Enhanced Care Management (ECM)

Provider Toolkit

DECEMBER 2021

Introduction/User Guide

Enhanced Care Management (ECM) is an essential component of **California Advancing and Innovating Medi-Cal (CalAIM)**. ECM is a Medi-Cal managed care benefit that addresses clinical and non-clinical needs of high-need individuals through the coordination of services and comprehensive care management.

This toolkit is intended for physical health, behavioral health, and social service providers, county and social service agencies, community-based entities, and other stakeholders that may play a role in delivery of ECM. It includes information to help providers understand what ECM is, who it serves, what is expected of those who provide ECM, and other important policy and programmatic details. Toolkit contents are designed to be actionable and easy-to-use. Each section of the toolkit can function as a standalone document that may be shared with colleagues and key stakeholders (e.g., organizational leadership, hospital partners, community collaborators, etc.).

This toolkit includes the following sections:

- **Overview**
- **Eligibility and Enrollment**
- **The Seven ECM Core Services**
- **Care Management Through ECM**
- **Roles and Responsibilities**
- **Information Sharing, Reporting, and Payment**
- **Expressing Interest and Applying to Become an ECM Provider**
- **Resources**
- **Glossary of Key Terms**

Readers are encouraged to refer to the Glossary of Key Terms as they go through the toolkit. It includes definitions for terms such as "provider," "community-based entity," and "lead care manager" and information about how they are used that can help provide clarity.

Those interested in learning more about Community Supports (previously known as In Lieu of Services or ILOS) may refer to the **Community Supports Explainer**. Community Supports are separate but complementary to ECM.

Overview

Enhanced Care Management (ECM) is a Medi-Cal managed care benefit that addresses clinical and non-clinical needs of high-need individuals through the coordination of services and comprehensive care management.

What Is ECM?

- ECM gives qualified members extra services from a dedicated ECM provider, which is an entity that contracts with a Medi-Cal managed care health plan.
- A **lead care manager**, who works for the ECM provider, coordinates the member's health care services and links them to community and social services.
- The member's ECM provider works with all of their providers to give an **added layer of support**.
- Members get these **extra services at no cost** as part of their Medi-Cal benefits.
- ECM will **not take away** any of the member's current Medi-Cal benefits.

ECM is exclusively for Medi-Cal managed care health plan members. Only managed care health plan members can access the ECM benefit. Medi-Cal beneficiaries who receive care through the fee-for-service (FFS) delivery system **must enroll in a managed care health plan** to receive ECM services.

Who Can Access the ECM Benefit?

ECM is intended for the highest risk Medi-Cal members with the most complex medical and social needs, such as a lack of stable housing. ECM will provide these members with long-term help coordinating their services across delivery systems to address their needs. To be eligible for ECM, members must be enrolled in a Medi-Cal health plan and meet certain criteria.

If members qualify, it is their choice whether they would like to receive the ECM benefit or not.

See the Eligibility and Enrollment section for more information on who may qualify.

What Services Does ECM Offer?

ECM offers seven types of services to help a member manage and improve their health:

1. **Outreach and Engagement:** Contact and engage the member in their care.
2. **Comprehensive Assessment and Care Management Planning:** Complete a comprehensive assessment with the member and work with them to develop a care plan to manage and guide their care and meet their goals.
3. **Enhanced Coordination of Care:** Coordinate care and information across all of the member's providers and implement the care plan.
4. **Health Promotion:** Provide tools and support that will help the member better monitor and manage their health.
5. **Comprehensive Transitional Care:** Help the member safely and easily transition in and out of the hospital or other treatment facilities.
6. **Member and Family Supports:** Educate the member and their personal support system about their health issues and options to improve treatment adherence.
7. **Coordination of and Referral to Community and Social Support Services:** Connect the member to community and social services.

Who Provides ECM?

ECM is delivered primarily by community-based entities that hold contracts with Medi-Cal health plans. Examples of entities that might deliver ECM include Federally Qualified Health Centers (FQHCs) and other community clinics, county and social service agencies, and other community-based entities.

The Medi-Cal health plan assigns each member to an ECM provider, which will include a lead care manager. The lead care manager serves as the member's primary point of contact and works with all their providers – such as doctors, specialists, pharmacists, social service providers, and others – to make sure everyone is in agreement about the member's needs and care.

Members can change their ECM provider and lead care manager if they wish to do so.

How Do Qualified Medi-Cal Members Access the ECM Benefit?

There are three ways that a member can access the ECM benefit:

1. Members who qualify may be contacted directly by their Medi-Cal health plan and/or an ECM provider.
2. A health or social services provider, including an ECM or Community Supports provider, may submit a referral for a member. If they are eligible, the Medi-Cal health plan will assign them an ECM provider.
3. A member or a member's family member may contact their health plan to see if they qualify. Members can contact their Medi-Cal health plan by calling the number on the back of their insurance card. If they are eligible, the health plan will assign them an ECM provider.

Can Members Receive the ECM Benefit While Receiving Services from Other State Programs?

