Enhanced Care Management Provider Reference Guide

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1 Introduction

The Enhanced Care Management (ECM) benefit is a statewide benefit established by the Department of Health Care Services (DHCS) to provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care coordination/care management services to populations of focus.

Health Net*, on behalf of CalViva Health (the "Plan"), launched the Medi-Cal ECM benefit designed by DHCS and authorized by the Centers for Medicare and Medicaid Services (CMS). The following seven core services are provided at the point of care:

1. Outreach and engagement.
2. Comprehensive assessment and care management plan.
3. Enhanced care coordination.
4. Health promotion.
5. Comprehensive transitional care.
6. Member and family supports.
7. Coordination of and referral to community and social support services.

The overall goal of the ECM benefit is to provide comprehensive care and achieve better health outcomes for the highest need beneficiaries in Medi-Cal.

The Plan contracts with community-based ECM providers who have experience serving the ECM populations of focus, and expertise providing the core ECM services, to provide services to eligible members under the Medi-Cal ECM benefit. The ECM populations of focus eligible for the ECM benefit are:

ECM Populations of Focus	Adults ages 21 and over	Children & youth up to age 21
1. Individuals experiencing homelessness: a. Adults without Dependent Children/Youth Living with Them Experiencing Homelessness b. Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	X	
2. Individuals at risk for avoidable hospital or emergency department (ED) utilization (formerly called high utilizers)	X	X
3. Individuals with serious mental health and/or substance use disorder (SUD) needs	X	X
4. Individuals transitioning from incarceration	X	X
5. Adults living in the community and at risk for long-term care institutionalization	X	
6. Adult nursing facility residents transitioning to the community	X	
7. Children or youth enrolled in California Children's Services (CCS) or CCS whole child model (WCM) with additional needs beyond the CCS condition		X
8. Children or youth involved in child welfare		X
9. Birth Equity Population of Focus	X	X

Detailed eligibility criteria of these populations of focus per DHCS are included in Section 4.1 of this guide.

This ECM Provider Reference Guide outlines the requirements and expectations for ECM providers contracted with the Plan. The Plan may provide updated versions of this ECM Provider Reference Guide in the future.

2 Regulatory Authorities

By signing the Enhanced Care Management Services Agreement (contract) with the Plan, the ECM provider agrees to follow the program requirements as established under law, regulation, and through the Plan's contract with DHCS, including those applicable to member materials. The ECM provider will provide the ECM services in accordance with all applicable federal and state law and regulatory guidance as outlined in the signed contract.

3 Getting Ready for ECM: The ECM Provider and Care Team

ECM providers are community-based entities with experience and expertise providing intensive, in-person care coordination and care management services to individuals in one or more of the Populations of Focus and often employs those with lived experience in these populations. ECM will be offered **primarily through in-person interaction** where members and their families and support networks live, seek care, and prefer to access services. The Plan is required to contract with ECM providers to deliver ECM to members. In order to contract with the Plan, and before providing ECM services, the ECM provider must meet several requirements.

3.1 Provider Experience and Qualifications

A wide range of entities may operate as ECM providers, including but not limited to:

- Counties.
- Behavioral health providers.
- Primary care physicians (PCPs).
- Federally Qualified Health Centers (FQHCs).
- Community Health Centers.
- Hospitals or hospital-based physician groups or clinics (including public hospitals and district and/or municipal public hospitals).
- Rural Health Clinics.
- Indian Health Service Programs.
- Local health departments.
- Behavioral health entities.
- Community mental health centers.
- Substance use disorder (SUD) treatment providers.
- Organizations serving individuals experiencing homelessness.
- Managed Care Plans.
- Organizations serving justice-involved individuals.
- California Children's Services (CCS) providers.
- Other community-based organizations.

To become an ECM provider, the ECM provider must be **experienced in serving the ECM Population(s) of Focus** it will serve **and have the experience and expertise with the ECM services** it will provide. The ECM provider will be able to communicate in **culturally and linguistically appropriate and accessible** ways. The ECM provider will have the capacity to **provide culturally appropriate and timely in-person care management activities** including accompanying members to critical appointments when necessary. The ECM provider should have **formal arrangements and processes** in place to engage and cooperate

with area hospitals, primary care practices, behavioral health providers, specialists, and other entities, including Community Supports providers, to coordinate care as appropriate to each member.

The ECM provider will use a **care management documentation system or process** that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a member care plan that can be shared with other providers and organizations involved in each member's care. Other providers and organizations could include, but are not limited to, primary care doctors, participating physician groups (PPGs), specialists, etc. Care management documentation systems could include certified electronic health record technology, or other documentation tools that can:

- Document member goals and goal attainment status.
- Develop and assign care team tasks.
- Define and support member care coordination and care management needs.
- Gather information from other sources to identify member needs and support care team coordination and communication.
- Support notification regarding member health status and transitions in care (e.g., discharges from hospital or long-term care facility, housing status).

The ECM provider must comply with all applicable state and federal laws and regulations and all ECM program requirements in the DHCS-health plan ECM contract and associated guidance.

3.2 Provider Certification

The purpose of the ECM provider Certification Process is to certify organizations that are qualified to serve as an ECM provider. Certification is the process used by the Plan to evaluate and verify the potential ECM provider's ability to comply with ECM requirements as outlined by DHCS, including the provision of ECM core services to the ECM populations of focus, and the ability to submit data files and claims.

To become an ECM provider, organizations must meet the criteria described in the DHCS CalAIM ECM guidance documents and submit a Provider Interest Form (PIF) to the Plan. The Plan reviews all PIFs and invite select organizations to submit the ECM Provider Certification Application with accompanying documentation supportive of their application. Upon review, the health plan may approve providers to be contracted for ECM services, provide feedback on missing requirements within a prospective provider's documentation, or decide not to move forward with providers who lack key qualifications to support the program.

Once a provider passes the initial documentation review, a live system walk through will be completed of the provider's case management system and process that will be used for documenting all ECM activities. Key areas of focus for the Readiness and Gap Closure Plan are driven by the 12 required areas in the ECM Certification Application:

#	Area of Focus
1	Overview of ECM Structure
2	ECM Core Service Components: Outreach & Engagement
3	ECM Core Service Components: Comprehensive Assessment & Care Plan Management
4	ECM Core Service Components: Enhanced Coordination of Care
5	ECM Core Service Components: Health Promotion
6	ECM Core Service Components: Comprehensive Transitional Care
7	ECM Core Service Components: Member & Family Supports
8	ECM Core Service Components: Coordination & Referrals to Community & Social Support Services

#	Area of Focus
9	ECM Provider Administration & Operations: Claims/Encounters
10	ECM Provider Administration & Operations: File Data Exchange
11	ECM Provider Administration & Operations: Staffing
12	ECM Provider Administration & Operations: Oversight & Monitoring

If the prospective ECM provider is unable to fulfill the ECM requirements and/or determines the ECM provider will not be able to meet ECM requirements, the prospective ECM provider cannot be certified by the Plan, and therefore will not be contracted with the Plan to provide ECM services under the ECM benefit. The Plan may request an on-site visit with the prospective ECM provider during the certification process and/or program administration period.[1]

3.3 Medi-Cal Enrollment/Vetting for ECM Providers

Pursuant to relevant DHCS All Plan Letters (APLs) including provider credentialing/recredentialing and screening/enrollment APL 19-004, if a state-level enrollment pathway exists, the ECM provider will enroll as a Medi-Cal provider. If APL 19-004 does not apply to an ECM provider, the ECM provider must comply with the Plan's process for vetting the ECM provider, which may extend to individuals employed by or delivering services on behalf of the ECM provider, to ensure it can meet the capabilities and standards required to be an ECM provider. The Plan will request information from the ECM provider to fulfill this requirement.

3.4 Contracting

ECM providers will work with the Plan to establish and execute a contract and prepare to provide ECM services by the agreed-upon start date.

3.5 Staffing, Provider Capacity and Training

3.5.1 ECM Provider Care Team Staffing

Highly qualified and skilled staff are essential to the success of the ECM benefit. ECM providers are required to develop and maintain a care team, including all required care team roles and/or functions, to deliver ECM services to members. The ECM provider is responsible to maintain adequate staff and ensure the ECM provider's ability to carry out responsibilities for each assigned member consistent with the DHCS provider standard terms and conditions, the DHCS-MCP ECM Contract and any other related DHCS guidance. The Plan will work with the ECM provider to ensure the ECM provider's ECM staffing model emphasizes and optimizes the roles of different team members, while meeting the ECM requirements including required ECM staffing ratios.

DHCS specifies that each ECM provider must have a **Lead Care Manager**. An **ECM Lead Care Manager** is a member's designated care manager for ECM, who works for the ECM provider organization. The Lead Care Manager operates as part of the member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and coordination with a Community Supports provider, as applicable. To the extent a member has other care managers, the Lead Care Manager is considered to be the primary care manager, and single point of contact, for the member and will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the member and non-duplication of services. Each Lead Care Manager must be able to provide both in-person and telephonic services to the member, depending on the member's need and preferences. ECM providers must have protocols in place outlining how clinical supervision is provided to non-licensed (i.e., paraprofessional) staff members by the clinical consultant (see below) to ensure continued guidance,

[1] On-site visits will be subject to the standard public health protocols and may need to occur virtually.

training, and clinical support to appropriately oversee the non-licensed (i.e., paraprofessional) staff members activities aligning to the ECM member's care plan and care coordination needs.

