Los Angeles County Managed Care Plans:

L.A. Care Health Plan
Anthem Blue Cross
&
Blue Shield Promise Health Plan

Enhanced Care Management (ECM) Provider Reference Guide

Version 4.0

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1 Introduction

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

Effective January 1, 2022, MCPs in Los Angeles County (LA MCPs) will launch the Medi-Cal ECM benefit designed by the Department of Health Care Services (DHCS) and authorized by the Centers for Medicare and Medicaid Services (CMS) to provide seven core services at the point of care:

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

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

The Los Angeles MCPs are required to contract with community-based ECM Providers that have experience serving the ECM populations of focus, and expertise providing the core ECM services, to provide services to eligible Members under the Medi-Cal ECM benefit. The ECM populations of focus eligible for the ECM benefit are:

ECM Population of Focus	L.A. County Go-Live Date[1]
1. Individuals and families experiencing homelessness	January 1, 2022
2. Adult High Utilizers	
3. Adults with Serious Mental Illness (SMI) or Substance Use Disorder (SUD)	
4. Individuals transitioning from incarceration (adults and children/youth)	
5. Members Eligible for Long Term Care (LTC) services and at Risk of Institutionalization	January 1, 2023
6. Nursing home residents transitioning to the community	
7. Children and Youth Populations of Focus high utilizers or with Serious Emotional Disturbance (SED)	July 1, 2023

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[1] As of DHCS Guidance (DHCS ECM Policy Guide) provided September 2021, and subject to further change by DHCS.

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

This ECM Provider Reference Guide outlines the requirements and expectations for ECM Providers contracted with each individual LA MCP. The MCP may provide updated versions of this ECM Provider Reference Guide in the future.

2   Regulatory Authorities

By entering into the Enhanced Care Management Services Agreement (contract) with each LA MCP, the ECM Provider agrees to follow the ECM benefit requirements as established under Law, regulation, and through any service agreements between the MCP and DHCS, including Member materials applicable to the ECM benefit. The ECM Provider will provide the ECM services in accordance with all applicable Federal and State law and regulatory guidance as outlined in the signed contract.

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

ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus, with which they have experience and expertise. ECM will be offered primarily through in-person interaction where Members and their families and support networks live, seek care, and prefer to access services. MCPs are required to contract with ECM Providers to deliver ECM to Members. To contract with MCPs and before providing ECM services, the ECM Provider must meet several requirements.

3.1   Provider Experience and Qualifications

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

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

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

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

The ECM Provider must comply with all applicable state and federal laws and regulations and all ECM benefit requirements in the DHCS-MCP ECM contract and associated guidance.

3.2   Provider Certification

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

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

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

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

8	ECM Core Service Components: Coordination & Referrals to Community & Social Support Services
9	ECM Provider Administration & Operations: Claims/Encounters
10	ECM Provider Administration & Operations: File Data Exchange
11	ECM Provider Administration & Operations: Staffing
12	ECM Provider Administration & Operations: Oversight & Monitoring

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

3.3   Medicaid Enrollment/Vetting for ECM Providers

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

3.4   Contracting

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

3.5   Staffing, Provider Capacity & Training

3.5.1   ECM Provider Care Team Staffing

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

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

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

aspects of ECM and coordination with a Community Supports Provider, as applicable. To the extent a Member has other care managers, the Lead Care Manager is considered to be the primary care manager for the Member and will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services. ECM Providers must have protocols in place outlining how clinical supervision is provided to non-licensed (i.e., paraprofessional) staff Members serving as a Lead Care Manager to ensure continued guidance, training, and clinical support to appropriately oversee an ECM Member's Care Plan and care coordination.

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

- Lead Care Manager/s
- ECM Director
- ECM Clinical Consultant/s

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

- Community Health Workers

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

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

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

3.5.2   Lead Care Manager Caseload Ratio

LA MCPs require Lead Care Managers to be assigned a **maximum** caseload of 50 ECM enrolled patients to 1 Lead Care Manager (a 50:1 ratio).

3.5.3   Staffing and Capacity Report

To understand the organization's staffing capacity, measure network adequacy, demonstrate growth over time, and identify staff who will need to complete required training, ECM Providers are required to submit an initial, prospective ECM Provider Staffing and Capacity Report to the LA MCP before providing ECM services (as part of the ECM Provider Certification process). After ECM go-live, ECM Providers will be required to submit Staffing and Capacity reports at minimum on a monthly basis. LA MCPs provide ECM Providers a standard ECM Provider & Staffing Capacity reporting template (Appendix B) for the ECM Providers to use. The required report includes the following, subject to change:

- TIN/NPI
- Team members' names
- Team members' contact information
- Team members' ECM role
- Team members' ECM caseload capacity for ECM enrolled Members (quarterly)
- Identification of ECM PoF's served at each provider NPI location
- Member caseload for each MCP within the context of service provision to all MCPs with whom the ECM Provider is contracted

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

3.5.4   Training

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

4   ECM Member Eligibility, Assignment and Enrollment

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

4.1   ECM Eligibility Criteria

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

ECM Population of Focus	Los Angeles County Go-Live Date for ECM Providers to Serve these Members
1. **Individuals and families who are experiencing homelessness AND** have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes ***AND/OR*** decreased utilization of high-cost services. See DHCS definition of homelessness below.	January 1, 2022
2. **Adult High Utilizers** are adults with 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** three or more unplanned hospital and/or short-term skilled	January 1, 2022

nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.	
3. **Adults with Serious Mental Illness (SMI) or Substance Use Disorder (SUD)** are adults who meet the eligibility criteria for participation in or obtaining services through the County Specialty Mental Health (SMH) System **AND/OR** the Drug Medi-Cal Organization Delivery System (DMC-ODS) **OR** the Drug Medi-Cal (DMC) program **AND** are actively experiencing 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** meet one or more of the following criteria: are at high risk for institutionalization, overdose and/or suicide; use crisis services, ERs, urgent care or inpatient stays as the <u>sole</u> 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 women (12 months from delivery).	January 1, 2022
4. **Individuals who are transitioning from incarceration** or transitioned within the past 12 months **AND** have at least one of the following conditions: chronic mental illness, SUD, chronic disease (e.g., hepatitis C, diabetes), intellectual or developmental disability, traumatic brain injury, HIV or pregnancy. This list of criteria is aligned with the eligibility criteria for pre-release coverage in California's 1115 Demonstration Amendment and Renewal Application (pg. 37): https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Waiver-Renewal-Application.pdf	January 1, 2022
5. **Individuals at risk for institutionalization and eligible for long-term care services** who, in the absence of services and supports, would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF). Individuals must be able to live safely in the community with wraparound supports.	January 1, 2023
6. **Nursing facility residents who want to transition to the community**, who are strong candidates for successful transition back to the community and have a desire to do so.	January 1, 2023
7. **Children and Youth Populations of Focus*** include children (up to Age 21) experiencing homelessness; High utilizers; Serious Emotional Disturbance (SED) or identified to be at Clinical High Risk (CHR) for Psychosis or Experiencing a First Episode of Psychosis; enrolled in California Children's Services (CCS)/CCS Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition; involved in, or with a history of involvement in, child welfare (Including Foster Care up to Age 26); and transitioning from incarceration.	July 1, 2023

Note: Eligibility criteria and Los Angeles County Go-Live Dates are as of DHCS Guidance provided September 2021 (DHCS Policy Guide), and subject to further change by DHCS.

*DHCS indicated that definitions and detailed eligibility criteria for the Children and Youth Populations of Focus (Population of Focus #7) are forthcoming.

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

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

In addition, in Los Angeles County, the MCPs will support the transition of Members to ECM and enrollment in ECM January 1, 2022, for:

- All Members enrolled in a WPC Pilot as of 12/31/21, who are identified by the WPC Lead Entity as belonging to a Population of Focus (includes children and youth currently served by WPC-LA)
- All Members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in the HHP as of 12/31/21 (includes children and youth currently served by HHP)

4.2   Continuity of ECM Services for Members who Change Managed Care Plans

The Los Angeles-area health plans will preserve continuity of ECM services for members who were receiving ECM with a prior health plan and have changed health plans. Members and/or their family member or Authorized Representative may request enrollment into ECM upon the transfer of their care from a prior Managed Care Plan where they were receiving the ECM benefit. Members will be requested to provide the name of the prior Managed Care Plan and/or the prior ECM Provider to facilitate continuity and mitigate gaps in care.

Requests should be submitted via referral to the new Managed Care Plan using the ECM referral form and identifying ECM eligibility as Continuity of Care, in addition to any applicable ECM Populations of Focus.

Managed Care Plans will also conduct a retrospective review of data supplied by DHCS to identify members who have changed health plans and received ECM services with their prior health plan. These

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[3] This definition is based on the US Department of Housing and Urban Development (HUD) definition of homelessness with modifications as noted below.

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

members, when identified through the data, will be identified as ECM eligible and included on the Member Information File (MIF) for outreach and engagement.

4.3   ECM "Exclusion Criteria" And ECM Overlapping Programs

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

Approach	Explanation	Programs
ECM as a "wrap"	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. These Programs are considered to be complementary of ECM.	**Programs Carved Out of Managed Care** • California Children's Services (CCS) • Genetically Handicapped Person's Program (GHPP) • County-based Targeted Case Management (TCM) • Specialty Mental Health (SMHS) TCM • Adult Full Service Partnership (FSP) • SMHS Intensive Care Coordination for children (ICC) • Drug Medi-Cal Organized Delivery Systems (DMC-ODS) **Programs Carved into Managed Care** • CCS Whole Child Model • Community Based Adult Services (CBAS) **Coverage for MCP Members Dually Eligible for Medicare and Medicaid** *Note: Dually eligible MCP Members can receive ECM if they meet ECM Population of Focus criteria.* • Dual Eligible Special Needs Plans (D-SNPs) (from 2023) • D-SNP look-alike plans • Other Medicare Advantage Plans • Medicare FFS **Other Programs** • AIDS Healthcare Foundation Plans *Members receiving FSP services from counties can be eligible for and receive ECM services. MCPs will work with counties to identify Members receiving FSP services and ensure non-duplication of services.*

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. These Programs are considered to be duplicative of ECM.	**1915 c Waiver Programs** • Multipurpose Senior Services Program (MSSP) • Assisted Living Waiver (ALW) • Home and Community-Based Alternatives (HCBA) Waiver • HIV/AIDS Waiver • HCBS Waiver for Individuals with Developmental Disabilities (DD) • Self-Determination Program for Individuals with I/DD **Programs Carved into Managed Care** • Basic Case Management • Complex Case Management **Other Programs** • California Community Transitions (CCT) Money Follows the Person (MFTP)
Excluded from ECM	Medi-Cal beneficiaries enrolled in the other program are excluded from ECM. These Programs are ECM exclusionary criteria.	**Coverage for MCP Members Dually Eligible for Medicare and Medicaid** • Cal MediConnect • Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) • Program for All Inclusive Care for the Elderly (PACE) **Other Programs** • Family Mosaic Project Services • Hospice

Unlike HHP, Members with a share of cost are not excluded from ECM. Full scope Members enrolled in the MCP are eligible for ECM if they meet ECM eligibility criteria, regardless of their share of cost.

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

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

4.3.1   ECM Provider Expectations

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

## 4.4 Methods to Identify Potentially Eligible Members

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

- **ECM Member Information File (MIF)** which is a list of assigned Members provided by the MCPs to ECM Providers on a regular basis. It is a list of Members assigned to each ECM Provider who may potentially meet the ECM eligibility criteria based on the lists DHCS provides to the MCP and internal MCP data. This will be the primary source for outreach, engagement, and enrollment in ECM. ECM Providers are required to utilize this list to identify, screen, enroll, and provide ECM core services to eligible and enrolled ECM Members.

- **ECM Provider Referrals** to the MCP of potentially eligible Members identified at the point of care. The ECM Provider is encouraged to identify Members who would benefit from ECM. After the ECM Provider identifies a Member, the ECM Provider needs to complete and send an ECM Member referral form, along with a completed Population of Focus Screening Checklist and any applicable supporting documentation as evidence of the member meeting ECM criteria to the MCP through the MCP's designated method. All ECM Member referrals will be clinically reviewed by the MCP and may either be approved or denied for ECM. Upon approval from the MCPs, Members will be added to the ECM Member Information File (MIF). Please refer to Section 4.3.2 ECM Eligibility Referral Process for more details on the referral process.

- **Referrals** from other MCP staff, homeless services providers, shelters, recuperative care providers, community partners and other service providers. The referring entities will follow the same referral process as the ECM Provider Referrals. Please refer to Section 4.3.2 ECM Eligibility Referral Process for more details on the referral process.

- **Member Self-Referrals** to ECM Provider or MCP due to the Member receiving information about the ECM benefit through Member-informing materials.

4.4.1 MCP Member Assignment to ECM Providers

The MCP is responsible for communicating new Member assignments to the ECM Provider as soon as possible, but no later than ten business days after ECM authorization.

