	County of Sacramento **Department of Health Services** **Division of Behavioral Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**BHS**
		Policy Number	**ECM-02**
		Effective Date	**October 1, 2022**
		Revision Date	**N/A**
Title: **Behavioral Health Services CalAIM Enhanced Care Management Provider Service Provisions**		Functional Area: **BHS ECM**	
Approved By: **Signed version available upon request** **Ryan Quist, Ph.D.** Director, Division of Behavioral Health Services			

BACKGROUND/CONTEXT:

California Advancing and Innovating Medi-Cal (CalAIM) is a new initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal Members by implementing a broad delivery system, program and payment reform across the Medi-Cal program. A key feature of CalAIM is the statewide introduction of an Enhanced Care Management (ECM) benefit for Medi-Cal Managed Care Plan (MCP) members.

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

DHCS' adoption of ECM on a statewide scale will support the highest-need MCP members, with the provision of ECM services anchored in the community, where services can be delivered in-person by community-based ECM providers, to the greatest extent possible.

MCPs are mandated to provide ECM services to MCP members. Four MCPs in Sacramento County, Aetna, Anthem, Health Net, and Molina, will contract with the Division of Behavioral Health Services (BHS) to provide ECM program services to MCP members through the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) sub-contracted ECM providers.

DEFINITIONS:

Drug Medi-Cal Organized Delivery System (DMC-ODS): On July 1, 2019, Sacramento County Substance Use Prevention Treatment (SUPT) began implementing the DMC-ODS State Pilot to test a new way of delivering health care services for Medi-Cal eligible individuals with substance use disorders (SUDs). Critical elements of the DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for substance use treatment services, increased local control and accountability, evidence-based practices in substance use treatment, and increased coordination of care.

Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost MCP members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch (i.e. characterized by regular meetings with the MCP member), and person-centered. ECM is a Medi-Cal benefit.

ECM Provider: A provider of ECM services. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the ECM Populations of Focus.

Managed Care Plan (MCP): A Medi-Cal managed care contract for health care services that emphasize primary and preventative care with a current executed Memorandum of Understanding (MOU) with Sacramento County Behavioral Health Services.

Mental Health Plan (MHP): Sacramento County is the entity responsible for the oversight and implementation of Managed Care Medi-Cal Specialty Mental Health Services (SMHS) for Sacramento County and the Mental Health Services Act. All Sacramento County SMHS providers, contract organizational SMHS providers, and network SMHS providers are providers for the MHP. All consumers who receive services under the MHP are the members.

Social Determinants of Health (SDOH): Conditions in the environments where people live, learn, work, play, and age that affect a wide range of a person's health and well-being.

Treatment Provider: For the purpose of this policy, treatment provider refers to the DMC-ODS or MHP provider that is providing concurrent ECM services.

PURPOSE: The purpose of this policy is to provide a guide for MHP and DMC-ODS sub-contracted providers on the required core components of ECM services in accordance with the Sacramento County Division of BHS agreement with local MCPs to provide ECM program services to identified MCP members.

DETAILS:

ECM Program Description:

The BHS ECM program will be administered through an infrastructure of County staff and MHP and DMC-ODS provider staff (See ATTACHMENT 1 BHS ECM Organizational Chart).

The BHS ECM program will coordinate all primary, acute, behavioral, developmental, oral, social needs, and long-term services and supports (LTSS) for MCP members, including participating in the care planning process, regardless of setting for those who are eligible and meet ECM criteria. LTSS include the broad range of medical and personal care assistance that people may need due to difficulty completing self-care tasks on their own. ECM activities will be integrated with other care coordination processes and functions, and in most cases, the ECM provider will assume primary responsibility for coordination of MCP members' needs, including collaboration with other coordinators who operate in a more limited scope.

Whole-person, interdisciplinary, high-touch (i.e. characterized by regular meetings with the MCP member), and person-centered services will be provided primarily through in-person interactions with MCP members where they live, seek care and prefer to access services. Eligible MCP members are expected to be among the most vulnerable and highest-need and, as such, the ECM providers will establish strong relationships with these MCP members through in-person interactions. Both clinical and non-clinical needs of high-cost and/or high-

need MCP members will be addressed through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch (i.e. characterized by regular meetings with the MCP member), and person-centered. When in-person communication is unavailable or does not meet the needs of the MCP member, the ECM provider will use alternative methods (including traditional and innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with MCP member choice.

In some instances ECM services may mirror case management services provided by treatment providers; particularly when ECM MCP members are being served by a full service partnerships (FSP). ECM care management services are meant to complement MHP/DMC-ODS case management services and may be used as an extension of MHP/DMC-ODS services. When providing ECM services to a MCP member who is also enrolled in a MHP/DMC-ODS, make sure both providers are working collaboratively so that services are not duplicated.

Access to interpretation services will be provided at no cost to the ECM MCP member. The BHS ECM program shall budget for costs associated with interpreters, translation services, and providing materials in alternative format, including Braille, upon request.

ECM Population of Focus #3: Adult SMI/SUD Medical Necessity:

Adult MCP members who meet the ECM eligibility criteria as follows:

(1) Meet medical necessity for a Serious Mental Illness (SMI) **and/or** Substance Use Disorder (SUD);

AND
(2) are actively experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, history of Adverse Childhood Experiences (ACEs), former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms or associated behaviors);

AND
(3) Meet one or more of the following criteria:

- Are at high risk for institutionalization, overdose and/or suicide;
- Use crisis services, emergency rooms, urgent care or inpatient stays as the sole source of care;
- Experienced two or more emergency department visits or two or more hospitalizations due to SMI or SUD in the past 12 months; or
- Are pregnant or post-partum women (12 months from delivery).

ECM Core Services/Core Components:

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

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

ECM Provider Staff:

ECM Providers must have consistent, adequate staff to carry out responsibilities for each assigned member. ECM provider staff positions include *ECM Care Coordinators* that are required to be the lead for the MCP member's ECM care management (See ATTACHMENT 2 ECM Job Descriptions). ECM staffing will be reflective of the cultural, racial, ethnic, linguistic, sexual, and gender diversity of Sacramento County, an array that includes different combinations of education and life experiences, and specialized, relevant to program practices, in system navigation such as housing supports, benefit acquisition, and employment resources.

ECM Provider Staff Registration:

All ECM provider staff need to be registered with Quality Management (QM) under the appropriate ECM staff registration classification. Licensed/Waived ECM staff will register as Clinical ECM Staff while non-licensed ECM staff will register as Non-Clinical ECM staff. Please use attached ECM Staff Registration Form to complete ECM staff registration. Once ECM staff registration is completed with QM, please complete the Avatar Account/Training Registration Form for the registered ECM staff member. (See ATTACHMENT 3 ECM Staff Registration Form).

ECM Provider Training:

ECM staff must complete ECM Electronic Health Record (EHR) training prior to service delivery. This EHR training will be tailored to meet ECM requirements. ECM staff must also attend ECM provider training provided by Sacramento County BHS prior to service delivery. This provider training will include necessary documentation requirements.

