Gold Coast Health Plan℠
A Public Entity

ECM/CS

GCHP Frequently Asked Questions

Enhanced Care Management (ECM) and Community Supports (CS)

GENERAL INFORMATION ABOUT GOLD COAST HEALTH PLAN'S (GCHP) ENHANCED CARE MANAGEMENT (ECM) PROGRAM AND ONGOING FAQs

Q: How can providers pose ongoing questions to GCHP regarding ECM and CS?

A: GCHP has created the following mailbox for provider inquiries: calaimpr@goldchp.org. GCHP will make every effort to respond to questions sent to the mailbox within five days after receipt of the question.

Q: How frequently will GCHP update these FAQs based on ongoing questions relating to ECM and CS?

A: GCHP will update these FAQs upon receipt of ongoing questions and additional guidance from the state Department of Health Care Services (DHCS) quarterly.

Q: What are the links to all relevant ECM and CS forms for the ECM and CS program?

A: Please see links to all the relevant ECM and CS forms:

- ECM Provider Certification Application - English
- ECM Provider Certification Application - Spanish
- CS Provider Certification Application - English
- CS Provider Certification Application - Spanish

Q: Will GCHP offer training for ECM and CS providers? If so, when will this be offered?

A: Yes. GCHP will offer regular training sessions for ECM and CS providers. Please check the GCHP webpage for future updates.

Q: Will GCHP invite more community based organizations (CBOs) to serve as ECM and CS providers?

A: Yes. Consistent with DHCS' goals of increasing capacity and access, GCHP will invite more CBOs to serve as ECM and CS providers.

Q: What should a CBO do if it wishes to become an ECM or CS provider?

A: If a CBO wishes to become an ECM or CS provider, email calaimpr@goldchp.org.

BECOMING AN ECM PROVIDER

Q: How can a provider become an ECM provider?

A: An entity can become an ECM provider by completing a GCHP ECM Provider Certification Application.

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Q: How long does it take to become a GCHP ECM provider?

A: The time will vary depending on the completeness of the application and the successful completion of the GCHP readiness review process.

SERVING AS AN ECM PROVIDER

Q: Are ECM providers required to serve all eligible ECM target populations?

A: No. ECM providers may serve one or more of the ECM target populations or a subset of target populations with which they have experience and expertise. DHCS has identified seven mandatory "target populations" for ECM. Health plans must proactively identify and offer ECM to high-needs, high-cost members who meet the target population criteria. These target populations are:

1. Children or youth with complex physical, behavioral, or developmental health needs (e.g., California Children's Services, foster care, youth with Clinical High Risk Syndrome, or first episode of psychosis).
2. Individuals experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions.
3. High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
4. Individuals at risk for institutionalization who are eligible for long term care services.
5. Nursing facility residents who want to transition to the community.
6. Individuals at risk for institutionalization who have co-occurring chronic health conditions and:
   - Serious Mental Illness (SMI, adults);
   - Serious Emotional Disturbance (SED, children, and youth); or
   - Substance Use Disorder (SUD).
7. Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition to the community.

Q: Do ECM providers need to be Medi-Cal enrolled?

A: Yes. ECM providers must be Medi-Cal enrolled. For more information on Medi-Cal enrollment, visit the DHCS Provider Enrollment Division (PED) webpage.

Q: What is an outreach attempt for purposes of ECM services?

A: An outreach attempt is an interaction with a referred GCHP member who is not yet enrolled in ECM but who appears to be eligible for ECM.

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Q: How should providers keep track of outreach attempts?

A: Providers should track outreach attempts in the Electronic Health Record (EHR).

Q: How should providers make notes regarding the care that they give?

A: Depending upon the type of provider, the notes would vary. ECM providers are required to have integrated care plans that prescribe goals, next steps, collaborations, etc. All notes should be documented in the EHR under the member's care plan.

Some CS providers, like medically tailored meals providers, would not have care plans but would be updating as services are provided. Recuperative care providers should be documenting member's status and need for continued supports. If a member is receiving ECM and CS, the CS services should not only be documented by the CS provider, but should also be included in the member's ECM care plan and tracked as a part of their overall treatment / support.

Q: How does GCHP handle the Targeted Engagement List (TEL)?