LA MCPs conduct data mining and risk stratify Members to assign Members to ECM Providers, and will distribute lists of the eligible Members to the ECM Provider.
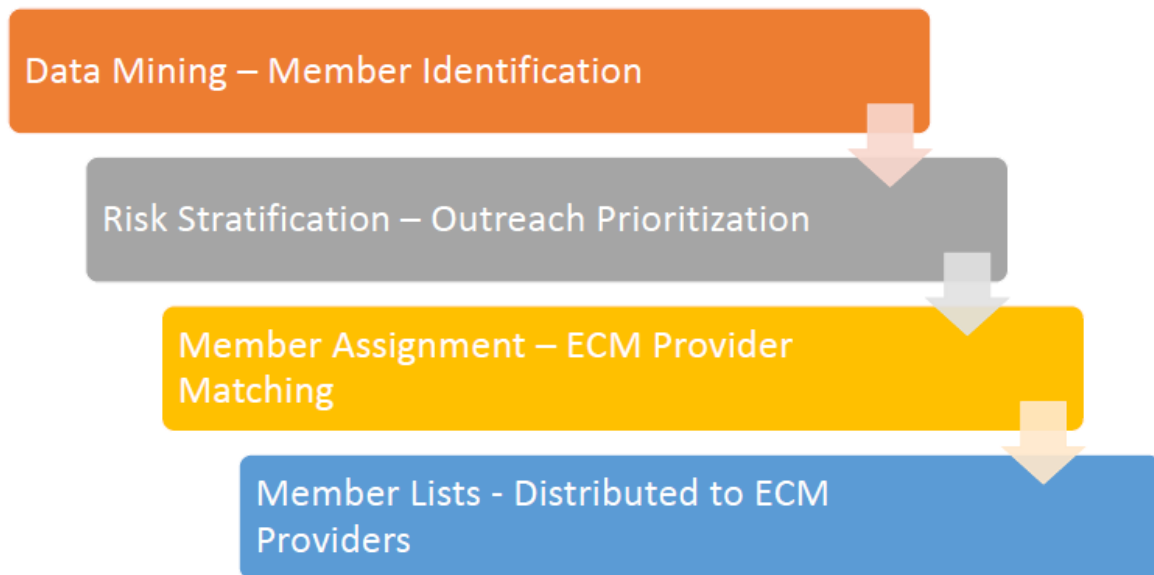
The ECM Provider is responsible to immediately accept all Members assigned by the MCP for ECM, with the exception that if the ECM Provider is at its pre-determined capacity, an ECM Provider is allowed to decline a Member assignment. If an ECM Provider is at capacity, the ECM Provider must notify the MCP if it does not have the capacity to accept a Member assignment.

4.4.2   ECM Eligibility Referral Process

Members, providers (ECM Providers and non-ECM Providers), community-based organizations and other MCPs are encouraged to refer Members identified as potentially eligible for the ECM benefit. Providers may see Members that are not listed on the Member Information File (MIF) file distributed from the MCPs to each ECM Provider.

4.4.2.1   ECM Provider or Other Referring Entity Initiated Eligibility Referral

There are 3 steps to the LA ECM screening and referral process:

- **Step 1:** Complete the **Population of Focus Screening Checklist** to confirm member eligibility in **one or more** Populations of Focus.
- **Step 2:** Complete the **Exclusionary Screening Checklist as a 2nd step** to verify member eligibility.
- **Step 3:** If the ECM Provider or Referring Entity determines the member to be eligible for the ECM benefit based on **both Screening Checklists,** complete and submit the **ECM Referral Form** and **Population of Focus Screening Checklist** to the MCP. To expedite the review and approval process, **please also submit applicable supporting documentation as evidence of the member meeting ECM criteria**. Send securely through the MCP's designated method listed on the referral form. The Exclusionary Screening Checklist is not required to be submitted. The MCP will review and verify the member's eligibility and respond within one week (5 business days).

The LA MCPs will provide to ECM Providers, community partners, and other relevant service providers:

1. LA County ECM Benefit Populations of Focus Screening Checklist (Appendix C)
2. LA County ECM Benefit Exclusionary Screening Checklist (Appendix C)
3. LA County ECM Benefit Member Referral Form to complete and submit to the applicable MCP (Appendix C)

The LA MCPs request [4] the referring entities to complete and submit the standardized Population of Focus Screening Checklist and referral form to the applicable MCP.

L.A. Care recommends the following documentation be submitted with the referral form and completed Population of Focus Screening Checklist, based on Populations of Focus criteria (Reference Populations of Focus Screening Checklist):

1. For Populations of Focus #1: Individuals and Families Experiencing Homelessness
   a. Individuals and Families Experiencing Homelessness: Attestation of provider or member's self-report required

   b. Has 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: Supporting documents (clinic note, discharge summary, problem list, etc.) required

2. For Populations of Focus #2: Adult High Utilizers with Frequent hospital or ER Admissions
   a. ER visits, unplanned hospital admissions, short term skilled nursing facility stays: Supporting documentation (clinic notes, discharge summary, etc.) required

3. For Populations of Focus #3: Adults with SMI/SUD and other Health Needs
   a. Obtain services through County SMH system and/or DMC-ODS: Provider or member attestation required

   b. Experiencing one complex social factor: Provider or member's attestation required

   c. Meet one or more of High risk for institutionalization, overdose and/or suicide; Use crisis services, ERs, urgent care or inpatient stays as the sole source of care; 2+ ED visits or 2+ hospitalizations due to SMI or SUD in the past 12 months; Pregnant or post-partum: Provider or member attestation required

4. For Populations of Focus #4: Individuals Transitioning from Incarceration
   a. Individuals Transitioning from Incarceration or have transitioned within the past 12 months: Provider or member attestation required
   b. Has at least one of the conditions listed on the Populations of Focus Screening Checklist: Supporting document (clinic note, discharge summary, problem list) required

Once the completed referral form is received and reviewed, the MCP may follow up with the referring entities (e.g., ECM and non-ECM Providers, Members, other organizations) to request supporting documentation and/or evidence to facilitate making an eligibility determination.

Once the MCP makes a final ECM eligibility determination for the Member, the MCP will notify the ECM Provider. If the Member is found to be ineligible and denied for ECM, the Member will receive a notice of action from the MCP.

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[4] Some MCPs may require the submission of the L.A. County ECM Populations of Focus (PoF) Screening Checklist and/or the L.A. County ECM Benefit Exclusionary Screening Checklist.

If the Member is determined to be eligible for the ECM, the MCP will notify the ECM Provider, the Member will be authorized for ECM services, and the ECM Provider must conduct the required outreach and engagement activities to obtain Member opt-into ECM and begin to provide the ECM core services.

4.4.2.2   Member Initiated Eligibility Referral

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

ECM Providers are required to notify the MCP of any Members who express interest in enrolling in the ECM Members, including members who may not be ECM eligible.

4.5   Outreach & Member Engagement

4.5.1   ECM Provider Conducted Outreach

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

The ECM Provider is expected to conduct outreach **primarily through in-person interaction** where Members and/or their family member/s, guardian, caregiver, and/or authorized support person/s live, seek care, or prefer to access services in their community, subject to public health protocols. The ECM Provider may supplement in-person visits with secure teleconferencing and telehealth[5], where appropriate and with the Member's consent. The ECM Provider must use the following modalities for engagement, as appropriate and as authorized by the Member, and to the extent possible if in-person modalities (including community and street-level outreach) are unsuccessful or to reflect a Member's stated contact preferences: mail/letter, email, texts, telephone calls, and telehealth. ECM Providers should use an active and progressive approach to outreach and engagement until the Member is engaged. ECM Providers should provide culturally and linguistically appropriate communication and information to engage Members.

The LA MCPs require that one in five outreach attempts to assigned members must be in-person and that a minimum of three different types or modes of outreach should be utilized within a 30 day period.[6] ECM Providers must have the capacity and strong commitment to conduct in-person outreach.

The ECM Provider must comply with non-discrimination requirements set forth in State and Federal law and the Contract with the MCP.

Member engagement and response will vary based on the particular Member's circumstances. ECM Providers' ECM outreach activity protocols to assigned members must include active, meaningful, and progressive attempts to reach Members each month between the initial 30 and 90 day period, until each

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[5] The ECM Provider is responsible to ensure secure teleconferencing and telehealth systems meet DHCS requirements. DHCS provides information on Medi-Cal and Telehealth at: https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx.
[6] In-person/face to face visits are subject to public health protocols per DHCS.

Member is notified and engaged. The ECM Providers should document outreach and engagement attempts and modalities. The outreach and engagement expectations outlined in this section apply to assigned members not yet enrolled into ECM.

Please reference Appendix F: Outreach Protocol for more information as to outreach protocols.

Once the ECM Provider determines that a Member is not reachable within 90 days, declines to participate, continues to disengage, or meets an exclusion criterion, the ECM Provider is expected to exclude the Member from further outreach and report the information to the MCP in the Member Information Response File submission to the MCP. If the ECM Provider cannot contact an enrolled member after three attempts and a mailed letter, the ECM Provider is expected to exclude the Member from further outreach and report the member disenrollment information to the MCP in the Return Transmission File (RTF) submission to the MCP.

ECM Providers are required to also report monthly on member outreach activity to the MCPs in the Outreach Tracker File (OTF).

ECM Providers are expected to provide a phone number for Members to reach their ECM care team.

4.5.2   MCP Conducted Outreach, including WPC/HHP Transition Notices

MCPs will outreach to its ECM-eligible Members, including notifying HHP Members of the transition to ECM and working with WPC Lead Entities to notify WPC Members of the transition to ECM. WPC Lead Entities are anticipated to outreach to WPC enrollees transitioning to ECM per DHCS requirement.

4.6   Whole Person Care / Health Homes Program (WPC / HHP) Transition

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

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

- Automatically enroll all Members enrolled in a WPC Pilot on 12/31/21, who are identified by the WPC Lead Entity as belonging to an ECM Population of Focus; and
- Ensure each Member is automatically enrolled under this provision (also referred to as the grandfathered ECM Member population) is assessed by the ECM Provider within six months of enrollment in ECM, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.

To ensure continuity between HHP and ECM, the MCP will:

- Automatically enroll ECM for all Members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in HHP on 12/31/21; and
- Ensure each Member is automatically enrolled in ECM under this provision (also referred to as the grandfathered ECM Member population) is assessed by the ECM Provider within six months of enrollment in ECM, to determine the most appropriate level of services for the Member, and to confirm whether ECM or a lower level of care coordination best meets the Member's needs.

ECM Providers will need to reassess grandfathered WPC and/or HHP members assigned to them by the MCP within six months or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs. ECM Providers will be required to conduct a Member re-assessment by or before six months of enrollment in ECM based on the ECM program completion/step-down criteria. Additional information on the ECM program completion/step-down criteria can be found in Section 4.8.2.3 Program Completion.

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

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

4.7.1 Confirm Member Eligibility

At the time of outreach, if the Member expresses interest in opting into the ECM benefit, ECM Providers are requested to confirm Member eligibility and appropriateness for ECM at the time of Member opt-in. During initial engagement, ECM Providers are expected to use methods appropriate to their workflow to identify, to the best of their ability, if the Member meets any exclusion criteria or is enrolled in any duplicative care coordination programs as outlined. The MCPs provide the ECM Providers with the LA County ECM Benefit Populations of Focus Screening Checklist (Appendix C) and the LA County ECM Benefit Exclusionary Screening Checklist (Appendix D) to support ECM Providers during the Member engagement and intake process.

ECM Providers are encouraged [7] to utilize and integrate the L.A. County ECM Benefit Populations of Focus Screening Checklist and the L.A. County ECM Benefit Exclusionary Screening Checklist in their initial engagement workflow when determining eligibility. ECM Providers may utilize the following during their ECM eligibility screening process:

- Reviewing available data or reports provided to the ECM Provider by the MCP
- Reviewing Member Electronic Health Records (EHR), Health Information Exchange (HIE), and admit discharge transfer (ADT) data
- Member discussion

ECM Providers are required to notify the MCP of any Members who express interest in enrolling in the ECM benefit, and notify the MCP of any Members who may not be ECM eligible. If a question arises regarding an MCP Member's eligibility for ECM, the ECM Provider should contact the MCP. The MCP may request supporting documentation from the ECM Provider to assist in the eligibility determination for members ECM Providers identify as potentially eligible for ECM.

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[7] Some MCPs may require the submission of the L.A. County ECM Populations of Focus (PoF) Screening Checklist and/or the L.A. County ECM Benefit Exclusionary Screening Checklist

4.7.2   Member Opt-in to Enroll

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

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

4.7.3   Member Authorization for Data Sharing

The ECM Provider is required to obtain, document, and manage Member authorization for the sharing of Personally Identifiable Information between MCP and ECM, Community Supports, and other Providers involved in the provision of Member care to the extent required by federal law.

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

4.7.4   Assign Lead Care Manager

Upon initiation of ECM, the ECM Provider must assign each ECM enrolled Member a Lead Care Manager who interacts directly with the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any Community Supports, and other services that address social determinants of health (SDOH) needs, regardless of setting.

4.7.5   Member Ability to Change Provider

ECM Members can request to change their ECM Provider at any time.