County staff will provide training, guidance, and technical assistance for County contracted ECM providers. Curriculum will include, but is not limited to:

1. Eligibility and authorization requirements, notices of adverse beneficiary determination process, and policy related to grievances and appeals.
2. Core items required to complete a comprehensive assessment for ECM eligibility determination and services.
3. Development of an individualized, person-centered Care Management Plan, that includes input from the beneficiary and/or family member(s), and/or other authorized support person(s) as appropriate to assess beneficiary gaps in care, identify goals, and recommendations for service needs.
4. Standards for documenting services provided to and on behalf of beneficiaries.

Prior to receiving EHR and ECM training, ECM staff should be registered with QM (See ATTACHMENT 3 ECM Staff Registration Form). All ECM staff will be responsible for abiding by all legal requirements related to consent to treat, exchange of information, and confidentiality (HIPAA, CFR 42). ECM Provider is responsible for ensuring all staff are properly trained in HIPAA.

ECM Scope of Services/Workflow:

For a visual diagram of the ECM work flow reference (ATTACHMENT 4 ECM Work Flow).

Referral/Authorizations

ECM providers will receive a Member Information File (MIF) from the County that includes currently enrolled MCP members who are authorized to receive ECM services. The County will work with the MCPs and treatment provider to curate a MIF that does not surpass ECM

provider capacity. During the authorization process (and reflected on the MIF), MCPs will assign MCP members a priority level of 1, 2, or 3; with 1 being the highest risk level and 3 being the lowest. ECM providers shall begin outreach and engagement efforts to each of the MCP members included in the MIF; prioritizing clients with the highest level of need.

If a treatment provider identifies a MCP member that could benefit from ECM services and the MCP member is not included in the MIF, or if the treatment provider opens a new client to their treatment program that meets ECM eligibility criteria, the provider can complete an ECM Benefit Populations of Focus Screening Checklist, an ECM Benefit Exclusionary Screening Checklist, and, if the MCP member is determined to be eligible for ECM based on both screening checklists, an ECM Benefit Member Referral Form (See ATTACHMENT 5 ECM Benefit Populations of Focus Screening Checklist; ATTACHEMENT 6 ECM Benefit Exclusionary Screening Checklist; ATTACHEMENT 7 ECM Benefit Member Referral Form). Submit the referral form to the appropriate Health Plan using the Health Plan's ECM Provider Communication Method outlined in the ECM Referral Form for authorization. Upon authorization, the ECM provider may begin outreach efforts. Please note, providers may refer MCP members to Kaiser's ECM services but will not provide the ECM services to Kaiser members.

It is recommended that treating providers evaluate each new MCP member admit for ECM eligibility.

Outreach and Engagement

ECM provider shall use culturally and linguistically appropriate communication to attempt to locate, contact, and engage MCP members who have been identified as eligible to receive ECM services, promptly after assignment. ECM provider shall ensure outreach to assigned MCP members prioritizes those with the highest level of risk and need for ECM.

ECM Provider shall conduct outreach primarily through in-person interaction where MCP members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM provider shall use an active and progressive approach with multiple strategies to outreach and engage MCP member, including:

- Direct communications with the MCP member, such as: in-person meetings where the MCP member lives, seeks care or is accessible;
- Mail;
- Email;
- Text messages;
- Telephone;
- Community and street-level outreach;
- Follow-up if the MCP member presents to another partner in the ECM network.

Outreach attempts and timelines depend on the member's priority group. See chart below for timelines.

Outreach Priority Group	Risk Type	Outreaches to be completed
Priority Group #1	Highest Risk	5 attempts (live called, text, or in person); then a letter

		Attempts should be multi-modal and over the initial period of 30 days
Priority Group #2	Moderate	5 attempts (live called, text, or in person); then a letter Attempts should be multi-modal and over the initial period of 60 days
Priority Group #3	Lowest Risk	5 attempts (live called, text, or in person); then a letter Attempts should be multi-modal and over the initial period of 90 days

If unable to reach the MCP member, **a minimum of 5 outreach attempts** staggered within **30, 60, or 90 days** of receipt of the referral (depending on risk level) will be made, which will include at least:

- One phone call;
- A written letter that includes a description of services offered, location and contact information; and,
- An attempt to meet MCP member in person.

ECM provider shall follow timeframes for discharge due to lack of contact as outlined in their MHP/DMC-ODS contract if different than above.

Comprehensive Assessment for SMI and/or SUD
Initiate an assessment within 30 days of MCP member ECM enrollment and complete the assessment within 60 days after MCP member opt-in.

Existing MHP or DMC-ODS Client: If the MCP member already has a current assessment that has determined medical necessity for an SMI and/or SUD, a new assessment is not required. The ECM provider shall confirm the information in the assessment is still correct and document confirmation and any changes in a progress note. The provider can then move forward with the development of the ECM Care Management Plan (see below).

New MHP or DMC-ODS Client: MHP/DMC-ODS treatment provider staff shall conduct an assessment, including a Health Questionnaire, to determine medical necessity for an SMI and/or SUD. If MCP member is eligible for MHP or DMC-ODS services, ECM provider shall utilize the MHP or DMC-ODS comprehensive assessment to inform ECM services and the ECM Care Management Plan. The ECM provider shall confirm the information in the assessment is still correct and document confirmation and any changes in a progress note.

a. In-person contact shall primarily be used to conduct the assessment of the MCP member.

b. When in-person communication is unavailable or does not meet the needs of the MCP member, alternative methods (including traditional or innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with MCP member choice should be used.
c. The assessment will be individualized, person-centered and the process will involve the MCP member and and/or their family member(s), guardian, authorized representative (AR), caregiver and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs.

d. Necessary clinical and non-clinical resources that may be needed to appropriately assess MCP member's health status and gaps in care will be identified and provided.

Enrollment Acuity Levels: All ECM MCP members must be assigned an acuity level upon assessment as determined by the ECM provider. The acuity level may change during the course of the member's enrollment in ECM. ECM services may be provided to members who are categorized with medium, high, or catastrophic acuity levels. Low acuity members should not be enrolled in ECM. At this time, acuity level is defined by the ECM staff. DHCS is working on defining acuity levels further. This policy will be updated accordingly.

Reassessment: Reassess when clinically indicated, when new needs are identified, or following transitions of care, but no less frequently than every six months. Reassessment must occur within 6 months of enrollment. Members are reassessed against ECM eligibility and graduation criteria. During the reassessment, determine the most appropriate level of services and acuity for ECM. The member may remain in the program if he/she/they meet the applicable ECM Population of Focus eligibility criteria. MCP members who no longer meet ECM Population of Focus criteria shall be disenrolled.

ECM Care Management Plan

ECM provider staff will develop a comprehensive ECM Care Management Plan with the MCP member and family support person(s) (as applicable). ECM provider staff shall utilize the assessment/problem list to inform the development of the ECM Care Management Plan.

a. ECM provider staff will primarily use in-person contact to develop the ECM Care Management Plan.
b. When in-person communication is unavailable or does not meet the needs of the MCP member, alternative methods (including traditional or innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with MCP member choice should be used.
c. The ECM Care Management Plan will be individualized, person-centered and involve the MCP member and and/or their family member(s), guardian, caregiver and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs.
d. The ECM Care Management Plan will include problems (opportunities), objectives, interventions, and SMART goals (Specific, Measurable, Achievable, Realistic, Timely).
e. Necessary clinical and non-clinical resources that may be needed to appropriately assess MCP member's health status and gaps in care will be identified and provided.
e. The ECM Care Management Plan shall be developed to incorporate the MCP member's needs and desires in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports and SDOH. Please note, the ECM staff is not expected to operate outside his/her/their scope of practice and will coordinate with appropriate providers to help the MCP member manage his/her/their individual needs.
f. The ECM Care Management Plan will include comprehensive care management that may include case conferences to ensure that the MCP member's care is continuous and integrated among all service providers.
g. The ECM Care Management Plan will be reviewed, maintained and updated under appropriate clinical oversight.
h. The ECM Care Management Plan will be updated when clinically indicated, when new needs are identified, or following transitions of care, but no less frequently than every six months.
i. Document MCP member's agreement with ECM Care Management Plan.

