Santa Clara Family Health Plan™

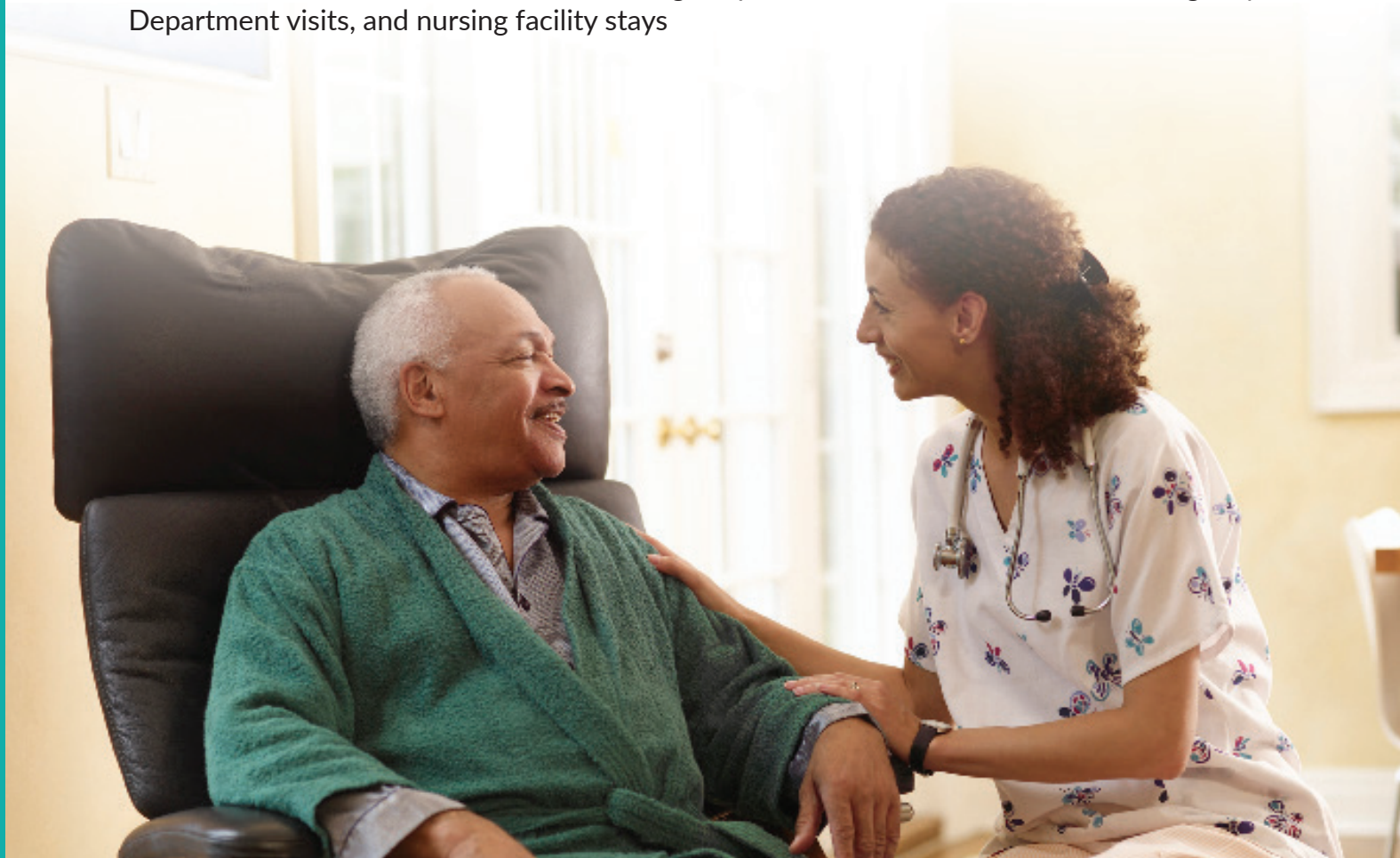
ENHANCED CARE MANAGEMENT
PROVIDER OVERVIEW

In accordance with California Advancing and Innovating Medi-Cal (CalAIM), Santa Clara Family Health Plan (SCFHP) will offer a new Medi-Cal benefit called **Enhanced Care Management** (ECM).

