Enhanced Care Management Provider Reference Guide

Table of Contents

1 Introduction

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

Effective January 1, 2022, Health Net*, on behalf of CalViva Health (the "Plan"), will launch and administer the operational aspects of the Medi-Cal ECM benefit designed by DHCS and authorized by the Centers for Medicare and Medicaid Services (CMS). The following seven core services will be provided at the point of care:

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

The overall goal of the ECM benefit is to provide comprehensive care and achieve better health outcomes for the highest need beneficiaries in Medi-Cal. The benefit builds on the current Whole Person Care (WPC) pilots, and transitions those services and members who are in a population of focus to this new statewide managed care benefit to provide a broader platform to build on positive outcomes from those programs. The Plan will support the members' transition and automatically authorize ECM for the transitioning members.

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

ECM population of focus	**Go-live date**[1]
1. Individuals and families experiencing homelessness	January 1, 2022
2. High utilizer adults	
3. Adults with serious mental illness (SMI) or substance use disorder (SUD)	
4. Adults and children/youth transitioning from incarceration	
5. Adults at risk for institutionalization who are eligible for long-term care services	January 1, 2023
6. Nursing facility residents who want to transition to the community	
7. Children or youth up to ages 21 high utilizers or with serious emotional disturbance (SED)	July 1, 2023

[1] As of DHCS guidance provided June 3, 2021, and subject to further change by DHCS.

Detailed eligibility criteria of these populations of focus per DHCS are included in Section 4.1 of this guide. DHCS will launch further stakeholder work to define the children/youth population (Population of Focus #7) prior to 2023.

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

2 Regulatory Authorities

Signing the Enhanced Care Management Services Agreement (contract) with Health Net, on behalf of the Plan, the ECM provider agrees to follow the program requirements as established under Law, regulation, and through the Plan's contract with DHCS, including those applicable to member materials. The ECM provider will provide the ECM services in accordance with all applicable Federal and State law and regulatory guidance as outlined in the signed contract.

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

ECM providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus, with which they have experience and expertise. ECM will be offered primarily through in-person interaction where members and their families and support networks live, seek care, and prefer to access services. Health Net, on behalf of the Plan, is required to contract with ECM providers to deliver ECM to members. In order to contract with Health Net and before providing ECM services, the ECM provider must meet several requirements.

3.1 Provider Experience and Qualifications

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

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

To become an ECM provider, the ECM provider will be **experienced in serving the ECM Population(s) of Focus** it will serve **and have the experience and expertise with the ECM services** it will provide. The ECM provider will be able to communicate in **culturally and linguistically appropriate and accessible** ways. The ECM provider will have the capacity to **provide culturally appropriate and timely in-person care management activities** including accompanying members to critical appointments when necessary. The ECM provider will have **formal arrangements and processes** in place to engage and cooperate with area hospitals, primary care practices, behavioral health providers, specialists, and other entities, including Community Supports providers, to coordinate care as appropriate to each member.

The ECM provider will use a **care management documentation system or process** that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a member care plan that can be shared with other providers and organizations involved in each member's care. Other providers and organizations could include, but are not limited to, primary care doctors, IPAs, specialists, etc.

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

3.2 Provider Certification

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

To become an ECM provider, organizations must meet the criteria described in the DHCS CalAIM ECM guidance documents and submit a Letter of Intent (LOI) to the Plan with whom they would like to contract. The Plan will invite select organizations to submit the ECM Provider Certification Application with accompanying documentation supportive of their application and work with the Plan to establish an understanding of the ECM requirements such as services offered, populations served, staffing, and system readiness as they relate to the prospective ECM provider. Together the prospective ECM provider and the Plan will determine where additional effort(s) will be necessary to meet the contracted ECM provider requirements.

