Enhanced Care Management (ECM) Frequently Asked Questions

CenCal HEALTH
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Enhanced Care Management Services

What is Enhanced Care Management (ECM)?

Enhanced Care Management (ECM) is a new, statewide Medi-Cal benefit available to selected "Populations of Focus" as part of multi-year initiatives under California Advancing and Improving Medi-Cal (CalAIM).

ECM addresses the clinical and non-clinical needs of the highest-need Members through intensive whole person, community-based care coordination.

When will the ECM benefit start and which Populations of Focus will be served?

CenCal Health launched ECM on July 1, 2022 and has a phased implementation approach based on the Department of Health Care Services (DHCS) defined Populations of Focus or POFs.

Please reference the table below for information on the implementation of the various POFs. Implementation timelines are subject to change based on DHCS guidance.

Phase	Effective Date	Populations of Focus (POFs)
1	**7/1/2022 (Live)**	• Individuals & Families Experiencing Homelessness (POF 1) • Adults At Risk for Avoidable Hospital and Emergency Department (ED) Utilization (POF 2) • Adults with SMI/SUD Needs (POF 3) • Adults with Intellectual/Developmental Disability (I/DD) (POF 9) • Pregnant or Postpartum Adults (POF 10)
2	**1/1/2023 (Live)**	• Adults Living in the Community At Risk for Institutionalization (POF 5) • Adults who are Nursing Facility Residents Transitioning to the Community (POF 6)
3	**7/1/2023**	• Adults without Dependent Children/Youth Living with Them Experiencing Homelessness (POF 1) • Children & Youth Populations of Focus: ° Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness (POF 1) ° Children and Youth At Risk for Avoidable Hospital or ED Utilization (POF 2) ° Children and Youth with Serious Mental Health and/or SUD Needs (POF 3) ° Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition (POF 7) ° Children and Youth Involved in Child Welfare (POF 8) ° Children and Youth with Intellectual/Developmental Disability (I/DD) (POF 9) ° Pregnant or Postpartum Youth (POF 10)
4	**1/1/2024**	• Individuals Transitioning from Incarceration (POF 4) • Birth Equity - Adults and Youth (POF 10)

Are ECM Providers required to serve all eligible ECM target populations?

No. ECM Providers may serve one or more of the ECM target populations or a subset of target population(s) with which they have experience and expertise.

How will ECM Members be identified?

Member identification can happen in one of three (3) ways:

1. CenCal Health will use claims and/or other data available to identify Members presumed eligible for ECM.
2. Providers can identify and refer a Member as a potential ECM beneficiary.
3. The Member or the Member's representative can refer them(selves) to the program.

What are the Core Service Components required for ECM?

1. **Outreach and Engagement**
   ECM Providers are responsible for reaching out to and engaging with assigned Members in several ways, such as in-person, mail, telephone, community, or street outreach.

2. **Comprehensive Assessment and Care Management Plan**
   The Comprehensive Assessment will assess the clinical and non-clinical needs of a Member, and the Care Management Plan will be based on the Member's individual progress or changes in their needs.

3. **Enhanced Coordination of Care**
   Intensive, primarily in-person contact with the Member and their family member(s), guardian, authorized representative (AR), caregiver, and/or authorized support person.

4. **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.

5. **Comprehensive Transitional Care**
   Services intended to support ECM Members and their families and/or support networks during discharge from hospital and institutional settings.

6. **Member and Family Supports**
   Activities that ensure ECM Members and their family and/or supports are knowledgeable about the Member's conditions, with the overall goal of improving their adherence to treatment and medication management.

What are the Core Service Components required for ECM (cont.)?

7. **Coordination of and Referral to Community and Social Support Services**
   Determining and coordinating appropriate services to meet the needs of Members, including services that address social determinants of health (SDOH) needs such as housing and/or other offered services.

How does ECM Member assignment work?