4.7.5.1   Provider Expectations

Upon initiation of ECM, the ECM Provider must advise the ECM Member on the process for changing ECM Providers, which is permitted at any time. If the ECM Member requests, the ECM Provider must advise the Member on the process for switching ECM Providers. If the Member wishes to change ECM Providers, the ECM Provider must notify the MCP as such. Members may also call the MCP Member Services line to initiate a provider change. Reminder that the Member's right to choose between the ECM benefit and other duplicative programs must always be maintained.

4.7.5.2   MCP Expectations

The MCP is required to implement any requested ECM Provider change within thirty days.

4.8   ECM Service Provision Expectations

ECM Providers are expected to ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members enrolled in managed care. The ECM Provider must ensure the approach is person-centered, goal oriented, and culturally appropriate. If the ECM Provider subcontracts with other entities to administer ECM functions, the ECM Provider will ensure agreements with each entity bind the entities to the terms and conditions

set forth here and that its Subcontractors comply with all requirements in these Standardized Terms and Conditions and the DHCS-MCP ECM Contract. The utilization of any ECM Provider subcontractors must be vetted and approved by MCPs and subject to the requirements outlined in Required Area 12 of the ECM Provider Certification Application.

Reminder, as stated in [Section 3.5.1 of this guide](#), the ECM Provider must ensure each Member receiving ECM has a Lead Care Manager.

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

The ECM Provider must also collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and other associated entities, such as Community Supports Providers, as appropriate, to coordinate Member care.

4.9   ECM Core Services

The MCP will work closely with contracted ECM Providers to deliver all core service components of ECM to each of the ECM Provider's assigned Members, in compliance with the MCP's Policies and Procedures. The core services of ECM consist of the following core services.

4.9.1   Outreach and Engagement of MCP Members into ECM

See [Section 4.4.1. of this guide](#).

4.9.2   Comprehensive Assessment and Care Management Plan

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

- In-Person Contact
- Person-centered
- Comprehensive assessment
- Member-centered Care Plan
- Timely reassessment

ECM Providers are required to engage with each Member authorized to receive ECM primarily through **in-person contact**. Public health precautions and recommendations should be used to accomplish the community-based, in-person approach of ECM. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider is expected to use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication according to Member choice.
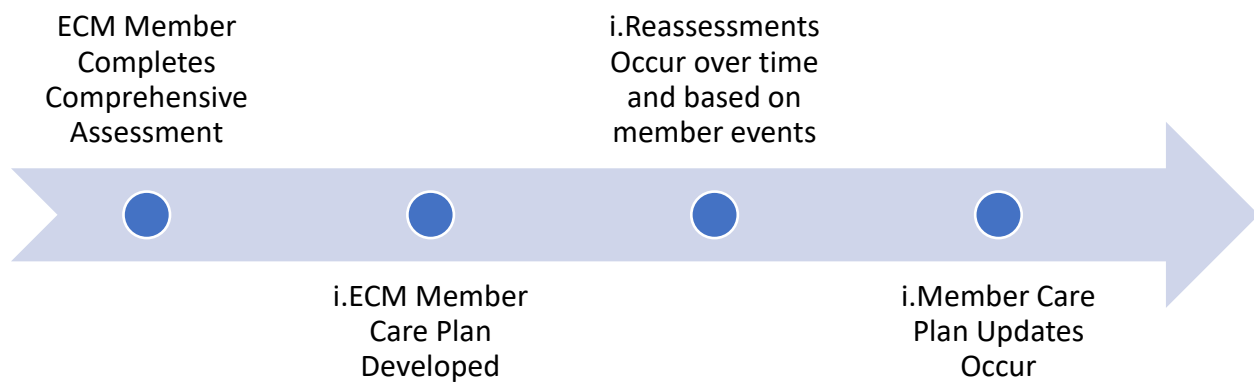
ECM Providers are required to identify necessary clinical and non-clinical resources that may be needed to appropriately **assess Member health status and gaps in care** and may be needed **to inform the**

development of an individualized Care Management Plan. ECM Providers are required to initiate an assessment within 30 days and complete the assessment within 60 days after member opt-in. ECM Providers are encouraged to initiate and complete the assessment as soon as possible.

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

ECM Providers are required to create the Member's Care Plan immediately following the comprehensive member assessment. ECM Providers are expected to incorporate into the Member's Care Plan identified needs and strategies to address those needs, including, but not limited to, **physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing.** The ECM Providers are required to ensure **the Care Plan is reassessed** at a frequency appropriate for the Member's individual progress or changes in needs, and as identified in the Care Plan. The ECM Providers must ensure **the Care Plan is reviewed, maintained and updated under appropriate clinical oversight.** The ECM Providers must update the Care Plan regularly and/or when clinically indicated – for example after reassessment or transitions of care, and when a new need is identified, but no less frequently than every six months.

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

ECM Member Completes Comprehensive Assessment

i.Reassessments Occur over time and based on member events

i.ECM Member Care Plan Developed

i.Member Care Plan Updates Occur

4.9.2.1 Comprehensive Assessment

ECM Providers are required to conduct a comprehensive assessment that identifies a Member's physical, mental health, substance use, palliative, trauma-informed care, and social service needs. ECM Providers are required to start a Member's assessment within 30 days and complete a Member's assessment within 60 days of the Member's enrollment in ECM. ECM Providers are encouraged to initiate and complete the assessment as soon as possible. The Comprehensive Assessment is a used to assess an ECM Member's current health status, establish a platform to begin building care management and coordination goals, and develop an individualized Care Plan. ECM Providers must reassess the Member when clinically

indicated or when new needs are identified, or after transitions of care, but no less frequently than every six months. MCPs recommend Care Plans be updated during reassessments as well.

The LA MCPs provide a standardized LA County ECM Comprehensive Assessment Template (Appendix G) for ECM Providers to adopt as their Comprehensive Assessment and incorporate into their workflows and systems. The LA MCPs encourage the ECM Providers to adopt the LA County ECM Common Assessment Template, however some plans will require ECM Providers to adopt the template, and some plans will encourage ECM Providers to adopt the tool.

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

ECM Providers are required to submit assessments to the MCP at a frequency communicated by the MCP.

4.9.2.2   Care Plan

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

ECM Providers are required to submit Care Plans to the MCP at a frequency communicated by the MCP.

4.9.2.3   Program Completion

ECM Providers will be required to conduct a Member re-assessment by or before six months of enrollment in ECM based on the ECM program completion/step-down criteria. Each MCP has its own Program Completion criteria. In general, members will be considered ready to graduate from ECM when they have completed their care plan goals, and demonstrated improvement in self-management, including of physical and behavioral health, SDOH and activities of daily living.   Most plans encourage ECM Lead Care Managers to use a questionnaire (based on the program completion/step-down criteria) with the member to help determine readiness for program completion of ECM and/or transition out of ECM to a lower level of care management.

L.A. Care's ECM Program Completion Questionnaire can be found in Appendix H. When a provider identifies an L.A. Care member who is ready to graduate from ECM, the provider should conduct an ECM case conference with the multidisciplinary team to review and ensure any resources and / or care coordination needs are in place. L.A. Care's ECM representatives will attend these case conferences as

appropriate and will support ECM providers in identifying appropriate resources and levels of care management for graduating members.

4.9.3   Enhanced Coordination of Care

ECM Providers are responsible for the ongoing care coordination for ECM authorized Members. ECM Providers are encouraged to use case conferences to ensure integrated, effective implementation of the Care Management Plan. Regular frequent Member support and coordination services are essential to the success of ECM. Member contact should be in person wherever feasible and possible. Key components to this service provision include:

- Member Care Plan implementation
- Continuous and integrated care
- Treatment adherence
- Communication
- Fostered and on-going engagement with Member

ECM Providers are responsible for **organizing patient care activities**, as laid out in the Care Management Plan, **sharing information** with the Member's multi-disciplinary care team, and **implementing activities identified in the Member's Care Management Plan**.

ECM Providers are responsible for maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team. The care team's input is necessary for successful implementation of Member goals and needs. ECM Providers are responsible to ensure care is **continuous and integrated among all service Providers and referring to and following up** with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed.

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

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

Stakeholders, such as internal MCP business units, may outreach to ECM Providers to help coordinate care or follow up with Members.

4.9.3.1   Coordination & Communication: Connecting with Other Programs and Services

ECM means coordinating care and services with other programs:

- Including any complementary programs the member is participating
- Includes *Community Supports* members may be receiving
- Identified during the assessment process

Recommended steps the ECM Providers can take to connect with other programs and services are as follows.

- **Step 1:** Gain member consent to communicate with the other program/s
- **Step 2:** Contact the Alternate/Community Support program/case manager
- **Step 3:** Meet with the CM together with the member, if possible (recommended)

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

The following criteria are offered by the MCP as guidance for determining frequency of ECM Provider contact post-enrollment, and subject to the clinical judgement of the ECM Provider based on the Member's needs and intensity of service provision. It is anticipated that Members may move between tiers based on clinical or psychosocial needs.

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

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

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

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

- ED visit or hospitalization in the last 2-6 months
- Newly sustained treatment adherence (medications, appointments)
- Newly integrated social support
- Secured permanent housing within last 3-6 months
- At risk of homelessness

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

- Clinically stable on examination and laboratory findings (in maintenance phase)
- No ED visit or hospitalization (in the last 6 months)
- Ongoing treatment adherence (medications, appointments)
- Strong family/social support
- Stable housing
- On target to achieve at least one Care Plan goal (in the next 3 months)

MCPs expect that ECM Providers make active, meaningful, and progressive attempts to contact the Member, however if after three attempts to contact the Member and a mailed letter to the Member the Member remains unable to contact, the ECM Provider is expected to exclude the Member from further

outreach and report the member disenrollment information to the MCP in the ECM Monthly Provider Reporting submission to the MCP.

4.9.4   Health Promotion

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

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

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

ECM Providers are required to support Members in **strengthening skills that enable them to identify and access resources** to assist them in managing their conditions and preventing other chronic conditions.

4.9.5   Comprehensive Transitional Care

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

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

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

- Developing and regularly updating **a transition of care plan** for the Member;
- **Conducting an assessment to evaluating a Member's medical care needs and coordinating any support services** to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;
- **Tracking each Member's admission or discharge** to/from an emergency department, hospital inpatient facility, skilled nursing facility, residential/treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;
- Coordinating **medication review/reconciliation**; and
- Providing **adherence support and referral** to appropriate services.

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

4.9.6 Member and Family Support Services

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

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

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

The ECM Provider is responsible through the ECM service provision includes **activities to ensure the Member and their supports – family member(s), AR, guardian, caregiver, and/or authorized support person/s – are knowledgeable about the Member's conditions** with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws.

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

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

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

The ECM Provider **must ensure that the Member has a copy of their Care Plan** and information about how to request updates.

4.9.7 Coordination of and Referral to Community and Social Support Services

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

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

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

ECM Providers are encouraged to build and strengthen strong relationships with community members to support this service provision. ECM Providers are encouraged to maintain a Community Resource Directory and/or actively utilized the online Community Resource Referral Platform offered by the MCPs.

4.10 Member Discontinuation

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

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

The MCPs will provide a technical assistance resource to support ECM providers in identifying when Members are no longer eligible for the ECM benefit. MCPs developed Policies and Procedures for discontinuing ECM. Please refer to Section 4.8.2.3 Program Completion for the program completion/step-down criteria MCPs will apply to transition a Member to a lower level of care management or coordination.

4.10.1 ECM Provider Initiated Disenrollment

The ECM Provider must notify the MCP to discontinue ECM for a Member under any the following circumstances:

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

4.10.2 Member Initiated Disenrollment

A Member can contact their ECM Provider or MCP Member Services to request to disenroll from ECM at any time if they no longer wish to receive the ECM benefit.

4.10.3 MCP Initiated Disenrollment

The MCP will notify ECM Providers, via the regular ECM Member Information File (MIF), of ECM enrolled Members who no longer qualify for the ECM benefit.

4.10.4 The Notice of Action (NOA)

4.10.4.1 MCP Expectations

When ECM is discontinued, or will be discontinued for the Member, the MCP is responsible for sending a Notice of Action (NOA) notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the NOA. MCPs must ensure authorization or a decision not to authorize ECM occurs in accordance with existing federal and state regulations for processing Grievances and Appeals.

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

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

4.10.4.2 ECM Provider Expectations

ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Care Management, Basic Care Management, etc.).

4.10.5 Complaints, Grievances and Appeals

The standard grievance and appeals processes apply to ECM for all Members. If a Member has concerns or complaints, the Member can contact the MCP's Member Services. If the Member feels that he or she has been wrongfully denied enrollment or wrongfully disenrolled from ECM, the Member can initiate an appeal via the MCP's existing complaints, grievances and appeals process.

4.11 Data to Support ECM

4.11.1 Care Management Documentation System or Process

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

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

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

- Referrals to other providers and support persons
- Screenings and assessments (e.g., Comprehensive Assessment, PHQ-9, etc.)

Care management documentation systems also need to be able to:

- Support the sharing of the Member's Care Plan amongst the Member's care team
- Support the sharing of the Member's Assessment, Care Plan and other required data to the LA MCPs, as requested
- Assist with informing the ECM Provider's regular reporting to the LA MCPs, as requested
- Support and track the ECM services provided to the Member to enable ECM Providers to appropriately submit claims[8] to the LA MCPs

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

4.11.2 Provision of Data/Reports from the MCP to the ECM Provider

The MCP and the ECM Provider will exchange data on Members on a regular basis.

