ENHANCED CARE MANAGEMENT

Provider User Guide

January 2022

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SECTION I: OVERVIEW

Purpose

The purpose of this *Enhanced Care Management (ECM) Provider User Guide* is to provide an overview of ECM, Santa Clara Family Health Plan's (SCFHP) Medi-Cal care management benefit for members who qualify. This user guide covers the following: ECM Populations of Focus (POF), the ECM core services, the integration of ECM with Community Supports, and the required core services. This guide also provides an overview of the process for member referral, eligibility determination, authorization, provider assignment, and payment. Contracted ECM providers must adhere to the processes for credentialing, referral, authorization, member outreach, data sharing, reporting, achieving outcomes, and submitting claims and encounters requirements outlined in this *ECM Provider User Guide,* and the *ECM Agreement.*

Overview

ECM is one initiative out of California Advancing and Innovating Medi-Cal (CalAIM), the Department of Health Care Services' multi-year process to transform Medi-Cal. As an extension of the Whole Person Care (WPC) pilot and the Health Homes Program (HHP), ECM contributes to an integrated approach to coordinating medical care, behavioral health, and social services to improve beneficiary health outcomes. Both the WPC and HHP pilot programs concluded on December 31, 2021.

The Department of Health Care Services (DHCS) defines ECM as a whole person care approach that addresses the clinical and non-clinical needs of high-need, high-cost Medi-Cal members through systematic coordination of services. ECM is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals. ECM is a community based, interdisciplinary, and high touch, in-person intervention, with a focus on person centered, goal oriented, and culturally appropriate models of care. The goals of ECM are to improve care coordination, integrate services, facilitate community resources, address social determinants of health (SDOH), improve health outcomes, and decrease inappropriate utilization and duplication of services.

ECM Populations of Focus

To be eligible for ECM, members must be enrolled in a Medi-Cal managed care plan and meet the eligibility criteria for one or more of the ECM Populations of Focus (POF). The seven POF are:

1. Adults and families experiencing homelessness, chronic homelessness, or who are at risk of homelessness
2. High utilizers adults with frequent hospital admissions, short-term skilled nursing facility stays or emergency room visits
3. Adults with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD)
4. Individuals transitioning from incarceration and have significant complex health needs
5. Individuals at-risk for institutionalization and are eligible for long term care (LTC)
6. Nursing facility residents who are willing and able to transition to the community
7. Children with complex health needs

ECM Core Services

ECM providers are required to provide all six core services to ECM enrollees, which include:

- Outreach and engagement
- Comprehensive assessment and care management plan
- Enhanced coordination of care
- Health promotion

- Comprehensive transitional care
- Coordination of and referral to Community Supports and social supportive services.

Identification of Eligible Members

SCFHP identifies and authorizes members who meet the eligibility criteria for one or more of the ECM POF. In addition, members, authorized representatives, family supportive individuals, primary care providers (PCPs), ECM providers, Community Supports providers, community-based organizations, and other providers and entities may identify members who may be eligible and will benefit from ECM. A referral can be submitted to SCFHP for authorization of ECM services.

Referrals, Authorizations and Assignment

Each month, SCFHP screens its Medi-Cal population to determine if members are eligible for ECM. If eligible, this screening process serves as an automated authorization for ECM. SCFHP utilizes logic to assign members to an appropriate contracted ECM provider with consideration of member needs. Notification of the assignment to ECM providers occurs through the transmission of the Member Information File (MIF), which also contains member demographic and contact information, relevant health conditions, and other clinical data that assigned providers need to conduct outreach and engage members in ECM.

Members not initially identified as being eligible for ECM as part of the MIF process can be referred to SCFHP for eligibility determination and authorization. SCFHP encourages referrals from providers that are both contracted and non-contracted for ECM services including, but not limited to ECM Lead Care Managers, primary care physicians (PCPs), specialists, Community Supports providers, behavioral health representatives, community-based organizations, internal or external case managers, and others. It is highly recommended that providers, community-based organizations, and others complete and submit a referral form to SCFHP with the appropriate documentation to ensure a timely turnaround time. SCFHP accepts referrals for ECM by phone, fax, mail, email, or in person. Referrals can also be submitted by members, members' authorized representative, or other individuals by calling SCFHP; a referral form does not need to be submitted.

Upon receipt of a referral, SCFHP determines eligibility for ECM and either authorizes or denies the referral, taking into consideration: medical necessity, criteria for populations of focus, exclusions as identified by DHCS, and prior enrollment in ECM through another managed care plan either within the county or in another county. For authorized ECM services, members are assigned to a contracted ECM provider that has experience, expertise, and capacity to serve the specific member's POF. If members are denied ECM services following eligibility determination, a member is provided a notice of action letter (NOA). The NOA letter provides further details on how a member may appeal SCFHP's decision.

Data Sharing, Reporting, Outcomes, and Performance Measures

Per DHCS requirements, SCFHP monitors the implementation of and compliance with ECM requirements across multiple domains including membership, service provision, grievances and appeals, provider capacity, and quality. In addition, SCFHP will monitor and evaluate outcomes for its members who received ECM through the use of quality measures.

Data Sharing

SCFHP requires ECM providers to have systems and processes in place that allow them to track and manage assigned members for outreach and engagement activities and delivered services. SCFHP shares relevant data with ECM providers to enable them to conduct member outreach and promote engagement, provide the contracted services, and report the outcome of the services rendered.

SCFHP shares all of the following:

- Demographic and administrative information confirming the referred member's eligibility and authorization for ECM
- Appropriate administrative, clinical, and utilization information needed to effectively provide ECM

In turn, ECM providers must share data related to service provision status, encounters, quality, and performance outcomes with SCFHP. The required data elements, frequency, and transmission methods for the bi-directional data exchange between SCFHP and ECM providers are detailed in Exhibit A-3 in the *ECM Agreement*.

Reporting

SCFHP requires ECM providers to submit a monthly *Return Transmission File (RTF)* and *Initial Outreach Tracker File (IOTF)*, as well as other supplemental reports as required and defined by DHCS. SCFHP utilizes data reported in the *RTF and IOTF*, along with other available data to monitor outreach and engagement success, service delivery, progress towards improving the health of enrolled members, and key indicators for ECM. Examples of key implementation indicators that SCFHP will be monitoring include, but are not limited to, members receiving ECM and their characteristics, including ECM Populations of Focus, ethnicity, gender, age, and primary language; ECM utilization and program engagement; and ECM provider types and capacities. The required data elements, reporting timing, submission timing, and transmission method are detailed in Exhibit A-3 in the *ECM Agreement*.

Outcomes

As a means of monitoring the provision and impact of ECM on improving the health of enrolled members, SCFHP requires ECM providers to report on designated outcomes as defined by DHCS and SCFHP. Outcomes are designed to monitor the timeliness to outreach and engage members; type of ECM services provided and in what cadence; and successfulness in enrolling members into ECM, influencing members moving to lower acuity levels, and graduating from ECM. In addition, outcomes assist SCFHP in monitoring any challenges and barriers to engagement and/or the service delivery, and best practices that can be shared with other ECM providers. The required outcomes, reporting timing, submission timing, and transmission method are detailed in Exhibit A-3 in the *ECM Agreement*.

Quality and Performance Measures

Per DHCS requirements, SCFHP requires ECM providers to prepare and submit data that supports meeting designated quality and performance measures for ECM. The required quality and performance measures, reporting timing, submission timing, and transmission method are detailed in Exhibit A-3 in the *ECM Agreement*.

Claims, Invoices, and Encounters

To the extent possible, SCFHP requires ECM providers to submit ANSI ASC X12N 837P claims to SCFHP using DHCS-defined standard specifications and code sets. SCFHP's administrative system requires ECM providers to have a valid organization National Provider Identifier (NPI) in order to submit claims to

SCFHP. An NPI is a unique identification number for health care providers, which is part of the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For how to apply for an NPI, go to https://nppes.cms.hhs.gov/#/. For the claims submission requirements, see Exhibit C in the *ECM Agreement.*

If an ECM is not able to submit ANSI ASC X12N 837P claims, they are able to submit invoices to SCFHP. As required by DHCS, SCFHP requests ECM providers to include the *minimum necessary* data elements in their invoices, including information about the member, service(s) rendered, and the rendering provider. Invoices are to be used by SCFHP to pay ECM providers and develop DHCS-compliant encounters as part of their regular encounter file submissions to DHCS. SCFHP provides invoice submission instruction, training, and technical assistance to support ECM providers in properly submitting invoices to SCFHP. For more details on the invoice submission process, see Exhibit C in the *ECM Agreement*.

Payment

SCFHP releases payment to ECM providers for the provision of authorized ECM to members in accordance with the requirements outlined in the *ECM Agreement*. SCFHP adheres to the claims timeline and process as described in Exhibit C in the *ECM Agreement* and directly aligns with the requirements set forth in the contract between DHCS and SCFHP.

Provider Credentialing and Oversight

DHCS requires managed care plans to ensure that each contracted ECM provider has the appropriate experience and expertise in providing the required services and serving ECM POF. See Exhibit A-1 in the *ECM Agreement* for the credentialing requirements for ECM providers.

SECTION II: DEFINITIONS

This section defines the following terms: Enhanced Care Management, Enhanced Care Management providers, Populations of Focus, and Lead Care Manager. See section XVI for a full glossary.

ENHANCED CARE MANAGEMENT

Enhanced Care Management (ECM) is a whole person care approach that addresses the clinical and non-clinical needs of high-need, high-cost Medi-Cal members through systematic coordination of services. ECM is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals that is community based, interdisciplinary, high touch, and person centered. The goals of ECM are to improve care coordination, integrate services, facilitate community resources, address social determinants of health (SDOH), improve health outcomes, and decrease inappropriate utilization and duplication of services.

ENHANCED CARE MANAGEMENT PROVIDERS

Enhanced Care Management (ECM) providers are contracted community-based entities with the experience and expertise to provide intensive, in-person care management services to individuals who meet the eligibility criteria for one or more of the ECM Populations of Focus.

POPULATIONS OF FOCUS

To be eligible for ECM, members must be enrolled in Medi-Cal Managed Care, not be currently enrolled in a program or benefit identified by DHCS as a duplicate program to ECM, and meet the eligibility criteria for one or more of the **ECM Populations of Focus (POF)**. The seven POF are:

1. Adults and families experiencing homelessness, chronic homelessness, or who are at risk of homelessness
2. High utilizers adults with frequent hospital admissions, short-term skilled nursing facility stays or emergency room visits
3. Adults with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD)
4. Individuals transitioning from incarceration and have significant complex health needs
5. Individuals at-risk for institutionalization and are eligible for long term care (LTC)
6. Nursing facility residents who are willing and able to transition to the community
7. Children with complex health needs

LEAD CARE MANAGER

A **Lead Care Manager (LCM)** is a member's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be SCFHP staff). The LCM operates as part of the member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any community-based services. To the extent a member has other care managers, the LCM will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the member and non-duplication of services.

