DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

ENHANCED CARE MANAGEMENT FOR LONG-TERM CARE POPULATIONS

A POPULATION OF FOCUS SPOTLIGHT

This **Enhanced Care Management Population of Focus Spotlight** illustrates how Enhanced Care Management (ECM) is delivered for adults in, or at risk of entering, long-term care (LTC) settings who can be safely cared for outside of those settings with intensive care management. It is intended to help future ECM Providers get started and current ECM Providers refine their ECM approach. It is also intended to highlight how providers can also leverage two related Community Support services designed to support members at risk for entering long-term care settings or may currently be in such settings and can safely transition to the community.

ECM is a Medi-Cal managed care plan (MCP) benefit available in all California counties to support comprehensive care management for MCP Members with complex needs. ECM launched in 2022 and is the highest level of care management in the Medi-Cal Population Health Management (PHM) continuum. MCPs contract with community-based providers to deliver ECM. For more information, see the ECM Policy Guide.

Enhanced Care Management is organized by "Populations of Focus" (POFs), each with unique eligibility criteria and service requirements. This Spotlight focuses on two of those POFs:

- **Adults Living in the Community and At Risk for LTC Institutionalization:** Many MCP Members living in the community with complex social needs that influence their health are at risk of institutionalization when they experience a significant change in health status and are unable to manage care for themselves without additional support. However, they are still

able to reside in the community safely and avoid institutionalization if wraparound supports, including in-home visits, are made available.

- **Adult Nursing Facility Residents Transitioning to the Community:** Other MCP Members are already residing in a skilled nursing facility (SNF) and express a desire for a less restrictive setting or a return to a community setting once they have healed. Some Members who enter a SNF for a prolonged period during a health crisis may lose or experience a change in housing when their benefit status changes and Social Security income is diverted to pay for a long-term stay. With additional support, some of these individuals may be able to live in the community instead. These may be individuals who have recovered after an injury or medical event, and those who feel a community setting would give them more access to friends, family, and chosen family or otherwise improve their wellbeing and independence.

For both these populations, ECM pairs a Member with a community-based Lead Care Manager who works with them to establish a care plan and coordinate the Member's care team. The aim of ECM for both populations is to enhance their ability to live independently and safely and remain connected to what matters most to them.

In the first nine months of launching ECM for the LTC POFs, over **10,000** Members at risk of or transitioning from institutional long-term care received ECM. Of those Members, **92%** were living in the community and at risk of needing institutional long-term care.

In this ECM POF Spotlight, readers will find operational guidance for the two LTC POFs, vignettes showing how ECM might support two Medi-Cal Members in this POF, and extensive resources for assessing an organization's capacity to contract with MCPs as an ECM Provider.

Table of Contents

The strategies and Member vignettes included in this Spotlight are informed in part by a series of informational interviews conducted with the following ECM Providers that serve the LTC POFs.

- MasterCare, a provider blending expertise with non-medical senior care with health care and delivering services under managed care contracts across the state.
- Partners in Care Foundation, a non-profit, community-based organization providing health and social care services in Southern California.

DHCS thanks these organizations for their insights and contributions to this resource.

Published May 2024

ECM in Context: Medi-Cal and Long-Term Services and Supports

California's Department of Health Care Services (DHCS) administers Medi-Cal Long-Term Services and Supports (LTSS), which provide a continuum of care for older adults and people with disabilities. Medi-Cal coverage offers several programs to support members in home- and community-based settings, as well as institutional care. The ECM LTC populations (which are not mutually exclusive) at risk and in need of long-term care are diverse and include:

Older Adults with Complex Health or Social Needs

Individuals Living with Long-Term Disabilities

Individuals with Episodic LTSS Needs or Requiring Short-Term Post-Acute Care Transition Support

ECM is the highest level of care management in the Medi-Cal continuum. The benefit sits within a broader strategy to improve care coordination for the populations in need of long-term care and is part of an evolving policy landscape reshaping Medi-Cal service delivery.

Medi-Cal Members have historically accessed Home and Community Based-Services (a component of LTSS) through several programs, including:

- The In-Home Supportive Services (IHSS) program, and Home and Community-Based Services (HCBS) Waiver Programs, (with access variable by county);
- The Program for All-Inclusive Care for the Elderly (PACE); or
- Services carved into managed care such as Community-Based Adult Services (CBAS).

In 2019, DHCS announced the California Advancing and Innovating Medi-Cal (CalAIM), the plan to modernize California's Medicaid program and improve the quality of life and health outcomes of Medi-Cal beneficiaries, including those with the most complex LTSS needs. Since then, several initiatives have begun to streamline and improve care for individuals with LTSS needs through Medi-Cal managed care.

- *Transitioning all Dual-Eligible and Institutional Long-Term Care Members to Medi-Cal Managed Care:* Beginning in 2023, all Medi-Cal MCPs cover and coordinate Medi-Cal institutional LTC for all Members residing in Skilled Nursing Facilities to help expand access to coordinated and integrated care. Also beginning in 2023, all dual eligible beneficiaries with Medicare and Medi-Cal must enroll in an MCP for Medi-Cal benefits. MCPs can offer care management and provide a broad array of services to Members who qualify, including ECM and Community Supports.
- *Strengthened Transitional Care Services (TCS):* As part of CalAIM's Population Health Management program, MCPs are accountable for providing strengthened TCS. TCS are designed to help Members as they transfer from one setting or level of care to another, including, but not limited to transferring from a hospital setting, acute care facility, or SNF to home or community-based settings, post-acute care facilities, or long-term care settings. Medi-Cal MCPs through providing TCS, must ensure Members are supported from discharge planning until they have been successfully connected to all needed services and supports, including setting up care and services in their new location prior to discharge, exploring opportunities to successfully discharge members and help them remain home with wraparound services, where appropriate, and ensuring Members can access and receive care and services they need after discharge.
- *Medicare and Medi-Cal Integration:* Medi-Medi Plans are Medicare Advantage plans that combine Medicare and Medi-Cal benefits and are available in select counties in California in 2024. Benefits include hospital, doctor, specialist, prescription, lab, transportation, and intensive care management similar to ECM. These plans provide coordinated care through one health plan. Medi-Medi Plans are available for voluntary enrollment in twelve counties in 2024, and will be expanded statewide in 2026.

What are the Key Features of ECM?

DHCS, Medi-Cal MCPs, and providers across the state launched ECM in phases, by "Population of Focus" (POF), from 2022 to 2024. Each POF requires a unique model, referral pipeline, and provider network to meet the needs of eligible members, and the key features of ECM across all POFs include:

COMMUNITY-BASED PROVIDERS

Medi-Cal MCP Members are matched to community-based ECM Providers with expertise supporting their needs and experience in intensive care management. Wherever possible, the ECM Provider should have an existing, trusted relationship with the Member.

PERSON-CENTERED CARE

ECM Providers develop individualized care plans based on Members' needs and coordinate all medical care, behavioral health support, and social services across the continuum.

HIGH-TOUCH, IN-PERSON SUPPORT

ECM entails high-touch support provided by a Lead Care Manager primarily through in-person interactions with Members where they live, seek care, or prefer to access services.

