

DEPARTMENT OF HEALTH CARE SERVICES

**CaAIM**  
**ENHANCED CARE**  
**MANAGEMENT**  
**POLICY GUIDE**

Updated December 2022

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## I. Introduction

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

CalAIM is an initiative of the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal Members by implementing delivery system, program and payment reforms across the Medi-Cal program. A key feature of CalAIM is the statewide introduction of an ECM benefit and a menu of Community Supports, which, at the option of an MCP and a Member, can substitute for covered Medi-Cal services as cost-effective alternative services. MCPs are responsible for administering both ECM and Community Supports in close collaboration with their network of community-based Providers.

ECM and Community Supports have been developed from lessons learned, as well as MCP and Provider experience, in the Whole Person Care (WPC) Pilots and Health Homes Program (HHP). Both WPC and HHP led the way in providing a set of intensive care coordination services that spanned multiple delivery systems to provide a person-centered approach to care. These initiatives also pushed the boundaries of a traditional health care delivery approach to begin formally considering the impact of social drivers of health (SDOH) on health outcomes and experience of care in Medi-Cal.<sup>1</sup>

DHCS’ adoption of ECM and Community Supports on a statewide scale supports the highest-need Medi-Cal MCP Members. ECM and Community Supports are anchored in the community, where services can be delivered in an in-person manner by community-based ECM and Community Supports Providers, to the greatest extent possible. While ECM and Community Supports may both be appropriate for certain Members, they are separate initiatives, and some Medi-Cal Members will qualify for only ECM or only Community Supports. For detailed information about Community Supports, please refer to the separate [Community Supports Policy Guide](#).

ECM is an integral component of DHCS’ Population Health Management (PHM) Program under CalAIM. The PHM Program is designed to ensure that all Members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, ranging from wellness and prevention to ECM for those with the highest health and social needs. For more on the PHM Program, see the [PHM Policy Guide](#) and [DHCS’ PHM webpage](#).

Each MCP is required to develop and submit for DHCS approval an ECM and Community Supports Model of Care (MOC). The MOC is each MCP’s detailed plan for providing ECM and Community Supports in accordance with DHCS’ requirements. Each MCP’s MOC includes its overall approach to ECM and Community Supports; its detailed policies and procedures for partnering with Providers, including non-traditional Medi-Cal Providers, for the administration of ECM and Community Supports; its ECM and Community Supports Provider capacity; and the contract language that will define its arrangements with its ECM and Community Supports

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<sup>1</sup> Refer to the [All Plan Letter \(APL\) 21-009 \(Revised\)](#) for more information.

Providers. Starting in 2023, The MOC should also include information about how the MCP is identifying and internally tracking key performance indicators for successful growth of ECM, such as the volume of referrals from providers and others, and self and family referrals.

DHCS is committed to data driven-oversight of ECM, and expects MCPs to have a data-driven approach to their implementation and monitoring of ECM. DHCS is doing a thorough and regular review of inbound MCP data known as the [Quarterly Implementation Monitoring Report](#) and will be analyzing ECM encounter data, when fully available. Consistent communication with partners and stakeholders is also key to DHCS' plans for monitoring, targeting technical assistance, and modifying program policies and procedures. DHCS is in continuous communication with MCPs, Providers, and other stakeholders involved in ECM through the PHM Advisory Group, CalAIM Implementation Advisory Group, and other forums for stakeholder feedback on implementation.

The requirement for MCPs to implement ECM is derived from the [MCP Contract](#), the ECM APL ([APL 21-012](#)), and [DHCS' ECM and Community Supports Standard Provider Terms and Conditions](#). This Policy Guide is intended to serve as a comprehensive resource for MCPs administering ECM, as well as for other key stakeholders involved in ECM, including Providers, counties, and community based organizations (CBOs). Updates will be published as needed and posted on [DHCS' ECM and Community Supports webpage](#), where stakeholders can also find other resources, including [FAQs](#) (Frequently Asked Questions). MCPs and other stakeholders may direct their questions to DHCS using the following email address: [CalAIMECMILOS@dhcs.ca.gov](mailto:CalAIMECMILOS@dhcs.ca.gov).

## II. What Is Enhanced Care Management (ECM)?

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

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

ECM builds on both the design and the learning from the WPC Pilots and the HHP. ECM, with Community Supports, replaces both initiatives, scaling up the interventions to form a statewide care management approach that is a key component of the overall PHM Program. ECM offers comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members, with the overarching goals of:

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

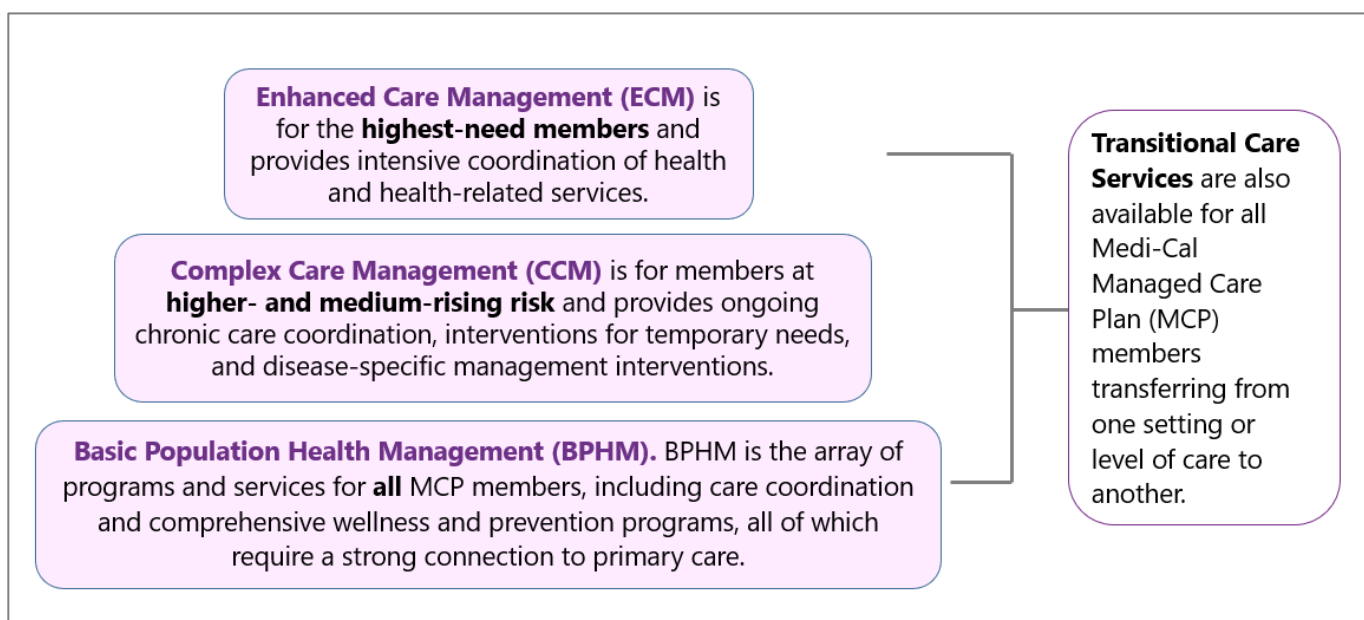
### ***ECM and the PHM Program (Updated December 2022)***

On January 1, 2023, DHCS is launching a new, comprehensive **Population Health Management (PHM) Program** as part of CalAIM. ECM is one component of that overarching program. Under the new PHM Program, MCPs and their networks and partners will be responsive to individual Member needs within the communities they serve while working within a common framework and expectations. The PHM Program is designed to ensure that all Medi-Cal managed care Members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, with ECM intended for Members with the highest needs on that CalAIM Care Management Continuum. Two other care management programs exist within the Continuum, including Complex Care Management (CCM) for higher- and medium-rising risk Members and

Basic Population Health Management (BPHM) for all Members. See Figure 1 below outlining the CalAIM Care Management Continuum and the [PHM Policy Guide](#) for more information.

DHCS is also building a statewide **PHM Service**, which is a technology service designed to support PHM Program functions, including ECM. When fully operational, the PHM Service will provide MCPs, Providers, counties, Members, and other authorized users with access to comprehensive data on Members' health history, needs, and risks, including historical administrative, medical, behavioral, dental, and social service data and other program information. The PHM Service will use these data to support risk stratification, segmentation and tiering, assessment and screening processes, and analytics and reporting functions. The PHM Service will also improve data accuracy and timeliness by providing For more information about PHM, refer to the [PHM Policy Guide](#) and [DHCS' PHM webpage](#).

**Figure 1: CalAIM Care Management Continuum**



### III. ECM Implementation Timeline

**(Updated December 2022)**

Below is the most up to date ECM Implementation Timeline. Notice to MCPs and stakeholders will be provided in the event the timeline is modified. For more information, visit [DHCS' ECM and Community Supports webpage](#).

Go Live Timing	Populations of Focus
January 1, 2022  <i>(Counties that participated in WPC, HHP or both)</i>	<ul style="list-style-type: none"> <li>• Adults and their Families Experiencing Homelessness<sup>2</sup></li> <li>• Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization (formerly “High Utilizers”)</li> <li>• Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs</li> <li>• Individuals Transitioning from Incarceration (some WPC counties)</li> <li>• Adults with Intellectual or Developmental Disabilities (I/DD)<sup>3</sup></li> <li>• Pregnant or Postpartum Adults<sup>4</sup></li> </ul>
July 1, 2022  <i>(Counties that participated in neither WPC nor HHP)</i>	<ul style="list-style-type: none"> <li>• Adults and their Families Experiencing Homelessness</li> <li>• Adults At Risk for Avoidable Hospital or ED Utilization</li> <li>• Adults with Serious Mental Health and/or SUD Needs</li> <li>• Adults with I/DD</li> <li>• Pregnant or Postpartum Adults</li> </ul>
January 1, 2023  <i>(Statewide)</i>	<ul style="list-style-type: none"> <li>• Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization</li> <li>• Adult Nursing Facility Residents Transitioning to the Community</li> </ul>
July 1, 2023  <i>(Statewide)</i>	<ul style="list-style-type: none"> <li>• Adults without Dependent Children/Youth Living with Them Experiencing Homelessness</li> <li>• Children and Youth Populations of Focus</li> </ul>

<sup>2</sup> In the period between January 2022 and July 2023, ECM is available to adults and their dependent children experiencing homelessness. With the launch of ECM for children and youth, the definition will expand for children, youth, and families; and remain as in the January 2022 – July 2023 period for adults without dependent children. See Section IV. ECM Populations of Focus for more details.

<sup>3</sup> ECM has been available for adults with developmental needs from the launch of ECM if they meet the eligibility criteria for any existing Population of Focus. As of December 2022, DHCS is clarifying that Individuals with I/DD is a distinct Population of Focus to provide more prominence to the availability of ECM for this population. See Section IV. ECM Populations of Focus for more details.

<sup>4</sup> ECM has been available to pregnant and postpartum adults from the launch of ECM if they meet the eligibility criteria for any existing Population of Focus. As of December 2022, DHCS is clarifying that “Pregnant and Postpartum Individuals” is a distinct Population of Focus to provide more prominence to the availability of ECM for this population. See Section IV. ECM Populations of Focus for more details.

	<ul style="list-style-type: none"> <li>○ Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness</li> <li>○ Children and Youth At Risk for Avoidable Hospital or ED Utilization</li> <li>○ Children and Youth with Serious Mental Health and/or SUD Needs</li> <li>○ Children and Youth Enrolled in California Children’s Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition</li> <li>○ Children and Youth Involved in Child Welfare</li> <li>○ Children and Youth with I/DD</li> <li>○ Pregnant or Postpartum Youth</li> </ul>
<p>January 1, 2024 <i>(Statewide)</i></p>	<ul style="list-style-type: none"> <li>● Birth Equity Population of Focus</li> <li>● Individuals Transitioning from Incarceration<sup>5</sup> (<i>statewide, inclusive of the former WPC counties that already went live on January 1, 2022</i>)</li> </ul>

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<sup>5</sup> As of December 2022, the CalAIM 1115 justice initiative waiver request is pending with the Centers for Medicare and Medicaid Services (CMS), and, as such, the criteria are subject to change.



## IV. ECM Populations of Focus

*(Updated December 2022)*

To be eligible for ECM, Members must be enrolled in a Medi-Cal Managed Care Plan<sup>6</sup> and meet at least one of the ECM Populations of Focus definitions described below:

ECM Populations of Focus		Adults	Children & Youth
<b>1a</b>	Individuals Experiencing Homelessness: <i>Adults without Dependent Children/Youth Living with Them Experiencing Homelessness</i>	✓	
<b>1b</b>	Individuals Experiencing Homelessness: <i>Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness</i>	✓	✓
<b>2</b>	Individuals At Risk for Avoidable Hospital or ED Utilization ( <i>Formerly “High Utilizers”</i> )	✓	✓
<b>3</b>	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
<b>4</b>	Individuals Transitioning from Incarceration	✓	✓
<b>5</b>	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
<b>6</b>	Adult Nursing Facility Residents Transitioning to the Community	✓	
<b>7</b>	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✓
<b>8</b>	Children and Youth Involved in Child Welfare		✓
<b>9</b>	Individuals with I/DD	✓	✓
<b>10</b>	Pregnant and Postpartum Individuals; Birth Equity Population of Focus	✓	✓

### **Detailed Population of Focus Definitions** *(Updated December 2022)*

The Populations of Focus definitions given below supersede the definitions originally described in the [CalAIM Proposal](#) of January 2021. Each Population of Focus includes a detailed definition for the Population of Focus with eligibility criteria; examples of eligible Members; and operational guidance to support implementation. In the Populations of Focus definitions, “**adult**” is defined as an individual who is 21 years of age or older, and a “**child or youth**” is defined as an individual under 21. Consequently, the Children and Youth-specific definitions for ECM apply up to age 21, with limited exceptions as called out below. When a Member under 21 is served in ECM and does meet adult ECM criteria upon turning 21, the Member should not be disenrolled from ECM; rather,

<sup>6</sup> Medi-Cal recipients with a Share of Cost, excluding long-term care share of cost, are excluded from managed care and are thus not eligible for ECM.

the ECM Provider and MCP should apply the MCP's usual, DHCS-approved "graduation" criteria to determine when the Member is ready to disenroll.

## 1. Individuals Experiencing Homelessness (Updated December 2022)

Individuals and families experiencing homelessness are among the highest-need and vulnerable individuals in Medi-Cal, in that they lack access to shelter and food, both of which are critical to health. These individuals often have extensive medical and behavioral health needs that are difficult to manage due to the social factors that influence their health. This can result in reduced quality of life and high utilization of avoidable, costly services in EDs and inpatient settings that could be avoided with appropriate care management and potentially the provision of Community Supports. ECM provides the needed link between physical and behavioral health care and connection to housing. In addition, communities of color are disproportionately impacted by homelessness in California and nationally, making ECM for this Population of Focus a critical tool in achieving racial health equity.

### A. Population of Focus Eligibility Criteria:

This Population of Focus went live with the launch of ECM in 2022. With the launch of ECM for children and youth in July 2023, eligibility criteria will be broadened for children, youth and families, as laid out below.

#### **Eligibility Criteria Applicable from January 2022 Until Launch of ECM for Children/Youth (In Effect Through June 30, 2023)**

Adults and their families who:

(1) Are experiencing homelessness, defined as meeting one or more of the following conditions<sup>7</sup>:

- (i) Lacking a fixed, regular, and adequate nighttime residence;
- (ii) 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;
- (iii) 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);
- (iv) Exiting an institution into homelessness (regardless of length of stay in the institution);
- (v) Will imminently lose housing in next 30 days;
- (vii) Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence;

**AND**

<sup>7</sup> This definition of homelessness is based on the U.S. Department of Health and Human Services (HHS) [42 CFR § 11302 - General definition of homeless individual](#) with the modification to Clause (v) timeframe for an individual who will imminently lose housing has been extended from 14 days (HHS definition) to 30 days. The wording of this definition has also been slightly modified for clarity, relative to the originally-released definition.

(2) Have at least one complex physical, behavioral, or developmental 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.<sup>8</sup>

The ECM eligibility criteria for this Population of Focus will be modified when ECM launches for children and youth, as shown below. The purpose of these modifications is to ensure that ECM captures the breadth of unsafe, substandard, and insecure living conditions that families, children, and youth may experience. To do this, the Population of Focus eligibility criteria are modified from 45 CFR 11431a McKinney-Vento Homeless Assistance Act's definition of "at risk of homelessness." The California Department of Education (CDE) uses a similar definition of homelessness to identify students in need of housing support. DHCS continues to strengthen partnerships with CDE, such as the requirement for MCPs and Local Educational Agencies (LEAs) to enter into memoranda of understanding (MOUs) per the upcoming Medi-Cal Managed Care contract procurement going live in January 2024.

**Eligibility Criteria Applicable from Date of Launch of ECM for Children/Youth ECM**  
**(In Effect July 1, 2023, and Onwards)**

**a. Adults without Dependent Children/Youth Living with Them**

Adults who:

- (1) Are experiencing homelessness, defined as meeting one or more of the following conditions:
- (i) Lacking a fixed, regular, and adequate nighttime residence;
  - (ii) 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;
  - (iii) 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);
  - (iv) Exiting an institution into homelessness (regardless of length of stay in the institution);
  - (v) Will imminently lose housing in next 30 days;
  - (vii) Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence.

**AND**

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<sup>8</sup> Pregnant and postpartum individuals who are homeless are considered to have met this definition. See also Population of Focus 10 for how ECM can address the needs of pregnant and postpartum individuals.

(2) Have at least one complex physical, behavioral, or developmental 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.<sup>9</sup>

**Notes on the (a) Definition:**

- This definition is identical to the eligibility criteria applicable from January 2022 until the launch of ECM for children and youth, given above.<sup>10</sup>

**b. Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness (In Effect July 1, 2023, and Onwards)**

Children, Youth, and Families who:

(1) Are experiencing homelessness, as defined above in (a) under the modified HHS 42 CFR Section 11302 “Homeless” definition;

**OR**

(2) 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).

**Notes on the (b) Definition:**

- Children, youth, and families do not need to meet the additional “complex physical, behavioral, or developmental need” criteria noted above in Clause (2) for adults in (a).
- Clause (2) for children, youth, and families in (b) is modified from the 45 CFR 11434a McKinney-Vento Homeless Assistance Act definition of “at risk of homelessness”<sup>11</sup> and is included in this Population of Focus to ensure ECM captures the breadth of unsafe, substandard, and insecure living conditions that Members, particularly children and youth, may experience.

**B. Examples of Eligible MCP Members Under this Population of Focus:**

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

<sup>9</sup> Pregnant and postpartum individuals who are homeless are considered to have met this definition. See also Population of Focus 10 for how ECM can address the needs of pregnant and postpartum individuals.

<sup>10</sup> This definition is identical to the eligibility criteria applicable from January 2022 until launch of ECM for children and youth, given above.

<sup>11</sup> See [McKinney-Vento Homeless Assistance Act](#).

- Youth who has been excluded from home due to their gender identity or sexual orientation and is now temporarily living with the family of a friend (e.g., couch surfing).
- Parent and child who are fleeing domestic violence from a spouse at home.