Enhanced Coordination of Care
ECM provider staff will provide services necessary to implement the Care Management Plan and must include, but are not limited to:

a. Organizing patient care activities as included in the MCP member's Care Management Plan; sharing information with those involved as part of the MCP member's multi-disciplinary care team; and implementing activities identified in the MCP member's Care Management Plan.
b. Maintaining regular contact with all providers that are identified as being a part of the MCP member's multi-disciplinary care team, whose input is necessary for successful implementation of MCP member goals and needs. Enhanced Coordination of Care may include case conferences in order to ensure that the MCP 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 MCP 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 MCP member's needs and preferences in a timely manner to the MCP member's multi-disciplinary care team in an effort to ensure safe, appropriate and effective person-centered care.
f. Ensuring regular contact with the MCP member and their family member(s), guardian, Authorized Representative (AR), caregiver and/or authorized support person(s), when appropriate, consistent with the Care Management Plan and to ensure information is shared with all involved parties to monitor
g. MCP member's conditions, health status, care planning, medications usages and side effects.

Health Promotion
ECM provider staff will provide services that encourage and support MCP member to make lifestyle choices based on healthy behavior, with the goal of motivating MCP members to successfully monitor and manage their health. These services can include, but are not limited to:

a. Working with MCP members to identify and build on successes and potential family and/or support networks.
b. Providing services, such as coaching, to encourage and support the MCP member to make lifestyle choices based on healthy behavior, with the goal of supporting the MCP member's ability to successfully monitor and manage their health.
c. Supporting the MCP member 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 the MCP member to resources for smoking cessation, management of MCP members' chronic conditions, self-help recovery resources and other services based on MCP member needs and preferences.
e. Using evidence-based practices, such as motivational interviewing, to engage and help the MCP member participate in and manage their care.

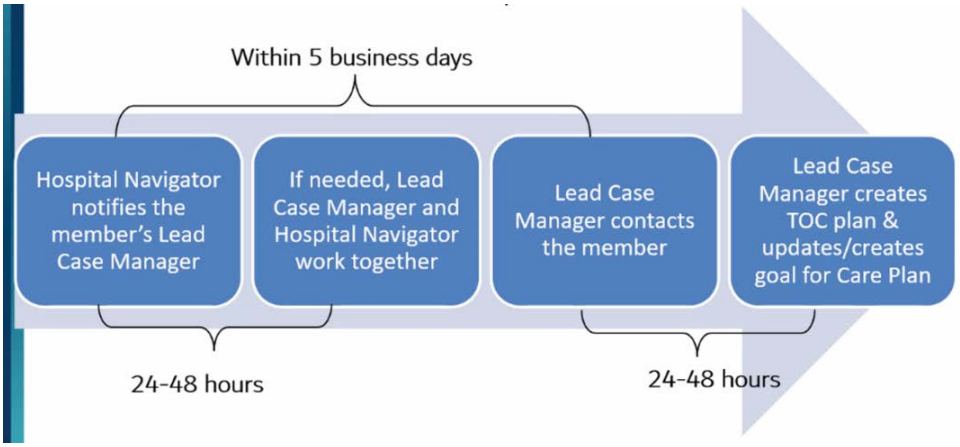
Comprehensive Transitional Care

ECM provider staff will support the MCP member and the MCP member's families and/or support networks during discharge from hospital and institutional settings. Services include facilitating the MCP member's transitions from and among treatment facilities, including admissions and discharges. Additionally, ECM provider staff will provide information to hospital discharge planners about ECM so that collaboration on behalf of the MCP member can occur in as timely a manner as possible.

Comprehensive Transitional Care includes, but are not limited to:

a. Developing strategies to reduce avoidable MCP member admissions and readmissions. Examples include establishing agreements and processes to ensure prompt notification to the MCP member's lead ECM staff member; planning timely scheduling of follow-up appointments with outpatient providers and/or community partners; 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 MCP member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management.
b. For MCP members who are experiencing or are likely to experience a care transition, ECM provider staff will:
    i. Develop and regularly updating a transition plan for the MCP member; this includes facilitating discharge instructions developed by a hospital discharge planner.
    ii. Evaluate a MCP member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges.
    iii. Track each MCP member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members.
    iv. Coordinate medication review/reconciliation.
    v. Provide adherence support and referral to appropriate services.
    vi. Coordinate MCP member transition process.
    vii. Work closely with the MCP member and new provider to ensure a smooth and coordinated transition when a MCP member is ready to transition to a new service level/service provider. This will also include coordinating and referring MCP members to available community resources and following up with MCP members to ensure services were rendered (i.e., "closed loop referrals").

Below is a recommended time frame to follow when MCP member is admitted to the hospital. ECM staff may coordinate care for MCP beneficiaries admitted into a facility.



Member and Family Supports
Member and Family Supports include activities that ensure the MCP member and family/support are knowledgeable about the MCP member's conditions, with the overall goal of improving their adherence to treatment and medication management.

Member and Family Supports will include, but are not limited to:

a. Documenting a MCP member's authorized family member(s), guardian, AR, caregiver and/or other authorized support person(s) and ensuring all required authorization are in place to ensure effective communication between the ECM provider; the MCP member, and/or the MCP member's family member(s), AR, guardian, caregiver and/or authorized support person(s); and ECM provider, as applicable.
b. Conducting activities to ensure the MCP member and/or their family member(s), guardian, AR, caregiver and/or authorized support person(s) are knowledgeable about the MCP member's condition(s), with the overall goal of improving the MCP 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 MCP member's ECM lead ECM staff serves as the primary point of contact for the MCP member and/or family member(s), guardian, AR, caregiver and/or other authorized support person(s).
d. Identifying supports needed for the MCP member and/or the MCP member's family member(s), AR, guardian, caregiver and/or authorized support person(s) to manage the MCP 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 MCP member and/or the MCP member's family member(s), guardian, AR, caregiver and/or authorized support person(s) about care instructions for the MCP member.
f. Ensuring that the MCP member has a copy of his/her ECM Care Management Plan and information about how to request updates.

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 MCP 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 the MCP member, including services that address SDOH, including housing, and services offered by the ECM provider.
b. Coordinating and referring the MCP member to available community resources and following up with the MCP member to ensure services were rendered (i.e., "closed loop referrals").

Disenrollment
A MCP member is able to opt-out of the ECM program at any time. Program disenrollment will be discussed by the team, as needed and with the MCP member, as appropriate to ensure communication and agreement. MCP members who are disenrolled from the program on a voluntary basis may re-enroll into the ECM program at a later date if they wish, provided that the MCP member still meets program eligibility criteria.

