CHCF Issue Brief

FEBRUARY 2023

by Aurrera Health Group

Billing Better in CalAIM:
How to Improve Reimbursement for Enhanced Care Management and Community Supports

CalAIM (California Advancing and Innovating Medi-Cal), which launched in 2022, is a multi-year initiative led by the California Department of Health Care Services (DHCS) to transform service delivery and improve outcomes for Californians covered under Medi-Cal. Enhanced Care Management (ECM) and Community Supports are core components of CalAIM that take a person-centered approach to social service delivery and care management for individuals with complex health and social needs. These services also require significant coordination between community-based organizations (CBOs), local and county entities, and Medi-Cal managed care plans (MCPs). The nature of Medi-Cal managed care billing, which requires confirmation of beneficiary enrollment in an MCP, authorization from the MCP, submission of claims or invoices, and tracking and correcting errors on claims or invoices before payment, results in complex billing protocols. Navigating this complex process is a barrier to entry for new providers and poses ongoing challenges for many existing contracted ECM and Community Supports providers. Integration of CBOs and other local entities new to Medi-Cal managed care is essential to providing ECM and Community Supports services, yet many lack the resources, experience, and capacity needed to successfully bill for the services that they provide.

For some providers, billing challenges have resulted in a significant number of unpaid claims. Some have waited six or more months to receive payment, and many have reported receiving payments for few claims submitted during the first 10 months since the launch of CalAIM. For smaller providers, the lag between submission of claims and invoices and receipt of payment can create cash flow challenges and result in providers opting out of ECM and Community Supports.

To better understand the situation facing ECM and Community Supports providers and identify potential solutions, Aurrera Health Group, with support from the California Health Care Foundation, conducted a series of stakeholder interviews with health plan representatives, county providers, CBOs, and MCP and provider associations (see Appendix A for a list of the interviewees). This issue brief outlines key challenges with each step of the billing process and technological and process-oriented recommendations for addressing them. Recommendations reflect potential strategies that could be implemented by DHCS, MCPs, and providers in the current delivery system, with the understanding that increased workforce, financing, and other resources are essential to improving the billing process.

Billing and Revenue Cycle Requirements

This brief identifies challenges that providers may face throughout the billing process and provides considerations for solutions. Figure 1 illustrates steps in the billing process from the identification of eligible clients to service delivery. For more key recommendations on enrollment, eligibility, and authorizations, see the section called Prior to Billing: Enrollment and Authorizations. Figure 2 outlines the process for

claims submission through adjudication and payment, highlighting areas of potential variability between the MCPs and common reasons for claims denials. For more information, see the section called Preparing and Submitting Claims.

Key Challenges and Recommendations for Improving Billing Processes for ECM and Community Supports Providers

Overall Recommendations

The overall message that interviewees shared is that the billing process is complicated and that it requires many resources from both MCPs and providers to develop internal billing workflows, seek authorization, address denials, and, ultimately, reconcile payments for services delivered.

Interviewees included providers at the forefront of implementing ECM and Community Supports in advance of additional technical assistance and resources offered through the state's Providing Access and Transforming Health (PATH) Technical Assistance (TA) marketplace in 2023. PATH TA resources may be instrumental in setting up small providers for successful billing by providing them with free technical assistance (i.e., PATH TA will be paid for through DHCS and is free to providers). Billing-related TA products and services providers would benefit from could include:

A billing guide targeted at CBOs that includes:

- A detailed walk-through of generic billing workflows and expectations
- Coding guidance
- Frequently asked questions (FAQs)

One-on-one support from billing experts to help providers:

- Understand MCP requirements and processes and reconcile different processes between MCPs
- Develop internal billing processes
- Train staff

Information on clearinghouses and billing software, including:

- List of clearinghouse vendors
- The role of clearinghouses and what billing-related activities are in and out of the scope of clearinghouse vendors
- Cost expectations and payment models