DHCS's ECM Policy Guide contains comprehensive details about the ECM benefit, and a policy "cheat sheet" streamlines key guidance. The subsequent sections highlight aspects of ECM specific to the LTC POFs, including how they require:

- Their own **referral pipeline** and process for leveraging existing relationships with Members to identify and refer eligible Members to ECM, as well as using existing data sets to identify eligible Members.
- A **provider network** that is community-based and *uniquely* experienced and expert in addressing the needs of Members in the POFs.
- An **interdisciplinary team composition and high-touch model** that positions the ECM Provider as the member's primary point of contact and additional support across existing clinical and nonclinical service delivery systems for Members.
- DHCS requires each MCP to have a detailed plan ("Model of Care") addressing how it will implement ECM, covering each of these issues for each POF.

Who Is Eligible for the ECM Long-Term Care POFs?

To be eligible for ECM, Medi-Cal Members must be enrolled in an MCP. As of January 1, 2023, both of the LTC POFs listed below launched statewide for Medi-Cal MCP Members. The ECM Policy Guide includes a detailed list of the eligibility criteria for:

1. Adults Living in the Community and At Risk for LTC Institutionalization; and
2. Adult Nursing Facility Residents Transitioning to the Community.

For both these POFs, the MCP must determine the Member is able to reside continuously in the community with appropriate support.

Connecting the Dots: How ECM Intersects with Programs for Adults At-Risk of Long-Term Care Institutionalization

Members with LTSS needs may receive coverage and care management support through Medi-Cal, Medicare or both. As an ECM Provider, understanding these different intersections and the programs available to Members is an important part of helping Members connect to the services they need while also reducing duplication of services. The Table below describes these coverage types and programs briefly and explains how ECM intersects with these models to care for Members.

Program	Can Members be Enrolled in this Program and ECM at the Same Time?	
California Community Transitions (CCT)[1] CCT is a program funded through the Money Follows the Person federal demonstration that offers wraparound transition support to eligible Medi-Cal Members who have continuously resided in state-licensed health care facilities for 60 days or longer. Upon transitioning to the community, a CCT transition coordinator follows the Member for one year while the Member lives in their home or in approved community care facilities. Meanwhile, the Member receives LTSS included in their individual comprehensive service plan.	✕	Members can be enrolled in CCT **or** ECM, but because both offer comprehensive care management, a Member cannot enroll in both at the same time.

[1] The state also has an accompanying state-funded CCT-like program funding transition support and coordination for individuals in institutional settings for 1–60 days.

Program	Can Members be Enrolled in this Program and ECM at the Same Time?	
Community Based Adult Services (CBAS) CBAS is a community-based day health program that provides services to older adults and adults with chronic medical, cognitive, or behavioral health conditions and/or disabilities that make them at risk of needing institutional care. CBAS centers have health professionals who assess each participant to identify and plan services needed to meet the individual's specific health and social needs. Individuals can access daily care and activities through community-based centers.	✔	Members receiving support through CBAS are eligible to receive ECM if they meet POF criteria. ECM can offer comprehensive care management beyond the services provided through CBAS, which are primarily provided within the four walls of the CBAS center. When a Member's CBAS center is a contracted ECM Provider, the MCP should assign that CBAS Provider as the Member's ECM Provider, unless the Member prefers differently.
Dual Eligible Special Needs Plans (D-SNPs) D-SNPs are Medicare Advantage plans available to Members who are enrolled in both Medicare and Medicaid. D-SNPs offer specialized care and wraparound services and offer varying levels of integration between Medicare and Medi-Cal plans. D-SNPs also offer care management for Member's needs.	✕	Members enrolled in a D-SNP receive their care management and care through the D-SNP, rather than an MCP. D-SNPs provide "ECM-like" care management services, so that Members who meet ECM criteria for the LTC POF receive similar levels of support through their D-SNP. As of January 2024, all Members newly eligible for ECM receive ECM-like care management through their D-SNP.
In-Home Support Services (IHSS) IHSS is a program that provides in-home assistance to eligible older, blind and disabled individuals as an alternative to out-of-home care and enables recipients to remain safely in their own homes. Services may include house cleaning, personal care, meal preparation and accompaniment to medical appointments.	✔	Members can receive support through the IHSS program and enroll in ECM. ECM Lead Care Managers can also support Members in ECM by making referrals to IHSS programs if the Member needs available support to remain safely in their living arrangement.
Program for All-Inclusive Care for the Elderly (PACE) The PACE model uses an interdisciplinary team approach in a PACE Center to provide and coordinate all needed preventive, primary, acute and long-term care services to older adults who would otherwise reside in nursing facilities. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care, and be able to live safely in their home or community at the time of enrollment.	✕	Members can be enrolled in a PACE program **or** ECM, but because both offer comprehensive care management, a Member cannot enroll in both at the same time.

Program	Can Members be Enrolled in this Program and ECM at the Same Time?	
1915(c) HCBS Waiver Programs Home and Community-Based Services (HCBS) Waiver Programs provide services aimed at serving individuals who would otherwise qualify for institutional care in community-based settings. In California, there are several waiver programs eligible Members can enroll in to receive these services, including but not limited to: » Assisted Living Waiver: Care for Members in residential care as an alternative to a SNF. » Home and Community Based Alternatives Waiver: Care management and services to support Member's living in a community-based arrangement. » Multipurpose Senior Services Program Waiver: Provides HCBS to Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement. » Medi-Cal Waiver Program (MCWP, formerly AIDS Waiver Program): Provides comprehensive case management and direct care services to persons living with HIV/AIDS as an alternative to nursing facility care or hospitalization. » HCBS Waiver for the Developmentally Disabled (HCBS-DD)*: Administered by the California Department of Developmental Services (DDS), HCBS-DD provides services for developmentally disabled persons who are Regional Center consumers. » Self Determination Program (SDP) Waiver: Administered by DDS, SDP allows participants who are Regional Center consumers the opportunity to have more control in developing their service plans and selecting service providers to better meet their needs.	✕	Members can be enrolled in a 1915(c) waiver program **or** ECM, but because both offer comprehensive care management, a Member cannot enroll in both at the same time.
1915(i) State Plan HCBS Benefit for the Developmentally Disabled *This program makes the services available through the 1915(c) HCBS DD waiver also available to individuals with qualifying I/DD conditions that do not meet Nursing Facility Level of Care (NF LOC) as required by 1915(c) HCBS waivers.	✔	Members can receive support through a 1915(i) program and enroll in ECM.