### C. Operational Guidance:

- **Identification:**
  - As for all ECM Populations of Focus, MCPs must establish policies and procedures that allow network providers to refer patients to the MCP for ECM if they suspect eligibility criteria are met and track key performance indicators to monitor and improve the volume of provider referrals.
  - Engagement in ECM for this population may include street outreach or coordinating with shelters, Homeless Services Providers, Recuperative Care Providers, Community Partners (e.g., Homeless Coordinated Entry Systems) and other service Providers with experience working with homeless individuals and families.
  - Members and their families may self-refer to ECM.
  - MCPs should utilize data from their regional Continuum of Care Homeless Management Information System (HMIS) to determine which of their members are experiencing homelessness and should be referred for ECM.
- **Outreach and Engagement:**
  - As is true for all ECM Lead Care Managers, ECM requires engagement with the Member in the community or at Provider locations. Street medicine provides an opportunity to provide care to individuals who are experiencing homelessness by meeting them where they are. Separately from ECM, DHCS issued a [Provider Bulletin](#) to clarify how street medicine providers may utilize Presumptive Eligibility in mobile clinics, street teams or other locations to be able to provide immediate access to Medi-Cal Services. Street medicine providers may be ideally suited to conduct outreach and engage with Members who are experiencing homelessness, whether serving as ECM Lead Care Managers within their own teams or handing off to other ECM Providers who will take on the longitudinal role.
- **Comprehensive Assessment and Care Management Plan:**
  - For this Population of Focus, the Comprehensive Assessment and Care Management Plan should specifically address housing needs and next steps for the ECM Lead Care Manager to help connect the Member to sources of housing support, including (but not limited to) the pre-approved Community Supports. MCPs should ensure that ECM Providers serving members of this Population of Focus have detailed and up to date information about how to refer Members to housing Community Supports, including eligibility criteria and the operation of lifetime limits, where applicable.
  - Per federal requirements, if the Member has LTSS needs, the care plan must be developed by an individual who is trained in person-centered planning, using a person-centered process;<sup>12</sup> should consider and reflect what is important to the

<sup>12</sup> As established in [42 CFR § 438.208](#) and [42 CFR § 441.301](#).

Member regarding their preferences for the delivery of LTSS (for example, specific treatment goals, services or functional needs the Member prefers to prioritize).

- **Examples of Applicable ECM Services for this Population of Focus:**

For this Population of Focus, ECM should include addressing barriers to housing stability by connecting Members and their families to housing, health and social support resources. Examples of applicable services for this Population of Focus to be included in ECM include (but are not limited to):

- Facilitating access to housing-related Community Supports to identify housing and preparing individuals to secure and/or maintain stable housing.
  - Maintaining regular contact with Members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing any gaps to ensure progress toward regaining health and function.
  - Coordinating and collaborating with various health and social services providers, including Regional Centers, including sharing data (as appropriate) to facilitate better-coordinated whole-person care.
  - Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
  - Utilizing best practices such as Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.
- **Community Supports:** MCPs are strongly encouraged to offer the housing-related Community Supports to Members who enroll in ECM under this Population of Focus.<sup>13</sup>
    - Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services provide support to achieve long-term housing.
    - Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing provide recovery-focused housing.
    - Medically Tailored Meals/Medically-Supportive Food, Day Habilitation Programs, or Sobering Centers may also address the needs of this Population of Focus, depending on individual circumstances.
  - **Provider Contracting:**
    - As suggested above, MCPs are encouraged to contract with street medicine providers to serve as ECM Providers, provided they meet all other ECM Provider requirements. For homeless families, MCPs are strongly encouraged to work with ECM Providers to serve the family unit together through one ECM team, whenever possible and appropriate. MCPs may develop specific payment models (e.g., bundled rates) to reimburse ECM Providers for ECM delivered to a family.

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<sup>13</sup> For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the [Community Supports Policy Guide](#).

## 2. Individuals At Risk for Avoidable Hospital or ED Utilization

DHCS is renaming the “High Utilizers” ECM Population of Focus to “Individuals At Risk for Avoidable Hospital or ED Utilization,” to reflect that ECM for this Population of Focus aims to reduce avoidable care in costly settings and settings that are of higher acuity than would be necessary with earlier and more whole-person care interventions and approaches.

### A. Population of Focus Eligibility Criteria:

#### a. Adults At Risk for Avoidable Hospital or ED Utilization

Adults who meet one or more of the following conditions:

- (1) **Five or more** emergency room visits in a **six-month** period that could have been avoided with appropriate outpatient care or improved treatment adherence;<sup>14</sup>
- (2) **Three or more** unplanned hospital and/or short-term skilled nursing facility (SNF) stays in a **six-month** period that could have been avoided with appropriate outpatient care or improved treatment adherence.

#### b. Children and Youth At Risk for Avoidable Hospital or ED Utilization (Updated December 2022)

Children and youth who meet one or more of the following conditions:

- (1) **Three or more** ED visits in a **12-month** period that could have been avoided with appropriate outpatient care or improved treatment adherence;<sup>15</sup>
- (2) **Two or more** unplanned hospital and/or short-term SNF stays in a **12-month** period that could have been avoided with appropriate outpatient care or improved treatment adherence.

### B. Examples of Eligible MCP Members under this Population of Focus:

- An adult with repeated incidents of avoidable ED visits in a six-month period who has a medical, psychiatric or SUD-related condition requiring intensive coordination beyond telephonic intervention.
- An adult with repeated incidents of avoidable ED visits in a six-month period who has significant functional limitations and/or adverse SDOH that impede them from navigating their health care and other services.
- A child with repeated incidents of ED visits in a 12-month period to address untreated asthma that could have been avoided with improved inhaler and nebulizer treatment.

<sup>14</sup> Including appropriate timing, interventions within outpatient care settings, care plan development, communication with the Member, interdisciplinary care team, or referrals.

<sup>15</sup> Including appropriate timing, interventions within outpatient care settings, care plan development, communication with the Member, interdisciplinary care team, or referrals.



- Siblings and their adult parent(s) with repeated incidents of avoidable ED visits in a 12-month period due to unsafe housing conditions and/or other adverse SDOH that impede their caregiver from navigating their health care and other services. In this example, ECM could be provided to the family as a whole.
- Youth with repeated avoidable inpatient hospitalizations in a 12-month period due to a behavioral health condition.

### C. Operational Guidance:

- **Identification:**

- MCPs must use the numerical thresholds described in eligibility criteria (a) and (b) above to identify Members in this Population of Focus. MCPs should have a consistent approach (e.g., algorithms or other methodologies) for identifying eligible Members.
- MCPs should utilize a “rolling” lookback period based on the most recent month of adjudicated claims data. Effective January 1, 2023, when all MCPs are expected to use Admission, Discharge, Transfer (ADT) feed data, whenever available, across their PHM Programs, MCPs should use ADT feed data to identify members potentially eligible for ECM in a timelier fashion.
- ED visits that result in an inpatient stay should only count as one inpatient visit.
- MCPs may also authorize ECM for individuals who are at risk for avoidable hospital or ED utilization and who would benefit from ECM but who may not meet numerical thresholds eligibility criteria (a) and (b) above. This flexibility is in addition to and does not displace the numerical thresholds provided in the eligibility criteria.
- Members and their families may self-refer to ECM.
- MCPs are currently required to report Ambulatory Care: Emergency Department Visits (AMB-CH) (a National Committee for Quality Assurance (NCQA) metric required in [CMS’ 2023 and 2024 Child Core Set Measures](#)) and should align efforts to identify and serve this ECM Population of Focus with improvement on these metrics.

- **Outreach and Engagement:**

- Under PHM requirements, by January 1, 2023, MCPs are responsible for knowing when all Members are admitted, discharged or transferred and must assign a single point of contact/care manager to ensure all transitional care services are complete for all high risk Members, as defined in the [PHM Policy Guide](#). MCPs are responsible for ensuring that ECM Providers have access to or are provided ADT feed data information for enrolled Members to allow them to manage transitions as part of ECM.
- As is true for all ECM Lead Care Managers, ECM requires engagement with the Member in the community or at Provider locations.
- ECM Providers may choose to embed staff directly within EDs to identify Members who are eligible for this Population of Focus and coordinate closely with ED staff. MCPs may also or alternatively embed their own staff to perform the same function and hand off to an ECM Provider for further assessment.

- **Comprehensive Assessment and Care Management Plan:**

- The assessment and care planning process should identify the drivers of the ED or inpatient episodes in detail, which may extend beyond conditions into specific social needs. Since repeat ED utilization is often a result of lack of access to usual care, special attention should be given (including research with the MCP, as needed) to the Member's primary care provider (PCP) and connection to that PCP, or selection of a different PCP. Similarly, any gaps in access to specialists that may have driven the admission should be carefully assessed and addressed with the MCP. As part of its monitoring and oversight of ECM, DHCS will be reviewing medical conditions/diagnoses associated with avoidable ED utilization within members of this Population of Focus.
  - Per federal requirements, if the Member has LTSS needs, the care plan must be developed by an individual who is trained in person-centered planning, as noted above under Population of Focus 1.
- **Examples of Applicable ECM Services for this Population of Focus:**
    - Ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain healthy in the community.
    - Ensure the identification of, and consistent engagement with, the Member's PCP and other specialists and behavioral health clinicians (as needed) to ensure appropriate outpatient treatment for underlying medical conditions.
    - Connecting to housing-related Community Supports to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual's health outcomes.
    - Connecting the family, caretakers and circles of support to resources regarding the Member's conditions to assist them with providing support for the Member's health.
    - Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
  - **Community Supports:** MCPs are strongly encouraged to connect Members of this Population of Focus to Community Supports where the underlying driver(s) of ED or inpatient utilization are social needs. For children with uncontrolled asthma, Asthma Remediation has a particularly compelling evidence base for reducing the need for emergency care.<sup>16</sup>
  - **Provider Contracting:** The appropriate ECM Provider for this Population of Focus will depend on specific needs, as well as the Member's preferences. Generally speaking, grounding ECM in primary care for this population is likely to make sense where possible, to establish a strong tie to usual and routine care grounded in trusted relationships.

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<sup>16</sup> Marshall, E.T., Guo, J., Flood, E., Sandel, M.T., Sadof, M.D., Zotter, J.M. Home Visits for Children with Asthma Reduce Medicaid Costs. Preventive Chronic Disease. February 2020. Available [here](#).

### 3. Individuals with Serious Mental Health and/or SUD Needs (Updated December 2022)

Medi-Cal MCP Members with serious mental health and SUD needs, as defined below, have disproportionately high rates of chronic physical health conditions as well as complex social needs. For children and youth, a number of social conditions and risk factors (e.g., exposure to trauma or other adverse childhood experiences (ACEs)) often present as behavioral health needs. Enrolling this child and youth Population of Focus into ECM is critical to addressing risk early and averting long-term chronic illness.

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including updates to the criteria to access specialty mental health services (SMHS). On January 1, 2022, DHCS implemented new criteria for enrollees to access SMHS, medical necessity requirements, and other coverage requirements. See [Behavioral Health Information Notice \(BHIN\) No. 21-073](#) for more information. Aligning the ECM Population of Focus eligibility criteria with this new SMHS access criteria ensures Members who are at high risk for mental health disorders, in addition to those already diagnosed, are eligible for ECM.

Implementation of ECM for this Population of Focus is designed to provide Members with a trusted Lead Care Manager who can coordinate and help integrate care and services, bridging across delivery systems. Care management through ECM may also help some MCP Members receive SMHS through the county's Mental Health Plan (MHP) who may have been undiagnosed or otherwise not yet connected to the services they need.

#### A. Population of Focus Eligibility Criteria:

##### a. Adults with Serious Mental Health and/or SUD Needs

Adults who:

- (1) Meet the eligibility criteria for participation in, or obtaining services through:
  - (i) SMHS delivered by MHPs;
  - (ii) The Drug Medi-Cal Organization Delivery System (DMC-ODS) **OR** the Drug Medi-Cal (DMC) program;<sup>17</sup>

**AND**

- (2) Are 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, high measure (four or more) of ACEs based on screening, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms;

**AND**

<sup>17</sup> Further information on access criteria for the SMHS for adults and children can be found in [BHIN 21-073](#) and for the DMC-ODS delivery system in [BHIN 21-075](#). The medical necessity criteria for DMC services can be found in [California Code of Regulations, Title 22, § 51341.1](#) and [BHIN 21-071](#). See also **Appendix B** of this Policy Guide.

- (3) Meet one or more of the following criteria:
- (i) Are at high risk for institutionalization,<sup>18</sup> overdose, and/or suicide;
  - (ii) Use crisis services, EDs, urgent care, or inpatient stays as the primary<sup>19</sup> source of care;
  - (iii) experienced two or more ED visits or two or more hospitalizations due to serious mental health or SUD in the past 12 months;
  - (iv) are pregnant or postpartum (12 months from delivery).

### **b. Children and Youth with Serious Mental Health and/or SUD Needs**

Children and youth who:

- (1) Meet the eligibility criteria for participation in, or obtaining services through one or more of:
- (i) SMHS delivered by MHPs;
  - (ii) The DMC-ODS **OR** the DMC program.

No further criteria are required to be met for children and youth to qualify for this ECM Population of Focus.

## **B. Examples of Eligible MCP Members Under this Population of Focus**

- A Member who is pregnant, has the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions, and who is experiencing one complex social factor influencing their health. See also Population of Focus 10 for examples of how ECM can serve pregnant and postpartum individuals.
- A Member who is a former foster youth who has a psychiatric or SUD-related condition, and is currently using EDs as the primary source of care.
- A child or youth who screens positive for four or more ACEs in their primary care practice and meets the access criteria for SMHS services, but has not been linked to care and does not have the family or social support needed to further evaluate or address their needs.
- A child or youth who is receiving services from the SMHS, DMC–ODS, and/or DMC delivery systems.

## **C. Operational Guidance**

- **Identification:**
  - As for all ECM Populations of Focus, MCPs must establish policies and procedures that allow network Providers to refer patients to the MCP for ECM if they suspect eligibility criteria are met.
  - Effective January 1, 2023, when all MCPs are expected to use ADT feed data. when available, across their PHM Programs, MCPs should use ADT feed data to identify potentially eligible members in a timelier fashion.

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<sup>18</sup> “Institutionalization” in this context is broad and means any type of inpatient, SNF, long-term, or ED setting.

<sup>19</sup> From December 2022, modified from “sole” to “primary.”

- MCPs and MHPs are required to enter into MOUs that define and describe in greater detail covered services and populations; screening, assessment and referral processes; care coordination requirements; oversight responsibilities of the MCP and MHP; and data and information sharing procedures, among other items, At the time of this update, DHCS is updating the MOU guidance to align with upcoming January 2024 Medi-Cal Managed Care contract procurement and will encompass federal and state developments, including strengthening requirements on referrals to ensure Members receive needed care and the California Health and Human Services Agency (CalHHS) [Data Exchange Framework](#). Updated requirements will require that county MHPs should have specific procedures for their providers and contractors to identify and refer to MCPs clients who meet criteria for this Population of Focus.
  - Members are not required to be enrolled in, or have accessed services through, SMHS, DMC-ODS, or DMC to be eligible for ECM.
  - Members and their families may self-refer to ECM.
  - MCPs may identify Members who meet this Population of Focus definition through analysis of Non-Specialty Mental Health Services and SUD services that are covered under MCPs, such as alcohol and drug screening; assessments; brief interventions; referral to treatment for members aged 11 and older; and medications for addiction treatment, as described in [APL 22-005](#). Analysis of this data allows identification of Members who might meet SMHS/DMC-ODS/DMC thresholds. Analysis of this data allows identification of Members who might meet SMHS/DMC-ODS/DMC thresholds.
  - As for all ECM Populations of Focus, MCPs must establish policies and procedures that allow network Providers to refer patients to the MCP for ECM if they suspect eligibility criteria are met. For children and youth, MCPs should establish robust referral pathways with all pediatric providers and should work to develop referral pathways with schools and childcare settings. DHCS expects to reflect these expectations in forthcoming updated MOU guidance to be released in 2023.
  - MCPs are encouraged to partner with child care settings and LEAs to create referral pathways to help support identification of ECM eligible children and youth.
- **Outreach and Engagement:**
    - ECM requires engagement with the Member in the community or at Provider locations. In instances where the Member’s behavioral health provider, such as a county contracted SMHS or DMC / DMC-ODS Provider, is also their ECM Provider, ECM services could be provided wherever they receive behavioral health services.
- **Comprehensive Assessment and Care Management Plan:**
    - ECM is a whole person care management benefit, which includes coordinating the medical and social needs beyond the Member’s mental health or SUD conditions. Thus, when serving as ECM Provider, the county behavioral health agency and/or its subcontracted SMHS/DMC/DMC-ODS Providers must also document and manage those needs beyond the clients’ mental health or SUD needs.

- When a county behavioral health agency or its contracted provider is also serving as an ECM Provider, MCPs must avoid imposing assessment requirements that are duplicative of the SMHS/DMC/DMC-ODS screening domain requirements. In practice, this might require MCPs to develop modified assessment policy/templates. The county behavioral health agency or its contracted provider may start by utilizing the SMS/DMC/DMC-ODS screening domain requirements (described in [BHIN 22-019](#)) and add any missing component (i.e., physical health required for “whole person” ECM assessment).
- [BHIN 22-019](#) seeks to streamline and standardize clinical documentation requirements across Medi-Cal, SMHS, DMC, and DMC-ODS services by allowing creation of progress notes to document treatment and care plans, including for the required SMHS Targeted Case Management (TCM) care planning documentation elements. MCPs must not impose care planning documentation requirements that duplicate existing SMHS/DMC/DMC-ODS Provider processes, but instead work with the county behavioral health agency and/or their subcontracted SMHS/DMC/DMC-ODS Providers to meet both ECM and SMHS/DMC/DMC-ODS care planning requirements in a way that leverages existing documentation processes. Specifically, the county behavioral health agency and/or their subcontracted SMHS/DMC/DMC-ODS Providers may use the progress note approach as the method of recording the ECM care plan as long as the following principles are taken into account:
  - ECM is a whole person care management benefit, which includes coordinating the medical and social needs beyond the Member’s mental health or SUD conditions. Thus, the county behavioral health agency and/or its subcontracted SMHS/DMC/DMC-ODS Providers must also document and manage those needs beyond the clients’ mental health or SUD needs.
  - If the county behavioral health agency and/or their subcontracted SMHS/DMC/DMC-ODS Providers use the progress note approach, they must be able to communicate the content of the full care plan to other providers and to the Member themselves, in order to meet ECM requirements. MCPs must reflect these provisions on recording an ECM care plan in their contracts with counties.
- **Examples of Applicable ECM Services for this Population of Focus:**
  - Facilitating regular culturally and linguistically appropriate contact with Members to ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain in the community.
  - Connecting to housing-related Community Supports to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual’s health outcomes.
  - Supporting the Member’s behavioral health recovery goals with related improvements in physical and oral health and long-term services and supports.
  - Connecting the family, caretakers and circles of support to resources regarding the Member’s conditions to assist them with providing support for the Member’s health and behavioral health.