Prior to Billing: Enrollment and Authorizations

Verifying Medi-Cal managed care enrollment

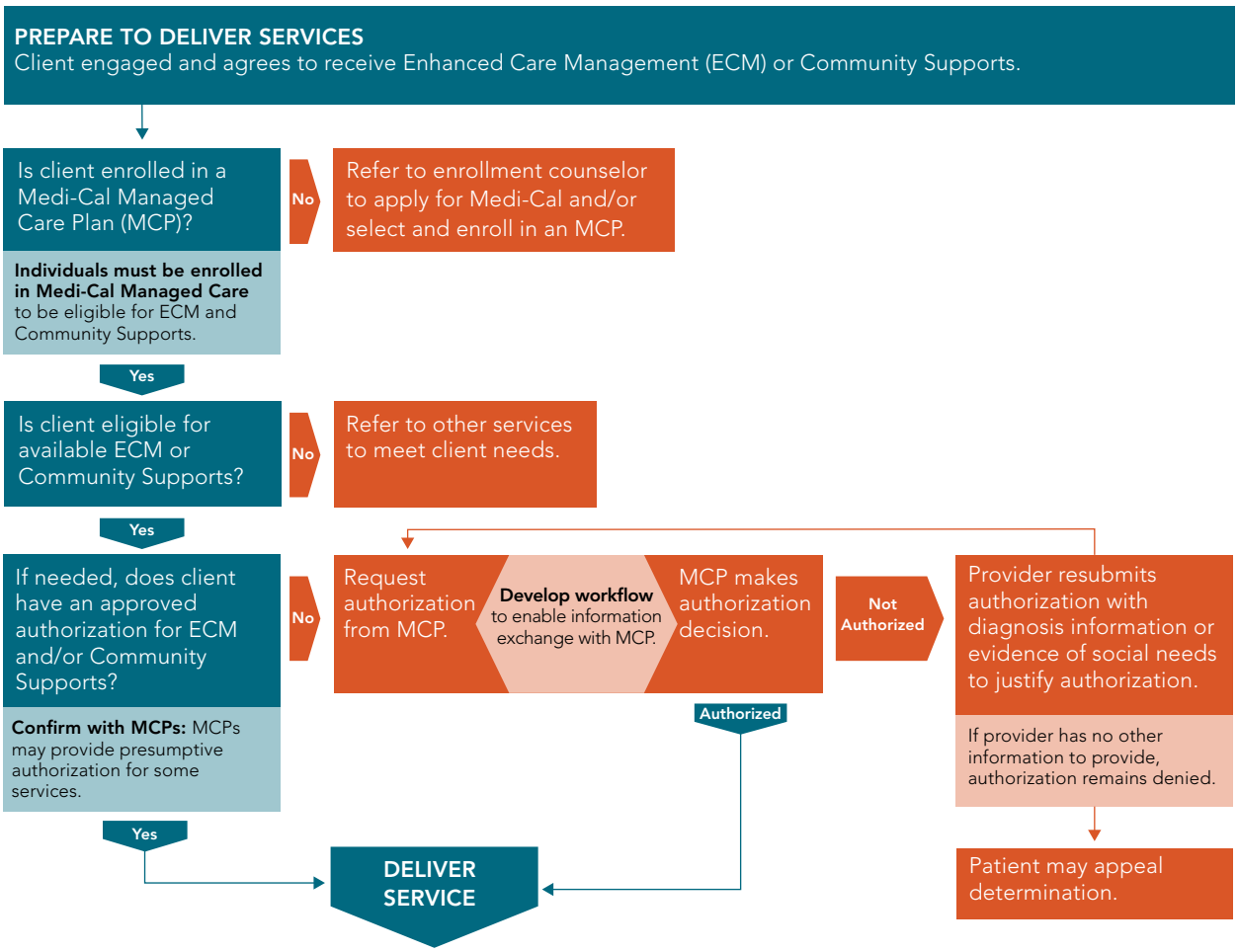
Providers must verify that their clients are enrolled with a Medi-Cal MCP as the first step before delivering a service to submit a claim (see Figure 1). However, some providers who verified enrollment reported claim denials due to a lag between the member's enrollment and the MCP's receipt of up-to-date enrollment files.