The ECM provider is responsible for maintaining the following roles/positions on the care team:

- Lead care manager(s).
- ECM director.
- ECM clinical consultant(s).

Many ECM program models also include Community Health Workers (CHWs). CHWs can be included in the care team at the ECM provider's discretion or may serve as the lead care manager.

The table below describes the DHCS ECM care team requirements. As DHCS may provide additional guidance regarding staffing, this section of the guide may be updated in the future.

ECM Team Member	Qualifications	Role
Lead Care Manager	Professional (i.e., licensed mental health or behavioral health professional/clinician, social worker, or nurse) ***or*** Paraprofessional (with appropriate training, lived experience, and oversight)	• Engage eligible members. • Utilize motivational interviewing, trauma-informed care, and harm-reduction approaches. • Coordinate with individuals and entities to ensure a seamless experience for the member and avoid service duplication. • Oversee provision of ECM services and ensure the implementation of the Comprehensive Assessment and Care Management Plan. • Offer services where the member lives, seeks care, or most convenient for members and within MCP guidelines. • Facilitate connection between members and other social services including transportation. • Advocate on behalf of the member with health care professionals. • Coordinate with hospital staff on discharge plan. • Accompany the member to office visits, as needed and according to MCP guidelines. • Monitor treatment adherence (including medication). • Provide health promotion and self-management training. • Any POF-specific roles as stipulated by DHCS in the DHCS ECM Policy Guide and related DHCS guidance.
ECM Director	Ability to manage multi-disciplinary care teams	• Responsible for the management of the multi-disciplinary care team. • Responsible for overseeing compliance with multi-disciplinary care team quality measures and reporting requirements.

ECM Team Member	Qualifications	Role
ECM Clinical Consultant	Clinician consultant(s), independently licensed clinician who may be a primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, licensed clinical social worker, or other licensed behavioral health care professional	• Responsible for ensuring clinical assessment elements leading to the creation of the plan of care are completed under the direction of an independently licensed clinician. • Review and inform the multi- disciplinary care team. • Act as clinical resource for multi- disciplinary care team, as needed. • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator and multi- disciplinary team.
Community Health Worker (recommended)	Paraprofessional or peer advocate	• Engage eligible members. • Accompany member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines. • Health promotion and self-management training. • Arrange transportation. • Link the member to other social services and supports the member may need. • Distribute health promotion materials. • Call the member to facilitate visit with care coordinator. • Advocate on behalf of the member with health care professionals. • Use motivational interviewing, trauma-informed care, and harm-reduction approaches. • Monitor treatment adherence (including medication).

3.5.2 Staffing Ratios

We expect ECM providers to staff appropriately for the population of focus that they serve for whom they are providing ECM services. Though maximum caseloads are defined below, providers are encouraged to reduce those based on the level of needs of the member and populations of focus that they serve to best support the members at the intensity that is expected in the ECM program.

3.5.3 Provider Caseloads

The Lead Care Manager caseload ratio recommendation is 50:1 but not to exceed 60:1

3.5.4 Staffing and Capacity Report

To understand the staffing capacity, measure network adequacy, demonstrate growth over time, and identify staff who will need to complete required training, ECM providers are required to submit an initial, prospective staffing and capacity report before providing ECM services (as part of the ECM Provider Certification process). After ECM go-live, ECM providers will be required to submit staffing and capacity reports at minimum on a quarterly basis. The required report will include the following, subject to change:

- Tax identification number (TIN)/National Provider Identifier (NPI).
- Team members' names.
- Team members' ECM role.
- Team members' ECM caseload capacity for ECM enrolled members (quarterly).
- Member caseload for the Plan within the context of service provision to all MCPs with whom the ECM provider is contracted.

Capacity reports are due quarterly on:

- January 31st
- April 30th
- July 31st
- October 31st

The Plan will utilize the data provided in the Staffing and Capacity reports to ensure the ECM provider's caseloads do not surpass the thresholds outlined by the Plan. The individual Lead Care Manager's caseload count is the cumulative count of members regardless of the member's health plan assignment. Lead care managers can serve members from different MCPs, but the individual Lead Care Manager's caseload capacity count cannot exceed the threshold number for each individual care manager as a whole.

3.5.5 Training

ECM providers are expected to participate in all mandatory, provider-focused ECM training and technical assistance provided by the Plan, including in-person sessions, webinars, and/or calls, as necessary.

4 ECM Member Eligibility, Assignment and Enrollment

This section outlines information regarding ECM member eligibility, assignment and enrollment (including disenrollment). This section also includes a description of the ECM eligibility screening process and referral process.

4.1 ECM Eligibility Criteria

Medi-Cal managed care members are eligible for the ECM benefit if they meet the following eligibility criteria as members of the ECM populations of focus. The ECM populations of focus seek to improve the health outcomes of a group by monitoring and identifying members within that group. ECM providers can serve one or more populations of focus.

ECM Populations of Focus and Eligibility Criteria
1. Individuals Experiencing Homelessness **A. Adults without dependent children/youth living with them experiencing homelessness who:** • Are experiencing homelessness, defined as meeting one or more of the following conditions[2]:   ○ Lacking a fixed, regular, and adequate nighttime residence;

[2] This definition of homelessness is based on the U.S. Department of Health and Human Services (HHS) 42 CFR § 11302 - General definition of homeless individual with the modification to Clause (v) timeframe for an individual who will imminently lose housing has been extended from 14 days (HHS definition) to 30 days. The wording of this definition has also been slightly modified for clarity, relative to the originally released definition.

ECM Populations of Focus and Eligibility Criteria
○ Having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; ○ Living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by federal, state, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing); ○ Exiting an institution into homelessness (regardless of length of stay in the institution); ○ Will imminently lose housing in next 30 days; ○ Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence; **and** • Have at least one complex physical, behavioral or developmental need, with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes **and/or** decreased utilization of high-cost services[3]. **B**. **Homeless families or unaccompanied children/youth and youth** Children, youth and families with members under age 21 who are: • Experiencing homelessness as defined above in under the modified HHS 42 CFR Section 11302 homeless definition; or Sharing the house of other persons (i.e., couch surfing) due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals (in hospital without a safe place to be discharged to), as modified from the 45 CFR 11434a McKinney-Vento Homeless Assistance Act definition of "at risk of homelessness[4]."
2. Individuals at Risk for Avoidable Hospital or Emergency Department (ED) Utilization **A. Adults** who meet one or more of the following conditions: • Five or more emergency room visits in a **6-month** period that could have been avoided with appropriate outpatient care or improved treatment adherence[5]. • Three or more unplanned hospital and/or short-term skilled nursing facility (SNF) stays in a 6-month period that could have been avoided with appropriate outpatient care or improved treatment adherence. **B. Children and youth** who meet one or more of the following conditions: • Three or more ED visits in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence[6]. • Two or more unplanned hospital and/or short-term SNF stays in a **12-month** period that could have been avoided with appropriate outpatient care or improved treatment adherence.
3. Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs

[3] Pregnant and postpartum individuals who are homeless are considered to have met this definition.

[4] See McKinney-Vento Homeless Assistance Act.

[5] Including appropriate timing, interventions within outpatient care settings, care plan development, communication with the Member, interdisciplinary care team, or referrals.

[6] Including appropriate timing, interventions within outpatient care settings, care plan development, communication with the Member, interdisciplinary care team, or referrals.

ECM Populations of Focus and Eligibility Criteria

A. Adults who:
• Meet the eligibility criteria for participation in or obtaining services through specialty mental health services (SMHS) delivered by Mental Health Plans (MHPs); the Drug Medi-Cal Organization Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) program[7]; and
• Are experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, high measure (four or more) of adverse childhood experiences (ACEs) based on screening, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms); and
• Meet one or more of the following criteria:
  ○ Are at high risk for institutionalism[8], overdose and/or suicide.
  ○ Use crisis services, EDs, urgent care or inpatient stays as the primary[9] source of care.
  ○ Experience two or more ED visits or two or more hospitalizations due to serious mental health or SUD in the past 12 months.
  ○ Are pregnant and postpartum (12 months from delivery).
 	
B. Children and youth who meet the eligibility criteria for participation in or obtaining services through one or more of:
• SMHS delivered by MHPs.
• The DMC-ODS **or** the DMC program.

