State of California—Health and Human Services Agency
Department of Health Care Services

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CalAIM Enhanced Care Management Policy Guide

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I. Introduction

This California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management (ECM) Policy Guide is intended to serve as a resource for Medi-Cal Managed Care health plans (MCPs) in the implementation of ECM. The Policy Guide provides a comprehensive overview of ECM as well as additional operational guidance for MCPs as they prepare to offer ECM beginning in 2022.

CalAIM is a new initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal Members by implementing broad delivery system, program and payment reform across the Medi-Cal program. A key feature of CalAIM is the statewide introduction of an ECM benefit and a menu of Community Supports (ILOS), which, at the option of an MCP and a Member, can substitute for covered Medi-Cal services as cost-effective alternatives. MCPs will be responsible for administering both ECM and Community Supports.

ECM and Community Supports have been developed from lessons learned, as well as MCP and Provider experience, in the Whole Person Care (WPC) Pilots and Health Homes Program (HHP). Both WPC and HHP led the way in providing a set of intensive care coordination services that spanned multiple delivery systems to provide a person-centered approach to care. These initiatives also pushed the boundaries of a traditional health care delivery approach to begin formally considering the impact of Social Determinants of Health (SDOH) on health outcomes and experience of care in California's Medicaid program.

DHCS' adoption of ECM and Community Supports on a statewide scale will support the highest-need MCP Members, with the provision of ECM and Community Supports anchored in the community, where services can be delivered in an in-person manner by community-based ECM and Community Supports Providers, to the greatest extent possible.

DHCS' requirements for MCPs to implement ECM and Community Supports are contained in the ECM All Plan Letter (APL), ECM and Community Supports Contract Template (ECM and Community Supports Contract), which will become part of the MCPs' contract with DHCS, and the DHCS' ECM and Community Supports Standard Provider Terms and Conditions.[1] ECM and Community Supports are separate initiatives, and some Medi-Cal Members will qualify for only ECM or only Community Supports.

The combination of ECM and Community Supports represents an opportunity for MCPs to work with Providers, counties and community-based organizations (CBOs) to deliver a strong set of integrated supports for those who need them most.

As part of the implementation and ongoing administration of ECM and Community Supports, each MCP will be required to develop and submit for DHCS approval an ECM and Community Supports Model of Care (MOC). The MOC will be each MCP's detailed plan for providing ECM and Community Supports in accordance with DHCS' requirements. Each MCP's MOC will include its overall approach to ECM and Community Supports; its detailed policies and procedures for

[1] Refer to the DHCS-MCP ECM and Community Supports Contract and DHCS MMCD Boilerplate Contracts for definitions of capitalized terms within this document.

partnering with Providers, including non-traditional Medi-Cal Providers, for the administration of ECM and Community Supports; its ECM and Community Supports Provider capacity; and the contract language that will define its arrangements with its ECM and Community Supports Providers.

This Policy Guide is intended to serve as a resource for MCPs preparing to offer ECM, as well as for other key stakeholders involved in ECM, such as Providers, counties and CBOs. Updates will be published as needed and posted on the ECM and Community Supports webpage, where stakeholders can also find other resources, including FAQs. MCPs and other stakeholders may direct their questions to DHCS using the following email address: CalAIMECMILOS@dhcs.ca.gov.

II. What Is Enhanced Care Management (ECM)?

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. DHCS' vision for ECM is to coordinate all care for Members who receive it, including across the physical and behavioral health delivery systems. ECM is a Medi-Cal benefit that will be phased into each county, according to the schedule in Section III below.

DHCS has long understood that the need for care management and coordination increases with clinical and social complexity and has worked for several years to build capacity for a more comprehensive approach to care management and coordination in Medi-Cal. In 2016, DHCS launched the WPC Pilots as part of its Medi-Cal 2020 Section 1115 Demonstration. WPC Pilots have tested interventions to coordinate physical, behavioral and social services in a patient-centered manner, including interventions that address SDOH such as improving access to housing and supportive services, and have built significant infrastructure to ensure local collaboration for improved outcomes. In 2018, DHCS launched the Health Homes Program (HHP). The HHP serves eligible Medi-Cal Members with complex medical needs and chronic conditions who may benefit from intensive care management and coordination, and coordinates the full range of physical health, behavioral health and community-based long-term services and supports (LTSS).

ECM builds on both the design and the learning from the WPC Pilots and the HHP. ECM, with Community Supports, will replace both initiatives, scaling up the interventions to form a statewide care management approach. ECM will offer comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members, with the overarching goals of:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Addressing SDOH;
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

ECM is part of a broader population health strategy design within CalAIM, under which MCPs will systematically risk-stratify their enrolled populations and offer a menu of care management interventions at different levels of intensity, with ECM at the highest intensity level. ECM will be implemented ahead of broader population health strategy requirements, which will start in 2023.

III. ECM Implementation Timeline

(Updated May 2022)

For the most updated ECM Implementation Timeline information, please visit the ECM and Community Supports DHCS webpage or access:

- Finalized ECM Key Design Implementation Decisions

IV. ECM Populations of Focus

To be eligible for ECM, Members must be enrolled in Medi-Cal Managed Care[2] and meet the criteria provided below in each of the Populations of Focus definitions. DHCS has created distinct Populations of Focus definitions for adults and children/youth.

The Populations of Focus definitions given below update and replace the definitions described in the CalAIM Proposal of January 2021.

[2] Medi-Cal recipients with a Share of Cost, excluding long-term care share of cost, are excluded from managed care and are not eligible for ECM.

Population of Focus #1:
Individuals and Families Experiencing Homelessness

Individuals and families who:

(1) are experiencing homelessness (as defined below)

AND

(2) have at least one complex physical, behavioral or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes **and/or** decreased utilization of high-cost services.

An Individual or Family Experiencing Homelessness is defined as:

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

Notes on the definition:

- This definition is taken from the US Department of Housing and Urban Development (HUD) definition of "Homeless"[3] with the following modifications:
  - If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization.
  - The timeframe for an individual or family who will imminently lose housing has been extended from 14 days (HUD definition) to 30 days.

Examples of eligible MCP Members under this Population of Focus:

- Members experiencing homelessness with complex health care needs as a result of an unmanaged medical, psychiatric or SUD-related condition.

[3] HUD Definition of Homelessness 42 U.S. Code § 11302 - General definition of homeless individual. https://www.govinfo.gov/app/details/USCODE-2010-title42/USCODE-2010-title42-chap119-subchapI-sec11302.

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

Additional Guidance & Examples of ECM Services:
Individuals experiencing homelessness are among the highest-need individuals in Medi-Cal. They often lack access to necessities such as food and shelter that are critical to attaining health. These individuals often have extensive medical and behavioral health needs that are difficult to manage due to the social factors that influence their health. This often results in high utilization of costly services such as emergency departments and inpatient settings.

Engagement for this population may include street outreach or coordinating with shelters, Homeless Services Providers, Recuperative Care Providers, Community Partners (e.g., Homeless Coordinated Entry Systems) and other service Providers.[4] As individuals are connected to resources, the ECM Lead Care Manager will meet the Member in the community or at Provider locations.

ECM can be used to link individuals with a variety of services to meet their complex needs. In addition to the Core Service Components, examples of applicable services for this Population of Focus include (but are not limited to):

- Utilizing housing-related Community Supports to identify housing and preparing individuals to secure and/or maintain stable housing.
- Coordinating short-term post-hospitalization housing and recuperative care services as appropriate.
- Maintaining regular contact with Members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to ensure progress toward regaining health and function continues.
- Coordinating and collaborating with various health and social services Providers, including Regional Centers, including sharing data (as appropriate) to facilitate better-coordinated whole-person care.
- Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
- Addressing barriers to housing stability by connecting Members and their families to housing, health and social support resources.
- Utilizing best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions, including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing and Trauma Informed Care.

[4] These same entities will be important referral partners to identify potential enhanced care management candidates.

Population of Focus #2:
Adult High Utilizers

Adults with:
(1) **five or more** emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence;

AND/OR

(2) **three or more** unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

MCPs may also authorize ECM for other individuals with a pattern of very high utilization that could have been avoided with appropriate care or improved treatment adherence.

Notes on the definition:

- The definition allows MCPs to authorize ECM services for very high utilizer individuals who would benefit from ECM but who may not meet numerical thresholds (1) and/or (2).
- However, this flexibility does not displace the numerical thresholds provided in the definition to identify high utilizers. MCPs must use the numerical thresholds to identify Members in this Population of Focus. MCPs should have a consistent approach (e.g., algorithms or other methodologies) for identifying high utilizers and should describe it in their Model of Care Template submission to DHCS.
- MCPs should utilize a "rolling" six-month lookback period based on the most recent month of adjudicated claims data.
- ED visits that result in an inpatient stay should only count as one inpatient visit.

Examples of eligible MCP Members under this Population of Focus:

- Members with repeated incidents of avoidable emergency room visits in a six-month period, who have a medical, psychiatric or SUD-related condition requiring intensive coordination beyond telephonic intervention.

- Members with repeated incidents of avoidable emergency room visits in a six-month period who have significant functional limitations and/or adverse social determinants of health that impede them from navigating their health care and other services.

Population of Focus #3:
Adult SMI/SUD

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

AND
(2) are actively experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, history of Adverse Childhood Experiences (ACEs), former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms or associated behaviors);
AND
(3) **meet one or more of the following criteria:**
- are at high risk for institutionalization, overdose and/or suicide;
- Use crisis services, emergency rooms, urgent care or inpatient stays as the sole source of care;
- experienced two or more ED visits or two or more hospitalizations due to SMI or SUD in the past 12 months; or
- are pregnant or post-partum individuals (12 months from delivery).

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

Examples of eligible MCP Members under this Population of Focus:

- Members who have the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions, who are experiencing one complex social factor influencing their health and are pregnant.

- Former foster youth Members with a psychiatric or SUD-related condition, who are currently using emergency rooms as the sole source of care.

Additional Guidance and Examples of ECM Services:
Initial engagement for adults with SMI/SUD may occur in treatment settings such as psychiatric inpatient units, Institutions for Mental Diseases (IMDs) or residential settings. However, ECM Providers are expected to coordinate across all the delivery systems through which Members need to access care. Further, as detailed in Section V. Program Overlaps and Exclusions, MCPs are responsible for ensuring non-duplication of services across delivery systems. Given that adults with SMI/SUD might also be receiving services through Specialty Mental Health Plans (SMHPs) and/or the Drug Medi-Cal Organized Delivery Systems (DMC-ODS) or Drug Medi-Cal Program (DMC), it is especially important for MCPs to coordinate with county behavioral health staff. As such, MCPs should prioritize contracting with county behavioral health staff to serve as ECM

Providers, provided they agree and are able to coordinate all services needed by the Member, not just behavioral health services. When MCPs are not able to contract with county behavioral health staff as the ECM Provider, ECM Providers for this population should have experience and expertise working with individuals with SMI and SUD, as well as the ability to adequately coordinate services across multiple delivery systems. In addition to the Core Service Components, examples of applicable services for this Population of Focus include (but are not limited to):

- Providing post-hospitalization or post-residential medical treatment care planning to connect individuals with the supports they need to avoid rehospitalization, including identifying culturally and linguistically appropriate community placements. These services should be provided in close coordination with county behavioral health plans when the hospitalization or residential treatment occurs due to mental illness or substance use disorder.
- Facilitating regular culturally and linguistically appropriate contact with Members to ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain in the community placement.
- Utilizing housing-related Community Supports to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual's health outcomes.
- Supporting the Members' behavioral health recovery goals with related improvements in physical and oral health and long-term services and supports.
- Connecting families, caretakers and circles of support to resources regarding the Member's conditions to assist them with providing support for the Member's health/behavioral health.
- Coordinating and collaborating with various health, behavioral health, developmental disability and social services Providers, including sharing data (as appropriate).
- Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.