ECM provider staff shall ensure there is coordination with identified resources prior to discharge to confirm that adequate supports are in place and receiving providers have the information needed to expedite follow-up services.

For MCP members that disengage, cannot be reached, or are otherwise unable to be contacted, ECM provider staff will send an unable to contact letter to the MCP member after various outreach attempts have been made. The letter will request the MCP member to contact the MCP, at which time, the MCP member would be re-instated into the ECM program if the MCP member opts to do so (See ATTACHMENT 8 ECM Unable to Contact Letter Template). It is the responsibility of the MCP to send a Notice of Action to the MCP member when ECM services are discontinued, or will be discontinued, for the member.

ECM program services should be discontinued when:

- Member is no longer eligible
- Member has met their ECM Care Management Plan goals
- Member is ready to transition to a lower level of care
- Member wishes to discontinue services
- Member is unresponsive or lost to follow-up contact
- Member is deceased

A MCP member will be considered graduated from ECM and will transition to a lower level of care management/coordination when the MCP member is actively taking responsibility for his/her/their own healthcare, demonstrates understanding of mental health diagnosis and/or SUD, treatment, and knows where and when to seek care and make informed decisions about care, is in a sustainable housing situation or knows how to identify resources to secure new housing, and can perform, or has sustainable assistance, with daily living skills.

Documentation Requirements for ECM Services:

All ECM MCP members and services will be recorded in the EHR. Authorized ECM services will be documented in an ECM specific episode. ECM staff will be the only staff to have permissions to the ECM episode. Avatar has released an ECM Training Guide to help with documentation in Avatar that can be found on the Avatar Training Webpage.

Referral and Authorization

If a MCP member outside of the MIF is identified as being eligible for ECM services, the treatment provider may make an ECM referral on the MCP member's behalf. Once a referral is made by a treatment provider, the treatment provider will use the primary MHP/DMC-ODS episode to document the referral in a progress note using the CalAIM – ECM Referral option in the "Referrals Completed/Linkages Section" of the note. The treatment provider can scan the screening tools and referral form into the "ECM/CS Referral Authorization" non-episodic folder located in the MCP member's chart. If the MCP member is authorized for services, admit the MCP member into an ECM program and scan the authorization into the "ECM/CS Referral and Authorization" non-episodic folder in the MCP member's chart. If the MCP member is denied for services, document the denial in a progress note and scan the denial into the "ECM/CS Referral and Authorization" non-episodic folder in the MCP member's chart.

Admission into ECM Episode

Once a MCP member is authorized for ECM services, ECM staff will admit the MCP member into an ECM program. The admission must take place prior to service delivery. All outreach and ECM services will be documented in this ECM episode.

Financial Eligibility Form

Once a MCP member is admitted into an ECM program, record the MCP guarantor associated with the MCP member's MCP into the MCP member's chart using the "Financial Eligibility" form. If part of the MHP, enter a secondary guarantor of "MH County Funds". If part of DMC-ODS, enter a secondary guarantor of "ADS-DMS R Match" Utilize the date of admission as the start date for the guarantor.

Assessment
The treatment provider will send the ECM staff the MCP member's assessment and the ECM staff will scan the assessment into the "Assessments" folder in the MCP member's chart.

ECM Care Management Plan
The ECM Care Management Plan will be recorded in the MCP member's ECM program using the current "Client Plan" form. The ECM Care Management Plan will be created with input from the MCP member and will be authorized by the MCP member as indicated by a client signature and/or by a verbal agreement documented on the care management plan and/or in the associated ECM progress note. The ECM provider will send the ECM care management plan to the treatment provider and the treatment provider will scan the ECM care management plan into the "Client Plans-Not Avatar Generated" folder in the MCP member's chart.

Diagnosis
ECM staff will utilize MCP member report to determine a Z-Code SDOH diagnosis. This diagnosis will be recorded in the MCP member's ECM episode utilizing the "Diagnosis" form.

Problem List
ECM staff will update the "SAC MH Problem List" form for MHP MCP members and will update the "SAC SUPT Problem List" for DMC-ODS MCP members utilizing the diagnosis determined above.

Outreach and ECM Services
All ECM services shall be documented by using Progress Notes in the EHR. Progress Notes shall include any efforts made on behalf of the MCP member including but not limited to the following:

a. Number of outreach attempts and outreach modalities (mail, phone, text, etc.),
b. MCP member's decision to consent to or decline ECM services;
c. Documenting a MCP member's authorized family member(s), guardian, AR, caregiver and/or other authorized support person(s) and ensuring all required authorization are in place to ensure effective communication between the ECM provider;
d. Method used to deliver ECM services (i.e., in person, by phone, or by tele-health); contact location;
e. Staff involved/serving the MCP member;
f. Referrals made and specifics on each service or program the MCP member was referred to if applicable;
g. ECM services provided (Outreach, Care Management Plan, Enhanced Care Coordination, Health Promotion, Comprehensive Transitional Care, Member and Family Supports, Coordination of and Referral to Community and Social Support Services
h. Disposition following services (i.e., MCP member was returned to the community, required further crisis intervention, emergency room services, inpatient hospitalization, etc.).
i. Reason for disenrollment.

Discharge

Document MCP member discharge from ECM services using a discharge progress note. Indicate the reason for discharge utilizing the following ECM discharge reasons:

ECM Discharge Reasons
ECM – Member has met their ECM Care Plan goals
ECM – Member is ready to transition to a lower level of care
ECM – Member is unresponsive or lost to follow-up contact
ECM – Member wishes to discontinue services
Other

If "Other" is chosen, indicate reason in text field. The reasons may include: Unsafe Behavior/Environment; Member is Deceased; No Longer with Health Plan; Member on Hold/Termed with Medi-Cal; ECM Provider at Full Capacity; Outreach Not Enrolled; Member Does Not Meet ECM Population of Focus Eligibility Criteria or Member Meets an Exclusionary Criteria of Duplicative Program; and/or Unable to Serve Member's Population of Focus.

Discharge the MCP member from the ECM episode.

ECM Per Member, Per Month (PMPM) Billing:

Providers are responsible for drawing down their contracted ECM funds. Once enrolled in ECM, ECM services will be reimbursed by the County PMPM. Services prior to ECM enrollment will not be reimbursed. Payment cycle will begin on the first of each month and end the last day of the month. In order to receive ECM payment, an ECM service needs to have been provided in that month. ECM services will be provided in-person when possible and appropriate to the MCP member's need. When in-person communication is unavailable or does not meet the needs of the MCP member, the ECM Provider must use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with MCP member choice. It is the responsibility of the ECM provider to provide the amount of ECM services appropriate for the MCP member's level of need. Providers are responsible for correcting denied claims, as needed.

ECM Service Codes:

The tables below includes ECM service codes. ECM codes are based on the staff providing the service rather than the service itself. For clinical (LPHA) staff members providing ECM outreach or ECM services, use "Clinical" service code associated with the ECM service provided. For non clinical staff members providing ECM outreach or ECM services, use "Non Clinical" service code associated with the ECM services provided.