CenCal Health eligible Members presumed eligible for ECM will be assigned to a contracted ECM Provider based on several factors that include the ECM Provider's ability to serve the Member's specific POF, the location of the Member, the Member's preference, and/or if the Member has an established relationship with the ECM Provider.

Will ECM Providers receive a list of their assigned CenCal Health Members who are presumed-eligible for ECM?

At least once a month, CenCal Health will provide each ECM Provider with a list of prospective ECM Members via the Member Information File for the ECM Provider to review and begin outreach. This Member Information File will be transmitted to the ECM Provider through a secure file transfer protocol (SFTP).

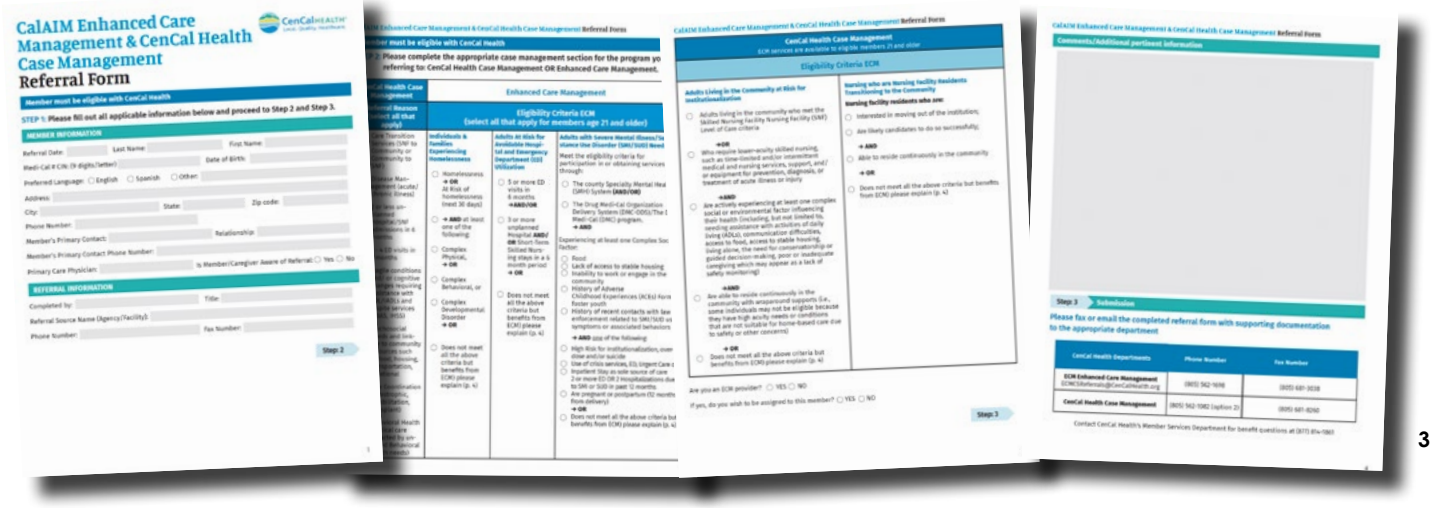
Are Medi-Cal Members with dual health coverage, such as Medicare or Other Health Care, eligible to receive ECM?

Yes. Members with Medi-Cal and Other Health Coverage such as Medicare who meet the ECM eligibility criteria are eligible to receive ECM.

What is the method by which ECM Providers should refer Members who are identified as presumed eligible for ECM?

ECM Providers can refer Members who may benefit from ECM through the ECM Member Referral File or the ECM referral form.

Please use the below link to access the ECM referral form.
www.cencalhealth.org/~/media/files/pdfs/providers/for-providers/calaim/calaim-enhanced-care-managementcencal-health-cm-referral-form-20221230.pdf?la=en


CalAIM Enhanced Care Management & CenCal Health Case Management
Referral Form

ECM Authorization Request

Will all ECM services require a Treatment Authorization Request (TAR)?

Yes. All ECM services require a pre-service authorization in the form of a TAR. Please see the table below for information on approval, timeframes, and renewal options for the respective ECM authorization types.