Population of Focus #4 *(Updated May 2022)*:
Individuals Transitioning from Incarceration

Adults:
Individuals who:
(1) are transitioning from incarceration or transitioned from incarceration within the past 12 months

AND

(2) have at least one of the following conditions:
- Mental illness
- Substance Use Disorder (SUD)
- Chronic Condition/Significant Clinical Condition
- Intellectual or Developmental Disability (I/DD)
- Traumatic Brain Injury
- HIV/AIDS
- Pregnancy or Postpartum

Children:
Youth who are transitioning from incarceration or transitioned from incarceration from a youth correctional facility within the past 12 months [5]

Notes on the definition:

- The conditions listed above align with the eligibility criteria for targeted pre-release services that will be available to inmates in prisons, jails and youth correctional facilities as requested in California's 1115 Demonstration Amendment and Renewal Application as of the date of publication of this Guide. The 1115 Demonstration has not yet been approved by the Centers for Medicare and Medicaid Services (CMS), and, as such, the above criteria are subject to change.

Additional Guidance and Examples of ECM Services:
Some Members transitioning from incarceration have significant health and behavioral health care needs that require ongoing treatment in the community post-release. These Members often also experience significant social factors that impact their ability to successfully manage their health, such as lack of safe and stable housing and unemployment. Upon transition back to the community, individuals are required to coordinate a significant number of basic life needs and, as a result, often experience care disruptions, which result in deterioration of their conditions and increased use of emergency departments and inpatient settings. For some individuals, unmet health care needs can increase their likelihood of returning to incarceration; diversion programs are designed to address these needs and avoid incarceration.

[5] Eligibility criteria for ECM Individuals Transitioning from Incarceration Population of Focus align with eligibility criteria for individuals to receive pre-release Medi-Cal services. As such, all individuals (including adults and children/youth) who receive pre-release Medi-Cal services will be eligible to receive ECM until a reassessment is conducted by the MCP, which may occur up to six months after release.

For this Population of Focus, ECM requires coordination with the state prison system, county jails, youth correctional facilities, and local corrections departments, including probation and parole offices and courts to identify and refer Members and also to ensure connections to care once individuals are released from incarceration. Further details on how to enroll individuals transitioning from incarceration will be released after approval of the request to provide targeted pre-release services to inmates under the 1115 Demonstration. Upon release, all individuals receiving ongoing behavioral health treatment (including treatment for SUD) should be referred to county behavioral health programs and MCPs on an as-needed basis. MCPs and county behavioral health programs should coordinate closely to better serve clients that receive services from both entities.

The initial ECM engagement locations will depend on the collaborations that MCPs are able to build with local justice partners. At first, ECM Lead Care Managers will begin working with individuals expected to transition from incarceration in the setting where they are incarcerated (or just outside that setting), or in criminogenic treatment programs.[6] Post-transition, ECM Lead Care Managers will engage individuals in the most easily accessible setting for the Member. In addition to community-based engagement such as a Member's home or regular Provider office, this may also include parole or probation offices if the MCP builds partnerships that allow for engagement in those settings.

ECM can be used to link individuals transitioning from incarceration (or in diversion programs) with a variety of services to meet their complex needs. In addition to the Core Service Components, examples of applicable services for this Population of Focus include (but are not limited to):

- Coordinating an initial risk assessment to evaluate medical, psychiatric, substance use and social needs for which the individual requires assistance.
- Establishing direct connections with community Providers to ensure continuity of care for their conditions (especially for medications) and to address any health care needs not treated while they were incarcerated. This will also include peer mentorship to help provide positive social support.
- Utilizing housing-related Community Supports to identify housing and prepare individuals for securing and/or maintaining stable housing.
- Ensuring regular contact with Members to safeguard against gaps in the activities designed to address an individual's health and social service needs, and swiftly address those gaps to prevent reincarceration and ensure progress toward regaining health and function continues.
- Screening and providing referrals for various health, developmental disabilities, mental health, substance use disorder and social service needs.

[6] DHCS is looking to leverage H.R. 6 SUPPORT Act to begin providing ECM for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release. ECM dollars will not be able to be used to provide services directly to justice-involved Members prior to release.

- Coordinating and collaborating with various health, behavioral health and social services Providers as well as parole/probation, including sharing data (as appropriate) to facilitate better-coordinated, whole-person care.
- Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
- Helping Members set and monitor health goals to maintain or improve their health.
- Providing culturally and linguistically appropriate education to families, caretakers and circles of support regarding the Member's health care needs and available supports.
- Navigating Members to other reentry support Providers to address unmet needs.
- Facilitating reinstatement of benefits, not including Medi-Cal (e.g., SNAP or TANF).[7]

[7] To complement these efforts, state statute mandates that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023.The intent is that individuals reentering the community from incarceration would already be enrolled in Medi-Cal upon release. The ECM Lead Care Manager would also help facilitate accessing other benefits as needed by the Member.

Population of Focus #5 *(Updated May 2022)*:

Adults Living in the Community who Are at Risk for LTC Institutionalization

(1) Adults living in the community who meet the Skilled Nursing Facility (SNF) Level of Care criteria;[8] **OR** who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury;[9]

AND

(2) are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring),[10]

AND

(3) are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).

Notes on the definition:

Living in the Community

Members who meet this Population of Focus may live in independent housing, Residential Care Facilities, Residential Care Facilities for the Elderly (RCFEs), or any other dwelling that meets the requirements established in the Home and Community Based Services (HCBS) Settings Final Rule.[11]

[8] As established in the California Code of Regulations 51335: https://www.law.cornell.edu/regulations/california/22-CCR-Sec-51335.

[9] Criteria adapted from the 2020 Medi-Cal Long-Term Care At Home proposal: https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2020/07/Medi-Cal-Long-Term-Care-at-Home-Benefit-Design_Accessible-Doc.pdf

[10] Criteria adapted from the Community-Based Health Home eligibility criteria: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6827350/

[11] CMS Final Rule 79 FR 2947, Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; 42 CFR 441.301(c)(4) and (5)

Exclusions

Adults living in the community who are at risk of institutionalization into Intermediate Care Facilities (ICF)[12] and subacute care facilities[13] are excluded from this Population of Focus.

Operational Guidance:

Identification

Referrals will be the predominant pathway MCPs use to identify Members who may be eligible for this Population of Focus. MCPs are encouraged to leverage existing and develop new partnerships with providers who have experience serving Members who meet this Population of Focus and are thus well positioned to make referrals. This includes but is not limited to Community Based Adult Services (CBAS) Centers, Area Agencies on Aging, Home Health Agencies, Centers for Independent Living, In Home Supportive Services (IHSS) Providers, and other Home and Community-Based Services (HCBS) Waiver Providers.

MCPs are encouraged to establish relationships with Adult Protective Services (APS) agencies.[14] Each county in California has an APS agency specifically dedicated to helping elder and dependent adults, and regularly meet with individuals in their homes. These agencies may serve as a useful referral source.

MCPs may also utilize existing Member data, establish regular data sharing arrangements with contracted Providers, or leverage 1915 (c) HCBS waiver program wait lists to identify members who may meet this Population of Focus definition. MCPs may use previous SNF Level of Care determinations to confirm Member eligibility. The 1915(c) waiver programs[15] require Members to meet the SNF LOC criteria to be eligible for participation. As such, SNF LOC determination may have already been made for some Members who meet this Population of Focus.

Member choice and preferences must be considered during the identification and eligibility determination process for enrolling Members in ECM.

Comprehensive Assessment & Care Management Plan

Once a Member is successfully engaged in ECM, a comprehensive assessment should be conducted, and care plan developed, as described in Section V: Core Service Components of ECM. As part of the assessment, MCPs must include DHCS' standardized Long Term Services

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[12] Definition and more information about Intermediate Care Facilities located here: https://www.dds.ca.gov/services/icf/

[13] Definition and more information about subacute care facilities located here: https://www.dhcs.ca.gov/provgovpart/Pages/SubacuteCare.aspx

[14] Adult Protective Services website: https://www.cdss.ca.gov/inforesources/adult-protective-services; For a list of APS Offices by county, please see: https://www.cdss.ca.gov/Portals/9/APS/County_APD_Contacts.pdf?ver=2022-01-20-142432-943

[15] Assisted Living Waiver; Home and Community Based Alternatives Waiver; and Multipurpose Senior Services Program

and Supports (LTSS) referral questions[16] to identify and refer Members who may have LTSS needs, unless the Member has already answered these questions. Assessments should be conducted face-to-face whenever possible.

Per federal requirements, if the Member has LTSS needs, the care plan must be developed by an individual who is trained in person-centered planning, using a person-centered process.[17] Thus, for this Population of Focus, the ECM Lead Care Manager must meet these requirements. The care plan should consider and reflect what is important to the Member regarding their preferences for the delivery of LTSS (for example, specific treatment goals, services or functional needs the Member prefers to prioritize). As for all ECM Populations of Focus, the care plan should incorporate the Member's needs across all delivery systems inclusive of LTSS, and must contain the wraparound services and supports that will ensure the Member is setup to live continuously in the community.

Community Supports

MCPs are strongly encouraged to offer Community Supports[18] to Members who meet this Population of Focus. Doing so can enhance care, prevent costly and unnecessary hospitalizations, and help Members live continuously in the community. The entire menu of Community Supports may be applicable to Members who meet this Population of Focus, but each Member will have different needs and functional limitations. Below are a few examples of Community Supports that may be particularly beneficial:

- **Environmental Accessibility Adaptations (EAAs also known as Home Modifications)** are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual. Some examples of environmental accessibility adaptions include:
    - Ramps and grab-bars to assist Members in accessing the home
    - Making a bathroom and shower wheelchair accessible
    - Doorway widening for Members who require a wheelchair.
- **Respite Services** are provided to Members in his or her home to temporarily relieve those persons who normally care for and supervise the Member.
- **Personal Care and Homemaker Services** are provided for Members who need assistance with the Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management.

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[16] As established in APL 17-013: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-013.pdf

[17] As established in 42 CFR § 438.208: https://www.law.cornell.edu/cfr/text/42/438.208 and 42 CFR § 441.301: https://www.law.cornell.edu/cfr/text/42/441.301#c_1

[18] For the comprehensive menu of Community Supports services and their corresponding service definitions, please refer to the Community Supports Policy Guide: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

ECM Provider Contracting

MCPs are required to contract with Providers who have experience serving Members who meet this Population of Focus to serve as the ECM Provider. These Providers may include, but are not limited to, CBAS Centers, Area Agencies on Aging, Home Health Agencies, and Centers for Independent Living.