The Plan and the prospective ECM provider discuss, document, and agree on a Readiness and Gap Closure Plan to ensure the prospective ECM provider's readiness by the agreed upon go-live date and expectations following the go-live date into program administration. Key areas of focus for the Readiness and Gap Closure Plan are driven by the 12 required areas in the ECM Certification Application:

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

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

The Plan and the prospective ECM provider connect regularly to evaluate progress made towards closing the gaps documented in the Readiness and Gap Closure Plan. If the prospective ECM provider is unable to fulfill the ECM requirements and/or determines the ECM provider will not be able to meet ECM requirements, the prospective ECM provider cannot be certified by the Plan, and therefore will not be contracted with the Plan to provide ECM services under the ECM benefit. The Plan may request an on-site visit with the prospective ECM provider during the certification process and/or program administration period.[2]

3.3 Medicaid Enrollment/Vetting for ECM Providers

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

3.4 Contracting

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

3.5 Staffing, Provider Capacity and Training

3.5.1 ECM provider Care Team Staffing

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

DHCS specifies that each ECM provider must have a **Lead Care Manager**. An **ECM Lead Care Manager** is a member's designated care manager for ECM, who works for the ECM provider organization (except in circumstances under which the Lead Care Manager could be on staff with the Plan, as described in the DHCS-MCP ECM and ILOS Contract, Section 4: ECM Provider Capacity). The Lead Care Manager operates as part of the member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and coordination with a Community Supports provider, as applicable.

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

To the extent a member has other care managers, the Lead Care Manager is considered to be the primary care manager for the member and will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the member and non-duplication of services. ECM providers must have protocols in place outlining how clinical supervision is provided to non-licensed (i.e., paraprofessional) staff members by the Lead Care Manager to ensure continued guidance, training, and clinical support to appropriately oversee the non-licensed (i.e., paraprofessional) staff members activities aligning to the ECM member's care plan and care coordination needs.

The ECM provider is responsible to maintain the following roles/positions on the care team. The ECM provider's multi-disciplinary care team consists of the following roles and/or functions, at minimum:

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

Many care team models also include, at the ECM provider's discretion:

- Community health workers.

As DHCS may provide additional guidance regarding staffing, this section of the guide may be updated in the future.

Team members	**Qualifications**	**Role**
Lead Care Manager	Professional (e.g., licensed mental health or behavioral health professional/clinician, social worker, or nurse) or paraprofessional (with appropriate training and oversight)	• Responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the member and non-duplication of services. • Engage eligible members. • Oversee provision of ECM services and implementation of the care plan. • Offer services where the member lives, seeks care, or finds most easily accessible and within the Plan guidelines. • Connect member to other social services and supports the member may need, including transportation. • Advocate on behalf of members with health care professionals. • Use motivational interviewing, trauma- informed care, and harm-reduction approaches. • Coordinate with hospital staff on discharge plan. • Accompany member to office visits, as needed and according to the Plan guidelines. • Monitor treatment adherence (including medication). • Provide health promotion and self- management training.

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

3.5.2 Staffing Ratios

The Plan will provide additional information. We expect them to staff appropriately for the population of focus that they serve that they are providing ECM services for.

3.5.3 Provider Caseloads

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

3.5.4 Staffing and Capacity Report

To understand the staffing capacity, measure network adequacy, demonstrate growth over time, and identify staff who will need to complete required training, ECM providers are required to submit an initial, prospective staffing and capacity report to the before providing ECM services (as part of the

ECM Provider Certification process). After ECM go-live, ECM providers will be required to submit staffing and capacity reports at minimum on a quarterly basis. The required report will include the following, subject to change:

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

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

3.5.5 Training

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

4 ECM Member Eligibility, Assignment and Enrollment

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

4.1 ECM Eligibility Criteria

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

ECM population of focus	Go-live date for ECM providers to serve these members
1. **Individuals and families experiencing homelessness AND** 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. See DHCS definition of homelessness below.	January 1, 2022
2. **High Utilizer Adults** are members with five or more emergency room visits **AND/OR** three or more unplanned hospital admissions and/or multiple short-term skilled nursing facility stays in a six-month period that	January 1, 2022

