Enhanced Care Management (ECM) Provider Certification Application

This ECM provider Certification Application is intended to ensure the new ECM provider provides satisfactory evidence of meeting ECM requirements as outlined by the Department of Health Care Services (DHCS) Model of Care to be certified as an ECM provider. **Please complete the ECM Provider Certification Application and submit** to **CalAIM_providers@healthnet.com.** If you have any questions or concerns as you are completing the application, please contact us immediately via email above. Please refer to the Enhanced Care Management Population of Focus descriptions to determine the appropriate population(s) of focus for your organization, and to review the specific required services for that population that are to be addressed in your application.

Please indicate **which ECM Population of Focus** this application is submitted for (check the applicable box(es) below).

Note: For full details on the Populations of Focus, refer to pages 8-48 of the *CalAIM Enhanced Care Management Policy Guide* at **www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf**.

Current Populations of Focus as of January 1, 2022

☐ Adults (whether or not they have dependent children/youth living with them) who are experiencing homelessness, defined as meeting one or more of the following conditions: (1) lacking a fixed, regular, and adequate nighttime residence, (2) having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport or camping ground, (3) living in a supervised publicly or privately operated shelter, designed to provide temporary living arrange (including hotels and motels paid for by federal, state, or local government programs for low income individuals or by charitable organizations, congregate shelters, and transitional housing); (4) Exiting an institution into homelessness (regardless of length of stay in the institution); (5) Will imminently lose housing in next 30 days; (6) Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence **AND** have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.

☐ **Adults at risk for avoidable hospital or emergency department (ED) utilization** who meet one or more of the following conditions: (1) Five or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence; (2) **Three or more** unplanned hospital and/or short-term skilled

☐ **Adults transitioning from incarceration** who: (1) Are transitioning from a correctional facility (e.g., prison, jail, or youth correctional facility) or transitioned from correctional facility within the past 12 months; AND (2) Have at least one of the following conditions (**See Appendix C** for definitions): (i) mental illness; (ii) SUD; (iii) chronic condition/significant non-chronic clinical condition; (iv) intellectual or developmental disability (I/DD); (v) traumatic brain injury (TBI); (vi) HIV/AIDS; (vii) pregnant or postpartum.

nursing facility (SNF) stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence. ☐ **Adults with serious mental health and/or Substance Use Disorder (SUD) needs** who: (1) Meet the eligibility criteria for participation in, or obtaining services through: (i) SMHS delivered by MHPs; (ii) The Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program; **AND** (2) Are experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, high measure (four or more) of ACEs based on screening, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms; **AND** (3) Meet one or more of the following criteria: (i) Are at high risk for institutionalization, overdose, and/or suicide; (ii) Use crisis services, EDs, urgent care, or inpatient stays as the primary source of care; (iii) experienced two or more ED visits or two or more hospitalizations due to serious mental health or SUD in the past 12 months; (iv) are pregnant or postpartum (12 months from delivery).	
Current Populations of Focus as of January 1, 2023	
☐ **Adults living in the community and at risk for long-term care (LTC) institutionalization**, who: (1) Are living in the community who meet the SNF Level of Care (LOC) criteria; OR who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury **AND** (2) Are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring) **AND** (3) Are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).	☐ **Adult Nursing facility residents transitioning to the community**. Adult nursing facility residents who: (1) Are interested in moving out of the institution; **AND** (2) Are likely candidates to do so successfully; **AND** (3) Are able to reside continuously in the community.
Current Populations of Focus as of July 1, 2023	
☐ **Homeless families or unaccompanied children/youth experiencing homelessness** Children, youth and families with members under age 21 who: 1) are experiencing homelessness, as defined above in (a) under the modified HHS 42 CFR Section 11302	☐ **Children/youth who are transitioning from a youth correctional facility** or transitioned from being in a youth correctional facility within the past 12 months.