4. Individuals Transitioning from Incarceration **A. Adults who**: • Are transitioning from incarceration or have transitioned within the last 12 months; **and** • Have at least one of the following conditions: mental illness, SUD, chronic condition/significant non-chronic clinical condition, intellectual or developmental disability (I/DD), traumatic brain injury (TBI), HIV/AIDS, pregnant or postpartum. **B. Children and youth** who are transitioning from a youth correctional facility or transitioned from being in a youth correctional facility within the past 12 months. No further criteria are required to be met for children and youth to qualify for this ECM population of focus.
5. Adults Living in the Community and at Risk for Long-Term Care (LTC) Institutionalization Adults who are: • Living in the community who meet the SNF Level of Care (LOC) criteria[10]; **OR** who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury[11]; **and** • Actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need

[7] Further information on access criteria for the SMHS for adults and children can be found in BHIN 21-073 and for the DMC-ODS delivery system in BHIN 21-075. The medical necessity criteria for DMC services can be found in California Code of Regulations, Title 22, § 51341.1 and BHIN 21-071. See also Appendix B of this Policy Guide.

[8] "Institutionalization" in this context is broad and means any type of inpatient, SNF, long-term, or ED setting.

[9] From December 2022, modified from "sole" to "primary."

[10] As established in the California Code of Regulations Title 22, § 51335.

[11] Criteria adapted from the 2020 Medi-Cal Long-Term Care At Home proposal.

ECM Populations of Focus and Eligibility Criteria
for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring) [12]; **and** • Able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).
6. Adult Nursing Facility Residents Transitioning to the Community Adult nursing facility residents who are: • Interested in moving out of the institution; and • Likely candidates to do so successfully; and • Able to reside continuously in the community.
7. Children or Youth Enrolled in CCS or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition Children and youth who are: • Enrolled in CCS **or** CCS WCM; and • Experiencing at least one complex social factor influencing their health. Examples include (but are not limited to) lack of access to food; lack of access to stable housing; difficulty accessing transportation; high measure (four or more) of ACEs screening; history of recent contacts with law enforcement; or crisis intervention services related to mental health and/or substance use symptoms.
8. Children or Youth Involved in Child Welfare Children and youth who meet one or more of the following conditions: • Under age 21 and currently receiving foster care in California. • Under age 21 and previously received foster care in California or another state within the last 12 months. • Aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state. • Under age 18 and are eligible for and/or in California's Adoption Assistance Program. • Under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months.
9. Birth Equity Population of Focus • Adults and youth who are pregnant or postpartum (through 12 months period); **and** • Are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality (effective January 1, 2024).

DHCS defines homelessness as one of the following[13]:

- An individual or family who lacks a fixed, regular, and adequate nighttime residence.

[12] Criteria adapted from the Community-Based Health Home eligibility criteria here.

[13] This definition is based on the HUD definition of homelessness with modifications as noted below.

- If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization.
- The timeframe for an individual or family who will imminently lose housing has been extended from 14 (HUD definition) to 30 days.

- An individual or family having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground.
- An individual or family living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by federal, state, or local government programs for low-income individuals.
- An individual or family living in a shelter.
- An individual exiting an institution to homelessness.
- An individual or family who will imminently lose housing in next 30 days.
- Unaccompanied youth and homeless families and children and youth defined as homeless under other federal statutes.
- Victims fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence.

In addition, and as of January 1, 2022, the Plan supported the transition of members to ECM and enrollment in ECM for:

- All members enrolled in a WPC pilot as of December 31, 2021, who are identified by the WPC Lead Entity as belonging to a population of focus (includes children and youth currently served by WPC).
- All members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in the HHP as of December 31, 2021 (includes children and youth currently served by HHP).

4.2 ECM Exclusion Criteria and ECM Overlapping Programs

DHCS examined other programs with an existing element of care management and/or care coordination to determine approaches to program coordination and to prevent non-duplication across programs. DHCS categorized three potential approaches to ECM coordination and non-duplication, listed below along with programs that fall under each category.

Approach	Explanation	Programs
ECM as a "wrap"	CalViva Health members can be enrolled in **both** ECM and the other program. ECM enhances and/or coordinates across the case/care management available in the other program. The Plan must ensure non-duplication of services between ECM and the other program. These programs are considered to be complementary of ECM.	**Programs carved out of managed care:** • California Children's Services (CCS) • Specialty Mental Health Services (SMHS) Targeted Case Management (TCM) • SMHS Intensive Care Coordination (ICC) for Children • Drug Medi-Cal Organized Delivery System (DMC-ODS) and Drug Medi-Cal (DMC) Care Coordination & Management Programs • Fall Service Partnership (FSP) • Health Care Program for Children in Foster Care (HCPCFC) • In Home Supportive Services (IHSS) • Genetically Handicapped Person's Program (GHPP) **Programs carved into managed care** • CCS Whole Child Model

Approach	Explanation	Programs
		• Community Based Adult Services (CBAS) **Coverage for CalViva Health members dually eligible for Medicare and Medicaid** *Note: Dually eligible CalViva Health members can receive ECM if they meet ECM Population of Focus criteria.* • Other Medicare Advantage Plans. • Medicare FFS. **Other programs** • California Wraparound • Regional Centers for Individuals with I/DD **Programs serving pregnant & postpartum individuals** • Comprehensive Perinatal Services Program (CPSP) • Black Infant Health (BIH) Program • California Perinatal Equity Initiative (PEI) • American Indian Maternal Support Services (AIMSS) • CDPH California Home Visiting Program (CHVP) • CDSS CalWORKs Home Visiting Program (HVP)
Either ECM or the other Program	CalViva Health members can be enrolled in ECM **OR** in the other program, not in both at the same time. These programs are considered to be duplicative of ECM.	**1915(c) waiver programs** • Multipurpose Senior Services Program (MSSP). • Assisted Living Waiver (ALW). • Home and Community-Based Alternatives (HCBA) Waiver. • HIV/AIDS Waiver. • HCBS Waiver for Individuals with Developmental Disabilities (DD). • Self-Determination Program for Individuals with DD. **Programs carved out of managed care** • County-based Targeted Case Management (TCM)* Beginning July 1, 2024, members who meet ECM POF criteria should be enrolled in ECM and may no longer be enrolled in both programs at the same time. **Programs carved into managed care** • Complex Case Management (CCM).

Approach	Explanation	Programs
		Other programs • California Community Transitions (CCT) Money Follows the Person (MFTP).
Excluded from ECM	Medi-Cal beneficiaries enrolled in the other program are excluded from ECM. These programs are ECM exclusionary criteria.	**Coverage for CalViva Health members dually eligible for Medicare and Medicaid** • Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) • Program for All Inclusive Care for the Elderly (PACE) • Exclusively Aligned Enrollment (EAE) DSNP **Other programs** • Family Mosaic Project Services. • Hospice

Unlike HHP, members with a share of cost are not excluded from ECM. Full scope CalViva Health members are eligible for ECM if they meet ECM eligibility criteria, regardless of their share of cost.

Given the number of care management and care coordination programs, initiatives, or waivers in existence today, the exclusion and overlapping criteria are intended to ensure that the most appropriate individuals that would benefit from ECM can participate.

ECM providers are encouraged to review the latest DHCS guidance for more information on exclusion criteria and overlapping programs.

4.2.1 ECM Provider Expectations

If a member is receiving care management from multiple sources or systems of care, ECM providers are expected to coordinate across all sources or systems of care to provide care management. If a member is receiving care management or duplication of services from multiple sources/systems, ECM providers are expected to alert the Plan to ensure non-duplication of services. ECM providers are also expected to follow the Plan instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

4.3 Methods to Identify Potentially Eligible Members

ECM providers are responsible for driving member identification and ECM enrollment primarily through community-based referrals. As such, the primary mechanism for member identification should be referrals from the community. ECM providers are responsible for informing members and their families, guardians and caregivers, Community Support providers, other providers, and CBOs, about ECM, the ECM Populations of Focus (POF), and the process to request ECM. ECM providers are to consider requests for ECM from members and on behalf of members, from all entities described above. In addition, members may be identified as potentially eligible for the ECM benefit using multiple methods including:

- **ECM member information file (MIF)** includes potentially eligible members provided by the Plan to ECM providers on a regular basis. In addition to all currently active members, it includes members assigned to each ECM provider who may potentially meet the ECM eligibility criteria based on the lists DHCS provides to the Plan and internal Plan data. This will be the primary source for outreach, engagement, and enrollment in ECM. ECM providers are required to utilize

this list to identify, screen, enroll, and provide ECM core services to eligible and enrolled ECM members.