Recommendation #1: Align claims submission timeline with MCP enrollment. Providers with experience in the Whole Person Care Pilots and Health Homes Program shared that delaying their claims submission timeline by up to a month to align with the MCP's receipt of enrollment data helps prevent denials due to data lags. Providers may work with MCPs to identify enrollment data cycles and align claims submissions accordingly.

Validating eligibility for benefits or services

For providers working with more than one MCP, variability between MCPs' service eligibility criteria leads to confusion regarding which members are eligible for Community Supports and ECM (see Figure 1).

Figure 1: Preparing to Deliver ECM and/or Community Supports Services



Recommendation #2: Outline standard eligibility criteria. MCPs may consider developing and disseminating consistent eligibility screening checklists or resources that providers can use to support or submit with referrals. An ECM and/or Community Supports eligibility screening checklist or resource can help outline standard eligibility criteria for services.

Seeking authorizations

When seeking authorizations from MCPs, providers reported that traditional authorization workflows do not always map to the social service-based model of care delivery required for certain Community Supports, which are novel services that are often delivered in diverse community settings rather than clinics or hospitals (see Figure 1).

Recommendation #3: Align Community Supports authorization parameters to model of care. MCPs can improve the authorization process by working with Community Supports providers to integrate nuances of the Community Supports model of care delivery within existing referral and authorization systems. For example, one MCP and a Medically Tailored Meals/Medically Supportive Food provider worked together to ensure billing processes and authorizations accounted for a weekly delivery cadence, which decreased time-consuming claims denials and improved workflows for both parties.

Preparing and Submitting Claims

Understanding the process

All provider interviewees noted the need for hands-on TA to address each step of the billing process, from reviewing 837-P and CMS-1500 claims forms and acceptable submission modalities to navigating each MCP's billing portal and/or invoicing processes. Providers noted that in addition to MCP-specific TA, TA on billing basics (e.g., Billing 101) is needed to ensure that they understand all components of the process and are well prepared for future audits.

Recommendation #4: Make one-on-one TA easily accessible. Some providers reported improved learning when MCPs provided TA in a variety of formats, such as webinars, reference guides, and one-on-one TA. While asynchronous and easily referenced TA offerings such as webinar recordings and tip sheets are helpful in building organizational knowledge, one-on-one TA is also necessary for answering organization-specific questions. Providers that had close relationships with contacts from their MCP reported that such access to a consistent point of contact who could offer one-on-one TA was fundamental to successful program implementation and ongoing operations. While most MCPs provide some TA and a contact person to support providers through the billing process, MCPs are also new to ECM and Community Supports and may not always have the capacity to connect each provider with someone who can answer a provider's range of programmatic and technical billing questions. As DHCS prepares to open the PATH TA marketplace in early 2023, this provides an opportunity for providers to access billing-specific TA resources, such as: 1) off-the-shelf billing guides, 2) information on billing software and clearinghouses, and 3) access to additional vendors offering one-on-one TA to help them establish effective, automated, and audit-ready internal billing processes.

"[Our county] wants to continue providing Enhanced Care Management, but senior leadership may have to pull the plug on the program because we haven't been paid for the majority of the services we've provided since January 2022."