Authorization Type	Approval	Time frame	Renewal
Outreach Authorization	Auto-Approved	Six Weeks	Yes*
Services Authorization	Requires UM Review	Six Months	Yes*

** If additional time is needed to renew an existing TAR, please submit the request at least ten (10) days prior to the end of the prior approval period to avoid gaps in care or issues with billing.*

How does CenCal Health reassess the Member's ECM eligibility as part of the six (6) month reauthorization process?

CenCal Health will reassess the Member's eligibility against ECM discontinuation criteria to evaluate whether the Member is ready to transition out of ECM or would continue to benefit from ECM services.

Are ECM Providers required to use a specific Care Management Plan template?

CenCal Health has developed a Care Management Plan and Assessment form that ECM Providers are strongly encouraged, but not required, to utilize. The Care Management Plan should be based on the Member's goals, health status, needs, and preferences regarding physical health, mental health, disabilities, substance use, oral health, community-based long-term services and supports, supports to manage serious illness, trauma-informed care needs, and social services.

ECM Authorization Request

Are there specific assessments that need to be submitted in addition to the Care Management Plan and will periodically updated Care Management Plans and Assessments be required?

The completion of a Comprehensive Assessment is required for all Members enrolled in ECM. A copy of the Comprehensive Assessment must be submitted with the initial ECM TAR. The Care Management Plan must be submitted via fax promptly after initial completion, or no later than sixty (60) days, from the approved authorization. Reassessments (if applicable) and Care Management Plans are required for all reauthorization requests.

What is the role of the ECM Lead Care Manager and Community Supports?

The ECM Lead Care Manager is responsible for identifying Members' care needs, providing linkage to appropriate services (including Community Supports), and engaging in coordination with an appropriate CenCal Health-contracted Community Supports Provider. If the ECM Provider is also the respective Community Support Provider with which the Member is established, then the ECM and Community Supports services can be dually managed.

What is the ECM discontinuation criteria?

Members enrolled to receive ECM services may be discontinued in response to the Member's request for discontinuation or as a result of a determination by an ECM Provider and/or CenCal Health that discontinuation is appropriate in accordance with the ECM discontinuation criteria listed below:

- The Member has met all their Case Management (CM) 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);
- The ECM Provider has not been able to connect with the Member after multiple attempts; or
- The Member loses CenCal Health eligibility (Medi-Cal).

How does an ECM Provider request to discontinue a Member from ECM?

ECM Provider must:

- Submit Form E (along with any relevant documentation, as appropriate) to CenCal Health, identifying the reason for discontinuation. Form E can be found at the following link: CalAIM | CenCal Health Insurance Santa Barbara and San Luis Obispo Counties;
- Make efforts to notify the Member telephonically, in person or in writing, of the reason why the ECM services will be discontinued; and
- Continue to provide ECM services until CenCal Health has authorized the discontinuation.

ECM Authorization Request

How does an ECM Provider request to discontinue a Member from ECM? (cont.)

CenCal Health will:

- Review the discontinuation request and contact the ECM Provider if additional information is required; and
- If the discontinuation request is approved, send a Notice of Action (NOA) letter to the Member and the ECM Provider to inform them of the discontinuation of ECM services.

For those Members experiencing homelessness with complex medical and behavioral health needs, what are some evidence-based practices ECM and Community Supports Providers should use to engage and help the Member participate in and manage their care in particular?

CenCal Health encourages the use of the following evidence-based practices, including, but not limited to:

- **Motivational Interviewing:** a client-centered, yet directive style of case management interaction that helps clients explore and resolve their ambivalence and concerns about changing one or more lifestyle and risk behaviors.
- **Trauma Informed Care:** an approach, based on knowledge of the impact of trauma, aimed at ensuring environments and services are welcoming and engaging for service recipients and staff.
- **Harm Reduction:** an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services.
- **Housing First:** an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service participation requirements.

What would be considered a duplication of ECM services and why is this important?

DHCS examined existing programs that include elements of care management and/or care coordination to determine approaches to program coordination and the prevention of non-duplication with ECM services. In many of these instances, the ECM benefit will be additive, improving management of care across delivery systems; however, other programs would be considered "duplicate," where the Member would be given the choice between participating or receiving benefits from ECM or the other program. DHCS does not permit duplication of services, and ECM and Community Supports Providers share the responsibility of non-duplication with CenCal Health. Please see the following guide for reference on the next page.

1915 c Waivers	Services Carved Out of Managed Care Management Plan	Services Carved into Managed Care Management Plan	Duals	Other
1. EMC as a "wrap"	MCP Members can be enrolled in both EMC and the other programs. EMC enhances and/or coordinated across the case/care managment available in theother program. MCP must ensure non-duplication of services between EMC and the other programs			
2. Either EMC or the other program	MCP Members can be enrolled in EMC or in the other prgrams, not in both at the same time.			
3. Excluded from EMC	Excluded from EMC Medi-Cal beneficiaries enrolled in the other program are excluded from ECM			
Multipurpose Senior Services Program (MSSP)	**California Children's Services (CCS)**	**CCS Whole Child Model**	**Dual Eligibility Special Needs Plans (D-SNPs) [from 2023]**	**AIDS Healthcare Foundation Plans**
Assisted Living Waiver (ALW)	**Genetically Handicapped Person's Program (GHPP)**	**Basic Care Management**	**D-SNP look alike plans**	**California Community Transitions (CCT) Money Follows the Person (MFTP)**
Home and Community Based (HCBA) Waiver	**County-Based Targeted Case Management (TCM)**	**Complex Case Management**	**Other Medicare Advantage Plans**	**Mosaic Family Services**
HIV/AIDS Waiver	**Specialty Mental Health (SMHS) TCM**	**Community Based Adult Services**	**Medicare FFS**	**Hospice**
HSBCS Waiver for Individuals with Developmental Disabilities (DD)	**SMHS Intensive Care Coordination for Children (DMC-ODS)**		**Cal MediConnect**	
Self-Determination Program for Individuals with I/DD	**Drug Med-Cal Organized Delivery System (DMC-ODS)**		**Fully Integrated Dual Eligible Special Needs Plans (FIODE-SNPs)**	
			Program for All-Inclusive Care for the Elderly (PACE)	

ECM Provider Medi-Cal Enrollment and Credentialing

Do ECM Providers need to be Medi-Cal enrolled?

ECM Providers must be Medi-Cal enrolled if they have a pathway for enrollment. For more information about provider types supported by DHCS's Provider Application and Validation Enrollment (PAVE) portal and Medi-Cal enrollment, please visit the DHCS Provider Enrollment (PED) website: https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

Rendering Providers affiliated with Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHFs) and Community Clinics, and who are certified as Medicare providers, are exempt from the requirement to enroll as Medi-Cal Providers.

ECM Provider Medi-Cal Enrollment and Credentialing (cont.)

Who needs to be credentialed for ECM?

CenCal Health follows NCQA credentialing standards and credentials all licensed, certified, and registered providers, such as MDs, DOs, LCSWs, LMFTs, NPs, and PAs. CenCal Health does not credential RNs.

DHCS has not released details on who qualifies as "Clinical Providers." Absent a clear definition from DHCS, CenCal Health has interpreted "Clinical Provider" as someone who is a licensed Provider, someone who has a certification, or has equivalent training. An example of a Non-Clinical Provider would be a Community Health Worker (CHW). Any staff not licensed is required to have clinical oversight.

How will CenCal Health vet Providers who aren't credentialed?

Those Providers who are outside the scope of credentialing will go through a vetting process. The vetting process may include, but is not limited to, a review of the following items: background check, verification of business license, proof of insurance, and review of history of liability claims.

CenCal Health Credentialing Specialists will prioritize ECM Providers to expedite timely processing.

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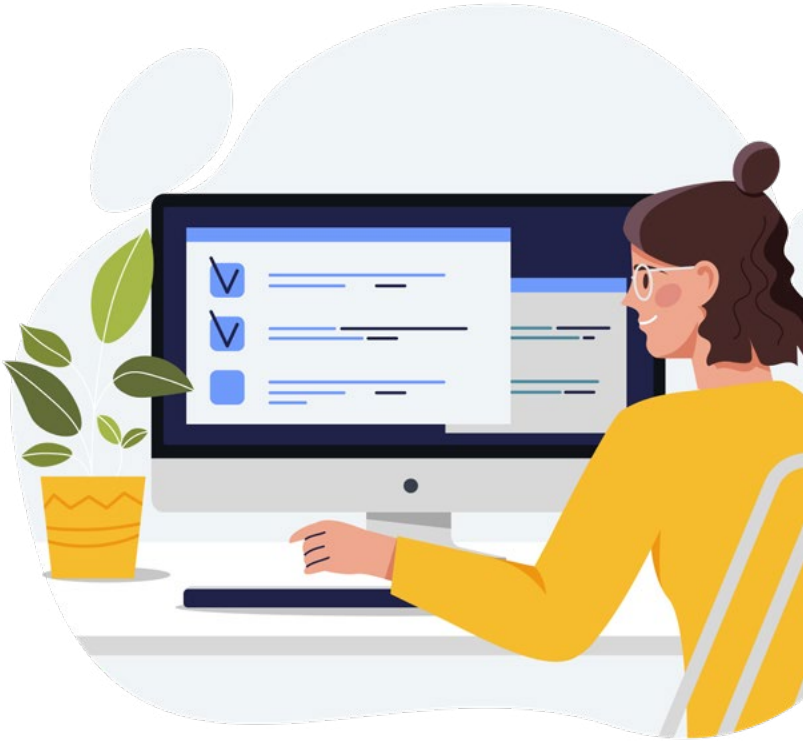

ECM Data Sharing and Reporting

Are there specific SDOH screenings that ECM providers must use?

Yes. DHCS issued a list of comprehensive SDOH codes to maximize the capture of actionable information. Please use the following link to view the SDOH codes which allow CenCal Health to better track our Members' needs and find solutions to help them thrive: https://www.cencalhealth.org/providers/social-determinants-of-health/

What are the requirements for ECM data sharing?

DHCS requires standardized reporting of information on Members receiving ECM services as follows:

File Name and Description	Required?	Responsibility	Frequency
ECM Member Information File To equip ECM Providers with data that reflects the total clinical and non-clinical picture for each Member. Please note that the data to be reported is limited to the data CenCal Health has access and availability to at the time of reporting.	**Yes**	CenCal Health to ECM Provider	**1st business day** of month; weekly for new Member assignments
ECM Provider Return Transmission File To standardize and streamline key information that CenCal Health will most commonly require about Members from ECM Providers beyond information contained in billing and invoicing.	**Yes**	ECM Provider to CenCal Health	**Monthly** Last business week of the month
ECM Provider Initial Outreach Tracker File To standardize provider outreach reporting of the total number of both successful and unsuccessful initial outreaches to Members occurring by ECM Providers.	**Yes**	ECM Provider to CenCal Health	**Monthly** Last business week of the month
ECM Member Information File To refer Members identified by ECM Providers for consideration for enrollment into ECM. ECM Providers are encouraged to identify Members who may belong to an ECM Population of Focus and thus may benefit from ECM.	**Yes**	ECM Provider to CenCal Health	**As Needed**

Please clarify telephonic outreach: will these be included for failed calls or calls less than 15 minutes?

Yes. ECM Providers are to count all outreach attempts, which includes failed calls or unsuccessful outreach. The ECM Provider may bill one (1) outreach/unit even if the outreach is less than 15 minutes.

How do we document unanswered outreach attempts for enrolled Members?