SECTION III: POPULATIONS OF FOCUS

To be eligible for ECM, members must be enrolled in Medi-Cal Managed Care and meet the criteria provided below in each of the Population of Focus (POF) definitions.

1. INDIVIDUALS AND FAMILIES EXPERIENCING HOMELESSNESS
Launch Date: January 1, 2022

Individuals who:

1) Are experiencing homelessness (as defined below);
   AND
2) Have at least one complex physical, behavioral or developmental health 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.

The U.S. Department of Housing and Urban Development (HUD) defines an individual or family experiencing homelessness if they meet any of the criteria below:

- Lacks adequate nighttime residence
- Primary residence is a public or private place not designed for or ordinarily used for habitation
- Lives in a shelter
- Exiting an institution into homelessness
- Will imminently lose housing in the next **30 days**
- Fleeing domestic violence
- Defined as homeless under other federal statutes for unaccompanied youth and families

Notes on the definition:

- This definition is taken from the HUD definition of "Homeless" with the following modifications: 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.
- Based on HUD definition, the timeframe for an individual or family who will imminently lose housing in **30 days**.

Examples of eligible members under this POF:

- Members experiencing homelessness with complex health care needs as a result of an unmanaged medical, psychiatric or SUD-related condition.
- Members with complex health care needs as a result of a medical, psychiatric or SUD-related condition, who have recently received an eviction notice and will imminently lose housing in the next **30 days**.

2. ADULT HIGH UTILIZERS
Launch Date: January 1, 2022

Adults with:

1) Five or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence;
   AND/OR
2) Three or more unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

Notes on the definition:

- The definition allows plans to authorize ECM services for very high utilizer individuals who would benefit from ECM but who may not meet the numerical thresholds 1) and/or 2) above.
- However, this flexibility does not displace the numerical thresholds provided in the definition to identify high utilizers. Plans must use the numerical thresholds to identify members in this POF. Plans should have a consistent approach (e.g., algorithms or other methodologies) for identifying high utilizers.
- Plans should utilize a "rolling" six-month look-back period based on the most recent month of adjudicated claims data.
- Emergency Department (ED) visits that result in an inpatient stay should only count as one inpatient visit.

Examples of eligible members under this POF:

- Members with repeated incidents of avoidable emergency room visits in a six-month period, who have a medical, psychiatric or SUD-related condition requiring intensive coordination beyond telephonic intervention.
- Members with repeated incidents of avoidable emergency room visits in a six-month period who have significant functional limitations and/or adverse social determinants of health that impede them from navigating their health care and other services.

3. ADULT SERIOUS MENTAL ILLNESS/SUBSTANCE USE DISORDER
Launch Date: January 1, 2022

Adults who:

1) Meet the eligibility criteria for participation in or obtaining services through:
   - The county Specialty Mental Health (SMH) System **AND/OR**
   - The Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program;

   AND
2) Are actively 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, history of Adverse Childhood Experiences (ACEs), former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms or associated behaviors);
   AND

3) Meet one or more of the following criteria:
    - Are at high risk for institutionalization, overdose and/or suicide;
    - Use crisis services, emergency rooms, urgent care or inpatient stays as the sole source of care;
    - Experienced two or more ED visits or two or more hospitalizations due to SMI or SUD in the past 12 months; **OR**
    - Are pregnant or post-partum women (12 months from delivery).

Notes on the definition: Institutionalization in this context is broad and means any type of inpatient, SNF, long-term or emergency department setting.

Examples of eligible members under this POF:

- Members who have the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions, who are experiencing one complex social factor influencing their health and are pregnant.
- Former foster youth members with a psychiatric or SUD-related condition, who are currently using emergency rooms as the sole source of care.

4. INDIVIDUALS TRANSITIONING FROM INCARCERATION
Launch Date: January 1, 2023

Individuals who:

1. Are transitioning from incarceration or transitioned from incarceration within the past 12 months;
   AND
2. Have at least one of the following conditions:
    - Chronic mental illness
    - Substance Use Disorder (SUD)
    - Chronic disease/condition (e.g., hepatitis C, diabetes)
    - Intellectual or developmental disability
    - Traumatic brain injury
    - HIV
    - Pregnancy

5. INDIVIDUALS AT RISK FOR INSTITUTIONALIZATION AND ELIGIBLE FOR LONG-TERM CARE SERVICES
Launch Date: January 1, 2023

Individuals at risk for institutionalization who are eligible for Long-Term Care services who, in the absence of services and supports, would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF). Individuals must be able to live safely in the community with wraparound supports.

Examples of eligible MCP Members under this POF:

- Individuals in need of increasing assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
- Possibly, individuals with changes to family or caregiver status.
- Possibly, individuals with medical or surgical setbacks resulting in a decrease in functional, cognitive or psychological status.
- Possibly, individuals showing early signs of dementia with few or no natural supports.
- Possibly, individuals who are noncompliant with their prescribed medical regime.
- Possibly, individuals who are not appropriately engaged to take advantage of necessary health care services.
- Possibly, individuals who lack a family or community support system to assist in appropriate follow-up care at home.

6. NURSING FACILITY RESIDENTS WHO WANT TO TRANSITION TO THE COMMUNITY
Launch Date: January 1, 2023

Nursing facility residents who are strong candidates for successful transition back to the community and have a desire to do so.

Individuals should be:

- Interested in moving out of the institution,
- Medically appropriate to live in the community, and
- Able to reside safely in the community.

7. CHILDREN AND YOUTH
Launch Date: July 1, 2023

POF includes:

- Children (up to Age 21) experiencing homelessness;
- High utilizers;
- Serious Emotional Disturbance (SED) or identified to be at Clinical High Risk (CHR) for Psychosis or Experiencing a First Episode of Psychosis;
- Enrolled in California Children's Services (CCS)/CCS Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition;
- Involved in, or with a history of involvement in, child welfare (Including Foster Care up to Age 26);
  AND
- Transitioning from incarceration.

According to DHCS, the definitions and detailed eligibility criteria for the Children and Youth POF are forthcoming.

SECTION IV: PROVIDER READINESS AND CREDENTIALING

SCFHP is required to develop and manage a network of ECM providers that are sufficient to meet the capacity of all eligible members for all seven ECM POFs. In doing so, SCFHP requires interested providers to complete the ECM Readiness Assessment process and adhere to the credentialing requirements as defined by SCFHP:

1. SCFHP Readiness Assessment
    a. All community-based organizations interested in providing ECM to SCFHP members must complete a readiness assessment and submit supporting documentation that illustrates their experience and expertise in providing, as well as capacity to provide all of the required services as defined in this *ECM Provider User Guide*.
        i. Once an organization contacts SCFHP about their interest in providing ECM, SCFHP assesses the adequacy of the existing ECM network by POF and determines if the network needs to expand to accommodate anticipated growth.
        ii. If SCFHP identifies a need to expand the ECM network capacity, SCFHP sends the *SCFHP ECM Readiness Assessment* template to the interested provider with a submission deadline. The submission deadline is estimated to be between two and three weeks from the organization's receipt of the assessment and instructions.
        iii. SCFHP reviews the submitted assessment and supporting documentation within two to three weeks of receipt.
        iv. After SCFHP's internal review of the assessment, program staff contacts the interested organization to request responses to follow-up questions, provide clarification on any service requirements, and answer any questions from the organization.
        v. SCFHP conducts at least one site review per application and visits the organization either in person or via a virtual meeting to gather additional information and review the submitted readiness assessment. A second site review may be requested by SCFHP if the provider needs to submit additional evidence to SCFHP.
        vi. After SCFHP determines that the interested organization has the appropriate experience, expertise, and capacity to serve as a contracted ECM provider, the ECM team progresses to the contracting phase.

2. Credentialing
    a. All community-based organizations interested in providing ECM to SCFHP members are required to complete the ECM credentialing process as required by all contracted SCFHP contracted providers. The purpose of the credentialing process is to ensure that ECM providers are not excluded from providing Medicare services to beneficiaries and can maintain the ability to operate in good standing from a business licensing and compliance perspective.
    b. Exclusion Screening
        i. ECM providers are required to adhere to SCFHP's *Mandatory Exclusion Screening Process* to ensure SCFHP is not entering into or maintaining certain relationships with individuals or entities that have been excluded from participation in federal health care programs. The Medicare statute also excludes from coverage any item or service that has been ordered, supervised, or furnished by an individual or entity during time when the individual or entity has been excluded from the federal program.
        ii. ECM providers must agree to consent to initial and monthly exclusion screening for the entity.

iii. All ECM providers are required to complete SCFHP's *Mandatory Exclusion Screening Checklist a*nd return to SCFHP.
iv. In the event the initial and/or monthly exclusion screening results in an exclusion match indicating that an interested or current ECM provider is barred from participation in a federal health care program, SCFHP's Contracting Department reaches out to the provider for additional information to ensure the accuracy of the match.
    - If a match is verified for an initial screening, SCFHP will not execute an agreement with the organization for ECM.
    - If a match is verified for a subsequent monthly screening, SCFHP may suspend and/or terminate payments to the provider, and/or terminate the ECM Agreement.

3. Re-credentialing Process: ECM providers must consent to a re-credentialing process every three years to ensure that providers are still able to meet the requirements as forth by DHCS and SCFHP for the delivery of ECM.

SECTION V: TRANSITION FROM HEALTH HOMES PROGRAM AND WHOLE PERSON CARE

As of January 1, 2022, DHCS required SCFHP to automatically transition eligible members enrolled in the Health Homes Program (HHP) or the Whole Person Care Pilot (WPC) as of 12/31/2021 to ECM. Both programs ended on 12/31/2021.

A. MEMBER IDENTIFICATION

1. HHP: HHP was implemented and operated by SCFHP. Members who remained enrolled in HHP as of 12/31/2021, transitioned to ECM and thereby automatically authorized for ECM services. The majority of members who transitioned from HHP to ECM retained their HHP provider under ECM. For those HHP providers who did not transition to being an ECM provider, their members were reassigned to an ECM provider in accordance with SCFHP's standard assignment process. See section B for the provider assignment process.

2. WPC: WPC pilot was implemented and operated by the Santa Clara County. To ensure a smooth transition for members transitioning from WPC to ECM and the administration changing from Santa Clara County to SCFHP, the County worked directly with DHCS to determine which WPC enrollees met the eligibility criteria for one or more of the seven ECM POF. The County provided WPC enrollment files to DHCS that were subsequently shared with SCFHP to transition the members from WPC to ECM. SCFHP automatically authorized members for ECM. All members who transitioned from WPC to ECM retained their WPC providers under ECM. See section B for the provider assignment process.