ECM population of focus	Go-live date for ECM providers to serve these members
could have been avoided with appropriate outpatient care or improved treatment adherence.	
3. Adults with Serious Mental Illness (SMI) or Substance Use Disorder (SUD) who 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** are actively experiencing one complex social factor influencing their health e.g., food, housing, employment insecurities, history of ACES, history of recent contacts with law enforcement related to SMI/SUD, former foster youth. etc. **AND** meet one or more of the following criteria: high risk for institutionalism, overdose and/or suicide, use crisis services, ERs, urgent care or inpatient stays as the sole source of care, two+ ED visits or two+ hospitalizations due to SMI or SUD in the past 12 months, pregnant and post-partum (12 months from delivery).	January 1, 2022
4. Adults and Children/Youth transitioning from incarceration or have transitioned within the last 12 months AND have at least one of the following conditions: chronic mental illness, SUD, chronic disease (e.g., hepatitis C, diabetes), intellectual or developmental disability, traumatic brain injury, HIV or pregnancy. This list of criteria is aligned with the eligibility criteria for pre-release coverage in California's 1115 Demonstration Amendment and Renewal Application (pg. 37): https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Waiver-Renewal-Application.pdf	January 1, 2022
5. Adults 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. Individuals must be able to live safely in the community with wraparound supports.	January 1, 2023
6. Nursing facility residents who want to transition to the community, who are strong candidates for successful transition back to the community and have a desire to do so.	January 1, 2023
7. Children or youth up to 21 high utilizers, OR with Serious Emotional Disturbance (SED), identified to be at clinical high risk (CHR) for psychosis or experiencing a first episode of psychosis, OR enrolled in in California Children Services (CCS)/CCS Whole Child Model with additional needs beyond CCS OR involved in Child Welfare (including those with a history of involvement, and foster care up to 26).	July 1, 2023

Note: Eligibility criteria and go-live dates are as of DHCS guidance provided June 3, 2021, and subject to further change by DHCS. DHCS indicated it will be holding workgroups to further define Population of Focus #7 (Children/Youth) prior to 2023.

DHCS defines homelessness as one of the following[3]:

- 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 to homelessness.
- An individual or family who will imminently lose housing in next 30 days.
- Unaccompanied youth and homeless families and children and youth defined as homeless under other federal statutes.
- Victims fleeing domestic violence.

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

- All members enrolled in a WPC pilot as of December 31, 2021, who are identified by the WPC Lead Entity as belonging to a Population of Focus (includes children and youth currently served by WPC).

4.2 ECM Exclusion Criteria and ECM Overlapping Programs

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

Approach	Explanation	Programs
ECM as a "wrap"	CalViva Health members can be enrolled in **both** ECM and the other program. ECM enhances and/or coordinates across the case/care management available in the other program. The Plan must ensure non-duplication of services between ECM and the other program.	**Programs carved out of managed care** • California Children's Services (CCS) • County-based Targeted Case Management (TCM) • Specialty Mental Health (SMHS) TCM • SMHS Intensive Care Coordination for children (ICC) • Drug Medi-Cal Organized Delivery Systems (DMC-ODS) **Programs carved into managed care** • CCS Whole Child Model • Community Based Adult Services (CBAS) **Coverage for CalViva Health members dually eligible for Medicare and Medicaid**

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

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

Approach	Explanation	Programs
	These programs are considered to be complementary of ECM.	*Note: Dually eligible CalViva Health members can receive ECM if they meet ECM Population of Focus criteria.* • Dual Eligible Special Needs Plans (D-SNPs). • D-SNP look-alike plans. • Other Medicare Advantage Plans. • Medicare FFS. **Other programs** • AIDS Healthcare Foundation Plans. • Adult Full Service Partnership (FSP). *members receiving FSP services from counties can be eligible for and receive ECM services. The Plan will work with counties to identify members receiving FSP services and ensure non-duplication of services.*
Either ECM or the other Program	CalViva Health members can be enrolled in ECM **OR** in the other Program, not in both at the same time. These Programs are considered to be duplicative of ECM.	**1915 waiver programs** • Multipurpose Senior Services Program (MSSP). • Assisted Living Waiver (ALW). • Home and Community-Based Alternatives (HCBA) Waiver. • HIV/AIDS Waiver. • HCBS Waiver for Individuals with Developmental Disabilities (DD). • Self-Determination Program for Individuals with DD. **Programs carved into managed care** • Basic Case Management. • Complex Case Management. **Other programs** • California Community Transitions (CCT) Money Follows the Person (MFTP).
Excluded from ECM	Medi-Cal beneficiaries enrolled in the other program are excluded from ECM. These Programs are ECM exclusionary criteria.	**Coverage for CalViva Health members dually eligible for Medicare and Medicaid** • Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) (effective January 1, 2025). • Program for All Inclusive Care for the Elderly (PACE). • Hospice. **Other programs** • Family Mosaic Project Services.