- Coordinating and collaborating with various health, behavioral health, developmental disability and social services Providers, including sharing data (as appropriate).
  - Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
  - Identifying and coordinating among other care managers across delivery systems who have been assigned to assist the individual with any aspect of their health and related social needs.
  - Understanding and identifying root causes of a Member's behavioral health need, particularly with children and youth who may not have a diagnosed SMHS or DMC-ODS/DMC condition but require additional supports and care due to family dynamics, social situations, historical trauma, and other concerns, all requiring a multi-agency approach and solution to appropriately address for the child or youth.
- **Community Supports:** MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus. Doing so can enhance care and prevent costly and unnecessary hospitalizations. Each Member will have different needs and functional limitations.<sup>20</sup> While nearly all Community Supports may be relevant for individuals with SMI or SED depending on their needs, examples of Community Supports that Members of this Population of Focus may benefit from include:
    - Sobering Centers (including ensuring communication and coordination between ECM Providers and Sobering Centers for assigned members receiving Community Supports sobering center services).
    - Housing Transition Navigation Services.
    - Housing Deposits.
    - Housing Tenancy and Sustaining Services.
    - Short-Term Post-Hospitalization Housing.
    - Medically-Supportive Food/Meals/Medically Tailored Meals.
  - **Provider Contracting:**
    - Members in this Population of Focus are also likely receiving SMHS services through county MHPs and/or SUD services through DMC-ODS or DMC programs. Therefore, it is important for MCPs to coordinate with county behavioral health agencies and providers to ensure continuity of care and non-duplication of care management services with ECM. As such, the DHCS MCP contract requires that MCPs must prioritize contracting with county behavioral health agencies or their subcontracted providers to serve as ECM Providers, provided they agree and are able to coordinate all services needed by the Member, not just behavioral health services; and unless the Member (or their parent, guardian, or caretaker) desires a different ECM Provider.
    - When MCPs are not able to contract with the county behavioral health agency or its subcontracted provider as the ECM Provider, the ECM Provider for a Member within

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<sup>20</sup> For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the [Community Supports Policy Guide](#).

this population should have experience and expertise working with individuals with serious mental health needs and SUD, as well as the ability to adequately coordinate services across multiple delivery systems.

- For the children and youth in this Population of Focus, given the broader ECM eligibility criteria, it is possible that the county MHPs or their subcontracted Providers may not have sufficient capacity to serve all ECM eligible children and youth. MCPs should work closely with the county behavioral health agency to determine which sub-populations would best be served by a county behavioral health ECM Provider (e.g., those with ongoing mental health or SUD needs) versus an alternative community-based provider that may be better poised to meet the underlying social and other needs of the Member (e.g., a dyadic services provider integrated with the Member's primary care clinic).



#### 4. Individuals Transitioning from Incarceration (Updated December 2022)

Many Members transitioning from incarceration have disproportionately high physical and behavioral health care needs that require ongoing treatment and medication maintenance when they are released into the community. Individuals re-entering the community often experience a lack of continuous physical and behavioral health care which results in a deterioration of their physical and behavioral health conditions, increased use of EDs and inpatient settings, and, in some instances, a return to incarceration.

For this Population of Focus, MCPs must coordinate with state prisons (including California Correctional Health Care Services), county jails/sheriff's departments, youth correctional facilities, probation and parole offices, courts, and Providers to identify Members who are eligible for ECM; accept referrals; and ensure that individuals who qualify are connected with ECM Providers upon re-entry into the community.

The eligibility criteria listed below and detailed in **Appendix C** align with the eligibility criteria for individuals who are incarcerated to receive targeted pre-release Medi-Cal services, as requested by DHCS in the pending CalAIM 1115 demonstration waiver.<sup>21</sup> Upon the effective date of the 1115 demonstration waiver, Members who received pre-release services will also be eligible to receive ECM at least until reassessment is conducted by the MCP, which may occur up to six months after release. Members do not need to have received pre-release services to be eligible for this Population of Focus, and this Population of Focus is not dependent on CMS' approval of the CalAIM 1115 demonstration waiver.

#### A. Population of Focus Eligibility Criteria:

##### a. Adults Transitioning from Incarceration

Adults who:

(1) Are transitioning from a correctional facility (e.g., prison, jail, or youth correctional facility) or transitioned from correctional facility within the past 12 months;

**AND**

(2) Have at least one of the following conditions (See **Appendix C** for definitions):

- (i) Mental illness;
- (ii) SUD;
- (iii) Chronic Condition/Significant Clinical Condition;
- (iv) I/DD;
- (v) Traumatic Brain Injury (TBI);
- (vi) HIV/AIDS;
- (vii) Pregnancy or Postpartum.

<sup>21</sup> As of December 2022, the CalAIM 1115 justice initiative waiver request is pending with CMS, and, as such, the definitions are subject to change.

### **b. Children and Youth Transitioning from a Youth Correctional Facility**

Children and youth who are transitioning from a youth correctional facility or transitioned from being in a youth correctional facility within the past 12 months.

No further criteria are required to be met for Children and Youth to qualify for this ECM Population of Focus.

### **B. Examples of Eligible MCP Members Under this Population of Focus:**

- A Member who has a SUD diagnosis, was incarcerated in a county jail for 15 days and released into the community within the last three months, and was referred to the MCP by a federally qualified health center (FQHC).
- A Member who has HIV, was incarcerated in a California state prison for two years, was found eligible for and received targeted pre-release services which included pre-release care management, and was referred to the MCP.
- A Member who has a mental illness diagnosis, was incarcerated in a county jail for 30 days, was found eligible for and received targeted pre-release services, and was referred to the MCP by the county jail.

### **C. Operational Guidance:**

- **Identification:**
  - For this Population of Focus, MCPs should coordinate with state prisons, county jails, youth correctional facilities, probation and parole offices, courts, and community-based providers who serve justice-involved populations to identify and refer Members upon their release into the community.
  - All individuals who are found eligible to receive a targeted set of Medi-Cal pre-release services while incarcerated and enroll in an MCP will be eligible to receive ECM under this Population of Focus. It is expected that MCPs will coordinate with the FFS care manager who is providing care management services to individuals while incarcerated, to effectuate a closed-loop referral and information sharing.
  - Members and their families may self-refer to ECM.
- **Outreach and Engagement:**
  - The initial ECM engagement locations will depend on the collaborations that MCPs are able to build with local justice partners. At first, ECM Providers will begin working with individuals expected to transition from incarceration in the setting where they are incarcerated (or just outside that setting), or in criminogenic treatment programs. In this setting, the ECM provider will coordinate with the pre-release care manager who will assist with the warm hand-off by sharing re-entry care transition plans. In some cases, the ECM Provider may also serve as the Fee For Service (FFS) pre-release care management provider and provide FFS care management services in the carceral setting.

- Post-transition, ECM Providers will engage individuals in the most easily accessible setting for the Member. In addition to community-based engagement such as a Member's home or regular Provider office, this may also include parole or probation offices if the MCP builds partnerships that allow for engagement in those settings.
- **Comprehensive Assessment and Care Management Plan:**
  - The ECM Provider must work closely with the individual's pre-release care manager to ensure that the individual's re-entry care transition plan (developed by the prerelease care manager before the Member is released) is executed.
  - If an ECM Provider receives a referral of an individual who does not have a re-entry transition plan, the ECM Provider must conduct a comprehensive assessment and develop a care management plan.
- **Examples of Applicable ECM Services**
  - Conducting an initial risk assessment, if not already developed through a re-entry care transition plan while the individual was incarcerated, to evaluate medical, psychiatric, substance use and social service needs for which the individual requires assistance.
  - Ensuring individual is able to access required medications, as described in the re-entry transitional care plan, if applicable.
  - Ensuring individual is able to access, and correctly use, appropriate and necessary Durable Medical Equipment (DME), as described in the re-entry transitional care plan, if applicable.
  - Providing referrals for various health, developmental disabilities, mental health, SUD, and social service needs and navigating Members to other reentry support Providers to address unmet needs, as identified in the re-entry care transition plan, if applicable.
    - Coordinating and collaborating with various health, behavioral health and social services Providers as well as parole/probation, including sharing data (as appropriate) to facilitate better-coordinated, whole-person care.
    - Identifying a PCP and behavioral health Provider(s) and scheduling a follow-up appointment at appropriate time post-release.
    - Coordinating and scheduling required specialty, mental health, substance use, dental, and MCP Community Supports appointments.
  - As follow up to the pre-release care coordinator's initial coordination:
    - Coordinating access to medication-assisted treatment (MAT) and psychotropic medications.
    - Coordinating community service referrals.
    - Coordinating SDOH referrals, (e.g., nutrition, housing, transportation).
  - Providing culturally and linguistically appropriate education to families, caretakers and circles of support regarding the Member's health care needs and available supports.
  - Ensuring all needed consents have been provided to ensure ability to share information for seamless care.

- Facilitating reinstatement of benefits, not including Medi-Cal (e.g., Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF)).<sup>22</sup>
  - Ensuring regular contact with Members to safeguard against gaps in the activities designed to address an individual's health and social service needs, and swiftly address those gaps to prevent reincarceration and ensure progress toward regaining health and function continues.
- **Community Supports:** MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus.<sup>23</sup> Doing so can enhance care and prevent costly and unnecessary hospitalizations. Each Member will have different needs and functional limitations. Below are a few examples of Community Supports that may be particularly beneficial:
    - Housing Transition Navigation Services.
    - Housing Deposits.
    - Housing Tenancy and Sustaining Services.
    - Short-Term Post-Hospitalization Housing.
- **Provider Contracting:**
    - Members in this Population of Focus are also likely receiving behavioral health services through county MHPs and/or SUD services through DMC-ODS or DMC programs. Therefore, it is important for MCPs to coordinate with county behavioral health agencies and providers to ensure continuity of care and non-duplication of care management services with ECM. As such, the DHCS MCP contract requires that MCPs must prioritize contracting with county behavioral health agencies or their subcontracted providers to serve as ECM Providers, provided they agree and are able to coordinate all services needed by the Member, not just behavioral health services; and unless the Member (or their parent, guardian or caretaker) desires a different ECM Provider.
    - When MCPs are not able to contract with the county behavioral health agency or its subcontracted provider as the ECM Provider, the ECM Provider for a Member within this population should have experience and expertise working with individuals with serious mental health needs and SUD, as well as the ability to adequately coordinate services across multiple delivery systems.
    - In order to maintain continuity of care management relationships from the pre-release period to post-release, MCPs will also be required to contract with the same ECM Providers serving this Population of Focus as the other MCPs in the county. DHCS intends to release operational guidance on implementation expectations.

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<sup>22</sup> To complement these efforts, state statute mandates that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023. The intent is that individuals reentering the community from incarceration would already be enrolled in Medi-Cal upon release. Refer to [Medi-Cal Eligibility Division Information Letter No.: I 22-46](#) for more information.

<sup>23</sup> For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the [Community Supports Policy Guide](#).

- MCPs should prioritize contracting with ECM Providers that demonstrate linguistic and cultural competence, have demonstrated experience serving this Population of Focus, and that employ individuals with lived experiences.

## 5. Adults Living in the Community and At Risk for LTC Institutionalization

Intensive care coordination through ECM can help adults continue to reside in the community who would otherwise have entered into an institutional setting for care.

### A. Population of Focus Eligibility Criteria:

#### Adults Living in the Community and At Risk for LTC Institutionalization

Adults who:

(1) Are living in the community who meet the SNF Level of Care (LOC) criteria;<sup>24</sup> **OR** who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury;<sup>25</sup>

**AND**

(2) Are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring);<sup>26</sup>

**AND**

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

#### Notes on the Definition:

- **Living in the Community.** Members who meet this Population of Focus may live in independent housing, Residential Care Facilities, Residential Care Facilities for the Elderly (RCFEs), or any other dwelling that meets the requirements established in the Home and Community Based Services (HCBS) Settings Final Rule.<sup>27</sup>

<sup>24</sup> As established in the [California Code of Regulations § 51335](#).

<sup>25</sup> Criteria adapted from the [2020 Medi-Cal Long-Term Care At Home proposal](#).

<sup>26</sup> Criteria adapted from the Community-Based Health Home eligibility criteria [here](#).

<sup>27</sup> CMS [Final Rule 79 FR 2947](#), Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and HCBS Waivers; [42 CFR § 441.301\(c\)\(4\) and \(5\)](#).

- **Exclusions.** Adults living in the community who are at risk of institutionalization into Intermediate Care Facilities (ICF)<sup>28</sup> and subacute care facilities<sup>29</sup> are excluded from this Population of Focus.

## **B. Examples of Eligible MCP Members Under this Population of Focus:**

- A 65-year-old Member with cancer who underwent surgery for Gastrostomy tube placement; the Member needs assistance with Gastrostomy tube feedings and maintenance of the site, personal care services and medication administration.
- A 75-year old Member who was recently discharged from the hospital after suffering a stroke; the Member lives alone and will need In Home Supportive Service (IHSS) services, nursing visits for medication management, meal preparation, potentially additional personal care services beyond what IHSS may authorize, and coordination of transportation to a rehabilitation clinic for bi-weekly physical and occupational therapy services.

## **C. Operational Guidance:**

- **Identification:**
  - Referrals are expected to be the predominant pathway MCPs identify Members who may be eligible for ECM through this Population of Focus. MCPs are encouraged to leverage existing and develop new partnerships with Providers who have experience serving Members who meet this Population of Focus eligibility criteria and are thus well positioned to make referrals. This includes but is not limited to Community-Based Adult Services (CBAS) Centers, Area Agencies on Aging, Home Health Agencies, Centers for Independent Living, IHSS Providers, and other HCBS Waiver Providers.
  - Members and their families may self-refer to ECM.
  - Effective January 1, 2023, when all MCPs are expected to use ADT feed data, when available, across their PHM Programs, MCPs should use ADT feed data to identify potentially eligible members in a timelier fashion.
  - MCPs are encouraged to establish relationships with Adult Protective Services (APS) agencies.<sup>30</sup> Each county in California has an APS agency specifically dedicated to helping elder and dependent adults, and regularly meet with individuals in their homes. These agencies may serve as a useful referral source.
  - MCPs may also utilize existing Member data, establish regular data sharing arrangements with contracted Providers, or leverage 1915(c) HCBS waiver program wait lists to identify Members who may meet this Population of Focus definition. MCPs may use previous SNF LOC determinations to confirm Member eligibility. The 1915(c) waiver programs<sup>31</sup> require Members to meet the SNF LOC criteria to be eligible for participation. As such, SNF LOC determination may have already been made for some Members who meet this Population of Focus.

<sup>28</sup> Definition and more information about ICFs located [here](#).

<sup>29</sup> Definition and more information about subacute care facilities located [here](#).

<sup>30</sup> A list of APS Offices by county located [here](#).

<sup>31</sup> [Assisted Living Waiver \(ALW\)](#), [Home and Community Based Alternatives \(HCBA\) Waiver](#), and [Multipurpose Senior Services Program \(MSSP\) Waiver](#).

- Member choice and preferences must be considered during the identification and eligibility determination process before enrolling Members into ECM, when assigning them to an ECM Provider, and when designing the Member’s care plan.
- **Comprehensive Assessment & Care Management Plan:**
  - Once a Member is enrolled in ECM, a comprehensive assessment should be conducted, and care plan developed, as described in Section V. Core Service Components of ECM. As part of the assessment, MCPs must include DHCS’ standardized LTSS referral questions<sup>32</sup> to identify and refer Members who may have LTSS needs, unless the Member has already answered these questions. Assessments should be conducted face-to-face and in the community whenever possible.
  - Per federal requirements, if the Member has LTSS needs, the care plan must be developed by an individual who is trained in person-centered planning, using a person-centered process.<sup>33</sup> Thus, for this Population of Focus, the ECM Lead Care Manager must meet these requirements. The care plan should consider and reflect what is important to the Member regarding their preferences for the delivery of LTSS (for example, specific treatment goals, services or functional needs the Member prefers to prioritize). As for all ECM Populations of Focus, the care plan should incorporate the Member’s needs across all delivery systems inclusive of LTSS, and must contain the services and supports that will ensure the Member is setup to live continuously in the community.
- **Community Supports:** MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus.<sup>34</sup> Doing so can enhance care, prevent costly and unnecessary hospitalizations, and help Members live continuously in the community. Each Member will have different needs and functional limitations. Community Supports that may be particularly beneficial include:
  - Environmental Accessibility Adaptations (Home Modifications).
  - Respite Services.
  - Personal Care and Homemaker Services.
  - Medically Tailored Meals/Medically-Supportive Food.
- **ECM Provider Contracting:** MCPs are required to contract with ECM Providers who have experience serving Members who meet the eligibility criteria for this Population of Focus. These ECM Providers may include, but are not limited to, CBAS Centers, Area Agencies on Aging, Home Health Agencies, and Centers for Independent Living.

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<sup>32</sup> As established in [APL 17-013](#).

<sup>33</sup> As established in [42 CFR § 438.208](#) and [42 CFR § 441.301](#).

<sup>34</sup> For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the [Community Supports Policy Guide](#).



## 6. Adult Nursing Facility Residents Transitioning to the Community

Intensive care coordination through ECM can help nursing facility residents transition safely into the community.

### A. Population of Focus Eligibility Criteria:

#### Adult Nursing Facility Residents Transitioning to the Community

Adult nursing facility residents who:

- (1) Are interested in moving out of the institution; **AND**
- (2) Are likely candidates to do so successfully; **AND**
- (3) Are able to reside continuously in the community.

#### Notes on the Definition:

- **Able to Reside Continuously in the Community.** Members transitioning to the community may need to return to the hospital or SNF intermittently for short admissions (potentially due to changes in medical conditions or other acute episodes). They should not be precluded from being considered able to reside continuously in the community.
- **Exclusions.** Individuals residing in ICFs<sup>35</sup> and subacute care facilities<sup>36</sup> are excluded from this Population of Focus.

### B. Examples of Eligible MCP Members Under this Population of Focus:

- A 70 year old Member with multiple chronic conditions and social needs who has been residing in a SNF for the past 6 months after recovering from a stroke; the Member currently does not have a residence to return to but has indicated on the Minimum Data Set (MDS) assessment that they would like to transition back to the community. As far as the facility knows, the Member does not have family supports.
- A 58 year old Member with Lou Gehrig's disease (ALS) who has been residing in a SNF for the past year; prior to their admission into the SNF, they had been living with family members; recently, they expressed an interest to their SNF care coordinator in returning home.

### C. Operational Guidance:

- **Identification:**
  - MCPs can rely on referrals, analysis of their own data, or direct data feeds from and relationships with SNFs or other Providers to identify Members who may be eligible for this Population of Focus.
  - Members and their families may self-refer to ECM.
  - Effective January 1, 2023, when all MCPs are expected to use ADT feed data, when available, for their PHM Programs, MCPs should use ADT feed data to identify potentially eligible members in a timelier fashion.

<sup>35</sup> Definition and more information about ICFs located [here](#).

<sup>36</sup> Definition and more information about subacute care facilities located [here](#).

- One of the pathways MCPs can leverage is the MDS, which is part of the federally mandated process for clinical assessment of all residents in certified nursing facilities. MDS assessments are completed for all residents, regardless of source of payment, and are required on admission to the nursing facility, periodically, and upon discharge.<sup>37</sup> Section Q of the MDS uses a person-centered approach to ensure that all individuals residing in the SNF have the opportunity to indicate their interest in receiving long term care in the least restrictive setting possible.<sup>38</sup> MCPs who have access to MDS assessment data are encouraged to analyze responses to Section Q on a regular basis to identify Members who may be eligible for this Population of Focus.
- MCPs are encouraged to leverage existing and develop new partnerships with SNFs and Providers who have experience serving Members who meet this Population of Focus, and are thus well positioned to make referrals. This includes but is not limited to Area Agencies on Aging, and California Community Transitions (CCT) Money Follows the Person (MFTP) Lead Organizations. MCPs should also institute data sharing requirements with their contracted SNF Providers.
- **Comprehensive Assessment and Care Management Plan:**
  - The assessment and care management plan processes for Members who meet this Population of Focus are expected to be time intensive. MCPs must assess Members against criteria to determine who could be successful to reside continuously in the community, which may include but is not limited to functional status, the availability of appropriate services and resources in the community, existing support systems, and safety. DHCS encourages MCPs to use the CCT assessment tool for this Population of Focus. This tool is already being used across the state to successfully transition Members from SNFs into home and community-based settings, and could serve as a helpful resource.
  - The development of the care plan for a Member to transition from SNF to the community is an effort that will require considerable planning. The ECM Care Manager is responsible for identifying all resources to address all needs of the Member, including coordinating with local housing agencies and identifying the least restrictive community housing option, ongoing medical care that may be needed, and other community-based services to ensure a Member will be able to transition and reside continuously in the community. The development of the care plan should be led by the ECM Lead Care Manager and involve the Member, their family and friends (as requested), legal representative (as applicable), and the interdisciplinary care team, the SNF facility discharge planner, and any other relevant clinical, behavioral health, and social work staff.
  - Per federal requirements, if the Member has LTSS needs, the care plan must be developed by an individual who is trained in person-centered planning, using a person-centered process.<sup>39</sup> Thus, for this Population of Focus, the ECM Lead Care Manager must meet these requirements. The care plan should consider and reflect what is important to the Member regarding their preferences for the delivery

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<sup>37</sup> See [MDS 3.0 Public Reports](#).