—County ECM provider

Invoice and claims submission

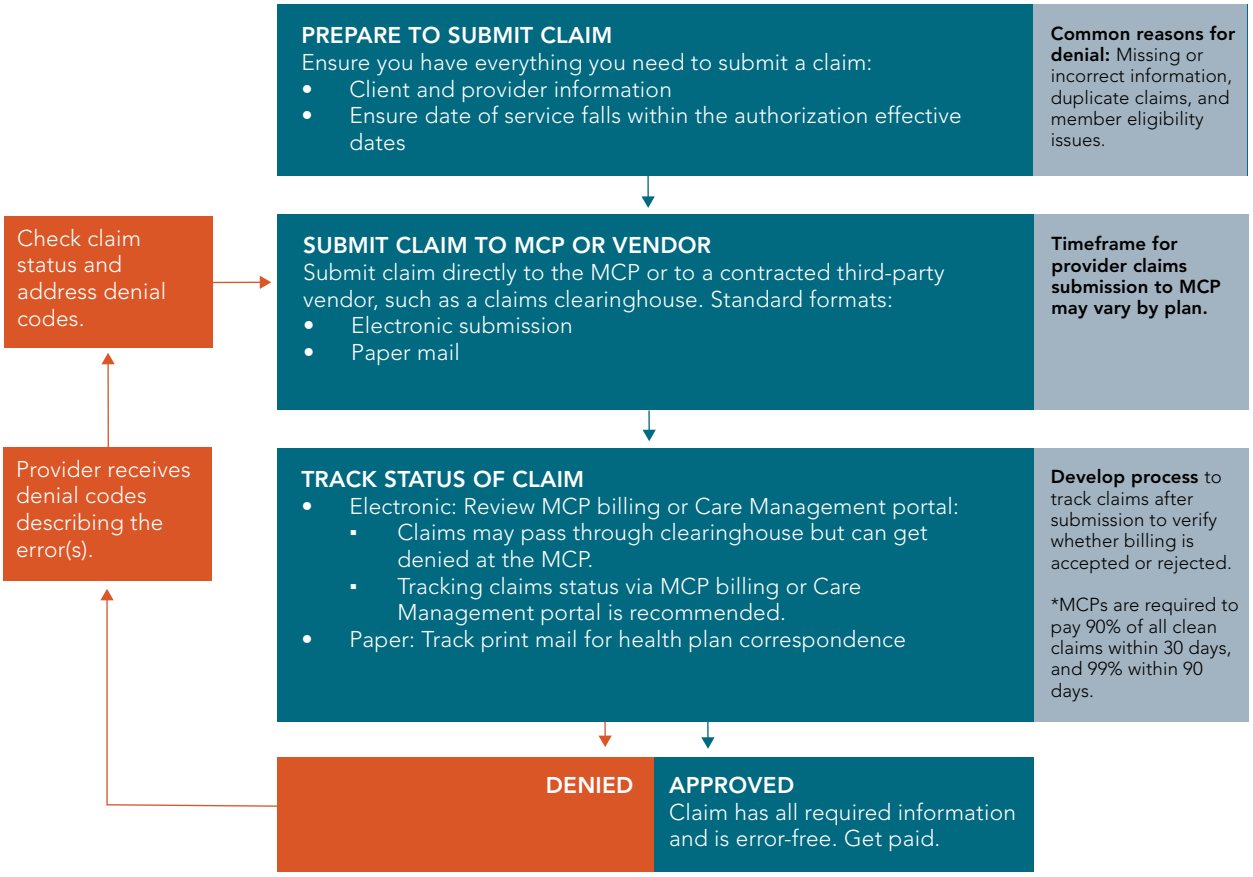
Providers that submit invoices instead of claims need instructions on invoicing formats and submission processes. When procedures for submitting batched invoice data are unclear or not available, providers manually enter individual submissions, leading to increased administrative burden and higher risk for manual data entry errors. Additionally, it is standard practice for MCPs to defer to providers regarding which billing codes to use based on their clinical expertise. However, small providers with less billing experience believe additional clarification around coding from the MCP would be helpful in decreasing denials (see Figure 2, next page).

Test claim and invoicing submission systems and collaborate across MCPs to standardize diagnosis codes

To reduce claims denials and increase clean claims submissions, MCPs and providers should test claims and invoicing systems prior to service delivery and collaborate to standardize the use of diagnosis and billing codes to streamline workflows and improve claims processing.

