pre-contract Process, Tools, and Solutions_NW ○ Review process, pain point and layering in slide deck. ○ Identify organizational pain points and on the process map. ○ Leave in action: All participants will leave with a tool and action	**Adapt new tools and resources to Pre-Contract and Post-Contract Process, Tools, and Solutions:** • PHIL is developing a business planning tool with Camden Coalition. Tools such as this and more will be added to this tool-kit for organizations in any stage of contracting. • Include z codes and g code requests in the Issue Tracker. Follow up with Collaborative upon update (See Appendix B-D for peer resources). • Include CalAIM Initiative information for school-based clinics. Follow up with Collaborative upon update (See Appendix D for links).	**Pre-Contracted Pain Points, Opportunity, and Solution:** • A school-based clinic from the Collaborative is in the discovery and pre-contracting phase of ECM. ***Peer Recommendation:*** ○ *Learn about financial strategies and g-codes to move work forward in the contracting process.* **Post-Contracted Pain Points, Opportunity, and Solution:** • Program sustainability is a concern for some FQHC's. This includes needing to fund case managers, maintaining a case load, and administrative time. • Billing and reimbursements remain a challenge for some Community Supports organizations. ***Peer Recommendation:*** ○ *Meet with Partnership to go through billing and understanding what can be approved/ denied and what data would be they can accept.*

	steps for their point in the ECM/CS implementation process.		○ *Ask for G codes and when to use them to better support financials.*
Shared Learning from Breakouts	**Breakout group representatives share at least one actionable step to move forward in their process.**	• Invite leadership from Humboldt Continuum of Care.	
Wrap Up and Next Steps			

Identified Gaps/Challenges in CalAIM/ECM/Community Supports

Topic	Gaps/Challenges Identified	Actions Taken/Next Steps	Best Practices/Lessons Learned
-	-	-	-

Identified Successes Experienced by Participants

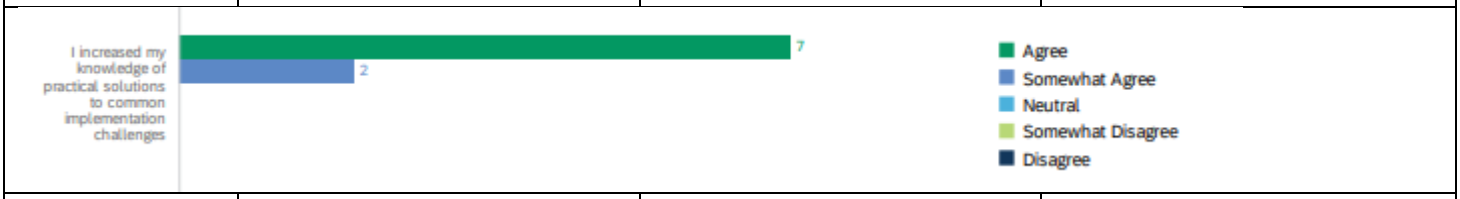
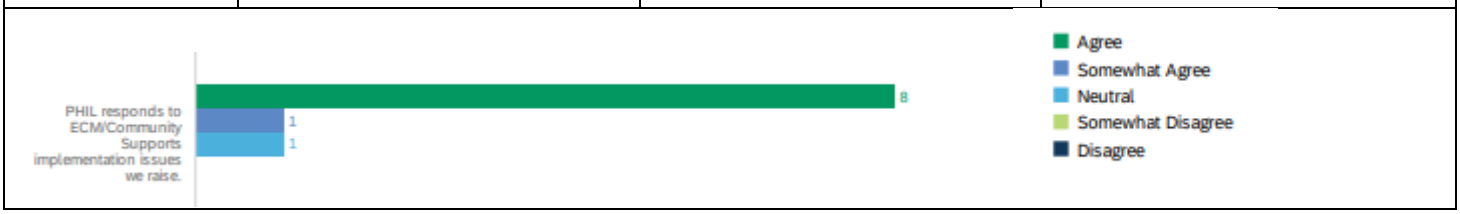
Topic	Successes Identified	Actions Taken/Next Steps	Best Practices/Lessons Learned
Outreach Efforts	Arcata House Partnership shared their process of handing out informational flyers on their ECM and Community Supports services as a mode of outreach and referral facilitation.	• Make space for implementation best practices in toolkit, newsletter, or convenings for peer learning.	Partnership HealthPlan encourages internal referrals. Sharing this method of referral attempts is helpful and identified as a best practice.
Reduced Health Care Associated Costs	Arcata House Partnership shared that a client with a history of hundreds of Emergency Room visits reduced their ER costs to zero after being housed for six months.	• Make space for spotlight experiences in newsletter, or convenings for peer learning.	Sharing big picture success stories for ECM and CS are helpful as they reframe participant roles in public health.

Summary of Complaints & Grievances

Topic	Summary of Complaint/Grievance	Actions Taken	Next Steps
CITED grants	Delays, timelines, and transparency of CITED fund awardees and Round 3 dates makes planning for organizations difficult.	Added to 1:1 meeting with PCG.	Upon learning about new details, PHIL will share with collaboratives.

Specific comments, questions, or concerns regarding policy/implementation/change goals for TPA/DHCS

Topic	Comment/Concern/Question	Actions Taken	Next Steps
Practical solutions to common	Of 9 respondents to the post-convening evaluation, 7 agreed that this convening increased their knowledge of practical	The Pre-Contract and Post-Contract Process, Tools, and Solutions packet developed for this convening will be a living	Share iterations of the packet as they become updates. Share packets with other CPI Facilitators.

implementation challenges.	solutions to common implementation challenges.	document, and adapted to include new practical solutions for implementation that become available.	
			