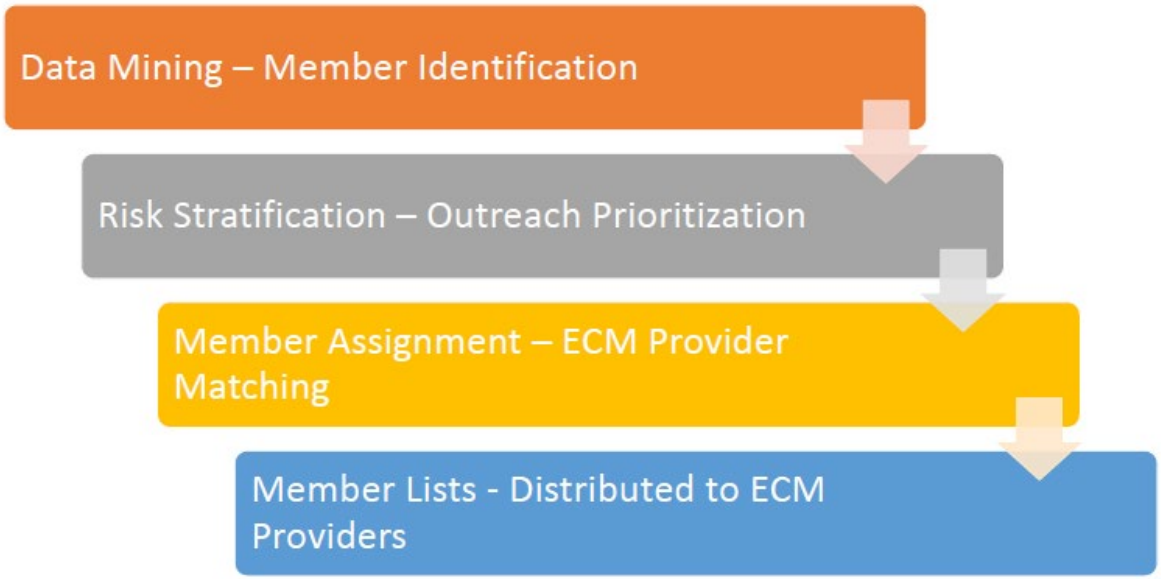
- **ECM provider referrals** to the Plan of potentially eligible members identified at the point of care. The ECM provider is encouraged to identify members who would benefit from ECM. After the ECM provider identifies a member and validates eligibility with the Health Plan, the ECM provider needs to complete and send an ECM member referral to the Plan. All ECM member referrals will be clinically reviewed by the Plan and may either be approved or denied for ECM. Upon approval from the Plan, members will be added to the ECM MIF file and other files communicated through sFTP.
- **ECM Community Referrals** are eligible members who have been directly referred to ECM by non-contracted providers, community partners which include but are not limited to PCPs, hospitals/inpatient facilities, shelters, recuperative care providers, correctional facilities, Community Support providers, CBOs, members' families, and other referral sources from the community.
- **Member self-referrals** to ECM provider or the Plan due to the member receiving information about the ECM benefit through member-informing materials.

The Plan may request supporting documentation from referring entities (e.g., ECM and non-ECM providers, members, other organizations) to assist in the eligibility determination for members who are identified as potentially eligible for ECM. The Plan will ask referring entities to complete and submit a referral form to the Plan. The Plan will provide the ECM referral form to ECM providers, community partners, and other relevant service providers to complete and submit to the Plan.

4.3.1 CalViva Health Member Assignment to ECM Providers

The Plan is responsible for communicating new member assignments to the ECM provider as soon as possible, but no later than 10 business days after the member is assigned to an ECM provider.

The Plan conducts data mining and risk stratification of members to assign members to ECM providers and will distribute lists of the eligible members to the ECM provider.



The ECM provider is responsible to immediately accept all members assigned by the Plan for ECM, with the exception that if the ECM provider is at its pre-determined capacity, an ECM provider is allowed to decline a member assignment. If an ECM provider is at capacity, the ECM provider must notify the Plan if it does not have the capacity to accept a member assignment.

4.3.2 ECM Eligibility Referral Process

Members, providers (ECM providers and non-ECM providers), community-based organizations and the Plan are encouraged to refer members identified as potentially eligible for the ECM benefit. Providers may see members that are not listed on the ECM MIF distributed to each ECM provider from the Plan, which is an opportunity to connect a member to the ECM program prior to identification through plan data.

4.3.2.1 ECM Provider Initiated Eligibility Referral

If an ECM provider identifies a potentially eligible member, the ECM provider should complete the ECM referral form with the member's information and submit to the Plan.

The Plan has a variety of methods to receive the referral information, however the preferred method for the referrals is through the provider portals for ease to allow the provider access to real time status updates.

Once the referral form is received and reviewed, the Plan may follow up with the ECM provider to request supporting documentation and/or evidence to facilitate making an eligibility determination. Once the Plan makes a final ECM eligibility determination for the member, the Plan will notify the ECM provider. If the member is found to be ineligible and denied for ECM, the member will receive a notice of action from the Plan.

If the member meets the ECM eligibility criteria, the provider will be informed to conduct outreach for ECM services in order to engage the member. If enrolled, the ECM provider will notify us of member enrollment status in the monthly RTF.

4.3.2.2 Member Initiated Eligibility Referral

Members may self-refer into the ECM benefit by: (1) contacting the Plan's Member Services Department (2) with ECM provider assistance or (3) through the Findhelp platform. ECM providers must assist any member who expresses interest in enrolling in the ECM Benefit and complete a referral form on their behalf if the ECM provider determines the member may be potentially eligible for participation in the ECM Benefit.

ECM providers are required to notify the Plan of any members who express interest in enrolling in the ECM Program, including members who may not be ECM eligible.

4.3.2.3 ECM Community Initiated Eligibility Referrals

Communities may refer members into ECM benefit by: (1) contacting the Plan's Member Services Department (2) with ECM provider assistance or (3) through the Findhelp platform. Community referrals received by the Plan, will process the referrals, and disseminate information about member assignment to the designated ECM provider. Upon notification of an assigned member, ECM provider is responsible for assigning the member to an ECM Lead Care Manager to begin outreach and engagement within 72 hours.

The ECM provider is responsible for immediately accepting all members assigned by the Plan for ECM, except if the ECM provider has reached its pre-determined capacity. If the ECM provider has reached its pre-determined capacity, the ECM provider is allowed to decline member assignment. However, the ECM provider must notify the Plan within one business day if they are unable to accept the referral.

4.4 Outreach and Member Engagement

4.4.1 ECM Provider Conducted Outreach

Outreach and engagement of ECM-eligible members is critical for the program's success. ECM providers are responsible for conducting outreach to each assigned member and engaging each assigned member to enroll into ECM. The ECM provider must ensure outreach to assigned members prioritizes those assigned members with the highest level of risk and need for ECM.

The ECM provider is expected to conduct outreach **primarily through in-person interaction** where members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community, subject to public health protocols. The ECM provider may supplement in-person visits with secure teleconferencing and telehealth,[14] where appropriate and with the member's consent. The ECM provider must use the following modalities, as appropriate and as authorized by the member, if in-person modalities are unsuccessful or to reflect a member's stated contact preferences: mail/letter, email, texts, telephone calls, and telehealth. The Plan requires ECM provider to initiate outreach and complete at least five outreach attempts within 90 calendar days of the receipt of ECM data file from the Plan. At least three different modalities will be used in attempt to reach members who are unable to be contacted in person and before a member is identified as an unsuccessful engagement.

All outreach attempts to enroll members identified on a providers monthly MIF must be tracked and reported to the plan monthly through the outreach tracking file (OTF).

ECM providers must have the capacity and strong commitment to conduct in-person outreach. Should an ECM provider's program or staffing change where in-person services can no longer be provided, the provider must notify the Plan immediately.

The ECM provider must comply with non-discrimination requirements set forth in state and federal law and the contract with the Plan.

Member engagement and response will vary based on the particular member's circumstances. ECM providers' ECM outreach activity protocols to assigned members must include active, meaningful, and progressive attempts to reach members each month between the initial 30-day and 90-day period, until each member is notified and engaged. The outreach and engagement expectations outlined in this section apply to assigned members not yet enrolled into ECM.

Once the ECM provider determines that a member is not reachable within 90 days, declines to participate, continues to disengage, or meets an exclusion criterion, the ECM provider is expected to exclude the member from further outreach and report the information to the Plan in the Return Transmission File (RTF) and to the Plan.

If the ECM provider cannot contact an enrolled member after three attempts using different modalities (in-person, mail/letter, email, texts, phone calls and telehealth), the ECM provider is expected to exclude the member from further outreach and report the member disenrollment information to the Plan in the RTF submission to the Plan.

ECM providers are expected to provide a phone number for members to reach their ECM care team.

[14] The ECM provider is responsible to ensure secure teleconferencing and telehealth systems meet DHCS requirements. DHCS provides information on Medi-Cal and Telehealth at: www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx.

4.4.2 The Plan Conducted Outreach, Including WPC/HHP Transition Notices

In an effort to mitigate adverse impacts to members transitioning to ECM and leverage the member's existing relationship with WPC Lead Entity and/or HHP CB-CME, the WPC Lead Entity and/or HHP CB-CME shall be responsible for communicating to members about the transition to ECM. The Plan shall collaborate with and provide the WPC Lead Entity with guidance on communication with the member. The Plan will utilize DHCS' HHP to ECM Transition Notice template to communicate transition expectations to the member.

4.5 Whole Person Care/Health Homes Program (WPC/HHP) Transition

The ECM benefit replaces the HHP and elements of the WPC pilots, building on positive outcomes from those programs over the past several years. DHCS requires that beneficiaries receiving Health Homes or Whole Person Care services are transitioned to continue receiving care coordination services by way of the new ECM benefit to eligible members.