"Homeless" definition **OR** (2) Sharing the housing of other persons (i.e., couch surfing) due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or abandoned in hospitals (in hospital without a safe place to be discharged to), as modified from the 45 CFR 11434a McKinney-Vento Homeless Assistance Act definition of "at risk of homelessness". ☐ **Children/youth at risk for avoidable hospital or emergency department (ED) Utilization** who meet one or more of the following conditions: (1) Three or more ED visits in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence; (2) **Two or more** unplanned hospital and/or short-term SNF stays in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence. ☐ **Children and youth with serious mental health and/or SUD needs** who: (1) Meet the eligibility criteria for participation in, or obtaining services through one or more of: (i) SMHS delivered by MHPs; (ii) The DMC-ODS **OR** the DMC program. No further criteria are required to be met for children and youth to qualify for this ECM Population of Focus.	☐ **Children/youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS Condition** who: (1) Are enrolled in CCS OR CCS WCM; AND (2) Are experiencing at least one complex social factor influencing their health. Examples include (but are not limited to) lack of access to food; lack of access to stable housing; difficulty accessing transportation; high measure (four or more) of ACEs screening; history of recent contacts with law enforcement; or crisis intervention services related to mental health and/or substance use symptoms. ☐ **Children/youth involved in Child Welfare** who meet one or more of the following conditions: (1) Are under age 21 and are currently receiving foster care in California; (2) Are under age 21 and previously received foster care in California or another state within the last 12 months; (3) Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state; (4) Are under age 18 and are eligible for and/or in California's Adoption Assistance Program; (5) Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months.
Population of Focus Going Live January 1, 2024	
☐ **Birth Equity Population of Focus:** Adults and youth who (1) are pregnant **OR** are postpartum (through 12 months period) **AND** are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.	

Instructions for Evidence:

Suggested evidence is to be met by an ECM program description where all documentation (e.g., policies & procedures (P&P), organization charts, workflows, etc.) are collated, attached and referenced. Please indicate the required area for which the evidence is submitted (e.g., Required Area 1: Overview of ECM Structure).

Guiding principles to keep in mind as you prepare your application:

- The recommended evidence submitted to meet the required area criteria should be specific to the population(s) of focus for which the application is submitted as each population of focus may require specific types of documents, policies and/or procedures to demonstrate compliance with the criteria. If there is more than one population that is included in the application, be sure to identify the populations of focus that is being addressed by the evidence.
- The expectations for providing enhanced care management services are set forth in the **required area** sections of this document. Please review these expectations within your organization to ensure that you have a clear understanding of them and are prepared to deliver the services. There may be additional discussion and/or requirements for specific populations of focus (as described in the ECM population of focus document referenced above).
- The Recommended Evidence section is where you will provide information that describes in detail how your organization will implement the ECM services to meet the expectations of the program. Please be clear and concise in your submissions so that reviewers will understand how your organization provides ECM services.
- If you have any subcontractors providing any part of ECM services on behalf of your organization, a copy of the MOU/contract must be submitted as part of your application. Furthermore, any inclusion of a subcontractor being proposed, in order to fulfill the ECM provider requirements, must also complete "Required Area 12: Oversight & Monitoring."

Post Application Submission:

The Health Plan will review all submitted applications and evidence and will respond to individual ECM providers with request for additional information or clarification for areas of the application that do not satisfy the ECM requirement. The Health Plan will be available to work with you over the course of completion of this application and post submission to ensure certification requirements are satisfied. If the ECM requirements are not met, certification will not be granted.

An ECM provider must be one of the following types of organizations and be able to meet the qualifications and perform the duties below to be authorized to serve as an ECM provider:

• Accountable care organization • Behavioral health entity • Child welfare organization • City/county government agency • County behavioral health provider • Community health center • Community mental health center • Community-based organization • Federally qualified health center (FQHC)	• Hospital or hospital-based physician group or clinic (including public hospital and/or district/municipal public hospital) • Independent physician • Local health department • Organizations serving individuals experiencing homelessness • Organizations serving justice-involved individuals • Primary care or specialist physician or physician group	• Private non-profit organization • Rural health center/Indian health center • School/school-based organization • Substance use disorder (SUD) treatment provider • Other qualified provider or entity that are not listed, as approved by DHCS (if this applies to your organization, please describe)

This ECM provider Certification Application is intended to ensure the ECM provider provides ***satisfactory evidence*** of meeting the ECM requirements as outlined by DHCS to be certified as an ECM provider. **Please complete the ECM Provider Certification Application and submit to CalAIM_providers@healthnet.com.**

If you have any questions or concerns as you are completing the application, please email the inbox above immediately.

ECM Provider Organization:			
ECM Provider Organization Type:			
Tax Identification Number (TIN):			
National Provider Identifier (NPI) (i.e., Type 2 NPI):			
Completed By:		**Date:**	
Title:			
Phone Number:		**Email Address:**	

Location and National Provider Identifier (NPI) (i.e., type 2 NPI): ***Please list each location and associated NPI. Add additional rows if needed.***			
Location 1 Address:		**Location 1 NPI:**	
Location 2 Address:		**Location 2 NPI:**	
Location 3 Address:		**Location 3 NPI:**	
Location 4 Address:		**Location 4 NPI:**	
Location 5 Address:		**Location 5 NPI:**	