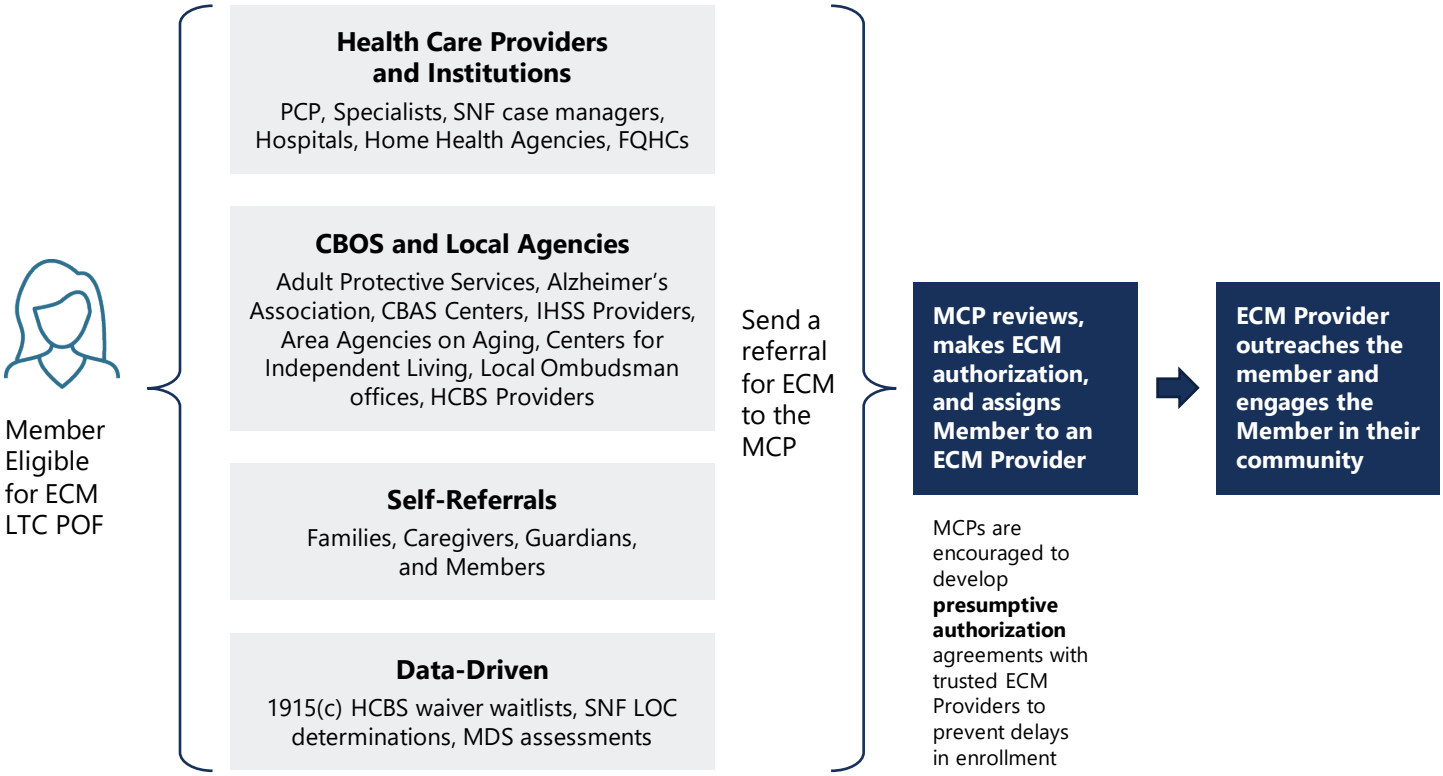
How Do Adults Eligible for the Long-term Care POFs Access ECM?

Providers and patients can access ECM in multiple ways.

- **Community-Based Organization (CBO) and Provider Referrals:** Eligible members can be referred to the Medi-Cal MCP from a provider, case manager, or other professional already serving them. DHCS expects MCPs to source most ECM referrals in this way.
  - **CBOs, Local Agencies, and Patient Advocates:** Adult Protective Services Agencies, Alzheimer's Associations, Area Agencies on Aging, Centers for Independent Living, CBAS Centers, local Ombudsman offices, IHSS Providers, other HCBS Waiver Providers, and other service providers with experience working with adults to safely stabilize them outside institutional settings are well positioned to identify and refer individuals in these POFs to ECM.
  - **Health care providers and institutions:** Primary Care Physicians (PCPs) and federally qualified health centers (FQHCs), hospitals and acute care facilities, specialists, SNF case managers, county agencies, Home Health Agencies, and other providers are encouraged to identify and refer eligible individuals to their MCPs, whether or not referring organizations are ECM Providers.
  - MCPs should work with their ECM Providers to receive ECM referrals from the Providers' current clients who meet eligibility criteria or who are already receiving other services aligned with ECM eligibility criteria.
- **Self-Referrals:** Families, caregivers, legal guardians, and adults may self-refer to the MCP. MCPs must include up-to-date information on their website for Members about ECM and how to self-refer for the benefit.
- **Data Driven Referrals:** MCPs must also have a process for using data to proactively identify members who may benefit from ECM and meet POF criteria. This process should supplement, and not replace, community-based provider referral sources.
  - **Adults Living in the Community and At Risk for LTC Institutionalization:** MCPs may leverage 1915(c) HCBS waiver program wait lists as a data source to identify Members who may meet this POF criteria. MCPs may also use previous SNF level of care (LOC) determinations to confirm Member eligibility.
  - **Adult Nursing Facility Residents Transitioning to the Community:** The Minimum Data Set (MDS) is an assessment conducted with SNF residents to review their preferences and goals for living arrangements that are in the least restrictive possible setting. DHCS encourages MCPs and the SNFs serving their Members to leverage data from Section Q of the MDS to identify Members who may want the support of ECM to transition to a community-based living arrangement.

How Is an Individual Matched with an ECM Provider?

Figure 1: Members Eligible for ECM Can Be Identified in Several Ways



ECM Providers, CBOs, and other providers refer adults in or at risk of needing institutional LTC and the MCP reviews eligibility and authorizes ECM services. MCPs must ensure that referrals are processed as soon as possible, in accordance with the required authorization times for the benefit (e.g., within five days for routine authorizations and 72 hours for expedited requests). To speed up authorizations, DHCS encourages MCPs to use Presumptive Authorization approaches where appropriate. For Members eligible for ECM transitioning from institutional LTC, MCPs must ensure discharging facilities have processes in place *prior* to discharge to screen and refer Members for ECM and share information from discharge planning evaluation and discharge instructions with the Lead Care Managers. A best practice is for the Lead Care Manager working with the facility to include their name and contact information in the discharge documents. In addition, Lead Care Managers should review information from the discharging facility's assessment(s) and discharge planning process to identify Members who may be newly eligible for ECM. Lead Care Managers should make effort to establish contact with eligible Members *prior* to discharge to review the discharge instructions and ensure that ECM services are in place in a timely manner at the point of discharge.

After authorization, the MCP assigns the Member to an ECM Provider in the Member's area. MCPs should prioritize assigning the individual to an ECM Provider that has an established and trusted relationship with the Member and that is contracted to provide ECM for the specific POF. As required

by federal law, ECM provider staff members tasked with developing a care plan for a Member with LTSS needs must be trained in person-centered planning using a person-centered process.

The list below outlines organizations that may be a natural fit to serve as ECM Providers for the LTC POFs. This list is **non-exhaustive** and is in addition to organizations that serve multiple POFs, such as FQHCs, rural health centers, and county behavioral health programs.

Entities Positioned to Serve as ECM Providers for The LTC POFs

Adults Living in the Community and At Risk of LTC Institutionalization	Adult Nursing Facility Residents Transitioning to the Community
» CBAS Centers » Area Agencies on Aging » Home Health Agencies » Centers for Independent Living » Memory Care, Assisted Living, and Independent Living Organizations » Alzheimer's Association » HCBS Providers	» CCT Lead Organizations » Affordable Housing Communities » Memory Care, Assisted Living and Independent Living Organizations » Alzheimer's Association » HCBS Providers

Once a Member is referred by the MCP to an ECM Provider, ECM Providers identify an ECM Lead Care Manager for each ECM Member. Lead Care Managers serve as the main point for contact the Member, coordinate care across clinical and nonclinical systems and provide additional support to identify and address needs.