<sup>38</sup> See [CMS 3.0 Manual](#).

<sup>39</sup> As established in [42 CFR § 438.208](#) and [42 CFR § 441.301](#).

of LTSS (for example, specific treatment goals, services or functional needs the Member prefers to prioritize). As for all ECM Populations of Focus, the care plan should incorporate the Member's needs across all delivery systems inclusive of LTSS, and must contain the services and supports that will ensure the Member is setup to live continuously in the community.

- **Community Supports:** MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus.<sup>40</sup> Doing so can enhance care, prevent costly and unnecessary hospitalizations, and help Members live continuously in the community. Each Member will have different needs and functional limitations. Community Supports that may be particularly beneficial include:
  - Community Transition Services/Nursing Facility Transition to a Home.
  - Nursing Facility Transition/Diversion to Assisted Living Facilities, such as RCFE and Adult Residential Facilities (ARF).

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

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

See Section VI. Program Overlaps and Exclusions for interactions with programs for Medi-Cal MCP Members dually eligible for Medicare.

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<sup>40</sup> For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the [Community Supports Policy Guide](#),

## **7. Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition (Updated December 2022)**

CCS and CCS WCM serve some of Medi-Cal's most vulnerable children. In addition to their physical health condition qualifying them for CCS/CCS WCM – such as cancer, cerebral palsy, and cystic fibrosis (see full eligibility criteria [here](#)) – these children often experience a high co-occurrence of social and behavioral health challenges beyond their CCS/CCS WCM qualifying condition. As a result, many children in CCS/CCS WCM work with multiple care/case managers to navigate many delivery systems, creating a need for the child's guardian or other advocate to navigate a variety of fragmented care delivery systems and discordant care plans. For this population, a dedicated ECM Lead Care Manager can help take the navigational burden off of children and their families, while helping Providers from the varied delivery systems harmonize with the family-centered plan of care. ECM Care Managers act as “air traffic control” and are responsible for whole-child care coordination between and among all participants in the child's care plan, thereby ensuring each child's needs are met.

### **A. Population of Focus Eligibility Criteria:**

#### **Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition**

Children and youth who:

(1) Are enrolled in CCS **OR** CCS WCM;

**AND**

(2) Are experiencing at least one complex social factor influencing their health. Examples include (but are not limited to) lack of access to food; lack of access to stable housing; difficulty accessing transportation; high measure (four or more) of ACEs screening; history of recent contacts with law enforcement; or crisis intervention services related to mental health and/or substance use symptoms.

### **B. Examples of Eligible MCP Members Under this Population of Focus:**

- Child enrolled in CCS due to their cerebral palsy and child's family requests assistance to address food insecurity within the child's household.
- Child enrolled in CCS WCM due to traumatic injuries from a car accident and developed post-traumatic stress disorder due to the accident, and has a recent law enforcement interaction.
- Toddler is enrolled in CCS while in the hospital to treat recent lead poisoning and is receiving chelation medication through a gastric tube. The child is clinically ready for hospital discharge, but cannot safely transfer home because the family cannot afford the necessary repairs to abate the environmental lead housing hazards identified by the local health department inspector.

### **C. Operational Guidance:**

- **Identification:**
  - As for all ECM Populations of Focus, MCPs must establish policies and procedures that allow network Providers to refer Members to the MCP for ECM if they suspect eligibility criteria are met. Specialty Care Center (SCC) Coordinators, other Members of the child's SCC core team (including pediatricians, PCPs, specialty care providers, and others), and local CCS county offices, especially, may all submit referrals for Members they suspect are eligible for ECM.
  - Effective January 1, 2023, when all MCPs are expected to use ADT feed data, when available, across their PHM Programs, MCPs should use ADT feed data to identify potentially eligible members in a timelier fashion.
  - Members and their families may self-refer to ECM.
  - MCPs may also identify eligible Members for ECM through analysis of CCS/CCS WCM enrollment and additional data available to MCPs, including z-codes identifying SDOH and high measures on ACEs screening.
  - Children in CCS or CCS WCM are eligible to receive ECM if they meet the criteria of any other ECM Population of Focus, even if they do not have a complex social factor that causes them to meet the criteria in Clause (2) of this Population of Focus. For example, many children in CCS have a co-occurring behavioral health need; these children would be eligible for ECM.
  
- **Outreach and Engagement:**
  - ECM requires engagement with the Member in the community or at Provider locations. In instances where the Member's CCS/CCS WCM Provider is also their ECM Provider, ECM services could be provided at their SCC or wherever they receive CCS/CCS WCM services.
  
- **Comprehensive Assessment and Care Management Plan:**
  - The ECM Provider is expected to leverage CCS' comprehensive assessment (includes psychosocial, cognitive, developmental assessing, and planning) and the care plan developed by CCS in developing the Member's ECM care management plan. Additional assessments may be needed to ensure the Member's ECM care management plan incorporates the Member's needs and strategies to address those needs across the areas of physical health care, mental health care, SUD care, community-based LTSS, oral health care, palliative care, social supports, SDOH care, and others.
  - The ECM Provider is expected to leverage CCS WCM's Individual Care Plan (ICP) (includes physical health care, mental health care, SUD care, home health needs, and Regional Center needs) when developing the Member's ECM care management plan. CCS WCM Members also undergo a risk stratification and annual assessment (includes general health status, recent health care utilization, health history, medical history, demographics, and social history) on Members' risk-levels and CCS eligibility determination, all of which should be considered when developing the Member's ECM care management plan.
  
- **Examples of Applicable ECM Services for this Population of Focus:** For this Population of Focus, ECM should include addressing other needs that are not already

being met by CCS/CCS WCM. Examples of applicable ECM services for this population include (but are not limited to):

- Facilitating access to the Environmental Accessibility Adaptions (Home Modifications) Community Support to have ramps and a stair lift installed in the Member's home (see more below).
  - Coordinating the transition from hospital to inpatient rehabilitation and to home after a traumatic injury.
  - Coordinating care across all applicable delivery systems (Medi-Cal Managed Care or Medi-Cal FFS; SMHS; DMC or DMC-ODS; Dental Managed Care or FFS; and Medi-Cal Rx) and care coordinators.
- **Community Supports:** MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus.<sup>41</sup> Doing so can enhance care and prevent costly and unnecessary hospitalizations. Each Member will have different needs and functional limitations. Below are a few examples of Community Supports that may be particularly beneficial:
    - Personal Care and Homemaker Services.
    - Environmental Accessibility Adaptions (Home Modifications).
    - Respite Services.
    - Medically Tailored Meals/Medically-Supportive Food.
    - Asthma Remediation.
- **Provider Contracting:**
    - If a child or youth is enrolled in both ECM and CCS/CCS WCM and their CCS/CCS WCM Provider elects to become a contracted ECM Provider, then the MCP should assign the CCS/CCS WCM Provider as that Member's ECM Provider, unless the Member (and/or their parent, guardian, caretaker) prefers a different ECM Provider.
    - ECM Providers must be community based. MCPs that offer CCS WCM are expected to adhere to all ECM requirements including contracting with community-based Providers, even if CCS WCM is delivered in house at the MCP. Where it is appropriate, CCS WCM elements can be delegated to ECM Providers to ensure children and youth receive comprehensive, non-duplicated care across ECM and CCS WCM.

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<sup>41</sup> For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the [Community Supports Policy Guide](#).

## 8. Children and Youth Involved in Child Welfare (Updated December 2022)<sup>42</sup>

Children and youth in California who are currently or were previously involved in Child Welfare Services provided through the California Department of Social Services (CDSS) often experience an extraordinary amount of transition and fragmentation of health care, social support services, and adult advocates in their childhoods. Research supports that those negative impacts which occur during these experiences may affect their physical and mental health beyond childhood. Many of the children in child welfare have co-occurring mental health and substance use treatment needs that are often unmet due to the challenge of navigating multiple and siloed service delivery systems. ECM Care Managers act as “air traffic control” and are responsible for whole-child care coordination between and among all participants in the child’s care plan, thereby ensuring each child’s needs are met.

### A. Population of Focus Eligibility Criteria:

#### Children and Youth Involved in Child Welfare

Children and youth who meet one or more of the following conditions:

- (1) Are under age 21 and are currently receiving foster care in California;
- (2) Are under age 21 and previously received foster care in California or another state within the last 12 months;
- (3) Have aged out of foster care up to age 26 (having been in foster care on their 18<sup>th</sup> birthday or later) in California or another state;
- (4) Are under age 18 and are eligible for and/or in California’s Adoption Assistance Program;
- (5) Are under age 18 and are currently receiving or have received services from California’s Family Maintenance program within the last 12 months.

#### Notes on the Definition:

- Foster care is defined in California by [Welfare and Institutions Code \(WIC\) 11400\(f\)](#) as the “24-hour out-of-home care provided to children whose own families are unable or unwilling to care for them, and who are in need of temporary or long-term substitute parenting.”
- California’s [Adoption Assistance Program](#) is defined by [WIC 16120](#) and available to children under age 18 *or* under age 21 if the child has a mental or physical disability that warrants the continuation of assistance, per [WIC 16120\(d\)](#). Adoption Assistance Program provides financial and medical coverage with the goal of facilitating the adoption of children who otherwise may have remained in long-term foster care. Adoption Assistance Program is provided for up to five years.
- California’s Family Maintenance program is defined by [WIC 16506](#) as services that “shall be provided or arranged for by county welfare department staff in order to maintain the child in his or her own home.” Family Maintenance provides strength-based, family-focused services to support a child or youth remaining in a safe, secure, stable home. Services are only eligible up to age 18.

<sup>42</sup> ECM is a Medi-Cal Managed Care benefit and only available to Members enrolled in Managed Care.

## **B. Examples of Eligible MCP Members Under this Population of Focus:**

- A Member under age 21 who is currently receiving foster care services.
- A Member under age 21 who has received foster care services any time in the last 12 months.
- A Member up to age 18 (or under age 21 for children with a “mental or physical disability”) who is eligible for and/or are in California’s Adoption Assistance Program.
- A Member up to age 18 who is receiving (or has received in the last 12 months) Family Maintenance services.

## **C. Operational Guidance:**

### **• Identification:**

- Members and their families may self-refer to ECM.
- MCPs have access to aid codes and eligibility groups that can help identify children and youth involved in child welfare, specifically for children receiving foster care, children with an approved relative caregiver, children who are in the former foster care youth eligibility group, children who are in the Adoption Assistance Program (see **Appendix D** for more information on the aid codes and eligibility groups). MCPs will need to access other information and data to help identify children eligible for ECM through this Population of Focus who are eligible for or enrolled in Family Maintenance or they were eligible for Adoption Assistance Program but not enrolled.
- California Wraparound Care Coordinators, Health Care Program for Children in Foster Care (HCPCFC) Public Health Nurses, other support staff of these programs, county child welfare program staff, and any local program supporting children involved in child welfare all may submit referrals for members they suspect are eligible.

### **• Outreach and Engagement:**

- ECM requires engagement with the Member in the community or at ECM Provider locations. In instances where the Member’s California Wraparound Care Coordinator or HCPCFC Public Health Nurses is also their ECM Provider, ECM services could be provided where the Member receives California Wraparound or HCPCFC services.
- For Members who also have a Child Family Team (CFT) through California Wraparound, the ECM Provider is expected to consult with them and keep them informed as appropriate.

### **• Comprehensive Assessment and Care Management Plan:**

- For children enrolled in California Wraparound or HCPCFC, the ECM Provider is expected to leverage the comprehensive assessments conducted and the care plans developed by California Wraparound (called a “Wraparound Plan”) and HCPCFC (called a “care plan” and coupled with a “Health Education Passport” to document medical and education information) in developing the Member’s ECM care management plan. The California Wraparound Plan is developed in partnership with the CFT and includes clinical and nonclinical information. The



- HCPCFC care plan includes an assessment of medical, dental, developmental, behavioral, personal and child welfare history, and other applicable SDOH care.
- Additional assessments may be needed to ensure the Member's ECM care management plan incorporates the Member's needs and strategies to address those needs across the areas of physical health care, mental health care, SUD care, community-based LTSS, oral health care, palliative care, social supports, SDOH care, and others.
  - **Examples of Applicable ECM Services for this Population of Focus:** For this Population of Focus, ECM should include addressing other needs that are not already being met by California Wraparound or HCPCFC. Examples of applicable ECM services for this population include (but are not limited to):
    - Facilitating enrollment in SNAP.
    - Supporting enrollment in educational opportunities and grants, such as Cal Grant B for Foster Youth and Chafee Foster Youth Grant Program.
    - Assisting the Member with scheduling appointments with their PCP and coordinating referrals to specialists.
    - Ensuring the Member's foster parents have the resources and knowledge to monitor the Member's medication-assisted treatment to address a SUD.
  - **Community Supports:** MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus.<sup>43</sup> Doing so can enhance care and prevent costly and unnecessary hospitalizations. Each Member will have different needs and functional limitations. Below are a few examples of Community Supports that may be particularly beneficial:
    - Day Habilitation Programs.
    - Medically Tailored Meals/Medically-Supportive Food.
    - Environmental Accessibility Adaptions (Home Modifications).
    - Asthma Remediation.
  - **Provider Contracting:**
    - If a child or youth is enrolled in both ECM and California Wraparound or HCPCFC and their existing care manager is a contracted ECM Provider, then the MCP should assign the care manager as that Member's ECM Provider, unless the Member (and/or their parent, guardian, caretaker) prefers a different ECM Provider.

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<sup>43</sup> For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the [Community Supports Policy Guide](#).

**9. Individuals with I/DD (Updated December 2022)**

Individuals with I/DD often require additional care and support across multiple systems of care. As of December 2022, DHCS is defining “individuals with I/DD” as a freestanding ECM Population of Focus to focus attention and care on strengthening care management with this population and to encourage MCPs to develop networks of ECM Providers with special expertise service individuals with I/DD.

The addition of this Population of Focus does not establish new ECM eligibility criteria. Rather, DHCS is creating this distinct Population of Focus for individuals with I/DD to acknowledge the unique needs of this population. ECM is currently available, as of January 2022, for adults with an I/DD who qualify for ECM based on the adult Populations of Focus. Starting July 2023, ECM will be available for children and youth with an I/DD who qualify for ECM based on the children/youth Populations of Focus.

Individuals receiving 1915(c) waiver services and those residing in an ICF are not eligible for ECM (see Section VI. Program Overlaps and Exclusions).

**A. Population of Focus Eligibility Criteria: <sup>44</sup>**

**a. Adults with an I/DD**

Adults who:

(1) Have a diagnosed I/DD;

**AND**

(2) Qualify for eligibility in any other adult ECM Population of Focus.

**b. Children and Youth with an I/DD**

Children and youth who:

(1) Have a diagnosed I/DD;

**AND**(2) Qualify for eligibility in any other children and youth ECM Population of Focus.

<sup>44</sup> I/DD for adults, children, and youth is defined in California by [WIC 4512\(a\)](#) as “a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.”

## **B. Examples of Eligible MCP Members Under this Population of Focus:**

- A Member under the age of 21 who has a diagnosis of Autism spectrum disorder and significant functional limitations that impede them from navigating their health care and other services, with repeated incidents of avoidable ED visits in a six-month period.
- A Member who is experiencing homelessness and who has a TBI resulting in an intellectual disability and an inability to self-manage their health care needs, for whom coordination of services would likely result in improved health outcomes.
- A Member who has a diagnosis of Down syndrome and currently resides in a SNF, but who would like to move out of the institution and is a likely candidate to successfully reside continuously in the community.

## **C. Operational Guidance:**

- Adults, children, and youth with an I/DD who are served by a Regional Center can qualify for ECM if they meet the eligibility criteria for any ECM Population of Focus. Regional Centers are community-based, non-profit agencies that operate statewide in California across 21 regions. Regional Centers are overseen by the California Department of Developmental Services (DDS) and provide assessments, determine eligibility for services, offer case management services, and develop, purchase, and coordinate services in each individual's Individual Program Plan.<sup>45</sup> Regional Centers may contract with MCPs to serve as ECM Providers and they may refer Members they believe may be eligible for ECM.
- ECM can be used to link individuals with an I/DD with a variety of services to meet their complex needs. In addition to the Core Service Components (see Section V. Core Service Components of ECM), examples of applicable services for this Population of Focus include (but are not limited to):
  - Utilizing Community Supports, particularly to help individuals with an I/DD experiencing homelessness to identify housing and preparing individuals to secure and/or maintain stable housing.
  - Maintaining regular contact with Members to ensure there are not gaps in the activities designed to address an individual's health and social service needs – in addition to supporting I/DD care management – and swiftly addressing those gaps to ensure progress toward regaining health and function continues.
  - Coordinating and collaborating with various health and social services Providers, including Regional Centers, including sharing data (as appropriate) to facilitate better-coordinated whole-person care.
  - Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
  - Addressing barriers to stability and positive outcomes by connecting Members and their families to health and social support resources.
  - Members and their families may self-refer to ECM.

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<sup>45</sup> Description and more information about Regional Centers located [here](#).

## 10. Pregnancy, Postpartum, and Birth Equity Population of Focus *(Updated December 2022)*

Pregnant and postpartum individuals often require care that is accessed across many delivery systems to support themselves and their newborn. Pregnant and postpartum individuals can receive ECM if they qualify under any of the ECM Populations of Focus, including those that already are in effect as of January 1, 2022, and those that will go into effect in future months. In addition, as of December 2022, DHCS is defining pregnant and postpartum individuals as a freestanding ECM Population of Focus to address the unique needs of birthing individuals and to encourage MCPs to develop networks of ECM Providers with special expertise in pregnancy and postpartum care. Given the significant racial and ethnic disparities in maternal outcomes in California, effectively addressing the needs of this Population of Focus is a critical part of DHCS' health equity vision. DHCS is making this change simultaneous with the launch of Children and Youth Population of Focus in recognition of the tie between investment in perinatal care and outcomes for children and youth, especially those who are zero to three years of age.

The addition of this Population of Focus does not establish new eligibility criteria prior to January 2024. During this period before January 2024, ECM is available to pregnant and postpartum individuals who meet criteria for any other ECM Population of Focus, including pregnant and postpartum youth who qualify for ECM based on the children/youth Populations of Focus when ECM goes live for children and youth in July 2023. The overlapping eligibility is set out here to explicitly call out the different pathways pregnant individuals can qualify for ECM and to ensure that MCPs are creating ECM Provider networks with the unique expertise to serve this Population of Focus.

From January 1, 2024, this Population of Focus will expand to the Birth Equity Population of Focus to address known disparities in health and birth outcomes in racial and ethnic groups with high maternal morbidity and mortality rates. DHCS is adding this eligibility pathway in recognition that living within communities subject to historically poor birth outcome disparities related to social inequity is itself a risk factor that can be addressed through comprehensive, whole-person care management.