Overview of ECM Structure

Required Area 1. Overview of ECM Structure

Required Area 1 Overview of ECM Structure	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
Provide a brief overview of the overall structure of the ECM Care Model, including roles and responsibilities.	**Recommended documentation:** Program description of how **population(s) of focus-specific members** will receive high-touch, community-based, in-person care management, coordinating all primary, acute, behavioral, oral, and long-term services and supports for the member, including the following: • Organization Chart that demonstrates how ECM is integrated within your existing organizational structure. • Job descriptions for each member of the care team that includes their role and responsibilities in providing ECM services and is inclusive of the minimum education and experience requirements. • Memoranda of understanding (MOUs)/contracts for any subcontractor that is engaged to provide ECM services, including a description of workflows and communication that will occur.			Yes ☐ No ☐
Describe the approach to ensuring that each member receives the ECM benefit in a face-to-face manner where the members live, seek care, or prefer to access services, meeting the member where they are in the community. Public health precautions and recommendations should be used to accomplish	**Recommended documentation:** Program description of how the services will be provided primarily face-to-face in settings that reflect the individualized need of the **population(s) of focus**, including: • When face-to-face settings are unavailable, alternate methods should be used. • The provision of culturally appropriate and timely in-person care management			Yes ☐ No ☐

Required Area 1 Overview of ECM Structure	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
community-based, in-person approach of ECM.	activities including accompanying members to critical appointments when necessary. • Communication with and serve members in a culturally and linguistically appropriate and accessible way. • The provision of ECM services that demonstrate cultural and linguistic competency and humility. • Formal agreements or processes in place to engage and cooperate with hospitals, primary care practices, behavioral health providers, specialists, and other entities, to coordinate as appropriate to each member. • Oversight and monitoring of the ECM service provision to ECM enrolled members to ensure compliance with the ECM provider requirements.			
Identification of what preferences or specifications, in addition to your identified population(s) of focus above, your organization has existing care teams and experience in serving members, as applicable, such as: • Zip Codes. • Empaneled members or primary care assigned members only, as applicable. • For providers interested in serving the Birth Equity Population of Focus, please indicate the racial and ethnic groups experiencing disparities	Program description of the specifications of members to be served under ECM by your organization. These specifications must be driven by existing capacity or care teams to demonstrate the ability to provide ECM services. Provide policy or narrative description on how you interact with other organizations that support the Birth Equity Population of Focus.			

Required Area 1 Overview of ECM Structure	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
in care for maternal morbidity and mortality you have experience serving. Groups may include but are not limited to: Black, American Indian and Alaska Native, and Pacific Islander pregnant and postpartum individuals. We encourage you to include additional groups not listed. Please refer to CDPH data for more information: https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/CA-PMSS.aspx • For providers interested in serving the Birth Equity Population of Focus, please describe any background your organization has in working with other organizations that support the pregnant/postpartum PoF, including California Perinatal Services Program (CPSP), Black Infant Health Program (BIH), Perinatal Equity Initiative (PEI), American Indian Maternal Support Services (AIMSS), etc.				

ECM Core Service Components

Required Area 2. Outreach and Engagement

Required Area 2 Outreach and Engagement	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
Describe the required responsibilities for direct outreach activities to locate and engage potentially eligible or ECM-authorized members. Include, at a minimum, the following: 1) Strategies 2) Method(s) of outreach 3) Staffing structure 4) Staff expectations 5) Timeframes 6) Number of attempts ECM provider is responsible for conducting outreach and engagement to assigned members. If any member materials or call scripts are intended to be used to support ECM member outreach and engagement, these will be subject to the Health Plan's review and approval.	**Recommended documentation:** Policy/procedure that describes the comprehensive outreach and engagement process including: • Strategies for locating and engaging with the member, including working with community partners; and use of best practices such as trauma-informed care, and use of trauma-sensitive practices, harm reduction practices, motivational interviewing, and any other best practice specific to the population that would enhance the direct outreach activities. • Specific methods that demonstrate a progressive approach to outreach and engagement such as telephonic, face-to-face interactions (online/in person), street outreach or any other method that meets the member where they are geographically, emotionally and physically as appropriate for the specific **population(s) of focus.** • Staffing structure that shows who is conducting the outreach activities, including protocols for ensuring the safety for staff performing street outreach, as applicable. • Staff roles and responsibilities in outreach and documentation, including			Yes ☐ No ☐