ECM Providers consider the needs, backgrounds and language preferences of Members in identifying a best-fit Lead Care Manager. Providers often employ staff with similar lived experiences of Members or with experience working closely with similar populations, so they can establish strong connections between Members and their Lead Care Manager. The first meeting between an ECM Lead Care Manager and a Member can confirm the Member feels comfortable working with the Lead Care Manager and establish early priorities for ECM support.

What Does ECM Delivery Look Like for LTC POFs?

There are **seven ECM core services** available to all Members receiving ECM (see right). ECM Providers design their care to parallel these core services and are required to offer all seven services to the Members they serve. The *"ECM in Action"* section describes examples of how these core services are offered to Members. For detailed information on each of these services, consult the **ECM Policy Guide**.

For Members in the LTC POF, the seven ECM core services are tailored to the needs of the Member receiving support in their transition from an institutional setting or in maintaining their life in the community. The ECM Lead Care Manager links physical, behavioral health care, and social services to support the Member in meeting their goals and remaining safely in the living arrangement of their choice.

ECM Core Services
Outreach and Engagement
Comprehensive Assessment and Care Management Plan
Enhanced Coordination of Care
Health Promotion
Comprehensive Transitional Care
Member and Family Supports
Coordination of and Referral to Community and Social Support Services

How Does ECM Intersect with Transitional Care Services?

When Members transition between levels or settings of care, such as discharges from a hospital, or SNF to another level of care, the ECM Lead Care Manager serves a crucial role in providing **Transitional Care Services** (TCS) (see Section E.3 of the PHM Policy Guide). MCPs are accountable for providing TCS across all settings and delivery systems, ensuring members are supported from discharge planning until they have been successfully connected to all needed services and supports.

Members with LTSS needs (including older adults and persons with disabilities) who meet the definitions of high-risk, including any member already enrolled in ECM, are considered "high-risk" transitioning Members, and are required to have an assigned TCS care manager/single point of contact to assist throughout their transition and ensure all required care coordination and follow-up services are complete.

For those enrolled in ECM, the **ECM Lead Care Manager serves as the assigned TCS care manager/ single point of contact** and provides all TCS, including coordinating all follow up care, connecting the Member to primary care and needed Community Supports, ensuring the completion of medication reconciliation, and making referrals to social services and supports the Member in a safe transition to their new living arrangement. For those Members getting discharged from acute care facilities that require SNF-level of care, the Lead Care Managers should ensure that there is a clear plan for successful secondary discharges to the least restrictive care setting, with needed wrap around supports.

Using Community Supports to Provide Additional Support in the Community

Community Supports are services that address Medi-Cal MCP Members' health-related social needs and help them avoid higher, costlier levels of care. DHCS has preapproved 14 Community Supports that MCPs are encouraged (but not required) to offer to their Members. Available supports vary by county and may change over time; see the **Community Supports available in each county**. For comprehensive data on Community Supports implementation to date, visit the ECM and Community Support Quarterly Implementation Report. ECM Providers can also view the **Community Supports Policy Guide** to learn more about eligibility and services. Community Supports are intended to be customized to an individual's needs and can be offered **with or without ECM**. Members may receive ECM in conjunction with Community Supports, and, in many cases, it makes sense to combine ECM and Community Supports. However, Members are not required to enroll in ECM to receive Community Supports.

Members in the ECM LTC POFs will often need intensive planning prior to transitions and support in setting up access to medical care, meals, home-based services, and caregiver support. ECM Lead Care Managers play an important, time intensive role in setting up care and coordinating with additional members of the care team before, during and after these periods of transition. Individuals may also need modifications to their home environment to make it accessible and safe for their use. As a result, individuals in the LTC POFs may benefit from many of the 14 Community Supports. Some are specifically designed for individuals who need help accessing independent living arrangements and avoiding SNF stays. Working with MCPs, ECM Providers for the LTC POF should be familiar with these supports and work to connect the Members they serve in ECM with Community Supports, as appropriate.

Community Supports Particularly Beneficial to LTC POFs include:	
Community Transition Services/Nursing Facility Transition to a Home *Applies to Members transitioning from nursing facilities to a private residence*	Facilitates a Member's transition from a licensed facility to a living arrangement in a private residence where the person is directly responsible for their own living expenses. Covers non-recurring set-up expenses to help Members establish a basic household, along with transitional care coordination.

Community Supports Particularly Beneficial to LTC POFs include:	
Nursing Facility Transition/ Diversion to Assisted Living Facilities (ALF) *Applies to Members transitioning from nursing facilities into an Assisted Living Facility*	Facilitates a Member's transition back into an Assisted Living Facility (ALF), Residential Care Facility for the Elderly (RCFE), or Adult Resident Facilities (ARF) for Members who are currently receiving medically necessary nursing facility level of care (LOC) or who meet the minimum criteria to receive nursing facility LOC services. Support includes 1) time-limited transition services and expenses (excluding room and board) that enable a person to establish a community facility residence in an ALF/RCFE/ARF, as well as 2) ongoing assisted living expenses.
Environmental Accessibility Adaptations (Home Modifications)	Provides funding for physical adaptations to a home that are necessary to ensure the health, welfare, and safety of an individual, or enable them to function with greater independence in their home. Example uses of funding include: Ramps and grab-bars to assist Members in accessing the home, doorway widening for Members who require a wheelchair, stair lifts, bathroom remodeling to make wheelchair accessible, specialized electric and plumbing systems that are necessary to accommodate medical equipment, and Personal Emergency Response Systems.
Personal Care and Homemaker Services	Provides personal care services and homemaker services for individuals who need assistance with ADLs, such as bathing, dressing, toileting, ambulation, or feeding. Can also include assistance with Instrumental Activities of Daily Living (IADLs), such as meal preparation, grocery shopping, and money management. Includes services provided through the IHSS program, such as house cleaning, meal preparation, laundry, grocery shopping, personal care services, accompaniment to medical appointments, and protective supervision for the mentally impaired. Entities should refer Members to the IHSS program benefits prior to the Personal Care and Homemaker Services Community Support.
For detailed information on each of these services, consult the Community Supports Policy Guide.	

A Member can receive ECM and simultaneously receive the care management included in these Community Supports services, and providers may be contracted to provide both ECM and Community Supports. 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.

ECM in Action

Sonja, an Older Adult Living with Parkinson's Disease Who Wishes to Remain in Her Home

The following vignette describes how Member named Sonja might be supported by ECM from a nonprofit—Community Partners—collaborating with hospitals, physician groups, health plans, community-based organizations, and public agencies to deliver services that support diverse adults with complex health and social services needs and their caregivers. The Members and ECM Providers represented in the following vignettes are fictional, but are informed by interviews with ECM Providers.

Sonja is a 62-year-old with Parkinson's disease (PD) and recently diagnosed with possible Parkinson's disease dementia (PDD). Sonja values her neighborhood community but is facing challenges living alone.

Sonja is a Medi-Cal MCP member enrolled in Fee-For-Service Medicare in San Bernadino County living alone in a studio apartment, where she has lived for 14 years. The unit is in need of updates and repairs, and, while on the first floor, has not been updated with accessibility features.