Interaction with Other Long-Term Care/Home and Community-Based Programs[19]

CBAS

Members who are participating in a CBAS program are also eligible to receive ECM if they meet the ECM Population of Focus criteria. If an individual is enrolled in both ECM and CBAS, and their CBAS Provider is a contracted ECM Provider, the MCP should assign that Provider to be the Member's ECM Provider, unless the Member desires a different ECM Provider.

IHSS

Members who receive IHSS services are also eligible for ECM if they meet the ECM Population of Focus criteria.

1915(c) Waiver Programs

Members can be enrolled in ECM or in a 1915(c) waiver program, not in both at the same time. As mentioned, Members who are on a wait list for a 1915(c) waiver program are likely good candidates to receive ECM until a slot in a 1915(c) waiver program becomes available. If a Member is receiving ECM and then a slot to enroll in a 1915(c) waiver program becomes available, the MCP should ensure that the Member has the choice of whether they will continue receiving ECM or enroll in the 1915(c) waiver program. The MCP should provide education to the Member about their options, including describing what is available through the ECM benefit compared with 1915(c) waiver programs, so the Member can make an informed decision. Members who are identified as eligible for ECM who are already receiving 1915(c) services have a choice of continuing 1915(c) services, or disenrolling in the 1915(c) waiver program to begin receiving ECM.

Please also see section VI below for interactions with programs for Medi-Cal MCP members dually eligible for Medicare.

[19] For a comprehensive set of approaches regarding ECM Program Overlaps and Exclusions, please refer to ECM Policy Guide, Section VI. Program Overlaps and Exclusions.

Population of Focus #6 *(Updated May 2022)*:
Nursing Facility Residents Transitioning to the Community

Nursing facility residents who are:
- Interested in moving out of the institution;
- Are likely candidates to do so successfully; and
- Able to reside continuously in the community.

Notes on the definition:

Able to Reside Continuously in the Community

Members transitioning to the community may need to return to the hospital or SNF intermittently for short admissions (potentially due to changes in medical conditions or other acute episodes). They should not be precluded from being considered able to reside continuously in the community.

Exclusions

Individuals residing in Intermediate Care Facilities (ICF)[20] and subacute care facilities[21] are excluded from this Population of Focus.

Operational Guidance:

Identification

MCPs can rely on referrals, analysis of their own data, or direct data feeds from and relationships with SNFs or other Providers to identify Members who may be eligible for this Population of Focus.

One of the pathways MCPs can leverage is the Minimum Data Set (MDS), which is part of the federally mandated process for clinical assessment of all residents in certified nursing facilities. MDS assessments are completed for all residents, regardless of source of payment, and are required on admission to the nursing facility, periodically, and upon discharge.[22] Section Q of the MDS uses a person-centered approach to ensure that all individuals residing in the SNF have the opportunity to indicate their interest in receiving long term care in the least restrictive setting possible.[23] MCPs who have access to MDS assessment data are encouraged to analyze responses to Section Q on a regular basis to identify Members who may be eligible for this Population of Focus.

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[20] Definition and more information about Intermediate Care Facilities located here: https://www.dds.ca.gov/services/icf/
[21] Definition and more information about subacute care facilities located here: https://www.dhcs.ca.gov/provgovpart/Pages/SubacuteCare.aspx
[22] Minimum Data Set 3.0 Public Reports: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports
[23] CMS's 3.0 Manual: https://aapacn.org/wp-content/uploads/2021/02/11133-MDS-3.0-Chapter-3-Section-Q-v1.17.1.pdf

MCPs are encouraged to leverage existing and develop new partnerships with SNFs and Providers who have experience serving Members who meet this Population of Focus, and are thus well positioned to make referrals. This includes but is not limited to Area Agencies on Aging, and California Community Transitions (CCT) Money Follows the Person (MFTP) Lead Organizations. MCPs may also institute data sharing requirements with their contracted SNF providers.

Comprehensive Assessment and Care Management Plan

The assessment and care management plan processes for Members who meet this Population of Focus are expected to be more time intensive compared with the other ECM Populations of Focus. MCPs must assess Members against criteria to determine who could be successful to reside continuously in the community, which may include but is not limited to functional status, the availability of appropriate services and resources in the community, existing support systems, and safety. DHCS encourages MCPs to use the California Community Transitions (CCT) assessment tool for this Population of Focus[24]. This tool is already being used across the state to successfully transition Members from SNFs into home and community-based settings, and could serve as a helpful resource.

The development of the care plan for a Member to transition from SNF to the community is an effort that will require considerable planning. The ECM Care Manager is responsible for identifying all resources to address all needs of the Member, including coordinating with local housing agencies and identifying the least restrictive community housing option, ongoing medical care that may be needed, and other community-based services to ensure a Member will be able to transition and reside continuously in the community. The development of the care plan should be led by the ECM Lead Care Manager and involve the Member, their family and friends (as requested), legal representative (as applicable), and the interdisciplinary care team, the SNF facility discharge planner, and any other relevant clinical, behavioral health, and social work staff.

Community Supports

MCPs are strongly encouraged to offer Community Supports services[25] to Members who meet this Population of Focus. Doing so can enhance care, prevent costly and unnecessary hospitalizations, and help Members live continuously in the community. The entire menu of Community Supports may be applicable to Members who meet this Population of Focus, but each Member will have different needs and functional limitations. Because lack of access to housing is anticipated to be one of the most pressing issues for Members who meet this Population of Focus, below are a few examples of Community Supports that may be particularly beneficial, as they are focused on securing and transitioning Members into community-based housing:

- Community Transition Services / Nursing Facility Transition Community Supports

[24] Placeholder for CCT Assessment tool

[25] For the comprehensive menu of Community Supports services and their corresponding service definitions, please refer to the Community Supports Policy Guide: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)

A Member can receive ECM and can also simultaneously receive the care management included in these Community Supports services. For MCPs offering these Community Supports services, they are encouraged to assign the same Community Supports Provider as the ECM Provider, so long as the Community Supports Provider is contracted as an ECM Provider, and is therefore able to coordinate all services needed. If a different Community Supports Provider and an ECM Provider are both serving a Member at the same time, the ECM Provider remains primarily responsible for the overall coordination across the physical and behavioral health delivery systems and social supports.

Provider Contracting

MCPs are required to contract with Providers who have experience working with Members who meet this Population of Focus. MCPs are strongly encouraged to contract with CCT Lead Organizations, as these Providers have existing relationships with community-based organizations, can coordinate community wrap around supports effectively, and have extensive knowledge of existing local community resources (e.g., housing wait lists).

Interaction with California Community Transitions (CCT) Money Follows the Person (MFTP)

Members can be enrolled in ECM or in CCT MFTP, not in both at the same time. Nevertheless, ECM for this Population of Focus is modeled off of the CCT Program, and MCPs are encouraged to contract with CCT Lead Organizations to leverage their expertise.

Please see section VI below for interactions with programs for Medi-Cal MCP members dually eligible for Medicare.

Children and Youth Populations of Focus not otherwise covered above

Definitions and detailed eligibility criteria for the Children and Youth Populations of Focus are forthcoming.

V. Core Service Components of ECM

Overview of ECM Core Service Components

The goal of ECM is to coordinate all primary, acute, behavioral, developmental, oral, social needs, and long-term services and supports for Members, including participating in the care planning process, regardless of setting. ECM activities should become integrated with other care coordination processes and functions, and in most cases, the ECM Provider must assume primary responsibility for coordination of the Member's needs, including collaboration with other coordinators who operate in a more limited scope.

ECM is intended to be interdisciplinary, high touch, person centered and provided primarily through in-person interactions with Members where they live, seek care and prefer to access services. Members who will be eligible for ECM are expected to be among the most vulnerable and highest-need Medi-Cal Managed Care Members. It will be critical for ECM Providers to establish strong relationships with these Members, and this will occur most effectively through in-person interactions. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider is permitted to use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.

This section describes the seven ECM core services. The core components of ECM that are universal for all Populations of Focus include (1) Outreach and Engagement; (2) Comprehensive Assessment and Care Management Plan; (3) Enhanced Coordination of Care; (4) Health Promotion; (5) Comprehensive Transitional Care; (6) Member and Family Supports; and (7) Coordination of and Referral to Community and Social Support Services. Notably, the nuances of supports and services provided through ECM will vary based on the needs of the Member. **Appendix B** contains detailed examples of interventions that ECM may support for each unique Population of Focus.

1) Outreach and Engagement

MCPs are responsible for identifying (or accepting referrals for) Members who are eligible for ECM. MCPs will then assign every Member authorized for ECM to an ECM Provider. ECM Providers are responsible for reaching out to, and engaging, assigned Members.

MCPs must develop comprehensive outreach Policies and Procedures as part of the MOC. Activities in the Outreach and Engagement core service can include, but are not limited to:

a. Attempting to locate, contact and engage Members who have been identified as good candidates to receive ECM services, promptly after assignment.
b. Using multiple strategies for engagement, as appropriate and to the extent possible, including direct communications with the Member, such as in-person meetings where the Member lives, seeks care or is accessible; mail, email, texts and telephone; community and street-level outreach; follow-up if the Member presents

to another partner in the ECM network; or using claims data to contact Providers the Member is known to use.

c. Using an active and progressive approach to outreach and engagement until the Member is engaged.
d. Documenting outreach and engagement attempts and modalities.
e. Utilizing educational materials and scripts developed for outreaching and engaging Members, as appropriate.
f. Sharing information between the MCP and ECM Providers, to ensure that the MCP can assess Members for other programs if they cannot be reached or decline ECM.
g. Providing culturally and linguistically appropriate communications and information to engage Members.

2) Comprehensive Assessment and Care Management Plan

After the initial step of successful engagement with an ECM Member, a comprehensive assessment should be conducted and a care plan developed. As part of the assessment, MCPs must include DHCS standardized Long Term Services and Supports (LTSS) referral questions[26] to identify and refer Members who may have LTSS needs, unless the Member has already answered these questions. This process involves the ECM Members and their family/support persons as well as appropriate clinical input in developing a comprehensive, individualized, person-centered care plan. The care plan is based on the needs and desires of the Member and should be reassessed based on the Member's individual progress or changes in their needs and/or as identified in the care plan. The care plan incorporates the Member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports and SDOH. Comprehensive care management may include case conferences to ensure that the Member's care is continuous and integrated among all service Providers.

Activities in the Comprehensive Assessment and Care Management Plan core service must include, but are not limited to:

a. Engaging with each Member authorized to receive ECM primarily through in-person contact.

b. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider must use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.

[26] Current LTSS questions are those established in APL 17-013: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-013.pdf .

c. 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.

d. 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.

e. 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.

f. 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.

g. Ensuring the Care Management Plan is reviewed, maintained, and updated under appropriate clinical oversight.