To ensure continuity between WPC and ECM, the following steps will be taken:

- The Plan automatically authorized all members enrolled in a WPC Pilot on December 31, 2021, who are identified by the WPC Lead Entity as belonging to an ECM population of focus; and
- For those members transitioned to ECM and who continue to see their current WPC provider, the ECM provider will assess to determine the most appropriate level of services for the member. The assessment is done within six months of enrollment in ECM or other timeframes provided by DHCS in guidance for specific transitioning subpopulations. This is to confirm whether ECM or a lower level of care coordination best meets the member's needs.
- For those members transitioned to ECM and who are seen by a new ECM provider (not their current WPC provider), the ECM provider will assess the member upon engagement.

To ensure continuity between HHP and ECM, the Plan will:

- Automatically authorize ECM for all members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in HHP on benefit effective date.
- Ensure each member who is automatically authorized for ECM under this provision (also referred to as the grandfathered ECM member population) is assessed by the ECM provider within six months of enrollment in ECM, to determine the most appropriate level of services for the member, and to confirm whether ECM or a lower level of care coordination best meets the member's needs.

ECM providers need to reassess grandfathered WPC and/or HHP members assigned to them by the Plan within six months or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the member, to confirm whether ECM or a lower level of care coordination best meets the member's needs. ECM providers will be required to conduct a member re-assessment by or before six months of enrollment in ECM based on the ECM program completion/step-down criteria. The Plan will provide additional information on the ECM program completion/step criteria.

Members enrolled in WPC and HHP received notices from the Plan or WPC LE in late 2021 about the upcoming transition of WPC and HHP to ECM. Additionally, WPC Lead Entities have reached out to WPC enrollees transitioning to ECM per DHCS requirement. The Plan informed the grandfathered ECM member population of their provider assignments.

4.6 Member Enrollment/Initiation of Delivery of ECM Services

4.6.1 Confirm Member Eligibility

At the time of outreach, if the member expresses interest in opting into the ECM benefit, ECM providers are requested to confirm member eligibility and appropriateness for ECM at the time of member opt-in. During initial engagement, ECM providers are expected to use methods appropriate to their workflow to identify, to the best of their ability, if the member meets any exclusion criteria or is enrolled in any duplicative care coordination programs as outlined.

ECM providers are expected to utilize and integrate the ECM referral form, in their initial engagement workflow when determining eligibility for all potential ECM members. This is applicable to members identified in the community as well as members assigned for outreach and assigned to the provider by the Health Plan. ECM providers may use the following during their ECM eligibility screening process:

- Available data or reports provided to the ECM provider by the Plan.
- Member Electronic Health Records (EHR), Health Information Exchange (HIE), and admit discharge transfer (ADT) data.
- Member input on qualifications questions in the screening form.

If a question arises regarding a Plan member's eligibility for ECM, the ECM provider should contact the Plan. The Plan may request supporting documentation from the ECM provider to assist in the eligibility determination for members ECM providers identify as potentially eligible for ECM.

4.6.2 Member Opt-in to Enroll

It is important to get the member's informed opt-in for the member to participate in ECM to ensure the member is aware of the provider's expectations of them and the member's expectations for their care from the ECM provider. ECM is an opt-in benefit.

Opting into the program can be provided verbally, however all verbal opt-ins must be documented and maintained by the ECM provider. This also applied to members from HHP and WPC even if they are already identified as enrolled in MIF. The Plan may request evidence of member opt-in, as needed or applicable per any DHCS monitoring request.

4.6.3 Member Authorization for Data Sharing

The ECM provider is required to obtain, document and manage member authorization for the sharing of personally identifiable information between the Plan and ECM, Community Supports, and other providers involved in the provision of member care to the extent required by federal law.

Member authorization for ECM-related data sharing is not required for the ECM provider to initiate delivery of ECM unless such authorization is required by federal law. When federal law requires authorization for data sharing, the ECM provider must communicate that it has obtained member authorization for such data sharing back to the Plan.

4.6.4 Assign Lead Care Manager

Upon initiation of ECM, the ECM provider must assign each ECM enrolled member a Lead Care Manager with the experience and skills, including culture and linguistic skills, that match the member's needs. The Lead Care Manager interacts directly with the member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any Community Supports, and other services that address social determinants of health (SDOH) needs, regardless of setting.

4.6.5 Member Ability to Change Provider

ECM members can request to change their ECM provider at any time by contacting member services. ECM providers may also make a request for a member to change ECM providers by submitting the ECM referral form to the health plan and include a signed note from the member requesting the change.

4.6.5.1 Provider Expectations

If the ECM member requests, the ECM provider must advise the member on the process for switching ECM providers. Members must call the Plan's Member Services Department to initiate a provider change. The member's right to choose between the ECM benefit and other duplicative programs must always be maintained.

4.6.5.2 The Plan Expectations

The Plan is required to implement any requested ECM provider change within thirty calendar days.

4.7 Continuity of ECM Services for Members Who Change Managed Care Plans

The Plan will preserve continuity of ECM services for members who were receiving ECM with a prior health plan and have changed health plans. Members and/or their family member or authorized representative may request enrollment into ECM upon the transfer of their care from a prior managed care plan where they were receiving the ECM benefit. Members will be requested to provide the name of the prior managed care plan and/or the prior ECM provider to facilitate continuity and mitigate gaps in care.

Requests should be submitted via referral to the new managed care plan using the ECM referral form and identifying ECM eligibility as continuity of care, in addition to any applicable ECM Populations of Focus.

4.8 ECM Service Provision Expectations

ECM providers are expected to ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal members enrolled in managed care. The ECM provider must ensure the approach is person-centered, goal oriented, and culturally appropriate. If the ECM provider subcontracts with other entities to administer ECM functions, the ECM provider will ensure agreements with each entity bind the entities to the terms and conditions set forth here and that its subcontractors comply with all requirements in these Standardized Terms and Conditions and the DHCS-MCP ECM Contract. The utilization of any ECM provider subcontractors must be vetted and approved by the Plan and are subject to the requirements outlined in Required Area 12 of the ECM provider Certification Application.

Reminder, as stated in Section 3.5.1 of this guide, the ECM provider must ensure each member receiving ECM has a Lead Care Manager.

As stated in Section 4.2 of this guide, if a member is receiving care management from multiple sources, ECM providers are expected to coordinate across all sources of care management. If a member is receiving care management or duplication of services from multiple sources, ECM providers are expected to alert the Plan to ensure non-duplication of services. ECM providers are also expected to follow the Plan instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

The ECM provider must also collaborate with area hospitals, PCPs (when not serving as the ECM provider), behavioral health providers, specialists, dental providers, providers of services for LTSS and

other associated entities, such as Community Supports providers, as appropriate, to coordinate member care.

4.9 ECM Core Services

The Plan will work closely with contracted ECM providers to deliver all core service components of ECM to each of the ECM provider's assigned members, in compliance with the Plan's policies and procedures. The core services of ECM consist of the following core services.

4.9.1 Outreach and Engagement of CalViva Health Members into ECM

See Section 4.4.1. of this guide.

4.9.2 Comprehensive Assessment and Care Management Plan

ECM providers are required to provide person-centered care management by working with the member to assess risk, needs, goals, barriers, and preferences, and have a care management plan that coordinates and integrates all of the member's clinical and non-clinical health care related needs. Key components to this core service provision include:

- In-person contact.
- Person-centered.
- Comprehensive assessment.
- Member-centered care plan.
- Timely reassessment.

ECM providers are required to engage with each member assigned to receive ECM primarily through **in-person contact**. Public health precautions and recommendations should be used to accomplish the community-based, in-person approach of ECM. When in-person communication is unavailable or does not meet the needs of the member, the ECM provider is expected to use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication according to member choice.

ECM providers are required to identify necessary clinical and non-clinical resources that may be needed to appropriately **assess member health status and gaps in care** and may be needed **to inform the development of an individualized Care Management Plan.** ECM providers are required to initiate an assessment within 30 days and complete the assessment's essential elements needed to develop plan of care within 60 days after member opt-in. ECM providers are encouraged to initiate and complete the assessment as soon as possible**.**

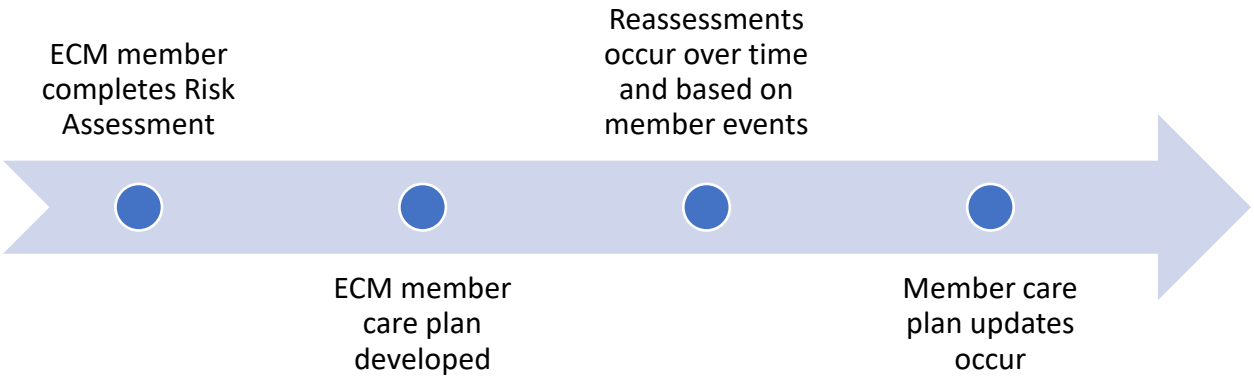
The comprehensive assessment may need to be completed during multiple member visits, adhering to the timeliness requirements above. During the assessment of the ECM member, critical services and referrals are encouraged to be provided as timely as possible. The full assessment and care plan do not have to be completed in full before a member is connected to any critical services identified.