### A. Population of Focus Eligibility Criteria:

#### **Pregnancy, Postpartum and Birth Equity Population of Focus (Adults and Youth)**

Adults and youth who:

(1) Are pregnant **OR** are postpartum (through 12 months period);

**AND**

(2) Meet one or more of the following conditions:

(i) Qualify for eligibility in any other adult or youth ECM Population of Focus;

(ii) **[Birth Equity Population of Focus Effective January 1, 2024]** Are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

### Notes on the Definition:

- Clause (1) with “pregnant or are postpartum (through 12 months period)” is defined as individuals who are currently pregnant or currently postpartum. For the purposes of this Population of Focus definition, “postpartum” means having delivered, whether a live birth or stillbirth; or a late term abortion.
- Clause (2)(i) is already live statewide as of January 1, 2022, for adult Populations of Focus and will go live statewide starting July 1, 2023, for children and youth Populations of Focus.
- Clause (2)(ii) will go-live statewide on January 1, 2024. Based on the California Department of Public Health’s (CDPH) most recent State public health data (including the [Prenatal Care Dashboard](#) and [Pregnancy-Related Mortality Dashboard](#)), the racial and ethnic groups experiencing disparities in care for maternal morbidity and mortality are Black, American Indian and Alaska Native, and Pacific Islander pregnant and postpartum individuals. This maternal morbidity and mortality data will be calculated at the State level (not county level) to guide ECM eligibility at the MCP and Member level.

### B. Examples of Eligible MCP Members Under this Population of Focus:

- Pregnant or postpartum adult Member who qualifies for ECM through another Population of Focus, such as experiencing homelessness, transitioning from incarceration, or experiencing a serious mental health need.
- Pregnant or postpartum youth Member who qualifies for ECM through another Population of Focus, such as experiencing homelessness, transitioning from incarceration, or experiencing a serious mental health need (*go live on July 1, 2023*).
- Black, American Indian or Alaska Native, or Pacific Islander Member who is pregnant or postpartum (up to 12 months) and does *not* qualify for ECM through another Population of Focus (*go live on January 1, 2024*).

### C. Operational Guidance:

- **Identification:**
  - MCPs must work to identify eligible Members for this Population of Focus as soon as they become aware of a Member’s pregnancy (e.g., encounter data, Provider records or reports). MCPs must have strategies in place to support timely identification of a Member’s pregnancy and not rely solely on claims and encounter data, which have significant lag time.
  - DHCS and MCPs collect race and ethnicity data at multiple interventions (e.g., eligibility, enrollment, Provider recorded). MCPs will be expected to leverage any data source available to them in order to identify pregnant and postpartum (up to 12 months) individuals who may experience health disparities with maternal morbidity and mortality (aligned with Clause (2)(ii)).
  - MCPs should partner with local programs serving pregnant and postpartum individuals to help with identification, including Comprehensive Perinatal Services Program (CPSP), Black Infant Health (BIH) Program, California Perinatal Equity Initiative (PEI), American Indian Maternal Support Services (AIMSS), CDPH’s

California Home Visiting Program (CHVP), and CDSS' CalWORKs Home Visiting Program (HVP).

- As for all ECM Populations of Focus, MCPs must establish policies and procedures that allow network Providers to refer patients to the MCP for ECM if they suspect eligibility criteria are met. MCPs should specifically focus on establishing robust referral pathways with all maternity care providers, including midwives, doulas, and hospitals to identify and refer eligible Members.
- Effective January 1, 2023, when all MCPs are expected to use ADT feed data, when available, across their PHM Programs, MCPs should use ADT feed data to identify potentially eligible members in a timelier fashion.
- Members and their families may self-refer to ECM.

- **Outreach and Engagement:**

- ECM requires engagement with the Member in the community or at Provider locations. In instances where the Member is also enrolled in a local pregnant or postpartum program (i.e., CPSP, BIH Program, PEI, AIMSS, CHVP, HVP) and that program is also their ECM Provider, ECM services could be provided where the Member receives those services.
- In instances where the Member is enrolled in a local pregnant or postpartum program (i.e., CPSP, BIH Program, PEI, AIMSS, CHV, HVP) and that program is *not* their ECM Provider, the ECM Provider is expected to consult with the local pregnant or postpartum program and keep them informed as appropriate.

- **Comprehensive Assessment and Care Management Plan:**

- For Members enrolled in CPSP, the ECM Provider is expected to leverage the comprehensive assessments conducted by CPSP, including the CPSP individualized care plan and postpartum assessment, in developing the Member's ECM care management plan.<sup>46</sup> The CPSP individualized care plan is reassessed at each trimester with a strengths-based assessment.
- Additional assessments may be needed to ensure the Member's ECM care management plan incorporates the Member's needs and strategies to address those needs across the areas of physical health care, mental health care, SUD care, community-based LTSS, oral health care, palliative care, social supports, SDOH care, and others.
- A Member who qualifies for ECM through this Population of Focus would not be disenrolled from ECM simply because their pregnancy and/or postpartum period concludes. Rather, just as any other Member enrolled in ECM, a Member who is enrolled in ECM through this Population of Focus would only disenroll if they meet graduation criteria.

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<sup>46</sup> At this time, BIH Program, CPEI, and AIMSS do not have detailed care management plans that are established for Members enrolled in the program.

- **Examples of Applicable ECM Services for this Population of Focus:** For this Population of Focus, ECM should include addressing the needs of the pregnant or postpartum individual to ensure the best health and lifelong outcomes for them, as well as their newborn or infant. Examples of applicable ECM services for this Population of Focus include (but are not limited to):
  - Facilitating access to Community Supports that will help the pregnant or postpartum individual as they prepare for or recover from labor and delivery, including housing and food related Community Supports.
  - Coordinating the transition from hospital to home after labor and delivery and with various health and social services providers, including sharing data (as appropriate), to facilitate better-coordinated whole-person care.
  - Supporting Member treatment adherence, including scheduling prenatal and postpartum appointments and well-child visits, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
  - Connecting the pregnant or postpartum individual, their partner, and/or their family with resources regarding the Member's conditions to assist them with providing support for the Member's health and newborn or infant's health.
  - Coordinating care across all applicable delivery systems (Medi-Cal Managed Care or Medi-Cal FFS; SMHS; DMC or DMC-ODS; Dental Managed Care or Dental FFS; and Medi-Cal Rx) and care coordinators.
  
- **Community Supports:** MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus.<sup>47</sup> Doing so can enhance care and prevent costly and unnecessary hospitalizations. Each Member will have different needs and functional limitations. Below are a few examples of Community Supports that may be particularly beneficial:
  - Housing Transition Navigation Services.
  - Housing Deposits.
  - Housing Tenancy and Sustaining Services.
  - Short-Term Post-Hospitalization Housing.
  - Housing Transition Navigation Services.
  - Medically Tailored Meals/Medically-Supportive Food.
  - Sobering Centers.
  
- **Provider Contracting:**
  - There are no limitations on who can be an ECM Provider for this Population of Focus. There are natural fits on who this Provider type could be to best support pregnant and postpartum individuals, such as OB/GYNs (Obstetrics / Gynecology), Family Medicine Physicians, Doulas, Promotoras, or Midwives. There are also existing California programs that support pregnant and postpartum

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<sup>47</sup> For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the [Community Supports Policy Guide](#).

individuals – including home visiting programs,<sup>48,49</sup> CPSP, BIH Program, PEI, and AIMSS – who could serve as an ECM Provider and support pregnant and postpartum individuals already receiving care through these programs in order to receive additional support, as needed, through ECM (see Section VI. Program Overlaps and Exclusions).

- DHCS has recently introduced a Doula benefit in Medi-Cal. Members receiving doula services who also qualify for ECM are not be precluded from receiving ECM as long as the MCP ensures that Providers do not receive duplicative reimbursement for the same services provided to the same Member. Doula services are available to any birthing individual in Medi-Cal, whereas ECM eligibility is limited to a qualifying Population of Focus. Doulas and ECM Care Coordinators are envisioned to have separate and distinct roles, though if eligible (see Section VII. ECM Provider Network), doulas are welcome to contract with MCPs as ECM Providers. To learn more about DHCS' new Medi-Cal covered doula benefit, see the [DHCS Doula Services webpage](#).

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<sup>48</sup> CDPH operates the California Home Visiting Program (CHVP) and provides infrastructure, support, and funding for evidence-based home visiting programs statewide. As of December 2022, CHVP has approved three evidence-based home visiting models: Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). See more on these programs [here](#).

<sup>49</sup> CDSS operates the CalWORKs Home Visiting Program (HVP) and provides infrastructure and supervision, with administration provided by participating California counties. CDSS permits counties to adopt HVPs that align with the U.S. HHS' evidence-based home visiting requirements, available [here](#).



## V. Core Service Components of ECM

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### Overview of ECM Core Service Components

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

ECM is intended to be interdisciplinary, high touch, person centered and provided primarily through in-person interactions with Members where they live, seek care and prefer to access services. Members who will be eligible for ECM are expected to be among the most vulnerable and highest-need Medi-Cal Managed Care Members. It will be critical for ECM Providers to establish strong relationships with these Members (and their parent, caregiver, guardian if applicable), and this will occur most effectively through in-person interactions in locations most convenient for the Member. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider is permitted to use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice. As the benefit becomes more established, DHCS will be interested, in the course of its monitoring, in understanding the efficacy between ECM Provider location-based in-person interactions vs. community/home-based interactions.

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

#### 1) Outreach and Engagement

MCPs are responsible for identifying (or accepting referrals for) Members who are eligible for ECM. MCPs will then assign every Member authorized for ECM to an ECM Provider. ECM Providers are responsible for reaching out to, and engaging, assigned Members. DHCS will be monitoring rates of ECM penetration for each Population of Focus as a key marker of the benefit's efficacy; MCPs should track key performance indicators to ensure that Member outreach and engagement strategies do not perpetuate health disparities and, in fact, help address disparities by race, ethnicity, Healthy Places Index, and other factors. This monitoring and oversight approach is aligned with the State's approach broadly with the CalAIM Program, as well as the Incentive Payment Program (IPP).

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

- a. Attempting to locate, contact and engage Members (and/or their parent, caregiver, guardian) who have been identified as good candidates to receive ECM services, promptly after assignment.
- b. Using multiple strategies for engagement, as appropriate and to the extent possible, including direct communications with the Member (and/or their parent, caregiver, guardian), such as in-person meetings where the Member lives, seeks care or is accessible; mail, email, texts and telephone; community and street-level outreach; follow-up if the Member presents to another partner in the ECM network; or using claims data to contact Providers the Member is known to use.
- c. Using an active and progressive approach to outreach and engagement until the Member (and/or their parent, caregiver, guardian) is engaged.
- d. Documenting outreach and engagement attempts and modalities.
- e. Utilizing educational materials and scripts developed for outreaching and engaging Members, as appropriate.
- f. Sharing information between the MCP and ECM Providers, to ensure that the MCP can assess Members for other programs if they cannot be reached or decline ECM.
- g. Providing culturally and linguistically appropriate communications and information to engage Members (and/or their parent, caregiver, guardian) and ensuring that such approaches build trust with communities that have historically been underserved in the Medi-Cal program.

## **2) Comprehensive Assessment and Care Management Plan**

After the initial step of successful engagement with an ECM Member, a comprehensive assessment should be conducted and a care plan developed. As part of the assessment, MCPs must include DHCS standardized LTSS referral questions<sup>50</sup> to identify and refer Members who may have LTSS needs, unless the Member has already answered these questions. This process involves the ECM Members (and their parent, caregiver, guardian) as well as appropriate clinical input in developing a comprehensive, individualized, person-centered care plan. The care plan is based on the needs and desires of the Member and should be reassessed based on the Member's individual progress or changes in their needs and/or as identified in the care plan. The care plan incorporates the Member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports and SDOH. Comprehensive care management may include case conferences to ensure that the Member's care is continuous and integrated among all service Providers.

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

- a. Engaging with each Member (and/or their parent, caregiver, guardian) authorized to receive ECM primarily through in-person contact.
- b. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider must use alternative methods (including innovative use

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<sup>50</sup> Current LTSS questions are those established in [APL 17-013](#).

of telehealth) to provide culturally appropriate and accessible communication in accordance with Member (and/or their parent, caregiver, guardian) choice.

- c. Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan.
- d. Developing a comprehensive, individualized, person-centered care plan with input from the Member (and/or their parent, caregiver, guardian) as appropriate to prioritize, address, and communicate strengths, risks, needs, and goals. The care plan must also leverage Member strengths and preferences and make recommendations for service needs.
- e. In the Member's care plan, incorporating identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing.
- f. Ensuring the Member is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and/or as identified in the Care Management Plan. There is not a required annual reassessment for Members.
- g. Ensuring the Care Management Plan is reviewed, maintained, and updated under appropriate clinical oversight.

### **3) Enhanced Coordination of Care**

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

- a. Organizing patient care activities, as laid out in the Care Management Plan; sharing information with those involved as part of the Member's multi-disciplinary care team; and implementing activities identified in the Member's Care Management Plan.
- b. Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of Member goals and needs. Further, in alignment with the PHM BPHM requirements, the assigned ECM Lead Care Manager is responsible for ensuring that the Member has an assigned PCP and that they are engaging with that PCP for appropriate care. Enhanced Coordination of Care may include case conferences in order to ensure that the Member's care is continuous and integrated among all service Providers.
- c. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed.

- d. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment.
- e. Communicating the Member's needs and preferences in a timely manner to the Member's multi-disciplinary care team in an effort to ensure safe, appropriate and effective person-centered care.
- f. Ensuring regular contact with the Member (and/or their parent, caregiver, guardian) when appropriate, consistent with the care plan and to ensure information is shared with all involved parties to monitor the Member's conditions, health status, care planning, medications usages and side effects.

#### **4) Health Promotion**

As established in the [PHM Policy Guide](#), the assigned ECM Lead Care Manager is responsible for ensuring that BPHM is in place as part of the Members' care management.<sup>51</sup> BPHM includes Health Promotion services to encourage and support Members receiving ECM to make lifestyle choices based on healthy behavior, with the goal of motivating Members to successfully monitor and manage their health. Health Promotion services can include, but are not limited to:

- a. Working with Members to identify and build on successes and potential family and/or support networks.
- b. Providing services, such as coaching, to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health.
- c. Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.
- d. Linking Members to resources for smoking cessation, management of Member chronic conditions, self-help recovery resources and other services based on Member needs and preferences.
- e. Using evidence-based practices, such as motivational interviewing, to engage and help the Member participate in and manage their care.

#### **5) Transitional Care Services**

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<sup>51</sup> See the [PHM Policy Guide](#) Section E. Providing PHM Program Services & Supports.

Transitional Care Services include services intended to support Members and their families and/or support networks as Members transfer from one setting or level of care to another, including, but not limited to discharges from hospitals, institutions, other acute care facilities, and SNFs to home- or community-based settings, Community Supports, post-acute care facilities, or LTC settings. Services include supporting Members' transitions from discharge planning until they have been successfully connected to all needed services and supports. Additionally, ECM Providers should provide information to the hospital discharge planners or discharging facility staff about ECM so that collaboration on behalf of the Member can occur in as timely a manner as possible and that the member does not receive two different discharge planning documents. Transitional Care Services can help avoid unnecessary readmissions.

Transitional Care Services include, but are not limited to:

- a. Knowing, in a timely manner, each Member's admission, discharge, or transfer to or from an ED, hospital inpatient facility, SNF, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members. MCPs are responsible for ensuring that ECM Providers have access to or are provided ADT feed data information for enrolled Members to provide transitional care services for ECM Members.
- b. Developing strategies to reduce avoidable Member admissions and readmissions. Examples include ensuring timely prior authorizations and discharges, establishing agreements and processes to promptly notify to the Member's Lead Care Manager, who will ensure all Transitional Care Services are complete, including but not limited to: ensuring discharge risk assessment and discharge planning document is created and shared with appropriate parties; planning timely scheduling of follow-up appointments with recommended outpatient Providers and/or community partners; conducting medication reconciliation or Closed Loop Referrals, developing policies to arrange transportation for transitional care, including to medical appointments, as per Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) policy and procedures; and easing the Member's transition by addressing their understanding of rehabilitation activities, self-management activities and medication management.
- c. For Members who are experiencing or are likely to experience a care transition, the ECM Lead Care Manager is responsible for:
  - i. Developing and regularly updating a discharge planning document for the Member; this includes facilitating discharge instructions developed by a hospital discharge planner or discharge facility staff.
  - ii. Ensuring the completion of discharge risk assessment and coordinating any follow up provider appointments and support services to facilitate safe and appropriate transitions from one setting or level of care to another.
  - iii. Coordinating medication review/reconciliation.
  - iv. Providing adherence support and referral to appropriate services.

For more information about transitional care more broadly (for those in and not in ECM), refer to the [PHM Policy Guide](#), Section E. Providing PHM Program Services and Supports: c. Transitional Care Services.

## **6) Member and Family Supports**

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

- a. Documenting a Member's authorized parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM Providers; the Member and/or their Member's authorized parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) , as applicable.
- b. Conducting activities to ensure the Member and/or parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) are knowledgeable about the Member's condition(s), with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.
- c. Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and/or parent, caregiver, guardian, other family member(s) and/or other authorized support person(s)
- d. Identifying supports needed for the Member and/or their parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) to manage the Member's condition and assist them in accessing needed support services and assist them with making informed choices.
- e. Providing for appropriate education of the Member parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) about care instructions for the Member.
- f. Ensuring that the Member parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) has a copy of his/her care plan and information about how to request updates.

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

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

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

- b. Coordinating and referring Members to available community resources and following up with Members (and/or parent, caregiver, guardian) to ensure services were rendered (i.e., “closed loop referrals”).

## VI. Program Overlaps and Exclusions

*(Updated December 2022)*

ECM will coordinate all care for the highest-risk Members with complex medical and social needs, including across the physical and behavioral health delivery systems. Sometimes stakeholders refer to this function as “air traffic control” – the ECM Lead Care Manager must know every component of the Member’s needs and services and ensure that they are coordinated.

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

**Figure 2: Summary of Approaches to ECM Overlaps/Non-duplication**

1) 1915(c) Waivers	2) Services Carved Out of Managed Care	3) Services Carved into Managed Care	4) Dual-Eligible Members	5) Other Programs	6) Programs Serving Pregnant & Postpartum Individuals
Multipurpose Senior Services Program (MSSP)	California Children’s Services (CCS)	CCS Whole Child Model (WCM)	Dual Eligible Special Needs Plans (D-SNPs)	California Community Transitions (CCT) Money Follows the Person (MFTP)	Comprehensive Perinatal Services Program (CPSP)
Assisted Living Waiver (ALW)	County-Based Targeted Case Management (TCM)	Complex Care Management (CCM)	D-SNP Look-Alike Plans	Family Mosaic Project	Black Infant Health (BIH) Program
Home and Community-Based Alternatives (HCBA) Waiver	Specialty Mental Health Services (SMHS) TCM	Community-Based Adult Services (CBAS)	Other Medicare Advantage Plans	Hospice	California Perinatal Equity Initiative (PEI)
HIV/AIDS Waiver	SMHS Intensive Care Coordination for Children (ICC)		Medicare Fee For Service (FFS)	California Wraparound	American Indian Maternal Support Services (AIMSS)
HCBS Waiver for Individuals with Developmental Disabilities (I/DD)	Drug Medi-Cal Organized Delivery System (DMC-ODS) & Drug Medi-Cal (DMC) Program Care Coordination & Management Programs		Cal MediConnect		CDPH California Home Visiting Program (CHVP)
Self-Determination Program for Individuals with I/DD	Full Service Partnership (FSP)		Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)		CDSS CalWORKs Home Visiting Program (HVP)
	Health Care Program for Children in Foster Care (HCPCFC)		Program for All-Inclusive Care for the Elderly (PACE)		
	In Home Supportive Services (IHSS)				
	Genetically Handicapped Person’s Program (GHPP)				



<b>1. ECM and the other program</b>	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.
<b>2. Either ECM or the other program</b>	MCP Members can be enrolled in ECM or in the other program, not in both at the same time.
<b>3. Not Eligible to Enroll in ECM</b>	Medi-Cal beneficiaries enrolled in the other program are excluded from ECM.