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

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

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

4.2.1 ECM Provider Expectations

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

4.3 Methods to Identify Potentially Eligible Members

Members may be identified as potentially eligible for the ECM benefit using multiple methods including:

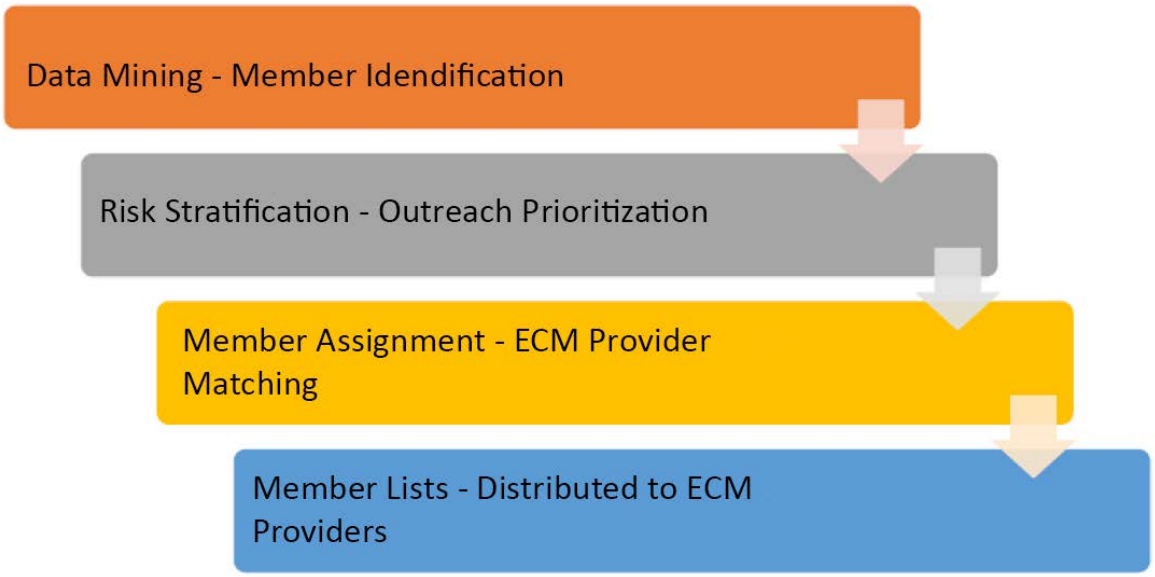
- **ECM targeted engagement list (TEL)** which is a list of potentially eligible members provided by the Plan to ECM providers on a regular basis. It is a list of members assigned to each ECM provider who may potentially meet the ECM eligibility criteria based on the lists DHCS provides to the Plan and internal Plan Health data. This will be the primary source for outreach, engagement, and enrollment in ECM. ECM providers are required to utilize this list to identify, screen, enroll, and provide ECM core services to eligible and enrolled ECM members.
- **ECM provider referrals** to the Plan of potentially eligible members identified at the point of care. The ECM provider is encouraged to identify members who would benefit from ECM. After the ECM provider identifies a member, the ECM provider needs to complete and send an ECM member referral to the Plan. All ECM member referrals will be clinically reviewed by the Plan and may either be approved or denied for ECM. Upon approval from the Plan, members will be added to the ECM TEL file.
- **Member self-referrals** to ECM provider or the Plan due to the member receiving information about the ECM benefit through member-informing materials.
- **Referrals** from other MCP staff, homeless services providers, shelters, recuperative care providers, community partners and other service providers.

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

4.3.1 CalViva Health Member Assignment to ECM Providers

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

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



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

4.3.2 ECM Eligibility Referral Process

Members, providers (ECM providers and non-ECM providers), community-based organizations and the Plan are encouraged to refer members identified as potentially eligible for the ECM benefit. Providers may see members that are not listed on the ECM TEL member file distributed to each ECM provider from the Plan.