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

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

4.11.3 Provision of Data/Reports from the ECM Provider to the MCP

ECM Providers are responsible to submit required reports to the MCP. Required ECM Provider reports include but are not limited to the following:

- ECM Monthly Return Transmission File (RTF)
- ECM Monthly Outreach Tracker File (OTF)
- Staffing and Capacity Reports

4.11.4 Data and File Exchange Operations

On a regular basis, ECM providers must retrieve the ECM Member Information file via secure file transfer protocol (SFTP) site or Portal (depends on the MCP's method of delivery) that contains assigned ECM Members that are eligible to receive ECM services, including both new and existing Members. This file or data is called the Member Information File (MIF).

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

On a minimum of a monthly basis, ECM providers must update and report back to the MCPs via an SFTP file upload or via the MCP's portal (depends on the MCP's method of delivery) identifying the services provided and status of each eligible and enrolled ECM Member. This reporting requirement is called the Return Transmission File (RTF).

On a minimum of a monthly basis, ECM providers must update and report back to the MCPs via an SFTP file upload or via the MCP's portal (depends on the MCP's method of delivery) identifying the outreach services provided to assigned ECM Member(s). This reporting requirement is called the Outreach Tracker File (OTF).

MCPs may also utilize the SFTP site or their Portals to exchange other data files to support ECM Provider service delivery (e.g., ADT reports, capitation reports, etc.).

5   Claims Submission

The ECM Provider is required to submit claims and/or encounter data (at minimum monthly) for the provision of ECM-related services to MCP using the national standard specifications and code sets to be defined by DHCS as evidence of all ECM services provided to ECM Members. The DHCS Coding guidance is included as Appendix A "DHCS Coding Guidance" in this guide. This ensures the MCP can effectively monitor the volume and frequency of ECM service provision and shows the true cost of providing ECM services to the MCP and DHCS.

In the event the ECM Provider is unable to submit claims to MCP for ECM-related services using the national standard specifications and DHCS-defined code sets, the ECM Provider can submit an invoice to the MCP with a minimum set of data elements (to be defined by DHCS) necessary for the MCP to convert the invoice to an encounter for submission to DHCS. DHCS is developing guidance that describes the minimum set of data elements required to be included in an invoice and outlining criteria for ECM Providers that would qualify to submit invoices in lieu of claims. ECM Providers and MCPs may need to reconfigure their existing systems to meet these requirements.

6   Quality, Monitoring and Oversight

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

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

7   MCP Payment to Providers

The MCP will pay contracted ECM Providers for the provision of ECM in accordance with contract established between MCP and ECM Provider. MCP shall pay 90 percent of all clean claims from practitioners who are individual or group practices or who practice in shared health facilities within 30 days of date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the

date MCP receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

The ECM Provider is eligible to receive payment when ECM is initiated for any given ECM Member.

Appendix A: DHCS Coding Guidance, ECM Coding Options Excerpts

ECM Coding Options Excerpts on Pages 1-9 of DHCS Guidance:

[Coding-Options-for-ECM-and-Community-Supports (ca.gov)](#)

DHCS
MICHELLE BAASS
DIRECTOR

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

GAVIN NEWSOM
GOVERNOR

Enhanced Care Management and Community Supports
Coding Options
Updated March 2022

Encounter Data Submission Process

The Department of Health Care Services (DHCS) requires Medi-Cal Managed Care Health Plans (MCP) to submit encounter data in accordance with requirements in the MCP contract and All Plan Letter 14-019, or any subsequent updates. For Enhanced Care Management (ECM) and Community Supports, MCPs are required to submit encounter data for these services through the existing encounter data reporting mechanisms for all covered services for which they have incurred any financial liability, whether directly or through subcontracts or other arrangements, using ASC X12 837 version 5010 x223 Institutional and Professional transactions and the new ECM and Community Supports coding requirements outlined in this document, to the Post Adjudicated Claims and Encounters System (PACES) effective January 1, 2022.

Enhanced Care Management – Coding Options

MCPs must use the Healthcare Common Procedure Coding System (HCPCS) codes listed in the table to report ECM services. The HCPCS code and modifier combined define the service as ECM. As an example, HCPCS code G9008 by itself does not define the service as an ECM service. HCPCS code G9008 must be reported with modifier U1 for the care coordination service to be defined and categorized as an ECM service. MCPs may utilize alternative payment approaches with ECM Providers, but must use the below HCPCS codes and modifiers for reporting applicable encounters to DHCS. **If an ECM service is provided through telehealth, an additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy.**[1]

HCPCS Level II Code	HCPCS Description	Modifiers	Modifier Description
G9008	ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1	Used by Managed Care with HCPCS code G9008 to indicate Enhanced Care Management services
G9008	ECM Phone/Telehealth: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1, GQ	Used by Managed Care with HCPCS code G9008 to indicate Enhanced Care Management services.

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[1] For more information refer to the DHCS Medi-Cal Provider Manuals

HCPCS Level II Code	HCPCS Description	Modifiers	Modifier Description
G9008	ECM Outreach In Person: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	U8	Used by Managed Care with HCPCS code G9008 to indicate a single in –person Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management.
G9008	ECM Outreach Telephonic/Electronic: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	U8, GQ	Used by Managed Care with HCPCS code G9008 to indicate a single telephonic/electronic Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management. Telephonic/electronic methods can include text messaging or secure email individualized to the Member. However, mass communications (e.g., mass mailings, distribution emails, and text messages) do not count as outreach and should not be included.
G9012	ECM In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services
G9012	ECM Phone/Telehealth: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2, GQ	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services.
G9012	ECM Outreach In Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere	U8	Used by Managed Care with HCPCS code G9012 to indicate a single in –person Enhanced Care Management outreach attempt for an

Department of Health Care Services | Health Care Delivery Systems

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HCPCS Level II Code	HCPCS Description	Modifiers	Modifier Description
	classified.		individual member, for the purpose of initiation into Enhanced Care Management.
G9012	ECM Outreach Telephonic/Electronic: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U8, GQ	Used by Managed Care with HCPCS code G9012 to indicate a single telephonic/electronic Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management. Telephonic/electronic methods can include text messaging or secure email individualized to the Member. However, mass communications (e.g., mass mailings, distribution emails, and text messages) do not count as outreach and should not be included.

Community Supports (ILOS) – Coding Options

MCPs must use the HCPCS codes listed in the table to report Community Supports services. The HCPCS code and modifier combined define the service as a Community Supports service. As an example, HCPCS code H0043 by itself does not define the service as a Housing Transition/Navigation Community Supports service. HCPCS code H0043 must be reported with modifier U6 for the supported housing services to be defined and categorized as a Community Supports service. MCPs may utilize alternative payment approaches with Community Supports providers, but must use the below HCPCS codes and modifiers for reporting applicable encounters to DHCS. For example, an MCP might opt to pay a provider for Housing Transition and Navigation Services as a per member per month (PMPM) payment. That MCP must still report encounters to DHCS as a per diem for every service rendered by that provider, using the HCPCS codes and modifiers below. MCPs may use either the per diem or per 15 minutes HCPCS codes for Community Support services that have both options available. **If a Community Supports service is provided through telehealth, the additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy.**[2]

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
Housing Transition/Navigation Services			
H0043	Supported housing; per diem	U6	Used by Managed Care with HCPCS code H0043 to indicate Community Supports Housing Transition/Navigation Services
H2016	Comprehensive community support services; per diem	U6	Used by Managed Care with HCPCS code H2016 to indicate Community Supports Housing Transition/Navigation Services
Housing Deposits			
H0044	Supported housing, per month. Requires deposit amounts to be reported on the encounter. Modifier used to differentiate housing deposits from Short-Term Post-Hospitalization Housing.	U2	Used by Managed Care with HCPCS code H0044 to indicate Community Supports Housing Deposit

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[2] For more information refer to the DHCS Medi-Cal Provider Manuals

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
Housing Tenancy and Sustaining Services[3]			
T2040	Financial management, self-directed; per 15 minutes	U6	Used by Managed Care with HCPCS code T2040 to indicate Community Supports Housing Tenancy and Sustaining Services
(New) T2050	Financial management, self-directed; per diem	U6	Used by Managed Care with HCPCS code T2050 to indicate Community Supports Housing Tenancy and Sustaining Services
T2041	Support brokerage, self-directed; per 15 minutes	U6	Used by Managed Care with HCPCS code T2041 to indicate Community Supports Housing Tenancy and Sustaining Services
(New) T2051	Support brokerage, self-directed; per diem	U6	Used by Managed Care with HCPCS code T2051 to indicate Community Supports Housing Tenancy and Sustaining Services
Short-Term Post-Hospitalization Housing			
(New) H0043	Supported housing; per diem. Modifier used to differentiate Short-Term Post Hospitalization Housing from Housing Transition/ Navigation Services.	U3	Used by Managed Care with HCPCS code H0043 to indicate Community Supports Short-Term Post-Hospitalization Housing
H0044	Supported housing; per month. Modifier used to differentiate Short-Term Post Hospitalization Housing from Housing Deposits.	U3	Used by Managed Care with HCPCS code H0044 to indicate Community Supports Short-Term Post-Hospitalization Housing
Recuperative Care (Medical Respite)			
T2033	Residential care, not otherwise specified (NOS), waiver; per diem	U6	Used by Managed Care with HCPCS code T2033 to indicate Community Supports Recuperative Care (Medical Respite)

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[3] MCPs may use either the per diem or per 15 minutes code to indicate the provision of the Housing Tenancy and Sustaining Services Community Support.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
Respite Services			
H0045	Respite care services, not in the home; per diem	U6	Used by Managed Care with HCPCS code H0045 to indicate Community Supports Respite Services
S5151	Unskilled respite care, not hospice; per diem	U6	Used by Managed Care with HCPCS code S5151 to indicate Community Supports Respite Services
S9125	Respite care, in the home; per diem	U6	Used by Managed Care with HCPCS code S9125 to indicate Community Supports Respite Services
Day Habilitation Programs			
T2012	Habilitation, educational; per diem	U6	Used by Managed Care with HCPCS code T2012 to indicate Community Supports Day Habilitation Programs
T2014	Habilitation, prevocational; per diem	U6	Used by Managed Care with HCPCS code T2014 to indicate Community Supports Day Habilitation Programs
T2018	Habilitation, supported employment; per diem	U6	Used by Managed Care with HCPCS code T2018 to indicate Community Supports Day Habilitation Programs
T2020	Day habilitation; per diem	U6	Used by Managed Care with HCPCS code T2020 to indicate Community Supports Day Habilitation Programs
H2014	Skills training and development; per 15 minutes[4]	U6	Used by Managed Care with HCPCS code H2014 to indicate Community Supports Day Habilitation Programs

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[4] MCPs may also use the provided per diem code for Day Habilitation Programs - Skills Training.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
Day Habilitation Programs (Continued)			
(New) H2038	Skills training and development; per diem	U6	Used by Managed Care with HCPCS code H2038 to indicate Community Supports Day Habilitation Programs
H2024	Supported employment; per diem	U6	Used by Managed Care with HCPCS code H2024 to indicate Community Supports Day Habilitation Programs
H2026	Ongoing support to maintain employment; per diem	U6	Used by Managed Care with HCPCS code H2026 to indicate Community Supports Day Habilitation Programs
Nursing Facility Transition/Diversion to Assisted Living Facilities[5]			
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Community Transition Services/Nursing Facility Transition to a Home.	U4	Used by Managed Care with HCPCS code T2038 to indicate Community Supports Nursing Facility Transition/ Diversion to an Assisted Living Facility
H2022	Community wrap-around services, per diem. Requires billed amount(s) to be reported on the encounter.	U5	Used by Managed Care with HCPCS code H2022 to indicate Community Supports Community Transition Services/Nursing Facility Transition to a Home

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[5] Multiple encounters may be submitted for a single transition if different services are involved. A transition can also be indicated on a single encounter with a Begin and End date.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
Community Transition Services/Nursing Facility Transition to a Home			
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Nursing Facility Transition/Diversion to Assisted Living Facilities.	U5	Used by Managed Care with HCPCS code T2038 to indicate Community Supports Community Transition Services/Nursing Facility Transition to a Home
Personal Care/Homemaker Services			
S5130	Homemaker services; per 15 minutes	U6	Used by Managed Care with HCPCS code S5130 to indicate Community Supports Personal Care/Homemaker Services
T1019	Personal care services; per 15 minutes	U6	Used by Managed Care with HCPCS code T1019 to indicate Community Supports Personal Care/Homemaker Services
Environmental Accessibility Adaptations			
S5165	Home modifications; per service. Requires billed amount(s) to be reported on the encounter.	U6	Used by Managed Care with HCPCS code S5165 to indicate Community Supports Environmental Accessibility Adaptations/Home Modifications
Medically-Supportive Food/Medically Tailored Meals			
S5170	Home delivered prepared meal	U6	Used by Managed Care with HCPCS code S5170 to indicate Community Supports Medically-Supportive Food/Medically Tailored Meals
S9470	Nutritional counseling, diet	U6	Used by Managed Care with HCPCS code S9470 to indicate Community Supports Medically-Supportive Food/Medically Tailored Meals

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description
Medically-Supportive Food/Medically Tailored Meals (Continued)			
S9977	Meals; per diem, not otherwise specified	U6	Used by Managed Care with HCPCS code S9977 to indicate Community Supports Medically-Supportive Food/Medically Tailored Meals
Sobering Centers			
H0014	Alcohol and/or drug services; ambulatory detoxification	U6	Used by Managed Care with HCPCS code H0014 to indicate Community Supports Sobering Centers
Asthma Remediation			
S5165	Home modifications; per service	U5	Used by Managed Care with HCPCS code S5165 to indicate Community Supports Asthma Remediation

Appendix B: Staffing & Capacity Report

The LA County ECM Provider Staffing & Capacity Report Template includes three tabs that ECM providers must report:

- Current Staffing

Current ECM Care Team Staffing

This tab requires ECM providers to complete all yellow cells. Please enter all information for each column specified for each Staff Position Type (ECM Role) that is part of your organization's ECM Care Team.