PHIL responds to implementation issues raised	Of 10 respondents to the post-convening evaluation, 8 agreed that PHIL responds to ECM/Community Supports implementation issues we raise.	The Issue Tracker is a helpful knowledge management tool that allows PHIL to collect and respond to implementation issues and concerns.	Strategize methods for Issue Tracker transparency.
			

Shared Collaborative Resources (Chronological order)

#	Resource	Category/Type	Link/Access Information
1.	Population Health Innovation Lab Website	Website	https://pophealthinnovationlab.org/projects/path/
2.	California Health Care Foundation (CHCF) statewide CalAIM survey	Survey	https://bit.ly/CalAIMsurvey
3.	Partnership Healthplan's Billing and Authorizations Trainings for ECM/CS	Flyer	https://bit.ly/45AR7ST
4.	Partnership Healthplan's ECM/CS Billing Tips	Cheat Sheet	https://bit.ly/45xxomR
5.	Partnership Healthplan's ECM/CS Electronic Treatment Authorization Request Tips	Cheat Sheet	https://bit.ly/3qsg7gh
6.	Breakout Group: Pre-Contract Process, Tools, and Solutions	Resource Packet	Pre-contract Process, Tools, and Solutions_NW
7.	Enhanced Care Management (ECM) Billing Codes & Rates	Cheat Sheet	https://bit.ly/45JwQuk
8.	Breakout Group: Post-Contract Process, Tools, and Solutions	Resource Packet	Post-contract Process, Tools, and Solutions_NW
9.	A Contracting Best Practices Guide for Becoming A Medicaid Community Supports Provider	Guide	https://bit.ly/45LpG94
10.	PHC CalAIM Webpage	Website	http://www.partnershiphp.org/Community/Pages/CalAIM.aspx
11.	ECM Populations of Focus	Flyer	https://bit.ly/3OPSLcr
12.	PHC ECM Referral Form	Form	https://bit.ly/45nqZLj

#	Resource	Category/Type	Link/Access Information
13.	PHC CS Referral Form	Form	https://bit.ly/44qg42c
14.	CITED Funding	Website	https://www.ca-path.com/cited
15.	PHC'S CalAIM email	Email	CalAIM@parntershiphp.org
16.	HealthBegins Website	Website	https://healthbegins.org/calaim/
17.	Convening Evaluation	Survey	https://bit.ly/47U72Ob
18.	See the Appendix in this months slide deck for several additional resources	Slide Deck	Pending Link

Individuals in Attendance

	Name	Organization	Position / Title	MCP Y/N	Email
1.	Alissa Smith	Arcata House	Community Health Worker	N	asmith@arcatahouse.org
2.	April Joyce	Adult Day Health Care of Mad River	Administrator	N	ajoyceadhc@gmail.com
3.	Ashley Peel	Partnership HealthPlan	Program Manager, ECM	Y	apeel@partnershiphp.org
4.	Barbara LaHaie	Humboldt Senior Resource Center	Director	N	blahaie@humsenior.org
5.	Becca Fink	Population Health Innovation Lab	Communications Manager	N	bfink@phi.org
6.	Caroline Fichtenberg	SIREN- UCSF	Co-Director of the Social Interventions Research and Evaluation	N	Caroline.Fichtenberg@ucsf.edu
7.	Chris Davis	North Coast Health Improvement & Information Network	Project Manager	N	cdavis@humboldtipa.com
8.	Connie Thomas	Open Door Community Health Center	Supervising Case Manager	N	cthomas@opendoorhealth.com
9.	Dallas Segall	Arcata House Partnership	Community Health Worker	N	dsegall@arcatahouse.org
10.	Elece Hempel	Petaluma People Services Center	Executive Director	N	elece@petalumapeople.org
11.	Esmeralda Salas	Population Health Innovation Lab	Research Associate II	N	esalas@phi.org
12.	Hector Medina	Serene Health IPA	Senior Vice President	N	hector@serenehealth.com
13.	Jessica Osborne-Stafsnes	North Coast Health Improvement and Information Network	COO	N	josborne@nchiin.org
14.	Jessica Sanchez	Population Health Innovation Lab	Project Coordinator	N	jsanchez2@phi.org
15.	Kathryn Stewart	Population Health Innovation Lab	Director of Learning and Action	N	kathryn.stewart@phi.org