A: GCHP pulls targeted engagement lists together through data mining using utilization data, encounter data, ICD codes, and social determinants of health data. Report logic is created in a collaboration between data and clinical teams and based on DHCS guidance.

Q: How often does GCHP update the TEL?

A: Monthly.

Q: If GCHP refers a member to an ECM provider, what must the provider do before engaging with the GCHP member?

A: The ECM provider should provide outreach and initial assessment to ensure the member meets the criteria for ECM program. This is funded through outreach codes. Once the assessment is complete, the ECM provider submits an authorization request for review / approval for ECM services.

Q: If GCHP refers a member to an ECM provider, can the provider assume that GCHP has verified the member's eligibility?

A: The ECM provider can assume that GCHP has verified Medi-Cal eligibility and potential eligibility based on the information the plan has. However, this may not ensure that the member is eligible for or necessitates ECM level of care.

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Q: Does the ECM provider have to verify a member's GCHP eligibility status?

A: No. If ECM provider receives a member's information from a GCHP referral or from Targeted Outreach lists, the member will be eligible with GCHP. In some rare circumstances, a member may lose eligibility between the time that the lists were run, or the referral was sent.

Q: Does GHCP have a care plan template that ECM providers can use?

A: GCHP has requirements for what a care plan should contain, but providers can document these within the structure of existing EHR. If a provider needs assistance or would like guidance, the GCHP Care Management Team has technical assistance materials to support care plan development.

Q: Does GCHP allow ECM providers to make referrals to CS providers?

A: Yes.

Q: Can ECM providers make referrals to any other Medi-Cal providers on behalf of the member?

A: This is dependent upon the type of provider. ECM providers can refer members to additional supports and services, and, if needed, support a member in changing a primary care provider (PCP). However, it is the PCP assigned to the member who would be the point of contact for any specialist referrals.

Q: Can an ECM provider speak to a family member and have that count as a monthly encounter?

A: If the family member is the authorized representative and the ECM provider is discussing care plan issues during that call, the ECM provider can count the call as a monthly encounter.

Q: Can a Community Health Worker serve as the lead on an Individualized Care Plan?

A: Per DHCS guidance, Community Health Workers (CHWs) are authorized to act as an ECM Lead Care Manager for the ECM benefit. This includes developing and maintaining the member's Individualized Care Plan (ICP) for ECM.

Q: What does GCHP require in the care plan?

A: Per DHCS guidelines, activities in the Comprehensive Assessment and Care Management Plan core service must include, but are not limited to:

1. Engaging with each member authorized to receive ECM primarily through in-person contact.
2. When in-person communication is unavailable or does not meet the member's needs, the ECM provider must use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with the member's choice. Current Long-Term Services and Supports (LTSS) questions are those established in APL 17-013.

3. Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan.
4. Developing a comprehensive, individualized, person-centered care plan with input from the member and/or their family member(s), guardian, AR, caregiver and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs.
5. In the member's care plan, incorporating 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.
6. Ensuring 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. There is not a required annual reassessment for members.
7. Ensuring the Care Management Plan is reviewed, maintained, and updated under appropriate clinical oversight.

Q: When does GCHP require the care plan to be updated?

A: The care plan is a working document between the ECM provider and the member and, as such, needs to reflect the ongoing needs and changes in the member's needs and progress towards goals while the member is receiving ECM services.

GETTING PAID BY GCHP FOR ECM SERVICES

Q: How should ECM providers submit claims for failed and successful outreach?

A: The contract between the ECM provider and GCHP will address payment. As a DHCS requirement, all outreach needs to be submitted via billing (claim or invoice) and on the Initial Outreach Tracker (IOT) reporting file.

Q: How does an ECM provider document unanswered outreach attempts for enrolled patients, if at all?

A: The contract between the ECM provider and GCHP will address payment. As a DHCS requirement, all outreach needs to be submitted via billing (claim or invoice) and on the IOT reporting file.

Q: What are the required steps that ECM providers must take to be paid?

A: The contract between the ECM provider and GCHP will address payment. As a DHCS requirement, all outreach needs to be submitted via billing (claim or invoice) and on the IOT reporting file.

Q: Do ECM providers need to report all outreach attempts on the claim and the report?

A: Yes.