3) Enhanced Coordination of Care

Enhanced Coordination of Care includes the services necessary to implement the care plan. Enhanced Coordination of Care services must include, but are not limited to:

a. Organizing patient care activities, as laid out in the Care Management Plan; sharing information with those involved as part of the Member's multi-disciplinary care team; and implementing activities identified in the Member's Care Management Plan.

b. Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of Member goals and needs. Enhanced Coordination of Care may include case conferences in order to ensure that the Member's care is continuous and integrated among all service Providers.

c. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed.

d. 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.

e. Communicating the Member's needs and preferences in a timely manner to the Member's multi-disciplinary care team in an effort to ensure safe, appropriate and effective person-centered care.

f. Ensuring regular contact with the Member and their family member(s), guardian, AR, caregiver and/or authorized support person(s), when appropriate, consistent with the care plan and to ensure information is shared with all involved parties to monitor the Member's conditions, health status, care planning, medications usages and side effects.

4) Health Promotion

Health Promotion includes services to encourage and support Members receiving ECM to make lifestyle choices based on healthy behavior, with the goal of motivating Members to successfully monitor and manage their health. Health Promotion services can include, but are not limited to:

a. Working with Members to identify and build on successes and potential family and/or support networks.

b. Providing services, such as coaching, 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.

c. Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

d. Linking Members to resources for smoking cessation, management of Member chronic conditions, self-help recovery resources and other services based on Member needs and preferences.

e. Using evidence-based practices, such as motivational interviewing, to engage and help the Member participate in and manage their care.

5) Comprehensive Transitional Care

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

Comprehensive Transitional Care services include, but are not limited to:

a. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM. Examples include establishing agreements and processes to ensure prompt notification to the Member's Lead Care Manager; planning timely scheduling of follow-up appointments with recommended outpatient Providers and/or community partners; developing policies to arrange transportation for transitional care, including to medical appointments, as per Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) policy and procedures; and easing the Member's transition by addressing their understanding of rehabilitation activities, self-management activities and medication management.

b. For Members who are experiencing or are likely to experience a care transition:

    i. Developing and regularly updating a transition plan for the Member; this includes facilitating discharge instructions developed by a hospital discharge planner.

    ii. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges.

    iii. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members.

    iv. Coordinating medication review/reconciliation.

    v. Providing adherence support and referral to appropriate services.

6) Member and Family Supports

Member and Family Supports include activities that ensure the ECM Member and family/support are knowledgeable about the Member's conditions, with the overall goal of improving their adherence to treatment and medication management. Member and Family Supports could include, but are not limited to:

a. Documenting a Member's authorized family member(s), guardian, AR, caregiver and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM Providers; the Member and/or their family member(s), AR, guardian, caregiver and/or authorized support person(s); and Contractor, as applicable.

b. Conducting activities to ensure the Member and/or their family member(s), guardian, AR, caregiver and/or authorized support person(s) are knowledgeable about the

Member's condition(s), with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.

c. Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and/or family member(s), guardian, AR, caregiver and/or other authorized support person(s).

d. Identifying supports needed for the Member and/or their family member(s), AR, guardian, caregiver and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services and assist them with making informed choices.

e. Providing for appropriate education of the Member and/or their family member(s), guardian, AR, caregiver and/or authorized support person(s) about care instructions for the Member.

f. Ensuring that the Member has a copy of his/her care plan and information about how to request updates.

7) Coordination of and Referral to Community and Social Support Services

Coordination of and Referral to Community and Social Support Services involves determining appropriate services to meet the needs of Members receiving ECM, to ensure that any present or emerging social factors can be identified and properly addressed. Coordination of and Referral to Community and Social Support Services could include, but are not limited to:

a. Determining appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services offered by Contractor as Community Supports.

b. Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

VI. Program Overlaps and Exclusions

ECM will coordinate all care for the highest-risk Members with complex medical and social needs, including across the physical and behavioral health delivery systems. Many Members who will be eligible for ECM may already be receiving some care management through other programs. In many of these instances, the ECM benefit will be additive, improve management of care across delivery systems, and comprehensively address any unmet medical and/or social needs. DHCS has determined three approaches for how ECM may overlap with existing programs that provide care management/care coordination services. Below is a summary of the programs that have been considered and the three potential approaches.

Figure 1: Summary of Approaches to ECM Overlaps/Non-duplication in 2022

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

1. ECM as a "wrap"	MCP 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. MCP must ensure non-duplication of services between ECM and the other program.

2. Either ECM or the other program	MCP Members can be enrolled in ECM or in the other program, not in both at the same time.
3. Not Eligible to Enroll in ECM	Medi-Cal beneficiaries enrolled in the other program are excluded from ECM.

Ultimately, MCPs are responsible for ensuring non-duplication of services provided through ECM and any other program(s). As such, MCPs should regularly check available data feeds to evaluate which of their Members might be enrolled in other programs that provide care coordination. In addition, MCPs should establish processes and requirements to ensure ECM Providers ask Members about their participation in other programs as part of the in-person comprehensive assessment and care planning process.

The section below offers additional guidance about the relationship between ECM and the other programs listed in the diagram above.

ECM Interactions with Other Care Management Programs for Adults

1915(c) Waiver Programs

1915(c) Waiver Programs:
MCP Members can be enrolled in ECM or in a 1915(c) waiver program, not in both at the same time.

- 1915(c) waiver programs provide services to many Medi-Cal Members who will likely also meet the eligibility criteria for ECM (by belonging to at least one of the Populations of Focus).
- There are comprehensive care management components within the 1915(c) waiver programs that are duplicative of ECM services.
- Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving ECM services.

Programs Carved Out of Managed Care

County-specified Targeted Case Management (TCM):[27]

[27] County-specified TCM is distinct from TCM provided as a component of Specialty Mental Health Services (SMHS), which is covered below.

MCP Members can be enrolled in ECM and county-specified TCM. ECM may enhance and/or coordinate across the case/care management available in county-specified TCM. ***The MCP must ensure non-duplication of services between ECM and county-specified TCM.***

- The TCM program is an optional Medi-Cal program funded by federal and local funds, serving approximately 30,000 Medi-Cal beneficiaries each year. **See Appendix C: Targeted Case Management** for which counties currently participate.
- CMS requires that states require non-duplication between TCM and other care management approaches; however, CMS requirements do not prohibit Members from receiving both TCM and ECM at any given time, as long as the state ensures that services are not duplicated.
- MCPs are responsible for analyzing whether TCM is duplicative of ECM at the county program level and at the Member level.
    - ECM will act as a "wrap" on TCM **where TCM is not comprehensive** (e.g., in a county that offers specific homelessness interventions via TCM but without coordination of other health and social needs).
    - If an MCP determines that the TCM **is comprehensive** and therefore substantially duplicative of ECM, the MCP must ensure that individuals do not receive both in that county.
- MCPs are expected to work with Local Governmental Agencies (LGAs) to ensure that Members receiving ECM services do not receive duplicative TCM services.
- Specifically, MCPs are required to demonstrate how they will prevent duplication in their respective Models of Care. The MOC Template requires MCPs to (a) list the TCM populations that LGAs are serving in each county they operate in, and (b) explain how the MCP will work with the county to ensure that Members do not receive duplicative services between ECM and TCM.

Specialty Mental Health Services (SMHS) Targeted Case Management (TCM):

MCP Members can be enrolled in ECM and SMHS TCM. ECM enhances and/or coordinates across the case/care management available in SMHS TCM. MCP must ensure non-duplication of services between ECM and SMHS TCM.

- DHCS administers the SMHS program, which is "carved out" of the broader Medi-Cal program under the authority of a 1915(b) waiver approved by CMS.
- The SMHS waiver program is administered locally by each county's Mental Health Plan (MHP), and each MHP provides, or arranges for, SMHS for Medi-Cal beneficiaries, including SMHS TCM and Full Service Partnerships (FSPs).
- MCP Members receiving SMHS TCM and FSP services from counties can also be eligible for and receive ECM services.

- MCPs are required to work with counties to identify Members receiving SMHS TCM or FSP services and ensure non-duplication of services.
- MCPs are required to prioritize contracting with county behavioral health Providers, as stated in the ECM and Community Supports Contract Template Provisions: 3. ECM Providers.
- If an MCP Member receives services from a Specialty Mental Health Plan, and the Member's behavioral health Provider is a contracted ECM Provider, the MCP must assign that Member to the behavioral health Provider as the ECM Provider.

Drug Medi-Cal Organized Delivery Systems (DMC-ODS) and Drug Medi-Cal (DMC) Program:

MCP Members can be enrolled in ECM and the DMC-ODS/DMC Program. ECM enhances and/or coordinates across the case/care management available in the DMC-ODS/DMC Program. MCP must ensure non-duplication of services between ECM and the DMC-ODS/DMC Program.

- MCP Members participating in the DMC-ODS/DMC Program can also receive ECM services, so long as they also meet the eligibility criteria for ECM (by belonging to at least one of the Populations of Focus).
- Given that many Members receiving services through the DMC-ODS/DMC Programs are also likely to be receiving SMHS TCM, MCPs are required to ensure non-duplication of services across all three programs.
- Please refer to Appendix C for an overview of counties participating in the DMC-ODS/DMC Programs.

Genetically Handicapped Person's Program (GHPP)

MCP Members can be enrolled in ECM and the GHPP. ECM enhances and/or coordinates across the case/care management available in the GHPP. MCP must ensure non-duplication of services between ECM and the GHPP.

- There are approximately 1,500 individuals enrolled in the GHPP program across the state; approximately 650 of them are also enrolled in Medi-Cal Managed Care.
- MCP Members participating in the GHPP can also receive ECM services, so long as they also meet the eligibility criteria for ECM (by belonging to at least one of the Populations of Focus).

Programs Carved into Managed Care

Basic and Complex Case Management:

MCP Members can be enrolled in ECM or in either Basic or Complex Case Management, not in both at the same time.

MCPs are required to offer Basic and Complex Case Management for Medi-Cal Managed Care Members. Please refer to Medi-Cal Managed Care Boilerplate Contract Exhibit A, Attachment 11, Provision 1. Comprehensive Care Management Including Coordination of Care Services.

Basic Case Management Services are provided by the Primary Care Provider, in collaboration with the MCP, and include:

- Initial Health Assessment (IHA);
- Individual Health Education Behavioral Assessment (IHEBA);
- Identification of appropriate Providers and facilities (such as medical, rehabilitation and support services) to meet Member care needs;
- Direct communication between the Provider and Member/family;
- Member and family education, including healthy lifestyle changes when warranted; and
- Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

Complex Case Management Services are provided by the MCP, in collaboration with the Primary Care Provider, and include, at a minimum:

- The same services as covered by Basic Case Management;
- Management of acute or chronic illness, including emotional and social support issues, by a multidisciplinary case management team;
- Intense coordination of resources to ensure the Member regains optimal health or improved functionality;
- With Member and Primary Care Provider (PCP) input, development of care plans specific to individual needs, and updating of these plans at least annually;

MCP Members can only be enrolled in one case/care management approach at any given time. In addition, MCPs must assess the needs of their Members to determine which level of care management is most appropriate.

For Members transitioning from the WPC Pilots and HHP, the MCP must ensure that each Member is reassessed to determine the most appropriate level of care management or coordination of services. Basic or Complex Case Management may be alternatives to ECM that meet the needs of a Member who does not need the intensity of services offered by ECM.

Community-Based Adult Services (CBAS):

MCP Members can be enrolled in ECM and receive CBAS services. ECM enhances and/or coordinates across the case/care management available in CBAS centers. MCP must ensure non-duplication of services between ECM and CBAS centers.