Location Number	Location/Provider Name	ECM Role	Role, If Other	Staff Last Name	Staff First Name	License/Certificate (if Applicable)	Staff E-mail Address	Completed required training (yes/no)	Language	If language is marked "Other", please specify here	Staff Race and Ethnicity	% of time dedicated to ECM
NPI1	Clinic Example 1	Lead Care Manager		Last Name	First Name		A123@provider.org	Yes	Spanish		Black of African-American (N	100%
NPI1	Clinic Example 2	Lead Care Manager		Last Name	First Name		B456@provider.org	No	Spanish		White (Non-Hispanic)	50%
NPI1	Clinic Example 3	Lead Care Manager	▼	Last Name	First Name		C789@provider.org	Yes	Spanish		Asian Indian	25%
NPI1	Clinic Example 3	Lead Care Manager		Last Name	First Name		D123@provider.org	Yes	Spanish		Hispanic of Latinx	25%
NPI1	Clinic Example 3	Other		Last Name	First Name		E456@provider.org	Yes	Spanish		Other	25%
NPI1	Clinic Example 3	Lead Care Manager		Last Name	First Name		F789@provider.org	Yes	Spanish		Chinese	25%
NPI1	Clinic Example 3	Lead Care Manager		Last Name	First Name		G123@provider.org	Yes	Spanish		Cambodian	25%
NPI1	Clinic Example 3	Lead Care Manager		Last Name	First Name		H456@provider.org	Yes	Spanish		Filipino	25%

- Staff time by PoF

Staff Time by Population of Focus

This tab requires ECM providers to identify the breakdown of staff by each ECM Population(s) of Focus. Please enter all information applicable to your organization. Information should only be populated for the ECM PoF that your organization serves. Please fill in all yellow cells.

Location Number	Adult - Experiencing Homelessness	Adult - High Utilizer	Adult - Serious Mental Illness (SMI) or Substance Use Disorder (SUD)	Adult - Transitioning from Incarceration	Adult - LTC Eligible At-Risk for Institutionalization	Adult - NF Residents Transitioning to Community	Child/Youth - Experiencing Homelessness	Child/Youth - High Utilizer	Child/Youth - Serious Emotional Disturbance (SED) or Identified to be at Clinical High Risk (CHR) for Psychosis	Child/Youth - Enrolled in California Children's Services (CCS)/CCS Whole Child Model (WCM)	Child/Youth - Involved in Child Welfare (Including Foster Care up to age 26)	Child/Youth - Transitioning from Incarceration	Total (Must add up to 100%)	Flag
	25%	25%	25%	25%	0%	0%	0%	0%	0%	0%	0%	0%		

- Caseload by MCP

Caseload and MCPs

This tab requires ECM providers to complete the yellow cells below. The purpose of this information is to allow ECM providers to appropriately identify ECM care team staff allocations across their contracted MCPs for ECM.

Please complete this tab based on the understanding that the Caseload Ratio is based on the ECM Lead Care Manager role only. The maximum number of members the ECM Lead Care Manager may serve is 50. ECM Providers may choose to serve fewer than 50 with the understanding of ramping up the caseload served per ECM Lead Care Manager over time.

The Market Share for each contracted MCP identifies the breakdown of ECM eligible and enrolled

Caseload Ratio	50				

Managed Care Plan	Contracted (Y/N)	Contract Start Date	Market Share (Must add up to 100%)	ECM Capacity	Flag
L.A. Care Health Plan	Y or N	MM/YYYY	20%	28	
Anthem Blue Cross	Y or N	MM/YYYY	20%	28	
Blue Shield Promise	Y or N	MM/YYYY	20%	28	
L.A. Care & Plan Partners			60%	83	
Health Net	Y or N	MM/YYYY	20%	28	
Molina Healthcare	Y or N	MM/YYYY	20%	28	
Health Net & Plan Partner			40%	55	
TOTAL ECM CAPACITY			100%	138	

Appendix C: LA County ECM Benefit Member Eligibility Checklists / Referral Form

LA County Enhanced Care Management (ECM) Benefit
Member Eligibility Checklists/Referral Forms

Overview

ECM is a Medi-Cal benefit that provides comprehensive care management services to Medi-Cal members with complex health and/or social needs with the goal to improve the health and social outcomes of the ECM-enrolled member. Members enrolled in ECM will primarily receive in-person care management services that will be provided in the member's community by contracted ECM Provider agencies who serve the member's specific Population of Focus.

*To be eligible for ECM, members must qualify as one or more of the identified **ECM Populations of Focus** and are not enrolled in duplicative services (as defined in the **ECM Exclusionary Screening Checklist**).*

There are 3 steps to the ECM screening and referral process:

- **Step 1:** Complete the *Population of Focus Screening Checklist* to confirm member eligibility in **one or more** Populations of Focus.
- **Step 2:** Complete the *Exclusionary Screening Checklist* as a 2nd **step** to verify member eligibility.
- **Step 3:** If you determine the member to be eligible for the ECM benefit based on *both Screening Checklists*, complete the referral form and submit *all three forms* (1. Population of Focus Checklist, 2. Exclusionary Checklist, 3. Referral Form) to the Managed Care Plan. To expedite the review and approval process, *please also submit applicable supporting documentation as evidence of the member meeting ECM criteria*. Send securely through the Managed Care Plan's designated method listed below. The Managed Care Plan will review and verify the member's eligibility and respond within one week.

Health Plan	ECM Provider Communication Method	Community Provider (Non-ECM Provider) Communication Method
☐ Anthem Blue Cross	*Submit via Anthem Provider Portal:* https://providers.anthem.com *or secure fax: 844-429-9626 or secure email:* CalAimreferrals@anthem.com	Call Customer Care Center at 888-285-7801 (TTY 711) request "CalAIM or ECM"
☐ Blue Shield Promise Health Plan	*Submit via SFTP*	*Submit via secure email:* ECM@blueshieldca.com
☐ Health Net	*Submit via Health Net's Provider Portal* provider.healthnetcalifornia.com *or secure fax: 800-743-1655*	*Submit via secure fax:* 800-743-1655
☐ Kaiser Permanente	*Submit via secure email:* RegCareCoordCaseMgmt@KP.org *with "ECM Referral" as the subject line*	*Submit via secure email:* RegCareCoordCaseMgmt@KP.org *with "ECM Referral" as the subject line*
☐ L.A. Care Health Plan	*Submit through LA Care E-Form:* https://thwebprd.lacare.org/TWA/Client/forms/embed/104?allowanonymous=1 *or your assigned SFTP*	*Submit through LA Care E-Form:* https://thwebprd.lacare.org/TWA/Client/forms/embed/104?allowanonymous=1 *or via secure fax: (213) 438-5694 or via secure email:* ECMMembership@lacare.org
☐ Molina Healthcare of California	*Submit via secure email:* MHC_ECM@molinahealthcare.com *Please note underscores in email address*	*Submit via secure email:* MHC_ECM@molinahealthcare.com *Please note underscores in email address*

PL1635 0723

LA County Enhanced Care Management (ECM) Benefit Populations of Focus Screening Checklist

Step 1: Complete the Populations of Focus Screening Checklist

ECM Population of Focus

POF 1.0: Adults Experiencing Homelessness

Adult **without** Dependent Children/Youth Living with Them who:

☐ Individual is 21 years of age or older; **AND**

    ☐ Is experiencing **homelessness**, defined as meeting one or more of the following conditions:

- *Lacking a fixed, regular, and adequate nighttime residence;*
- *Having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;*
- *Living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing;*
- *Exiting an institution into homelessness (regardless of length of stay in the institution);*
- *Will imminently lose housing in the next 30 days;*
- *Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence;*

    AND

    ☐ Has at least **one complex physical, behavioral, or developmental health need** (please note in Conditions Table below*) 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.

POF 1.1: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness

☐ **Adult WITH Dependent Children/Youth Living with Them**. Individual**,** 21 years of age and older, is part of a family that includes child/youth (under age 21) that is experiencing homelessness, defined as meeting one or more of the following conditions;

    OR

☐ **Unaccompanied Children/Youth Experiencing Homelessness (under age 21)** defined as meeting one or more of the following conditions:
- *Lacking a fixed, regular, and adequate nighttime residence;*

- *Having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;*
- *Living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing;*
- *Exiting an institution into homelessness (regardless of length of stay in the institution);*
- *Will imminently lose housing in the next 30 days;*
- *Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence;*

OR

☐ Sharing the housing of other persons (i.e., couch surfing) due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or abandoned in hospitals (in hospital without a safe place to be discharged to).

POF 2.0: Adults at Risk for Avoidable Hospital or Emergency Department (ED) Utilization

Adult who meets **one or more** of the following conditions in the last **6-months**:

☐ Individual is 21 years of age or older; *AND*

    ☐ **5 or more emergency** room visits; *AND/OR*
    ☐ **3 or more** unplanned **hospital** admissions *AND/OR* short-term **skilled nursing facility** stays

    AND

    ☐ All of the emergency room, unplanned hospital admissions, and/or short-term skilled nursing facility stays could have been avoided with appropriate outpatient care or improved treatment adherence.

POF 2.1: Children/Youth at Risk for Avoidable Hospital or Emergency Department (ED) Utilization

Children/Youth who meet the following conditions in the last **12-months**:

☐ Individual is under age 21; *AND*

    ☐ **3 or more emergency** room visits; *AND/OR*
    ☐ **2 or more** unplanned **hospital** admissions *AND/OR* short-term **skilled nursing facility** stays

    AND

    ☐ All of the emergency room, unplanned hospital admissions, and/or short-term skilled nursing facility stays could have been avoided with appropriate outpatient care or improved treatment adherence.

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POF 3.0: Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
(please note in Conditions Table* below)

☐ Individual is 21 years of age or older; *AND*

Meets the eligibility criteria for participation in or obtaining services through:

☐ Specialty Mental Health Services (SMHS) delivered by Mental Health Plans *AND/OR*
☐ The Drug Medi-Cal Organized Delivery System (DMC-ODS) or Drug Medi-Cal (DMC) Program *AND*

If **ONE** of the 2 boxes above are checked, continue below.

☐ Actively experiencing **one complex social factor** influencing their health such as:

- Lack of access to **food**, lack of access to **stable housing**, inability to **work** or **engage in the community**, high measure (4 or more) of Adverse Childhood Experiences (**ACEs**) based on screening, **former foster youth**, history of recent contacts with **law enforcement** related to SMI/SUD symptoms, **and/or (specify)** _____, *AND*

☐ Meets one or more of the following **additional criteria**:

- High risk for institutionalization, overdose and/or suicide
- Use crisis services, ERs, urgent care or inpatient stays as the sole source of care
- 2+ ED visits **or** 2+ hospitalizations due to SMI or SUD in the past 12 months
- Pregnant or post-partum (12 months from delivery)

POF 3.1: Children/Youth with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
(please note in Conditions Table* below)

☐ Individual is under age 21; *AND*

Meets the eligibility criteria for participation in or obtaining services through:

☐ Specialty Mental Health Services (SMHS) delivered by Mental Health Plans *AND/OR*
☐ The Drug Medi-Cal Organized Delivery System (DMC-ODS) or Drug Medi-Cal (DMC) Program

POF 4.0: Adults Transitioning from Incarceration within the **past 12 months**

☐ Individual is 21 years of age or older; **AND**

☐ Is transitioning from a correctional setting or transitioned from a correctional setting within the **last 12-months AND**

☐ Has at least one complex physical, behavioral, or developmental health need of the following conditions (Please note specifics in Conditions Table*****)
- Mental illness
- Substance Use Disorder (SUD)
- Chronic Condition/Significant Clinical Condition
- Intellectual or Developmental Disability (I/DD)
- Traumatic Brain Injury
- HIV/AIDS
- Pregnant or Postpartum

POF 4.1: Children/Youth Transitioning from Youth Correctional Facility within the **past 12 months**

☐ Individual is under age 21; **AND**

☐ Is transitioning from a youth correctional setting or transitioned from a youth correctional setting within the **last 12-months**

POF 5.0: Adults Living in the Community who are at Risk for LTC Institutionalization
(Supporting documents are required to be submitted with the referral for this population of focus)

☐ Individual is 21 years of age or older; **AND**

☐ Living in the community who meet the **Skilled Nursing Facility (SNF) Level of Care criteria; *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/injury; **AND**

☐ Is actively experiencing **at least one complex social or environmental factor** influencing their health; **AND**

☐ **Is able to reside continuously in the community** with wraparound supports

POF 6.0: Adult Nursing Facility Residents transitioning to the Community
(Supporting documents are required to be submitted with the referral for this population of focus)

☐ Individual is 21 years of age or older; **AND**

☐ Nursing facility resident who is interested in moving out of the institution, **AND**

☐ Individual is a likely candidate to move out of the institution successfully, **AND**

☐ Is able to reside continuously in the community

POF 7.0: Children/Youth Enrolled in California Children's Services (CCS) or CCS Whole Children Model (WCM) with Additional Needs beyond the CCS Condition

☐ Child/Youth is under age 21; *AND*

☐ Individual is enrolled in CCS or CCS WCM, *AND*

☐ Individual is actively experiencing **at least one complex** social factor influencing their health such as food, housing, employment insecurities, history of ACEs/trauma, and history of recent contacts with law enforcement related to SMI/SUD, and/or former foster youth.

