# Enhanced Care Management (ECM) FAQ

1. **What is ECM?**

   ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs. Members are assigned an ECM lead care manager (LCM) who provides high-touch, community-based, comprehensive care management and care coordination. ECM builds on both the design and the lessons from the Whole-Person Care (WPC) pilots and the Health Homes Program (HHP). For more detailed information, please see page 5 of the Department of Health Care Services (DHCS) CalAIM Enhanced Care Management Policy Guide.

2. **What are the criteria for ECM?**

   To be eligible for ECM, members must be enrolled in Medi-Cal managed care and meet the eligibility criteria of at least one of the California Advancing and Innovating Medi-Cal (CalAIM) ECM Populations of Focus. The Populations of Focus definitions can be found in the DHCS CalAIM Enhanced Care Management Policy Guide.

3. **Can members meet the criteria for more than one Populations of Focus?**

   Yes, members may meet eligibility criteria for one or more Populations of Focus. They will receive the same ECM services regardless of Populations of Focus.

4. **Who authorizes ECM services?**

   As of January 1, 2023, CalOptima Health is responsible for authorizing ECM services for all members regardless of their health network (HN). Please refer to CalOptima Health's Centralization of CalAIM Services FAQ.

5. **Who provides ECM services?**

   In Orange County, the majority of CalOptima Health's delegated HNs currently serve as CalAIM ECM providers and are responsible for providing the seven core components of ECM services:
   1. Outreach and engagement
   2. Comprehensive assessment and care management plan
   3. Enhanced coordination of care
   4. Health promotion
   5. Transitional care services
   6. Member and family supports
   7. Coordination of and referral to community and social support services

Please see pages 11–35 of the DHCS CalAIM Enhanced Care Management Policy Guide for additional guidance and examples of ECM services.

CalOptima Health ECM providers (list available in CalOptima Health's Provider Directory) are contracted for specific Populations of Focus as described below:

Population of Focus 1: Individuals Experiencing Homelessness; Population of Focus 2: Individuals at Risk for Avoidable Hospital or Emergency Department Utilization; Population of Focus 5: Adults Living in the Community and at Risk for Long-Term Care (LTC) Institutionalization; Population of Focus 9: Individuals with Intellectual and/or Developmental Disabilities; and Population of Focus 10: Pregnant and Postpartum Individuals at Risk for Adverse Perinatal Outcomes:

- AltaMed Health Services
- AMVI Medical Group
- CalOptima Health Community Network
- CHOC Health Alliance
- Family Choice Medical Group
- Noble Mid-Orange County
- Optum Care Network Arta
- Optum Care Network Monarch
- Optum Care Network Talbert
- Prospect Medical Group
- United Care Medical Group

Population of Focus 3: Individuals with Serious Mental Health Needs and/or Substance Use Disorder Needs:

- Orange County Health Care Agency

Population of Focus 6: Adult Nursing Facility Residents Transitioning to the Community:

- Libertana Home Health

In addition, CalOptima Health began its ECM Academy in January 2023 to expand the ECM provider network with Federally Qualified Health Centers, community health centers and community-based organizations, which will start providing services in July of 2023.

6. **How does CalOptima Health define and identify members with needs related to social determinants of health (SDOH)?**

SDOH are the environmental conditions where people are born, live, learn, work, play and worship, as well as their age, that affect a wide range of health, functioning and quality-of-life outcomes and risks. For each Population of Focus, CalOptima Health will use all available data sources — including ICD-10 diagnoses — to identify SDOHs.

7. **How does CalOptima Health plan to outreach to members at risk of being homeless and are limited English proficiency (LEP), as well as CalOptima Health members at risk of being homeless due to the pandemic?**

   CalOptima Health's ability to identify members at imminent risk of homelessness will be largely based on information received from an impacted member, family member or from their health care team (provider, hospital, case manager or community-based organization). In addition, CalOptima Health's Customer Service department provides interpreter services, bilingual staff and materials in all seven Orange County threshold languages to connect with LEP individuals.

8. **Is CalOptima Health planning on following the same system developed for HHP in terms of sending out a finalized engagement list (FEL) with eligible ECM members to the HNs?**

   CalOptima Health is providing a monthly list of members meeting the criteria for a Population of Focus to ECM providers.

9. **What is Orange County Behavioral Health Services' role in CalAIM?**

   CalOptima Health is working with the county to coordinate the provision of ECM services through Orange County Behavioral Health Services for member who are authorized for ECM under Population of Focus 3: Serious Mental Health Needs and/or Substance Use Disorder Needs.

10. **Will the Orange County Health Care Agency be held to the same requirements as other ECM providers?**

    Yes, the county is contracted as an ECM provider for members eligible in Population of Focus 3, and they are responsible for delivering the seven ECM core service components, including outreach and engagement services.

11. **Who is financially responsible for ECM services provided by the county?**

    Like the financial structure that CalOptima Health created to provide Community Supports to eligible members, CalOptima Health will be financially responsible for the ECM services provided by the county. The county will submit claims directly to CalOptima Health for payment.

12. **How will a member be notified that they will receive ECM services from the county?**

    If a member meets the criteria for ECM and is authorized for services, the county, CalOptima Health and HNs will collaborate on providing notices of the approval of ECM

services to the member. Following approval of the ECM authorization, the county will begin outreach and engagement activities with the member, if it has not already been initiated.

13. **How will HNs and the county collaborate and share data?**

    The county and HN case managers will be responsible for sharing information via Secure File Transfer Protocol (SFTP), secure email, telephone and CalOptima Health Connect.

14. **What is the reassessment time frame for ECM (after the initial six months)?**

    To ensure members receive the most appropriate level of care management or coordination of services, ECM reauthorization will occur every six months.

15. **Will CalOptima Health share the expected ECM program staffing ratios or those that CalOptima Health Community Network (CCN) plans on using?**

    DHCS did not provide a staffing ratio model for the number of members who can be served by each care manager. CalOptima Health is relying on its HHP experience to determine the number of staff needed for ECM. In addition, ratios are expected to be tailored to the specific Populations of Focus being served.

16. **How will ECM providers be paid?**

    ECM payment is on a per-eligible-member-per-month basis. ECM providers will only receive payment if an ECM member received six units of service per month. One unit equals 15 minutes of interaction with the member or work done on the member's behalf. Engagement and outreach services may count towards the six-unit threshold if the member has been authorized for ECM as of the outreach and engagement dates of service.

17. **Can a member's Personal Care Coordinator (PCC) be the LCM?**

    Yes, a PCC can be the LCM, but, depending on the member's medical needs, they should work with a registered nurse as part of the member's care team to review the care plan and coordinate care. The LCM is responsible for interacting directly with the member and/or family, authorized representatives, caretakers, and/or other authorized support persons as appropriate. At a minimum, they are also responsible for engaging with a multidisciplinary care team to identify gaps in the member's care and ensure appropriate input is obtained to effectively coordinate all primary, behavioral, developmental, oral health, long-term services and supports (LTSS), Community Supports and other services that address SDOHs, regardless of setting.

18. **How do the HNs track referrals and what information does CalOptima Health need? Is there a universal procedure, such as a predetermined format for Community Supports providers to report back to the HNs, or do they create their own?**

    The HNs need to track both authorized services for their assigned members and whether services have been initiated. HNs can create their own procedure for this and will be required to submit this information for reporting purposes to CalOptima Health.

19. **Can CalOptima Health provide a list of the CalAIM file names, location (if different than the SFTP) and frequency of when they are sent to the HN each month?**

    The ECM Activity Log will be provided weekly and outbound ECM member eligibility will be provided monthly.