This will be documented in the monthly ECM Provider Return Transmission File under the applicable encounter counts, and the ECM Provider will bill CenCal Health for all the applicable outreach attempts.

ECM Data Sharing and Reporting (cont.)

Is there a time limit for completing outreach?

No. CenCal Health will issue Outreach Authorizations in six-week increments. If additional time is needed beyond the initial six (6) weeks, ECM Providers can contact CenCal Health for an authorization extension. Outreach efforts to contact the Member should be a minimum of three (3) attempts with at least one (1) of those attempts to be in person. For homeless and/or other hard-to-reach and/or difficult to engage populations, including but not limited to Members with literacy or language barriers, those suffering from addiction or severe mental illness, and those living in remote locations, the ECM Provider will complete at least four (4) attempts to contact Members.

How do ECM Providers document/report the actual number of contacts with each Member per month?

This will be documented in both the monthly reporting and billing. For reporting, this will be captured in the ECM Provider Return Transmission File via the applicable encounter count fields (in-person vs telephonic). The ECM Provider will also need to bill CenCal Health for any ECM services for payment and encounter reporting to DHCS.

What happens when a Member does not re-engage after initial enrollment in the ECM program?

ECM Providers should make every effort to attempt outreach to the Member; however, if the Member is unresponsive, unwilling to engage, or if the Provider is unable to connect with the Member after multiple attempts, a written notification will be provided to CenCal Health to indicate the Member requires discontinuation of ECM services. These notifications will be assessed by CenCal Health. ECM Providers should make efforts to notify the Member telephonically, in person, or in writing of the reason why the ECM services will be discontinued.

Billing/Claims

Does CenCal Health and the Provider's "system" need to communicate?

No. ECM Providers do not need to have a system that will communicate with CenCal Health's system. Our respective electronic systems are not required to interact with each other.

How will ECM Providers submit a claim?

ECM Providers will be expected to submit claims to CenCal Health using the national standards such as ANSI ASC x12N837P or submit claims via the CenCal Health's online Provider Portal. ECM Providers who are unable to submit compliant claims have the option to submit invoices for payment; however, the preferred option is claims entry through the Provider Portal. Online claim entry allows for immediate adjudication of a claim and expedites reimbursement. If you have questions about a claim, please contact CenCal Health's Claims Customer Service at cencalclaims@cencalhealth.org or (805) 562-1083.

Billing/Claims (cont.)

Do we need to bill using units?

Yes. All procedure codes for outreach/assessment as well as ECM services, will be billed in 15-minute increments (i.e., 1 unit = 15 minutes).

Do we need to report all outreach attempts on the claim and the report?

Yes. As a DHCS requirement, all outreach attempts as well as rendered ECM services need to be submitted via billing (claim or invoice) for payment.

Are ECM services considered part of a FQHC's visit count associated with their Prospective Payment System (PPS) wrap-around payment mechanism?

Based on current DHCS guidance (as can be found in their ECM FAQ at https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Community-Supports-FAQs-May-2022.pdf, ECM services are not included in the calculation of an FQHC's PPS rate, and plan payments to FQHCs for ECM services will be excluded from the reconciliation of an FQHC's PPS "wrap" reimbursement.

DHCS requirements are subject to change and plans may not be immediately notified. Please refer to the DHCS website to ensure you have the most up-to-date information regarding this matter.

Will there be technical support?

CenCal Health will be providing technical assistance by scheduling regular meetings with ECM Providers for ECM support.

Does the Case Rate include time coordinating services with other agencies?

Yes. The Case Rate will include the time an ECM Provider is coordinating care with other agencies and Providers associated with the Member.

The ECM Provider will use procedure code G9012 "Other specified case management services not elsewhere classified".

Where can I find NPI Guidance?

If you need to apply for a National Provider Identifier (NPI), please refer to the following link for DHCS' A Step-by-Step Guide for Providers Participating: https://www.dhcs.ca.gov/Documents/MCQMD/NPI-Application-Guidance-for-MCPs-ECM-and-Community-Services-Providers.pdf