B. PROVIDER ASSIGNMENT

1. To ensure continuity of care after the transition from HHP and WPC to ECM, SCFHP worked to assign as many transitioned members to the ECM provider who served them under HHP or WPC. For the HHP or WPC providers who are not serving as a contracted ECM provider, those members were reassigned to a different provider for ECM services.

2. For members who needed to be reassigned to a new provider for ECM, SCFHP adhered to the following simplified process:
    a. SCFHP identifies any known providers to which the member is connected, including their PCP or behavioral health provider.
    b. If SCFHP has not identified any existing relationship with a provider, SCFHP assigns the member to an ECM provider that has the expertise and experience serving the member's POF.

3. ECM providers were notified of their assigned transitioned members on the January 2022 Monthly Information File (MIF). On a monthly basis, newly eligible members are assigned an ECM provider and added to the MIF. For more details on the MIF, see Section VI.A.

C. MEMBER COMMUNICATION

SCFHP mailed a letter to all members who were transitioned from HHP or WPC to ECM. The letter provided details on the transition, frequently asked questions (FAQs) on the transition and the new ECM benefit, and contact information for SCFHP.

D. PROVIDER REQUIREMENTS

1. Automatic Enrollment in ECM: Members who were transitioned from HHP and WPC to ECM included an ECM enrollment date of 1/1/2022 on the January MIF to signify that the members were automatically enrolled in ECM as part of the transition.

2. Initial Engagement: Upon receipt of the January MIF, ECM providers are expected to conduct outreach to engage the members in ECM, deliver the core ECM services as needed, and assess members if they are in need of housing services.

3. Prioritized Outreach for Assessing Housing Needs: As part of the ECM core services, ECM providers are required to assess a member for housing needs as part of their initial assessment after the transition. In contrast to HHP and WPC, housing services are not bundled under ECM. Rather, they are independent services under Community Supports. See Section XI for more details on Community Supports.

4. Need for Housing Services: If transitioned members are in need of housing transition navigation services or a housing deposit, the ECM provider is expected to document the need in the member's care plan and complete and submit a referral to SCFHP for services through Community Supports. SCFHP distributed an independent Housing Transition Services List (HTSL) to ECM providers who were assigned transitioned members who were previously receiving housing services through HHP or WPC. ECM providers are expected to document outreach attempts, the outcome of the outreach, and the date a referral was submitted to SCFHP for Community Supports for members who continue to need housing services. ECM providers must submit the response HTSL to SCFHP via SFTP no later than the close of business on 2/4/2022.

SECTION VI: MEMBER IDENTIFICATION AND REFERRAL PROCESS

Five ways SCFHP identifies members who may benefit from ECM:

1. Proactively identifies members who meet the eligibility criteria for one or more of the ECM POF on monthly basis. When identifying such members, SCFHP considers members' health care utilization, health risks and needs due to SDOH, and LTSS. SCFHP identifies members for ECM using such data as stated below in Section A.2.
2. Encourages ECM providers to identify members who meet the eligibility criteria for ECM and submit referrals to SCFHP for ECM.
3. Disseminates information and provides details on its referral process to primary care physicians (PCPs) and other provider groups to encourage them to submit referrals to SCFHP for ECM when providing care to their patients.
4. Promotes ECM to community-based organizations and provides details on the ECM referral process, including how to access the referral form on SCFHP's website.
5. Promotes the self-referral process for members, their authorized representatives, and/or family supports for submitting referrals for ECM.

A. MEMBER INFORMATION FILE (MIF)

Each month, SCFHP screens its members to determine if they meet the eligibility criteria for one or more POF. Members who meet the eligibility criteria are automatically authorized for ECM, assigned an ECM provider, and placed on the Member Information File (MIF). ECM providers are notified of their new or ongoing assigned members through receipt of the monthly MIF. SCFHP adheres to the following process when generating the monthly MIF:

1. SCFHP generates the MIF on the 10th of each month and shares it with contracted ECM providers.

2. SCFHP determines the members who are eligible for ECM using the following data sources, if available:
   a. Enrollment data, encounter data, utilization/claims data, pharmacy data, laboratory data, screening or assessment data, clinical information on physical and/or behavioral health, and SMI/SUD data;
   b. Risk stratification information for children in County Organized Health System (COHS) counties with Whole Child Model (WCM) programs, information about social determinants of health, including standardized assessment tools (e.g., PRAPARE) and/or ICD10 codes; and
   c. Results from any Adverse Childhood Experience (ACE) screening, and other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM POF (e.g., Homeless Management Information System (HMIS), available data from the education system).

3. The MIF contains but is not limited to the following data:
   a. Member demographics and contact information
   b. Member's clinical information
   c. Primary Care Provider/Clinic information
   d. Administrative and plan information
   e. ECM provider information
   f. ECM service information
   g. Member's current ECM enrollment status

h. Utilization data (e.g., count of ED admissions within the previous 6 months, most recent ED admission date, most recent ED admission facility, count of inpatient days in the previous 6 months, most recent inpatient admission date, most recent inpatient admission facility)
i. Other relevant data as required by DHCS

4. In addition to the monthly MIF, SCFHP shares the following three supplemental files with ECM providers on a monthly basis:
   a. Population of Focus: Provides the POF for members.
   b. Health Indicators: Provides relevant health indicators, along with SDOH diagnosis
   c. MedRx: Provides details on the member's current prescriptions

Members who have been disenrolled from ECM or meet one of the exclusions identified by DHCS as a duplicate program are discontinued from ECM and removed from the MIF after 60 days of discontinuance. See Section XII for details on the discontinuation process.

B. EXTERNAL REFERRALS

SCFHP disseminates information and shares details on its referral process to primary care physicians (PCPs), ECM providers, Community Supports providers, specialists, community-based organizations, and other provider groups to encourage them to submit referrals for members who may benefit from and be eligible for ECM. In addition, SCFHP accepts self-referrals to ECM from members, their authorized representatives, and/or family supports.

Referral Submission Process

1. Referring entities must:
   a. Complete the ECM Referral Form, which is located at www.scfhp.com/ecm; and
   b. Submit the completed ECM Referral Form and required documentation to SCFHP by secured email, fax, or mail.
2. Members, providers, or others can call SCFHP Customer Service to see if they are eligible for ECM.
3. Internal Review: The ECM team reviews the referral information (e.g., referral form, member recent medical records and/or chart notes, care plan, and other documentation that may assist with determining eligibility) and determines if the member is eligible for ECM.
4. Missing Documentation or Medical Records Needed
   a. If the referral is not accompanied by required documentation or missing documentation, the ECM team reaches out to the referring entity or the members' known Providers to request the needed documentation.
   b. If medical records are required to determine eligibility for ECM, the ECM team will request them from the member's primary care provider. This may extend the review process beyond the standard 3-5 business days for authorization.
5. Upon receiving all required documentation, the ECM team reviews and determines if the member is eligible for ECM services.
6. Approved Authorization for ECM: Members who are authorized for ECM services are assigned an ECM provider and are mailed an ECM eligibility letter within 1-3 business days after the authorization has been approved. The member's newly assigned ECM provider is notified of the authorization, the assignment, and advised to begin outreach and engagement activities.
7. Denied Authorization for ECM: Members who are denied ECM services undergo a medical review by a licensed medical practitioner.

a. If after the review, the medical practitioner determines that ECM services are in fact denied, SCFHP sends the member a Notice of Action letter that states the denial reason and the process for appealing the decision.
b. If after review, the medical practitioner disagrees with the original determination and approves the authorization for ECM services, SCFHP assigns the member to an ECM provider and mails an ECM eligibility letter.
c. For more details on the review process, see Section VII.C.

SECTION VII: ECM AUTHORIZATION

SCFHP authorizes or denies the ECM benefit based on strict adherence to the eligibility criteria as defined by DHCS and further refined by SCFHP. SCFHP adheres to its process for authorizing members for ECM in an equitable and non-discriminatory manner and within an appropriate timeline that ensures members access services in a timely manner. In cases where situations warrant presumptive authorization or preauthorization of ECM, SCFHP can expedite the review in a shorter timeline.

A. ELIGIBILITY DETERMINATION

As notes in Section III.A., SCFHP either (1) screens its members to determine if they meet the eligibility criteria for one or more POF through the MIF process, or (2) reviews received referrals to determine if the members meet the eligibility criteria using the data provided by the referring entity.

For the eligibility criteria for ECM, see Section II for the specific criterion for each POF.

B. PROGRAM OVERLAP OR EXCLUSIONS

Members who are determined as eligible for ECM may already be receiving some care management services through other programs. In many of these instances, ECM will be additive, improve management of care across delivery systems, and comprehensively address any unmet medical and/or social needs. DHCS has determined three options for members who can either be (1) simultaneously enrolled in both ECM and an existing program that provides care management/care coordination services; (2) enrolled in either ECM or another similar program, but not both; or (3) excluded from ECM due to enrollment in a particular program. Below is a summary of the programs that have been considered and the three options for members as a means of preventing duplication of services.

1915 c Waivers	Services Carved Out of Managed Care Plans	Services Carved into Managed Care Plans	Duals	Other
Multipurpose Senior Services Program (MSSP)	California Children's Services (CCS)	CCS Whole Child Model	Dual Eligible Special Needs Plans (D-SNPs) [from 2023]	AIDS Healthcare Foundation Plans
Assisted Living Waiver (ALW)	Genetically Handicapped Person's Program (GHPP)	Basic Case Management	D-SNP look-alike plans	California Community Transitions (CCT) Money Follows the Person (MFTP)
Home and Community-Based Alternatives (HCBA) Waiver	County-based Targeted Case Management (TCM)	Complex Case Management	Other Medicare Advantage Plans	Mosaic Family Services
HIV/AIDS Waiver	Specialty Mental Health (SMHS) TCM	Community-Based Adult Services (CBAS)	Medicare FFS	Hospice
HCBS Waiver for Individuals with Developmental Disabilities (DD)	SMHS Intensive Care Coordination for children (ICC)		Cal MediConnect	
Self-Determination Program for Individuals with I/DD	Drug Medi-Cal Organized Delivery Systems (DMC-ODS)		Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)	
			Program for All-Inclusive Care for the Elderly (PACE)	

ECM as a *Wrap*	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. SCFHP ensures that there is not any duplication of services between ECM and the other program.
Either ECM or the Other Program	Members can be enrolled in ECM or in the other program, not in both at the same time.
Excluded from ECM	Members enrolled in the other program are excluded from ECM.