4.3.2.1 ECM Provider Initiated Eligibility Referral

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

When an ECM provider identifies a potentially eligible member for ECM, the ECM provider should complete the ECM referral form with the relevant member information and submit to the Plan. The Plan has a variety of methods to receive the referral information, however the preferred method for the referrals is through the provider portals for ease to allow the provider access to real time status updates. The Plan will review the referral information to make a determination on eligibility for the ECM benefit.

If the member meets the ECM eligibility criteria, the provider will be authorized to conduct outreach for ECM services in order to engage the member. A letter informing the member and referring/servicing provider will be sent as confirmation. If engaged, authorization for full ECM services will be completed upon notification from the ECM provider.

If there is not enough information included with the referral to confirm ECM program eligibility, the Plan will request additional information. Based on information received, the Plan will render a decision to authorize or deny services.

4.3.2.2 Member Initiated Eligibility Referral

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

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

4.4 Outreach and Member Engagement

4.4.1 ECM provider Conducted Outreach

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

The ECM provider is expected to conduct outreach **primarily through in-person interaction** where members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community, subject to public health protocols. The ECM provider may supplement in-person visits with secure teleconferencing and telehealth,[4] where appropriate and with the member's consent. The ECM provider must use the following modalities, as appropriate and as authorized by the member, if in-person modalities are unsuccessful or to reflect a member's stated contact preferences: mail/letter, email, texts, telephone calls, and telehealth. The Plan requires ECM provider shall initiate outreach and complete at least five outreach attempts within 30 calendar days of the receipt of ECM data file/authorization from the Plan. At least three different modalities will be used in attempt to reach members who are unable to be contacted in person and before a member is identified as an unsuccessful engagement.

ECM providers must have the capacity and strong commitment to conduct in-person outreach.

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

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

Once the ECM provider determines that a member is not reachable within 90 days, declines to participate, continues to disengage, or meets an exclusion criterion, the ECM provider is expected to

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

exclude the member from further outreach and report the information to the Plan in the TEL response file submission to the Plan. If the ECM provider cannot contact an enrolled member after three attempts and a mailed letter, the ECM provider is expected to exclude the member from further outreach and report the member disenrollment information to the Pan in the TEL response file submission to the Plan.

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

4.4.2 The Plan Conducted Outreach, including WPC Transition Notice

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

4.5 Whole Person Care (WPC) Transition

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

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

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

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

Members enrolled in WPC will receive notices from the Plan or WPC LE in late 2021 about the upcoming transition of WPC to ECM. Additionally, WPC Lead Entities are anticipated to outreach to WPC enrollees transitioning to ECM per DHCS requirement. The Plan will inform the grandfathered ECM member population of their provider assignments.

4.6 Member Enrollment and Authorization/Initiation of Delivery of ECM Services

4.6.1 Confirm Member Eligibility

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

ECM providers are expected to utilize and integrate the ECM eligibility screening checklist in their initial engagement workflow when determining eligibility. ECM providers may utilize the following during their ECM eligibility screening process:

- Reviewing available data or reports provided to the ECM provider by the Plan.
- Reviewing member Electronic Health Records (EHR), Health Information Exchange (HIE), and admit discharge transfer (ADT) data.
- member discussion.

ECM providers are required to notify the Plan of any members who express interest in enrolling in the ECM benefit, and notify the Plan of any members who may not be ECM eligible. If a question arises regarding a CalViva Health member's eligibility for ECM, the ECM provider should contact the Plan. The Plan may request supporting documentation from the ECM provider to assist in the eligibility determination for members ECM providers identify as potentially eligible for ECM.

4.6.2 Member Opt-in to Enroll

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

Opting into the program can be provided verbally, however all verbal opt-ins must be documented by the ECM provider. ECM providers are required to document and maintain each individual member's opt-in to ECM. The Plan may request evidence of member opt-in, as needed or applicable per any DHCS monitoring request.