Recommendation #5: Test systems before providing services at scale. Providers and MCPs can run tests with "dummy" claims and invoices and/or small batches of real claims prior to and during ramp-up of service delivery. CBO providers reported that when MCPs gave them the opportunity to submit test invoices after the contracting process and prior to

Figure 2: Submitting Claims and Receiving Payment



*Department of Health Care Services managed care plan boilerplate contracts Exhibit A, Attachment 8, Section 5b. https://www.dhcs.ca.gov/provgovpart/Documents/2-Plan-Non-CCI-Boilerplate-Final-Rule-Amendment.pdf

service delivery, it helped prevent payment delays by enabling MCPs and providers to identify and address portal navigation issues and fix submission errors before program go-lives.

Claims management and tracking through third-party vendors

Providers may leverage electronic health record (EHR) systems and third-party clearinghouses to streamline billing and decrease administrative burden while improving efficiency, quality, and consistency in claims submissions. EHRs enable providers to pull necessary billing data automatically, rather than through a manual process. Clearinghouses can streamline claims submission and serve as a validation step to support clean claims submission to MCPs. Clearinghouses are potentially a cost-effective strategy for claims processing for providers operating in counties with multiple MCPs whose submission processes and requirements vary. They also can simplify the process of tracking errors and adhering to multiple submission formats for providers with limited administrative capacity. More information on clearinghouse vendors and common functions can be found in Appendix B.

Despite their interest in exploring the use of clearinghouses, most providers lack the capacity to research appropriate vendors and vet their ability to integrate into MCPs' existing systems. Several providers also noted that without sustainable funding streams, long-term contracting with clearinghouses may be a challenge. Many providers felt limited in their ability and bandwidth to research and evaluate potential vendors.

While some MCPs provide information about clearinghouses or even free access to them for contracted providers, it is not a universal practice. One MCP noted that after several challenges with providers submitting invoices, they began requiring providers to use clearinghouses.

Recommendation #6: Publish clearinghouse guidance. Several interviewees suggested that MCPs or another organization (perhaps funded through PATH) could help facilitate outreach to vendors and decrease their research burden by offering guidance about which vendors would best be able to meet MCP billing requirements. A PATH TA vendor and/or MCPs may consider developing provider-facing resources that list compliant clearinghouses that interface with MCP billing platforms, the process for contracting with them, and their associated estimated costs.

Tracking Submitted Claims and Managing Denials and Payment Delays

Administrative capacity

Providers interviewed noted that they need more billing staff to manage claims submission and tracking. For small providers, this presents a particular challenge as many do not have the financial capacity to hire new staff. Providers contracted with multiple MCPs face increased workflow challenges and require additional resources to navigate each plan's billing processes (see Figure 2).

Recommendation #7: Lower barriers to using clearinghouses. As noted, clearinghouses can help providers submit, track, and manage claims. Early experience suggests that portals create inefficiencies in multi-plan counties because the user experience and workflow differ between plans. Where MCPs can coordinate to offer a single user experience, they can create efficiencies for smaller providers and decrease billing challenges.

If providers have an electronic billing system (e.g., an EHR or practice management software), they also can work with a clearinghouse through electronic data interchange (EDI), avoiding the need to use a portal. Contracting directly with a clearinghouse provides real-time information to support billing, reduces denial rates, creates a single workflow for the provider, and allows flexibility in staffing and hiring. In addition, many plans provide access to EDI through a clearinghouse for free. The PATH TA marketplace may provide an opportunity for providers to obtain support in researching and contracting with a clearinghouse, and resources accessed through PATH's Capacity and Infrastructure Transition, Expansion and Development (CITED) initiative or from an MCP's incentive fund can help pay up-front costs.

Conclusion

ECM and Community Supports offer innovative opportunities for Medi-Cal to improve member experiences by coordinating care and addressing member health and social needs. As new Medi-Cal providers face barriers to billing, all CalAIM stakeholders can play a role in developing process-oriented and technological solutions that ensure smooth delivery of services through improved workflows and increased clarity, communication, and technical assistance, while the PATH TA marketplace offers an opportunity for new providers to access billing experts to help them address technical and process-based billing challenges.