POF 8.0: Children/Youth Involved in Child Welfare

☐ Children/Youth is under age 21 and are **currently receiving foster care** in California; *OR*

☐ Individual is under age 21 and previously received foster care in California or another state within the last 12 months; *OR*

☐ Individual is under age 26 and aged out of foster care (having been in foster care on their 18th birthday or later) in California or another state; *OR*

☐ Individual is under age 18 and are eligible for and/or in California's Adoption Assistance Program; *OR*

☐ Individual is under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months

POF 9.0: Adults with Intellectual or Developmental Disabilities (I/DD)

☐ Individuals is 21 years of age or older; *AND*

☐ Individual has a diagnosis of I/DD; *AND*

☐ Individual qualifies for eligibility in another adult ECM Population of Focus (POF 1.0, 2.0, 3.0, 4.0, 5.0, 6.0)

For Individuals with Intellectual or Developmental Disabilities (I/DD), identify at least one adult Population of Focus above and specify diagnosed I/DD in Conditions Table below. If Population(s) of Focus and Condition are checked, member eligibility will be considered.

POF 9.1: Children/Youth with Intellectual or Developmental Disabilities (I/DD)

☐ Children/Youth is under age 21; *AND*

☐ Individual has a diagnosis of I/DD; *AND*

☐ Individual qualifies for eligibility in another Children/Youth ECM Population of Focus (POF 1.1, 2.1, 3.1, 4.1, 7.0, 8.0)

For Individuals with Intellectual or Developmental Disabilities (I/DD), identify at least one Children/Youth Population of Focus above and specify diagnosed I/DD in Conditions Table below. If Population(s) of Focus and Condition are checked, member eligibility will be considered.

POF 10.0: Adults Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes

☐ Individual is 21 years of age or older; *AND*

☐ Individual is pregnant or postpartum through 12 months period; *AND*

☐ Individual qualifies for eligibility in another adult ECM Population of Focus (POF 1.0, 2.0, 3.0, 4.0, 5.0, 6.0)

For Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes, identify at least one adult Population of Focus above and specify pregnant or postpartum (through 12 months period) in Conditions Table below. If Population(s) of Focus and Condition are checked, member eligibility will be considered.

POF 10.1: Children/Youth Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes

☐ Individual is under age 21; *AND*

☐ Individual is pregnant or postpartum through 12 months period; *AND*

☐ Individual qualifies for eligibility in another Children/Youth ECM Population of Focus (POF 1.1, 2.1, 3.1, 4.1, 7.0, 8.0)

For Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes, identify at least one Children/Youth Population of Focus above and specify pregnant or postpartum (through 12 months period) in Conditions Table below. If Population(s) of Focus and Condition are checked, member eligibility will be considered.

*Conditions Table: For Reference Only

There may be qualifying conditions not listed in this table. Please list condition(s) in the "Other, please note:" field

Complex Physical, Behavioral Health and Developmental Conditions *(Check all that apply)*	
Physical Health	
☐Asthma	☐Dementia requiring assistance with IADLs
☐Chronic Kidney Disease	☐Diabetes (Insulin-dependent) poorly controlled
☐Chronic Liver Disease	☐History of stroke or heart attack
☐Chronic Obstructive Pulmonary Disease (COPD)	☐Hypertension (poorly controlled)
☐Congestive Heart Failure (CHF)	☐Traumatic Brain Injury (TBI)
☐Coronary Artery Disease	☐Pregnant
☐Post-partum	☐ Other, please note:
Behavioral Health	

☐ Bipolar disorder	☐ Psychotic disorders, including schizophrenia
☐ Major Depressive Disorder	☐ Substance Use Disorder, please specify:
☐ Other, please note:	
Developmental	
☐ Intellectual/Developmental Disability, please note:	

Summary of ECM Eligibility for Managed Care Plan Reference

	Member's Eligible Population(s) of Focus *(Check all that apply)*
☐	POF 1.0: **Adults** Experiencing **Homelessness**
☐	POF 1.1: Homeless Families or Unaccompanied **Children/Youth Experiencing Homelessness**
☐	POF 2.0: **Adults** at Risk for **Avoidable Hospital or ED Utilization**
☐	POF 2.1: **Children/Youth** at Risk for **Avoidable Hospital or ED Utilization**
☐	POF 3.0: **Adults** with **Serious Mental Health and/or Substance Use Disorder (SUD) Needs**
☐	POF 3.1: **Children/Youth** with **Serious Mental Health and/or Substance Use Disorder (SUD) Needs**
☐	POF 4.0: **Adults** Transitioning from **Incarceration** within the past 12 months
☐	POF 4.1: **Children/Youth** Transitioning from **Youth Correctional Facility** within the past 12 months
☐	POF 5.0: **Adults** Living in the Community who are **at Risk for LTC Institutionalization**
☐	POF 6.0: **Adult Nursing Facility Residents** transitioning to the Community
☐	POF 7.0: **Children/Youth** Enrolled in **CCS or CCS WCM** with Additional Needs beyond the CCS Condition
☐	POF 8.0: **Children/Youth** Involved in **Child Welfare**
☐	POF 9.0: **Adults** with **Intellectual or Developmental Disabilities** (I/DD) • Must also qualify for eligibility in any **other adult ECM Population of Focus**
☐	POF 9.1: **Children/Youth** with **Intellectual or Developmental Disabilities (I/DD)** • Must also qualify for eligibility in any **other children/youth ECM Population of Focus**
☐	POF 10.0: **Adults Pregnant and Postpartum** Individuals At Risk for Adverse Perinatal Outcomes • Must also qualify for eligibility in any **other adult ECM Population of Focus**
☐	POF 10.1: **Children/Youth Pregnant and Postpartum** Individuals At Risk for Adverse Perinatal Outcomes • Must also qualify for eligibility in any **other children/youth ECM Population of Focus**

LA County Enhanced Care Management (ECM) Benefit Exclusionary Screening Checklist

DHCS outlined approaches to program coordination and the prevention of non-duplication with ECM services: ***Absolute, Duplicative, and Wrap.*** Complete this ***Exclusionary Screening Checklist*** **as a 2nd step to:**

- Confirm eligibility
- Identify duplicative programs for which the member must choose, and
- Identify potential programs that the member can be enrolled in while also in ECM, which will require coordination of services

Step 2: Complete Exclusionary Screening Checklist

Active Medi-Cal

Individual must have active Medi-Cal status and assigned to a Managed Care Plan.
If either box is checked in this section, ***STOP.*** *Member **does not** meet eligibility criteria. If either box is not checked in this section, move on to next question.*

1. ☐ Non-active Medi-Cal
2. ☐ Fee-for-Service Medi-Cal

Absolute Exclusion Criteria

Medi-Cal beneficiaries enrolled in the programs below are excluded from ECM.

If any box is checked in this section, ***STOP.*** *Member **does not** meet eligibility criteria. If any box is not checked in this section, move on to next question.*

3. ☐ Hospice
4. ☐ D-SNP members who have both Medi-Cal and Medicare and assigned with the same Managed Care Plan (MCP)
5. ☐ Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
6. ☐ Program for All Inclusive Care for the Elderly (PACE)
7. ☐ Residing in an Intermediate Care Facility (ICF) or subacute care facility

Duplicative Programs – Either ECM or Other Program

Members who are enrolled in the below duplicative programs have a choice of continuing enrollment in these programs or enrolling in ECM. The member maintains the right to choose or switch between ECM and other duplicative care management programs. We encourage members to choose the program that best meets their needs.
If any box is checked in this section, ***STOP.*** *Member has a choice to continue in their existing 1915 Waiver program or switch to ECM. Please consult with the program if possible or member to confirm active enrollment. If enrollment has ended, please identify the program by name and enrollment end date in the comment section of the referral. If any box is not checked, move on to next question.*

8. Member is currently enrolled in one of the following **1915 Waiver Programs:**
   ☐ Multipurpose Senior Services Program (MSSP)
   ☐ Assisted Living Waiver (ALW)

□ Home and Community-Based Alternatives (HCBA) Waiver
□ HIV/AIDS Waiver
□ HCBS Waiver for Individuals with Developmental Disabilities (DD)
□ Self-Determination Program for Individuals for Individuals with I/DD

9. Member is currently enrolled in one of the following **Managed Care Programs** with the Managed Care Plan (MCP):
   □ Complex Case Management

10. Member is currently enrolled in one of the following **Other Programs:**
    □ California Community Transitions (CCT) Money Follows the Person (MFTP)

ECM as a "Wrap" – Can be in Both Programs

Members can be enrolled in **both** ECM and the other program. ECM enhances and coordinates across other care/case management programs. These programs are considered to be complementary to ECM.
The below programs are not exclusionary for ECM. Knowledge of the member's "wrap" programs will require coordination of care activities by the ECM provider.

11. Member is currently enrolled in one of the following **Non-Managed Care Programs**:
    □ California Children's Services (CCS)
    □ County-based Targeted Case Management (TCM)
    □ Specialty Mental Health (SMHS) TCM
    □ SMHS Intensive Care Coordination for Children (ICC)
    □ Drug Medi-Cal Organized Delivery Systems (DMC-ODS)
    □ Regional Center services
    □ AIDS Healthcare Foundation Plans
    □ Full Service Partnership (FSP) *Note: Recommend ECM Providers coordinate with FSP programs to ensure non-duplication of services.*

12. Member is currently enrolled in one of the following **Managed Care Programs**:
    □ CCS Whole Child Model (CCS WCM)
    □ Community Based Adult Services (CBAS)
    □ In-Home Supportive Supports (IHSS)
    □ CalAIM Community Supports (CS)

13. Member is currently receiving coverage for Members **Dually Eligible for Medicare and Medi-Cal:**
    □ Dual Eligible Special Needs Plans (D-SNPs) administered by two or more Managed Care Plans (MCPs)
    □ D-SNP Look-alike Plans
    □ Other Medicare Advantage Plans
    □ Medicare Fee-For-Service (FFS)

LA County Enhanced Care Management (ECM) Benefit
Member Referral Form

Step 3: Complete the Referral Form
Follow form submission instructions outlined on Page 1

REFERRAL SOURCE INFORMATION - *Asterisk (*) indicates required information.*	
Internal Referring Department* (select one): ☐ CM ☐ UM ☐ BH ☐ MLTSS ☐ Member Svcs ☐ Other:	
External Referral By* (select one): ☐ Hospital ☐ PPG ☐ PCP ☐ Clinic ☐ SNF ☐ DHS ☐ DMH ☐ DPH ☐ Other:	
Date of Referral:*	
Referring Organization Name:*	
Referring Organization NPI:	
Referring Individual Name & Title:*	
Referrer Phone Number:*	
Referrer Email Address:*	
Has the member or parent/guardian (as applicable) expressed interest in opting-into ECM?	☐ Yes, and I have already discussed the program with the member and parent/guardian (as applicable). Member and/or parent/guardian's preference of ECM Provider, if known:
Is the member transitioning their ECM services due to a change in their health plan? (Continuity of Care - COC)	☐ Yes ☐ No Please provide previous ECM provider name: Please provide previous CA Medi-Cal health plan name: Please provide last day member worked with previous ECM Provider:

MEMBER INFORMATION			
Member Name:*			
Member Medi-Cal Client ID # (CIN):*		Member Date of Birth:*	
Member Address:			
Member Primary Phone Number:*		Best Contact Time/Location:	
Member Preferred Language:*			
Caregiver Name & Role/Title:		Caregiver Phone/Email:	
Parent/Guardian, if applicable:		Parent/Guardian Phone/Email:	

MEMBER'S ECM ELIGIBILITY - Check all that Apply	
☐	POF 1.0: **Adults** Experiencing **Homelessness**
☐	POF 1.1: Homeless Families or Unaccompanied **Children/Youth Experiencing Homelessness**
☐	POF 2.0: **Adults** at Risk for **Avoidable Hospital or ED Utilization**
☐	POF 2.1: **Children/Youth** at Risk for **Avoidable Hospital or ED Utilization**
☐	POF 3.0: **Adults** with **Serious Mental Health and/or Substance Use Disorder (SUD) Needs**
☐	POF 3.1: **Children/Youth** with **Serious Mental Health and/or Substance Use Disorder (SUD) Needs**

☐	POF 4.0: **Adults** Transitioning from **Incarceration** within the past 12 months
☐	POF 4.1: **Children/Youth** Transitioning from **Youth Correctional Facility** within the past 12 months
☐	POF 5.0: **Adults** Living in the Community who are **at Risk for LTC Institutionalization**
☐	POF 6.0: **Adult Nursing Facility Residents** transitioning to the Community
☐	POF 7.0: **Children/Youth** Enrolled in **CCS or CCS WCM** with Additional Needs beyond the CCS Condition
☐	POF 8.0: **Children/Youth** Involved in **Child Welfare**
☐	POF 9.0: **Adults** with **Intellectual or Developmental Disabilities** (I/DD) Must also qualify for eligibility in any **other adult ECM Population of Focus**
☐	POF 9.1: **Children/Youth** with **Intellectual or Developmental Disabilities (I/DD)** Must also qualify for eligibility in any **other children/youth ECM Population of Focus**
☐	POF 10.0: **Adults Pregnant and Postpartum** Individuals At Risk for Adverse Perinatal Outcomes Must also qualify for eligibility in any **other adult ECM Population of Focus**
☐	POF 10.1: **Children/Youth Pregnant and Postpartum** Individuals At Risk for Adverse Perinatal Outcomes Must also qualify for eligibility in any **other children/youth ECM Population of Focus**
☐	**Continuity of Care (COC)** Only applies to members transitioning from ECM with another CA Medi-Cal health plan

EXCLUSIONARY CRITERIA

☐ I attest that the member is **not enrolled in programs that exclude** the member from ECM eligibility

☐ If member *is* enrolled in an ECM duplicative program, member is **opting** for **ECM** *instead of* the other program.