Accessing ECM

Sonja is closely connected with her neighbors and community. Her neighbor and friend, Arlene, notices she increasingly appears disoriented, gets confused about time, place, and life events, and is withdrawing socially. She also notices that Sonja, who has severe knee and hip arthritis, is having more difficulty getting around using her cane, and Sonja shares that she recently had a fall in her shower. Arlene asks Sonja if she has talked with her primary care provider recently, but Sonja cannot remember.

Worried about Sonja's health, Arlene offers and then helps Sonja make a PCP appointment and drives her there. Before the appointment, she also helps Sonja write notes describing her symptoms, which Sonja can share with her physician. Aware that Parkinson's puts her at an increased risk for related dementias, the PCP diagnoses her with Parkinson's related dementia, and sends a referral to a neurologist. Taking into account both insights from Sonja's medical records and her current symptoms, the PCP determines that Sonja could be a good candidate for ECM. Sonja's PCP speaks with her about what ECM can offer and places a referral for ECM. Sonja's MCP reviews the referral and authorizes her for the standard 12 months of ECM because she meets the POF criteria for:

Adults Living in the Community and At Risk for LTC Institutionalization, which means that Sonja:

1. Meets the SNF LOC criteria; and
2. Is actively experiencing at least one complex social or environmental factor influencing her health—including communication difficulties, living alone and needing assistance with ADLs (e.g., walking).

Assigning an ECM Provider

Sonja's MCP assigns Community Partners—a Provider serving several counties across Southern California—to serve as Sonja's ECM Provider, because of their expertise in serving older adults living with complex health conditions and experience supporting older adults like Sonja, so they can remain independent in their home environment with necessary support.

Outreach and Engagement

A member of Community Partners' Engagement Center reaches out to Sonja about receiving a referral and asks whether she is open to learning more about the services offered through ECM, and assures her that these services are available at no cost through her Medi-Cal MCP. She expresses reservations at first—and has trouble recalling the earlier conversation she had with her PCP about ECM. She agrees to continue the conversation when she learns the staff member on the phone has already spoken with her PCP to understand her hopes for care, her challenges associated with Parkinson's, and her goals to remain independent at home.

The Engagement Center staff member confers with Community Partners' administrative team and determines that Miguel, a non-clinical staff member who has experience with older adults with neurological conditions, would be a good match to serve as Sonja's Lead Care Manager. Miguel and the Engagement Center staff connect with Sonja again over the phone—after several missed calls—to briefly introduce Miguel and find a time that works best in two days when he can meet her at her apartment. Two days later, Miguel arrives at Sonja's apartment, but she is not at home, having forgotten about the appointment. He returns to the office and calls later in the day. Miguel asks if Sonja has a friend or neighbor they can coordinate the appointment with, so Sonja mentions Arlene could come to the phone. Miguel waits on the line for 10 minutes while Sonja brings Arlene to the phone. They arrange to meet the next day, and Miguel asks Arlene to remind Sonja about the appointment in the morning.

Comprehensive Assessment and Care Management Plan

The next day, Miguel returns to the apartment where he meets Sonja and Arlene after Sonja consents to allowing Arlene to participate and conducts a comprehensive assessment to understand how Sonja's Parkinson's—and related dementia—are affecting her ADLs. Miguel, Sonja and Arlene talk through detailed psychosocial elements that may be affecting her mood and related effects of social isolation. The conversation with the two friends helps to clarify Sonja's LTSS needs related to her mobility challenges and to determine what home safety elements should be put in place. Sonja expresses the importance of staying connected to her nearby friends and a strong desire to remain in her home; she does not want to live in an institutional setting. Miguel, trained in person-centered planning, takes note of this and centers this goal in the development of her care plan. Miguel obtains Sonja's permission for Community Partners to contact her PCP regarding her care.

Another layer of assessment that Community Partners conducts for older adults with complex chronic conditions is a medication reconciliation (HomeMeds℠ program) in the home setting. Instead of relying on self-reporting, Miguel, and Sonja, with Sonja's permission, look through her medications together, which Sonja stores under her bed in a large medicine box. She admits that she does not know which medications she is currently supposed to be taking. Miguel discovers she is taking seven medications—likely not regularly—including several medications for Parkinson's, hypertension, high cholesterol and an antidepressant. He logs them into a software system linked with a national database to identify potential adverse interactions. They also discuss if she has any ongoing medication needs or faces challenges in taking them regularly. After concluding his first visit with Sonja, he sends this information to a staff pharmacist, Faye, and orders a Medi-set—a helpful tool that assists with keeping track of medication on a daily basis.

Enhanced Coordination of Care

Faye reviews the HomeMeds file and places a call to Sonja's PCP, who was unaware that Sonja had been prescribed a high dose of antidepressants by a psychiatrist no longer in her MCP's network that may be aggravating her Parkinson's related tremors. Miguel works with Sonja's MCP to arrange for nonemergency transportation to a follow-up appointment with her PCP, who temporarily reduces her dose of antidepressants.

Sonja becomes anxious because of her PCP's initial determination that she may be suffering from Parkinson's Disease Dementia and is eager to see a specialist. Before his next meeting with Sonja, Miguel checks on the referral the PCP made earlier to a clinic in a nearby county specializing in neurological and movement disorders. The clinic is also part of the network of recognized Age-Friendly Health Systems, which means its clinicians have been trained on evidence-based elements of delivering high-quality care to older adults, including those living with Alzheimer's and related dementias. Arlene drives Sonja to the clinic and an interdisciplinary team consisting of a neuropsychologist, physical therapist, and neurologist, all meet with Sonja to provide therapeutic exercises, modify her medication, and conduct cognitive screenings (e.g., the Montreal Cognitive Assessment used to screen for mild cognitive impairment related to PDD).

Miguel also asks Arlene to connect him with the building's property management company to discuss the needed structural and accessibility updates as identified in her initial assessment. Community Partners also provides Community Supports to help individuals like Sonja regain and retain independence in the home setting. Critical for Sonja to meet her care plan goals, Miguel submits a referral to the MCP for Sonja to receive the Environmental Accessibility Adaptations, or Home Modifications, Community Support. The property management company agrees to have Sonja's unit updated with grab bars and other updates for bathroom safety. Miguel knows that Home Modifications should happen shortly after approval, so when a month passes and there has been no progress, Miguel reaches out to his Community Supports colleagues to ask about the delay and coordinate a contractor to install the equipment. His colleagues meanwhile confirm that there is no backlog for the items that she needs, and he has them delivered to Sonja's apartment.

Comprehensive Transitional Care

Before the apartment updates are completed, and while Arlene is out of town, Sonja develops a urinary tract infection that triggers delirium—a common occurrence for older people living with dementia. A neighbor down the hall hears her cries of distress and calls 9-1-1, and Sonja is admitted to the hospital to treat sepsis caused by her urinary tract infection. Per federal and state policy, hospitals can send notification to MCPs and ECM Providers with the right agreements when one of their Members is admitted to the hospital. The hospital sends an admission, discharge, or transfer (ADT) notification to Sonja's MCP about her admission. Discharge planning begins the same day as admission, and the MCP calls the discharging facility about Sonja, identifying her as requiring high-risk TCS due to her enrollment in ECM. Because the ECM Lead Care Manager must act as the single point of contact for her TCS, the MCP shares Miguel's name and contact information with the hospital case manager. After several days of antibiotics, Sonja is stable, but has become very weak and not able to get out of bed without assistance. She will also require IV antibiotics until she has completed therapy. The inpatient care team determines that she will need SNF care for at least ten days to complete her IV antibiotics and receive physical therapy. They place referrals for local SNFs and initiate the authorization process for SNF care with Sonja's MCP.