Document outreach services prior to ECM enrollment using the ECM outreach codes in the ECM Related Service Codes table below. Once enrolled in ECM services, ECM services shall be billed using the ECM service codes detailed in the ECM Related Service Codes table below. Once a MCP member is enrolled in ECM, ECM providers are no longer able to use outreach codes and must document non-billable services using non-billable service codes indicated in the Non-Billable Service Codes table below. Non-Billable Service code definitions can be found here for the MHP and here for DMC-ODS.

ECM Related Service Codes

HCPC	Service Code	Service Code Description	Modifier(s)

G9008	ECM1	ECM-Clinical Staff	U1,GY (In-Person)
G9008	ECM2	ECM-Clinical Staff Tele	U1,GY,GQ (Phone/Telehealth)
G9012	ECM3	ECM-Non Clinical Staff	U2,GY (In-Person)
G9012	ECM4	ECM-Non Clinical Staff Tele	U2,GY,GQ (Phone/Telehealth)
G9008	ECM5	ECM-Clinical Staff Outreach	U8 (Outreach)
G9008	ECM6	ECM-Clinical Staff Outreach Tele	U8,GQ (Phone/Telehealth)
G9012	ECM7	ECM-Non Clinical Staff Outreach	U8 (Outreach)
G9012	ECM8	ECM-Non Clinical Staff Outreach Tele	U8,GQ (Phone/Telehealth)

Non-Billable Service Codes

HCPC	Service Code	Service Code Description	Modifier(s)
N/A	90500	No-Show Client	N/A
N/A	90600	No-Show Staff	N/A
N/A	90501	Cancellation Client	N/A
N/A	90601	Cancellation Staff	N/A
N/A	11111	Client Non-Billable Activity	N/A

Data Reporting Requirements:

ECM providers are required to provide ECM data or reports as requested by the County and/or MCPs.

Grievance Process:

All MCP members who opt into ECM services will be provided with an ECM Grievance Flyer (See ATTACHMENT 9 Grievance Flyer) that directs MCP members to contact their MCP if they have an issue that cannot be successfully resolved at the ECM provider-level.

Quality Assurance:

The goal of the Quality Assurance (QA) process is to conduct oversight of ECM services to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations, including but not limited to, training, required reporting, audits, corrective actions and other oversight activities.

It is the policy of the Sacramento County BHS to conduct training and oversight activities for services provided by County contracted ECM service providers. Qualified staff and appropriate tools are to be utilized to review medical necessity, quality, quantity and appropriateness of care provided in accordance with contractual and regulatory requirements. The QM unit submits findings of reviews, trends and recommendations to the QM Manager for BHS, who

maintains operational direction for Utilization Review (UR) and QA activities. These findings are reviewed and analyzed by the BHS Management Team and shared with MCP administrators for identifying possible QA/QI activities.

The policy applies to county contracted ECM providers and outlines their responsibility for monitoring and quality assurance activities assigned within its organizational structure.

Oversight:

The QM Unit guides several types of oversight activities utilizing a variety of tools, reports available in the EHR and resources.

BHS's review processes include the following:

1. Will comply with regulatory oversight activities outlined by MCPs in the ECM contract language.
2. Will provide MCPs with documentation and support for Utilization Reviews per their request and direction.
3. Additional specialty EUR Reviews coordinated by QM and Program staff focused on specific areas of need or attention as directed by the QM Manager.
4. Other EUR activities to provide specialized technical assistance as requested by the provider, Program Managers or the QM Manager.

RESOURCES/ATTACHMENTS:

- *DHCS Enhanced Care Management Policy Guide*
- ATTACHMENT 1: Division of Behavioral Health ECM Organizational Chart
- ATTACHMENT 2: ECM Job Descriptions
- ATTACHMENT 3: ECM Staff Registration Form
- ATTACHMENT 4: ECM Work Flow
- ATTACHMENT 5: ECM Benefit Populations of Focus Screening Checklist
- ATTACHMENT 6: ECM Benefit Exclusionary Screening Checklist
- ATTACHMENT 7: ECM Benefit Member Referral Form
- ATTACHMENT 8: Unable to Contact Letter Template
- ATTACHMENT 9: ECM Grievance Flyer

RELATED POLICIES:

P&P QM-01-07 Determination of Medical Necessity and Access to Specialty Mental Health Services

P&P QM-01-09 Determination for Medical Necessity and Level of Care/DMC-ODS

DISTRIBUTION:

Enter X	Distribution List Name
X	BHS Avatar Team
X	BHS Quality Management
X	BHS REPO
X	Mental Health Staff
	Mental Health Treatment Center
X	Adult Mental Health Contract Providers
	Children's Mental Health Contract Providers
X	Substance Use Prevention and Treatment (SUPT) Staff
	SUPT System of Care

X	SUPT Treatment Providers
X	Specific grant/specialty resource

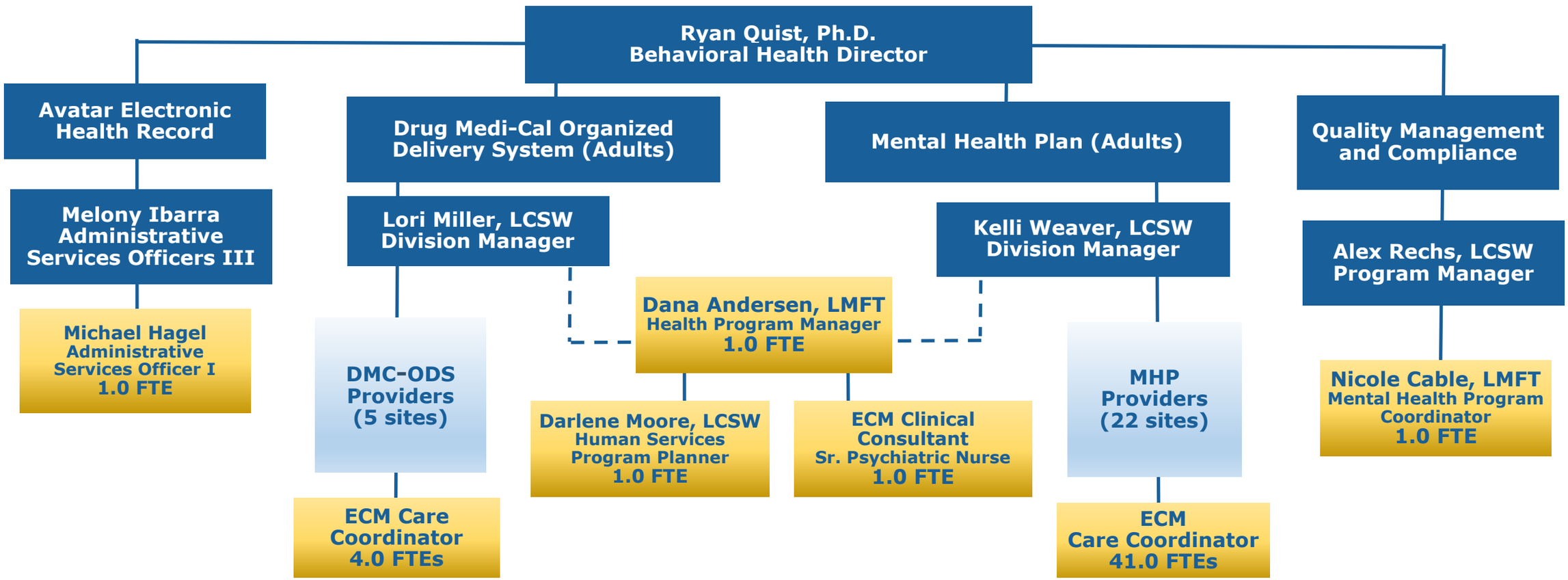
CONTACT INFORMATION:

Dana Andersen, LMFT – Program Manager, California Advancing and Innovating Medi-Cal
AndersenD@saccounty.net

SACRAMENTO COUNTY

Department of Health Services
DIVISION OF BEHAVIORAL HEALTH SERVICES

Behavioral Health Services Enhanced Care Management (ECM) Organizational Chart—OVERVIEW



Division of Behavioral Health Services
CalAIM Enhanced Care Management (ECM) Services
Job Description: CARE COORDINATOR
(SUB-CONTRACTED POSITION)

Qualifications:
Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse.