4.6.3 Member Authorization for Data Sharing

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

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

4.6.4 Assign Lead Care Manager

Upon initiation of ECM, the ECM provider must assign each ECM enrolled member a Lead Care Manager who interacts directly with the member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral,

developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any Community Supports, and other services that address social determinants of health (SDOH) needs, regardless of setting.

4.6.5 Member Ability to Change Provider

ECM members can request to change their ECM provider at any time.

4.6.5.1 Provider Expectations

Upon initiation of ECM, the ECM provider must advise the ECM member on the process for changing ECM providers, which is permitted at any time. If the ECM member requests, the ECM provider must advise the member on the process for switching ECM providers. If the member wishes to change ECM providers, the ECM provider must notify the Plan as such. Members may also call the CalViva Health Member Services Department at 888-893-1569 to initiate a provider change. Remember that the member's right to choose between the ECM benefit and other duplicative programs must always be maintained.

4.6.5.2 The Plan Expectations

The Plan is required to implement any requested ECM provider change within 30 days.

4.7 ECM Service Provision Expectations

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

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

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

The ECM provider must also collaborate with area hospitals, PCPs (when not serving as the ECM provider), behavioral health providers, specialists, dental providers, providers of services for LTSS and other associated entities, such as Community Supports providers, as appropriate, to coordinate member care.

4.8 ECM Core Services

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

4.8.1 Outreach and Engagement of CalViva Health Members into ECM

See Section 4.4.1. of this guide.

4.8.2 Comprehensive Assessment and Care Management Plan

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

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

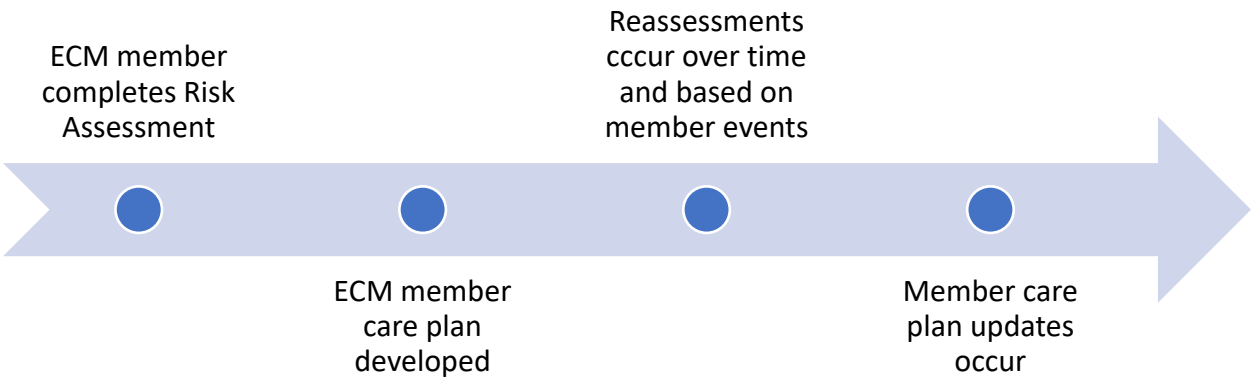
ECM providers are required to engage with each member authorized to receive ECM primarily through **in-person contact**. Public health precautions and recommendations should be used to accomplish the community-based, in-person approach of ECM. When in-person communication is unavailable or does not meet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

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

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

ECM providers are required to create the member's care plan immediately following the member assessment. ECM providers are expected to incorporate into the member's care plan identified needs and strategies to address those needs, including, but not limited to, **physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing.** The ECM providers are required to ensure **the care plan is updated** at a frequency appropriate for the member's individual progress or changes in needs, and at minimum bimonthly. The ECM providers must ensure **the care plan is reviewed, maintained and updated under appropriate clinical oversight.** Care plan updates should occur regularly – for example, after reassessment or transitions of care, and when a new need is identified.

ECM members will have varying levels of acuity and will require different levels of service intensity and frequency of contact with the ECM provider's multi-disciplinary care team.