1. Excluded Members
   a. During the monthly MIF generation process, SCFHP screens both eligible and enrolled members for enrollment into excluded programs as indicated in the above table.
      i. If a member is participating in excluded programs, SCFHP discontinues the member from ECM.
      ii. If a member is participating in a similar program that requires only enrollment into one or the other, SCFHP works with the ECM provider to determine the best program based on the member's needs and assists with disenrollment from either ECM or other program.
      iii. If a member is participating in a similar program with ECM being a wrap, SCFHP works with the other program to ensure there is not any duplication of services.

2. Expectations of ECM Providers
   a. SCFHP may not have access to data that confirms member enrollment in other programs that may exclude them from ECM. During the outreach and engagement process to enroll assigned members into ECM, ECM providers are required to screen their members and assess them for whether they are enrolled in an overlapping or excluded program as listed in Section B.
      i. If it is determined the member meets an exclusion that prohibits their enrollment into ECM, the ECM provider report to SCFHP the reason (e.g., enrolled in an excluded program, enrolled in a program that prohibits dual enrollment in ECM).
      ii. After informing the member, the ECM provider must document the member's exclusion on their monthly the Return Transition File (RTF). See Section XIII for details on the RTF and other provider reporting requirements.
      iii. Once SCFHP receives and processes the RTF, SCFHP documents the exclusion on the MIF and then eventually removes the member from the MIF after 60 days.
   b. If a member is currently enrolled in ECM and an exclusion is identified, the ECM provider must follow these guidelines:
      i. Complete the *ECM Disenrollment Reporting Template* for the member needing to be discontinued from ECM.
      ii. Assist as needed in the transition to another care manager if member will be discontinued from ECM.
      iii. Consult Section XII for more details on the discontinuation process.

C. AUTHORIZATION

SCFHP authorizes eligible members for ECM through the following methods:

1. MIF: Members are determined as eligible for ECM, assigned to an ECM provider, and placed on the MIF. Placement on the MIF serves as the authorization process for ECM. See Section VI.A for more details on the MIF process.

2. External Referrals: The ECM team reviews all referrals received from external sources, determines if members meet the eligibility criteria for ECM, authorizes ECM in its system, and assigns members to an ECM provider. See Section VI.B for more information on the authorization process for external referrals.

3. Eligibility Letter:
   a. SCFHP mails eligibility letters to newly eligible members in the month for which they are authorized for ECM.
   b. After sending the initial eligibility letter, SCFHP mails additional letters on a semi-annual or annual basis to eligible members placed on the MIF with the frequency being based on the member's acuity level.
      i. Tier 1: Mailed on a semi-annual basis
      ii. Tiers 3 -4: Mailed on annual basis
   b. Eligibility letters are written at a sixth grade reading level and translated into SCFHP's threshold languages.
   c. Members who did not receive an eligibility letter may request a letter by calling SCFHP Customer Service.

   ECM providers may request a copy of a member's eligibility letter by emailing ECM@scfhp.com.

4. Continuity of Care
   a. SCFHP automatically authorizes members who qualified for ECM with other Managed Care Plans (MCP) either in Santa Clara County or in another county.
      i. SCFHP requires the member, provider, family support individual, authorized representative, or another individual to submit a referral to SCFHP following the process as indicated in Section III.B.
      ii. Upon receipt of the referral, the ECM team automatically authorizes ECM and follows its standard process for authorization as indicated above.
      iii. The ECM team contacts the previous managed care plan and request historical utilization data within the last 90 days to mitigate any gaps in care and/or assist with determining eligibility for ECM over the longer term (e.g., HCPCS codes, medical records, other clinical information).
   b. Exclusion: If a member was disenrolled from ECM with their previous managed care plan due to one or more exclusions (e.g., lost Medi-Cal eligibility, unsafe behavior with a previous ECM provider, receiving hospice, etc.), the ECM team will review the member information and determine eligibility prior to automatically authorizing the member for ECM.
   c. Reassessment: For members automatically authorized for ECM, SCFHP reassesses the members to ensure that they met the eligibility criteria within 6 months of enrollment.
   3. Per DHCS Continuity of Care requirements, SCFHP does not adhere to the continuity with the previous ECM provider.

SECTION VIII: MEMBER ASSIGNMENT

SCFHP assigns to an appropriate contracted ECM provider that has the capacity and appropriate expertise to serve members based on the POF for which they are eligible. To the extent practicable, SCFHP takes into consideration member preference for assignment.

1. The standard assignment logic accounts for the following:
   - If a member's assigned PCP is also a contracted ECM provider, SCFHP assigns that member to their PCP who serves independently as the member's ECM provider. The exception to this assignment logic is if a member expresses a different preference or SCFHP identifies a more appropriate ECM provider given the member's individual needs and health conditions.
   - If a member receives services from a Specialty Mental Health Plan for SED, SUD, and/or SMI and the member's behavioral health provider is a contracted ECM provider, SCFHP assigns that member to that behavioral health provider as the ECM Provider, unless the member has expressed a different preference or SCFHP identifies a more appropriate ECM provider given the member's individual needs and health conditions.
   - For children enrolled in California Children's Services (CCS) and when the member's CCS case manager is affiliated with a contracted ECM provider, SCFHP assigns that member to the CCS case manager as the ECM provider, unless the member or family has expressed a different preference or SCFHP a more appropriate ECM provider given the member's individual needs and health conditions.
   - If the member does not have an existing relationship with one of SCFHP's contracted ECM providers, the member is assigned based on their POF and the ECM provider's ability to serve the POF.

2. SCFHP assigns members to an ECM provider within five business days of authorization.

3. SCFHP permits members to change ECM providers at any time and implements such change within 1-5 business days from when the request is made known to SCFHP.

SECTION IX: SERVICE DELIVERY INITIATION

Once members are authorized and assigned to an ECM provider, the assigned ECM provider can begin the process of initiating the delivery of ECM services.

A. LEAD CARE MANAGER ASSIGNMENT

1. Once ECM providers receive newly assigned members either on the MIF or through manual assignment, the ECM provider conducts outreach to engage and enroll members into ECM.
2. Upon enrollment into ECM, the ECM provider must assign a Lead Care Manager (LCM) to the member taking into consideration the following:
   a. The assigned LCM can provide services in accordance with the member's health care needs.
   b. Member preference and language.
3. The LCM name and contact information must be documented in the member's care plan.
4. The LCM is responsible for:
   a. Engaging with a multi-disciplinary care team to identify gaps in Member's care and ensure appropriate input is obtained to effectively coordinate all primary, behavioral, developmental, oral health, LTSS, Community Supports, and other services that address social determinants of health, regardless of setting, at a minimum.
   b. Directly interacting with the member and/or family, authorized representative, caretakers, and/or other authorized support person(s) as appropriate on a monthly basis and in accordance with the member's acuity level.
   c. Connecting with the member's PCP to discuss their care plan within 90 days of enrollment.
   d. Connecting with member's PCP once a quarter to coordinate services and share and update the member's care plan
   e. Updating and maintaining accurate and up-to-date member-level records related to the provision of ECM services.
5. Members are able to change their LCM at any time based on their preferences. Members are able to request a change in LCM by calling SCFHP. SCFHP makes the change within 30 days of receipt of the request.
6. Eligibility Verification: ECM providers are required to verify members' Medi-Cal eligibility with SCFHP both prior to initiating ECM services and each month while they are enrolled in ECM.

B. MEMBER CONSENT

1. ECM providers must receive and document member consent to receive ECM prior to the initiation of ECM services. ECM providers are able to follow their own process for obtaining consent and create a form for members to provide written consent or process for documenting verbal consent. The member's consent date must be shared with SCFHP through the RTF, PCPs, and other members of the care team. ECM providers are required to store and maintain member consents.
2. SCFHP does not require member consent for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM.

SECTION X: CORE ECM SERVICES

SCFHP requires ECM providers to adhere to its requirements for the provision of core ECM services to enrolled members. Below are the requirements for each of the seven core ECM services.

A. ACUITY LEVEL

ECM providers engage with ECM enrolled members on a monthly basis and frequency is based on the acuity level. SCFHP establishes and defines the acuity levels for ECM. Upon determining members are eligible for ECM, SCFHP assigns the initial acuity level (i.e., tier) and communicates such to the assigned ECM provider on the MIF. While SCFHP establishes the initial acuity level, ECM providers are responsible for determining if a member may need to be in a lower or higher acuity level on an ongoing basis. In these situations, the ECM provider is responsible for:

- Documenting the change in acuity level on the RTF and communicating such change to SCFHP on a monthly basis;
- Documenting the change in acuity level in the member's care plan; and
- Decreasing or increasing the engagement based on the outreach requirements in Section B.

To ensure our members with the highest needs are provided proper engagement, SCFHP established three levels of acuity for ECM. Upon eligibility determination, SCFHP sets the initial acuity level for members.

- Tier 1 (highest acuity): Members who meet three or more Populations of Focus
- Tier 2 (medium acuity): Members who meet at least two Populations of Focus
- Tier 3 (lower acuity): Members who meet at least one Populations of Focus

After enrollment into ECM, ECM providers are expected to reassess members to ensure they are categorized within the appropriate acuity level. ECM providers are required to base this reassessment on a myriad of factors including, but not limited to complexity of condition(s), compliance with treatment, medication adherence, homeless status, and social situation. ECM providers are expected to assess members initially upon enrollment, annually as part of the reassessment (every 12 months), and when there is any change to a member's health.

Through the course of delivering ECM services to enrolled members, ECM providers are required to assess the acuity levels of members on a monthly basis. The criteria for changing members to a lower acuity level involves assessing the following and determining an appropriate score:

- Care adherence
- Current health status
- Medication adherence
- Health literacy
- Sexual/reproductive health promotion
- Mental health
- Drug and alcohol use
- Housing
- Living situation/support systems
- Legal
- Income/personal finance
- Transportation

- Nutrition

ECM providers must provide monthly, community based, and in-person touch-ins with the enrolled member, seeking to provide the seven core services. The frequency of the touch-ins is based on the member's acuity level:

- Tier 1 (highest acuity) – Members require high level of care coordination and require at least two in-person touch-ins per month
- Tier 2 (medium acuity – Members require a medium level care coordination and require at least one in-person touch-ins per month
- Tier 3 (lowest acuity) – Members require a lower level of care coordination and are ready to graduate from ECM within six months or less, and require at least one in-person or via telehealth per month

When in-person communication is unavailable, unsuccessful, or does not meet the needs of the member, the ECM provider may use alternative methods (including innovative use of telehealth) to provide culturally-appropriate and accessible communication in accordance with the member's preference. If an ECM LCM needs to resort to telephonic communication for members in tier 1 or 2, the ECM LCM must seek written approval from SCFHP before engaging in telephonic touch-ins.

Note: See the ECM Billing Guide for the requirements for touch-ins by acuity level.