Required Area 2 Outreach and Engagement	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
	training requirements, specific for the **population(s) of focus.** • Protocol for the timeframe for conducting outreach that is specific for the **population(s) of focus.** • Protocol for the number of attempts to engage the member in ECM services, specific to the **population(s) of focus.** • Protocol demonstrating how outreach will be prioritized among the ECM population(s) of focus assigned to the ECM provider (i.e., determination of which member(s) to outreach and engage first with the highest level of risk and need for ECM).			
Describe all responsibilities to obtain and document verbal or written consent to receive the ECM benefit and to share information for care management purposes to the extent required by law.	**Recommended documentation:** Policy/procedure that describes the process for obtaining consent, and how the consent is documented, how the consent is stored, and including specific information pertinent to both written and verbal consent. The policy must address both the informed consent to receive ECM services, and the consent for release of information.			Yes ☐ No ☐

Required Area 3: Comprehensive Assessment and Care Management Plan

Required Area 3 Comprehensive Assessment and Care Management Plan	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
1) Incorporating clinical and non-clinical resources and needs into the **development of a member's care plan** related to physical and	**Recommended documentation:** 1) Comprehensive assessment and care plan that is specific for the **population(s) of focus** and includes the following elements:			Yes ☐ No ☐

Required Area 3 Comprehensive Assessment and Care Management Plan	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)

developmental health, mental health, SUD, community-based LTSS, oral health, palliative care, trauma-informed care, necessary community-based and social services, housing, in lieu of services (Community Supports), and social determinants of health.
2) **Working with member** to assess risks, needs, goals and preferences, and collaborate with members as part of the ECM process.
3) **Timing** of initial member assessment, including clinical, behavioral health, developmental, oral, substance use disorder, long-term services and supports, and social determinants of health.
4) **Ongoing member assessments**, including tools used, frequency, and staffing requirements, and setting (e.g., in person, by phone, etc.). Re-assessment requirements for ECM enrolled members will be defined by Health Plans per DHCS guidance.
	Assessment
	• Demographics.
	• Eligibility requirements (including validation/verification of non-duplicative services or programs, or member meets ECM exclusionary criteria).
	• Physical health status (current and previous).
	• Medication review (current and previous).
	• Pain management.
	• ADLs/IADLs.
	• Behavioral Health Status including:
	  ○ Cognitive function.
	  ○ Developmental factors.
	  ○ MH/SUD history.
	• Critical populations.[1]
	• Food insecurity.
	• Housing insecurity.
	• Culture.
	• Health literacy.
	• Vision and hearing
	• Caregiver resources and involvement.
	• Family and/or social support(s).
	• Benefits and eligibility.
	• End-of-Life.
	Care Management Plan template includes:
	• Member preference to receive a copy of the plan, in the member's preferred language and format.
	• Date of care plan update.
				Yes ☐ No ☐
				
				Yes ☐ No ☐

[1] Residential: Homeless, shelter resident, transitional housing, protective housing, PSH
Legal: court ordered services, probation/parole, re-entry, DUI/restricted license, APC/CPS
Disability: physical, SMI, SED, developmentally disabled, regional center client
Other: currently pregnant, gang involved, veteran, SOGIE

Required Area 3 Comprehensive Assessment and Care Management Plan	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
5) Sources of **data** that will inform care plan development. 6) Requirement to **co-develop care plan** with members, and as appropriate their social support networks and care team members, including those in other systems and organizations. 7) Ensuring member has a copy of their care plan and information about how to request updates. 8) Evidence of a care management documentation system or process to support the required documentation of ECM enrolled members and facilitate the necessary overall coordination and communication across the care team. 9) For members with long-term services and supports (LTSS) needs, the care plan must be developed by an individual **trained in person-centered planning** (as established in in 42 CFR § 438.208 & 441.301). 10) For members who may have LTSS needs, the assessment must include **DHCS' standardized LTSS referral questions** (as established in All Plan Letter 17-013), and the care plan should reflect member	• Individuals contributing to the development of the care plan. • Date(s) care plan reviewed with the member. • Identification of strengths and abilities. • Identification of problems, barriers, risks and/or needs. • Member's preferred goals (in SMART format), that include timelines or due dates. • Interventions, member outcomes, and follow up on referrals. • Coordination with other delivery systems. • Frequency of contact needed for each member based on their acuity and needs. 2) Policy/procedure that describes approach to patient-centered care planning, taking into account assessed risks, needs, goals and preferences, and approach to ongoing collaboration with members as part of the ECM process. 3) Policy/procedure that describes the timeframe of completion of the initial member assessment, based on the **population(s) of focus** being served. 4) Policy/procedure that describes the ongoing care management activities, including: • Tools used to document ongoing assessments and care management plans.			