ECM providers are required to **develop a comprehensive, individualized, person-centered care plan** by working with the member to assess strengths, risks, needs, goals, barriers, and preferences (including cultural and linguistic) and to make recommendations for service needs. This includes collaborating with the member and the member's support network, leveraging input from the member's family member(s), guardian, authorized representative (AR), caregiver, authorized support person, and/or care team members, as appropriate.

ECM providers are required to create the member's care plan immediately following the member assessment. ECM providers are expected to incorporate into the member's care plan identified needs and strategies to address those needs, including, but not limited to, physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports and social

determinants of health (SDOH). The ECM providers are required to ensure the care plan is updated at a frequency appropriate for the member's individual progress or changes in needs, and at minimum twice a month. The ECM providers must ensure **the assessment and care plan are reviewed, maintained and updated under appropriate clinical oversight.** Care plan updates should occur regularly – for example, after reassessment or transitions of care, and when a new need is identified.

ECM members will have varying levels of acuity and will require different levels of service intensity and frequency of contact with the ECM provider's multi-disciplinary care team. The diagram below illustrates the order of operations in developing and maintaining the Member's Care Plan.



4.9.2.1 Risk Assessment

ECM providers are required to conduct a comprehensive assessment that identifies a member's physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports and SDOH. ECM providers are required to start a member's assessment within 30 days and complete a member's assessment within 60 days of the member's enrollment in ECM. ECM providers are encouraged to initiate and complete the assessment as soon as possible.

The assessment used must include all required assessment questions identified in the Health Plan standard ECM assessment template at a minimum to meet ECM program requirements. Standard ECM assessment templates are available on the CalAIM provider resource page.

The Risk Assessment is used to assess an ECM member's current health status, establish a platform to begin building care management and coordination goals, and develop an individualized care plan. ECM providers must reassess the member when clinically indicated or new needs are identified, or after transitions of care. Care plans should be updated during reassessments to address any changes in the member's condition.

In addition to the member assessment, ECM providers are encouraged to review health plan data and reports, electronic health records, medications, and other available clinical and non-clinical data sources to inform the care plan.

ECM providers are required to submit assessments to the Plan at a frequency to be communicated by the Plan.

4.9.2.2 Care Plan

ECM providers are required to create the member's care plan immediately (as timely as feasible) following the member assessment. The care plan is a dynamic and person-centered plan of care that is maintained by ECM providers, and includes comprehensive input from the member, member's

authorized representative, PCP, specialists, and other service providers in accordance with the member's wishes.

Informed by the assessment, the ECM provider will develop the member's care plan together with appropriate stakeholders, including the member, the member's providers, and the member's family or support persons. The Plan recommends member's care plan includes problem (opportunity), interventions, goals and barriers. The Plan recommends goals be SMART (specific, measurable, achievable, realistic, and time bound).

The ECM provider should update the care plan as appropriate when goals are modified, new needs or goals are identified, after transition of care, or when a member's health is reassessed. The frequency for updating the care plan should be appropriate to the member's needs, when the member is reassessed, and when transitions in care or changes in member health, functional, or social status occur. The care plan will track and coordinate information on referrals, follow ups, and transitions in care.

The ECM provider will document member acuity as part of the care plan and will maintain an appropriate level of contact with ECM members for their health status and goals. ECM providers are required to submit care plans to the Plan at a frequency to be communicated by the Plan.

4.9.3 Enhanced Coordination of Care

ECM providers are responsible for the ongoing care coordination for ECM enrolled members. ECM providers are encouraged to use case conferences to ensure integrated, effective implementation of the care management plan. Regular and **very** frequent member support and coordination services are essential to the success of ECM. Member contact should be in person wherever feasible and according to member preferences. Key components to this service provision include:

- Member care plan implementation.
- Continuous and integrated care.
- Treatment adherence.
- Communication.
- Fostered and on-going engagement with member.

ECM providers are responsible for **organizing patient care activities**, as laid out in the care management plan, **sharing information** with the member's multi-disciplinary care team, and **implementing activities identified in the member's care management plan**.

ECM providers are responsible for maintaining regular contact with all providers that are identified as being a part of the member's multi-disciplinary care team. The care team's input is necessary for successful implementation of member goals and needs. ECM providers are responsible to ensure care is **continuous and integrated among all service providers and referring to and following up** with all referrals and services, including primary care, specialty referrals, SUD treatment, LTSS, oral health, palliative care, necessary community-based and social services, and all other plan aligned available services. This includes following up with members to ensure all services were rendered (i.e., closed loop referrals).

ECM providers are responsible for providing support to engage the member in their treatment, including **coordination for medication review and/or reconciliation**, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to member engagement in treatment.

ECM providers are responsible for **communicating the member's needs and preferences** timely to the member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective

person-centered care. ECM providers are responsible for **ensuring regular contact with the member and their supports** – family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

Stakeholders, such as internal Plan business units, may reach out to ECM providers to help coordinate care or follow up with members.

4.9.3.1 Acuity Tiering Guidance and Frequency of Contact (Post-Enrollment)

The following criteria are offered by the Plan as a recommendation for determining frequency of ECM provider contact, and subject to the clinical judgement of the ECM provider based on the member's needs and intensity of service provision. It is anticipated that members may move between tiers based on clinical or psychosocial needs.

Tier 1: High Acuity, minimum one contact per week if any of the below apply

- Newly enrolled in ECM (in the last month).
- Emergency department (ED) visit or hospitalization (in the last 30 days).
- New diagnosis or new initiation of treatment (in last 30 days).
- Documented or known non-adherence (medication, treatment or appointments).
- Little or no identified social support.
- Homeless or recently secured permanent housing (within the last 90 days).

Tier 2: Moderate Acuity, minimum biweekly (2x/month) contact if any of the below apply

- ED visit or hospitalization in the last two - six months.
- Newly sustained treatment adherence (medications, appointments).
- Newly integrated social support.
- Secured permanent housing within last three - six months.
- At risk of homelessness.

Tier 3: Low Acuity, minimum monthly contact if any of the below apply

- Clinically stable on examination and laboratory findings (in maintenance phase).
- No ED visit or hospitalization (in the last six months).
- Ongoing treatment adherence (medications, appointments).
- Strong family/social support.
- Stable housing.
- On target to achieve at least one care plan goal (in the next three months).

The Plan expects that ECM providers make active, meaningful, and progressive attempts to contact the member, however if the ECM provider cannot contact an enrolled member after three attempts using different modalities (in-person, mail/letter, email, texts, phone calls and telehealth), the ECM provider is expected to exclude the member from further outreach and report the member disenrollment information to the MCP in the RTF and OTF submission to the MCP.

4.9.4 Health Promotion

ECM providers are responsible for Health Promotion, following the federal care coordination and continuity of care requirements (42 CFR 438.208(b)). Key components to this service provision include, but are not limited to:

- Working with the member to identify and build on successes and potential family and/or support networks.
- Member skill development, such as coaching to support lifestyle choices based on healthy behavior with the goal of supporting the member's ability to monitor and manage their health.

- Strengthening the member's skills that enable them to identify and access resources to assist them in managing their conditions.
- Linking members to resources for smoking cessation, managing members chronic conditions, self-help recovery resources and other services based on member needs and preferences.
- Promoting self-management by utilizing evidence-based practices, such as motivational interviewing, to engage and help the member participate in their care.

4.9.5 Transitional Care Services (TCS)

Transitional Care Services (TCS) include services intended to support members and their families and/or support networks as members transfer from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home or community-based settings, Community Supports placements (including sobering centers, recuperative care and short-term post hospitalization), post-acute care facilities, or long-term care (LTC) settings. Although it is not a required component of TCS at this time, ECM providers are strongly encouraged to provide emergency department (ED) follow-up as part of TCS.

ECM providers are responsible for ensuring ECM members receive TCS to support members and their families and/or support networks as members transfer from one setting or level of care to another. TCS for ECM members should always extend at least thirty (30) days post-discharge to help avoid unnecessary readmissions.

ECM providers are required to sign up for and have a reliable Health Information Exchange (HIE) platform that provides admission, discharge, transfer (ADT) feeds support with TCS. L.A. Care will provide ADT feeds to ECM providers through Point Click Care. ECM providers are required to sign up for Point Click Care and turn on notifications.