B. OUTREACH AND ENGAGEMENT

Outreach and engagement is one of the ECM core services. ECM providers are responsible for outreaching to assigned members as included on their MIF.

1. SCFHP defines outreach as:
   a. In-person: Outreach is delivered in the community when locating a member and/or meeting with a member where they are the most comfortable within the community.
   b. Telephonic:
      i. Outreach is completed by phone. The member answers the phone and the conversation lasts at least seven minutes.
      ii. Outreach is completed by phone. The member does not answer the phone. The provider makes at least one additional attempt on the same day and/or seeks out an alternative phone number from member's PCP.
   c. Mail and Email: Outreach is completed by mail or email. Mail or emails must be individualized and cannot be sent as part of a mass mailing or mass email. Letters must include member name and address, the purpose of reaching the member, and contact information for the member's assigned Lead Case Manager.

2. ECM providers are expected to use multiple strategies for engagement, as appropriate, and to the extent possible. They are defined as:
   a. Direct communication with members, such as in-person meetings where members live, seek care or is accessible;
   b. Mail, email, texts and telephone;
   c. Community and street-level outreach;
   d. Follow-up if members present to another provider within the ECM network;
   e. Utilizing educational materials and scripts that are culturally and linguistically appropriate; and

f. Contacting PCP and other members of the care team for up-to-date contact information for members.

3. ECM providers are required to conduct outreach primarily through in-person or telephonic 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.

4. ECM providers may use the following modalities, as appropriate, and as consented by the member if in-person modalities are unsuccessful or to reflect a member's stated contact preference, and must be documented in the member's care file:
    - Mail
    - Email
    - Texts
    - Telephone calls
    - Telehealth

5. ECM Providers are required to comply with all non-discrimination requirements set forth in state and federal law.

6. Outreach Based on Acuity
    a. Tier 1 (highest acuity)
        i. Months 1-3: ECM providers are required to:
            1. Conduct outreach to assigned members at least two times per month either by phone or in-person each month for the first three months.
            2. Connect with members' health providers (primary care, behavioral health, specialist, Community Supports provider, housing provider, etc.) to assist with locating members.
            3. Send a letter by mail to members who have not been reached and inform them that the ECM provider will continue to outreach to member until the member no longer is eligible for ECM or declines ECM services.
        ii. Months 3-12: ECM Providers are required to continue conducting outreach to assigned members at least once a month either by phone, in-person, or by mail.
        iii. Month 13: If outreach has been unsuccessful for a year, SCFHP removes the member from the ECM provider's MIF.
        iv. Month 13+: If members are in contact with the ECM provider and are interested in enrolling into ECM after being removed from the MIF, members can call SCFHP Customer Service to request authorization of ECM.
    b. Tier 2 (medium acuity)
        i. Months 1-4: ECM providers are required to:
            1. Conduct outreach to assigned members at least once per month by phone or in-person for the first four months.
            2. Contact the member's PCP or health providers (primary care, behavioral health, specialist, Community Supports provider, housing provider, etc.) at least two times per month to locate the member if not previously reached.
            3. Send a letter by mail to members who have not been reached and inform them that the ECM provider will continue to outreach to member until the member no longer is eligible for ECM or declines ECM services.
        ii. Months 4-12: ECM Providers are required to continue conducting outreach to assigned members at least once a month either by phone, in-person, or by mail.

iii. Month 13: If outreach has been unsuccessful for a year, SCFHP removes the member from the ECM provider's MIF.
iv. Month 13+: If members are in contact with the ECM provider and are interested in enrolling into ECM after being removed from the MIF, members can call SCFHP Customer Service to request authorization of ECM.

c. Tier 3 (lowest acuity)
i. Months 1-6: ECM providers are required to:
1. Conduct outreach to assigned members at least once per every other month by phone or in-person for the first six months.
2. Contact the member's PCP or health providers (primary care, behavioral health, specialist, Community Supports provider, housing provider, etc.) at least two times per month to locate the member if not previously reached.
ii. Months 6-12: ECM providers are required to continue conducting outreach to assigned members at least once per quarter either by phone, in-person, or by mail.
iii. Month 13: If outreach has been unsuccessful for a year, SCFHP removes the member from the ECM provider's MIF.
iv. Month 13+: If members are in contact with the ECM provider and are interested in enrolling into ECM after being removed from the MIF, members can call SCFHP Customer Service to request authorization of ECM.

Outreach attempts must be reported to SCFHP through the monthly Initial Outreach Tracker File (IOTF). See Section XIII.B. for more details.

C. COMPREHENSIVE ASSESSMENT AND CARE MANAGEMENT PLAN

After the initial step of successful engagement with a member, a comprehensive assessment should be conducted and a care plan developed. This process involves the members and their family/support individuals as well as appropriate clinical input in developing a comprehensive, individualized, person-centered care plan. The care plan is based on the needs and desires of the member and should be reassessed based on the member's individual progress or changes in their needs and/or as identified in the care plan. The care plan incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports and SDOH. Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service Providers.

1. In-Person Interaction
   a. SCFHP requires ECM providers to engage with each member authorized to receive ECM primarily through in-person contact.
   b. When in-person communication is unavailable or does not meet the needs of the member, the ECM provider shall use alternative methods (including use of telehealth) to provide culturally-appropriate and accessible communication in accordance with member choice.

2. Clinical and Non-Clinical Data: ECM providers can use clinical and non-clinical resources to appropriately assess member's health status and gaps in care, and inform the development of a care management plan. Resources include, but not limited to:
   - Initial assessment of Members' health status, including condition specific issues
   - Documentation of clinical history, including medications
   - Initial assessment of the activities of daily living
   - Initial assessment of behavioral health status, including cognitive functions

- Initial assessment of social determinants of health
- Initial assessment of life-planning activities
- Evaluation of cultural and linguistic needs, preferences or limitations
- Evaluation of visual and hearing need, preferences or limitations
- Evaluation of caregiver resources and involvement
- Evaluation of available benefits
- Evaluation of community resources
- Provider engagement

3. Care Management Plan: The ECM provider is required to:
   a. Identify necessary clinical and non-clinical resources to appropriately assess member health status and gaps in care, and may be needed to inform the development of an individualized care management plan;
   b. Develop a comprehensive, individualized, person-centered care management plan with input from the member and/or their family member(s), guardian, authorized representative, caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
   c. Incorporate into the member's care management plan any identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing;
   d. Ensure the member is reassessed at a frequency appropriate for the member's individual progress or changes in needs and/or as identified in the care management plan; and
   e. Ensure the care management plan is reviewed, maintained, and updated under appropriate clinical oversight.

4. Care Management Plan Requirements
   a. Upon enrollment into ECM, the LCM must develop a comprehensive, individualized, person-centered care plan by working with the member and/or their family member(s), guardian, authorized representative (AR), caregiver, and the member's providers, to assess strengths, risks, needs, and goals.
   b. The LCM must share the comprehensive assessment with the member and supportive individuals to determine the member current health status. This may result in the LCM deciding to lower or raise the member's acuity level.
   c. The LCM must create the member's first care management plan within the first 90 days after enrollment into ECM.
   d. The LCM is responsible for engaging with the member's care team to identify gaps in the member's care and ensure appropriate input is obtained to effectively coordinate all primary, behavioral, developmental, oral health, LTSS, ILOS, and other services that address social determinants of health, regardless of setting.
   e. Within 90 days of enrollment into ECM, the CM is required to connect with the member's PCP to discuss the member's care plan.
   f. Care management plans must include both short- and long-term goals, interventions to reach each goal, and identified barriers that may keep the member from achieving their goals.
   g. Goals should focus on the following areas of health:
      i. Physical health, behavioral health, substance use disorder, long term services and supports, palliative care, trauma-informed care needs, social needs, and housing needs

ii. Goals are person-centered and are created with the member
iii. Referrals made to community based services and health care Providers

h. Reassessment: ECM providers must assesses the care management plans for:
   i. Tier 1 and Tier 2 members every six months and/or when changes occur in the members' progress or health status.
   ii. Tier 3 members prior to graduation to ensure members are ready to graduate from ECM or when changes occur in members' progress or health status.
i. Care management plans must be reviewed by a clinical team member who is part of the ECM care team when there is a change in the members' health and/or when a goal is clinical in nature.
j. ECM providers must review and discuss the care management plan at each in-person visits with members and make updates as needed.

D. ENHANCED COORDINATION OF CARE

ECM providers are required to provide enhanced coordination of care as part of the core ECM services.

1. Required Services: For delivering enhanced coordination of care, ECM providers are required to engage in the following, but are not limited to:
   a. Organizing patient care activities, as laid out in the care management plan, sharing information with those involved as part of the member's multi-disciplinary care team;
   b. Implementing activities identified in the Member's Care Management Plan
   c. Maintaining regular contact with all providers that are identified as being a part of the member's multi-disciplinary care team, whose input is necessary for successful implementation of member goals and needs;
   d. Ensuring care is continuous and integrated among all service providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
   e. 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;
   f. Communicating the member's needs and preferences timely to the ember's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
   g. Ensuring regular contact with the member and their family member(s), guardian, AR, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

2. Care Management Plan: ECM providers are required to organize patient care activities, as laid out in the member's care management plan, share information with those involved as part of the member's multi-disciplinary care team, and implement activities identified in the member's care plan. A few things to note on care management plans:
   a. The first care plan should be completed within the first 90 days after enrollment.
   b. Care plans include short- and long-term goals, interventions to reach each goal, and identified barriers that keep the member from achieving their goals.
   c. Goals should focus on the following areas of health – physical health, behavioral health, substance use disorder, long term services and supports, palliative care, trauma-informed care needs, social needs, and housing needs.

d. Goals are person-centered and are created with the member
e. New and updated care plans should be shared with the member and other members of the care team.
f. If a member has any care plans with any of their existing providers, the ECM provider must contact those providers to align care plans.
g. If needed, clinical oversight or consultation must be available upon member request and/or there is a change in the member's goals or health.
h. Care plans must be available to DHCS and SCFHP upon request.

3. Continuous Care: ECM providers must ensure care is continuous and integrated among all service providers, as well as referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed.

4. Member Support: ECM providers are required to provide support to engage the member in their treatment. Additional care coordination activities that may be required by members include, but are not limited to:
   a. Coordinating medication review and/or reconciling at least once a quarter;
   b. Scheduling appointments when requested by a member;
   c. Contacting a member to provide appointment reminders;
   d. Coordinating transportation when appropriate;
   e. Accompanying member to critical appointments when requested; and
   f. Identifying and helping to address other barriers to member engagement in treatment.

5. Communication Requirements:
   a. ECM providers must maintain regular contact with all providers that are identified as being a part of the member's multi-disciplinary care team, whose input is necessary for successful implementation of member goals and needs.
   b. ECM providers must communicate a member's needs and preferences to the member's multi-disciplinary care team when there is a change in the member's health. A change in a member's health may include, but not limited to reentry to prison, ED admission, inpatient stay, or admission to a long-term care facility or a skilled nursing facility.
   c. ECM providers must ensure regular contact with the member and their family member(s), guardian, AR, caregiver, and/or authorized support person(s), when appropriate.

E. HEALTH PROMOTION

Health Promotion includes services to encourage and support members receiving ECM to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health.

1. Required Services: ECM providers shall engage in the following activities:
   a. Work with members to identify and build on successes and potential family and/or support networks;
   b. Provide services to encourage and support members in making lifestyle choices based on healthy behavior, with the goal of supporting members' ability to successfully monitor and manage their health;

c. Support members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions;
d. Link members to resources for smoking cessation, management of member chronic conditions, self-help recovery resources and other services based on member needs and preference; and
e. Using evidence-based practices, such as motivational interviewing, engage and help the member participate in and manage their care.

2. Supportive Individuals: Upon enrollment into ECM, ECM providers work a member and individuals in the member's care team to identify potential family and/or support networks. These supportive individuals are documented in the member's care management plan along with their contact information. ECM providers must involve the supportive individuals into the member's care planning and ECM service delivery.

3. Healthy Lifestyle Choices: In an effort to assist members with making healthy lifestyle choices, ECM providers are required to participate in motivational interviewing training. This will assist ECM providers in successfully engaging members in health education opportunities. ECM providers may be required to assist members with enrolling and accessing the following:
   a. Heath education courses are offered at ECM provider sites or at community-based locations;
   b. Tools that assist members with self-managing their health; and
   c. Other resources that encourage and support members in making health lifestyle choices.

4. Member Engagement: To assist members in managing their health conditions and preventing other chronic conditions, ECM Providers must:
   a. Take a member's language into account and provide services in a culturally competent manner; and
   b. Follow up with a member during monthly one-on-one touch-ins to ensure the member is understanding the course content and if member could benefit from additional health education courses or resources.

F. COMPREHENSIVE TRANSITIONAL CARE

Comprehensive Transitional Care includes services intended to support members and their families and/or support networks during discharge from hospital and institutional settings. Services include facilitating members' transitions from and among treatment facilities, including admissions and discharges. Additionally, ECM providers should provide information to hospital discharge planners about ECM so that collaboration on behalf of the member can occur in as timely a manner as possible. Comprehensive Transitional Care can help avoid unnecessary readmissions.

1. Required Services: ECM providers are required to provide services as described below, but are not limited to the following:
   a. Developing strategies to reduce avoidable member admissions and readmissions across all members receiving ECM. Examples include:
      i. Establishing agreements and processes to ensure prompt notification to the member's LCM;
      ii. Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners;
      iii. Arranging transportation for transitional care, including to medical appointments, as needed; and

iv. Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management.

b. For Members who are experiencing or are likely to experience a care transition:
   i. Developing and regularly updating a transition plan for the member, including the facilitation of discharge instructions developed by a hospital discharge planner.
   ii. Evaluating a member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges.
   iii. Tracking each member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members.
   iv. Coordinating medication review/reconciliation.
   v. Providing adherence support and referral to appropriate services.

2. Strategies to Reduce Avoidable Admissions/Readmissions: Strategies to reduce avoidable member admissions and readmissions across all members receiving ECM include:
   a. Identify and manage members at risk for planned and unplanned transitions;
   b. Communicate with the member and/or the member's authorized representative, PCP, and specialists;
   c. Support member preferences and choice through monthly touch-ins;
   d. Promote the exchange of information across care settings; and
   e. Analyze and monitor data for process improvement.

3. Care Transition: ECM providers are required to contact members who discharged from any of the following facilities within 3-4 business days of notification:
   a. Acute hospitals
   b. Inpatient psychiatric hospitals
   c. Skilled Nursing Facilities (SNFs)
   d. Assisted living and residential care facilities
   e. Rehabilitation facilities
   f. Prison

4. Transition of Care Assessment: ECM providers are required to follow SCFHP's protocol for a Transition of Care (TOC) assessment, which includes the following:
   a. TOC outreach date and number of attempts;
   b. Reason member entered facility, as shared by the member ;
   c. Documentation provided to the member at discharge;
   d. Current medication, if applicable – a medication reconciliation and adherence should be performed with a clinician who is part of the care team during a TOC call; and
   e. Acknowledgement of the member's understanding of next steps, including scheduling a meeting with appropriate providers such as the member's PCP, scheduling a 30-day post discharge check-in, and providing adherence support and referral to appropriate services.

   ECM providers must track member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicate with the appropriate care team members.

G. MEMBER AND FAMILY SUPPORTS

Member and Family Supports include activities that ensure the members and their Family and/or supportive individuals are knowledgeable about the member's conditions, with the overall goal of improving their adherence to treatment and medication management.

Required Services: ECM providers are required to provide services as described below, but not limited to:

1. Documenting a member's authorized family member(s), guardian, AR, caregiver, and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM provider and the member and/or their family member(s), AR, guardian, caregiver and/or authorized support person(s); and Contractor, as applicable.
2. Conducting activities to ensure the member and/or their family member(s), guardian, AR, caregiver and/or authorized support person(s) are knowledgeable about the member's condition(s), 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.
3. Ensuring the member's LCM serves as the primary point of contact for the member and/or family member(s), guardian, AR, caregiver and/or other authorized support person(s).
4. Identifying 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 and assist them with making informed choices
5. Providing for appropriate education of the member and/or their family member(s), guardian, AR, caregiver and/or authorized support person(s) about care instructions for the member.
6. Ensuring that the member has a copy of his/her care plan and information about how to request updates.

H. COORDINATION OF AND REFERRAL TO COMMUNITY AND SOCIAL SUPPORT SERVICES

Coordination of and Referral to Community and Social Support Services involves determining appropriate services to meet the needs of members receiving ECM, to ensure that any present or emerging social factors can be identified and properly addressed.

1. Required Services: ECM providers may need to provide the following services, although not limited to:
    a. Determining appropriate services to meet the needs of members, including services that address social determinants of health needs, including housing, and Community Supports offered by SCFHP; and
    b. Coordinating and referring members to available community resources and following up with members to ensure services were rendered (i.e., closed loop referrals).

2. Referral Assistance: ECM providers must determine the appropriate services that members need during their participation in ECM. ECM providers are expected to:
    a. Assist members with accessing additional benefits and related documentation, such as Social Security Insurance (SSI), CalFresh, cash aid; and obtaining required documentation to apply (ID,

birth certificate, immigration status, financial records, marriage/divorce records, proof of medical conditions, etc.)

b. Document any member needs in the member's care plan and referral to services and reassess during each monthly contact if additional community and/or social support services are needed.
c. Ensure members are being referred appropriately to community and support services and connecting them with the entities that are providing the services.
d. Engage with the Community Supports provider throughout the duration of the services being delivered, if applicable.

3. SCFHP's Community Supports: ECM providers should have a basic understanding of the eligibility criteria for the Community Supports SCFHP offers to its members and are encouraged to submit referrals to SCFHP.
   a. Referral Process: ECM providers are required to:
      i. Identify programs or services that members are already accessing in the community to avoid duplication of services that may be provided under Community Supports.
      ii. Submit referrals for Community Supports if there are not any other options available to members (i.e., SCFHP is the payor of last resort).
      iii. Review the eligibility criteria for the Community Supports in which the member needs and collect the required documentation and data sharing consent from the member prior to submitting a referral.
      iv. Complete the Community Supports Referral Form through SCFHP's Provider Portal and upload all required documentation, or download the referral forms from SCFHP's website and submit them to SCFHP by email, fax, mail, or in person.

   b. ECM and Community Supports Overlap
      i. ECM providers are responsible for identifying an overlap between required services in ECM and Community Supports (e.g., housing assessment, completing a VI-SPDAT and updating HMIS)
      ii. If an overlap occurs, the ECM services as required in Section VII take precedence over the Community Supports services. The LCM must coordinate service delivery with the Community Supports provider to ensure there is not duplication of services.
      iii. If Community Supports services are discontinued for any reason, the ECM provider must support the member and/or their family supports in the transition to other programs or services that assist in meeting their needs, if needed.

   c. Required ECM Enrollment: Of the 14 DHCS-approved Community Supports, only Housing Deposits requires members to be enrolled in ECM to be eligible for services. All other Community Supports do not require ECM enrollment for eligibility.

SECTION XI: COMMUNITY SUPPORTS

Similar to ECM, Community Supports is another element of CalAIM, DHCS's multi-year process to transform Medi-Cal. Community Supports are medically-appropriate and cost-effective substitutes or settings for costlier state-paid health care services. They are not Medi-Cal benefits, but supplemental services paid by the managed care health plans to avoid higher levels of care and are typically delivered by a different provider or in a different setting than traditional Medi-Cal benefits. Community Supports are beneficial if integrated with case management for members at medium-to-high levels of risk and may fill gaps in Medi-Cal benefits to address medical or other needs that may arise due to social determinants of health. With the exception of Housing Deposits, members do not need to be enrolled in ECM to be eligible for Community Supports.

A. COMMUNITY SUPPORTS ELECTION

SCFHP will launch all 14 of the DHCS-approved Community Supports in six-month increments between January 1, 2022 and July 1, 2023. The following are the launch dates for each of the 14 Community Supports:

Community Supports	Launch Date
Housing Transition Navigation Services	1/1/2022
Housing Deposits	1/1/2022
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities	1/1/2022
Community Transition Services/Nursing Facility Transition to a Home	1/1/2022
Medically Supportive Food/Meals/Medically Tailored Meals	1/1/2022
Housing Tenancy and Sustaining Services	7/1/2022
Recuperative Care (Medical Respite)	7/1/2022
Sobering Center	7/1/2022
Personal Care and Homemaker Services	1/1/2023
Respite Services	1/1/2023
Environmental Accessibility Adaptations (Home Modifications)	1/1/2023
Asthma Remediation	1/1/2023
Short-term Post-Hospitalization Housing	7/1/2023
Day Habilitation Programs	7/1/2023

B. REFERRAL PROCESS

ECM providers can adhere to the following process for submitting referrals to SCFHP for Community Supports:

1. Set up a user account for SCFHP's Provider Portal. If you need assistance with setting up a user account, contact SCFHP's Provider Network Operations team at ProviderServices@scfhp.com.

2. Select the appropriate referral form from those listed on the Provider Portal.
3. Complete the referral form.
4. Upload a completed Release of Information (ROI) that allows data sharing from SCFHP to an assigned Community Supports provider and all other required documentation as stated on the referral form.
5. Submit referral form and required documentation to SCFHP for review.

Once SCFHP receives a completed referral form, the LTSS team:

1. Reviews the referral form and uploaded documentation;
2. Contacts the referring entity if any information is missing or if they have questions;
3. Determines eligibility for requested Community Supports;
4. Assigns member to a Community Supports provider;
5. Notifies the member, Community Supports provider, and referring entity in writing of the authorization for services;
6. Sends applicable referral information to the Community Supports provider to begin providing services; and
7. Communicates to the referring entity when services are rendered or if services were discontinued and the reason.

SECTION XII: DISCONTINUATION

Members enrolled in ECM are able to decline or end ECM upon initial outreach and engagement, or at any other time.

1. Discontinuation Reasons: ECM providers are required to notify SCFHP to discontinue ECM for members when any of the following circumstances are met:

Discontinuance Reason	Required Supporting Documentation
Duplicative Program • Members cannot be enrolled in both ECM and another program that provides the same services as ECM. • Duplicative programs include: MSSP, ALW, HCBA, HIV/AIDS Waiver, HCBS Waiver for DD, I/DD, Basic Case Management, Complex Case Management, FIDE-SNPs, PACE, Family Mosaic Project Services, CCT MFT, Cal MediConnect (CMC), Hospice	• Attestation from the alternate program, OR • Enrollment letter from alternate program, OR • Care plan from alternate program
Unsuccessful Engagement Members are considered uncooperative if they meet at least one of the following: • Member has missed three consecutive appointments with care team within the last 60 days. • Member has not completed a care plan within 90 days of enrolling in SCFHP's ECM Medi-Cal benefit. • Member has not followed care plan. • LCM could not reach member within 90 days after calling on three different days, at least once per month and an alternative outreach method is used outside of telephonic outreach to member.	• Case management notes detailing occurrences the member is not adhering to their care plan or has missed three appointments, OR • Case management notes detailing outreach attempts to contact the member including progressive phone outreach and at least one alternative outreach method

Discontinuance Reason	Required Supporting Documentation
Well Managed: Members are considered well managed if they meet one of the following: • Member has met all care plan goals and ECM provider has determined member does not have any additional goals. • Member has met all care plan goals and member has determined that they do not have any additional goals. • Member has continued to meet their care plan goals and ECM provider has determined member is able to self-manage their care needs. • Member has continued to meet their care plan goals and member has determined they are able to self-manage with care needs.	• PCP notes, progress notes, chart notes, or History of Physical Illness (HPI) • Case management notes and/or care plan
Transition to Lower Level of Care: Members are considered ready to transition to a lower level of care if they meet one of the following: • Member has met all care plan goals and ECM provider has determined member does not have any additional goals. • Member has met all care plan goals and member has determined that they do not have any additional goals. • Member has continued to meet their care plan goals and ECM provider has determined member is able to self-manage their care needs. • Member has continued to meet their care plan goals and member has determined they are able to self-manage their care needs.	• PCP notes, progress notes, chart notes, or History of Physical Illness (HPI) • Case management notes and/or care plan
Unsafe Behavior: Members are considered to be exemplifying unsafe behavior if they meet one of the following: • Member on three different occurrences have shown unsafe actions that keep ECM provider from providing ECM services. • Member has caused the environment in which they receive services to be unsafe for ECM provider to continue services on three separate occasions.	• Chart notes detailing unsafe environment and/or behavior, OR • Case management notes detailing unsafe environment and/or behavior

Discontinuance Reason	Required Supporting Documentation
Does Not Meet Eligibility Criteria: Members must have certain chronic medical conditions and experience complex social factors influencing their health. Current notes/documentation does not show member meets ECM program eligibility and, therefore, is denied.	PCP notes, progress notes, chart notes, or History of Physical Illness (HPI)

Discontinuation Review Process Not Required	
Discontinuance Reason	**Required Supporting Documentation**
Member Request: Member has notified ECM provider they have elected to disenroll and discontinue ECM services	• Case management notes detailing the reason(s) the member has chosen to disenroll and how it was communicated, OR • ECM provider disenrollment form
Medi-Cal Termed: Member is not actively enrolled in SCFHP's Medi-Cal plan	Documentation is not required

2. Transitioning Members from ECM: Members with a Tier 3 acuity (lowest level) who have completed all of their care plan goals in six months or less are eligible for graduating from ECM. The ECM provider must complete SCFHP's *ECM Disenrollment Reporting Template* and submit the proper documentation to SCFHP for their review and final determination.

SECTION XIII: DATA SYSTEMS AND DATA SHARING

ECM providers must have an IT infrastructure and data analytic capabilities to support ECM.

1. Required Capabilities: ECM providers are required to have the capabilities to:
   a. Utilize a secure file transfer protocol (SFTP) to receive secure data from and send to SCFHP (MIF, provider required reporting, care plans, medical records, social data, and other member-specific data;
   b. Store, update, and maintain member care plans with the ability to share them with DHCS and SCFHP as needed;
   c. Utilize the data received on the MIF to conduct outreach to assigned members to engage them into ECM and monitor any changes to member information as reflected on the MIF;
   d. Ability to receive up-to-date, real-time data on the status of members accessing ED, hospital, and/or behavioral health/SUD clinics;
   e. Create and utilize data for monitoring performance and quality measures;
   f. Obtain, store, and maintain member consent for receiving ECM services and ECM-related data sharing;
   g. Track all referrals for health education, Community Supports, and other community-based programs, document referral information in the member's care plan, and track and document the outcomes.
   h. Track ADT and other hospital utilization;
   i. Identify and track nursing facility utilization; and
   j. Submit required reporting to SCFHP as detailed in Exhibit A-3 of the *ECM Agreement*.

A. SCFHP DATA SHARING

1. Consistent with all federal, state, and local privacy and confidentiality laws, SCFHP provides the following data to ECM providers through a secure system:
   a. Demographic and administrative information confirming member's eligibility and authorization for ECM;
   b. Appropriate administrative, clinical, and social service information the ECM providers may need to effectively provide ECM; and
   c. Billing information necessary to support the ECM providers' ability to submit claims or invoices to SCFHP.

2. SCFHP's monthly files distributed to ECM providers
   a. SCFHP sends ECM providers a monthly MIF and three supplemental reports – POF, Health Indicators, and MedRX. See Section VI.A for more details.
   b. SCFHP sends the three monthly files to ECM providers using the following naming conventions:
      - MIF: ECMProviderName_ECM__MIF_YYYYMMDD.txt
      - POF: ECMProviderName_ECM__POF_YYYYMMDD.txt
      - Health Indicators: ECMProviderName_ECM__HI_YYYYMMDD.txt
      - MedRX: ECMProviderName_ECM__DrugSup_YYYYMMDD.txt

B. ECM PROVIDER REPORTING REQUIREMENTS

1. ECM providers are required to adhere to SCFHP's comprehensive technical specifications for the provider reporting requirements are documented in the *ECM Inbound Outbound Reporting Specs*.
2. ECM providers are required to prepare and submit a monthly Return Transmission File (RTF) and Initial Outreach Tracker File (IOTF) to SCFHP. For details on the required data fields, see *Exhibit A-3* of the *ECM Agreement*.
3. ECM providers are required to adhere to the following file requirements when submitted the monthly RTF and IOTF to SCFHP:
   a. The file must be in pipe delimited text file format.
   b. RTF naming convention ECMProviderName_ECM__RTF_YYYYMMDD.txt
   c. IOTF naming convention: ECMProviderName_ECM_OUTREACH_yyyymmdd.txt
4. ECM providers will submit both the RTF and IOTF by the 3rd of the month (submission acceptance period is open from the 25th of the previous month up to the third of the reporting month).
   a. In the event the RTF and/or IOTF needs to be corrected by the ECM provider, the ECM provider has until the 3rd of the month to correct the file(s) and resubmit to SCFHP.
   b. If there are still errors after the third of the month, the RTF and/or IOTF will be rejected and data will not be updated on the upcoming MIF. Files will need to be resubmitted with the following month's submission in a single RTF and/or IOTF.
   c. ECM providers must upload the RTF and IOTF to SCFHP's SFTP directory at \Inbound\ECM.
5. ECM providers will be required to submit quality measures to SCFHP. DHCS is still in the process of defining the measures. Once released, SCFHP will communicate the requirements to providers.

C. ADDRESSING PROVIDER DATA ERRORS

1. SCFHP adheres to the following process to address data errors on the submitted RTF and/or IOTF: Sends an email notification to providers informing provider of identified errors and confirm that SCFHP is not able to process the file(s).
2. Creates an error log documenting either file naming convention errors and/or formatting errors related to the submitted data, and uploads to the ECM provider's outbound SFTP file. The naming convention for the error log is OriginalRTFOutreachFileName_ErrorLog_YYYYMMDD_HHMMSS.csv.
3. Requires ECM providers correct their files and resubmit to SCFHP using the naming convention of ECMProviderName_ECM_RTF_POF_YYYYMMDD_V2.txt.

D. REFERENCE

For the specific reports and the required data elements that SCFHP requires of ECM providers, see *Exhibit A-3* of the *ECM Agreement*. For current inbound and outbound technical specifications, ECM providers can send a request to ECM@scfhp.com.

SECTION XIV: CLAIMS OR INVOICE SUBMISSION AND PAYMENT

ECM providers must submit either claims using specifications based on national standards and code sets as defined by DHCS or invoices with data elements defined by DHCS to SCFHP for payment of ECM services. Claims and invoices must be submitted within the designated timeframe as specified by DHCS and defined in the Exhibit C of the *ECM Agreement*.

1. Claims Submission
    a. ECM providers must record, generate, and send a claim to SCFHP for rendered ECM services.
    b. ECM providers must submit claims to SCFHP using specifications based on national standards and code sets to be defined by DHCS. The specifications are outlined in Exhibit C of the *ECM Agreement*.
    c. All claims must be submitted within twelve (12) months from the date of service or SCFHP may refuse payment.

2. Invoice Submission
    a. In the event an ECM provider is unable to submit claims to SCFHP using specifications based on national or DHCS-defined specifications and code sets, the ECM provider may submit invoices with minimum necessary data elements defined by DHCS, which includes information about the member, ECM enrollment date, and provider information to support appropriate payment from SCFHP. The specific data elements required by CS providers to include in their invoices are specified in Exhibit C of the *ECM Agreement*.
    b. SCFHP converts the data on the invoices to encounters using DHCS-defined standard specifications and code sets for submission to DHCS.
    c. ECM providers must submit their invoices within thirty (30) calendar days of the end of the service month or as otherwise specified by DHCS and in adherence to the requirements as outlined in the *ECM Billing Guide*.