Providers are hesitant to invest more resources into administrative capacity without assurances of sustainable funding and long-term contracts with the MCPs to provide Community Supports. Because Community Supports are optional for MCPs to offer, providers are concerned that MCPs may decide to stop offering these services, putting providers' investments into their programs at risk. As PATH funding becomes more widely available in 2023, it will be important to track whether it results in enough funding to help small providers develop service delivery and billing strategies that enable them to become long-term ECM and Community Supports providers.

About the Author

Lucy Pagel, MPH; Kathleen Kane, MPH; Kristin Mendoza-Nguyen, MPH; Lauren Block, MPA; and Jill Donnelly, MPH, are consultants at Aurrera Health Group, a mission-driven national health policy and communications firm based in Sacramento.

About the Foundation

The **California Health Care Foundation** (CHCF) is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Appendix A. Interviewees

Organization
California Association of Health Plans
Ceres Community Project
County Behavioral Health Directors Association of California (CBHDA) and representatives from Alameda, Los Angeles, Nevada, Placer, Santa Clara, San Bernardino, Shasta, and Tulare counties
Enhanced Care Management (ECM) providers from Marin, San Francisco, Santa Cruz, Placer, San Joaquin, Santa Clara, Riverside, and Shasta counties participating in the Whole Person Care Learning Collaborative
El Sol Neighborhood Educational Center
Kaiser Permanente
Pamela Mokler & Associates, Inc.
People Assisting the Homeless (PATH)
Regional Asthma Management and Prevention

Appendix B. Clearinghouse Vendors and Common Service Offerings

Providers may leverage third-party vendors, such as claims clearinghouses, to streamline billing and decrease administrative burden while improving efficiency, quality, and consistency in claims submissions. Clearinghouses can offer providers a higher likelihood of submitting claims without errors and potentially receiving timely payments from managed care plans (MCPs). Furthermore, clearinghouses may be especially useful for providers operating in counties with multiple MCPs with different requirements.

Providers considering contracting with a claims clearinghouse may consider the following questions to inform their decision:

1. **Check to see if the MCP(s) offers the use of a clearinghouse for free or at no cost to contracted providers.** If no vendor is offered for free or at no cost, providers interested in using a claims clearinghouse should work with their MCP to identify any recommended clearinghouses that the MCPs' provider networks currently use.
2. **Does the clearinghouse offer the following services?**
   - Claims submission tests
   - Real-time client benefits and eligibility review
   - Electronic claims review and submission
   - Electronic remittance advice (ERA)
   - Electronic funds transfer (EFT)
3. **Consider vendor costs and pricing structures if your MCP does not offer a free clearinghouse.** Common pricing structures include monthly fees, fixed service transaction fees or transaction fees based on volume, or a percent of monthly revenue collections.

The list below identifies some commonly used claims clearinghouses. This list is not comprehensive and there may be other vendors that may be able to meet provider and MCP needs and requirements.

Vendor	Contact	Payer List
Ability (By Inovalon)	https://www.inovalon.com/products/provider-cloud/	https://www.abilitynetwork.com/payer-list/
Availity	https://www.availity.com/	https://apps.availity.com/public-web/payerlist-ui/payerlist-ui/#/
Change Healthcare	https://www.changehealthcare.com/	https://payerfinder.changehealthcare.com/npd?adobe_mc=MCORGID%3D26CD3A665C7D19990A495D73%2540AdobeOrg%7CTS%3D1668642561
Conduent	https://www.conduent.com/	https://downloads.conduent.com/content/usa/en/document/edi-gateway-eligibility-payer-list.pdf
Office Ally	https://cms.officeally.com/	https://cms.officeally.com/Pages/ResourceCenter/PayerLists/PayerList.aspx
Optum Intelligent EDI	https://www.optum.com/business/health-plans/claims-payment-accuracy/edi-workflows.html	https://iedi.optum.com/iedi/enspublic/Download/Payerlists/Medicalpayerlist.pdf
The SSI Group	https://thessigroup.com/	https://cws.ssigroup.com/payerlist/