In some cases, ECM provides services that are different from the services they receive in other state programs. In these cases, a member can receive services from both programs simultaneously. In other cases, the state program may provide services similar to ECM. In these cases, they would not be eligible for ECM unless they discontinued from the similar service. For details, see the Eligibility and Enrollment section.

Eligibility and Enrollment

Enhanced Care Management (ECM) is a Medi-Cal managed care benefit that addresses clinical and non-clinical needs of high-need individuals through the coordination of services and comprehensive care management.

Who Qualifies for the ECM Benefit?

ECM is intended for the highest risk, highest-cost Medi-Cal managed care members with the most complex medical and social needs. ECM will provide these members with long-term help coordinating their services across delivery systems to address their needs. To be eligible for ECM, members must be enrolled in a Medi-Cal managed care health plan and meet criteria for at least one of the Populations of Focus. California's Department of Health Care Services (DHCS) has identified both adult and children/youth Populations of Focus for ECM.

Importantly, not all Populations of Focus become eligible at the same time. Please refer to the Resources section for additional information.

Adult Populations of Focus

Individuals who are experiencing homelessness and have at least one complex physical, behavioral, or developmental health need.
Individuals who are considered **high utilizers** of care, including those who have had 5+ emergency department visits or 3+ unplanned hospital or short-term skilled nursing facility says in the last 6 months, or those who have been identified by their health plan as having a pattern of high utilization that could have been avoided.
Adults with **serious mental illness or substance use disorder** who are experiencing at least one complex social factor and meet additional criteria.
Individuals **transitioning from incarceration**, or who have transitioned from incarceration within the past 12 months, who also have certain medical conditions.
Individuals **at risk for institutionalization and eligible for Long-Term Care** services.
Nursing facility residents who want to transition to the community and are strong candidates for a successful transition.

Detailed eligibility criteria for the Adult Populations of Focus can be found in the ECM Policy Guide on the ECM and Community Supports webpage.

Children/Youth Populations of Focus

Children (up to age 21) **experiencing homelessness.**
Children who are considered **high utilizers** of care, including children or youth who are frequently hospitalized and those who regularly use emergency rooms as a source of care.
Children with significant behavioral health needs, such as those with **serious emotional disturbance, identified to be at clinical high risk for psychosis, or experiencing a first episode of psychosis.**
Children **enrolled in California Children's Services (CCS) or the CCS Whole Child Model who have additional needs** beyond the CCS qualifying condition.
Children **involved in (or with a history of involvement in) child welfare**, including foster care up to age 26.
Children **transitioning from incarceration.**

DHCS is working on further defining Children/Youth Populations of Focus. When available, detailed criteria will be available on the CalAIM **ECM and Community Supports webpage**.

ECM is voluntary for members to receive. If they qualify, it is their choice whether they would like to receive the ECM benefit or not. Declining the ECM benefit will not affect any of their other Medi-Cal benefits.

How Is "Experiencing Homelessness" Defined?

Populations of Focus for ECM include individuals or families "experiencing homelessness," which is defined as:

- An individual or family who lacks adequate nighttime residence;
- An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation;
- An individual or family living in a shelter;
- An individual exiting an institution into homelessness;
- An individual or family who will imminently lose housing in the next 30 days;
- Unaccompanied youth, homeless families, and children and youth defined as homeless under other federal statutes; or
- Individuals fleeing domestic violence.

This definition of "experiencing homelessness" broadens the US Department of Housing and Urban Development (HUD) definition in the following ways:

- If an individual is existing an institution (e.g., a jail), they are considered homeless if they were homeless immediately before entering the institution, regardless of the length of stay.
- The timeframe for an individual or family who will imminently lose housing has been extended from 14 days to 30 days.

How Do Members Access the ECM Benefit?

There are three ways members can access the ECM benefit:

Members who qualify may be contacted directly by their health plan and/or an ECM provider.

Medi-Cal health plans are responsible for regularly identifying members who may benefit from ECM and who meet the criteria for the program. Once a member is identified, the health plan and/or their assigned ECM provider will contact them to discuss ECM.

A health and social services provider, including an ECM or Community Supports provider, may submit a referral for members.

If a member has not been identified by the Medi-Cal health plan as eligible for ECM, but meets the requirements, their provider can submit a referral to the member's health plan. The health plan is required to have a referral process that is available for health and social service providers. You do not need to be a clinician to refer someone to ECM.

Members may self-refer or ask for information to see if they qualify.

A member or the member's family can contact their Medi-Cal health plan to see if they qualify for ECM. Members can contact their health plan by calling the number on the back of their insurance card.

How Do Members Enroll in ECM and Get Assigned an ECM Provider?

In most cases, Medi-Cal health plans will determine a member is qualified to receive ECM and assign an ECM provider that will then reach out to the member to see if they would like to receive the benefit. If the member agrees to receive the benefit, the ECM provider will begin services. A member is not required to receive the ECM benefit, even if they qualify.

Medi-Cal health plans will assign an ECM provider to a member based on their needs. If a member's primary care provider or behavioral health provider is affiliated with an ECM provider organization, the member will most likely be assigned to that ECM provider. If one of the member's primary providers is not part of an ECM provider organization, the assigned ECM provider must coordinate with the member's existing providers. A member can also choose a different ECM provider if they want.