Miguel reaches out and meets Sonja in hospital to see how she's feeling and understand her care needs from the hospital inpatient case manager's discharge planning evaluation and instructions before Sonja is discharged to a short-term SNF stay. Miguel also reviews the discharge summary from the hospital and ensures the SNF provider has necessary clinical information to provide their skilled nursing care and follow-up rehabilitation.

Miguel keeps in touch with the SNF case manager on Sonja's condition and needs. After ten days in the SNF, Sonja has improved, but still is significantly deconditioned. The case manager, with Miguel's input on Sonja's home and supports and the clinician's input on her clinical and functional status, determines that Sonja cannot return to her home until the updates are complete and she has additional support in her home.

Community and Social Support Services

Before Sonja leaves the SNF, Miguel reaches out to a Short-Term Post-Hospitalization Housing Community Supports Provider via a presumptive authorization agreement to begin the service for Sonja while the updates are made to her apartment. His aim is to make sure that Sonja returns home to an updated environment and has in-home care in place to support her ADLs. Miguel works with the SNF case manager to ensure all needed MCP authorizations are in place to send her home with a wheelchair and home health services to help support her recovery in any subsequent transitional housing setting and back at home. Home health services can help address her immediate and clinically focused post-acute care needs at home and must be provided by a nurse, or physical or occupational therapist. As Sonja's ECM Lead Care Manager, Miguel also communicates with the home health nurse to provide additional support once Sonja is back at her apartment, including coordinating with Arlene to ensure Sonja's mediations are picked up from the pharmacy and incorporated into the Medi-set.

Miguel connects with a member of the internal team, Devlin, a specialist who supports coordination across ECM and individual Community Supports, and Devlin works behind the scenes with a contractor to complete the home modifications within the week. Devlin helps arrange for the structural supports needed to ensure Sonja's safe transition back home, such as the installation of additional new supports like a shower bench and handheld shower.

Sonja and Miguel also discuss that having day-to-day, in-home support with meals, medications and household tasks may help Sonja stay safely in her apartment. Since Sonja meets the criteria to receive IHSS through her Medi-Cal benefit, Miguel works with Sonja to fill out her IHSS application and coordinates with the county social services agency to schedule an interview to assess the services most appropriate for Sonja to receive. Given that she has been isolated in recent months by her mobility issues and her dementia, Miguel also suggests that Sonja may wish to consider attending a local CBAS Center—a day program servicing older adults and adults with chronic medical, cognitive, or behavioral health conditions and/or disabilities, and submits a referral to her MCP. Since CBAS Centers are only open during the day, IHSS hours can help fill in the gap in care in the evening and early morning. Arlene brings her to her first visit to the CBAS Center and is relieved to learn that the CBAS Center will also provide transportation services between Sonja's apartment and the center. Once her IHSS hours are approved by county social services, Devlin and Miguel can review the number of approved hours and assess whether an additional referral should be made for Personal Care and Homemaker Services Community Support to help fill in any gaps in the long-term services and supports received.

Health Promotion

Miguel and Sonja know that medication adherence is one of the most important components of maintaining independent living and Sonja's wellbeing. Miguel works to set up medication reminders and shows Sonja how to use the automated Medi-set (that is timed and has locking features) that the Community Partners' pharmacist ordered and shares them with her IHSS provider as well. He also helps her connect with the Alzheimer's Association and gain access to tools they offer for navigating the early stages of dementia.

Member and Family Supports

Sonja shares that many of her neighbors meet up weekly at a local park to talk about their families and share stories, and she'd like to be able to see them more regularly. Miguel speaks with Arlene and the IHSS team members to arrange a plan for her to safely join the meet ups on days she prefers to not visit the CBAS Center. He also contacts a staff member at the CBAS Center to connect her to therapeutic group activities offered like group therapy and movement classes tailored for individuals with neurological conditions.

Felix, a 72-Year Old Residing in a SNF and Recovering From a Stroke Who Wishes to Return Home

The following vignette describes how a Member named Felix might be supported by an ECM Provider—Vida Services—with expertise in non-medical senior care and healthcare.

Felix is a 72-year old living with multiple chronic conditions who has a stroke. Upon discharge from the hospital, he spends several months recovering in a SNF. Felix and his wife are looking for support as he prepares to transition back home.

Felix is a Medi-Cal MCP member enrolled in Fee-for-Service Medicare living in Sacramento County. He and his wife, Teresa, have lived in Sacramento over 40 years and raised their children there. Felix has been living with Type 2 diabetes, and high cholesterol for two decades.

After suffering a major stroke, he is admitted to the hospital for 12 days. He experiences partial paralysis on the right side of his body as a result and has limited ability to speak or swallow. His condition does not improve during his hospital stay, and he is admitted a SNF. He requires a feeding tube into his stomach and significant therapies for speech, swallowing and his right-sided paralysis.

Comprehensive Transitional Care

When Felix is initially admitted to the hospital for his stroke, his Medi-Cal MCP, identifies him as a "high-risk" transitioning member due to his LTSS needs. The MCP assigns a dedicated care manager/point of contact, Lenny, to support and meet all of his TCS needs, working in coordination with the hospital case manager to help provide a smooth transition from the hospital to the next care setting. Together with Felix and Teresa, the hospital care team determines that Felix should first be discharged to a SNF (rather than back home) for rehabilitation. Because the SNFs close to Felix's home don't have beds available, Lenny helped the hospital case manager identify a SNF within the MCP network with available beds and found Sunrise SNF, located 50 minutes from his wife Teresa and home. Upon the transition to Sunrise SNF, Lenny ensures the providers and staff have all the necessary clinical information from the hospital that they need to provide follow up care for Felix. Over time, with the therapy and treatment at the Sunrise SNF, Felix's ability to swallow improves, and he no longer needs the feeding tube, receiving pureed foods at the SNF. He still requires a high degree of assistance with his ADLs.

While Felix recovers, the Sunrise case management team reviews Felix's MDS assessment—part of the federally mandated process for clinical assessment of all residents in certified nursing facilities—which reveals his preference for returning home. Teresa has also shared that she'd like Felix to be closer to home than the 50-minute drive to Sunrise. The Sunrise case management team reaches out to Lenny to ensure that all the orders, authorizations and referrals are in place before discharge, so Felix has

all the services and supports he needs to remain at home, including home health nursing, physical therapy and speech therapy to support his rehabilitation and functional needs.

Accessing ECM

Lenny, the MCP contact overseeing Felix's Transitional Care Services, follows up with Felix and his family to discuss how ECM can help oversee his care coordination needs through his post-SNF recovery journey and beyond in the home setting. Lenny contacts Vida Services, an ECM and Community Supports Provider with experience providing integrated care support for older adults during care transitions. Vida has developed relationships with Sunrise's team and those relationships can make Felix's transfer from Sunrise SNF to home go more smoothly. After discussing with Felix and Teresa, Lenny places a referral for ECM. He hopes that ECM can support Felix and Teresa in determining a living arrangement that is best for their family and provide ongoing support to coordinate their needs. Felix's MCP reviews the referral and authorizes him for the standard 12 months of ECM because he meets the POF criteria for:

Adult Nursing Facility Residents Transitioning to the Community

Assigning an ECM Provider

Felix's MCP assigns Vida Services to serve as Felix's ECM Provider because of the organization's expertise and experience serving Members like Felix with complex LTSS needs and close working relationship with Sunrise SNF staff.