- CBAS and ECM services are complementary.
- ECM can serve as a “wrap” and offer comprehensive care management beyond the services provided through CBAS, which are primarily provided within the four walls of the CBAS center.

- Given their connection to community resources, CBAS centers may also be well positioned to serve as ECM Providers.

Dual-Eligible Members

2022 Policies

Dual eligible Medi-Cal Members may be eligible for ECM in 2022 if they meet the applicable Population of Focus criteria, and if they are **not** enrolled in any the following programs: Cal MediConnect (CMC), Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), Program for All-Inclusive Care for the Elderly (PACE), 1915(c) waivers, or CCT, as these plans/programs offer comprehensive care management that is duplicative of ECM services.

However, all dual eligible Members receiving HHP/WPC Pilot services have transitioned and were automatically authorized to receive ECM. See Figure 2 below for an overview of which dual eligible Members are eligible to receive ECM in 2022. DHCS strongly encourages MCPs to offer ECM to dual eligible Members, particularly when MCPs have information about Members receiving home and community-based services (HCBS). Additionally, dual eligible Members may be enrolled in Medicare Advantage plans or D-SNPs. DHCS highly encourages these MCPs to explore data sharing possibilities and coordination with the Medicare plan, particularly if the Medicare plan and MCP are affiliated.

Figure 2: Overview of ECM Eligibility for Dual-Eligible Members in 2022

Medicaid & Medicare Delivery Model or Other Programs	ECM Eligible
Cal MediConnect	**No**
FIDE-SNPs	**No**
PACE Programs	**No**
Medi-Cal MCP + Medicare FFS	**Yes**
Medi-Cal MCP + Other MA	**Yes**
Medi-Cal MCP + D-SNP Look-alike	**Yes**
Medi-Cal MCP + D-SNP	**Yes**
Medi-Cal FFS + Medicare FFS or Plan *(not MCP enrolled)*	**No**
Any other excluded program (e.g., 1915(c), CCT)	**No**

2023 Policies (Added May 2022):

For dual eligible Members eligible for ECM and also enrolled in a D-SNP, DHCS recognizes there is significant overlap across the D-SNP Model of Care and ECM requirements. As a result, there is potential for duplication and confusion for Members and care teams if both D-SNP care coordination and ECM are in place simultaneously, particularly for Members in D-SNPs with LTSS needs. To avoid duplication and confusion, beginning in 2023 DHCS will strengthen expectations for D-SNPs to provide comprehensive care coordination. **Thus, from 2023 onwards, DHCS will phase out Medi-Cal ECM eligibility for Medi-Cal MCP Members who are also enrolled in D-SNPs, as summarized below.** Over time, DHCS state-specific D-SNP model of care requirements will be more closely aligned with ECM requirements.

- The 2023 D-SNP Policy Guide will reflect the intent for Exclusively Aligned Enrollment (EAE) D-SNPs to provide sufficient care management so that members that would otherwise qualify for ECM receive an equivalent level of care coordination through their D-SNP.

- 2024 state-specific Model of Care Requirements for all D-SNPs will contain additional requirements for integrating elements of ECM into the D-SNP model of care, to be developed collaboratively with stakeholders.

DHCS will issue forthcoming guidance regarding continuity of care requirements for dual eligible Members engaged in ECM and who subsequently enroll in an EAE D-SNP, PACE, or FIDE-SNP.

Policies on availability of ECM for all other dual eligible Medi-Cal Members will remain unchanged in 2023 from 2022, as summarized below.

Figure 3: Overview of ECM Eligibility for Dual-Eligible Members in 2023 and Beyond

Medicaid & Medicare Delivery Model	ECM Eligible
Medi-Cal MCP + EAE D-SNPs	**No**
FIDE-SNPs	**No**
PACE Programs	**No**
Medi-Cal MCP + Medicare FFS	**Yes**
Medi-Cal MCP + Other MA	**Yes**
Medi-Cal MCP + non EAE D-SNP	**Yes in 2023; No from 2024**

Medi-Cal FFS + Medicare FFS or Plan ***(not MCP enrolled)***	**No**
Any other excluded program (e.g., 1915(c), CCT)	**No**

Other Programs

California Community Transitions (CCT) Money Follows the Person (MFTP)

MCP Members can be enrolled in ECM or in CCT MFTP, not in both at the same time.

Family Mosaic Project Services

Medi-Cal beneficiaries enrolled in Family Mosaic Project Services are excluded from ECM.

Hospice Recipients

MCP Members receiving hospice are excluded from ECM. The ECM benefit is fundamentally person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, members receive needed services in a supportive, effective, efficient, timely, and cost-effective manner. ECM emphasizes prevention, health promotion, continuity and coordination of care.

ECM Interactions with Other Care Management Programs for Children/Youth

California Children's Services (CCS) Classic,
CCS Whole Child Model (WCM)
Specialty Mental Health Services (SMHS) Intensive Care Coordination for Children (ICC)

Guidance forthcoming.

VII. ECM Provider Network

Overview of ECM Providers
ECM will be delivered primarily by community-based ECM Providers that enter into contracts with MCPs. To provide Members with ongoing care coordination previously provided in HHP and WPC Pilot counties, MCPs are expected to contract with each WPC Lead Entity or HHP Community-Based Care Management Entity (CB-CME) as an ECM Provider unless there is an applicable exception. All contracting exceptions must be approved by DHCS in advance. DHCS also expects MCPs to work in close collaboration, and prioritize contracting with, county behavioral health systems, who often are the primary Providers of services to a subset of Medi-Cal beneficiaries.

ECM Providers may include, but are not limited to, the following entities:

- Counties;
- County behavioral health Providers;
- Primary Care Providers or Specialist or Physician groups;
- Federally Qualified Health Centers;
- Community Health Centers;
- CBOs;
- Hospitals or hospital-based Physician groups or clinics (including public hospitals and district and/or municipal public hospitals);
- Rural Health Clinics and/or
- Indian Health Service Programs;
- Local health departments;
- Behavioral health entities;
- Community mental health centers;
- SUD treatment Providers;
- Community Based Adult Services (CBAS) Providers;
- Skilled Nursing Facilities;
- Organizations serving individuals experiencing homelessness;
- Organizations serving justice-involved individuals;
- CCS Providers; and
- Other qualified Providers or entities that are not listed above, as approved by DHCS.

Requirements to Be an ECM Provider
ECM and Community Supports *Providers as Medi-Cal Enrolled Providers*
MCP Network Providers (including those that will operate as ECM or Community Supports Providers) are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so. However, many ECM and Community Supports Providers (e.g., housing agencies, medically tailored meal Providers) may not have a corresponding state-level enrollment pathway and are not required to enroll in the Medi-Cal program. These Providers must be vetted by the MCP in order to participate as ECM Providers, as described below.

Process for Medi-Cal Enrollment

For those ECM and Community Supports Providers with a state-level Medi-Cal enrollment pathway, the process for enrolling would be identical to what happens today. The Provider would have to enroll through the DHCS Provider Enrollment Division, or the MCP can choose to have a separate enrollment process.

Clarifying Relationship with Provider "Credentialing" Requirements of APL 19-004
The credentialing requirements articulated in APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment only apply to Providers with a state-level pathway for Medi-Cal enrollment. ECM and Community Supports Providers without a state-level pathway to Medi-Cal enrollment are **not** required to meet the credentialing requirements in APL 19-004 in order to become "in-network" ECM and/or Community Supports Providers, but must be vetted by the MCP in order to participate. Furthermore, DHCS will not set licensing requirements for ECM care managers. MCPs should use and build on the processes they have already established for vetting the qualifications and experience of ECM Providers.

To include an ECM and Community Supports Provider in their networks when there is no state-level Medi-Cal enrollment pathway, MCPs are required to vet the qualifications of the Provider or Provider organization to ensure they can meet the standards and capabilities required to be an ECM or Community Supports Provider. MCPs must submit Policies and Procedures for how they will vet the qualifications of ECM and Community Supports Providers in their submission of Part 2 of the MOC. MCPs must create and implement their own processes to do this. Criteria MCPs may want to consider as part of their process include, but are not limited to:

- Ability to receive referrals from MCPs for ECM or the authorized Community Supports;
- Sufficient experience to provide services similar to ECM for Populations of Focus and/or the specific Community Supports for which they are contracted to provide;
- Ability to submit claims or invoices for ECM or Community Supports using standardized protocols;
- Business licensing that meets industry standards;
- Capability to comply with all reporting and oversight requirements;
- History of fraud, waste and/or abuse;
- Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and
- History of liability claims against the Provider.

The same principles would apply to any ECM Provider or Community Supports Provider for whom there is no state-level enrollment pathway.

ECM Provider Capacity
MCPs are required to contract with Providers that have experience serving the Populations of Focus, and that have expertise providing core ECM-like services. Because ECM will be a benefit, once an ECM Population of Focus is implemented in a county, MCPs must provide ECM to all

eligible Members if they request it, and MCPs will be responsible for ensuring sufficient ECM Provider capacity to meet the needs of all ECM Populations of Focus in the counties in which they operate. However, DHCS recognizes that ECM Provider network development will take time, and expects MCPs to expand ECM network capacity over the first 12 months and on an ongoing basis, as well as for each Population of Focus.

MCPs will report on their ECM Provider capacity to DHCS initially in their MOC Template, and on an ongoing basis pursuant to DHCS reporting requirements. Additionally, MCPs are required to report 60 days in advance or as soon as possible on significant changes to ECM Provider capacity.

MCP Serving as ECM Provider
If an MCP is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus in a community-based manner through contracts with ECM Providers, they may request written approval for an exception to use their own staff to deliver ECM services. In these limited circumstances, MCP staff must also comply with all the requirements of being an ECM Provider (e.g., providing ECM services through in-person interactions and in the community). Any such request must be submitted in accordance with DHCS guidelines and must evidence one or more of the following:

- There are insufficient ECM Providers, or a lack of ECM Providers with experience and expertise to provide ECM for one or more of the Populations of Focus in one or more counties;
- There is a justified quality-of-care concern with one or more of the otherwise qualified ECM Providers;
- Contractor and the ECM Provider(s) are unable to agree on contracted rates;
- ECM Provider(s) is/are unwilling to contract;
- ECM Provider(s) is/are unresponsive to multiple attempts to contract;
- (For ECM Providers that have a state-level pathway to Medi-Cal enrollment) Provider(s) is/are unable to comply with the Medi-Cal enrollment process; or
- (For ECM Providers without a state-level pathway to Medi-Cal enrollment) Provider(s) is/are unable to comply with Contractor's processes for vetting ECM Providers.

During any exception period approved by DHCS, the MCP must take steps to continually develop and increase the capacity of its ECM Provider Network. The initial exception period will be in effect no longer than one year. After the initial one-year period, the MCP must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis. Ultimately, these procedures have been established to align with the vision of providing ECM services through an in-person, community-based approach.

Experience Serving the ECM Populations of Focus:
ECM Providers may serve one or more of the Populations of Focus with which they have experience and expertise in serving, as well as the services they are proposing to provide to Members. ECM Providers do not have to have prior experience serving Medi-Cal MCP Members

specifically. MCPs should determine what they deem as “sufficient experience” and describe it in their MOC.