16.	Katie Christian	Population Health Innovation Lab	Communications Coordinator	N	kchristian@phi.org
17.	Laurie Schwartz	Roots Food Group	Nutrition Specialist Educator	N	laurie@rfoodx.com
18.	Lisa Green	North Coast Health Improvement and Information Network	Executive Assistant	N	lgreen@humboldtipa.com
19.	Max Chavez	Population Health Innovation Lab	Research Assistant II	N	mchavez@phi.org
20.	Meredith Wolfe	County of Humboldt	CCS Administrator	N	mwolfe@co.humboldt.ca.us
21.	Jodi Nerell	Sutter Health	Dir. Local Mental Health Engagement	N	jodi.nerell@sutterhealth.org
22.	Priscilla Acuna Mena	SIREN- UCSF	Unknown	N	priscilla.alban-acuna@ucsf.edu
23.	Rachael Sovereign	Humboldt Senior Resource Center	Director Of Operations	N	rsovereign@humsenior.org
24.	Rachel McCullough-Sanden	Population Health Innovation Lab	PATH Program Manager	N	rmcculloughsanden@phi.org
25.	Ramon Anguiano	Serene Health Group	Unknown	N	ramon@serenehealth.com
26.	Rhiannon Coxon	Sonoma County Human Services Department	Sonoma County In-Home Supportive Services Section Manager,	N	rcoxon@schsd.org
27.	Sandy Miliotti	Open Door Community Health Centers	Health Resources Manager	N	smiliotti@opendoorhealth.com
28.	Shari Brenner	Private Consultant	Consultant	N	sbrenner@sonic.net
29.	Sharon Hunter	Providence	Advisor/Analyst, Community Health Investment	N	sharon.hunter@stjoe.org
30.	Stefani Hartsfield	Hartsfield Consulting	Consultant	N	stefani@hartsfieldhealth.com
31.	Sue Grinnell	Population Health Innovation Lab	Director	N	sue.grinnell@phi.org
32.	Taylor Phelps	DN Mission Possible	Unknown	N	tphelps@dnmissionpossible.org
33.	Tim Rine# NCCN	North Coast Clinics Network	Executive Director	N	Tim@northcoastclinics.org
34.	Vicky Klakken	Partnership HealthPlan	Regional Manager	Y	vklakken@partnershiphp.org
35.	Virginia Beckman	Arcata House Partnership	Consultant	N	vbeckman@arcatahouse.org
36.	Zenia Leyva Chou	North Coast Opportunities	Project Manager	N	zchou@ncoinc.org
37.	17074990226	Unknown	Unknown	N	Unknown
38.	17078458028	Unknown	Unknown	N	Unknown

MCP Engagement (List all MCPs who should be engaged regardless of attendance)

MCP Name	Current Status of Relationship i.e. Excellent > Acceptable > Needs Improvement > In Direct Contact With > No Contact	MCP Engagement in Collaborative Yes/No	Engagement Concerns & Notes
Partnership HealthPlan of California (PHC)	Excellent	Yes	Members of PHC and Northern California CPI Facilitators met on 08/17/23 to discuss regional collaboration of prioritized issues.

KEY	
Acceptable	MCP attends 50%-75% collaborative convenings, MCP is responsive to collaborative requests but follow up is needed by facilitator
Excellent	MCP is engaged in collaborative, MCP attends 75%-100% collaborative convenings, MCP is presenter during collaborative meetings, MCP provides feedback and data where applicable, MCP works in partnership with facilitator and collaborative
In Direct Contact With	Facilitator has direct contact with MCP, MCP may not currently be attending collaboratives, MCP may be transitioning in 2024 and not yet active in collaborative
Needs Improvement	MCP is not or inconsistently engaged in collaborative, MCP attends 0%-25% of collaborative convenings, difficulties consulting with MCP, further partnership and relationship building is required
No Contact	There is no contact with MCP, MCP is not present for collaborative meetings, no relationship built with MCP

New Action Items (Identified this Meeting)

No.	Action Item	Owner	Created	Deadline	Status
1.	Follow-up with Arcata House Partnership to learn about their internal referral process. Share process with the Collaboratives.	PHIL-Outreach and Recruitment	08-28-2023	9-15-2023	Incomplete
2.	Follow-up with CPI participants who have notable progression on the Readiness Roadmap.	PHIL-Outreach and Recruitment	08-28-2023	9-15-2023	Incomplete
3.	Integrate tools for sustainability through the upcoming convenings, resources and conversations.	PHIL-Strategy and PCG Deliverables	08-28-2023	Continuous	Incomplete
4.	Continue collaboration with Camden Coalition on the development of a CalAIM tool for value case for complex care financing tool.	PHIL-Monitoring the Policy Landscape	08-28-2023	9-15-2023	Incomplete
5.	Issue Tracker additions: • Accessibility to tools from PHC including z codes, g code sheets, and eligible participant lists. • ECM and/or CS implementation barriers unique to school-based clinics.	PHIL-Strategy and PCG Deliverables & Monitoring the Policy Landscape	08-28-2023	9-15-2023	Incomplete

No.	Action Item	Owner	Created	Deadline	Status
6.	Integrate updated tools and resources in the Pre-Contract and Post-Contract Process, Tools, and Solutions packet. Share updates with collaboratives and CPI Facilitators as they become available.	PHIL-Strategy and PCG Deliverables	08-28-2023	Continuous	Incomplete
7.	Invite leadership from Humboldt Continuum of Care.	PHIL-Outreach and Recruitment	08-28-2023	8-31-2023	Incomplete

Action Items (Ongoing)

No.	Action Item	Owner	Created	Deadline	Status
1.	Develop *collaborative systems improvement* strategies	PHIL	04/21/23	Continuous	Strategizing
2.	Identify specific *capacity building* trainings.	PHIL	04/21/23	Continuous	Outlined and finalizing
3.	*Network and relationship building* with new members added to the asset maps.	PHIL	04/21/23	Continuous	Strategizing
4.	Recruitment of new CPI participants	PHIL and CPI Partners	Start of initiative	Continuous	Implementing
5.	Identify existing coalitions, collaboratives and roundtables for ECM, Community supports	PHIL and CPI Partners	3/30	Continuous	Data synthesized by mapping project will help to identify these initiatives.
6.	Re-vamp website with developing resource and information needs to continue serving current and prospective CPI participants	PHIL	05/30/2023	Continuous	Updates pending approval
7.	Re-connecting with participants with whom we've had discovery calls and other forms of communication to provide continuous support, assess progress and satisfaction	PHIL	05/30/2023	Continuous	Implementing
8.	MERLIN to review accuracy of maps (e.g., Redwood Quality Management were combined with Aliados) **UPDATE: Integration of new data**	MERLIN	04/21/23	Continuous	Updating with new CPI participants
9.	Appropriately share DHCS updates as they become available during this season of major updates to ECM and CS policy and implementation.	PHIL	01/29/2023	Continuous	Finalizing process for CPI Newsletter
10.	Follow up with organizations who show great and minimal progress along the Readiness Roadmap for support and guidance.	PHIL	06/29/2023	Continuous	Strategizing