Required Area 3 Comprehensive Assessment and Care Management Plan	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
preferences and incorporate LTSS and all wraparound services and supports that will ensure the member is set up to live continuously in the community. 11) For nursing facility residents transitioning to the community, DHCS encourages the use of the **California Community Transitions (CCT)** assessment tool. For the care plan: the LCM identifies resources to address needs, including coordination with housing agencies; identifies least restrictive housing options, ongoing medical care & other community-based service.	• Frequency of follow up, based on member needs, to ensure there are no gaps in the activities designed to address a member's health and social service needs, and to swiftly address those gaps to ensure progress towards regaining health and function continues. • Settings where meetings will take place, specific to the **population(s) of focus** where the members live, seek care or prefer to access services, i.e., meeting the person and caregivers where they are within the community (e.g., street outreach, shelters, respite care, schools, psychiatric units, institutions for mental diseases (IMDs) residential settings). • Methods to identify goal completion, including step down procedures to address overall completion of the program. This should include also protocols on warm handoff to a lower level of care/another program, as applicable. • For Children & Youth Population of Focus: transition the member to a provider who can service the member until program completion – regardless of age. • For Birth Equity Population of Focus: transition the member to a provider who can service the member until program completion – regardless of health condition and/or eligibility.			

Required Area 3 Comprehensive Assessment and Care Management Plan	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
	5) Policy/procedure that describes what sources of data (objective and subjective) are used to inform care plan development (may include screenshots). 6) Policy/procedure that describes the process for developing a care management plan that includes: • Member involvement in the care plan development. • Member's social support network involvement as appropriate in the care plan development. • Care team member involvement in the care plan development. • Member's PCP and/or care team involvement, partnership, and awareness of the member's ECM care plan (i.e., ECM provider care plan sharing and collaboration with the ECM member's PCP and/or care team). • For Birth Equity this can include the OB/GYN, registered nurse or other care team staff. • Involvement of the systems and organizations who are providing services to the member, such as Community Supports providers, as applicable.			

Required Area 4: Enhanced Coordination of Care

Required Area 4 Enhanced Coordination of Care	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
1) Ensuring that the ECM provider will act as the lead care manager' for all member needs, regardless of setting. Care plan will drive the patient care activities. 2) Coordination with other entities who may be providing some level of care coordination (California Children's Services, county behavioral health, the Health Plan, etc.) 3) Coordination with primary care providers, specialists, behavioral health, community-based long-term services and supports (LTSS) needs and oral health providers involved in the care of the member to support member treatment adherence including: • Medication review/reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to adherence. 4) Coordination with community agencies providing, or potentially	**Recommended documentation:** 1) Identification of the lead care manager(s) who will be responsible for all of the member's needs, regardless of setting, and including how this is communicated to the member and the member's social support networks. 2) Policy/procedure that describes how other entities who may be providing some level of care coordination are identified, and the process that ensures the coordination of care with that entity. 3) Policy/procedure that describes how primary care providers, specialists, behavioral health, health, and others who are providing care are identified and the process that ensures coordination of care with those providers. 4) Policy/procedure that describes how community agencies currently providing services or potential services are identified and the process that ensures coordination of care with those agencies. 5) Policy/procedure that describes how Community Supports are identified and the process that ensures coordination of care with contracted providers and/or vendors. 6) Policy/procedure that describes how social determinants of health needs, such as food security, housing, and employment, are identified on an ongoing basis. 7) Policy/procedure that describes how members and their social support			Yes ☐ No ☐

Required Area 4 Enhanced Coordination of Care	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
providing services to the member. 5) Coordination of Community Supports. 6) Addressing social determinants of health on an ongoing basis as part of the member's care needs. 7) Engaging members and respective social support networks in care coordination activities. 8) Obtain and document the member's authorization to share pertinent information across the care team supporting the member to in order to effectively coordinate the member's physical health, behavioral health, and community-based long-term services and supports (LTSS).	networks will be engaged in care coordination activities.			

Required Area 5: Health Promotion

Required Area 5 Health Promotion	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
1) Working with members to identify and build on resiliencies and potential family or community supports. 2) Providing services to encourage and support lifestyle choices based on healthy behavior, with	**Recommended documentation:** 1) Policy/procedure that describes the process of helping members to identify and build on resiliencies and potential family or community supports. 2) Policy/procedure that describes the services that will help the member			Yes ☐ No ☐

Required Area 5 Health Promotion	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
the goal of supporting member's ability to successfully monitor and manage their health. 3) Expectations for health promotion and preventive services above and beyond those services provided to the general Medi-Cal population. 4) Supporting members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.	develop self-management skills that support healthy lifestyle choices. 3) Policy/procedure that describes the health promotion and preventive services activities that are provided based on the complexity and required needs of the member. 4) Policy/procedure that describes the health promotion that would support member in accessing resources to assist them in managing their conditions and prevention of other chronic conditions.			