Culturally Appropriate and Timely Care
ECM Providers must have the capacity to provide culturally appropriate and timely in-person care management activities. ECM Providers and Lead Care Managers must meet Members where they are in terms of the physical location that is most convenient and desirable for the Member to engage in services and from a medical management and plan of care perspective. ECM Providers must be able to communicate with Members in a culturally and linguistically appropriate and accessible way.

Formal Agreements with Other Entities
ECM Providers should also have formal agreements 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. MCPs have the discretion to determine which agreements are necessary or acceptable to meet this requirement, acknowledging that provider organizations will vary greatly in their capacity to share data outside their four walls.

Care Management Documentation System
ECM Providers 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 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. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication; and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital or long-term care facility, housing status).

Transitioning HHP Model II and Model III
For MCPs that are transitioning their HHP to ECM and operate in alignment with either Model II or Model III, as described in the HHP Program Guide, DHCS expects that efforts will be made to shift those models to a more community-based Provider approach with less reliance on MCP staff in the provision of ECM. DHCS expects MCPs to submit a contract exception outlined in Section 4 of the Contract Template and will continue monitoring MCPs progress toward a community-based provider approach.

ECM Provider Payment
MCPs must pay contracted ECM Providers for the provision of ECM in accordance with contracts established between MCPs and each ECM Provider. MCPs must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member. MCPs are encouraged

to tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.

ECM Provider Directory

Effective no later than July 1, 2022:

1. MCPs are to list all ECM and Community Support Providers in the Provider Directory as Other Services Providers.
    a. If it is feasible, DHCS is requesting for MCPs to specify if a Provider is an ECM or Community Supports Provider.
    b. DHCS recognizes some MCPs already have a section for Other Services Providers.
    c. DHCS recognizes some MCPs may have to **create a new** "Other Services Providers" section.
2. MCPs will need to add a disclaimer in the Directory stating that both ECM and Community Supports require prior authorization and are limited to members who meet specific eligibility criteria.
3. DHCS may accept the use of symbols denoting ECM or Community Supports providers that may be listed in other sections of the Directory in lieu of listing providers multiple times.

VIII. Engaging Members in ECM

Identifying Members for ECM
MCPs are responsible for regularly and proactively identifying Members who may benefit from ECM and who meet the criteria for the Populations of Focus. To do this effectively, MCPs must consider Members' health care utilization; needs across physical, behavioral, developmental and oral health; health risks and needs due to social determinants of health; and LTSS needs.

There are a number of potential data sources MCPs can leverage to identify Members for ECM, including but not limited to:

- Enrollment data;
- Encounter data;
- Utilization/claims data;
- Pharmacy data;
- Laboratory results data;
- Assessment data;
- Clinical information on physical and/or behavioral health;
- Health Information Form (HIF)/Member Evaluation Tool (MET) data;
- DHCS standardized "Staying Healthy" assessment tools or alternative Individual Health Education Behavioral Assessment (IHEBA) tools approved by DHCS and utilized by Primary Care Providers;
- Health Risk Stratification and Assessment survey for Seniors and Persons with Disabilities (SPD);
- SMI/SUD data, as available;
- Risk stratification information for children in County Organized Health System (COHS) counties with Whole Child Model programs;
- Information about social determinants of health, including standardized assessment tools and/or ICD-10 codes;
- Results from any available Adverse Childhood Experience (ACE) screening; and
- Other cross-sector data and information, including housing, social services, foster care, criminal justice history and other information relevant to the ECM Populations of Focus (e.g., Homeless Management Information System (HMIS), available data from the education system).

MCPs will need to rely on a combination of information provided by DHCS on a regular basis and data internal to the plan. DHCS provides encounter data including physical and behavioral health utilization, to MCPs monthly in a standard file format. For example, to identify Members who are

high utilizers, MCPs could rely on the frequency of utilization reflected in the data feeds from DHCS. Whenever feasible, MCPs should also consider any data or relevant characteristics provided as part of data exchanged between the MCP and Provider organizations.

Another important avenue for Member identification is through referrals. MCPs are contractually obligated to inform Members and their families, guardians and caregivers, ECM Providers, Community Supports Providers, other Providers, and CBOs, about ECM, the ECM Populations of Focus, and how to request ECM. MCPs must consider requests for ECM from Members and on behalf of Members from all of the entities described above. It is expected that MCPs will establish strong referral relationships with ECM Providers and other CBOs, including developing a process for receiving and responding to referral requests from ECM Providers and other entities. For example, shelters, homeless services Providers, recuperative care Providers and other service Providers will be better positioned to identify individuals and families experiencing homelessness. Similarly, county behavioral health plans will be well-positioned to refer Adults with SMI and SUD who may benefit from ECM.

MCP Member Handbook and Public-Facing Websites
The MCP Member Handbook and public-facing website(s) must include up to date Member and provider facing information about ECM and how to request access to ECM.

Authorizing ECM for MCP Members
MCPs and/or their subcontractors or contracted Providers will evaluate Member eligibility for ECM and authorize individuals for ECM. MCPs are responsible for developing Policies and Procedures that explain how they will verify eligibility and authorize ECM for eligible Members in an equitable and non-discriminatory manner without disrupting their care.

For requests from Providers, other external entities, Members or family:

- MCP must ensure that authorization or a decision not to authorize ECM occurs as soon as possible (i.e., within five working days for routine authorizations and within 72 hours for expedited requests), in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization and APL 21-011: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
- If MCP does not authorize ECM, Contractor must ensure the Member and the requesting individual or entity (as applicable) who requested ECM on a Member's behalf are informed of the Member's right to appeal and the appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeal System, and APL 21-011: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
- For Members who were not authorized to receive ECM, Contractor must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System, and APL 21-011: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

- To inform Members that ECM has been authorized, Contractor must follow its standard notice process outlined in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and APL 21-011: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

MCPs are encouraged to work with ECM Providers to define a process and appropriate circumstances for presumptive authorization or preauthorization of ECM, whereby select ECM Providers would be able to directly authorize ECM and be paid for ECM services for a fixed period of time until Contractor authorizes or denies ECM based on a complete assessment of Member eligibility for ECM consistent with Population of Focus criteria. There may be a subset of high-performing Providers with the MCPs' contracted Network of Providers for whom this capability would make sense.

Automatically Authorizing ECM for Members Who Receive ECM and Change their Plan Selection/Enrollment (*Updated May 2022)*

Full Continuity of Care (COC) requirements do not apply to the ECM benefit.

However, Medi-Cal managed care Members who were receiving ECM in their previous MCP should continue receiving ECM when they enroll in a new MCP. As such, the new MCP must automatically authorize ECM for a newly enrolled Member if any the following conditions apply:

1. The previous MCP informs the new MCP that the Member received ECM during the last 90 days of enrollment in the previous MCP and did not subsequently either meet graduation criteria or choose to discontinue ECM;
2. Historical utilization data provided to the new MCP by DHCS (referred to as the Plan Data Feed) reveals one or more ECM HCPCS codes for ECM services delivered during the last 90 days of enrollment in the previous MCP;
3. The Member, family or authorized representative notifies the new MCP that the Member received ECM during the last 90 days of enrollment in the previous MCP and wishes to continue to do so;
4. The Member's previous ECM Provider notifies the new MCP that the Member received ECM during the last 90 days of enrollment in the previous MCP and recommends continuation of ECM; or
5. The new MCP becomes aware that a newly enrolled Member received ECM during the last 90 days of enrollment in the previous MCP, in any other way.

The new MCP must not implement any other steps to authorize ECM for newly enrolled Members who were receiving ECM in their previous MCP (including obtaining consent to ECM services) if any of the listed conditions for automatic authorization apply. Rather, the new MCP must assign the Member to an ECM Provider for outreach and continuation of ECM, in accordance with its DHCS- approved ECM Policies and Procedures. To promote smooth transitions, the new MCP must assign the Member to the same ECM Provider, to the extent its network aligns, unless the Member desires to change their ECM Provider. The new MCP must work with the previous MCP, ECM Provider and/or Member to obtain access to the Member's

Care Management Plan and transmit to the new ECM Provider (as applicable) to mitigate any gaps in care. The new MCP should apply its usual Policies and Procedures for reassessment against discontinuation criteria to determine if and when the Member may be stepped down from ECM.

Please note: DHCS reserves the right to establish different COC requirements for upcoming managed care plan transitions resulting from county plan model changes or MCP market entry and exits.

Assignment to an ECM Provider

MCPs will assign every Member authorized for ECM to an ECM Provider. MCPs will be responsible for maintaining a network of ECM providers with the appropriate competencies to serve all populations of focus, and MCPs should aim to assign members to ECM providers that have the appropriate capacities to meet their needs. Note that some Members authorized to receive ECM may meet the criteria for multiple Populations of Focus. MCPs will assign these individuals to an ECM Provider that has appropriate competencies and experience for the needs of the Member. For example, individuals with SUD may also be people experiencing homelessness. These Members may be assigned to an ECM Provider that has the necessary skills and experience to work with SUD and homeless populations.

MCPs will develop a process to disseminate information about assigned Members to ECM Provider(s) on a regular cycle, and will ensure that communication of Member assignment to the designated ECM Provider occurs within ten (10) business days of authorization. MCPs are also required to document the Member's ECM Lead Care Manager, who will serve as the point of contact for the Member, in its system of record.

Listed below are additional guidelines for the ECM Provider assignment process.

Member Preference

If Member preference for a specific ECM Provider is known to the MCP, the MCP must honor that preference when assigning the ECM Provider, to the extent practicable. Further, MCPs must permit Members to change ECM Providers at any time and are expected to implement any requested ECM Provider change within 30 days to the extent the requested ECM Provider is able to accommodate the change.

Member Primary Care Provider (PCP)

If the Member's assigned PCP is a contracted ECM Provider, the MCP must assign the Member to the PCP as the ECM Provider, unless the Member has expressed a different preference or MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions. The MCP must notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten (10) business days of the date of assignment.

Member Behavioral Health Provider

If a Member receives services from a Specialty Mental Health Plan for SUD and/or SMI, and the Member's Behavioral Health Provider is a contracted ECM Provider, the MCP must assign that

Member to that Behavioral Health Provider as the ECM Provider, unless the Member has expressed a different preference or the MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

Initiating Delivery of ECM

Member Consent
MCPs must not require ECM Providers or their own staff to obtain Member consent to participate (in writing or otherwise) as a condition of initiating delivery of ECM, unless required by federal law. DHCS removed documentation requirements to streamline and simplify implementation of the benefit. However, an individual may decline to engage in or continue ECM at any time.

Written Authorization for ECM-related Data Sharing
MCPs are not required to obtain Member authorization (in writing or otherwise) for data sharing as a condition of initiating delivery of ECM, unless such authorization is required by federal law. MCPs must develop Policies and Procedures with their Network of ECM Providers to:

- Where required by federal law, ensure that Members authorize information sharing with the Contractor and all others involved in the ECM Member's care as needed to support the Member and maximize the benefits of ECM.
- Communicate Member-level record of written authorization to allow data sharing (once obtained) back to the MCP.