Open Action Items

No.	Action Item	Owner	Created	Deadline	Status
1.	Continue populating a system for collecting, collating, collaborating, and sharing workarounds to issues identified in the collaborative.	PHIL	06/14/2023	7/15/2023	Drafting
2.	Invite interested and invested stakeholders to collaboratively work on solutions for identified issues	PHIL and CPI Partners	6/29/2023	07/15/2023	Strategizing
3.	Updating stakeholder information with participants' positions on the readiness roadmap to track advancement towards our Aim.	PHIL	05/30/2023	07/15/2023	Updating
4.	Incorporating breakout discussions into our Solutions Approach strategy	PHIL	05/30/2023	06/12/2023	Strategizing
5.	Create a concrete plan for the future of PHIL's Asset Maps	PHIL + MERLIN	04/21/23	05/15/23	Strategizing
6.	Follow up with organizations who are willing to share their process maps.	PHIL	06/29/2023	07/07/2023	Planning process for distribution.

Closed Action Items

No.	Action Item	Owner	Created	Deadline	Status
1.	Incorporating charter feedback	PHIL	01/01/2023	03/31/23	Completed
2.	Strategize methods of collecting the stop all participants are at on the Readiness Roadmap (polled during meetings as well as follow-up conversations)	PHIL	04/21/23	05/05/23	Planned
3.	Propose monthly meetings with Camden, HC2, HealthBegins and Partnership to efficiently collate common issues among CPI collaboratives across Northern California counties	PHIL	05/30/2023	06/05/2023	Meeting regularly
4.	PATH CPI Asset Mapping Survey	PHIL	January	May 15	Completed
5.	A report of the initial Asset Mapping Survey findings is to be shared with the participants on the website. **UPDATE: Integration of new data**	MERLIN	04/21/23	06/05/23	Completed; now planning to add new data
6.	Mapping care coordination processes.	PHIL	06/29/2023	08/05/2023	Closed

Appendix A:

Readiness Roadmap Steps Legend:

1. What are ECM & CS?
2. We're exploring the contracting process.
3. We have started to work on the contract!
4. We have a contract!
5. We are testing the service delivery and billing system.
6. We are delivering services and have an internal process, but are having issues with referrals, reimbursements, or other workflow complications.
7. Coordinated delivery, billing, and referral system in place and running smoothly!

Readiness Roadmap Poll:

N= 17 virtual respondents

1. In which month did you first attend a collaborative meeting?

a. January (4/17)
c. February (2/17)
d. March (4/17)
e. April (2/17)
f. May (2/17)
g. June (0/17)
h. July (3/17)
i. This is my first time (0/17)

2. Where on the Readiness Roadmap was your organization then?

a. Step 1 (2/17)
b. Step 2 (4/17)
c. Step 4 (3/17)
d. Step 5.5 (3/17)
e. Step 6 (1/17)
f. Step 7 (2/17)

3. As of today, on which step of the Readiness Roadmap is your organization?

a. Step 1 (0/17)
b. Step 2 (2/17)
c. Step 2.5 (1/17)
c. Step 3 (1/17)
d. Step 4 (0/17)
e. Step 5 (4/17)
f. Step 5.5 (1/17)
d. Step 6 (4/17)
e. Step 7 (4/17)

Appendix B: **Peer Resource**

HOUSING & WELLNESS PROGRAM
1410 Guerneville Rd. Ste. 1
Santa Rosa, CA 95404
PHONE (707) 757-7891
FAX (707) 573-6961

ECM & COMMUNITY SUPPORTS BILLING TIPS

Billing questions- email Partnership claims team at claimsecmhelpdesksr@partnershiphp.com or call (800)863-4155**

My name is Summer Hale and I am the ECM/Community Supports Biller at CSN Housing and Wellness Program. I am available and will be happy to walk you through the process until you find your flow or answer any questions that may arise. I can be reached at (707) 757-7891 and my email address is summer@csn-mh.com.

ECM BILLING CODES
When submitting TARs always leave the units field blank

G9012- No modifier
Enrollment $150.00
Billed only once per member
When requesting authorization, the quantity is 1

G9012- modifier U2
Case Management $350.00
Billed once every month
When requesting authorization, the quantity is 999

COMMUNITY SUPPORTS BILLING CODES

H0043- modifier U6
Housing Navigation $386.00
Billed once every month
When requesting authorization, the quantity is 6

H0044- modifier U2
Housing Deposit- Partnership will pay up to $5000.00 for this service. This also includes utility deposits.
Billed once in a member's lifetime.

**Before requesting authorization, the member will have had to have been receiving Housing Navigation services for a minimum of two months. You are required to attach a summary/letter explaining the need and what steps the member has been taking to become stable enough to sustain housing and why you think they are ready. **

H0044- modifier U3
Short-Term Post Hospitalization $108.00 a day up to 6 months
This is a date range code. I would bill monthly.
When requesting authorization, the quantity would be the amount of days the member would be residing in the place of choosing

T2040- modifier U6 (If a member is housed this is the CS you would get authorization on.)
Financial Management/ Sustaining Services $222.00
When requesting authorization, the quantity is 12
This service can be billed twice a month on separate dates of service at $222.00 each date.