Outreach and Engagement

Vida Services identifies one of its Care Navigators—Jolana—to serve as Felix's ECM Lead Care Manager, and she places an initial call to Felix and Teresa to explain ECM and her role. Jolana asks if Felix would be receptive to meeting her for an initial needs assessment at Sunrise, and Felix agrees.

Comprehensive Assessment and Care Management Plan

Jolana meets with Felix after one of his physical therapy sessions at Sunrise. They are joined by Teresa—Felix's wife—for a first conversation and assessment. In addition to leveraging the CCT assessment tool (a screening tool that can help identify Members' transitional care needs between SNFs into home and community-based settings), Vida Services uses their own assessment designed to surface as much actionable detail on the person-centered care needs specific to Felix. The team discusses Teresa's capacity to provide caregiving support, the respite their children could provide, and more details specific to Felix's LTSS needs (including a preliminary screen for Community Supports that he will likely need once transferred to a home setting). Jolana is well trained on how to elevate

the treatment goals and functional needs that Felix wishes to prioritize because of her extensive training in person-centered planning. At the end of the conversation, both Felix and Teresa feel that Jolana understands their needs and their goals for Felix to return to their apartment.

Enhanced Coordination of Care

Jolana, together with David, the Sunrise discharge planner, outline the breadth of services, supports, and equipment that will be helpful to transition Felix safely back to his apartment and address his post-stroke mobility challenges, including the role Jolana will play in remaining coordinated with a home health nurse. Once discharged from Sunrise, Jolana follows up with David's order for durable medical equipment like a shower chair, grab bars, a hemi-walker and raised toilet seat, and a referral for a speech therapist.

Understanding from his care plan that Felix worries about burdening Teresa with his care needs, the Vida team (also a Community Supports provider) begins to map out the Community Supports that are critical to facilitating a successful transition home. Vida Services brings in a specialist on staff—Justin—to serve as point on Community Support-related logistics and planning, while Jolana remains primarily responsible for the overall coordination across Felix's physical care, medications and social supports.

Community and Social Support Services

Justin, Jolana, Felix and Teresa have a team meeting and determine four Community Supports will improve the likelihood of a successful transition for Felix. Justin submits a referral for the following Community Supports:

- *Nursing Facility Transition*: Since Felix has been in a SNF for over 60 days, he is eligible for support in preparing for his transition back home. This service includes coordinating and funding non-emergency, non-medical transportation to assist Felix's mobility needs prior to transition and coordinating funding for environmental modifications to make his apartment accessible as he continues to regain mobility after his stroke.
- *Medically Tailored Meals/Medically-Supportive Foods*: Felix is still regaining his ability to swallow on his own and needs special pureed foods. He is also diabetic and has high cholesterol, so specialized nutrition support and help with groceries are critical to his recovery. Justin coordinates with Jolana and contacts the local Meals and Wheels to ensure that Teresa is present to receive the first delivery before Felix returns home.
- *Personal Care and Homemaker Services*: While Felix is on his way to recovering functional abilities and may not meet the eligibility requirements for IHSS, he can benefit from receiving support that can help avoid a short-term stay in a SNF, such as help with feeding, toileting, and accompaniment to his appointments.
- *Respite Services*: While Teresa is still working part-time at a convenience store while caring for Felix, respite services will be useful and necessary to preempt caregiver burnout and provide

her with an opportunity to rest so that she can continue to support Felix's ability to build more independence in the home environment.

Once Felix's MCP authorizes the Community Supports and the services are in place, Felix returns home. Jolana and Teresa continue to work as a team with a home health nurse on his physical therapy exercises. The home health nurse also helps identify and report on Felix's needs while Teresa is at work and provides updates to Jolana throughout his post-stroke recovery.

Health Promotion

Felix expresses an interest in accessing resources to manage Type 2 diabetes and high cholesterol using an integrated approach that balances physical activity with access to high-quality nutrition. Jolana shares resources from the American Stroke Association, which offers online movement classes and resistance training exercises to help ease Felix back into physical activity while also sharing tools like food diaries. She also contacts Felix's PCP ahead of his next visit to let her know that Felix would like the PCP's medical advice on managing both conditions. Finally, Jolana connects with Felix's MCP to make sure he gains access to the appropriate offerings that may be available through his MCP, like diabetic compression socks to support circulation or a free membership to the nearest YMCA health and wellness center.

Member and Family Supports

Supporting Teresa throughout Felix's recovery is a high priority identified early in Felix's ECM journey. While Teresa received caregiver respite services and is relieved to have additional coverage via Felix's Community Supports, Jolana also facilitates a connection to a regional Caregiver Resource Center for short-term counseling and support groups to help manage her stress and connect with others in the community outside of the home and work environment. Justin also speaks to Teresa and Felix about receiving formal caregiver support via respite services (a Community Support) to meet Felix's post-stroke care needs, especially given that Teresa is also helping with care for their grandchildren while working part-time. Respite services can be provided by the hour on an episodic basis because of the need for support for those normally providing care to individuals.

How Providers Can Get Started in Partnership With MCPs

To diversify and expand ECM Providers and build ECM capacity for MCP Members, DHCS has created a broad set of resources to support ECM development and planning. DHCS encourages new Providers to access the documents below starting with the ECM Policy Guide and ECM Provider Toolkit and to request access to the ECM Technical Assistance (TA) Marketplace as they refine their capacity to provide ECM.

1. Determine If ECM Is Right for Your Organization

Determine whether your organization has the relevant experience, capacity and infrastructure to become an ECM Provider. Here are some elements to consider:

- ☐ **Do you have the expertise and experience to provide ECM?**

  Providers of ECM must have capacity to provide intensive, in-person, timely care management; person-centered care coordination; and services to the specific POFs they would serve, in a culturally and linguistically competent manner.

  - Consult the **ECM Policy Guide** to learn the experience requirements for ECM Providers.

- ☐ **Do you have the necessary infrastructure to provide ECM—or could you create it?**

  Providers of ECM must be able to either submit claims to MCPs or use a DHCS invoicing template to bill MCPs, and they must have a documentation system for care management. They also must bidirectionally share data with their MCP partners about Members.

  - Review the DHCS **data guidance documents**.

DHCS Resources for Prospective and Contracted ECM Providers

DHCS is committed to supporting prospective and contracted ECM Providers through a broad range of resources. Please click the links below to learn more.

The **Providing Access and Transforming Health (PATH)** Initiative supports providers interested in building capacity and infrastructure and obtaining technical assistance to build and scale ECM and Community Supports. It includes the following resources:

- ☐ **Technical Assistance (TA) Marketplace** offers providers, CBOs, counties, tribal partners, and others access to a range of off-the-shelf and hands-on technical assistance (TA) resources needed to implement ECM. Providers can view potential TA offerings through the "Shop" tab on the Marketplace. DHCS encourages organizations hoping to learn more about TA offerings to create an account and request access from DHCS by sending an email to the TA Marketplace Team at ta-marketplace@ca-path.com. For more details visit the *'Am I eligible'* section of the TA Marketplace.