ECM Provider and Lead Care Manager Responsibilities

ECM providers are expected to support members' transitions from discharge planning until they have been successfully connected to all needed services and supports. The ECM Lead Care Manager is responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions.

While the ECM Lead Care Manager does not need to perform all activities directly, they must coordinate and ensure completion of the TCS tasks. The ECM Lead Care Manager is responsible for ensuring all TCS are completed including, but not limited to:

1. **Coordinating with Discharge Facility:** Upon notification of a member's transition, the ECM Lead care manager must begin outreach to the member and the discharging facility within twenty-four (24) hours to begin coordination and understanding of the potential needs and the needed follow-up plans for the member. ECM providers should provide information to the hospital discharge planners or discharging facility staff about ECM so that collaboration on behalf of the member can occur in a timely manner and that the member does not receive two different discharge planning documents. The ECM Lead Care Manager must also coordinate with the discharging facility to ensure the member participates in the discharge plan and receives and understands information about their needed care from the discharging facility.

2. **Discharge Risk Assessment:** The Discharge Risk Assessment supports the discharge planning process by helping to assess a member's risk of re-institutionalization, re-hospitalization, destabilization of a mental health condition, and/or SUD relapse following an admission. It also helps to identify interventions/services that benefit the member.

The ECM Lead Care Manager must ensure a discharge risk assessment is completed at any time during the inpatient admission or after discharge if the member has discharged prior to ECM outreach. This must include reviewing information from the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary). The ECM lead Care Manager must also ensure the discharge risk assessment is shared with appropriate parties such as the PCP, the member, and other service providers involved in the member's care.

It is recommended that the ECM provider consider the use of the Modified LACE Tool. This tool will yield a risk score of (low, moderate or high) indicating the member's risk for re-admission. Members who score at a high risk of readmission are considered to be high acuity. The ECM provider is expected to identify interventions and services that benefit the member and address their needs.

3. **Discharge Summary/Planning Document:** The ECM Lead Care Manager must ensure a discharge summary/planning document is created and shared with the member (if the member accepts a copy), PCP, and if applicable, receiving facility (e.g., skilled nursing facility (SNF), long-term care (LTC), or acute rehab unit). This includes ensuring the member has the ECM Lead Care Manager's contact information.

   A best practice is for the ECM Lead Care Manager to work with the discharging facility to ensure that the ECM Lead Care Manager's name and contact information are integrated into the discharge summary documents that the member receives. The ECM Lead Care Manager may consider faxing a TCS Admission Notification Letter to the discharge facility that will inform the facility and PCP about the member's enrollment in ECM services and the assigned ECM Lead Care Manager's name and contact information. The TCS Admission Letter explains the purpose of TCS and requests the facility to share the ECM Lead Care Manager's contact information directly with the member and include it in the discharge document. The ECM Lead Care Manager should also request that the facility send a copy of the discharge summary when it becomes available along with medical records relevant to coordination.

4. **Medication Reconciliation:** Lack of medication reconciliation presents a significant risk for adverse drug events, especially for the highest risk populations. Accurate and timely medication reconciliation is a critical element of TCS for ensuring patient safety during transitions of care.

   The ECM Lead Care Manager must ensure medication reconciliation is completed post-discharge. This means medication reconciliation should be completed upon discharge by the discharging facility (pre-discharge) and a second reconciliation must be completed after discharge once the member is in their new setting (post-discharge). This can be done by the follow-up provider, such as the PCP, home health provider, or by the ECM Lead Care Manager if they hold an appropriate license, or by another team member on the ECM care team that has an appropriate license, in a manner that is consistent with California's licensing and scope of practice requirements, as well as applicable federal and state regulations.

5. **Closed Loop Referrals:** The ECM Lead Care Manager must ensure member is connected to Community Supports as needed. This includes ensuring completion of referrals to social service organizations, and referrals to necessary at-home services (durable medical equipment, home health, along with others) and follow-up on referrals made with internal and external providers to ensure services were rendered.
6. **Transportation:** The ECM Lead Care Manager is responsible for arranging transportation for transitional care, including the use of non-medical transportation (NMT) and non-emergency

medical transportation (NEMT). The ECM provider is responsible for developing policies to arrange transportation for transitional care.

7. **Post-discharge Follow-up:** The ECM Lead Care Manager must ensure needed post-discharge services are provided and follow-ups are completed. The ECM Lead Care Manager is responsible for contacting the member no later than seven (7) days of discharge depending on the needs and acuity of the member.

   The Lead Care Manager must continue to support the member in all needed TCS identified at discharge, as well as any new needs identified through engagement with the member or their care providers. Post-discharge services include:

   - Reviewing the discharge instructions with the member.
   - Ensuring the member understands the process of navigating any resources or referrals initiated during their admission and addressing the potential delays with accessing these services.
   - Supporting the member in addressing barriers that prevent the member from following up with the discharge orders. This includes timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners, arranging transportation to any follow-up appointments and connecting the member to the PCP within seven (7) days post-discharge.

4.9.6 Member and Family Support Services

ECM providers are required to provide individual and family support services to the ECM member, with the goal of ensuring that both the member and their family/support persons are knowledgeable about the member's needs, care plan, and follow-up. Key components to this service provision include:

- Member chosen family/support.
- ECM Lead Care Manager.
- Provide education on the members' conditions and care instructions.
- Ensure each member and their supports are aware of the care plan and participate in its development, as appropriate.

ECM providers are responsible for **documenting a member's designated** supports – family member(s), AR, guardian, caregiver, and/or authorized support person(s). ECM providers are also responsible for **ensuring all appropriate authorizations are in place to ensure effective communication** between the ECM providers, the member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) and the Plan, as applicable.

The ECM provider is responsible through the ECM service provision includes **activities to ensure the member and their supports – family member(s), AR, guardian, caregiver, and/or authorized support person(s) – are knowledgeable about the member's conditions** with the overall goal of improving the member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state and local privacy and confidentiality laws.

The ECM provider must ensure the member's **ECM provider serves as the primary point of contact** for the **member and their supports** – family member(s), AR, guardian, caregiver, and/or authorized support person(s).

The ECM provider must **identify supports needed** for the member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the member's condition and assist them in accessing needed support services.

The ECM provider must provide for appropriate **education** of the member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) **about care instructions** for the member.

The ECM provider **must ensure that the member has a copy of their care plan** and is information about how to request updates.

4.9.7 Coordination of and Referral to Community and Social Support Services

The ECM provider is responsible for Coordination of and Referral to Community and Social Support Services. Key components to this service provision include:

- Member chosen family/support.
- ECM Lead Care Manager.
- Provide education on the resources available to the member.
- Ensure the care plan is updated to reflect the involvement of community and social support services.
- Follow up to ensure and document the coordination of services with community and social support services.

The ECM provider **must determine the appropriate services to meet the needs** of ECM members, including the services that address SDOH needs, including housing and services offered by the Plan as Community Supports. Additionally, the ECM provider is responsible for **coordinating and referring members** to available community resources and **following up with members to ensure services were rendered (i.e., closed loop referrals).**

ECM providers are encouraged to build and strengthen strong relationships with community members to support this service provision. ECM providers are encouraged to maintain a community resource directory and/or actively utilized the online community resource referral platform offered by the Plan.

4.10 Program Completion

DHCS has identified ECM as the most intensive level of care management services to be offered. Each member must be assessed for an ongoing need for the ECM benefit or readiness to graduate from ECM. To support this requirement, the ECM Program Completion Questionnaire (PCQ) serves as a standardized tool that ensures all contracted ECM providers are using the same set of criteria to assess a member's readiness for an ongoing need for ECM services or ECM completion.

Generally, members will be considered ready to graduate from the ECM benefit when they have completed their care plan goals, and demonstrated improvement in self-management of physical and behavioral health, SDOH, and activities of daily living. Most health plans encourage ECM Lead Care Managers to use a questionnaire (based on the program completion/step-down criteria) with the member to help determine readiness for program completion of ECM and/or transition out of ECM.

When an ECM provider identifies a member who is ready to graduate from the ECM benefit, the ECM provider will conduct an ECM case conference with the multidisciplinary team to review the recommendation to step down from ECM and transition to another setting, and ensure any resources and/or care coordination needs are in place. This can include community-based services and other case/care management programs.

4.11 Member Discontinuation

ECM services can be discontinued when deemed appropriate by the ECM provider or upon request by the member at any time. If any of the following circumstances are met, ECM should be discontinued:

1. The member has met all care plan goals.

2. The member is ready to transition to a lower level of care.
3. The member no longer wishes to receive ECM.
4. The ECM provider has not been able to connect with the member after multiple attempts.

The Plan has developed policies and procedures for discontinuing ECM, and the specific program completion criteria the Plan will apply to transition a member to a lower level of care management or coordination.

If a provider suspects that a member is ready to transition to a lower level of care or has completed all care plan goals, a program completion questionnaire should be used to assess readiness. This must be completed every 12 months from enrollment **at a minimum** and maintained in the member's records.