An example of the way I bill- The Case Manager goes out to do an intake (enrollment- G9012 $150). Once that intake has been completed the Case Manager sees that person throughout the month (Case Management- G9012 $350). If that person is homeless, I get authorization for them to get "Housing Navigation" services (H0043 $386.00). Below is what I would invoice Partnership for this member at the end of the month.

G9012	Enrollment	$150.00
G9012-U2	Case Management	$350.00
H0043-U6	Housing Navigation	$386.00

Each month after that I would bill the same except remove the enrollment.

If a member is housed the only thing, I do differently is get authorization for Financial Management Services (T2040 $222.) Their billing would look like this-

G9012	Enrollment	$150.00
G9012-U2	Case Management	$350.00
T2040-U6	Financial Management	$222.00
T2040-U6	Financial Management	$222.00

Eligibility Verification and TARS Submissions

Part 1: Eligibility Verification

The process of submitting a Treatment Authorization Request (TAR) starts with verifying eligibility in the Partnership Health Plan Online Services Portal.

Information needed before starting

- Full Legal Name of Client
- Date Of Birth

Steps to Verify Eligibility

1. Navigate to the Partnership Healthplan of California Online Services Portal located here: https://provider.partnershiphp.org/UI/Login.aspx and log in

2. Choose Eligibilty Module:

3. Next choose eEligibility

4. Enter the following information in the portal:

Date of Service: Date that the service begins (or if processing retroactively, enter the date the service began

Last Name: Client's legal last name

First Name: Client's legal first name

Date of Birth: Client's date of birth

Then select **Search Member**

5. A list of potential matches will populate, select the client with data that matches our records

6. The Member's Partnership records will be displayed on the screen. Look in the Eligibility Details Section below the Member's Demographics to see if the client is eligible to receive services

At the bottom section of the screen you can see if there is an expiration date of client's coverage coming up as well as details about which county they receive services from

7. If the member **is not eligible**, stop here and document in the client's case notes that they are not eligible for CalAIM services.

If the member **is eligible**, the next step is to submit a Treatment Authorization Request (TAR)

Part 2: Treatment Authorization Request (TARS) Process

Now that it has been verified that the client is eligible for services, the TAR Submission process can take place.

Required documents for submitting TARS for each CalAIM program:

Community Supports- Recuperative Care

• CS Referral Form- document medical necessity for services in the additional notes section such as homeless and need to recuperate in a clean environment to reduce risk of complications from

healing after hospitalization- state reason for hospitalization, procedures, medical diagnoses etc to support stay.

Community Supports- Housing Navigation/Transition Services

• CS Referral Form- document client's homeless status and health issues that would better be addressed if housed.

Community Supports- Housing Deposits

- CS Referral Form- be sure to note an itemized list of the cost what is requested and the total
- Supporting documents such as a lease agreement, past due utilities, letter from utility provider, etc.

Community Supports- Housing Sustaining/Tenancy

Note: An active TAR for Housing Navigation/Transition Services must be in place before submitting a Housing Deposits TAR

• CS Referral Form- document client's challenges with maintaining housing in additional notes section

Enhanced Care Management

- ECM Referral Form
- Individual Care Plan
- Signed ROI

Starting a TAR in the Partnership Online Services Portal

1. Verify that the member is eligible for services through the eEligibility process documented in Part One.
2. While still on the eEligibility screen**,** begin entering a Treatment Authorization Request (TAR) for the client by selecting Enter a new eTAR – Outpatient on the bottom right of the screen.

Tips for Completing a TAR

Member Details

Patient Ph#

Update the client's phone number if the one in their records isn't current.

TAR Start and End Dates

The **Start Date** will automatically be prepopulated with the Eligibility date that was entered on the prior screen. If that date is not correct, then return to the beginning of the eligibility module and enter the first date of service.

The **End Date** should be 180 days (90 for RC) after the Start Date- unless a retroactive TAR is being submitted. In that case, enter the exact days that the client was in the program.

Select Provider

Choose the first provider at the top of the drop down selection as shown in the screenshot. COTS information should automatically populate after making a selection.

TAR Type

Choose Community Supports or ECM from the dropdown list according to the service that is being requested for the client.

Patient Current Location

Choose Homeless if the client is living on the streets or in a shelter

Choose Home if the client is currently housed but is at risk of losing housing and needs new housing.

Is Urgent?

Choose this if the client needs Housing Deposit assistance within the next business day, or as soon as possible so that the client can take advantage of a housing opportunity. Describe why there is a sense of urgency to processing the TAR in the "Reason for the Urgent TAR" field.