Required Area 6: Comprehensive Transitional Care

Required Area 6 Comprehensive Transitional Care	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
1) Transitioning members safely and easily between different levels of care and delivery systems in order to reduce avoidable member admission and readmissions. 2) Care coordination activities triggered by care transitions, including the development and regular maintenance of a transition plan for members.	**Recommended documentation:** 1) Policy/procedure that describes the planning process, **specific to the population(s) of focus**, to ensure that all needs are met for members experiencing a transition in the level of care. Documentation of the needs should be in the written transition plan that is shared with the member, and any other service provider who provides care to this member. The transition plan should include: • Reason/cause for transition.			Yes ☐ No ☐

Required Area 6 Comprehensive Transitional Care	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
3) Technology and tools used to identify and support care transitions.	• Physical and/or mental health follow up requirements. • Medication review/reconciliation. • Member education requirements. • Self-management activities. • Transportation needs. • Social services supports. • Durable medical equipment needs, as needed. • Home safety evaluation, if needed. • Adherence support and referrals to appropriate services. 2) Policy/procedure that describes the types of activities and timelines that are critical to the success of the member's transition in the level of care, including: • Checking in with the member to ensure all needs are met. • Working with discharging facility staff to develop transition plan. • Connecting member back to PCP. • Conducting a case conference with appropriate social support person(s) and care team members, including those in other systems and organizations. • Arranging timely follow-up appointments as needed. • Evaluating and revising care plan as needed. 3) Description of the technology and tools used to identify and support care transitions (may include screenshots), including the ability to appropriately			

Required Area 6 Comprehensive Transitional Care	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
	track each member's admission or discharge from an emergency department, hospital inpatient facility, skilled-nursing facility, residential/treatment facility, incarceration facility, or other treatment centers. • Including any social determinate status changes (e.g., housing and employment).			
4) Guidelines related to transitioning members to lower levels of care management or graduating them from ECM, including a warm handoff to another entity/program, as applicable.	**Recommended documentation:** Description of the process and criteria for transitioning members out of ECM, including: • Requirements that need to be met such as progress towards goal completion. • Member self-efficacy and ability to function independently. • Member understanding of when, why, and how transition and/or termination will occur. • Criteria for graduation from the ECM program. • Criteria for transitioning to a lower level of case management/care coordination. • Safety plan as appropriate for the specific population. • Maintenance plan as appropriate for the specific population. • Warm handoff of member's case and care plan to another entity/program, as applicable			Yes ☐ No ☐

Required Area 7. Member and Family Supports

Required Area 7 Member and Family Supports	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
1) Documenting a member's chosen caregiver or family/support person, such as a guardian, AR, caregiver, and/or other authorized support person(s). 2) Ensuring the member's ECM lead care manager serves as the primary point of contact for the member and their chosen family/support persons 3) Identifying supports needed for the member and chosen family/support persons to manage the member's condition and assist them to access needed support services; and 4) Providing for appropriate education of the member, family members, guardians and caregivers on care instructions for the member 5) Ensuring staff are trained in mandatory reporting and your organization has a process in place for staff to carry out mandatory reporting, including escalations within the ECM team and completing the required documentation.	**Recommended documentation:** 1) Policy/procedure that clearly describes how member and family support services are identified, assessed, and provided. Documentation should include, but is not limited to descriptions and examples of the following: • Any aspects that are specific to the ECM population(s) of focus, including which population(s) of focus they pertain to. • Identification of member's caregiver(s) or family/support person(s) during assessment. • If none identified, document plan for identifying/creating supports with the member. 2) Policy/procedure that demonstrate the following: • Discussion with member about the lead care manager's communication (including type and frequency) with identified caregiver(s) or family/support person(s) as a part of services. • Obtained member consent to communicate with caregiver(s) or family/support person(s) as applicable. • Documentation that the lead care manager informed member, caregiver(s) and/or family/support person(s) that they are the primary			Yes ☐ No ☐ Yes ☐ No ☐

Required Area 7 Member and Family Supports	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
	point of contact for services and offered their contact information. 3) Policy/procedure that demonstrates: • Clear identification and description of supports needed for the member and caregiver(s) or family/support person(s) to manage the member's condition and assist with member's goals. • Description of how the lead care manager will assist the caregiver(s) or family/support person(s) with accessing support services, including a plan and timeline for follow-up on services. 4) Policy/procedure that clearly describe: • How and when the lead care manager will provide culturally appropriate person-centered planning, education, training, and care instructions for caregiver(s) or family/support person(s). • Where and how person-centered planning, education, training, and care instructions with caregiver(s) or family/support person(s) will be documented. • Documentation of the lead care manager plan for follow up with caregiver(s) or family/support person(s) post planning, education, and training post-instruction. • How the member may request to change their lead case manager and how those requests are managed.			