4.8.2.1 Risk Assessment

ECM providers are required to conduct a comprehensive assessment that identifies a member's physical, mental health, substance use, palliative, trauma-informed care, and social service needs. ECM providers are required to start a member's assessment within 30 days and complete a member's assessment within 60 days of the member's enrollment in ECM. ECM providers are encouraged to initiate and complete the assessment as soon as possible. The Risk Assessment is used to assess an ECM member's current health status, establish a platform to begin building care management and coordination goals, and develop an individualized care plan. ECM providers must reassess the member when clinically indicated or new needs identified, or after transitions of care, but no less frequently than every six months. The Plan recommends care plans be updated during reassessments as well.

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

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

4.8.2.2 Care Plan

ECM providers are required to create the member's care plan immediately following the member assessment. The care plan is a dynamic and person-centered plan of care that is maintained by ECM providers, and includes comprehensive input from the member, member's authorized representative, PCP, specialists, and other service providers in accordance with the member's wishes. Informed by the assessment, the ECM provider will develop the member's care plan together with appropriate stakeholders, including the member, the member's providers, and the member's family or support persons. The Plan recommends member's care plan including problem (opportunity), interventions, and goals. The Plan recommends goals be SMART (specific, measurable, achievable, realistic, and time bound). The ECM provider should update the care plan as appropriate when goals are modified, new needs or goals are identified, after transition of care, or when a member's health is reassessed. The frequency for updating the care plan should be appropriate to the member's needs, when the member is reassessed, and when transitions in care or changes in member health, functional, or social status occur. The care plan will track and coordinate information on referrals, follow ups, and transitions in care. The ECM provider will

document member acuity as part of the care plan and will maintain an appropriate level of contact with ECM members for their health status and goals.

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

4.8.3 Enhanced Coordination of Care

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

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

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

ECM providers are responsible for maintaining regular contact with all providers that are identified as being a part of the member's multi-disciplinary care team. The care team's input is necessary for successful implementation of member goals and needs. ECM providers are responsible to ensure care is **continuous and integrated among all service providers and referring to and following up** with 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.

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

ECM providers are responsible for **communicating the member's needs and preferences** timely to the member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care. ECM providers are responsible for **ensuring regular contact with the member and their supports** – family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

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

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

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

The Plan will require a minimum of one face-to-face contact per month for all tiers, subject to public health protocols.

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

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

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

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

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

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

The Plan expects that ECM providers make active, meaningful, and progressive attempts to contact the member, however if after three attempts to contact the member and a mailed letter to the member the member remains unable to contact, the ECM provider is expected to exclude the member from further outreach and report the member disenrollment information to the MCP in the Targeted Engagement List (TEL) response file submission to the MCP.

4.8.4 Health Promotion

ECM providers are responsible for Health Promotion, following the federal care coordination and continuity of care requirements (42 CFR 438.208(b)). Key components to this service provision include:

- Member resilience and support.
- Lifestyle changes.
- Member skill development.
- Promote self-management.

ECM providers are required to work with members to **identify and build on successes** and resiliencies and potential family and/or community support networks. ECM providers are required to provide **services to encourage and support members to make lifestyle choices** based on healthy behavior, with the goal of supporting members' ability to **successfully monitor and manage their health**.

ECM providers are required to 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.

4.8.5 Comprehensive Transitional Care

ECM providers are responsible for ensuring ECM members receive comprehensive transitional care. Key components to this service provision include:

- Focus on admission and readmissions.
- Care transition, Resource Coordination and Medication Review.

ECM providers are required to develop **strategies to reduce avoidable member admissions and readmissions** across all members receiving ECM. ECM providers must support members who are experiencing or are likely to experience a care transition in:

- Developing and regularly updating **a transition of care plan** for the member.
- **Conducting an assessment to 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.
- **Tracking each member's admission or discharge** to/from an emergency department, hospital inpatient facility, skilled nursing facility, residential/treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members.
- Coordinating **medication review/reconciliation.**
- Providing **adherence support and referral** to appropriate services.

When a member experiences a transition of care, the Plan expects the ECM provider to conduct a reassessment and update the member's documentation to reflect changes in condition, new diagnoses, referral to specialist, medication review, review and revision of goals, etc. within 30 days post-discharge.