Diagnosis Details and Medical Justification

Primary Diagnosis: Choose from the following:

Z5901- Sheltered Homeless

Z5902- Unsheltered Homeless

Z59811- Housing instability, housed, with the risk of homelessness

Secondary Diagnosis
Not required

Medical Justification

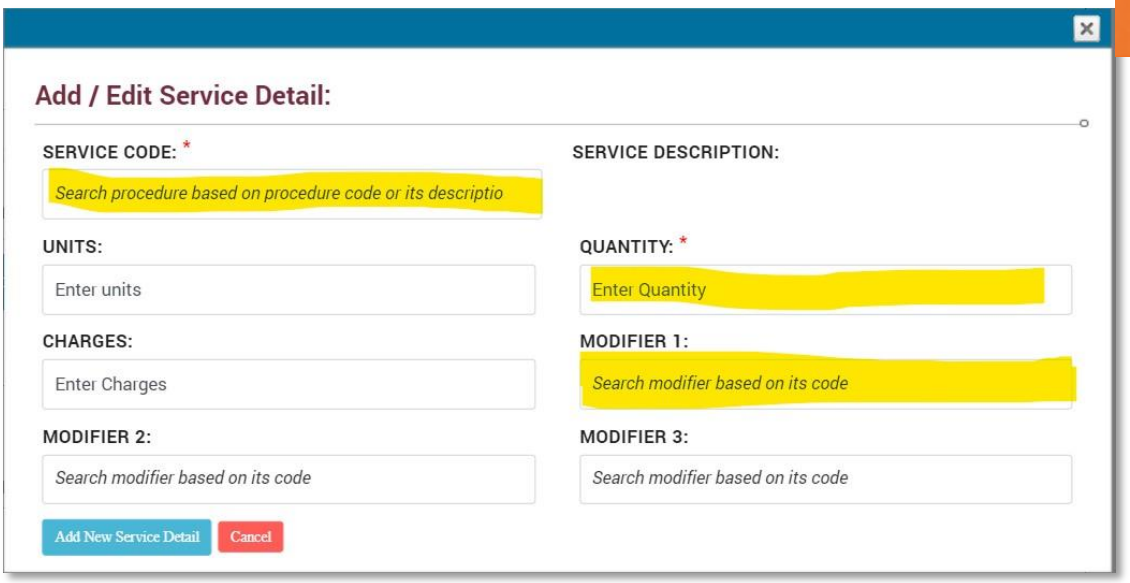
Document medical necessity for services such as homeless and need to recuperate in a clean environment to reduce risk of complications from healing after hospitalization- state reason for hospitalization, procedures, medical diagnoses etc. to support stay.

Service Details & Additional Notes

Choose 

and complete the highlighted fields of the

Add/Edit Service Detail form that pops up:



Service Codes

Please refer to the chart below when entering Service Codes, Quantities and Modifiers

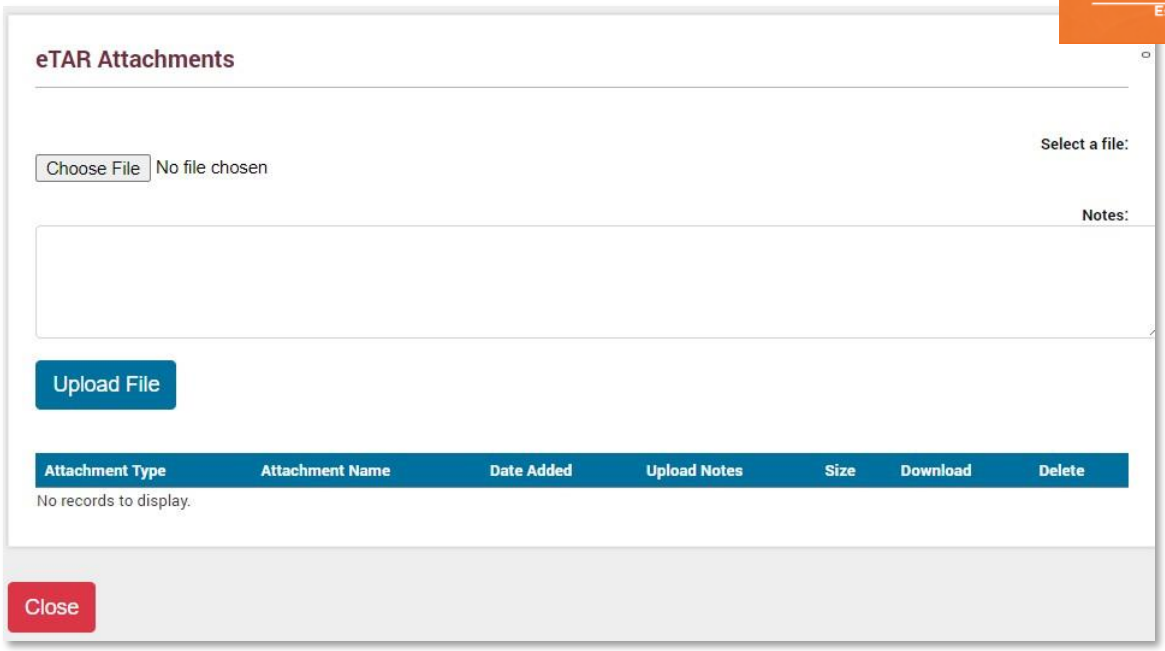
Service	Code	Quantity	Modifier
Recuperative Care	T2033	90 (Days)	U6
Housing Transition / Navigation Services	H0043	6 (Months)	U6
Housing Deposits	H0044	1 time only	U2
Housing Tenancy and Sustaining Services	T2041	6 (Months)	U6
Enhanced Care Management Services	G9012	6 (Months)	U2
ECM Successful Outreach	G9012	1	--

Additional Notes

Give details about client's circumstances related to their medical condition that could be improved by the services being requested.

Attachments

Located in the top right corner of the form, choose the Attachments: 0 button then choose the appropriate files to upload



Double Checking the TAR before submitting may save time in getting it processed. TAR errors need to be corrected and keeps the client waiting for services longer.