Dedicated Lead Care Manager
MCPs are required to ensure that each Member receiving ECM has a dedicated Lead Care Manager with responsibility for interacting directly with the Member and/or family, Authorized Representatives (ARs), caretakers, and/or other authorized support person(s), as appropriate. The assigned Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify gaps in the Member's care and ensure appropriate input is obtained to effectively coordinate all primary, behavioral, developmental, oral health, LTSS, Community Supports and other services that address social determinants of health (SDOS), regardless of setting, at a minimum. DHCS is not providing required staffing ratios for the number of Members who can be served by each care manager at this time.

Member-level Records
MCPs are required to ensure that accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

Discontinuing Delivery of ECM
Circumstances for Discontinuing ECM
Members are able to decline or end ECM upon initial outreach and engagement, or at any other time. ECM Providers will be required to notify MCPs to discontinue ECM for Members when any of the following circumstances are met:

- The Member has met all care plan goals;
- The Member is ready to transition to a lower level of care;

- The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage (this can include instances when a Member's behavior or environment is unsafe for the ECM Provider); or
- The ECM Provider has not been able to connect with the Member after multiple attempts.

Reassessment & Transitioning Members from ECM ***(Updated May 2022)***
As mentioned in Section V: Core Service Components, there is not a required annual reassessment for Members receiving ECM. Instead, MCPs must ensure that Members are reassessed at a frequency appropriate for their individual progress or changes in needs and/or as identified in the Care Management Plan. Further, MCPs should reassess Members against their ECM discontinuation criteria, **not** the ECM Population of Focus eligibility criteria, to evaluate whether Members are ready to transition out of ECM. MCPs must develop processes for transitioning Members from ECM to lower levels of care management to provide coordination of ongoing needs.

Notice of Action (NOA) Process
MCPs are required to develop processes to determine discontinuation of ECM and notify ECM Providers to initiate discontinuation of services in accordance with the Notice of Action (NOA) process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals, and APL 21-011: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

MCPs must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to appeal and the appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals, and APL 21-011: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

IX. Data System Requirements & Data Sharing to Support ECM

The vision of ECM is to embrace and integrate a greater diversity of non-traditional Providers in the delivery of whole-person care. DHCS acknowledges the tremendous investment required of both MCPs and Provider organizations to realize this vision from an information technology infrastructure and data sharing perspective. To that end, DHCS has developed comprehensive guidance to support standardized information exchange, increase efficiency and reduce administrative burden between MCPs and ECM and Community Supports Providers. Please see the Member Level Information Sharing Between MCPs and ECM Providers guidance document for a comprehensive overview of the standards for data exchange between MCPs and ECM Providers. In addition, listed below are high-level data system requirements for MCPs, along with data sharing requirements for MCPs and ECM Providers.

Data System Requirements
MCPs are required to have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:

- Consume and use claims and encounter data, as well as other data types listed in ECM Contract Template Section 7: Identifying Members for ECM, to identify Populations of Focus;
- Assign Members to ECM Providers;
- Keep records of Members receiving ECM and authorizations necessary for sharing Personally Identifiable Information between Contractor and ECM and other Providers, among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by Contractor;
- Securely share data with ECM Providers and other Providers in support of ECM;
- Receive, process and send encounters and invoices from ECM Providers to DHCS in accordance with DHCS standards;
- Receive and process supplemental reports from ECM Providers;
- Send ECM supplemental reports to DHCS; and
- Open, track and manage referrals to Community Supports Providers.

Data Sharing Requirements for MCPs
In order to support ECM, MCPs shall provide, at a minimum, the following information to all ECM Providers:

- Member assignment files, which include a listing of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
- Historical encounters/claims data for assigned Members;
- Physical, behavioral and administrative information, and information indicating Member social determinants of health (SDOH) needs, as specified on previously submitted claims encounters or identified through other data sources (e.g., HMIS) for assigned Members; and
- Reports of performance on quality measures and/or metrics, as requested.

MCPs are required to use defined federal and state standards, specifications, code sets and terminologies when sharing physical, behavioral, social and administrative data with ECM Providers and with DHCS. Please see the Member Level Information Sharing Between MCPs and ECM Providers guidance document for a comprehensive overview of the standards for data exchange between MCPs and ECM Providers.

Data Sharing Requirements for ECM Providers
DHCS' vision is that ECM Providers will submit encounters to MCPs for transmission to DHCS. Providers that do not have these capabilities will be allowed to submit invoices to MCPs.

DHCS is not specifying the payment model between MCPs and Providers for ECM, though DHCS encourages plans and Providers to adopt or progress to value-based payment models for ECM. Regardless of payment model or reimbursement modality, MCPs are expected to collect encounters from Providers for submission to HCS.

X. Oversight of ECM Providers

MCP Requirements
MCPs are required to perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in the ECM and Community Supports Contract Template, the MCP's MOC, and any associated guidance issued by DHCS. MCPs are expected to use ECM Provider Standard Terms and Conditions (STCs) to develop ECM contracts with ECM Providers, and are expected to incorporate all ECM Provider requirements reviewed and approved by DHCS as part of their MOC, including all monitoring and reporting criteria. To streamline the ECM implementation:

- MCPs must hold ECM Providers responsible for the same reporting requirements as those that the MCP must report to DHCS.
- MCPs will not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting.
- MCPs are encouraged to collaborate with other MCPs within the same county on oversight of ECM Providers.

NCQA Accreditation Requirements
In order to maximize ECM and Community Supports Provider networks and ease provider burden, the ECM Community Supports Contract Section 3.h specifies that the MCP *" shall not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of contracting as an ECM Provider."* Additionally, MCPs must not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.

All MCPs must be NCQA accredited by 2026. DHCS understands that MCPs may need to meet NCQA requirements as they pertain to their delivery of Complex Case Management (CCM) and that it can be helpful to NCQA and the MCPs if the state clarifies its position in formal guidance.

The below framework and core principles may be used by MCPs in their efforts on meeting NCQA accreditation.

1. A Managed Care Plan (MCP) may, or may not, choose to integrate the CCM program with ECM by delegating CCM functions to community-based ECM Providers. The MCP may decide to retain the CCM functions as MCP-operated functions, and keep the ECM functions separate and distinct.
2. If the MCP decides to retain the CCM functions, rather than delegating them to community-based ECM Providers, then CCM would not be considered to be delegated, and no CCM pre-delegation review activities would be required for community-based ECM Providers.
3. However, if the MCP decides to delegate CCM functions to ECM Providers, then these ECM Providers would be subject to CCM pre-delegation review requirements.

4. If the MCP delegates CCM, then the pre-delegation review would be the responsibility of the MCP. States may take on this responsibility in other parts of the country, but California will not do this.

DHCS continues to finalize guidance for ECM as it relates to NCQA and will make updates to the ECM Policy Guide as necessary.

Training
As previously stated, MCPs must notify all Providers in their network about ECM and Community Supports to enable appropriate referrals of their Members. MCPs must also provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars and/or calls, as necessary, in addition to Network Provider training requirements described in Medi-Cal Boilerplate Template, Exhibit A, Attachment 7, Provision 5, Network Provider Training.[28]

Subcontracting Agreements

MCPs may subcontract with other entities to administer ECM, provided they adhere to the below requirements:

- MCPs will maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting;
- MCPs will be responsible for developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions;
- MCPs will be responsible for evaluating the prospective Subcontractor's ability to perform services;
- MCPs will remain responsible for ensuring the Subcontractor's ECM Provider capacity is sufficient to serve all Populations of Focus;
- MCPs will report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or counties in which Members are served; and
- MCPs will make all Subcontractor agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation.

It is well understood by DHCS that primary plans and Subcontractors have different Provider networks. However, DHCS will hold the primary MCP accountable for the requirements of ECM and Community Supports. DHCS will assess the combined network of the primary MCP and Subcontractors for sufficiency and will hold the primary MCP responsible.

[28] DHCS MMCD Boilerplate Contracts Template.

MCPs may also choose to delegate ECM to Independent Physician/Provider Associations (IPAs), Medical Groups and Management Service Organizations (MSOs). MCPs must describe these arrangements in the MOC for DHCS approval. IPAs and MSOs must meet all requirements.

MCPs will ensure their Subcontractor agreements for ECM and Community Supports services include the requirements set forth in the ECM and Community Supports Contract Template, and the ECM Provider Standard Terms and Conditions, as applicable to Subcontractor. MCPs are encouraged to collaborate with their Subcontractors on the approach to ECM to minimize variance in how ECM will be implemented and to ensure a streamlined, seamless experience for ECM Providers and Members.

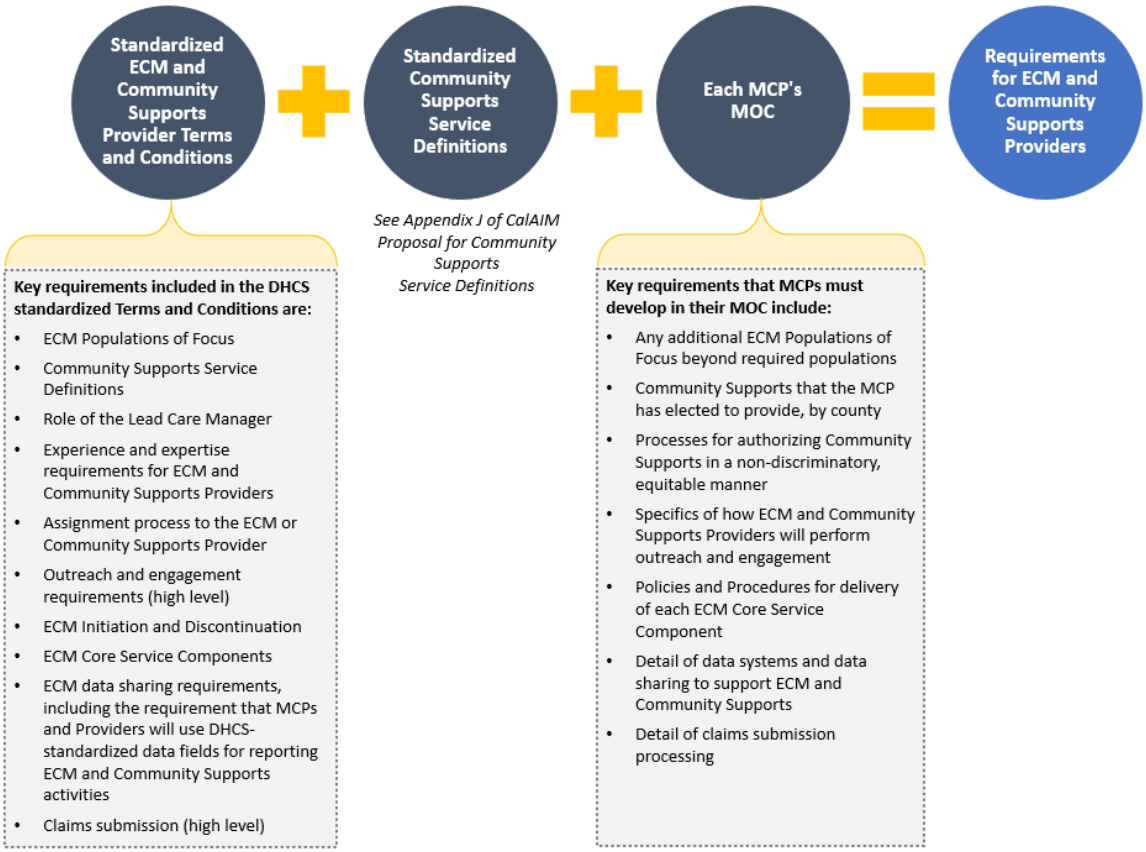
XI. DHCS Oversight of ECM

Model of Care (MOC) and Approval Process
The ECM and Community Supports MOC is each MCP's framework for providing ECM and Community Supports. Each MCP's MOC will include its overall approach to ECM and Community Supports; its detailed Policies and Procedures with regard to ECM and Community Supports Provider (including non-traditional Providers) contracting and oversight; its ECM and Community Supports Provider network capacity; and the contract language that will define key aspects of its arrangements with its ECM and Community Supports Providers. The MOC also includes specific "Transition and Coordination" content for MCPs operating in WPC and/or HHP counties. MCPs in these counties must describe how they will ensure smooth transitions for their Members from WPC and HHP into ECM and Community Supports.