Ultimately, MCPs are responsible for ensuring non-duplication of services provided through ECM and any other program(s). As such, MCPs should regularly check available data feeds to evaluate which of their Members might be enrolled in other programs that provide care coordination. In addition, MCPs should establish processes and requirements to ensure ECM Providers ask Members about their participation in other programs as part of the in-person comprehensive assessment and care planning process. If ECM is being provided in addition to an existing care management program, the existing program must not be discontinued.

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

### 1.) 1915(c) Waiver Programs

California has six 1915(c) waivers, including Multipurpose Senior Services Program (MSSP), Assisted Living Waiver (ALW), Home and Community-Based Alternatives (HCBA) Waiver, HIV/AIDS Waiver, HCBS Waiver for I/DD, Self-Determination Program for Individuals with I/DD.

***(Updated December 2022)***

*Adult, child, and youth MCP Members can be enrolled in ECM or in a 1915(c) waiver program, not in both at the same time.*

- 1915(c) waiver programs provide services to many Medi-Cal Members who will likely also meet the eligibility criteria for ECM (by belonging to at least one of the Populations of Focus).
- There are comprehensive care management components within the 1915(c) waiver programs that are duplicative of ECM services.
- As such, Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving ECM services.
- Members who are on a wait list for a 1915(c) waiver program are likely good candidates to receive ECM until a slot in a 1915(c) waiver program becomes available.

- If a Member is receiving ECM and then a slot to enroll in a 1915(c) waiver program becomes available, the MCP should ensure that the Member has the choice of whether they will continue receiving ECM or enroll in the 1915(c) waiver program.
- The MCP should provide education to the Member about their options, including describing what is available through the ECM benefit compared with 1915(c) waiver programs, so the Member can make an informed decision.

## 2.) Services Carved Out of Managed Care

### California Children's Services (CCS) *(Updated December 2022)*:

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

- CCS is a joint statewide program administered by DHCS and county health departments and is "carved out" of the broader Medi-Cal program. Children and youth enrolled in CCS (up to 21 years old) with CCS-eligible medical conditions receive diagnostic and treatment services, medical case management, physical and occupational therapy, and authorized medical equipment.
- Each CCS Member is supported by a paneled core team consisting of: Medical Director/Physician, SCC Coordinator, Registered Nurse, Medical Social Worker, and Registered Dietitian. The qualifications and responsibilities of each team member can be found in the [CCS Manual of Procedures](#).
- CCS medical case management service components include:
  - Intake: Conducting health and psychosocial assessment; developing care plan (including required coordination across organizations) and social work plan.
  - Ongoing treatment and patient follow-up: Conducting periodic reassessments; coordinating, referring, and monitoring all services and follow ups as outlined in the patient care plan; convening team conferences to coordinate decision making and delivery of health care services.
  - Patient and family teaching: Soliciting family (and child when mature enough) participation and collaboration in plan of care; providing education to parents and family members about the system of care and services (including social services) available.
  - Multidisciplinary comprehensive team assessments: Maintaining documentation of assessments/reassessments and medical emergency plan.
  - Transition support: Planning for the transition of youth to adult services by the age of 14 including sources of medical, vocational, financial, and support services and safety planning for youth with disabilities.
- ECM enhances, but does not displace, CCS. MCPs are expected to work with local county CCS offices to ensure that Members receiving ECM services do not receive duplicative CCS services. Specifically, MCPs are required to demonstrate how they will prevent duplication in their respective MOC.

- For more information on CCS, see the [CCS Manual of Procedures \(Chapter 3.37: Provider Core Standards\)](#), [DHCS' Information About CCS Brief](#), [DHCS' CCS Program Overview webpage](#), and [DHCS' CCS Medical Therapy Program webpage](#).

### County-Based Targeted Case Management (TCM):<sup>52</sup>

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

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

### Specialty Mental Health Services (SMHS) Targeted Case Management (TCM) *(Updated December 2022)*:

*MCP Members receiving SMHS TCM from counties can also be eligible for and receive ECM services. MCPs are required to work with counties to identify Members receiving SMHS TCM and ensure non-duplication of services.*

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<sup>52</sup> County-specified TCM is distinct from TCM provided as a component of SMHS, which is covered below.

- Counties administer the SMHS program, which is “carved out” of the broader Medi-Cal program under the authority of a 1915(b) waiver approved by CMS. The SMHS waiver program is administered locally by each county’s MHP, and each MHP provides, or arranges for, SMHS for Medi-Cal beneficiaries, including SMHS TCM and Peer Supports.
- SMHS TCM encompasses services that assist a beneficiary to access needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities include: communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development. TCM includes the following assistance:
  - Comprehensive assessment and periodic reassessment (annual basis or shorter as appropriate) of individual needs to determine the need for establishment of TCM services to access any medical, educational, social, or other services.
  - Development and periodic revision of client plan.
  - Referral and related activities to help an eligible individual obtain needed services including activities that help an individual with medical, alcohol and drug treatment, social, educational Providers or other programs and services that are capable of providing needed services.
  - Monitoring and follow up activities that are necessary to ensure the Client Plan is implemented and adequately addresses the individual's needs.
  - Further information about SMHS TCM services can be found under [State Plan Supplement 1 to Attachment 3.1-A – Targeted Case Management \(TCM\) Services for Medi-Cal Beneficiaries that Meet Medical Necessity Criteria for TCM Covered as Part of the Specialty Mental Health Services Program \(2012\)](#).

**SMHS Intensive Care Coordination (ICC) for Children (*Updated December 2022*):**

*Child and youth MCP Members can both be enrolled in ECM and receive SMHS ICC. ECM enhances ICC and coordinates across the case/care management available in SMHS ICC. The MCP is required to work with the county to ensure non-duplication of services between ECM and SMHS ICC.*

- SMHS ICC is a statewide intensive form of SMHS TCM (see above) that facilitates the assessment of, care planning for, and coordination of services for children and youth with more intensive needs who are in or at risk of placement in residential or hospital settings, but could be effectively served in the home and community.
- SMHS ICC service components include:<sup>53</sup>
  - Planning and assessment of strengths and needs: The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the

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<sup>53</sup>Refer to [Medi-Cal Manual For ICC](#) (January 2018) for more information about SMHS ICC program and services provided.

system partners (MHPs, child welfare, juvenile, probation, education, etc.) are integrated to comprehensively address the identified goals and objectives.

- Reassessment of strengths and needs: The ICC Coordinator and the CFT should reassess the strengths and needs of children and youth and their families, at least every 90 days, and as needed.
- Referral, monitoring and follow up activities: The ICC coordinator conducts referral, linkages, monitoring, and follow up activities, to ensure that the child's/youth's needs are met.
- Transition: When the child or youth has achieved the goals of his/her client plan, the CFT should engage in developing a transition plan for the child/youth and family, to promote long-term stability.

### **Drug Medi-Cal Organized Delivery System (DMC-ODS) and Drug Medi-Cal (DMC) Care Coordination & Management Programs *(Updated December 2022)*:**

*Adult, child, and youth MCP Members can be enrolled in both ECM and receive DMC-ODS/DMC services. ECM enhances the DMC-ODS/DMC care coordination available and coordinates across the DMC-ODS/DMC Program and other services. MCP must ensure non-duplication of services between ECM and the DMC-ODS/DMC Program.*<sup>54</sup>

- Care coordination for the DMC-ODS delivery system is provided to patients in conjunction with all levels of SUD treatment and consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care coordination includes one or more of the following components:<sup>55</sup>
  - Coordinating with medical and mental health care Providers to monitor and support comorbid health conditions.
  - Discharge planning, including coordinating with SUD treatment Providers to support transitions between levels of care and to recovery resources, referrals to mental health Providers, and referrals to primary or specialty medical Providers.
  - Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, child care, child development, family/marriage education, cultural sources, and mutual aid support groups.

### **Full Service Partnership (FSP) (Funded by Mental Health Services Act (MHSA)) *(Updated December 2022)*:**

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<sup>54</sup> Refer to **Appendix F** for an overview of counties participating in the DMC-ODS/DMC Programs.

<sup>55</sup> Additional information about DMC-ODS services can be found in [BHIN 21-075: DMC-ODS Requirements for the Period of 2022 – 2026](#).

Counties who are ECM Providers can deliver ECM to individuals who are also enrolled in an FSP program. MCPs may not exclude Members from ECM because they are FSP program participants. MCPs and counties that oversee the MHSA [funded](#) FSP programs must work together to share data and identify Medi-Cal managed care adult, child, and youth Members served by both programs and ensure non-duplication of services and funding between ECM and FSP programs.

Counties also have discretion to prioritize FSP program slots for individuals not eligible for ECM (e.g., because they are not Medi-Cal MCP Members, or they do not meet ECM Population of Focus criteria).

### **Health Care Program for Children in Foster Care (HCPCFC) (Updated December 2022):**

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

- HCPCFC is a statewide public health nursing program that provides care management and coordination of medical, dental, developmental, and behavioral health for foster children, probation youth, and non-minor dependents.
- HCPCFC is currently administered by a partnership with DHCS, CDSS, and county health departments under the Child Health Disability Prevention (CHDP) program.
  - CHDP will sunset by July 1, 2024. DHCS has started the transition of moving HCPCFC into a stand-alone program. HCPCFC will *not* sunset with CHDP.
- HCPCFC service components include:
  - Care planning: Evaluation of available information regarding physical, dental, developmental, and behavioral health; child welfare history; family history; and other social factors affecting the child's/youth's health. Development of a care plan which is shared with the youth's assigned case worker and substitute caregiver(s) as appropriate.
  - Ongoing care management and follow-up: Conducting periodic reassessments; psychotropic medication monitoring and oversight, coordinating, referring, and monitoring services and follow ups as applicable; Revising the care plan to reflect reassessment; Communicating progress with the assigned case worker and/or caregiver(s) as appropriate.
  - Patient and family teaching: Soliciting family (and child when mature enough) participation and collaboration in plan of care; providing education to caregivers to support the objectives described in the plan of care.
  - Care coordination: Facilitating the completion of the objectives identified in the plan of care.
- ECM can be provided in addition to services provided by HCPCFC. MCPs are expected to work with local county HCPCFC management (Public Health, Health and Human Services depending on the jurisdiction) to ensure that Members receiving ECM services do not receive duplicative HCPCFC services. Specifically, MCPs are required to demonstrate how they will prevent duplication in their respective MOCs.

### **In Home Supportive Services (IHSS) (Updated December 2022):**

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

### **Genetically Handicapped Person's Program (GHPP) (Updated December 2022):**

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

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

## **3.) Services Carved into Managed Care**

### **CCS Whole Child Model (WCM) (Updated December 2022):**

*Child and youth MCP Members can be enrolled in ECM and CCS WCM. ECM enhances a child and youth's care coordination and fills the gaps across the case/care management provided by CCS WCM while reducing the navigational burden for families and children needing services beyond these from other Providers. MCP must ensure non-duplication of services between ECM and CCS WCM.*

- CCS WCM is operated by MCPs in select counties, integrating Medi-Cal Managed Care and county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in primary, specialty, and behavioral health for CCS-eligible and non-CCS eligible conditions. CCS WCM is "carved-in" to the broader Medi-Cal Managed Care program.
- CCS WCM service components for medical case management include:
  - Screening and referrals: MCPs must refer potential CCS-eligible Members to county CCS program for CCS eligibility determination.
  - Risk level and needs assessment: MCPs must assess each CCS Member's risk level and needs by performing a pediatric risk assessment process (PRSP) to classify Members into high and low risk categories. MCPs must reassess a Member's risk level and needs annually at the CCS eligibility determination or upon a significant change to a Member's condition.
  - Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of an ICP.
    - The risk assessment must address general health status and recent health care utilization, health history, specialty Provider referral needs,

prescription medication utilization, specialized or DME needs, need for specialized therapies, limitation of ADLs or daily functioning, as well as demographics and social history.

- The ICP must, at a minimum, include medical (primary care and CCS specialty) services, mental health (non-specialty mental health and/ or county SMHS) services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, SUD (DMC-ODS or DMC) services, home health services, Regional Center services, and other medically necessary services.
- Case management and care coordination: MCPs must provide case management and care coordination across the health care systems, including transitions among levels of care and interdisciplinary care teams. Care coordination also includes referrals to sub-specialists and other services identified in the Member's ICP. MCPs must also ensure that information, education, and support is continuously provided to CCS-eligible Members and their families.
- Maintenance and transportation: MCPs must provide support for transportation and associated costs (e.g., meals, lodging) for family seeking transportation to a medical service related to their CCS-eligible condition.
- Refer to **Appendix G** for an overview of counties participating in the CCS WCM and to [APL 21-005](#) for all requirements of MCPs participating in the CCS WCM program.
- ECM can be provided in addition to WCM. MCPs are expected to ensure that Members receiving ECM services do not receive duplicative CCS WCM services. Specifically, MCPs are required to demonstrate how they will prevent duplication in their respective MOC. Where it is appropriate, CCS WCM elements can be delegated to ECM Providers to ensure children and youth receive comprehensive, non-duplicated care across ECM and CCS WCM.
- For more information on CCS WCM, see the [APL 21-005](#), [CCS WCM FAQs](#), and [DHCS' CCS WCM webpage](#).

### **Complex Care Management (CCM) (Updated December 2022):**

Effective January 1, 2023, MCPs will also be required to provide Complex Care Management (CCM) program and services under the PHM Program.<sup>56</sup> See Figure 1 in Section II above outlining the CalAIM Care Management Continuum.

CCM is a service for higher- and medium-rising-risk MCP Members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right

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<sup>56</sup> MCPs are still required to offer Basic and Complex Case Management for Medi-Cal Managed Care Members until January 1, 2023, when the PHM Program requirements are effective. Refer to Medi-Cal Managed Care Contract, Exhibit A, Attachment 11, Provision 1. Comprehensive Care Management Including Coordination of Care Services.



setting and in a cost-effective manner. MCPs are already required to provide CCM. MCPs will continue to be required to provide CCM in 2023, in line with the requirement that all MCPs must meet the NCQA PHM standards on January 1, 2023.

Following the Amended 2023 MCP Contract and in line with NCQA's requirements, MCPs must comply with the following requirements:

- MCPs are allowed to determine their own eligibility criteria (within NCQA guardrails<sup>57</sup>) based on the risk stratification process and local needs identified in the Population Needs Assessment (PNA) required under the PHM Program.
- CCM must include a comprehensive assessment, a Care Management Plan, and a variety of interventions to meet the differing needs of high and medium-/rising-risk populations, such as care coordination for longer-term chronic conditions or disease-specific management programs.
- MCPs must also assign a care manager for every Member receiving CCM to ensure all BPHM requirements and NCQA CCM standards are met. MCPs must provide the Member's PCP with the identity of a Member's assigned care manager (if the PCP is not assigned to this role) and a copy of the Member's Care Management Plan.

For children and youth under age 21, CCM must include EPSDT; all medically necessary services, including those that are not necessarily covered for adults, must be provided as long as they could be Medicaid-covered services.

MCPs must consider CCM to be an opt-out program – (i.e., Members may choose not to participate in CCM if it is offered to them), and MCPs may delegate CCM to Providers and other entities who are themselves NCQA-certified.

For more information about CCM, Refer to the [PHM Policy Guide](#), Amended 2023 MCP Contract (forthcoming), and [DHCS' CalAIM PHM webpage](#).

### ***ECM and CCM Overlap Policy and Delegation***

An individual cannot be enrolled in ECM and CCM at the same time; rather, CCM is on a care management continuum with ECM. CCM can be used to support Members who were previously served by ECM, are ready to step down, and who would benefit from CCM; but not all Members in CCM previously received ECM, and not all Members who step down from ECM require CCM. DHCS encourages MCPs to work with Providers to contract for a care management continuum of ECM and CCM programs, wherever possible, including as a way to maximize opportunities for Members to step down from ECM to CCM or BPHM under the care of a single Provider.

### **Community-Based Adult Services (CBAS):**

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

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<sup>57</sup> See [NCQA 2021 Health Plan Accreditation PHM Standards. PHM 5: Complex Case Management](#).

- CBAS and ECM services are complementary.
- ECM can offer comprehensive care management beyond the services provided through CBAS, which are primarily provided within the four walls of the CBAS center.
- Given their connection to community resources, CBAS centers may also be well positioned to serve as ECM Providers.
- If an individual is enrolled in both ECM and CBAS, and their CBAS Provider is a contracted ECM Provider, the MCP should assign that CBAS Provider to be the Member's ECM Provider, unless the Member prefers a different ECM Provider.

#### 4.) Dual-Eligible Members

##### 2022 Policies

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

However, all dual eligible Members receiving HHP/WPC Pilot services have transitioned and were automatically authorized to receive ECM. See Figure 3 below for an overview of which dual eligible Members are eligible to receive ECM in 2022. DHCS strongly encourages MCPs to offer ECM to dual eligible Members, particularly when MCPs have information about Members receiving HCBS. Additionally, dual eligible Members may be enrolled in Medicare Advantage plans or D-SNPs. DHCS highly encourages these MCPs to explore data sharing possibilities and coordination with the Medicare plan, particularly if the Medicare plan and MCP are affiliated.

**Figure 3: Overview of ECM Eligibility for Dual-Eligible Members in 2022**

Medicaid & Medicare Delivery Model or Other Programs	ECM Eligible
Cal MediConnect	No
FIDE-SNPs	No
PACE Programs	No
Medi-Cal MCP + Medicare FFS	Yes
Medi-Cal MCP + Other MA	Yes
Medi-Cal MCP + D-SNP Look-alike	Yes
Medi-Cal MCP + D-SNP	Yes

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

**2023 Policies (Updated May 2022):**

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

- The 2023 D-SNP Policy Guide will reflect the intent for Exclusively Aligned Enrollment (EAE) D-SNPs to provide sufficient care management so that Members that would otherwise qualify for ECM receive an equivalent level of care coordination through their D-SNP.
- 2024 state-specific Model of Care Requirements for all D-SNPs will contain additional requirements for integrating elements of ECM into the D-SNP MOC, to be developed collaboratively with stakeholders.

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

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

**Figure 4: Overview of ECM Eligibility for Dual-Eligible Members in 2023 and Beyond**

Medicaid & Medicare Delivery Model	ECM Eligible
Medi-Cal MCP + <u>EAE</u> D-SNPs	No
FIDE-SNPs	No
PACE Programs	No
Medi-Cal MCP + Medicare FFS	Yes

Medi-Cal MCP + Other MA	Yes
Medi-Cal MCP + <u>non EAE</u> D-SNP	Yes in 2023; No from 2024
Medi-Cal FFS + Medicare FFS or Plan (not MCP enrolled)	No
Any other excluded program (e.g., 1915(c), CCT)	No

## 5.) Other Programs

### California Community Transitions (CCT) Money Follows the Person (MFTP) *(Updated December 2022)*:

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

- However, importantly, the “Adult Nursing Facility Residents Transitioning to the Community” Population of Focus is modeled off of the CCT Program;
- As such, MCPs are encouraged to contract with CCT Lead Organizations to leverage their expertise.