Required Area 7 Member and Family Supports	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
	5) Policy/procedure that details: • Your organization's approach to mandatory reporting, including for the staff to escalate within the ECM team and complete the required documentation.			

Required Area 8: Coordination of and Referral to Community and Social Support Services

Required Area 8 Coordination of and Referral to Community and Social Support Services	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
1) Determining appropriate services to meet the needs of members, including services that address social determinants of health needs, housing and/or services that are offered as Community Supports. 2) Coordinating and referring members to available community resources and following up with the member to ensure services were rendered (i.e., closed loop referrals). 3) Obtain and document the member's authorization to share pertinent information across the care team supporting the member in order to effectively coordinate the member's physical health, behavioral health, and community-based	**Recommended documentation:** 1) Policy/procedure that describes how appropriate services, benefits and resources are determined for the member, and how they are located and accessed in the community (e.g., internal resource guide, directory of community partners, use of 211, findhelp.com, Community Health Record, etc.). If there is more than one population that is included in the application, please be sure to identify each population(s) of focus and your knowledge of accessing needed community resources for this specific population, if applicable. Please be specific in listing evidence of your knowledge of resources for the population(s) served. 2) Policy/procedure that describes the workflow of how the referrals are coordinated with the community resource, including how the referral is			Yes ☐ No ☐

Required Area 8 Coordination of and Referral to Community and Social Support Services	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
long-term services and supports (LTSS).	tracked and confirmation that the service/resource was provided. The procedure or workflow should also include the activities or interventions that support the appropriate completion of the referral. May include screenshots that support referral tracking, if used.			

ECM Provider Administration & Operations

Required Area 9: Claims/Encounters

Required Area 9: Claims/Encounters	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
1) ECM provider must demonstrate the ability to submit claims and/or encounters (at minimum monthly) to Health Plan in accordance with requirements in Department of Health Care Services (DHCS). 2) The exact claims/encounter submission process may differ by the Health Plan. 3) ECM provider must demonstrate the use of a care management documentation system or process. Care management documentation systems may include certified electronic health record technology, or other documentation tools that can: document member goals and goal attainment status; develop and	**Recommended documentation:** 1) Evidence of an electronic health record (EHR) or other compliant electronic system that will be used to capture ECM service encounters. 2) Evidence of where and how documentation will support coordination of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a member's care plan. 3) Screenshots or a walk-through, when appropriate, of the configuration changes in order to accommodate ECM claims/encounter submissions based on DHCS final guidance.			Yes ☐ No ☐

Required Area 9: Claims/Encounters	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
assign care team tasks; define and support member care coordination and care management needs; gather information from other sources to identify member needs and support care team coordination and communication and support notifications regarding member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).				

Required Area 10: File Data Exchange

Required Area 10: File Data Exchange	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
The data exchange and/or reporting platform or process may vary by the Health Plan. ECM provider to establish capability for **secure data transfer ability** in order to retrieve and deliver key operational and regulatory data and reporting to ensure the delivery of ECM services to eligible members. Secure data transfer ability means you are able to send secure email, and/or login/connect to the Health Plan secure file transfer protocol (SFTP) site and/or portal. 1. On a regular basis, ECM providers must retrieve an eligibility and/or enrollment member file that	**Recommended documentation:** 1) Attestation of ECM provider secure data transfer ability to retrieve and submit ECM provider files. ***NOTE:*** Participation and successful completion of Health Plan file and/or portal testing process is required to be certified as an ECM provider. 2) Demonstration of how the ECM provider will be tracking ECM services and any follow up with ECM enrolled members in order to appropriately report on services and activities. Reporting requirements for ECM will be defined by DHCS.			Able to successfully transfer file via SFTP or portal Yes ☐ No ☐ Able to successfully receive file via SFTP or portal Yes ☐ No ☐ Demonstrated understanding of file formatting expectations and due dates Yes ☐ No ☐

Required Area 10: File Data Exchange	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
contains assigned ECM members that are eligible to receive ECM services, including both new and existing members. The frequency may vary by the Health Plan. 2. On a minimum of a monthly basis, ECM providers must update and report back to the Health Plans via an SFTP file upload identifying the services provided and status of each eligible and enrolled ECM member. Reporting requirements for ECM providers will be defined by DHCS. 3. Health Plans may also use the SFTP site to exchange other data files to support ECM provider service delivery (i.e., ADT reports, capitation reports, etc.)				