Tips for Talking to Members about ECM

ECM is intended for high-risk Medi-Cal managed care members with the most complex medical and social needs. ECM will provide these members with long-term help coordinating their services across delivery systems to successfully address their needs.

Medi-Cal health plans, providers, and community-based entities play key roles in explaining ECM to members. When talking to members, consider sharing the following messages:

- You will have a dedicated **lead care manager** that works with you and your other providers to help you get the care you need.
- You will receive **extra services at no cost** as part of your Medi-Cal benefits, including help with:
  - Finding doctors and making appointments.
  - Understanding your prescription drugs.
  - Setting up transportation to your doctor visits.
  - Getting follow-up services after you leave the hospital.
  - Connecting to and applying for community programs and services, including food benefits or in-home help.
- Your care manager works with your current doctors, nurses, and other providers, giving you an **added layer of support.**
- To get the ECM benefit, you must have complex needs that make it difficult for you to manage your health without additional support, which could include health conditions and/or other challenges, such as not having a place to live.
- There will be no changes to your health plan and you can see the same doctors.
- We can work with you and help you talk to your health plan to determine if you are eligible for ECM.

ECM and Other State Programs

Medi-Cal has multiple programs designed to coordinate care for eligible individuals. Counties, health plans, and providers work together to coordinate services across these programs, but Medi-Cal health plans are ultimately responsible for ensuring that services are not duplicated.

Members may receive services from more than one program, including ECM. In many of these scenarios, ECM will serve as a "wrap" and help fill gaps and coordinate across case management services available in other programs. However, there are some instances where members cannot be enrolled in ECM at the same time as other programs.

Members can receive services through ECM AND the programs listed below:

- **California Children's Services (CCS),** the **CCS Whole Child Model**, and **Specialty Mental Health Services (SMHS) Intensive Care Coordination for children (ICC)**.
- **County-Based Case Management Programs**, including County-based Targeted Case Management (TCM) and SMHS TCM.[1]
- **Genetically Handicapped Person's Program (GHPP)**
- **Drug Medi-Cal Organized Delivery Systems (DMC-ODS)**
- **Community Based Adult Services (CBAS)**
- **AIDS Healthcare Foundation Plans**
- **Certain programs/plans that are available to dually eligible individuals**, or those who have both Medicare and Medi-Cal. These include Dual Eligible Special Needs Plans (D-SNPs) beginning in 2023, D-SNP look-alike plans, other Medicare Advantage plans, and Medicare Fee-for-Service.

1 Health plans will determine whether a TCM program is duplicative of ECM.

Members must choose ECM OR the program listed below:

- **1915(c) Home and Community-Based Waiver Programs**
  These programs include: Multipurpose Senior Services Program (MSSP), Assisted Living Waiver (ALW), Home and Community-Based Alternatives (HCBA) Waiver, HIV/AIDS Waiver, Home and Community-Based Services (HCBS) Waiver for Individuals with Developmental Disabilities (DD), and Self-Determination Program for Individuals with Developmental Disabilities
- **Other Health Plan Operated Care Management Programs**
  These programs include Basic Case Management and Complex Case Management
- **California Community Transitions (CCT) Money Follows the Person (MFTP)**

Members CANNOT receive the ECM benefit if they are:

- Enrolled in a specialized health plan that already provides comprehensive care coordination, including **Cal MediConnect, Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), or the Program for All-Inclusive Care for the Elderly (PACE)**
- Receiving comprehensive care coordination services through other programs or settings, such as the **Family Mosaic Project and Hospice**

Medi-Cal health plans are ultimately responsible for ensuring that services are not duplicated and work with their contracted providers to prevent duplication. This may involve designating certain care coordination programs (including at the county or member level) as duplicative of the ECM benefit.

Importantly, members of Medi-Cal health plans have certain rights. These apply to all Medi-Cal health plans and programs, including ECM. These rights include the right to file an appeal through the health plan for services that are denied or reduced.

The Seven ECM Core Services

Enhanced Care Management (ECM) offers extra services for qualified Medi-Cal managed care members. These services help members manage and coordinate their care and connect to community and social services.

What Services Does ECM Offer?

ECM offers seven core services to members who qualify:

1. **Outreach and Engagement**
2. **Comprehensive Assessment and Care Management Planning**
3. **Enhanced Coordination of Care**
4. **Health Promotion**
5. **Comprehensive Transitional Care**
6. **Member and Family Supports**
7. **Coordination of and Referral to Community and Social Supports**

1. Outreach and Engagement

Members are assigned to ECM providers by their Medi-Cal health plan. Once a member is assigned, their ECM provider contacts them to help them enroll in ECM and begin care.

If possible and in alignment with member preferences, outreach and engagement should primarily be conducted in-person. Specific activities may include:

- Locating, contacting, and engaging members who have been identified as candidates for ECM.
- Using multiple strategies and multiple attempts to engage members, including in-person meetings, digital or telephonic communications, and/or street outreach.
- Using an active and progressive approach to outreach and engagement until members are engaged.
- Documenting outreach and engagement attempts and modalities.
- Utilizing educational materials and scripts developed for outreaching and engaging members.
- Sharing information with the health plan to ensure that it can assess members for other programs if they cannot be reached or decline ECM.
- Providing culturally and linguistically appropriate communications and information to engage members.

2. Comprehensive Assessment and Care Management Planning

Once enrolled in ECM, the member and their ECM provider, including their lead care manager, work together to develop a comprehensive, patient-centered, and individualized care plan.

Assessment and care plan development activities may include:

- Identifying and understanding necessary clinical and non-clinical resources to appropriately assess the member's health status and gaps in care and set person-centered goals.
- Developing a comprehensive, individualized, person-centered care plan with input from the member and/or their personal support system.

- Ensuring the member is reassessed at a frequency appropriate for the member's individual process or changes in needs and/or as identified in the care plan.
- Ensuring the care plan is reviewed, maintained, and updated under appropriate clinical oversight.

The care plan is based on the member's health status, needs, preferences, and goals regarding:

- Physical health
- Mental health
- Disabilities
- Substance use
- Oral health
- Community-based long-term services and supports
- Supports to manage serious illness (e.g., palliative care)
- Trauma-informed care needs
- Community and social services

3. Enhanced Coordination of Care

Services are provided to help the member implement their care plan and navigate and connect to needed health and community services. The member's lead care manager is a key point of contact.

Enhanced coordination of care activities may include:

- Helping the member navigate, connect to, and communicate with physical health, behavioral health, and social service systems, including assistance with appointment and transportation scheduling, as needed.
- Sharing information with the member's care team regarding their conditions, health status, medications, and any side effects.

- Maintaining regular communication with all the member's providers and holding meetings for the care team to discuss the member's goals and needs.
- Helping the member access care and ensuring care is continuous, integrated, and accessible for members with disabilities.
- Helping the member follow their treatment plans, including managing and reconciling medications and accompanying them to appointments as needed.
- Regularly connecting with the member and their personal support system and communicating the member's needs and preferences to their providers in a timely manner.
- Monitoring referrals and needed services and supports, as well as coordination and follow-up.
- Facilitating transitions among treatment facilities, including admissions and discharges, and reducing avoidable hospital readmissions.

These services are integrated with current Medi-Cal health plan coordination activities, but ECM provides a more intensive level of support.

4. Health Promotion

The member is coached on how to better monitor and manage their health and identify and access helpful resources.

Health promotion activities may include:

- Supporting health education for the member and their family and/or personal support system.
- Providing services, such as coaching, to encourage and support the member to make choices that support healthy behavior.
- Supporting the member in strengthening skills that help them identify and access resources.
- Linking the member to resources for smoking cessation, chronic condition management, self-help recovery resources, and other services.
- Using evidence-based practices, such as motivational interviewing, to engage and help the member manage their care.

5. Comprehensive Transitional Care

The member receives services to help them transition between treatment facilities, including admissions and discharges, and to reduce avoidable hospital admissions and readmissions.

This includes transitions between the emergency department, hospital inpatient facility, residential/treatment facility, mental health facility, skilled nursing facility, correctional facility, or other treatment center, and where a member stays or lives.

Comprehensive transitional care may include:

- Developing strategies to reduce avoidable hospital stays or emergency department visits.
- Developing and regularly updating a transition plan for the member.
- Evaluating the member's medical care needs and coordinating any support services post-discharge.
- Tracking the member's admissions and discharges and communicating with their care teams.
- Coordinating medication review and reconciliation.
- Educating the member on self-management, rehabilitation, and medication management.

6. Member and Family Supports

The member, their family, and their personal support system are educated about the member's condition(s) and are connected to support to improve treatment adherence and medication management.

Member and family support activities may include:

- Documenting a member's family and/or personal support system and ensuring all required authorizations are in place so they can communicate with the care team.
- Ensuring the member, their family, and/or their personal support system is knowledgeable about the member's condition.
- Helping the member and/or their family and personal support system identify and obtain needed resources to support their health goals.
- Providing education to the member, their family, and/or their personal support system about their care plan.
- Ensuring that the member has a copy of their care plan and information about how to request updates.

7. Coordination of and Referral to Community and Social Supports

The member receives referrals to community and social support services and follow-up to help ensure they get the services they need.

Referral and coordination activities may include:

- Identifying community and social service needs, such as needs for food assistance or housing support.
- Determining appropriate resources to meet the member's needs, including services offered through Community Supports.
- Routinely assisting the member and following up to ensure needed services are obtained.

Where Do Members Access the ECM Benefit?

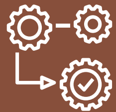
ECM services are primarily delivered in person where members live or receive care but can be delivered at any location they prefer. ECM services may also be delivered through other communication methods (e.g., phone or video visit) that work best for or are preferred by members.

Services must be culturally and linguistically appropriate.

What Transportation Services Are Offered?

ECM coordinates transportation but does not provide actual transportation to services.

Under Medi-Cal, health plans are responsible for providing transportation to all medically necessary services. ECM can support members in accessing, scheduling, and coordinating these services.



Care Management Through ECM

Enhanced Care Management (ECM) offers extra services, including the development of a care plan, for qualified Medi-Cal managed care members. These services help members manage and coordinate their care and connect to community and social services. The ECM provider will also assign a lead care manager, who will be the member's primary point of contact.

What Is a Care Plan?

Each member's ECM provider, including their lead care manager, will work with them and their providers to develop a comprehensive care plan to guide their services and care. The member will be a partner in developing the care plan.

The care plan is based on the member's goals, health status, needs, and preferences regarding:

- Physical health
- Mental health
- Disabilities
- Substance use
- Oral health
- Community-based long-term services and supports
- Supports to manage serious illness (e.g., palliative care)
- Trauma-informed care needs
- Community and social services

Who Provides Services?

Each member has an ECM provider that coordinates a multi-disciplinary care team which includes the member's other health care providers and community and family or personal support networks if they wish. Their ECM provider will also assign a lead care manager, who will be the member's primary point of contact.

The lead care manager works with the member to create a care plan, coordinate their care, and make sure they receive all needed services. Other providers also help develop and implement the care plan as appropriate.

ECM is delivered primarily by community-based entities, serving as ECM providers, that hold contracts with Medi-Cal health plans. If a member's primary care provider is affiliated with an ECM provider organization, the member will be assigned to that ECM provider unless they choose a different one. If a member's primary care provider is not part of the ECM provider organization, the lead care manager must coordinate with the members primary care provider.

How Is a Care Plan Used?

The lead care manager and multidisciplinary care team work with the member to implement their care plan. The care plan guides the care they receive to help them improve their health outcomes and achieve their health goals.

Services may be provided in person or through other communication methods that work for the member.

The care plan is reviewed together with the member and revised over time, based on the member's progress and changes in their needs.

ECM and Other Services

ECM provides comprehensive care management and coordination of services across multiple delivery systems. Each member's ECM provider gives them a lead care manager who works with all their providers – such as doctors, specialists, pharmacists, social service providers, and others – to make sure everyone is in agreement about the member's needs and care.

ECM & Adult Palliative Care

Palliative care can help people with serious illness manage their pain and other burdensome symptoms or side effects of treatment, consider how their treatment plan aligns with their personal goals and values, and improve their quality of life. California law (SB 1004) requires that Medi-Cal health plans provide this service to members who qualify. Some people who qualify for ECM may also qualify for Medi-Cal palliative care services, and ECM providers can help connect those members to these specialized supports.

Palliative care focuses on decreasing the stress and suffering that an individual may face when living with serious illness. A team of doctors, nurses, social workers, and others help the individual and their support system understand their conditions, manage their symptoms, make decisions about their care, and access needed supports. Often, they also provide spiritual and emotional support.

ECM providers may work closely with palliative care providers to ensure that the member's goals are known across the care team. ECM providers will develop a comprehensive care plan, identify support, and help coordinate care across the care spectrum.

ECM & Behavioral Health

Individuals who qualify for ECM often have extensive physical and behavioral health needs. For those receiving behavioral health services, particularly those with serious mental illness (SMI), serious emotional disturbance (SED), or substance use disorder (SUD), coordination across delivery systems will be an important component of ECM. DHCS expects Medi-Cal health plans to contract and closely collaborate with county behavioral health providers, who are often the primary providers for members with significant behavioral health needs. Further, if a member receives services from a County Behavioral Health Delivery System (i.e., Mental Health Plans, Drug Medi-Cal/Drug Medi-Cal Organized Delivery Systems, also referred to as Behavioral Health Plans) for SMI or SUD, and their behavioral health provider is a contracted ECM provider, the health plan must assign them as the member's ECM provider unless the member has expressed a different preference.

Regardless of whether members' behavioral health providers serve as ECM providers, close coordination, including involvement in care plan development and execution, is expected and necessary to meet member goals and facilitate better-coordinated, whole-person care.

Roles and Responsibilities

Enhanced Care Management (ECM) offers extra services for qualified Medi-Cal managed care members and a multi-disciplinary team of providers to manage and coordinate their care.

ECM Roles at a Glance

Three primary types of entities work together to deliver the ECM benefit:

- Medi-Cal managed care health plans
- ECM providers
- Community-based entities, if not serving as an ECM provider

Other entities that coordinate to deliver ECM services may include the member's current health and social services providers and people who are part of their personal support system if they wish.

Medi-Cal Health Plan Roles and Responsibilities

Medi-Cal health plans oversee the administration of ECM. They negotiate contracts with interested organizations to develop a network of ECM providers.

Health plan responsibilities include:

- Contracting with qualified ECM providers to provide and oversee ECM services.
- Identifying and assigning eligible members to ECM providers to coordinate their care.
- Responding to requests from members or providers for initiation of ECM.
- Tracking and sharing data with ECM providers to support ECM, including health and social services data for each member.
- Developing training tools and providing technical assistance for ECM providers.
- Providing customer service and member grievance resources.
- Conducting regular auditing and monitoring to ensure ECM requirements are met.
- Collecting, analyzing, and reporting health status, outcome, financial, and other data to the Department of Health Care Services (DHCS).

ECM Provider Roles and Responsibilities

Each eligible member is assigned an ECM provider that provides ECM services, including designating a lead care manager to serve as the primary point of contact and coordinator for the member, their providers, and personal support system.

If a member's primary care provider is affiliated with an ECM provider organization, the member will be assigned to that ECM provider. If a member's primary care provider is not part of an ECM provider organization, the assigned ECM provider must coordinate with the member's primary care provider.

A member can also choose a different ECM provider organization or a different lead care manager within their assigned ECM provider organization if they want.

ECM provider responsibilities include:

- Reaching out to the member to initiate care.
- Conducting ongoing outreach and engagement with each member, primarily through in-person contact or the member's preferred method of communication.
- Assigning a lead care manager to each member.
- Working with a member and their care team to conduct a comprehensive assessment and develop and update a care plan for each member.
- Organizing member care activities and maintaining regular contact with their providers to ensure coordination, including county substance use disorder and specialty mental health providers as appropriate.
- Managing referrals, coordination, and follow-up to needed services and supports.
- Supporting the member in making healthy choices and strengthening skills that allow them to better manage their conditions.
- Supporting the member and their personal support system during discharge from the hospital and other treatment facilities.
- Providing education and identifying support needs for a member and their family or other caregivers.
- Providing services in person and accompanying members to appointments when needed.
- Sharing information and reports with the health plan and submitting claims or invoices.

ECM providers must meet certain qualification requirements to serve ECM enrollees, such as those related to experience, capacity, and documentation. Additional details can be found in the ECM Policy Guide on the **ECM and Community Supports webpage**, and health plans may have additional requirements.

If your organization is interested in becoming an ECM provider and better understanding specific qualification requirements, please contact the **health plans in your county**.

ECM Provider Examples

The following list provides examples of possible ECM providers. Please note that this list is not exhaustive and does not include all entities that may serve as ECM providers.

- Primary care or specialist physicians or physician groups
- Community health centers
- Hospitals or hospital-based physician groups or clinics
- Providers serving individuals experiencing homelessness
- Providers serving justice-involved individuals
- Rural health centers
- Indian health centers or clinics
- Federally Qualified Health Centers
- Behavioral health entities
- Community mental health centers
- Substance use disorder treatment providers
- Local health departments
- Community-based entities

Role of Community-Based Entities (if not serving as ECM providers)

As part of providing comprehensive care coordination, ECM providers work with members to identify their community and social service needs and link them to these services. To accomplish this, ECM providers coordinate with community health workers, social service agencies, and other community-based entities.

Since many community-based entities have established, trusted relationships with members, they are an important source of information and support in helping members meet their health goals.

In addition to informal partnerships, ECM providers may establish formal subcontracting relationships with certain community-based entities or other partners to provide services to members.

Information Sharing, Reporting, and Payment

Enhanced Care Management (ECM) offers extra services for high-need Medi-Cal managed care members and requires close coordination across a variety of providers. Providers need to share information with each other about the services they each provide to best manage a member's care.

Information also needs to be shared with the member's Medi-Cal health plan. Health plans must report data to the Department of Health Care Services (DHCS) to allow for evaluation of enrollment, utilization of services, and the quality of care provided.

Is Member Information Shared across Entities?

For care management activities to be successful, Medi-Cal health plans, ECM providers, and all providers serving a member must share and access information about the member's health and services. This helps ensure everyone is on the same page about the member's care.

For example, health plans can provide electronic member-level data about hospital and emergency department utilization to ECM providers. Timely information about hospital discharge supports seamless care transitions.

ECM providers need to use a care management documentation system or process that allows the sharing of health and social service information with other providers. ECM providers need to coordinate with health plans to ensure their system or process for documentation can achieve necessary functions, including documenting member goals, gathering information to identify member needs, assigning care team tasks, and supporting care coordination and transitions in care.

DHCS has released specific guidance on **Member-Level Information Sharing Between MCPs and ECM Providers**, including standard data elements, file formats, and transmission methods for exchange of member-level information between health plans and ECM providers.

Are Providers Required to Have Certain Systems or Technology?

ECM providers and other providers are encouraged to use technology to ensure timely, accurate, and secure sharing of information. Ideally, providers should use electronic health records, health information technology, and health information exchange systems for tracking, charting, and sharing data.

In cases where this technology is not widely used or available, Medi-Cal health plans and providers should work together to develop alternative information sharing processes that are timely, accurate, and secure. Additionally, financial or technical support may be available to develop technological infrastructure over time.

Are Data Sharing Agreements Required?

Medi-Cal health plans are responsible for developing Data Sharing Agreements with ECM providers. These agreements will set parameters for exchange of information in accordance with DHCS data sharing authorization guidance (available on the **ECM and Community Supports webpage**), as well as existing federal and state requirements. For example, Data Sharing Agreements will ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all other relevant regulations. The **State Health Information Guidance (SHIG)** provides resources to help clarify federal and state laws that affect disclosure and sharing of health information.

What Are the Reporting Requirements?

Health plans must track and report data on: (1) enrollment and capacity; (2) utilization of services; and (3) quality of care. This information helps DHCS and the federal Centers for Medicare & Medicaid Services (CMS) evaluate ECM.

To ensure health plans can accurately report to DHCS and CMS, and to be paid, ECM providers must submit claims or invoices to health plans for services rendered. ECM providers should refer to DHCS ECM and Community Supports **Billing and Invoicing guidance** and **Member-Level Information Sharing Between MCPs and ECM Providers guidance**, for additional information and coordinate with health plans.

ECM Providers must also respond to health plan requests for information and documentation to permit ongoing monitoring and oversight of ECM.

What Are the ECM Service Codes?

Service codes provide a standardized way to describe services. This supports billing, reporting, and other functions. Medi-Cal health plans will provide guidance to providers on ECM service codes uses based on DHCS requirements, which can be found in **Finalized ECM & ILOS Coding Options**.

How Do ECM Payments Work?

- Medi-Cal health plans receive funding for ECM from the state through their capitated rates.
- Health plans have flexibility to negotiate individual contracts and payment terms with ECM providers to deliver ECM services. Payment terms may vary across plans.
- Services may be provided directly by the ECM provider, or certain activities may be subcontracted to other entities.
- If ECM providers subcontract with other entities, they will need to establish separate contracts and payment terms with those entities.

California Department of Health Care Services (DHCS)

Medi-Cal health plans will be paid fixed, per-member, per-month (PMPM) capitation payments for the ECM benefit.

Medi-Cal Health Plans

Payments to ECM providers are based on negotiations between Medi-Cal health plans and providers.

ECM Providers

NOTE: Some ECM providers may subcontract with other providers and would be responsible for negotiating associated payment rates.

Expressing Interest and Applying to Become an ECM Provider

Enhanced Care Management (ECM) offers extra services for qualified Medi-Cal managed care members and a multi-disciplinary team of providers to manage and coordinate their care.

How Does an Interested Provider Become an ECM Provider?

ECM providers are entities that contract with Medi-Cal health plans to deliver ECM services. ECM providers can be primary care providers, community health centers, or other community-based entities. Additional detail on the ECM provider role and requirements can be found in the ECM Policy Guide on the **ECM and Community Supports webpage**, and health plans may have additional requirements.

Entities interested in becoming ECM providers should reach out to the **Medi-Cal health plans** in their county to signal interest and begin conversations.

Tips: Prior to Health Plan Engagement

Before engaging health plans, providers should understand the services they currently provide, the individuals they serve, and potential areas of alignment with ECM. Providers may also consider:

- **Whether the individuals they serve would benefit from increased coordination across service providers;**
- **The percentage of individuals they serve that are currently enrolled in or eligible for Medi-Cal managed care;**
- **The technical sophistication of their data systems and ability to share and report information with external partners; and**
- **Whether existing staff can adequately support contract negotiation and execution with health plans.**

Tips: Signaling Interest

Providers should consider preparing the following information for initial conversations with health plans:

- **Rationale for participation, including how they already serve (or are capable of serving) Populations of Focus and how participation will benefit the health plan's members;**
- **Key strengths and areas of alignment between existing programs and ECM;**
- **Notable gaps or areas for improvement to meet requirements of ECM; and**
- **Questions for health plans about their model of care, provider expectations, or other program elements.**

If there is mutual interest in moving forward, providers can expect health plans to ask for documentation to demonstrate readiness in the following areas:

- ECM structure
- ECM core services
- Claims and invoicing
- Data exchange
- Staffing
- Oversight and monitoring

Health plans will review submitted materials to determine a potential ECM provider's qualifications and readiness. Following the review, health plans will determine next steps, which may include: additional documentation, meetings, conducting a gap analysis and gap closure activities, provider enrollment and vetting as appropriate, contract negotiation (including reimbursement) and execution, and provider set-up activities.

Demonstrating Readiness

Many Medi-Cal health plans are using a provider certification application to determine provider readiness for ECM. Even if a health plan is not using a specific tool, preparing similar materials will help support their readiness review.

The provider certification application outlines materials that document an ECM provider's approach to providing services, which may include organizational policies, procedures, charts, workflows, and assessments. Providers may already have many of these materials. However, they will need to be tailored to ECM.

Health plans will expect that all documents be tailored to the ECM Populations of Focus providers intend to serve, reflect an understanding of the expectations of ECM, and be clear and concisely written and organized. Providers should be clear about areas that require additional growth. A clear understanding of gaps and areas for growth are necessary to inform proper implementation and may help identify potential investments in infrastructure development.

What Medicaid Provider Enrollment Requirements Must an ECM Provider Meet?

Credentialing requirements only apply to providers with a state-level pathway for Medi-Cal enrollment. Providers may enroll through the DHCS Provider Enrollment Division or health plans can choose to have a separate enrollment process. Details for how to enroll through the DHCS Provider Enrollment Division can be found on the **Provider Enrollment** webpage. Health plans may provide additional information to support provider enrollment or to outline their own processes.

ECM providers without a state-level pathway to Medi-Cal enrollment will need to undergo health plan vetting processes to ensure they meet the standards and capabilities necessary to serve as an ECM provider. Health plan vetting processes may vary but will not require "credentialing." Credentialing is only required for Medi-Cal enrolled providers.

ECM providers do not need to be accredited or certified by the National Committee for Quality Assurance (NCQA). However, ECM provider organizations must have a National Provider Identifier.

How to Obtain a National Provider Identifier

ECM provider organizations must have a National Provider Identifier (NPI) to receive payments from the health plans. Some providers that participate in ECM may not currently have an NPI. Providers can refer to the NPI Application Guidance for additional information and assistance.

Resources

This section contains resources that provide additional background and policy information related to Enhanced Care Management (ECM).

Enhanced Care Management Implementation Timeline

ECM will be implemented in stages, by Population of Focus.

	Populations of Focus	Eligibility Timing
1.	Individuals and Families Experiencing Homelessness	January 2022 (Whole Person Care/Health Homes Program counties); July 2022 (other counties)
2.	Adult High Utilizers	
3.	Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)	
4.	Incarcerated and Transitioning to the Community	January 2023
5.	At Risk for Institutionalization and Eligible for Long Term Care	
6.	Nursing Facility Residents Transitioning to the Community	
7.	Children/Youth Populations of Focus	July 2023

NOTE: This timeline is simplified. Stakeholders can refer to a more detailed timelines here.

Community Supports will launch as an option statewide in January 2022.

Policy Guidance and Information

- Finalized DHCS-MCP ECM and ILOS Contract Template
- Finalized CalAIM ECM and ILOS Model of Care Template
- Finalized ECM Key Design Implementation Decisions
- NPI Application Guidance
- CalAIM Program Updates - Provider Focus
- CalAIM Program Updates - Provider Focus Part 2

Additional resources, including Provider Terms and Conditions, ECM Policy Guide, Community Supports Elections, and Frequently Asked Questions, can be found on the **ECM and Community Supports webpage**.

Glossary of Key Terms

Centers for Medicare & Medicaid Services (CMS): CMS is a federal agency within the United States Department of Health and Human Services that administers the Medicare program, works in partnership with state governments to administer Medicaid and the Children's Health Insurance Program (CHIP), and oversees state and federal health insurance marketplaces.

Claim: A standardized medical bill that is sent by a provider to a health plan for payment. Often, claim refers to 837 files, which are HIPAA-compliant documents and typically sent electronically.

Community-Based Entities: Provider entities that are based and deliver services in the community. Examples of these entities include Federally Qualified Health Centers (FQHCs) and other community clinics, county and social service agencies, community-based organizations (CBOs), and other community-based entities.

Community Supports: Services that Medi-Cal health plans are strongly encouraged but not required to provide as a substitute for utilization of other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

Community Supports Provider: An individual or entity that contracts with Medi-Cal health plans or ECM providers to deliver specific Community Supports.

Credentialing: Processes, including confirmation of licensure and certification, that verify that doctors, nurses, and other health care providers are properly trained and have the required professional experience to provide services to patients.

Data Sharing Agreement: A formal contract that clearly documents agreed upon parameters for data exchange and use.

Department of Health Care Services (DHCS): The California Department of Health Care Services (DHCS) is a department within the California Health and Human Services Agency that finances and administers a number of individual health care service delivery programs, including Medi-Cal.

ECM Lead Care Manager: ECM Lead Care Manager means a Member's designated ECM care manager who works for the ECM provider organization or as contracted staff, and is responsible for coordinating all aspects of ECM and any Community Supports as a part of the Member's multi-disciplinary care team, which may include other care managers.

ECM Provider: An entity that contracts with Medi-Cal health plans to deliver ECM services.

Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.

Invoice: An itemized breakdown of all services provided and associated costs that can serve as a bill for payment. In the ECM and Community Supports programs, an invoice is typically used when a provider is unable to submit a claim.

Medi-Cal: Medi-Cal (California's Medicaid program) is a public health insurance program that provides health care coverage for low-income individuals and families who meet defined eligibility requirements.

Medi-Cal Health Plans: Health plans that contract with DHCS to administer Medi-Cal coverage and services. "Medi-Cal health plans," "Medi-Cal managed care health plans," and "health plans" are used interchangeably throughout this toolkit.

Medi-Cal Managed Care: In Medi-Cal Managed Care, DHCS contracts with health plans to provide Medi-Cal benefits and additional services. Through this arrangement, each participating health plan is responsible for administering Medi-Cal coverage and assuming full financial risk for all covered services.

Per-Member, Per-Month (PMPM) Payment: A set amount of money paid on a monthly basis for each enrolled individual, often referred to as a capitated payment.

Populations of Focus: A subset of a Medi-Cal manged care health plan Members that meet eligibility criteria, as defined by DHCS, by which they are eligible to receive the ECM benefit.

Provider: An individual or entity that provides health or social services. This includes doctors, social workers, and other clinical providers as well as non-traditional providers like housing navigators and community health workers.

Provider Certification Application: A tool used by certain Medi-Cal health plans to determine provider readiness for ECM. This involves a review of provider policies, procedures, programmatic infrastructure, staffing, and capacities.

Enhanced Care
Management (ECM)

Provider Toolkit

Developed by Aurrera Health Group
for the California Department of
Health Care Services.

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