3. Payment
    a. ECM providers will be paid each month for each eligible enrolled member to whom the ECM providers provided at least the minimum required eligible ECM service visit(s).
    b. ECM providers are required to check SCFHP member eligibility before service provision every month. Ineligible members and services not accepted by DHCS may not result in a payment.
    c. ECM providers must submit claims or invoices with the HCPCS Level II Codes G9008 or G9012 and the appropriate modifiers for ECM services. Refer to Exhibit C of the *ECM Agreement* and the *ECM Billing Guide*.
    d. SCFHP processes Clean Claims within forty-five (45) business days of receipt; or within such shorter time period as is required by law.
    e. SCFHP does not delay payment of a claim from an ECM provider to await the submission of a claim from a hospital or other provider, without citing the specific rationale as to why the delay was necessary and will provide a monthly update regarding the status of the claims and of SCFHP's actions to resolve the claim to the ECM provider.
    f. For details on interest paid on late claims or invoices, see Exhibit C of the *ECM Agreement*.

SECTION XV: PROVIDER OVERSIGHT

SCFHP provides oversight of ECM providers, holding them accountable to all ECM requirements contained in the *ECM Agreement*, the *ECM Provider User Guide*, and any referenced document or template.

1. General Oversight
    a. SCFHP provides oversight of all ECM providers, holding them accountable to all ECM requirements as set forth by DHCS and SCFHP, and are subject to change based on updated guidance from DHCS.
    b. ECM providers that subcontract any ECM services to other entities must hold their subcontractors to the same requirements that SCFHP requires of all contracted ECM providers, including oversight of and monitoring the delivery of ECM and the outcomes associated with the provision of ECM.
    c. SCFHP requires all ECM providers to adhere to the same reporting requirements as those that DHCS requires of SCFHP.

2. Training and Technical Assistance
    a. ECM providers must attend SCFHP's standard Network Provider training within ten days of the execution of an ECM agreement.
    b. SCFHP provides an initial training on ECM services, eligibility requirements, acuity levels, transitioned member counts, provider assignment logic, data sharing, and required provider reporting.
    c. SCFHP provides annual trainings and convening with providers to:
        - Assess provider challenges and/or barriers with outreach activities and member engagement;
        - Explore feedback from the providers on the delivery of ECM, service requirements, reporting requirements, service quality, and outcome monitoring for process improvement;
        - Respond to questions from providers; and
        - Provide support and technical assistance as needed.

3. Utilization and Outcome Monitoring
    a. SCFHP designates the ECM team to provide oversight and monitoring of ECM providers. Their role is to:
        i. Ensure data is appropriately and accurately collected by providers and entered into the online platform for access by the referring entity and SCFHP.
        ii. Communicate any errors to ECM providers, work with them to correct the errors, and resubmit accurate data.
        iii. Utilize data submitted from ECM providers for monitoring and evaluation purposes.
        iv. Maintain communication with ECM providers for achieving quality measures and quality improvement.

4. Quality: The goals for ECM are to improve care coordination; integrate palliative care; strengthen community linkages and team-based care; improve the health outcomes of members enrolled in ECM; and wrap increased care coordination around existing care as close to the member's usual point of care delivery as possible in the community. Quality metrics surrounding benefit and program goals and outcomes for members enrolled in ECM will be identified and incorporated into this provider user guide through updates, once guidance is released by DHCS.

5. Auditing
    a. SCFHP will maintain strong oversight over ECM providers through semi-annual auditing and monitoring of activities to ensure that case conferences occur, the Health Action Plan (HAP) is updated as health care unfolds, and all other ECM service requirements are met.
    b. For the semi-annual audits, ECM providers must submit all requested information and documentation and actively participate in the audits based on the timelines determined by SCFHP.
    c. Should an audit result in findings, SCFHP may issue corrective actions to ensure that the ECM provider resolves the identified issues within the designated timeframe to ensure compliance with all benefit requirements.
    d. Audits will review records that show compliance with all requirements, including but not limited to:
        i. Coordinating all primary, acute, behavioral, developmental, oral, social needs, and LTSS for members, including participating in the care planning process, regardless of setting.
        ii. Assuming primary responsibility for coordination of the member's needs, including collaboration with other coordinators who operate in a more limited scope.
        iii. Delivering ECM in an interdisciplinary, high-touch, and person-centered manner, and primarily through in-person interactions with members where they live, seek care, and prefer to access services.
        iv. Establishing strong relationships with enrolled members.
        v. Delivering ECM using alternative methods (including telehealth) when in-person communication is unavailable or does not meet the needs of members and in a culturally-appropriate and accessible manner in accordance with members' preference.
        vi. Providing the required ECM seven core services along with the required activities under each core service:
            - Outreach and Engagement
            - Comprehensive Assessment and Care Management Plan
            - Enhanced Coordination of Care
            - Health Promotion
            - Comprehensive Transitional Care
            - Member and Family Supports
            - Coordination of and Referral to Community and Social Support Services\

SECTION XVI: GLOSSARY

California Advancing and Innovating Medi-Cal (CalAIM): The Department of Health Care Services' (DHCS) framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program. Key priorities of CalAIM are leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

Cal MediConnect (CMC): An aligned financial demonstration project that promotes coordinated health care delivery for Californians who are dually eligible for both Medicare and Medi-Cal. A partnership between California's Medi-Cal program and the Centers for Medicare & Medicaid Services (CMS), CMC aims to create a seamless service delivery experience for dual eligible beneficiaries, with the ultimate goals of improved care coordination, better health outcomes, and a more efficient delivery system. CMC combines Medicare and Medi-Cal benefits into one health plan, with additional care coordination benefits. The program launched in 2014 and ultimately implemented in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. The program ends on December 31, 2022.

Community-Based Adult Services (CBAS): Formerly Adult Day Health Care, CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. Effective on April 1, 2022 under the California Bridge to Health Care Reform waiver, CBAS services include: an individual assessment; professional nursing services; physical, occupational and speech therapies; mental health services; therapeutic activities; social services; personal care; a meal; nutritional counseling; and transportation to and from the participant's residence and the CBAS center. CBAS is an LTSS Medi-Cal benefit.

Community Supports: An initiative of CalAIM, Community Supports are medically-appropriate and cost-effective substitutes or settings for costlier state-paid health care services. They are not Medi-Cal benefits, but supplemental services paid by the managed care health plans to avoid higher levels of care and are typically delivered by a different provider or in a different setting than traditional Medi-Cal benefits. Community Supports are beneficial if integrated with case management for members at medium-to-high levels of risk and may fill gaps in Medi-Cal benefits to address medical or other needs that may arise due to social determinants of health. Community Supports is not a Medi-Cal benefit, but optional services the managed care plans provide to their members.

Dual Eligible Special Needs Plan (D-SNP): A Medicare Advantage (MA) health plan that provides specialized care and wrap-around services for dual eligible beneficiaries (eligible for both Medicare and Medicaid). Under CalAIM, DHCS is transitioning CMC and the Coordinated Care Initiative (CCI) to a statewide aligned Managed Long-Term Services and Supports (MLTSS) and D-SNP structure. DHCS will work with health plans, stakeholders, and CMS to transition and expand integrated care statewide. This policy is intended to help meet the statewide goals of improved care integration and person-centered care under both the CalAIM and the California Master Plan for Aging and includes: transitioning to mandatory MLTSS enrollment for dual eligible beneficiaries, expanding availability of aligned D-SNPs for voluntary enrollment for dual eligible beneficiaries; and strengthening care coordination and integration standards for plans serving dual eligible beneficiaries.

Enhanced Care Management (ECM): A whole person care approach that addresses the clinical and non-clinical needs of high-need, high-cost Medi-Cal members through systematic coordination of services. ECM is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals that is community based, interdisciplinary, high touch, and person centered. The goals of ECM are to improve care coordination, integrate services, facilitate community resources, address social determinants of health (SDOH), improve health outcomes, and decrease inappropriate utilization and duplication of services.

Enhanced Care Management (ECM) providers: Contracted community-based entities with the experience and expertise to provide intensive, in-person care management services to individuals who meet the eligibility criteria for one or more of the ECM Populations of Focus.

Health Homes Program (HHP): A California pilot program designed to serve eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by eligible beneficiaries. The HHP provides six core services: comprehensive care management; care coordination (physical health, behavioral health, community-based LTSS); health promotion; comprehensive transitional care; individual and family support; and referral to community and social support services, including housing. The HHP ended on December 31, 2022, but key elements of the program were expanded as part of ECM.

Home and Community-Based Services (HCBS): Opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. The programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

In Home Supportive Services (IHSS): The program provides in-home assistance to eligible aged, blind and disabled individuals as an alternative to out-of-home care and enables recipients to remain safely in their own homes. IHSS is an LTSS Medi-Cal benefit.

Lead Care Manager (LCM): A member's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the LCM could be SCFHP staff). The LCM operates as part of the member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any community-based services. To the extent a member has other care managers, the LCM will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the member and non-duplication of services.

Institutional Long Term Care (LTC) – Medi-Cal: A level of care that is the least intensive and is not skilled care. LTC provides assistance with activities of daily living, including assistance with feeding, bathing, dressing and mobility; also known as custodial care.

Long Term Services and Support (LTSS): Services and supports provided to individuals who have functional limitations and/or chronic illnesses and which have the primary purpose of supporting the ability of the individual to live or work in the setting of their choice, which may include their home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting. Medi-Cal LTSS benefits include: CBAS, LTC, IHSS, and MSSP.

Managed Long-Term Services and Supports (MLTSS): A delivery of long term services and supports through capitated Medi-Cal managed care programs. California uses the MLTSS as a strategy for expanding home- and community-based services, promoting community inclusion, ensuring quality, and increasing efficiency. The number of states with MLTSS programs increased from eight in 2004 to 16 in 2012. Currently in Santa Clara County, CBAS and institutional LTC are managed care benefits.

Medi-Cal Managed Care Plan (MCP): A health plan that engages in a contact with DHCS to provide health care services through established networks of organized systems of care, which emphasize primary and preventive care. MCPs are a cost-effective use of health care resources that improve health care access and assure quality of care.

Multipurpose Senior Services Program (MSSP): A waiver that providers Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement. The MSSP waiver allows the individuals to remain safely in their homes.

Serious Mental Inness (SMI): SMI is defined by someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. For people under the age of 18, the term *Serious Emotional Disturbance* refers to a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

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

Substance Use Disorder (SUD): Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Whole Person Care (WPC): A pilot program that coordinates health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered by a county, a city and county, a health or hospital authority, or a consortium of any of those entities serving a county or region consisting of more than one county, or a health authority, to receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC Pilot entities identify target populations, share data between systems, coordinate care real time, and evaluate individual and population progress – all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes. WPC Pilots ended on December 31, 2022, but key elements of the program were expanded as part of ECM.