Required Area 11: Staffing

Required Area 11: Staffing	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
ECM provider has the appropriate care team staffing to meet ECM required staffing ratios as outlined by DHCS. 1) At the minimum, ECM providers must have an ECM director, ECM clinical consultant(s), and lead case managers.	**Recommended documentation:** 1) Names, qualifications, and roles of ECM provider care team staff. 2) ECM organization staffing chart addressing the required roles and responsibilities and how the ECM care team is integrated within the ECM provider organization.			Complete capacity document (including names/titles and contact information of ECM CM team with current caseloads) Yes ☐ No ☐

Required Area 11: Staffing	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
2) Staffing ratios will be based on DHCS requirements. When available, Health Plans will provide guidance on staffing ratios for the members assigned to lead case manager(s) and potentially the ratio for lead case manager(s) assigned to clinical consultants. ECM lead case manager is responsible for: 1) Serving as the primary point of contact for the member, member's family, authorized representative (AR), caregiver, other authorized support person(s) as appropriate, and the multidisciplinary care team providing care to the member. 2) Developing a comprehensive care management plan with input from a multidisciplinary care team, as well as the member, to ensure a whole-person approach is taken in identifying gaps in treatment or gaps in available and needed services. ECM providers have protocols in place outlining how clinical supervision is provided to non-licensed (i.e., paraprofessionals) staff members serving as a lead case manager to ensure continued guidance, training,	3) Policy/procedure that describes the clinical supervision and oversight of the lead case managers, including the frequency of meetings, team huddles, or case conferences required to ensure continued support is provided to the team. 4) Policy/procedure that describes how the ECM care team should handle any escalated member cases (e.g., suicidal ideation) and which team members are involved and available to support the lead case managers. This policy/procedure should be specific to the **population(s) of focus.**			Plan for future staffing/ramp up over time and how they intend to meet ECM staffing requirements Yes ☐ No ☐ ECM organizational staffing chart provided displaying integration of ECM care team at ECM provider Yes ☐ No ☐

Required Area 11: Staffing	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
and clinical support to appropriate oversee an ECM member's care plan and care coordination.				

Required Area 12: Oversight and Monitoring

This required area only applies if the ECM provider is proposing to subcontract with another entity in order to fulfill the ECM provider requirements.

Please note that any proposal to include a subcontract to fill the ECM provider requirements must be reviewed individually by each Health Plan and will approved and vetted by each individual Health Plan through the ECM certification process.

Required Area 12: Oversight & Monitoring	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
The Health Plan's review and approval of the use of a subcontractor to fulfill the ECM provider requirements must demonstrate: 1) Specialized knowledge of the ECM **population(s) of focus** they intend to serve. 2) A pre-existing relationship or structure that has promoted the execution of a strong oversight and monitoring plan of the subcontractor(s) (i.e., demonstrated success in other programs with the same or similar subcontracting relationship in place). 3) Development and execution of oversight and monitoring activities to ensure compliance to the ECM provider requirements.	**Recommended documentation:** 1) A policy and procedure document that outlines the following regarding the use of subcontractor(s) for the provision of ECM services: • Review and selection process and/or criteria for selecting subcontractor(s). • Role of subcontractor(s) with regards to the provision of ECM core services, and agreement to communicate to the Health Plan in advance of any changes in responsibility. • Documentation of member care activities – describe where and how all documentation of ECM activity will be completed. • Data and reporting elements. • Method and frequency of oversight activities.			Comprehensive oversight and monitoring P&P Yes ☐ No ☐ Subcontractor demonstrates specialized knowledge of particular ECM populations of focus **AND** has previous success as a subcontractor with the applicant Yes ☐ No ☐

Required Area 12: Oversight & Monitoring	Recommended Evidence	Notes	Submitted Evidence	Compliant (For Internal Use Only)
4) Demonstration of the oversight and monitoring activities to the Health Plans, including the identification of any quality or compliance concerns and execution of corrective action, as applicable.	• How identified deficiencies are addressed and communicated to the Health Plan. • Notification to the Health Plan of changes in subcontractor network. • Subcontractor participation in required ECM trainings and technical assistance. 2) Demonstration of the execution of oversight and monitoring activities to ensure compliance to the ECM provider requirements, including the identification of any quality or compliance concerns and the execution of correction action, as applicable. 3) Oversight and monitoring plan for subcontractor(s) to review reporting and data submission by subcontractors on a monthly and/or quarterly basis, including the oversight of service provision and quality of care and execution of comprehensive audits. 4) Sample or template of subcontractor agreement. 5) ECM provider to submit quarterly progress reports to the Health Plan regarding performance of each subcontractor, at minimum or as requested by contractor.			