ECM providers should have policies on monitoring members for readiness to graduate from the ECM program which includes timelines for assessing readiness (every 12 months from enrollment at a minimum). Members that have completed their care plan goals, or critical care plan goals, and are able to effectively manage their own care should be assessed for graduation or readiness to move to a lower level of care management. Members that have graduated from ECM are eligible to re-enroll should they need and qualify for the service again.

4.11.1 ECM Provider Initiated Disenrollment

The ECM provider must notify the Plan to discontinue ECM via RTF for a member under any the following circumstances:

- Member is no longer eligible for the benefit or Medi-Cal coverage.
- Member has met their ECM care plan goals.
- Member is ready to transition to a lower level of care.
- Member no longer wishes to receive ECM.
- Member is unresponsive or unwilling to engage; and/or ECM provider has not had any contact with the member despite multiple attempts.
- Member expired or becomes deceased.
- Member moves out of the county.
- Member is exhibiting unsafe behaviors.

Member's behavior or environment is unsafe for the ECM provider: The Plan defines **disruptive behavior** as a member whose behavior substantially impairs the ECM provider's ability to arrange for or provide services to the member. An individual cannot be considered disruptive if such behavior is related to the compliance or non-compliance with medical advice or treatment. Members who behave in a disruptive way and make it difficult for the ECM provider to provide care management services will be given an opportunity to correct the behavior to allow them to continue participating in ECM.

Disruptive behavior consists of intimidating, hostile, or harassing behavior and threatening or any other behavior that makes the member unable to participate in the ECM process and/or interferes with the ECM providers' business operations. This may include, but is not limited to the following:

- Verbal abuse such as outbursts, yelling, swearing, harassing or intimidating phone calls, or cursing directed at ECM staff.
- Written harassing or intimidating letters or other forms of written or electronic communications directed at the ECM staff.
- Physical intimidation or harassment of ECM staff.

The Plan defines **threatening behavior** as a credible threat of violence or the manifestation of violence or harm to oneself, another individual, or a provider, participating provider group (PPG), plan partner, or health plan property.

Threatening behavior consists of a threat of violence or the manifestation of violence or harm to ECM staff. This may include, but is not limited to the following:

- Making a threat of violence, considered as a knowing and willful statement or course of conduct that would place a reasonable person in fear for his or her safety, or the safety of others.
- Unlawful violence.
- Intentional destruction or threat of destruction of property owned, operated, or controlled by the ECM provider.
- Harassing surveillance, also known as "stalking," which is the willful, malicious, and repeated following of ECM staff.
- Threatening phone calls, letters, or any other form of communication directed at ECM staff.
- Inappropriate use of a firearm, weapon, or any other dangerous device within proximity of ECM staff.

ECM providers are required to develop a policy & procedure on how to manage disruptive/threatening members.

4.11.2 Member Initiated Disenrollment

A member can contact their ECM provider or the Plan's Member Services Department at 888-893-1569 to request to disenroll from ECM at any time if they no longer wish to receive the ECM benefit.

4.11.3 The Plan Initiated Disenrollment

The Plan will notify ECM providers, via the regular ECM MIF, of ECM enrolled members who no longer qualify for the ECM benefit.

4.11.3.1 ECM Provider Expectations

The ECM provider shall communicate to the member other benefits or programs that may be available to the member, as applicable (e.g., complex care management, basic care management, etc.).

4.11.4 Complaints, Grievances and Appeals

The standard grievance and appeals processes apply to ECM for all members. If a member has concerns or complaints, the member can contact the Plan's Member Services Department at 888-893-1569. If the member feels that he or she has been wrongfully denied enrollment or wrongfully disenrolled from ECM, the member can initiate an appeal via the Plan's existing complaints, grievances and appeals process.

4.12 Data to Support ECM

4.12.1 Care Management Documentation System or Process

The ECM provider must use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities – including the Plan, ECM, Community Supports and other county and community-based providers – to support the management, maintenance, and sharing of a member care plan that can be shared with other providers and organizations involved in each member's care.

Care management documentation systems may include Certified Electronic Health Record (EHR) Technology, or other documentation tools that can support the documentation of:

- Member's enrollment into ECM.
- Member's authorization/approval to release information to other providers in the care team and anyone involved in execution of the care plan.
- Member's goals and goal attainment status as part of member care plan.
- Member's care coordination and care management needs (e.g., allow for documenting closed looped referrals to ensure the follow up with the member is tracked and completed).
- Information from other sources to identify member needs.
- The development and assignment of care team tasks.
- Care team coordination and communication.
- Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).
- Referrals to other providers and support persons.
- Screenings and assessments (e.g., Health Risk Assessment, PHQ-9, etc.).

Care management documentation systems also need to be able to:

- Support the sharing of the member's care plan amongst the member's care team.
- Support the sharing of the member's assessment, care plan and other required data to the Plan, as requested.
- Assist with informing the ECM provider's regular reporting to the Plan, as requested.
- Support and track the ECM services provided to the member to enable ECM providers to appropriately submit claims[15] to the Plan.

A care management documentation system is not required to be a certified EHR technology, and it may include systems that are securely managed and hosted by third parties, including the Plan partners.

4.12.2 Provision of Data/Reports from the Plan to the ECM Provider

The Plan and the ECM provider will exchange data on members on a regular basis.
The Plan will provide the following data to the ECM provider at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable:

- Member Information File (MIF), defined as a list of Medi-Cal members enrolled for ECM and assigned to the ECM provider (referred to as Targeted Engagement List).
- Encounter and/or claims data, including ADT data feeds.
- Physical, behavioral, administrative and SDOH data for all assigned members.
- Reports of performance on quality measures and/or metrics, as requested.

4.12.3 Provision of Data/Reports from the ECM Provider to the Plan

ECM providers are responsible to submit and confirm receipt of required reports to the Plan. Required ECM provider reports include but are not limited to the following:

- Monthly ECM provider reporting
    - RTF
    - OTF
- Quarterly

[15] DHCS has indicated that ECM providers may also submit invoices and/or an additional report or data to the Plan if they are unable to produce and submit ECM claims for submissions. DHCS has not yet identified the provider criteria that would qualify them to submit services via invoice or through the submission of minimum necessary data elements (i.e., not through claims or encounters submission).

- Staffing and capacity reports

4.12.4 Data and File Exchange Operations

On a monthly basis, ECM providers must retrieve the ECM MIF via secure file transfer protocol (SFTP) site that contains assigned ECM members that are eligible to receive ECM services, including both new and existing members.

On a monthly basis, ECM providers must complete the Return Transmission File (RTF) and Outreach Tracking File (OTF) to report back to the Plan via an SFTP file upload identifying the services provided and status of each ECM member assigned to their organization. Reporting requirements for ECM providers are defined by DHCS.

The Plan may also utilize the SFTP site to exchange other data files to support ECM provider service delivery (e.g., ADT reports, capitation reports, etc.).

5 Claims Submission

The ECM provider is required to submit claims for the provision of ECM-related services to the Plan using the national standard specifications and code sets to be defined by DHCS as evidence of all ECM services provided to ECM members. The DHCS Coding guidance is found on DHCS' website. This ensures that the Plan can effectively monitor the volume and frequency of ECM service provision and shows the true cost of providing ECM services to the Plan and DHCS. Paper claims maybe submitted using the Center for Medicare & Medicaid Services (CMS most current CMS – 1500 form or UB-04 in accordance with standard guidelines. For fastest delivery and processing, claims can be submitted electronically using the HIPAA 5010 standard 837I (005010X223A2) and 837P (005010X222A1) transaction. Each claim submitted must include all mandatory elements and situational elements, where applicable.

In the event the ECM provider is unable to submit claims to the Plan for ECM-related services using the national standard specifications and DHCS-defined code sets, the ECM provider can submit an invoice to the Plan with a minimum set of data elements (to be defined by DHCS) necessary for the Plan to convert the invoice to an encounter for submission to DHCS. For more detail, go to DHCS' website. Invoices can be submitted by via mail, email, fax and web. For more information on claims submission and payment, refer to the CalAIM Resources for Providers site at www.healthnet.com/providers/CalAIM.

For each unit approved on the claim, it is equivalent to one hour of services.

6 Quality, Monitoring and Oversight

The Plan will regularly monitor ECM provider performance and compliance with ECM requirements using a variety of methods which may include monitoring calls, on-site visits, progress reports, audits and/or corrective actions, as needed.

The ECM provider acknowledges the Plan will conduct oversight of its participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements using the modalities listed above. The ECM provider must respond to all the Plan's requests for information and documentation to permit ongoing monitoring of ECM.

7 Payment to Providers

The Plan will pay contracted ECM providers for the provision of ECM services in accordance with contract established between the Plan and ECM provider. The Plan shall pay 90 percent of all clean claims from practitioners who are individual or group practices or who practice in shared health facilities within 30 calendar days of date of receipt and 99 percent of all clean claims within 90 calendar days. The

date of receipt shall be the date the Plan receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

The ECM provider is eligible to receive payment when ECM is initiated for any given eligible ECM member. Remittance Advice and Payment can either be sent via the mail or electronically for faster receipt. For more information on claims submission and payment, refer to the provider operations manual in the Provider Library at providerlibrary.healthnetcalifornia.com.

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