      ○   **Other Program(s):**
      ○   **Other Program(s) disenrollment date:**

☐ If the member is enrolled in a Program that allows them to **concurrently** receive ECM services (per the Exclusionary Checklist "wrap" program section), **note Program(s):**

ADDITIONAL COMMENTS: (i.e. PCP or support person name and contact if applicable)	

Appendix D: ECM Comprehensive Assessment

LA County Enhanced Care Management (ECM) Comprehensive Assessment

Introduction statement that highlights the importance of the patient's role in the benefit:

By participating in the Enhanced Care Management benefit, you are committing to partnering with me in your care. Our team is here to provide support to help you work towards your health and social goals; we will work with you to help you develop your own management of your health and daily life.

Today and over the next 1-3 visits, we will complete this assessment together, and from there develop goals and next steps that support your overall health and wellness.

Engagement Questions: Purpose/Meaning and Strengths
Ask 3 or more of these during or at the end of the assessment

1. How strongly do you agree with this statement? I lead a purposeful and meaningful life.
2. Strengths: What is something that you are good at or really proud of?
3. Self-Efficacy: How confident are you in taking actions needed to maintain or improve your health?
4. Coping Skills: When you feel sad or worried, what helps you feel better? What do you do for fun or to relax?
5. Problem-Solving Skills: When you had a difficult situation in the past, what did you do?
6. Motivation: What do you want to improve about your health? Why do you want to improve your health?

Demographics

Today's date:	Patient name:
Date of Birth:	Medi-Cal ID:
Pop of Focus: ☐ Homeless ☐ High Utilizer ☐ SMI/SUD ☐ Transition from Incarceration	
Preferred name and/or pronouns:	Gender identification:
Preferred written/spoken language (*What language are you most comfortable speaking and reading?*):	Interpreter needed: Yes ☐ No ☐ Language:
Nationality/tribe/ethnicity: Select all that apply ☐ Hispanic or Latino ☐ Asian ☐ Pacific Islander / Native Hawaiian ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Other (please write): _____	
Where would you like to receive mail?	Home phone: / Cell phone:
Preferred method of contact: ☐ Phone ☐ Email	Email:
Preferred location of contact (*Are you comfortable meeting at your home? Where would you generally like to meet?*):	
Relationship status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic partnership ☐ Widower ☐ Other:	Opt-in to ECM Date: ☐ N/A - Grandfathered from HHP/WPC
Highest level of education: ☐ Less than high school degree ☐ High school diploma or GED ☐ More than high school/college	Refugee? ☐ Yes ☐ No ☐ Declined to state Comments:
Who can we contact in an emergency?	Veteran/Discharged from the U.S. Armed Forces? ☐ Yes ☐ No ☐ Choose not to respond
Emergency contact relationship (Legal Next of Kin? Friend?):	

M.2577 1221

Culture

Do you have any cultural, religious and/or spiritual beliefs that are important to your family's health and wellness? ☐ Yes ☐ No If yes, describe:

Health Literacy

I would like to ask you about how you think you are managing your health conditions
Do you need help taking your medicines? ☐ Yes ☐ No
Do you need help filling out health forms? ☐ Yes ☐ No
Do you need help answering questions during a doctor's visit? ☐ Yes ☐ No

Physical Health

In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor Please give me more information about why you chose this rating:
Compared to one (1) year ago, is your health: ☐ Much better ☐ Somewhat better ☐ About the same ☐ Somewhat worse ☐ Much worse now than one (1) year ago Comments about why you chose this rating?
How many times have you been to the emergency room in the past 6 months? ☐ None ☐ 1 time ☐ 2 times ☐ 3 times or more ☐ Don't remember/Not sure
How many times have you been a patient in the hospital in the past 6 months? ☐ None ☐ 1 time ☐ 2 times ☐ 3 times or more ☐ Don't remember/Not sure
In the last 12 months, how many times have you been in a nursing home and/or rehab? ☐ None ☐ 1 time ☐ 2 or more times
Do you have a regular or specialty doctor or health care provider? Yes ☐ No ☐ Provider name/clinic/phone #:
If yes, when was the last time you saw your regular doctor? ☐ Less than 3 months ago ☐ Less than 6 months ago ☐ 6-12 months ago ☐ More than 1 year ago ☐ Not sure ☐ No regular doctor
Are you currently pregnant? ☐ Yes ☐ No ☐ N/A If yes, do you have an OB/GYN and/or are receiving prenatal care? Have you given birth in the last 12 months? ☐ Yes ☐ No ☐ N/A
When was your last dental visit?
Do you have any problems eating (for example, appetite, chewing or swallowing)? ☐ Yes ☐ No Comments:
Have you been told by a doctor or medical provider that you have any medical conditions, or ? Yes ☐ No ☐ If yes, please check all that apply: ☐ Arthritis/chronic pain ☐ Asthma *(difficulty breathing)* ☐Ankle/leg swelling ☐ Alzheimer's/dementia/memory loss ☐ Cancer ☐ COPD/emphysema/bronchitis *(breathing problems)* ☐ Congestive Heart Failure ☐ Circulation problems ☐ Diabetes, Type 1 ☐ Diabetes, Type 2 ☐ Pre-Diabetic ☐ Heart problems *(heart attack, chest pain)* ☐ HIV/AIDS ☐ Hepatitis *(liver problems)* ☐ High cholesterol ☐ Hypertension *(high blood pressure)* ☐ Kidney disease ☐Osteoporosis ☐ Parkinson's ☐ Physical disability/para/quadriplegic/amputation   ☐Recent fracture ☐ Seizures ☐ Sickle Cell Disease ☐ Transplant:_____ ☐ History of TB ☐Urinary problems
☐ Other conditions not listed above:
Do you have trouble with your vision? ☐ Yes ☐ No If yes, describe:
If you have diabetes, have you had a Diabetic Eye Exam done in the last year? ☐ Yes ☐ No

Do you have trouble with your hearing? ☐ Yes ☐ No If yes, describe:
Are you getting wound care [from a health care professional or care team] now? ☐ Yes ☐ No
Preventative Care
Have you had any of the following vaccinations as an adult?
☐ COVID-19/Date: ☐ Tetanus/Date: ☐ Flu/Date: ☐ Pneumonia/Date: ☐ Shingles, Date: ☐ Other/Date:
Have you had the following screenings/tests? ☐ Colonoscopy (5 yrs) ☐ Mammogram (2 yrs) ☐ Pap smear (3-5 yrs) ☐ Bone density ☐ Blood sugar (HbA1C, 12 mo) ☐ Kidney function/Date: ☐ Eye exam/Date:

Medications

Please tell me what medications you are currently taking, including how often and the dose:
Have you had trouble filling medications in the last year? ☐ Yes ☐ No If yes, comments:
People sometimes miss taking their medications. Thinking over the past week, were there any days you did not take your medications as prescribed? ☐ Yes ☐ No If yes, please describe what gets in the way:
Would you like assistance with taking your medication as prescribed? ☐ Yes ☐ No

Pain Management

Do you experience pain? ☐ Yes ☐ No If yes, answer below.
During the past week, how much did pain interfere with your normal activities (including work outside the home and/or housework)? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Activities of Daily Living (ADLs)

Do you need help with any of these actions?	
Taking a bath or shower ☐ Yes ☐ No	Going up stairs ☐ Yes ☐ No
Eating ☐ Yes ☐ No	Getting Dressed ☐ Yes ☐ No
Brushing teeth, brushing hair, shaving ☐ Yes ☐ No	Making meals or cooking ☐ Yes ☐ No
Getting out of a bed or a chair ☐ Yes ☐ No	Shopping and getting food ☐ Yes ☐ No
Using the toilet ☐ Yes ☐ No	Walking ☐ Yes ☐ No
Washing dishes or clothes ☐ Yes ☐ No	Writing checks or keeping track of money ☐ Yes ☐ No
Getting a ride to the doctor or to see your friends ☐ Yes ☐ No	Doing house or yard work ☐ Yes ☐ No
Going out to visit family or friends ☐ Yes ☐ No	Using the phone ☐ Yes ☐ No
Keeping track of appointments ☐ Yes ☐ No	
If yes, are you getting all the help you need with these actions? ☐ Yes ☐ No	
Comments:	
Have you fallen the last month? ☐ Yes ☐ No Are you afraid of falling? ☐ Yes ☐ No	
Do friends or family members express concerns about your ability to care for yourself? ☐ Yes ☐ No	
Do you use or need any of the following? (Select all that apply.):	

☐ Glasses ☐Use ☐Need	☐ Cane ☐Use ☐Need	☐ Walker ☐Use ☐Need	☐ Hearing device ☐Use ☐Need
☐ TTY (visual support) ☐Use ☐Need	☐ Crutches ☐Use ☐Need	☐ Grab bars ☐Use ☐Need	☐ Raised toilet seat/chair ☐Use ☐Need

☐ Feeding tube ☐Use☐Need	☐ Wheelchair ☐Use☐Need	☐ Food supplements ☐Use☐Need	☐ Hospital bed ☐Use☐Need
☐ Oxygen ☐Use☐Need	☐ Ostomy supplies ☐Use☐Need	☐ CPAP/BiPAP ☐Use☐Need	☐ Diabetes supplies ☐Use☐Need
☐ Large print ☐Use☐Need	☐ Sideboard ☐Use☐Need	☐ Urinary catheter ☐Use☐Need	☐ IV infusions for meds ☐Use☐Need
☐ Incontinence supplies ☐Use☐Need	☐ Trach/suction supplies ☐Use☐Need	☐ Lift device (for transferring) ☐Use☐Need	☐ Other ☐Use☐Need
Comments:			

Behavioral Health

Mental health history
Has a healthcare or mental health provider ever told you that you have a mental health diagnosis? ☐ Yes ☐ No
If **Yes**, what diagnosis have you been given ☐ Depression ☐ Bipolar Disorder ☐Schizophrenia ☐Anxiety ☐PTSD ☐ Other Comments:

Mental Health Assessment Questions
Depression – Patient Health Questionnaire (PHQ) • *If a recent (within past month) PHQ-9 has been completed by another provider and is in chart, enter score here: _____ and follow scoring guidelines below. If no PHQ-9 in chart, complete the PHQ-2*
PHQ-2 plus Question 9   Over the last two weeks, how often have you been bothered by any of the following?
1.   Have you experienced a reduction in interest or pleasure in doing things?
Not at all ☐ Several days ☐ More than half the days ☐   Nearly every day ☐
2.   Have you felt down, depressed or hopeless?
Not at all ☐ Several days ☐ More than half the days ☐   Nearly every day ☐
3.   (Q.9) Thoughts that you would be better off dead or of hurting yourself in some way
Not at all ☐ Several days ☐ More than half the days ☐   Nearly every day ☐
Scoring: Not at all = 0, Several days = 1, More than half the days = 2, Nearly every day = 3. • *Score of 2 or greater AND/OR checks YES on Q.9 — Individual completes the PHQ-9 (recommend self-administer). Printable PHQ-9 in multiple languages: https://www.phqscreeners.com/* • *If PHQ-9 score is >10 consult with clinical consultant and supervisor. If >15 or positive for Q.9 request immediate consultation.*

Anxiety
Anxiety and Stress happens when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you? ☐ Not at all ☐ Somewhat ☐ Very much ☐ A little bit ☐ Quite a bit ☐ I choose not to answer

Trauma and Stressors
Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic, such as being in a serious accident, physical/emotional abuse, sexual assault or abuse, being in a war, seeing someone killed or assaulted, having a loved one die by suicide, being bullied/discriminated against, or other events/experiences that were distressing or disturbing to you.
Have you ever experienced traumatic events such as these or other trauma in your life? ☐ Yes   ☐ No   If YES, please comment:

Cognitive Functioning
Have you had any changes in thinking, remembering, or making decisions? ☐ Yes   ☐ No
In the past month, have you felt worried, scared or confused that something may be wrong with your mind or memory? ☐ Yes   ☐ No
Scoring: If the patient checks yes to either box, consult with the clinical consultant and supervisor.

Developmental Factors
Ask the following question only if this information is not already available to the ECM Provider Team

Question for patient OR family/caregiver/case manager (depending on individual's ability to answer):   Has a healthcare provider ever told you or your family that when you were a child or adult that you had a developmental delay, disability or brain injury that impacted your ability to think clearly (for example, traumatic brain injury, autism spectrum disorder, ADHD, learning disability)?   ☐ Yes ☐ No

Substance Use

I have some questions about your experience with alcohol, nicotine products, marijuana and other substances. Some of the substances we will talk about are prescribed by a doctor, but I will only be focusing on whether you have taken them for reasons other than prescribed or in doses other than prescribed.

In the past 6 months, how often have you used the following:	Never	1-2 times	Monthly	Weekly	Daily
Alcohol	☐	☐	☐	☐	☐
Nicotine Products (Cigarette, vaping, chewing tobacco)	☐	☐	☐	☐	☐
Using Prescription drugs not as prescribed (circle any relevant): • Pain medicines • ADHD medicines • Sleeping pills Other:	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Other substances: For example cocaine, meth, heroin, hallucinogens, inhalants, designer drugs	☐	☐	☐	☐	☐
1. Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No If yes, go to next question					
Would you like to talk with someone about your substance use, especially if you are thinking of quitting or cutting back? ☐ Yes ☐ No					
Comments:					

Social Determinants of Health (SDoH)
Housing

Where do you live? (check all that apply)   ☐ House ☐ Apartment complex ☐ Board and care facility ☐ Residential treatment center ☐ Assisted living   ☐ Nursing home ☐ Permanent Supported Housing ☐ Protective housing ☐ Homeless ☐ Other:
If you are homeless, where are you staying (transitional housing, in a motel, shelter, with friends)?
Are you worried about losing your housing? ☐ Yes ☐ No   If yes, please explain:
What concerns you the most about your housing situation?
Is anyone currently helping you with your housing support (for example, Housing Navigator, case management, or tenants' rights)? ☐ Yes ☐ No
Housing Environment: Can you live safely and easily around your home? ☐ Yes ☐ No   If NO, does the place where you live have:

Good lighting ☐ Yes ☐ No	Good heating ☐ Yes ☐ No	Good cooling ☐ Yes ☐ No
Rails for any stairs/ramps ☐ Yes ☐ No	Hot water ☐ Yes ☐ No	Indoor toilet ☐ Yes ☐No
A door to the outside that locks ☐ Yes ☐ No	Stairs to get into your home or stairs inside your home ☐Yes ☐No	Elevator ☐ Yes ☐ No
Space to use a wheelchair ☐ Yes ☐ No	Clear ways to exit your home ☐ Yes ☐ No	Comments:

Safety

Do you feel physically and emotionally safe where you currently live? ☐ Yes ☐ No If no, please describe:
Is anyone staying in your home without your permission? ☐ Yes ☐ No If yes, please explain:
Are you afraid of anyone or is anyone hurting you? ☐ Yes ☐ No If yes, please explain:
Is anyone using your money without your OK? ☐ Yes ☐ No If yes, please explain:

Food Security

In the last 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there was not enough money for food? ☐ Yes ☐ No
How often are you hungry or do not eat because there is not enough food in the house? ☐ Often ☐ Not often
Do you eat less than you feel you should because there is not enough food? ☐ Yes ☐ No
Comments:

Social Connection/Support

Who do you live with? ☐ Live alone ☐ Live with spouse or significant other ☐ Live with children or other relatives or friends ☐ Live with caregiver ☐ Live with other residents in my facility/program
How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings) ☐ Less than once a week ☐ 1 or 2 times a week ☐ 3 to 5 times a week ☐ 5 or more times a week
Are you caring for anyone and/or any pets? ☐ Yes ☐ No If yes, describe:
Over the past month (30 days), how many days have you felt lonely? (Check one.) ☐ None—I never feel lonely ☐ Less than 5 days ☐ More than half the days (more than 15) ☐ Most days—I always feel lonely

Family Member/Individual Supports (Including Caregiver Resources and Involvement)

Do you have family members, friends or others willing to help you when you need it? ☐ Yes ☐ No
Do you have a caregiver assisting you? ☐ Yes ☐ No Name/contact info (phone/email):
Do you ever think your caregiver has a hard time giving you all the help you need? ☐ Yes ☐ No If yes, please explain:
Do you have an In-Home Supportive Services (IHSS) worker? ☐ Yes ☐ No
Comments:

Benefits and Other Services

Funding/benefit source/services:	
☐ CalFresh benefits (SNAP) ☐ TANF recipient ☐ SSI recipient ☐ SSDI recipient ☐ SSA (retirement) recipient ☐ Other retirement income ☐ Employed ☐ VA Benefits ☐ General Relief ☐ None	
Do you sometimes run out of money to pay for food, rent, bills and medicine? ☐ Yes ☐ No	
What is your current work situation?	☐ Part-time or ☐ Full-time? Unpredictable (i.e. day labor) ☐ Yes ☐ No
Are there any concerns or challenges with your job? ☐ Yes ☐ No	If yes, describe:
☐ Student ☐ Retired	☐ Other

☐ Long-term care and support (SNF, Rehab Center) ☐ Family PACT	☐ Community-Based Adult Services ☐ Veterans Administration ☐ Other:	☐ Palliative care programs ☐ Regional Center ☐ California Children's Services

Legal Involvement

In the past 12 months, have you been involved with the following:
☐ Court ordered services ☐ On probation ☐ On parole ☐ Re-entry program ☐ DUI/restricted license ☐ Adult Protective Services (APS)/Child Protective Services (CPS) ☐ Community Legal Services ☐ None Comments:
In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility? ☐ Yes ☐ No
If yes, I would like to coordinate with anyone you are working with related to your stay in ___ so we can work together to support you and your goals. May I contact that person with you?"
Have you ever associated with members of a gang or been involved in one? ☐ Yes ☐ No If yes, what is your current status?

End-of-life Planning

Do you have a life-planning document or advance directive in place? ☐ Yes ☐ No
Do you want information on these topics? ☐ Yes ☐ No

Member Priorities

What concerns you most about your physical or mental health?
What is one thing you would like to do right now to improve your health (such as cutting back on caffeinated or sugary drinks? – *provide easy, harm reduction examples*)
What would you like to achieve from our work and time together?
From our meeting today what comes to mind as your top 2-3 goals for your health, wellness and social and/or living situation for the next 3-6 months? 1. 2. 3.

Narrative Summary

Include Primary Needs identified from Assessment:	
Next Steps	**Person Responsible**
1.	
2.	
3.	
Next Appointment/Location:	

Appendix E: ECM Program Completion Questionnaire

Enhanced Care Management (ECM) Program Completion Questionnaire

Member Name: _____

CIN:_____   Date of Birth:_____

Parent/Guardian/Caregiver Name: _____

Is the Parent/Guardian/Caregiver helping complete questionnaire: ☐ Yes   ☐ No

ECM Provider Name: _____

Lead Care Manager Name: _____

ECM Lead Care Managers are encouraged to use the questionnaire below with the member and/or with their Parent/Guardian/Caregiver as appropriate to help determine readiness for program completion of ECM and/or transition out of ECM to a lower level of care management.

Care Plan:

1) I met the goals on my care plan?
   ☐ Yes   ☐ No   ☐ Other:_____

Physical Health:

2) I can do the following on my own *or parent/guardian/caregiver can assist with the following:* (check all that apply)

   ☐ Make appointments.
   ☐ Track appointments on a calendar.
   ☐ Keep appointments or call to reschedule/cancel in advance.
   ☐ Know how to call the PCP or Nurse Advice Line.
   ☐ Utilize the ER appropriately.
   ☐ Know how to attend telehealth appointment.
   ☐ Find community resources.
   ☐ Call Customer Service to ask questions or request services (change provider, request case management).
   ☐ Call L.A. Care to schedule rides to appointments, pharmacy, food pantries.
   ☐ Understand the Member Bill of Rights.
   ☐ Use the Member EOC Handbook.

3) Do I understand why I take each of my medications and do I take them as instructed by my prescriber? *Or does parent/guardian/caregiver understand why member takes each of their medications and gives them as instructed by the prescriber?*

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☐ Yes   ☐ No   ☐ Other: _____

4) Do I know when I need to see my care provider? Do I feel comfortable talking to the care provider about what is bothering me and asking questions? *Or does parent/guardian/caregiver know when member needs to see their care provider? Does parent/guardian/caregiver feel comfortable talking to the care provider about what is bothering the member and asking questions?*
☐ Yes   ☐ No   ☐ Other: _____

5) Can I follow my care team's recommendations (e.g. eating right or exercising)? *Or can parent/guardian/caregiver follow the member's care team recommendations?*
☐ Yes   ☐ No   ☐ Other: _____

6) Do I feel like I can manage my stress?
☐ Yes   ☐ No   ☐ N/A   ☐ Other: _____

7) Do I know how to take care of my health and ask for help when I need it? *Or can parent/guardian/caregiver take care of member's health and ask for help when they need it?*
☐ Yes   ☐ No   ☐ Other: _____

Mental/Emotional Health:

8) I can do the following on my own. *Or can parent/guardian/caregiver assist me with the following* (check all that apply):
☐ N/A

☐ Understand my mental health diagnosis and treatment.
☐ Know where and when to seek care and make informed decisions about care.
☐ Recognize warning signs related to emotional health/mental health diagnosis.
☐ Recognize things that upset me and respond in a healthy way.
☐ Understand why I take my medications and know how to take my medications.
☐ Identify one or more people I can talk to (e.g. support person or group).
☐ Find help when I need it.

Housing:

9) Do I have safe and stable housing? Do I know how to find help if I need it?
☐ Yes   ☐ No   ☐ Other:_____

10) Do I know my rights in my current housing situation?

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☐ Yes ☐ No ☐ N/A ☐ Other:_____

11) Do I know how my actions can affect my housing (e.g. paying rent late, hoarding, smoking)? Or *does my parent/guardian/caregiver understand how their actions will affect member's housing?*
☐ Yes ☐ No ☐ N/A ☐ Other:_____

12) Do I understand why I need to maintain my relationship with the landlord?
☐ Yes ☐ No ☐ N/A ☐ Other:_____

Daily living:

13) Can I do things for myself, like cook, clean and shop? Can I ask for help when I need it? *Or can parent/guardian/caregiver do things for member, like cook, clean and shop? Can they ask for help when needed?*
☐ Yes ☐ No ☐ Sometimes:_____

14) Can I perform or get help with activities of daily living such as bathing, dressing, toileting, transferring, continence and feeding? *Or can parent/guardian/caregiver help member with activities of daily living such as bathing, dressing, toileting, transferring, continence and feeding?"*
☐ Yes ☐ No ☐ Other:_____

15) Do I have all of the supplies and equipment to live on my own*? Or does parent/guardian/caregiver have all of the supplies and equipment that member needs to live at home?*
☐ Yes ☐ No ☐ Other:_____

16) Am I able to get food, transportation, and seek help when I need it? *Or Is parent/guardian/caregiver able to get food, transportation and seek help when member needs it?*
☐ Yes ☐ No ☐ Other:_____

17) Do I have my birth certificate, Social Security card, driver's license, and other records to prove my identity?
☐ Yes ☐ No ☐ Other:_____

18) Do I know how to keep track of my money* and how and where I spend it (i.e. rent, bills, groceries)? *Note: intended to be inclusive of all sources of income, including CalFresh, etc. *or does parent/guardian/caregiver help member keep track of money and how and where they spend it (i.e. rent, bills, groceries)?*

☐ Yes ☐ No ☐ Other:_____

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19) **[REQUIRED] Please identify any programs or services to which the member was linked during ECM. Is the member still receiving services from these programs today?**

_____
_____
_____

20) **[REQUIRED] Please describe any ongoing need for care management services (i.e. related to a specific need or concern):**

_____
_____
_____

21) **[REQUIRED] If member meets criteria to transition to a lower level of care management, please identify a program(s) that may be a good fit to continue to serve the member after the end of ECM services (if known).**

_____
_____

Date of Completion:_____

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Internal Provider Use Only

Please identify the results of the Program Completion Questionnaire and return this portion with the complete Questionnaire to L.A. Care.

Questionnaire Results (choose one):

___ **Member meets graduation criteria and will graduate from ECM.**

___ **Member does not meet graduation criteria and reauthorization is requested.**

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