- Watch **DHCS webinars** that provide an overview of the **data sharing and billing requirements** and showcase **how ECM Providers have implemented those requirements**.
- Apply for **Capacity and Infrastructure Transition, Expansion, and Development (CITED) grants** to build the data and billing infrastructure needed for ECM.

☐ **Does ECM make financial sense for your organization?**

Organizations are encouraged to consider the financial impact of participating in ECM.

- The **TA Marketplace** provides both off-the-shelf and hands-on resources to help Providers implement ECM.
- The **ECM Provider Toolkit** offers guidance on how to talk with an MCP about ECM Provider payment rates, which are not set by DHCS.
- Providers are encouraged to explore funding sources, such as **(IPP)** and **(CITED) grants**, that might enhance capacity for launch.

☐ **Capacity and Infrastructure Transition, Expansion, and Development (CITED) grants** provide funding to ECM and Community Supports Providers to build capacity in areas such as limited staffing support, care management or billing capabilities, or other technology infrastructure such as data exchange with contracted MCPs or providers in network.

☐ Regional **Collaborative Planning and Implementation (CPI)** groups that support local information sharing and collaborative implementation among MCPs, providers, counties, and other local stakeholders.

☐ The **Incentive Payment Program (IPP)** supports the implementation and expansion of ECM by providing incentives to MCPs. Ask your local MCPs if IPP funds are available to help build capacity and infrastructure for ECM.

DHCS-hosted ECM and Community Supports **webinar series** also provides policy guidance, spotlights provider models for ECM, and lifts up other critical technical assistance to promote ECM program success.

☐ **Have you considered the related Community Support Services and whether they make sense for your organization?**

Organizations that are considering becoming ECM Providers for this population of focus are encouraged to consider also offering the related community support service (1) Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF); (2) Community Transition Services/Nursing Facility Transition to a Home. These Community Support services are designed to support these populations of focus and allow members to have access to related services that would enable them to safely transition or be in the community. For more details, consult the **Community Supports Policy Guide**.

- The **TA Marketplace** provides both off-the-shelf and hands-on resources to help Providers implement Community Support Services.
- Providers are encouraged to explore funding sources, such as **(IPP)** and **(CITED) grants**, that might enhance capacity for launch.

2. Determine Which POFs To Serve

For organizations that are a good fit for ECM, there are several steps to consider in determining which POF to serve, including:

☐ **Identify where you have specific expertise and experience within the communities your organization serves.**

Members in each POF have distinct needs, and the providers who serve them must have expertise and experience addressing those needs to ensure trust and engagement with these populations. Prospective providers are encouraged to review this Spotlight and the **ECM Policy Guide** and compare these elements to determine which POFs they are equipped to serve.

- One of the Providers interviewed for this Spotlight, Partners in Care Foundation participated in Health Homes Program through the Whole Person Care pilots, the CCT demonstration and was an experienced 1915(c) waiver provider before transitioning their expertise to ECM. Another provider, MasterCare, had extensive experience supporting older adults during care transitions, but was new to contracting with MCPs, and started by providing ECM to homeless individuals and individuals with SUD/SMI. Their goal was to learn how to partner with MCPs and learn about billings and claims processes so that when ECM for the LTC POFs launched, they would be able to expand their footprint. Their MCP partners asked them to expand to LTC because of their experience supporting older adults in navigating alternatives to institutional long-term care.

☐ **Talk with your local MCP(s) to understand potential referral volumes and what they are looking for in their network.**

MasterCare reflected on how they worked with their MCPs to determine which counties most needed their ECM support. "The MCPs identified some needs, in rural areas particularly. We put forth a regional strategy to leverage efficiencies and [the MCPs] approved it. We are serving ECM populations in some of California's most densely populated areas and some of the most rural. There are two different sets of challenges for those population mixes. We've been going where the health plans have asked us to go. We have been able to maintain a consistent level of quality services across all geographies."

☐ **If you have capacity constraints, determine whether it may be more feasible for your organization to launch with one or a small subset of POFs.**

3. Become an ECM Provider

For organizations that decide to become an ECM Provider, there are several steps to implementation.

- ☐ **Connect with local partners working on ECM implementation.**
  - Joining your regional **CPI groups** will connect you with local partners—including MCPs, county departments, and local TA providers—who can facilitate your entry into ECM.
- ☐ **Reach out to your local MCP(s) to discuss contracting for ECM.**
  - The **ECM Provider Toolkit** offers guidance on how to approach contracting with MCPs.
  - The **TA Marketplace** provides both off-the-shelf and hands-on resources to help providers with becoming Medi-Cal providers and contracting for ECM.
- ☐ **Determine the ECM model of care for each POF you'll serve.**

  Providers for the LTC POF are encouraged to work closely with other providers in their county to design their model and establish roles, data sharing, and referral systems with other care management and social service programs.

  - **DHCS webinars** spotlight various ECM models of care across the state and provide guidance on **how Community Supports can be integrated into ECM** for Long-term Care POFs.
  - The **TA Marketplace** has resources that help providers build models of care for specific POFs.
- ☐ **Build the capacity and infrastructure—including data sharing and billing workflows—needed to launch.**

  MasterCare reflected on their journey to readiness for ECM by sharing that "(one MCP) heard of what we were doing through a series of pilots and encouraged us through an RFI (request for information) to consider participating in ECM and Community Supports for Nursing Facility Transition and Diversion. Understanding the MCP world involved a fairly significant learning curve, but because our service model is based upon providing high quality care to older adults, the MCPs have appreciated that the goals were aligned. "The collaboration has been fantastic," reports MasterCare CEO, Debra Draves.

  - The **TA Marketplace** provides resources to support staff training, billing/coding, data sharing, and more.
  - Applying for a **CITED grant** could help you build capacity and infrastructure to provide ECM.
  - Your MCP may offer **IPP** funding opportunities to ECM Providers.

Your patients may be ready for ECM today.

All providers—prospective, contracted, or those serving individuals navigating LTC who need ECM—are strongly encouraged to reach out to their local MCP to learn how to refer eligible Members to the ECM benefit.

Key ECM Resources

- **ECM Policy Materials**
  - ECM Policy Guide
  - ECM and Community Supports Policy Cheat Sheet
- **ECM Technical Assistance**
  - ECM Provider Toolkits
  - ECM Member Toolkit
  - ECM Outreach Toolkit
  - ECM & Community Supports Webinar Series
  - TA Marketplace
  - Collaborative Planning and Implementation (CPI)
  - ECM for Children and Youth: A Population of Focus Spotlight
  - ECM for Individuals Experiencing Homelessness: A Population of Focus Spotlight
- **ECM Billing and Data Guidance**
  - ECM Member-Level Information Sharing Guidance
  - ECM & Community Supports Coding Options
  - Billing & Invoicing Guidance
  - National Provider Identifier (NPI) Application Guidance
  - Social Determinants of Health (SDOH) Coding Guidance
  - CalAIM Data Sharing Authorization Guidance (DSAG) 2.0
  - Quarterly Implementation Monitoring Report Requirements

- **ECM Model of Care Template**
  - ECM and Community Supports Model of Care Legacy Template
  - ECM Model of Care Template Addendum I for Long-Term Care POFs
- **Funding Opportunities**
  - Funding Opportunities Cheat Sheet
  - Incentive Payment Program (IPP)
  - Providing Access and Transforming Health (PATH)
  - PATH Capacity and Infrastructure Transition, Expansion, and Development (CITED) grants