In addition to the qualifications listed above, ECM staffing will be:

- Reflective of the cultural, racial, ethnic, linguistic, sexual, and gender diversity of Sacramento County
- An array that includes different combinations of education and life experiences
- Specialized, relevant to program practices, in system navigation such as housing supports, benefit acquisition, and employment resources

Summary of Duties:

- Maintain a caseload of MCP Members
- Serve as ECM Point of Contact/ Lead Care Manager for the MCP Members
- Work collaboratively with treatment team
- Oversee provision of ECM services at provider service site, including administrative and billing tasks
- Engage and conduct in-person outreach with eligible MCP Members
- Accompany MCP Member to office visits, as needed and according to MCP guidelines
- Extend health promotion and self-management training
- Arrange transportation
- Connect MCP Member to other social services and supports needed
- Educate MCP Members about MCP Member benefits, including crisis services, transportation services, etc.
- Distribute health promotion materials
- Offer services where the MCP Member lives, seeks care, or finds most easily accessible and within MCP guidelines
- Advocate on behalf of MCP Members with health care professionals
- Use motivational interviewing, trauma-informed care, and harm-reduction practices
- Work with hospital staff on discharge plan
- Monitor treatment adherence (including medication)
- Contact MCP Member to schedule in-person visit with the contract provider

Attachment 3

Sacramento County
Department of Health Services
Division of Behavioral Health Services

QUALITY MANAGEMENT
ECM STAFF REGISTRATION APPLICATION

Avatar Staff ID Number (if known): _____ New: ☐ Update: ☐

Agency

Agency Name: _____ Phone Number: _____ Date: _____

Contact Person: _____ Contact Email: _____

Program Name: _____ Address: _____ (Street) _____ (City) _____ (Zip Code)

Applicant

Applicant Name: _____ (Last) _____ (First) _____ (M.I.) DOB: _____ (required)

Previous Name/AKA: _____ (Last) _____ (First) _____ (M.I.) SSN: _____ (required)

Secondary Language: _____ _____ (Additional language) Gender: _____ (required)

Date of Employment: _____ Employment Status:

Start Date in Classification: _____ ◯ Full Time ◯ Part Time ◯ Contracted ◯ Temporary/On-Call ◯ Volunteer

ECM Professional Classification (choose one and attach license/certification)

◯ ECM Clinical Staff - LPHA (LCSW, LMFT, LPCC); Registered (ACSW, AMFT, APCC); Certified (ADS II)

◯ ECM Non-Clinical Staff - MHRS, MHA-III, MHA-II, MHA-I, ADS I, Peer Specialist-Supervisor, Peer Specialist-Senior, Peer Specialist

Registration/License # : _____ **NPI Number:** _____

Registration/Certification # : _____

Expiration Date: _____

Certification Organization Name: _____

Always Require Co-Signature ◯

Staff Termination

Date of Termination: _____

Send completed form to:
Email: DHSQMStaffReg@saccounty.net *-or-* Fax: (916) 875-0877
Notify Quality Management of any staffing changes or staff terminations.

SACRAMENTO COUNTY

Department of Health Services
Division of Behavioral Health

ENHANCED CARE MANAGEMENT (ECM) WORK FLOW

Referral

1. Managed Care Plan (MCP) send the Member Information File (MIF) to Sacramento County
2. Sacramento County sends MIF to ECM providers

Outreach and Engagement

- Active, progressive and meaningful attempts to engage MHP Member
- Commence in 30 days, culminating in 90 days
- 1 in 5 outreach attempts must be in person
- 3 different outreach types within 90 days

Enrollment

- Opt-in/consent by MCP Member

Comprehensive Assessment

- Drug Med-Cal Organized Delivery System (DMC-ODS) and Mental Health Plan (MHP) providers determine medical necessity for a mental health and/or substance use disorder diagnosis
- If MCP Member is eligible for DMC-ODS or MHP services, ECM Provider utilizes DMC-ODS or MHP comprehensive assessment to inform ECM services and Care Management Plan

Care Management Plan Development

- Informed by assessments
- Developed with Member and family/supports (as applicable)
- Re-assessment when new need identified, after key event, or transition of care
- Updated to reflect re-assessment and new goals

Service Delivery

- Use Acuity Tier Guidance
- ECM staff will perform tasks related to Member's needs and preferences, including:
- Coordinate care to ensure seamless experience by Member
- Offer services where Member lives, seeks care, or finds easily accessible
- Connect Member to services and supports
- Advocate on behalf of Member
- Use evidence-based and promising practices
- Coordinate transitions of care

Member & Family Support Services

- Ensure ECM Provider is point of contact for Member and family/supports
- Ensure Member and family/support persons are knowledgeable about the Member's needs, Care Management Plan, and follow-up
- Provide education on conditions and care instructions
- Ensure Member and family/supports participate in and are aware of Care Plan and Member has a copy

Transition of Care

- Develop and update a Transition of Care Management Plan
- Evaluate medical and other needs
- Track each Member's admission and discharge
- Coordinate medical review
- Provide treatment adherence support and referral to appropriate services
- Coordinate transitions of care (warm hand-off to new service provider)

Member Discontinuation

ECM services should be discontinued when:

- Member has met their ECM Care Plan goals
- Member is ready to transition to a lower level of care
- Member wishes to discontinue services
- Member is unresponsive to follow-up contact
- Other (Ex: Member is deceased, Member is no longer eligible)

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

The ECM Benefit provides comprehensive care management services to 4 different Populations of Focus with the goal to improve the health and social outcomes of the ECM-enrolled member.

*Medi-Cal members are eligible for the ECM Benefit if they meet the ECM Populations of Focus eligibility criteria as defined in this checklist **and** are not enrolled in duplicative services (as defined in the Exclusionary Checklist).*

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

- **Step 1:** Complete this ***Population of Focus Screening Checklist*** to confirm member eligibility for **one or more** Populations of Focus. This step is not needed for Kaiser Permanente referrals.
- **Step 2:** Complete the ***Exclusionary Screening Checklist*** **as a 2nd step** to verify member eligibility.
- **Step 3:** If you determine the member **to be eligible for ECM** based on ***both Screening Checklists***, complete the ***ECM Referral Form*** and send securely to the member's Managed Care Plan for review, with the completed ***Population of Focus Screening Checklist also attached.*** To expedite the review and approval process, ***please also submit applicable supporting documentation as evidence of the member meeting ECM criteria***. Note, the Exclusionary Checklist is not required as an attachment.