Before Submitting the TAR:

- Are the Start and End dates correct?
- Does the date range span 6 months for ECM or CSHN? 90 days/3 months or less for Recuperative Care?
- For ECM: Are both Enhanced Case Management and ECM Successful Outreach services requested?
- Does the quantity match the date range?
- Are the appropriate documents attached?
- Are there additional notes that could be added to the TAR to explain the client's needs?

After reviewing the TAR and making any necessary updates, submit it by pressing the Submit eTAR button located in the upper right corner of the screen.

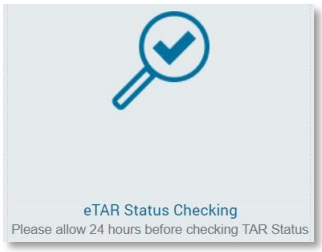
After submitting the TAR, email the Program Manager, Data Manager and CalAIM Admin to let them know that a TAR has been submitted for the client.

Questions? Please reach out to the CalAIM Administrator

Part 3: Checking the Status of Submitted TARS

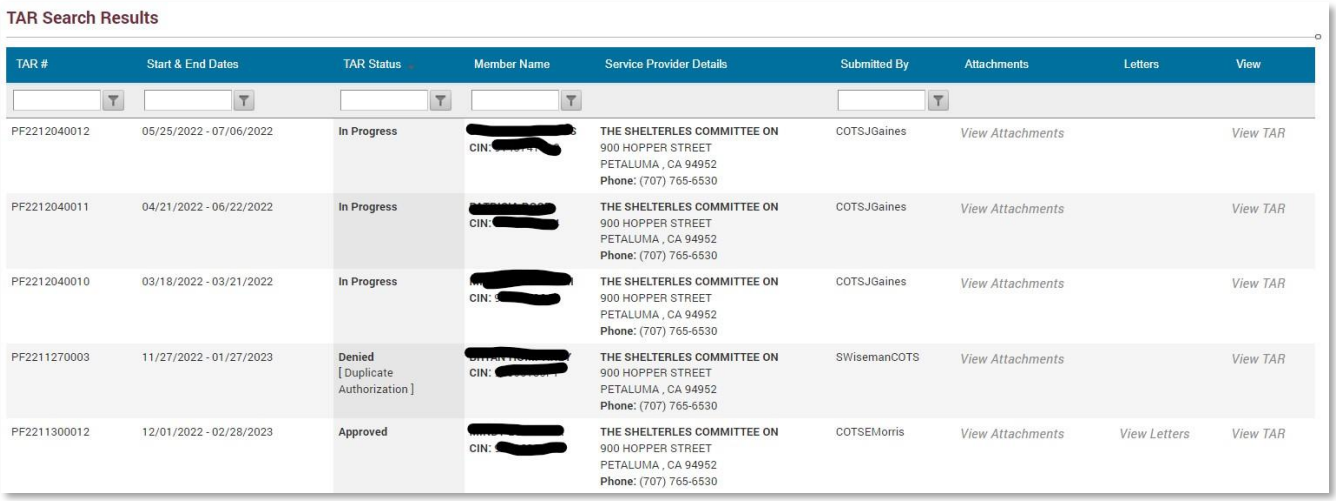
Once a TAR has been submitted, it typically will not show up in the system until the next day.

1. Log in to the Partnership Online Services Portal and then choose eTar Status Checking



2. In the TAR Search Criteria form choose **Out Patient** from the dropdown list and press **Search**

3. TAR Search Results will populate with all active TARS within the past year. Find the line with the TAR that was submitted and look in the 3rd column for the latest status.



4. On this screen, the TAR and it's attachments can also be viewed. If the TAR has been **Approved**, choose View TAR and download a
PDF of the file.

- Save in the **Approved TARs** folder located in the CalAIM folder on the S Drive. Be sure to follow the naming convention already in use there.
- Email the Program Manager and CalAIM Admin to let them know that the client's TAR has been approved
-

5. If the TAR has been **Denied**, please download the TAR to view the explanation, and reach out to the CalAIM Administrator for assistance with correcting the TAR and resubmitting it.

Questions? Please reach out to the CalAIM Administrator

Best Practices for TAR Submissions

TAR Start Date

Please refer to the CalAIM program below to determine what Start Date should be used

CS Housing Navigation	Date should match the date the Housing Support Plan (HSP) was developed
CS Housing Deposit	Date should occur within the span of the CS Housing Navigation TAR, and cover 2 months, in case the move-in date gets pushed out
CS Tenancy/Sustaining	Date should occur after the client has moved in. If client received Housing Navigation services, then use the date the HSP was updated after move in.
CS Recuperative Care	Date should be the day they enroll in RC
Enhanced Care Mgmt	Date should match the date the ICP and ROI were signed

TAR Renewals

- Submit TAR renewals as soon as the current TAR ends to ensure continuity of service.
- Renewal date should be the day after the prior TAR ends.

Appendix D: PHC Resource

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

DHCS has issued a list of 25 Priority SDOH Codes for providers to utilize when coding for SDOH to ensure correct coding and capture reliable data.

Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.11	Inadequate housing, environmental temperature
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

ICD-10-CM Codes Z55-Z65: Person with Potential Health Hazards Related to Socioeconomic and Psychosocial Circumstances.