### Family Mosaic Project:

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

### Hospice:

*MCP Members receiving hospice are excluded from ECM.*

### California Wraparound *(Updated December 2022)*:

*Child and youth MCP Members can be enrolled in ECM and California Wraparound. ECM enhances California Wraparound and coordinates across the case/care management available in California Wraparound. MCPs are expected to work with local [California Wraparound County Coordinator](#) to ensure that Members receiving ECM services do not receive duplicative California Wraparound services.*

- California Wraparound (also known as High Fidelity Wraparound) is a strengths-based, needs-driven planning process and approach that occurs in a team setting to engage children and youth involved in child welfare, probation, and/or county SMHS with their families to live and grow up in a safe, stable, permanent family environment.<sup>58</sup>

<sup>58</sup>Refer to [All County Information Notice No. I-52-15](#), [All County Letter 21-116/BHIN 21-061](#), and [CDSS' California Wraparound webpage](#) for more information on California Wraparound.

- California Wraparound service components include:<sup>59</sup>
  - [Integrated Core Practice Model \(ICPM\)](#): Wraparound is aligned with ICPM, which includes principles and practices for serving children and youth in child welfare, behavioral health, and juvenile probation.
    - The CFT process is core to ICPM. CFT includes the child or youth, their family, and professionals. When a child enters foster care, a child welfare social worker uses a variety of strategies to engage the child or youth and their families and other team members. The CFT develops and follows a service plan.
  - The Child and Family Plan is tailored to each child, youth, and family based on their specific needs and goals and should:
    - Identify specific, incremental steps that move the child, youth, and family toward their specific goals and away from involvement with child welfare or probation agencies; and
    - Define the roles and responsibilities of each team.
  - California Wraparound must also include, family support, peer advocacy and leadership, mentoring and coaching, community resource development, service evaluation, and cross–system collaboration.
  - Some Wraparound services can be billed to SMHS, including but not limited to Therapeutic Behavioral Services (TBS), Therapeutic Foster Care (TFC, sometimes called Treatment Foster Care), Intensive Home Based Services (IHBS), ICC, case management, and rehabilitative services.
- County child welfare, probation, and behavioral health agencies, in consultation with their county’s Interagency Leadership Team, are required to provide California Wraparound for children and youth in foster care exiting from a short-term residential therapeutic program (STRTP) to a family-based, setting by October 1, 2023, per WIC 4096.6. But California Wraparound is otherwise a voluntary program for counties to opt-in. Refer to **Appendix H** for an overview of counties participating in the California Wraparound Program.

## 6.) Programs Serving Pregnant & Postpartum Individuals

Adult and youth MCP Members participating in Comprehensive Perinatal Services Program (CPSP), Black Infant Health (BIH) Program, California Perinatal Equity Initiative (PEI), American Indian Maternal Support Services (AIMSS), CDPH’s California Home Visiting Program (CHVP), and/or CDSS’ CalWORKs Home Visiting Program (HVP) who meet the eligibility criteria of any ECM Population of Focus are eligible to receive ECM. MCPs are expected to work with the local administrators of each program to ensure Members do not receive duplicative ECM services. Providers serving these programs that meet the ECM Provider requirements detailed in Section VII. ECM Provider Network are encouraged to enroll as ECM Providers.

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<sup>59</sup> The High Fidelity Wraparound Standards are currently being updated with CDSS, DHCS, the University of California, Davis, and stakeholders. See the [draft version of the new California Wraparound Standards for more information](#). CDSS and DHCS intend to issue a joint letter when the new California Wraparound standards are finalized.

### **Comprehensive Perinatal Services Program (CPSP) *(Updated December 2022):***

[CPSP](#) serves low-income pregnant and postpartum individuals statewide that are enrolled in Medi-Cal from the start of pregnancy to 60 days postpartum. CPSP provides obstetric services, health education, nutrition services, case coordination including strengths-based assessments, individualized care planning (reassessed each trimester), and postpartum assessment. CPSP is provided to FFS enrollees, with Medi-Cal MCPs required to provide comparable CPSP services to Members. CPSP is administered by CDPH.

### **Black Infant Health (BIH) Program *(Updated December 2022):***

[BIH Program](#) serves Black pregnant and postpartum (up to 6 months) living in select California counties and cities, regardless of income, starting at age 16. BIH provides prenatal and postpartum group sessions, case management (for those who cannot attend group sessions), skills-based interventions (e.g., stress management, empowerment, healthy behaviors), and individual client-centered life planning. BIH is administered by county agencies, with funding and oversight provided by CDPH.

### **California Perinatal Equity Initiative (PEI) *(Updated December 2022):***

[California PEI](#) serves pregnant and parenting Black individuals and their partners, up to the child's first birthday. PEI complements the BIH program for whole family care with home visitation programs, group interventions, and fatherhood and partnership initiatives. California PEI is administered by county agencies, with funding and oversight provided by CDPH.

### **American Indian Maternal Support Services (AIMSS) *(Updated December 2022):***

[AIMSS](#) provides perinatal case management and home visitation services to American Indian pregnant and postpartum individuals through the infant's first year of life. The program assists program participants with receiving health care, education, emotional support, referrals to services (social and health), and follow-up visits. AIMSS is administered by the Primary, Rural, and Indian Health Department (PRIHD).

### **CDPH California Home Visiting Program (CHVP) *(Updated December 2022):***

[CHVP](#) serves pregnant and newly parenting families with at least one risk factor, including domestic violence, inadequate income, unstable housing, less than 12 years of education, SUD concerns, and/or mental health related issues. CHVP services are provided by a Public Health Nurse or paraprofessional in the family's house. This is a voluntary program with services beginning prenatally or right after labor and delivery until about age three, with the number of visits based on the family's need. CHVP services include, but are not limited to, teaching parenting skills, providing information and guidance on newborns and infants, providing referrals to community resources, and screening children for developmental delays and facilitating interventions. As of December 2022, there are three evidence-based home visiting models approved by CHVP, with participating counties adopting different models to fit their communities: [Healthy Families America \(HFA\)](#), [Nurse-Family Partnership \(NFP\)](#), and [Parents as Teachers](#)

(PAT). CHVP is administered by CDPH with funding provided through the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program.

**CDSS CalWORKs Home Visiting Program (HVP) *(Updated December 2022)*:**

HVP is the California Work Opportunity and Responsibility to Kids (CalWORKs) voluntary home visiting program that serves individuals who are pregnant or parenting a child less than 24 months of age *and* are members of a CalWORKs assistance unit; parent or caretaker relative for a child-only case; pregnant individual who as applied for CalWORKs aid within 60 calendar days prior to reaching the second trimester of pregnancy and would be eligible for CalWORKs aid other than not having reached the second trimester of pregnancy; *or* an individual who is apparently eligible for CalWORKs aid. HVP services include, but are not limited to, prenatal, infant, and toddler care; infant and child nutrition; child developmental screening and assessments; parent education and child interaction; child development and care; job readiness and barrier removal; and treatment and supports for domestic violence and behavioral health concerns. CDSS permits counties to operate HVP models that meet the U.S. HHS' [evidence-based home visiting model requirements](#). HVP is supervised by CDSS and administered by participating California counties.

## VII. ECM Provider Network

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### **Overview of ECM Providers (Updated December 2022)**

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

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

- Counties;
- County behavioral health Providers;
- PCPs or Specialist or Physician groups;
- FQHCs;
- Community Health Centers (CHCs);
- CBOs;
- Hospitals or hospital-based Physician groups or clinics (including public hospitals and district and/or municipal public hospitals);
- Rural Health Clinics (RHCs);
- Indian Health Service Programs;
- Local health departments;
- Behavioral health entities;
- Community mental health centers;
- SUD treatment Providers;
- CBAS Providers;
- SNFs;
- Organizations serving individuals experiencing homelessness;
- Organizations serving justice-involved individuals;
- CCS Providers;
- Regional Centers;
- First 5 County Commissions;
- School-Based Health Centers; and
- Other qualified Providers or entities that are not listed above, as approved by DHCS.

### **Requirements to Be an ECM Provider**

#### *ECM and Community Supports Providers as Medi-Cal Enrolled Providers*

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



### *Process for Medi-Cal Enrollment*

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

### *Clarifying Relationship with Provider “Credentialing” Requirements of APL 19-004*

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

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

- Ability to receive referrals from MCPs for ECM or the authorized Community Supports;
- Sufficient experience to provide services similar to ECM for Populations of Focus and/or the specific Community Supports for which they are contracted to provide;
- Ability to submit claims or invoices for ECM or Community Supports using standardized protocols;
- Business licensing that meets industry standards;
- Capability to comply with all reporting and oversight requirements;
- History of fraud, waste and/or abuse;
- Recent history of criminal activity that endangers Members and/or their families;<sup>60</sup> and
- History of liability claims against the Provider.

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

### **ECM Provider Capacity**

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

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<sup>60</sup> Note that ECM Providers serving the Individuals Transitioning from Incarceration Population of Focus may have lived experience with the justice system.

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

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

### **MCP Serving as ECM Provider**

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

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

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

### ***Experience Serving the ECM Populations of Focus***

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

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

#### *Culturally Appropriate and Timely Care*

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

#### *Formal Agreements with Other Entities*

ECM Providers should also have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists and other entities, including Community Supports Providers, to coordinate care as appropriate to each Member. MCPs have the discretion to determine which agreements are necessary or acceptable to meet this requirement, acknowledging that provider organizations will vary greatly in their capacity to share data outside their four walls.

#### *Care Management Documentation System*

ECM Providers must use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service and administrative data and information from other entities to support the management and maintenance of a Member care plan that can be shared with other Providers and organizations involved in each Member’s care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication; and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital or long-term care facility, housing status).

#### **Transitioning HHP Model II and Model III**

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

#### **ECM Provider Payment**

MCPs must pay contracted ECM Providers for the provision of ECM in accordance with contracts established between MCPs and each ECM Provider. MCPs must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member. MCPs are encouraged to tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.

## **ECM Provider Directory**

1. Effective no later than July 1, 2023:
2. MCPs are to list all ECM and Community Support Providers in the Provider Directory as Other Services Providers.
  - a. MCPs should specify if a Provider is an ECM, Community Supports Provider, or both.
  - b. DHCS recognizes some MCPs already have a section for Other Services Providers.
  - c. DHCS recognizes some MCPs may have to **create a new** “Other Services Providers” section.
3. MCPs will need to add a disclaimer in the Directory stating that both ECM and Community Supports require prior authorization and are limited to Members who meet specific eligibility criteria.
4. MCPs may use symbols denoting ECM or Community Supports Providers that may be listed in other sections of the Directory in lieu of listing Providers multiple times.

## VIII. Engaging Members in ECM

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### **Identifying Members for ECM *(Updated December 2022)***

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

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

- Enrollment data;
- Encounter data;
- Utilization/claims data;
- Pharmacy data;
- Laboratory results data;
- Assessment data;
- Clinical information on physical and/or behavioral health;
- ADT feed data;
- Local Health Information Exchange data;
- Health Information Form (HIF)/Member Evaluation Tool (MET) data;
- Utilization data from PCPs, including but not limited to results of the Individual Health Appointment, services, and screenings recommendation by the U.S. Preventive Services Task Force and American Academy of Pediatrics/Bright Futures;
- Health Risk Stratification and Assessment survey for Seniors and Persons with Disabilities (SPD);
- Behavioral Health/SUD data, as available;
- Regional Center data;
- Child Welfare data (including foster care, Adoption Assistance Program, and Family Maintenance);
- School-based health centers data and school absences data, as available;
- School district McKinney-Vento Program eligibility screenings to identify students experiencing homelessness;
- Risk stratification information for children in County Organized Health System (COHS) counties with CCS WCM programs;
- Information about SDOH, including standardized assessment tools and/or ICD-10 (International Classification of Diseases) codes;
- Results from any available ACEs screening; and
- Other cross-sector data and information, including housing, social services, criminal justice history and other information relevant to the ECM Populations of Focus (e.g., HMIS, available data from the education system).

Using data listed above, risk stratification and segmentation models performed by the plan will also be used to identify ECM Members. MCPs will need to rely on a combination of information provided by DHCS on a regular basis and data internal to the plan. DHCS provides encounter data including physical and behavioral health utilization, to MCPs monthly in a standard file format.

For example, to identify Members with a pattern of avoidable hospital or ED utilization, MCPs could rely on the frequency of utilization reflected in the data feeds from DHCS. Whenever feasible, MCPs should also consider any data or relevant characteristics provided as part of data exchanged between the MCP and Provider organizations.

Another important avenue for Member identification is through referrals. MCPs are contractually obligated to inform Members and their families, guardians and caregivers, ECM Providers, Community Supports Providers, other Providers, and CBOs, about ECM, the ECM Populations of Focus, and how to request ECM. MCPs must consider requests for ECM from Members and on behalf of Members from all of the entities described above. It is expected that MCPs will establish strong referral relationships with ECM Providers and other CBOs, including developing a process for receiving and responding to referral requests from ECM Providers and other entities. For example, shelters, homeless services Providers, recuperative care Providers and other service Providers will be better positioned to identify individuals and families experiencing homelessness. Similarly, county behavioral health plans will be well-positioned to refer Adults with serious mental health and/or SUD needs who may benefit from ECM. MCPs should be actively monitoring sources of referrals for ECM, levels of Member engagement/acceptance of ECM based off of referral type, and improving overall referral and engagement patterns to improve ECM utilization among eligible Members.

### **MCP Member Handbook and Public-Facing Webpages**

The MCP Evidence of Coverage Member Handbook and public-facing webpage(s) must include up to date Member and provider facing information about ECM and how to request an assessment for ECM.

### **Authorizing ECM for MCP Members**

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

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

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

- To inform Members that ECM has been authorized, Contractor must follow its standard notice process outlined in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and [APL 21-011](#).

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

### **Prime & Subcontractor Authorization Alignment *(Updated December 2022)***

Prime MCPs and their subcontractors must align all standards and Policies and Procedures related to authorizations for ECM and Community Supports, including both the adjudication standards and the documentation used for referrals and authorizations.

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

Full Continuity of Care requirements (see [APL 18-008](#)) do not apply to the ECM benefit.

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

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

The new MCP must not implement any other steps to authorize ECM for newly enrolled Members who were receiving ECM in their previous MCP (including obtaining consent to ECM services) if any of the listed conditions for automatic authorization apply. Rather, the new MCP must assign the Member to an ECM Provider for outreach and continuation of ECM, in

accordance with its DHCS- approved ECM Policies and Procedures. To promote smooth transitions, the new MCP must assign the Member to the same ECM Provider, to the extent its network aligns, unless the Member desires to change their ECM Provider. The new MCP is encouraged to contract with the member's ECM Provider when its network does not align with the member's previous MCP. The new MCP must work with the previous MCP, ECM Provider and/or Member to obtain access to the Member's Care Management Plan and transmit to the new ECM Provider (as applicable) to mitigate any gaps in care. The new MCP should apply its usual Policies and Procedures for reassessment against discontinuation criteria to determine if and when the Member may be stepped down from ECM.

Note: DHCS reserves the right to establish different Continuity of Care requirements for upcoming MCP transitions resulting from county plan model changes or MCP market entry and exits.

### **Assignment to an ECM Provider**

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

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

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

#### ***Member Pre-Existing Care Management Program (Updated December 2022)***

*(applies to Members enrolled in a pre-existing care management program(s) at the time of ECM enrollment)*

MCPs should contract with existing programs that provide care management services to ECM Populations of Focus and could serve as ECM Providers.

- If the Member is enrolled in an existing care management program (such as CCS, SMHS ICC, etc.) that the MCP has contracted with to be an ECM Provider, then the MCP **must** assign the Member to that existing care management program as the ECM Provider **unless** the Member (and/or parent, guardian, caretaker) indicates otherwise.
- If there are multiple existing care management programs that have been contracted with by the MCP to be ECM Providers (e.g., the Member is in both CCS and ICC, and both programs are contracted ECM Providers), then the MCP **must** assign the Member to the existing care management program the Member (and/or parent, guardian, caretaker) identifies as their **preferred** ECM Provider.



- The assigned ECM Provider is responsible for coordinating with the Member's other care managers and the MCP to ensure non–duplication of services
- If the Member’s existing care management program chooses not to serve as the ECM Provider, then the MCP:
  - Must assign the Member to an ECM Provider **AND**
  - Must ensure the Member receives ECM services **AND** does not receive duplicative care management services or be subject to processes that duplicate what the existing model is already doing (e.g., screening and assessment) **AND**
  - Must regularly check available data feeds and establish processes and requirements to identify and eliminate any duplication of services.

#### *Member Preference*

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

#### *Member (PCP)*

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

#### *Member Behavioral Health Provider*

If a Member receives services from an MHP or DMC/DMC-ODS for SUD and/or serious mental health needs, and the Member’s behavioral health Provider is a contracted ECM Provider, the MCP must assign that Member to that behavioral health Provider as the ECM Provider, unless the Member has expressed a different preference or the MCP identifies a more appropriate ECM Provider given the Member’s individual needs and health conditions.

### **Initiating Delivery of ECM**

#### *Member Consent*

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

#### *Written Authorization for ECM-related Data Sharing<sup>61</sup>*

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<sup>61</sup> Written authorization for ECM-related data sharing may be obtained from any Member’s personal representative as defined in the [Health Insurance Portability and Accountability Act \(HIPAA\) Privacy Rule 45 CFR § 164.502\(g\)](#). Under the Rule, a “personal representative” is any person authorized (under State

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

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

#### *Dedicated Lead Care Manager*

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

#### *Member-level Records*

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

### **Discontinuing Delivery of ECM**

#### *Circumstances for Discontinuing ECM*

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

- The Member has met all care plan goals;
- The Member is ready to transition to a lower level of care;
- The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage (this can include instances when a Member's behavior or environment is unsafe for the ECM Provider); or
- The ECM Provider has not been able to connect with the Member and/or parent, caregiver, guardian after multiple attempts.

#### *Reassessment & Transitioning Members from ECM (Updated May 2022)*

As mentioned in Section V. Core Service Components of ECM, there is not a required annual reassessment for Members receiving ECM. Instead, MCPs must ensure that Members are reassessed at a frequency appropriate for their individual progress or changes in needs and/or as identified in the Care Management Plan. Further, MCPs should reassess Members against their

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or other applicable law, e.g., tribal or military law) to act on behalf of the individual in making health care related decisions. Refer to [HHS](#) for more information.

ECM discontinuation criteria, **not** the ECM Population of Focus eligibility criteria, to evaluate whether Members are ready to transition out of ECM. MCPs must develop processes for transitioning Members from ECM to lower levels of care management to provide coordination of ongoing needs.

#### *NOA Process*

MCPs are required to develop processes to determine discontinuation of ECM and notify ECM Providers to initiate discontinuation of services in accordance with the NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals, and [APL 21-011](#).

MCPs must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to appeal and the appeals process by way of the NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals, and [APL 21-011](#).

## IX. Data System Requirements & Data Sharing to Support ECM

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

### **Data System Requirements**

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

- Consume and use claims and encounter data, as well as other data types listed in ECM Contract Template Section 7: Identifying Members for ECM, to identify Populations of Focus;
- Ingest, and utilize ADT feed data (*effective January 1, 2023*);
- Assign Members to ECM Providers;
- Keep records of Members receiving ECM and authorizations necessary for sharing Personally Identifiable Information between Contractor and ECM and other Providers, among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by Contractor;
- Securely share data with ECM Providers and other Providers in support of ECM;
- Receive, process and send encounters and invoices from ECM Providers to DHCS in accordance with DHCS standards;
- Receive and process supplemental reports from ECM Providers;
- Send ECM supplemental reports to DHCS; and
- Open, track and manage referrals to Community Supports Providers.