Populations of Focus Screening Checklist

ECM Population of Focus

1. ☐ Individual and/or family is **experiencing homelessness*** **AND**

☐has **at least one** complex **physical, behavioral, or developmental** health need (*please note in Conditions Table on page 3 below) with **inability to successfully self-manage** for whom **coordination of services** would likely result in **improved health outcomes *AND/OR* decreased utilization** of high-cost services.

**DHCS defines homelessness as one of the following:*

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

If **BOTH** boxes above are checked, member is eligible

2. Adult High Utilizers are individuals, who **in a six-month period,** with

☐ **5 or more emergency** room visits **AND/OR**

☐ **3 or more** unplanned **hospital** admissions **AND/OR**

☐ **3 or more short-term skilled nursing facility stays**

AND any of the above could have been avoided with appropriate outpatient care or improved treatment adherence

If **ONE or MORE** of these boxes are checked in this section, member is eligible

3. Adults with **Serious Mental Illness or Substance Use Disorder** (*please note in Conditions Table on page 3 below) who meet the eligibility criteria for participation in or obtaining services through

☐ the County Specialty Mental Health (SMH) System **AND/OR**

☐ the Drug Medi-Cal Organized Delivery System (DMC-ODS) **AND**

If **ONE** of the 2 boxes above are checked in this section, continue in this section

☐ Actively experiencing **one complex social factor influencing their health,** e.g.,

Food, Housing, Employment insecurities, History of ACES/trauma, History of recent contacts with law enforcement related to SMI/SUD, Former foster youth, and/or (specify) _____, **AND**

☐ Meet one or more of the following criteria:

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

If **BOTH** boxes above (1. complex social factors and 2. additional criteria) are checked in this section, member is eligible

4. ☐ **Individuals who are transitioning from incarceration** or transitioned from incarceration within the **past 12 months AND**
☐ Have at least one of the following conditions (*please note specifics in Conditions Table below) ☐ Chronic mental illness* ☐ Substance Use Disorder (SUD)* ☐ Chronic disease (e.g., hepatitis C, diabetes)* ☐ Intellectual or developmental disability* ☐ Traumatic brain injury* ☐ HIV/AIDS ☐ Pregnancy If **BOTH** boxes in this section are checked, member is eligible

*Conditions Table: For Reference Only

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

Complex Physical, Behavioral Health and Developmental Conditions *(Check all that apply)*	
Physical Health	
☐Asthma	☐Dementia requiring assistance with IADLs
☐Chronic Kidney Disease	☐Diabetes (Insulin-dependent) poorly controlled
☐Chronic Liver Disease	☐History of stroke or heart attack
☐Chronic Obstructive Pulmonary Disease (COPD)	☐Hypertension (poorly controlled)
☐Congestive Heart Failure (CHF)	☐Traumatic Brain Injury (TBI)
☐Coronary Artery Disease	☐Other, please note:
Behavioral Health	
☐Bipolar disorder	☐Psychotic disorders, including schizophrenia
☐Major Depressive Disorder	☐Substance Use Disorder, please specify:
☐Other, please note:	
Developmental	
☐Intellectual/Developmental Disability	☐Other, please note:

Summary of ECM Eligibility for Managed Care Plan Reference

Member's Eligible Population(s) of Focus *(Check all that apply)*	
☐	1. Individuals Experiencing **Homelessness**
☐	2. **Adult High Utilizers** with frequent hospital, skilled nursing facility or ER Admissions
☐	3. Individuals with **SMI/SUD** and other Health Needs
☐	4. Individuals Transitioning from **Incarceration**

PL1197 1221

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

DHCS outlined approaches to program coordination and the prevention of non-duplication with ECM services: ***Absolute, Duplicative, and Wrap.***

There are 3 steps to the screening and referral process:

- **Step 1**: Complete the ***Population of Focus Screening Checklist*** to confirm member eligibility for **one or more** Populations of Focus.
- **Step 2**: Complete this ***Exclusionary Screening Checklist*** **as a 2nd step**
  - To confirm eligibility
  - To identify duplicative programs for which the member must choose, and
  - To identify potential programs that the member can be enrolled in while also in ECM, which will require coordination of services
- **Step 3**: If you determine the member **to be eligible for ECM** based on ***both Screening Checklists***, complete the ***ECM Referral Form*** and send securely to the member's Managed Care Plan for review, with the completed ***Population of Focus Screening Checklist also attached.*** Note, the Exclusionary Checklist is not required as an attachment.

Exclusionary Screening Checklist

Active Medi-Cal

Individual must have active Medi-Cal status and assigned to a Managed Care Plan.

1. ☐ Non-active Medi-Cal
   If box is checked, **STOP.** Member **does not** meet eligibility criteria.
   If box is not checked, move on to next question.

2. ☐ Fee-for-Service Medi-Cal
   If box is checked, **STOP.** Member **does not** meet eligibility criteria.
   If box is not checked, move on to next question.

Absolute Exclusion Criteria

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

3. ☐ Cal MediConnect
   If box is checked, **STOP.** Member **does not** meet eligibility criteria.
   If box is not checked, move on to next question.

4. ☐ Hospice
   If box is checked, **STOP.** Member **does not** meet eligibility criteria.
   If box is not checked, move on to next question.

5. ☐ Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
   If box is checked, **STOP.** Member **does not** meet eligibility criteria.
   If box is not checked, move on to next question.

6. ☐ Program for All Inclusive Care for the Elderly (PACE)
   If box is checked, **STOP.** Member **does not** meet eligibility criteria.
   If box is not checked, move on to next question.

Duplicative Programs – Either ECM or Other Program

Members who are enrolled in the below duplicative programs have a choice of continuing enrollment in these programs or enrolling in ECM. The member maintains the right to choose or switch between ECM and other duplicative care management programs. We encourage members to choose the program that best meets their needs.

7. Member is currently enrolled in one of the following **1915 Waiver Programs:**
   - ☐ Multipurpose Senior Services Program (MSSP)
   - ☐ Assisted Living Waiver (ALW)
   - ☐ Home and Community-Based Alternatives (HCBA) Waiver
   - ☐ HIV/AIDS Waiver
   - ☐ HCBS Waiver for Individuals with Developmental Disabilities (DD)
   - ☐ Self-Determination Program for Individuals for Individuals with I/DD

   If a box is checked, **STOP.** Member has a choice to continue in their existing 1915 Waiver program or switch to ECM. Please consult with the 1915 Waiver program if possible.
   If box is not checked, move on to next question.

8. Member is currently enrolled in one of the following **Managed Care Programs**:
   - ☐ Basic Case Management
   - ☐ Complex Case Management

   If a box is checked, **STOP.** Member has a choice to continue in their existing Case Management program or switch to ECM. Please consult with Case Management program if possible.
   If box is not checked, move on to next question.

9. Member is currently enrolled in one of the following **Other Programs:**
   - ☐ California Community Transitions (CCT)

   If box is checked, **STOP.** Member has a choice to continue in their existing CCT program or switch to ECM. Please consult with the CCT program if possible.
   If box is not checked, move on to next question.