Eligible members will be assigned to an ECM provider who will provide community-based care management services. Once enrolled in ECM, the member will be provided a Lead Care Manager. The Lead Care Manager will work with the member and family support individuals to manage and coordinate the member's care and connect them to their providers, as well as community and social services.

ECM will serve as the central point for coordinating patient-centered care and aims to:

- ✓ Improve member outcomes by coordinating primary care, physical and developmental health, mental health, substance use disorder treatment (SUD), community-based Long Term Services and Supports (LTSS), oral health, palliative care, and community-based social services
- ✓ Create infrastructure to support multi-system coordination and care delivery, including connecting member to Community Supports
- ✓ Reduce avoidable health care costs, including hospital admissions/readmissions, Emergency Department visits, and nursing facility stays



ECM OFFERS MEMBERS:

Assessment and Care Management Plan

Develop and update a Health Action Plan (HAP) to guide services and care

Care Coordination

Coordinate care across **ALL** providers

Health Promotion

Educate members and support them in adopting healthy behaviors

Transitional Care

Facilitate care transitions between the hospital, nursing homes, other treatment facilities, and home

Member and Family Supports

Support the self-management and decision making efforts of members and their family and/or support team

Referral to Community and Social Supports

Connect members to community and social services, including housing, as needed

ECM PROVIDERS

SCFHP identifies members who are eligible for ECM and assigns them to ECM providers. ECM providers conduct outreach to assigned SCFHP members, engage them into enrolling into ECM, and deliver ECM services.

The Lead Care Manager oversees the delivery of ECM services and:

- Works with members to develop and update the Health Action Plan (HAP)
- Ensures members have access to care coordination services, including case conferences to ensure coordination among providers
- Manages referrals, coordination, and follow-up to needed services and supports
- Supports members and their families during discharge from the hospital, nursing facilities, and treatment facilities
- Provides services in-person and accompanies members to appointments when needed

IMPLEMENTATION TIMELINE

SCFHP will follow the following DHCS guidelines and implementation timelines for the Populations of Focus:

Starting January 1, 2022:

- Members enrolled in Health Homes Program (HHP) and Whole Person Care (WPC) will transition to ECM
- **Population of Focus #1** Individuals and Families Experiencing Homelessness;
- **Population of Focus #2** High Utilizer Adults; and
- **Population of Focus #3** Adults with serious mental illness (SMI)/ substance use disorder (SUD).

Starting January 1, 2023:

- **Population of Focus #4** Individuals Transitioning from Incarceration (adults and children/youth);
- **Population of Focus #5** Members Eligible for Long Term Care (LTC) and at Risk of Institutionalization; and
- **Population of Focus #6** Nursing Home Residents Transitioning to the Community.

Starting July 1, 2023:

- **Population of Focus #7** All other children and youth populations

ELIGIBILITY CRITERIA FOR THE POPULATIONS OF FOCUS

To be eligible for ECM, the member must be enrolled in Medi-Cal and meet the criteria requirements below:

1. **Not** enrolled in a program or service included in the ECM exclusions below:

- 1915(c) waivers: Multipurpose Senior Services Program (MSSP)
- Assisted Living Waiver (ALW)
- Home and Community-Based Alternatives (HCBA) Waiver
- HIV/AIDS Waiver
- HCBS Waiver for Individuals with Developmental Disabilities (DD)
- Self-Determination Program for Individuals with I/DD.
- Cal MediConnect (CMC)
- Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
- Program for All-Inclusive Care for the Elderly (PACE)
- Mosaic Family Services
- California Community Transitions (CCT) Money Follows the Person (MFTP)
- Basic or Complex Case Management
- Hospice