4.8.6 Member and Family Support Services

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

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

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

The ECM provider is responsible through the ECM service provision includes **activities to ensure the member and their supports – family member(s), AR, guardian, caregiver, and/or authorized support**

person(s) – are knowledgeable about the member's conditions with the overall goal of improving the member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state and local privacy and confidentiality laws.

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

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

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

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

4.8.7 Coordination of and Referral to Community and Social Support Services

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

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

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

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

4.9 Member Discontinuation

If the following circumstances are met, ECM should be discontinued:

1. The member has met all care plan goals;
2. The member is ready to transition to a lower level of care;
3. The member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
4. The ECM provider has not been able to connect with the member after multiple attempts.

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

4.9.1 ECM Provider Initiated Disenrollment

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

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

4.9.2 Member Initiated Disenrollment

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

4.9.3 The Plan Initiated Disenrollment

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

4.9.4 The Notice of Action (NOA)

4.9.4.1 The Plan Expectations

When ECM is requested and denied, the Plan is responsible for sending a Notice of Action (NOA) notifying the member of the denial/discontinuation of the ECM benefit and ensuring the member is informed of their right to appeal and the appeals process as instructed in the NOA. The Plan ensures authorization or a decision not to authorize ECM occurs in accordance with existing Federal and State regulations for processing grievances and appeals.

The Medi-Cal NOA is a written notice that explains an individual's eligibility for Medi-Cal coverage or benefits. The NOA includes the eligibility decision and effective date of coverage, as well as any changes made in an individual's eligibility status or level of benefits. The NOA includes information about how an individual may appeal a decision if the individual disagrees with the eligibility determination.

In addition, ECM is subject to standard utilization management medical authorization timeframes.

4.9.4.2 ECM Provider Expectations

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

4.9.5 Complaints, Grievances and Appeals

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

4.10 Data to Support ECM

4.10.1 Care Management Documentation System or Process

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

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

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

Care management documentation systems also need to be able to:

- Support the sharing of the member's care plan amongst the member's care team.
- Support the sharing of the member's assessment, care plan and other required data to the Plan, as requested.
- Assist with informing the ECM provider's regular reporting to the Plan, as requested.
- Support and track the ECM services provided to the member to enable ECM providers to appropriately submit claims[5] to the Plan.

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

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

The Plan and the ECM provider will exchange data on members on a regular basis.

The Plan will provide the following data to the ECM provider at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable:

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

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

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

ECM providers are responsible to submit required reports to the Plan, to be defined at a later date. Required ECM provider reports include but are not limited to the following:

- Monthly ECM provider reporting.
- Staffing and capacity reports.

4.10.4 Data and File Exchange Operations

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

On a minimum of a monthly basis, ECM providers must update and report back to the Plan via an SFTP file upload identifying the services provided and status of each eligible and enrolled ECM member. Reporting requirements for ECM providers will be defined by DHCS.

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

5 Claims Submission

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

In the event the ECM provider is unable to submit claims to the Plan for ECM-related services using the national standard specifications and DHCS-defined code sets, the ECM provider can submit an invoice to the Plan with a minimum set of data elements (to be defined by DHCS) necessary for the Plan to convert the invoice to an encounter for submission to DHCS. DHCS is developing guidance that describes the minimum set of data elements required to be included in an invoice and outlining criteria for ECM providers that would qualify to submit invoices in lieu of claims. Invoices can be submitted by via mail, email, fax and Web. For more information on claims submission and payment, refer to the provider operations manual in the Provider Library at providerlibrary.healthnetcalifornia.com.

6 Quality, Monitoring and Oversight

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

The ECM provider acknowledges the Plan will conduct oversight of its participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include audits and/or corrective actions. The ECM provider must respond to all the Plan's requests for information and documentation to permit ongoing monitoring of ECM.

7 Payment to Providers

The Plan will pay contracted ECM providers for the provision of authorized ECM services in accordance with contract established between the Plan and ECM provider. The Plan shall pay 90 percent of all clean claims from practitioners who are individual or group practices or who practice in shared health facilities within 30 calendar days of date of receipt and 99 percent of all clean claims within 90 calendar days. The date of receipt shall be the date the Plan receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

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

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