### **Data Sharing Requirements for MCPs**

In order to support ECM, MCPs must provide, at a minimum, the following information to all ECM Providers:

- Member assignment files, which include a listing of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
- Historical encounters/claims data for assigned Members;
- ADT feed data within 24 hours of admission, transfer, or discharge (if an ADT feed is available), unless the MCP has verified the ECM Provider has ADT feed data already accessible through another source (*effective January 1, 2023*);
- Physical, behavioral and administrative information, and information indicating Member SDOH needs, as specified on previously submitted claims encounters or identified through other data sources (e.g., HMIS) for assigned Members; and
- Reports of performance on quality measures and/or metrics, as requested.

MCPs are required to use defined federal and state standards, specifications, code sets and terminologies when sharing physical, behavioral, social and administrative data with ECM Providers and with DHCS. See the [Member Level Information Sharing Between MCPs and ECM Providers](#) guidance document for a comprehensive overview of the standards for data exchange between MCPs and ECM Providers. See **Appendix I** for more information about the guidance documents referenced in this section.

### **Data Sharing Requirements for ECM Providers**

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

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

## X. Oversight of ECM Providers

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### **MCP Requirements**

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

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

### *NCQA Accreditation Requirements*

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

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

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

1. A MCP may, or may not, choose to integrate the CCM program with ECM by delegating CCM functions to community-based ECM Providers. The MCP may decide to retain the CCM functions as MCP-operated functions, and keep the ECM functions separate and distinct.
2. If the MCP decides to retain the CCM functions, rather than delegating them to community-based ECM Providers, then CCM would not be considered to be delegated, and no CCM pre-delegation review activities would be required for community-based ECM Providers.
3. However, if the MCP decides to delegate CCM functions to ECM Providers, then these ECM Providers would be subject to CCM pre-delegation review requirements.
4. If the MCP delegates CCM, then the pre-delegation review would be the responsibility of the MCP. States may take on this responsibility in other parts of the country, but California will not do this.

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

### *Training*

As previously stated, MCPs must notify all Providers in their network about ECM and Community Supports to enable appropriate referrals of their Members. MCPs must also provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars and/or calls, as necessary, in addition to Network Provider training requirements described in Medi-Cal Boilerplate Template, Exhibit A, Attachment 7, Provision 5, Network Provider Training.<sup>62</sup> MCPs should use their key performance indicators tracking referral patterns to inform what additional trainings may be necessary.

### **Subcontracting Agreements**

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

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

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

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

MCPs will ensure their Subcontractor agreements for ECM and Community Supports services include the requirements set forth in the ECM and Community Supports Contract Template, and the ECM Provider Standard Terms and Conditions, as applicable to Subcontractor. MCPs are

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<sup>62</sup> See [Medi-Cal MCP Boilerplate Contracts Template](#).

encouraged to collaborate with their Subcontractors on the approach to ECM to minimize variance in how ECM will be implemented and to ensure a streamlined, seamless experience for ECM Providers and Members.



## XI. DHCS Oversight of ECM

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### **Model of Care (MOC) and Approval Process *(Updated December 2022)***

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

DHCS uses each MCP's MOC submission to determine its readiness to meet ECM requirements ahead of new ECM Populations of Focus being implemented. MCPs must also submit to DHCS any significant changes to their MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable DHCS APLs. Significant changes may include, but are not limited to, changes to the MCP's approach to administer or deliver ECM services, approved policies and procedures, and Subcontractor Agreements boilerplates.

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

### **Use of Data to Monitor ECM**

DHCS is taking a data driven approach to its oversight of ECM.

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

### **Quarterly Implementation Reporting Requirements**

DHCS is monitoring MCPs' implementation of and compliance with ECM requirements across multiple domains, including Membership, Service Provision, Grievances and Appeals, Provider Capacity, and Quality. DHCS will monitor the impact of ECM through a combination of data sources, including Member-level data reported by MCPs and as demographic data currently available to DHCS. The data supplied by MCPs will serve as a mechanism for DHCS to monitor

the initial rollout of ECM and some of the monitoring data will be used for the implementation of MCP Performance Incentives, as described further below. See the [Quarterly Implementation Monitoring Report](#) (defined in **Appendix I**) for a comprehensive description of these reporting requirements.

### **Requirements to Track Outreach**

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

### **ECM Provider Reporting in 274**

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

## XII. Appendices

### Appendix A: ECM Implementation Dates by County

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

## Appendix B: Access Criteria for SMHS, DMC-ODS, and DMC

- **SMHS Access Criteria:** [BHIN 21-073](#) updates and clarifies the criteria for access to SMHS, both for adults and beneficiaries under age 21.
  - For beneficiaries 21 years of age or older, a county MHP shall provide covered SMHS for beneficiaries who meet **BOTH of the following criteria**:
    - The beneficiary has one or both of the following:
      - Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities; and/or
      - A reasonable probability of significant deterioration in an important area of life functioning; AND
    - The beneficiary's condition as described is due to either of the following:
      - A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems; or
      - A suspected mental disorder that has not yet been diagnosed.
  - For enrolled beneficiaries under 21 years of age, a county MHP shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to enrolled beneficiaries who meet **either of the following criteria**, (1) or (2) below:
    - (1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness; OR
    - (2) The beneficiary meets **both of the following requirements** in a) and b), below:
      - a) The beneficiary has **at least one** of the following:
        - A significant impairment
        - A reasonable probability of significant deterioration in an important area of life functioning A reasonable probability of not progressing developmentally as appropriate.
        - A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a MCP is required to provide; AND
      - b) The beneficiary's condition as described in subparagraph (2) above is due to **one of the following**:
        - A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
        - A suspected mental health disorder that has not yet been diagnosed.
        - Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

- **DMC-ODS Access Criteria:** [BHIN 21-019](#) clarifies the policy related to access to treatment during the initial assessment period, medical necessity determination, and level of care placement for DMC-ODS. Within non-residential treatment settings, which includes mobile crisis services, DMC-ODS services are reimbursable for up to 30 days following a visit with a Licensed Professional of the Healing Arts (LPHA) or registered/certified counselor, whether or not a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days if the beneficiary is under 21 if a Provider documents that the beneficiary is experiencing homelessness and therefore requires additional time to complete the assessment. If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis, the time period starts over.
  - To qualify for DMC-ODS services after the initial assessment, beneficiaries 21 years of age or older must meet one of the following criteria:
    - Have at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non Substance-Related Disorders; OR
    - Have had at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders, prior to being incarcerated or during incarceration, as determined by substance use history.
  - Beneficiaries under age 21 are entitled to receive all medically necessary DMC-ODS services as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.
- **DMC Services Medical Necessity Criteria:** Providers must ensure that Members meet and document the medical necessity criteria for DMC services, further details can be found in [California Code of Regulations, Title 22, § 51341.1](#)

## Appendix C: Definitions for the Purposes of the Justice-Involved Population of Focus

Criteria	Definition
<b>Mental Illness</b>	<p>A person with a “Mental Illness” is a person who is currently receiving mental health services or medications <b>OR</b> meets both of the following criteria:</p> <ol style="list-style-type: none"> <li>i. The beneficiary has one or both of the following:               <ol style="list-style-type: none"> <li>1. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities. <b>AND/OR</b></li> <li>2. A reasonable probability of significant deterioration in an important area of life functioning; <b>AND</b></li> </ol> </li> <li>ii. The beneficiary’s condition as described in paragraph (i) is due to either of the following:               <ol style="list-style-type: none"> <li>1. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems; <b>OR</b></li> <li>2. A suspected mental disorder that has not yet been diagnosed.</li> </ol> </li> </ol>
<b>Substance Use Disorder (SUD)</b>	<p>A person with a “Substance Use Disorder” shall either:</p> <ol style="list-style-type: none"> <li>i. Meet SUD criteria, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems; <b>OR</b></li> <li>ii. Have a suspected SUD diagnosis that is currently being assessed through either NIDA-modified ASSIST or ASAM criteria.</li> </ol>
<b>Chronic Condition / Significant Clinical Condition</b>	<p>A person with a “Chronic Condition” or a “Significant Clinical Condition” shall have ongoing and frequent medical needs that can include one of the following diagnoses:</p> <ul style="list-style-type: none"> <li>▪ Active cancer, receiving treatment or treatment indicated</li> <li>▪ Active COVID-19 or Long COVID-19, receiving treatment or treatment indicated</li> <li>▪ Active hepatitis A, B, C, D, or E</li> <li>▪ Active respiratory conditions, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema, and severe bronchitis, receiving treatment or treatment indicated</li> <li>▪ Advanced liver disease</li> <li>▪ Advanced renal (kidney) disease</li> <li>▪ Dementia, including but not limited to Alzheimer’s disease</li> <li>▪ Arthritis that impacts the function of ADLs</li> <li>▪ Autoimmune disease, including rheumatoid arthritis, Lupus, inflammatory bowel disease, and multiple sclerosis</li> </ul>

Criteria	Definition
	<ul style="list-style-type: none"> <li>▪ Chronic musculoskeletal disorders that impact functionality of ADLs, receiving treatment or treatment indicated, including but not limited to osteoarthritis, muscular dystrophy.</li> <li>▪ Chronic neurological disorder, receiving treatment or treatment indicated</li> <li>▪ Congestive heart failure</li> <li>▪ Connective tissue disease, receiving treatment or treatment indicated</li> <li>▪ Coronary artery disease</li> <li>▪ Currently prescribed opiates or benzodiazepines</li> <li>▪ Currently undergoing a course of treatment for any other diagnosis that will require medication management of three or more medications or one complex medication therapy after reentry</li> <li>▪ Cystic fibrosis and other metabolic development disorders</li> <li>▪ Epilepsy or seizures, receiving treatment or treatment indicated</li> <li>▪ Foot, hand, arm, or leg amputee</li> <li>▪ Glaucoma</li> <li>▪ Hip/Pelvic fracture</li> <li>▪ HIV/AIDS</li> <li>▪ Hyperlipidemia, receiving treatment or treatment indicated</li> <li>▪ Hypertension, receiving treatment or treatment indicated</li> <li>▪ Incontinence, receiving treatment or treatment indicated</li> <li>▪ Moderate to severe atrial fibrillation/arrhythmia, receiving treatment or treatment indicated</li> <li>▪ Moderate to severe mobility or neurosensory impairment (including but not limited to spinal cord injury, multiple sclerosis, transverse myelitis, spinal canal stenosis, peripheral neuropathy)</li> <li>▪ Obesity, receiving treatment or treatment indicated</li> <li>▪ Peripheral vascular disease</li> <li>▪ Pressure injury or other chronic ulcers (vascular, neuropathic, moisture-related)</li> <li>▪ Previous stroke or transient ischemic attack (TIA)</li> <li>▪ Receiving gender affirming care</li> <li>▪ Severe chronic pain, receiving treatment or treatment indicated</li> <li>▪ Severe migraine or chronic headache, receiving treatment or treatment indicated</li> <li>▪ Severe viral, bacterial, or fungal infections, receiving treatment or treatment indicated</li> <li>▪ Sickle cell disease or other hematological disorders requiring treatment</li> <li>▪ Significant hearing or visual impairment</li> <li>▪ Spina Bifida or other congenital anomalies of the nervous system</li> <li>▪ Tuberculosis, receiving treatment or treatment indicated</li> <li>▪ Type 1 or 2 diabetes, receiving treatment</li> </ul>
<b>Intellectual or Developmental</b>	A person with an “Intellectual or Developmental Disability” shall have a disability that begins before the individual reaches age 18 and that is

Criteria	Definition
<b>Disability (I/DD)</b>	expected to continue indefinitely and present a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, autism, Down syndrome, and other disabling conditions as defined in <a href="#">Section 4512 of the California WIC</a> .
<b>Traumatic Brain Injury (TBI)</b>	A person with a “Traumatic Brain Injury”, or other condition, where the condition has caused significant cognitive, behavioral, and/or functional impairment.
<b>HIV/AIDS</b>	A person with “HIV/AIDS” shall have tested positive for either human immunodeficiency virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) at any point in their life.
<b>Pregnant or Postpartum</b>	A person who is “Pregnant or Postpartum” shall be either currently pregnant or within 12 months postpartum.



## Appendix D: Existing Aid Codes and Eligibility Groups for Children and Youth Involved in Child Welfare Population of Focus

- Foster Care Enrollment in California Aid Codes:<sup>63</sup>
  - Approved Relative Caregiver (youth in this category are eligible for former foster care youth eligibility group (see below) if they exit foster care at age 18 or older):
    - 2P – Approved Relative Caregiver (ARC) Only
    - 2R – ARC Only for Non-minor Dependents (NMD)
    - 2S – ARC Funding Option and Federal California Work Opportunity and Responsibility to Kids (CalWORKS)
    - 2T – ARC Funding Option and State CalWORKS
    - 2U – ARC and State CalWORKS for NMD
  - Foster Care (other than youth in aid codes 4E and 4M, youth in this category are eligible for former foster care youth eligibility group (see below) if they exit foster care at age 18 or older):
    - 4E – Foster Care Hospital Presumptive Eligibility (PE) (Age 18 to 26 Years)
    - 4H - Foster Care Child in CalWORKs
    - 4K – Emergency Assistance (EA) Foster Care
    - 4L – Foster Care Child in 1931(b)
    - 4M – Former Foster Youth Program (FFY) (see below)
    - 4N – CalWORKs NMD State Cash/FFP Medi-Cal
    - 40 – Aid to Families with Dependent Children (AFDC) Foster Care (FC) – Non-Federal
    - 42 – AFDC - FC – Federal
    - 43 – AFDC FC NMD State Cash/FFP Medi-Cal
    - 45 – Foster Care
    - 46 – Foster Care – Out of State (OOS) – CA Medi-Cal
    - 49 – AFDC-FC NMD Title IV-E Federal/FFP Medi-Cal
    - 5K – EA Foster Care – Child Welfare Services (CWS) – State Only
    - 5L – EA Foster Care-Non Fed; EA Program
- Former Foster Care Youth Eligibility Group (youth in this category are eligible if they exist foster care at age 18 or older, regardless of the state they were in foster care, up to age 26 and regardless of income):
  - 4M – Former Foster Youth Program (FFY)
- Adoption Assistance Program Aid Codes:<sup>64</sup>
  - 03 – Adoption Assistance Program (AAP) – Federal
  - 04 – AAP/Aid for the Adoption of Children (AAC)
  - 06 – AAP/Out of State (OOS) – CA Medi-Cal
  - 07 – AAP NMD Title IV-E/Federal Financial Participation (FFP) Medi-Cal
  - 4A – OOS of State AAP Children

There are no aid nor eligibility codes to track Family Maintenance eligibility or enrollment.

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<sup>63</sup> A child's involvement in foster care would only be identified by these aid codes if they were currently enrolled in foster care. These aid codes do not track former foster care enrollment in California or another state.

<sup>64</sup> A child's involvement in Adoption Assistance Program would only be identified by these aid codes if they currently were enrolled in the Program. These aid codes do not track eligibility for the Program.

**Appendix E: LGAs Participating in the County-specified TCM (as of April 2022)<sup>65</sup>**

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

<sup>65</sup> [LGAs Participating in the TCM Program.](#)

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

<b>LGAs</b>	<b>Children Under the Age of 21</b>	<b>Medically Fragile Individuals</b>	<b>Individuals at Risk of Institutionalization</b>	<b>Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes</b>	<b>Individuals with a Communicable Disease</b>	<b>LGAs not Participating in TCM</b>
<b>San Luis Obispo County</b>						X
<b>San Mateo County</b>	X	X		X		
<b>Santa Barbara County</b>						X
<b>Santa Clara County</b>	X	X	X	X	X	
<b>Santa Cruz County</b>	X	X		X		
<b>Shasta County</b>		X		X		
<b>Sierra County</b>						X
<b>Siskiyou County</b>						X
<b>Solano County</b>	X	X		X		
<b>Sonoma County</b>	X	X	X	X	X	
<b>Stanislaus County</b>	X	X	X	X	X	
<b>Sutter County</b>	X	X	X	X		
<b>Tehama County</b>						X
<b>Trinity County</b>				X		
<b>Tulare County</b>						X
<b>Tuolumne County</b>	X	X	X	X		
<b>Ventura County</b>	X	X	X	X	X	
<b>Yolo County</b>						X
<b>Yuba County</b>						X
<b>City of Berkeley</b>	X	X	X	X	X	
<b>City of Long Beach</b>	X	X	X	X	X	
<b>Total</b>	<b>23</b>	<b>21</b>	<b>14</b>	<b>29</b>	<b>13</b>	<b>33</b>

## Appendix F: DMC & DMC-ODS Counties (as of August 2022)<sup>66</sup>

DMC Counties	DMC-ODS Counties
Alpine Amador Butte Calaveras Colusa Del Norte Glenn Inyo Kings Lake Madera Mariposa Mono Plumas Sierra Sonoma Sutter Tehama Trinity Tuolumne Yuba	Alameda Contra Costa El Dorado Fresno Humboldt Imperial Kern Lassen Los Angeles Marin Mendocino Merced Modoc Monterey Napa Nevada Orange Placer Riverside Sacramento San Benito San Bernardino San Diego San Francisco San Joaquin San Luis Obispo San Mateo Santa Barbara Santa Clara Santa Cruz Shasta Siskiyou Solano Stanislaus Tulare Ventura Yolo

<sup>66</sup> [Counties Participating in DMC-ODS.](#)

## Appendix G: CCS & CCS WCM Counties (as of February 2022)<sup>67</sup>

CCS Counties		CCS WCM Counties
Alameda	Sutter	Del Norte
Alpine	Tehama	Humboldt
Amador	Tulare	Lake
Butte	Tuolumne	Lassen
Calaveras	Ventura	Marin
Colusa	Yuba	Mendocino
Contra Costa		Merced
El Dorado		Modoc
Fresno		Monterey
Glenn		Napa
Imperial		Orange
Inyo		San Luis Obispo
Kern		San Mateo
Kings		Santa Barbara
Los Angeles		Santa Cruz
Madera		Shasta
Mariposa		Siskiyou
Mono		Solano
Nevada		Sonoma
Plumas		Trinity
Placer		Yolo
Riverside		
Sacramento		
San Bernardino		
San Diego		
San Francisco		
San Joaquin		
San Mateo		
Santa Clara		
San Benito		
Sierra		

<sup>67</sup> [DHCS CCS WCM webpage.](#)

**Appendix H: California Wraparound & Non-Wraparound Counties (as of May 2022)<sup>68</sup>**

California Wraparound Counties		Non-Wraparound Counties
Alameda	Sonoma	Alpine
Butte	Stanislaus	Amador
Colusa	Sutter	Calaveras
Contra Costa	Tehama	El Dorado
Del Norte	Tulare	Glenn
Fresno	Ventura	Humboldt
Inyo	Yolo	Madera
Kern		Mariposa
Kings		Modoc
Imperial		Plumas
Lake		San Benito
Lassen		Sierra
Los Angeles		Siskiyou
Marin		Trinity
Mendocino		Tuolumne
Merced		Yuba
Mono		
Monterey		
Napa		
Nevada		
Orange		
Placer		
Riverside		
Sacramento		
San Bernardino		
San Diego		
San Francisco		
San Joaquin		
San Luis Obispo		
San Mateo		
Santa Barbara		
Santa Clara		
Santa Cruz		
Shasta		
Solano		

<sup>68</sup> [Wraparound County Coordinator List.](#)

## Appendix I: Data & Reporting Guidance Documents

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