2. Can check the box next to one of the following **ECM Populations of Focus:**

☐ **Population #1 | Individuals and Families Experiencing Homelessness**

Must meet all of the following criteria:

- ☐ Experiencing homelessness
- ☐ AND inability to successfully self-manage at least one complex physical, behavioral or developmental health need

☐ **Population #2 | Adult High Utilizers**

Must meet at least one of the following criteria:

- ☐ Visited the emergency department 5 or more times within a 6-month period that could have been avoided
- ☐ AND/OR have 3 or more unplanned hospital and/or short-term skilled nursing facility stays in a 6-month period

☐ **Population #3 | Adult SMI and SUD**

Must meet all of the following criteria:

- ☐ Meet the eligibility criteria for participation in or obtaining services through the County Specialty Mental Health (SMH) System or the Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program.
- ☐ AND actively experiencing at least one complex social factor influencing their health
- ☐ AND 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
  - ☐ Visited the emergency department or was hospitalized 2 or more times due to SMI or SUD in the past 12 months
  - ☐ Pregnant or post-partum (12 months from delivery)

Populations 4, 5, and 6 available 1/1/2023

- **Population #4 | Individuals Transitioning from Incarceration**
  - Are transitioning from incarceration or transitioned from incarceration within the past 12 months
  - AND have at least one of the following conditions:
    - Chronic mental illness
    - Substance Use Disorder (SUD)
    - Chronic disease
    - Intellectual or developmental disability
    - Traumatic Brain Injury (TBI)
    - HIV
    - Pregnancy
- **Population #5 | Individuals at Risk for Institutionalization and Eligible for Long-Term Care Services**
  - Are eligible for Long-Term Care services who, in the absence of services and support, would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF) Please note: individuals must be able to live safely in the community with wraparound supports
- **Population #6 | Nursing Facility Residents Who Want to Transition to the Community**
  - Nursing facility residents who are strong candidates for successful transition back to the community and have a desire to do so

Population 7 available 7/1/2023

How do eligible Medi-Cal members join ECM?

- **Most eligible members will be contacted about ECM**. SCFHP will identify members who are eligible for ECM and will receive a notice from SCFHP about their eligibility. SCFHP will also share the Member Information File (MIF) with contracted ECM providers so they can do their own outreach to members.
- **A provider submits a referral form for a member.** If a member is not on the MIF but may be eligible for ECM, the provider can submit a referral form to SCFHP for enrollment in ECM. This may be necessary if the individual is newly enrolled in Medi-Cal.
- **A member asks to join.** Individuals can contact SCFHP Customer Service at 1-800-260-2055 (TTY:711) and ask if they qualify for ECM.

HOW TO TALK WITH AN SCFHP MEMBER ABOUT ECM?

Consider using the following messages when talking with SCFHP members about ECM:

- ☐ Members **keep their doctors** and receive **extra support at no cost** as part of their Medi-Cal benefits
- ☐ Members are given a **Lead Care Manager** that works to help them get the health care and social services they need
- ☐ Joining ECM will **not take away or change** any of the member's Medi-Cal benefits
- ☐ Joining ECM is voluntary, and members can stop ECM services at any time

ECM services help your SCFHP members get the care they need to stay healthy. The ECM team works with you, as the member's doctor, and the member's other providers to connect them to services that they need.

For More Information

Online www.scfhp.com/ECM

Email ECM@scfhp.com

Call 1-408-874-1452

Visit Santa Clara Family Health Plan
6201 San Ignacio Ave
San Jose, CA 95119

Sign up to receive SCFHP's bi-monthly newsletter, Provider e-news.
http://bit.ly/SCFHPeNews_Signup

If your organization is interested in becoming an ECM Provider, please contact SCFHP at ECM@scfhp.com.

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