DHCS will use each MCP's MOC submission to determine its readiness to meet ECM and Community Supports requirements. MCPs must lay out their MOCs using the DHCS-developed standard template (MOC Template) and submit them to DHCS for review and approval prior to initial ECM and Community Supports implementation as well as for counties without HHP or WPC. MCPs must make updates to their MOCs (1) ahead of new ECM Populations of Focus being implemented in January and July 2023 and (2) to reflect any Community Supports changes, based on the Timelines for MOC Submission in the ECM and Community Supports Model of Care Cover Note. MCPs must also submit to DHCS any significant changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable DHCS APLs. Significant changes may include, but are not limited to, changes to the Contractor's s approach to administer or deliver ECM services, approved policies and procedures, and Subcontractor Agreements boilerplates.

MCPs should expect review of the MOC to be an iterative process with DHCS during each review period. DHCS may require resubmission of certain questions or additional material to ensure alignment with DHCS requirements.

Figure 4: Elements of ECM and Community Supports **Provider Requirements**



Encounter Data

DHCS will review encounter data submitted by MCPs to monitor the overall reach of ECM. MCPs must submit all ECM encounters to DHCS using national standard specifications and code sets defined by DHCS, including the Healthcare Common Procedure Coding System (HCPCS) codes established in the ECM and Community Supports Coding Options guidance document. MCPs will be responsible for submitting all encounter data for ECM services provided to its Members, regardless of the number of levels of delegation and/or sub-delegation. As mentioned above in Data System and Data Sharing Requirements to Support ECM, in the event the ECM Provider is unable to submit ECM encounters using the national standard specifications and code sets defined by DHCS, the MCP will be responsible for converting the ECM Provider's encounter information into the national standard specifications and code sets, for submission to DHCS. DHCS requires MCPs to submit encounter data in accordance with requirements in the MCP contract, All Plan Letter 14-019, and the ECM & Community Supports Billing & Invoicing guidance document. Please see Appendix D for more information about the guidance documents referenced in this section.

Quarterly Implementation Reporting Requirements
DHCS will monitor Medi-Cal Managed Care health plans' (MCPs') implementation of and compliance with Enhanced Care Management (ECM) and Community Supports requirements across multiple domains, including Membership, Service Provision, Grievances and Appeals, Provider Capacity, and Quality. DHCS will monitor the impact of ECM and Community Supports through a combination of data sources, including Member-level data reported by MCPs and as demographic data currently available to DHCS. The data supplied by MCPs will serve as a mechanism for DHCS to monitor the initial rollout of ECM and some of the monitoring data will be used for the implementation of MCP Performance Incentives, as described further below. Please see the Quarterly Implementation Monitoring Report (defined in Appendix D) for a comprehensive description of these reporting requirements.

Requirements to Track Outreach
The MCP contract specifies that *"Contractor shall track and report to DHCS, in a format to be defined by DHCS, information about outreach efforts related to potential Members to be enrolled in ECM".* The ECM and Community Supports Coding Options guidance document includes HCPCS codes MCPs must use to submit encounters for ECM outreach attempts. Additionally, the Quarterly Implementation Monitoring Report (see Appendix D) requires MCPs to aggregate and report the number of unique outreach attempts for initiation into ECM on a cumulative calendar year basis (whether outreach was performed by the MCP or the Provider), as well as the number of outreaches that resulted in successful engagement. In addition to this quarterly report, MCPs will, upon DHCS request, provide information about outreach for rate setting purposes by way of the Supplemental Data Request (SDR) process. Within the Member-Level Information Sharing Between MCPs and ECM Providers guidance document, DHCS lays out standards for outreach tracking at the provider level to create consistency in the way providers are being asked to track the information and share it with multiple MCPs. This set of standards is called the "ECM Provider Initial Outreach Tracker File."

ECM Provider Reporting in 274
In order to monitor ECM and Community Supports Providers on an ongoing basis, DHCS will require MCPs to report ECM Providers in the 274 Provider file, beginning upon implementation. Guidance related to reporting ECM Providers in the 274 Provider file is forthcoming.

XII. Performance Incentive Program

Overview:
CalAIM's ECM and Community Supports programs will require significant new investments in care management capabilities, Community Supports infrastructure, information technology (IT) and data exchange, and workforce capacity at both the MCP and Provider levels. Incentive payments will be a critical component of CalAIM to promote MCP and Provider participation in, and capacity building for, ECM and Community Supports.

The Governor's budget allocated $300 million for plan incentives from January to June 2022, $600 million from July 2022 to June 2023, and $600 million from July 2023 to June 2024. Incentive funding will phase out in FY 2024-25. DHCS has designed an incentive payment approach with input from stakeholders with the goal of issuing initial payments to MCPs beginning in January 2022, for the achievement of defined milestones. Infrastructure development, ECM and Community Supports Provider capacity building, and Community Supports take-up are priority areas for Program Year 1 (i.e., Calendar Year 2022). DHCS will incorporate behavioral and physical health integration and health disparities reduction measures within those priority areas. Quality will emerge as a priority area for Program Year 2 (i.e., Calendar Year 2023).

Listed below are the goals and design principles of the program.

Performance Incentive Goals:

- Build appropriate and sustainable ECM and Community Supports capacity.
- Drive MCP investment in necessary delivery system infrastructure.
- Incentivize MCP take-up of Community Supports.
- Bridge current silos across physical and behavioral health delivery.
- Reduce health disparities and promote health equity.
- Achieve improvements in quality performance.

Performance Incentive Design Principles:

1. Develop a clear incentive payment allocation methodology where all plans have an opportunity to participate equitably.
2. Set ambitious, yet achievable measure targets.
3. Ensure efficient and effective use of all performance incentive dollars.
4. Drive significant investments in core priority areas up front.
5. Minimize administrative complexity.
6. Address variation in existing infrastructure and capacity between Whole Person Care (WPC)/Health Home Program (HHP) counties and non-WPC/HHP counties.
7. Ensure use of incentive dollars does not overlap with other DHCS incentive programs or with services funded through the rates.
8. Measure and report on the impact of incentive funds.

XIIII. Appendices

Appendix A: ECM Implementation Dates by County

Counties with WPC Pilots and/or HHP[29] **(Begin ECM implementation on 1/1/22)**		**Counties without WPC Pilots and/or HHP** **(Begin ECM implementation on 7/1/22)**	
Alameda	HHP, WPC	Alpine	Trinity
Contra Costa	WPC	Amador	Tuolumne
Imperial	HHP	Butte	Yolo
Kern	HHP, WPC	Calaveras	Yuba
Kings	WPC	Colusa	
Los Angeles	HHP, WPC	Del Norte	
Marin	WPC	El Dorado	
Mendocino	WPC	Fresno	
Monterey	WPC	Glenn	
Napa	WPC	Humboldt	
Orange	HHP, WPC	Inyo	
Placer	WPC	Lake	
Riverside	HHP, WPC	Lassen	
Sacramento	HHP, WPC	Madera	
San Bernardino	HHP, WPC	Mariposa	
San Diego	HHP, WPC	Merced	
San Francisco	HHP, WPC	Modoc	
San Joaquin	WPC	Mono	
San Mateo	WPC	Nevada	
Santa Clara	HHP, WPC	Plumas	
Santa Cruz	WPC	San Benito	
Shasta	WPC	San Luis Obispo	
Sonoma	WPC	Santa Barbara	
Tulare	HHP	Sierra	
Ventura	WPC	Siskiyou	
		Solano	
		Stanislaus	
		Sutter	
		Tehama	

[29] List is subject to change based on WPC Pilots' decisions to continue operating through 2021.

Appendix B: Local Governmental Agencies Participating in the County-specified Targeted Case Management Program

Note: The table below reflects information as of March 2021. For the most accurate information, MCPs should check directly with the counties.

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Alameda County	X	X	X	X	X	
Alpine County						X
Amador County						X
Butte County				X		
Calaveras County						X
Colusa County						X
Contra Costa County	X	X	X	X	X	
Del Norte County						X
El Dorado County						X
Fresno County						X
Glenn County						X
Humboldt County	X	X		X	X	
Imperial County						X
Inyo County						X
Kern County	X			X		
Kings County						X

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Lake County						X
Lassen County						X
Los Angeles County	X			X		
Madera County				X		
Marin County						X
Mariposa County	X	X	X	X	X	
Mendocino County						X
Merced County				X		
Modoc County						X
Mono County						X
Monterey County	X	X		X		
Napa County	X	X		X		
Nevada County						X
Orange County	X			X	X	
Placer County		X	X	X		
Plumas County						X
Riverside County	X	X	X	X	X	
Sacramento County	X			X		
San Benito County						X
San Bernardino County						X
San Diego County	X	X	X	X	X	

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
San Francisco County						X
San Joaquin County						X
San Luis Obispo County						X
San Mateo County	X	X		X		
Santa Barbara County						X
Santa Clara County	X	X	X	X	X	
Santa Cruz County	X	X		X		
Shasta County		X		X		
Sierra County						X
Siskiyou County						X
Solano County	X	X		X		
Sonoma County	X	X	X	X	X	
Stanislaus County	X	X	X	X	X	
Sutter County	X	X	X	X		
Tehama County						X
Trinity County				X		
Tulare County						X
Tuolumne County	X	X	X	X		
Ventura County	X	X	X	X	X	
Yolo County						X

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Yuba County						X
City of Berkeley	X	X	X	X	X	
City of Long Beach	X	X	X	X	X	
Total	**23**	**21**	**14**	**29**	**13**	**33**

Appendix C: Data & Reporting Guidance Documents

Guidance	Description
Billing & Invoicing Guidance	Standard, “minimum necessary” data elements MCPs will need to collect from ECM or Community Supports Providers unable to submit ANSI ASC X12N 837P claims to MCPs.
Member Information File Guidance	Defines standards for data sharing between MCPs and ECM Providers.
Quarterly Implementation Monitoring Report Guidance	Time-limited quarterly MCP reporting requirements and Excel template related to ECM and Community Supports implementation across multiple domains. They are “supplemental” to encounters.
ECM & Community Supports Coding Options	Contains the HCPCS codes that MCPs must use for ECM and Community Supports services.