Category	Code	Description
Problem related to education & literacy	Z55.0	Illiteracy and low-level literacy
	Z55.1	Schooling unavailable and unattainable

	Z55.2	Failed school examinations
	Z55.3	Underachievement in school
	Z55.4	Educational maladjustment and discord with teachers and classmates
	Z55.5	Less than a high school diploma
	Z55.6	Problems related to health literacy
	Z55.8	Other problems related to education and literacy
	Z55.9	Problems related to education and literacy, unspecified
Problems related to employment and unemployment	Z56.0	Unemployment, unspecified
	Z56.1	Change of job
	Z56.2	Threat of job loss
	Z56.3	Stressful work schedule
	Z56.4	Discord with boss and workmates
	Z56.5	Uncongenial work environment
	Z56.6	Other physical and mental strain related to work
	Z56.81	Sexual harassment on the job
	Z56.89	Other problems related to employment
	Z56.9	Unspecified problems related to employment
Occupational exposure to risk factors	Z57.0	Occupational exposure to noise
	Z57.1	Occupational exposure to radiation
	Z57.2	Occupational exposure to dust
	Z57.31	Occupational exposure to environmental tobacco smoke
	Z57.39	Occupational exposure to other air contaminants
	Z57.4	Occupational exposure to toxic agents in agriculture
	Z57.5	Occupational exposure to toxic agents in other industries
	Z57.6	Occupational exposure to extreme temperature
	Z57.7	Occupational exposure to vibration
	Z57.8	Occupational exposure to other risk factors
	Z57.9	Occupational exposure to unspecified risk factor
Problems related to housing and economic circumstances	Z58.6	Inadequate drinking-water supply
	Z58.81	Basic services unavailable in physical environment
	Z58.89	Other problems related to physical environment
	Z59.00	Homelessness unspecified
	Z59.01	Sheltered homelessness
	Z59.02	Unsheltered homelessness
	Z59.11	Inadequate housing environmental temperature
	Z59.12	Inadequate housing utilities
	Z59.19	Other inadequate housing
	Z59.3	Problems related to living in residential institution

	Z59.41	Food insecurity
	Z59.48	Other specified lack of adequate food
	Z59.5	Extreme poverty
	Z59.6	Low income
	Z59.7	Insufficient social insurance and welfare support
	Z59.811	Housing instability, housed, with risk of homelessness
	Z59.812	Housing instability, housed, homelessness in past 12 months
	Z59.819	Housing instability, housed unspecified
	Z59.89	Other problems related to housing and economic circumstances (foreclosure, isolated dwelling, problems with creditors)
	Z59.9	Problem related to housing and economic circumstances, unspecified
Problems related to social environment	Z60.0	Problems of adjustment to life transitions (life phase, retirement)
	Z60.2	Problems related to living alone
	Z60.3	Accult6uration difficulty (migration, social transplantation)
	Z60.4	Social exclusion and rejection (physical appearance, illness, behavior)
	Z60.5	Target of (perceived) adverse discrimination and persecution
	Z60.8	Other problems related to social environment
	Z60.9	Problem related to social environment, unspecified
Problems related to upbringing	Z62.0	Inadequate parental supervision and control
	Z62.1	Parental overprotection
	Z62.21	Child in welfare custody (non-parental family member, foster care)
	Z62.22	Institutional upbringing (orphanage or group home)
	Z62.29	Other upbringing away from parents
	Z62.3	Hostility towards and scapegoating of child
	Z62.6	Inappropriate (excessive) parental pressure
	Z62.810	Personal history of physical and sexual abuse in childhood
	Z62.811	Personal history of psychological abuse in childhood
	Z62.812	Personal history of neglect in childhood
	Z62.813	Personal history of forced labor or sexual exploitation in childhood
	Z62.814	Personal history of child financial abuse
	Z62.815	Personal history of intimate partner abuse in childhood
	Z62.819	Personal history of unspecified abuse in childhood
	Z62.820	Parent-biological child conflict
	Z62.821	Parent-adopted child conflict
	Z62.822	Parent-foster child conflict
	Z62.890	Parent-child estrangement NEC
	Z62.891	Sibling rivalry
	Z62.898	Other specified problems related to upbringing
	Z62.9	Problem related to upbringing, unspecified

Other problems related to primary support group, including family circumstances	Z63.0	Problems in relationship with spouse or partner
	Z63.1	Problems in relationship with in-laws
	Z63.31	Absence of family member due to military deployment
	Z63.32	Other absence of family member
	Z63.4	Disappearance/death of family member (assumed death, bereavement)
	Z63.5	Disruption of family by separation and divorce (marital estrangement)
	Z63.6	Dependent relative needing care at home
	Z63.71	Stress on family due to return of family from military deployment
	Z63.72	Alcoholism and drug addiction in family
	Z63.79	Other stressful events affecting family/household (ill/disturbed member)
	Z63.8	Other specified problems related to primary support group (discord or estrangement, inadequate support)
	Z63.9	Problem related to primary support group, unspecified
Problems related to psychological circumstances	Z64.0	Problems related to unwanted pregnancy
	Z64.1	Problems related to multiparity
	Z64.4	Discord with counselors
Problems related to other psychological circumstances	Z65.0	Conviction in civil and criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison
	Z65.3	Problems related to other legal circumstances (arrest, custody, litigation)
	Z65.4	Victim of crime and terrorism
	Z65.5	Exposure to disaster, war and other hostilities
	Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)
	Z65.9	Problem related to unspecified psychosocial circumstances

Appendix E: DHCS Initiative on School-Based Clinics

Resources

1. Children and Youth Behavioral Health Initiative: https://www.dhcs.ca.gov/cybhi
2. School-Based Medi-Cal Administrative Activities: https://www.dhcs.ca.gov/provgovpart/Pages/SMAA.aspx