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

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

10. Member is currently enrolled in one of the following **Non-Managed Care Programs**:
    - ☐ California Children's Services (CCS)
    - ☐ County-based Targeted Case Management (TCM)
    - ☐ Specialty Mental Health (SMHS) TCM
    - ☐ SMHS Intensive Care Coordination for Children (ICC)
    - ☐ Drug Medi-Cal Organized Delivery Systems (DMC-ODS)

11. Member is currently enrolled in one of the following **Managed Care Programs**:
    ☐ CCS Whole Child Model
    ☐ Community Based Adult Services (CBAS)

12. Member is currently receiving coverage for Members **Dually Eligible for Medicare and Medicaid**. *Note: Dually eligible members can receive ECM if they meet ECM Population of Focus criteria*
    ☐ Dual Eligible Special Needs Plans (D-SNPs)
    ☐ D-SNP Look-alike Plans
    ☐ Other Medicare Advantage Plans
    ☐ Medicare FFS

13. Member is currently enrolled in one of the **Other Programs:**
    ☐ AIDS Healthcare Foundation Plans
    ☐ Adult Full Service Partnership (FSP) *Note: Recommend ECM Providers coordinate with FSP programs to ensure non-duplication of services.*

PL1198 1221

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

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

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

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

- **Step 1:** Complete the ***Population of Focus Screening Checklist*** to confirm member eligibility in **one or more** Populations of Focus. This step is not needed for Kaiser Permanente referrals.
- **Step 2:** Complete the ***Exclusionary Screening Checklist* as a 2nd step** to verify member eligibility.
- **Step 3:** If you determine the member to be eligible for the ECM benefit based on ***both Screening Checklists,*** complete and submit the ***ECM Referral Form*** and ***Population of Focus Screening Checklist*** to the Managed Care Plan**.** To expedite the review and approval process, ***please also submit applicable supporting documentation as evidence of the member meeting ECM criteria***. Send securely through the Managed Care Plan's designated method listed below. The Exclusionary Screening Checklist is not required to be submitted. The Managed Care Plan will review and verify the member's eligibility and respond within one week.

Health Plan	ECM Provider Communication Method	Community Provider (Non-ECM Provider) Communication Method
☐ Aetna Better Health of California	*Submit via secure email:* ABHCAEnhancedCareManagment@AETNA.com	*Submit via secure email:* ABHCAEnhancedCareManagment@AETNA.com
☐ Anthem Blue Cross	*Submit via Anthem Provider Portal: https://providers.anthem.com or secure fax: 844-429-9626 or secure email: CalAimreferrals@anthem.com*	*Call* 800-407-4627 (TTY 711); *mention ECM*
☐ Health Net	*Submit via Health Net's Provider Portal* provider.healthnetcalifornia.com *or secure fax:* 800-743-1655	*Submit via secure fax:* 800-743-1655
☐ Kaiser Permanente	*Submit via secure email:* REGMCDURNs-KPNC@kp.org *with "ECM Referral" as the subject line*	*Submit via secure email:* REGMCDURNs-KPNC@kp.org *with "ECM Referral" as the subject line*
☐ Molina Healthcare of California	*Submit via secure email:* MHC_ECM@molinahealthcare.com *Please note underscores in email address*	*Submit via secure email:* MHC_ECM@molinahealthcare.com *Please note underscores in email address*

Asterisk (*) indicates required information.

REFERRAL SOURCE INFORMATION	
Internal Referring Department* (select one): ☐ CM ☐ UM ☐ BH ☐ MLTSS ☐ Member Svcs ☐ Other:	
External Referral By* (select one): ☐ Hospital ☐ PPG ☐ PCP ☐ Clinic ☐ SNF ☐ DHS ☐ DMH ☐ DPH ☐ Other:	
Date of Referral:*	
Referring Organization Name:*	
Referring Individual Name & Title:*	
Referrer Phone Number:*	
Referrer Email Address:*	
Reason for Referral (Required only for Kaiser Permanente Referrals)	
Has the member expressed interest in opting-into ECM?	☐Yes, and I have already discussed the program with the member. Member's preference of ECM Provider, if known: _____ ☐No, I will validate ECM eligibility prior to discussing ECM with member
Is the member transitioning their ECM services due to a change in their health plan? (COC)**	☐ Yes ☐ No Please provide previous ECM provider name: _____ Please provide previous CA Medi-Cal health plan name: _____ Please provide last day member worked with previous ECM Provider: _____

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

MEMBER'S ECM ELIGIBILITY *(Complete, refer to, and attach ECM Population of Focus Screening Checklist)* Check all that Apply*	
☐	1. Individuals and Families Experiencing **Homelessness**
☐	2. Adult **High Utilizers** with Frequent hospital or ER Admissions
☐	3. Individuals Transitioning from **Incarceration**
☐	4. Adults with **SMI/SUD** and other Health Needs
☐	COC – only applies to members transitioning from ECM with another CA Medi-Cal health plan**

EXCLUSIONARY CRITERIA *(Complete and refer to ECM Exclusionary Screening Checklist – do not attach)* **BOTH boxes** must be checked for ECM member eligibility*

☐ I attest that the member is **not enrolled in programs that exclude** the member from ECM eligibility If member *is* enrolled in an ECM duplicative program, member is **opting** for **ECM *instead of*** the other program. ○ **Other Program(s):** ○ **Other Program(s) disenrollment date:** If the member is enrolled in a Program that allows them to **concurrently** receive ECM services (per the Exclusionary Checklist "wrap" program section), **note Program(s):**

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

PL1196 1221

Dear

has been unable to contact you regarding your Enhanced Care Management (ECM) services and has attempted to reach you on the following occasions:

This letter serves as notification that the above program will no longer attempt to engage you in ECM services at this time. If you would like to participate in the ECM program, please contact your Managed Care Plan directly. Contact information for your Managed Care Plan can be found below. Your Managed Care Plan is indicated with a check mark below.

☐	aetna™	**Member Services: (855) 772-9076**
☐	Anthem BlueCross	**Customer Care: (800) 407-4627 (TTY 711)**
☐	health net	**Member Services: (800) 675-6110**
☐	MOLINA HEALTHCARE	**Member Services: (888) 665-4621**

Best Regards,

SACRAMENTO COUNTY

DIVISION OF BEHAVIORAL HEALTH SERVICES

We are pleased that you have decided to take advantage of Enhanced Care Management Services as part of your treatment plan. We hope that you find these services to be beneficial. However, if at any time you have any issues regarding your Enhanced Care Management services that you can not successfully resolve with your service provider, please contact your Medi-Cal Managed Care Health Plan.

MEMBER GRIEVANCE

aetna™

Member Services: (855) 772-9076
https://www.aetnabetterhealth.com/california/medicaid-grievance-appeal.html

Anthem BlueCross

Customer Care: 800-407-4627 (TTY 711)
https://member.anthem.com/secure/grievances-form

health net

Member Services: (800) 675-6110
https://www.healthnet.com/content/healthnet/en_us/members/appeals-and-grievances/medi-cal-appeals-and-grievances.html

MOLINA HEALTHCARE

Member Services: (888) 665-4621
https://www.molinahealthcare.com/members/ca/en-us/mem/medicaid/medical/quality/cna/cna.aspx

California Department of Health Care Services, Office of the Ombudsman
Phone: (888) 452-8609
https://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx