Los Angeles County Managed Care Plans

Enhanced Care Management (ECM) Provider Reference Guide

Version 2.0

Revised 9/1/2024

1 About this Guide

The Los Angeles County Managed Care Plans' (L.A. MCPs) Enhanced Care Management (ECM) Provider Reference Guide is designed to support ECM Providers in the implementation of ECM. This Guide offers an overview of the general requirements and expectations for ECM Providers contracted with L.A. MCPs. It is important to note that each L.A. MCP may have specific models, processes, or operations unique to their plan. Additionally, L.A. MCPs may release revised editions of this ECM Provider Reference Guide in the future.

While this guide focuses on ECM-specific information, it should be noted that the L.A. Care Universal Provider Manual (UPM) serves as the overarching guide for all contracted providers. L.A. Care requires all providers to follow the guidance and requirements outlined in the UPM, in addition to the ECM-specific details provided in this reference guide.

2 Introduction

Enhanced Care Management (ECM) benefit is a statewide benefit established by the Department of Health Care Services (DHCS) to provide a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Medi-Cal Managed Care Members with the most complex medical and social needs. Enhanced Care Management provides systematic coordination of services and comprehensive care management to specific Populations of Focus (POF) that is community based, high touch and person centered.

Effective January 1, 2022, Managed Care Plans (MCPs) in Los Angeles County launched the Medi-Cal ECM benefit designed by the Department of Health Care Services (DHCS) and authorized by the Centers for Medicare and Medicaid Services (CMS) to provide seven core 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

The overall goal of the ECM benefit is to improve care coordination, integrate services, facilitate community resources, address social determinants of health (SDOH), improve health outcomes, and decrease inappropriate utilization and duplication of services for highest need, high-cost beneficiaries in Medi-Cal. The benefit builds on both the design and the learning from the Health Homes Program (HHP) and Whole Person Care (WPC) Pilots and replaces both initiatives.

The Los Angeles MCPs are required to contract with community-based ECM Providers that have experience serving the ECM Populations of Focus (POF), and expertise providing the core ECM services, to provide services to eligible Members under the Medi-Cal ECM benefit. The ECM POFs eligible for the ECM benefit are:

ECM Populations of Focus (POFs)		Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✔	

1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✔	✔
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✔	✔
3	Individuals with Serious Mental Health and/or SUD Needs	✔	✔
4	Individuals Transitioning from Incarceration	✔	✔
5	Adults Living in the Community and At Risk for LTC Institutionalization	✔	
6	Adult Nursing Facility Residents Transitioning to the Community	✔	
7	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✔
8	Children and Youth Involved in Child Welfare		✔
9	Birth Equity Population of Focus	✔	✔

Detailed eligibility criteria of these populations of focus per DHCS are included in Section 4 ECM Member Eligibility, Assignment and Enrollment.

3 Regulatory Authorities

By entering into the Enhanced Care Management Services Agreement (contract) with each L.A. MCP, the ECM Provider agrees to follow the ECM benefit requirements as established under law, regulation, and through any service agreements between the MCP and DHCS, including Member materials applicable to the ECM benefit. The ECM Provider will provide the ECM services in accordance with all applicable Federal and State law and regulatory guidance as outlined in the signed contract.

4 How to Become an ECM Provider

MCPs are required to contract with ECM Providers to deliver ECM to Members. ECM Providers are community-based entities who specialize in each of the specific POF and who have a well-established presence in the community they serve. These providers are experienced in delivering intensive, in-person care management services tailored to individuals within one or more POFs. ECM will be offered primarily through in-person interaction where Members and their families and support networks live, seek care, and prefer to access services.

This section goes over the requirements and process of becoming and ECM provider.

4.1 ECM Provider Experience and Qualifications

The ECM Provider shall be experience in serving the ECM Populations of Focus it will serve and possess expertise in the services it will provide. Compliance with all applicable state and federal laws, regulations,

and ECM program requirements in the DHCS-MCP ECM and CS Contract, and associated guidance, is mandatory. The ECM Provider should have the capacity to deliver culturally appropriate and timely in-person care management activities, including accompanying Members to critical appointments when necessary. All member communication should be culturally and linguistically appropriate, presented in the member's Threshold Language as defined by DHCS, and written at or below a sixth-grade reading level.

The ECM Provider should utilize a comprehensive care management documentation system or process that supports the documentation and integration of physical, behavioral, social services, and administrative data as outline in Section 10 Care Management Documentation System. This system should facilitate the creation and maintenance of the Member Care Plan and enable sharing with other providers and organizations involved in the Member's care, such as primary care physicians, Independent Physician Associations (IPAs), specialists, and others.

The ECM Provider should establish formal arrangements and processes in place to engage and collaborate with area hospitals, primary care practices, behavioral health providers, specialists, and other entities, including Community Supports Providers, to ensure coordination of care as appropriate for each Member's needs.

4.1.1 ECM JI ECM Providers

JI ECM Providers must meet the standard ECM Provider requirements and have a care delivery model specific to the JI Populations of Focus. They should participate in pre-release care management services and/or warm handoffs as appropriate. They must either enroll in Medi-Cal Fee-For-Service (FFS) via the Provider Application and Validation for Enrollment (PAVE) system or establish formal agreements to provide and be compensated for in-reach care management and participation in warm handoffs with correctional facilities in their operating counties.

Members who do not receive pre-release services may still qualify for ECM as part of the JI Populations of Focus. In such cases, the JI ECM Provider must follow all program requirements set forth in Enhanced Care Management Provider Standard Terms and Conditions, Section 8: ECM Requirements and Core Service Components of ECM.

4.2 Provider Certification

The purpose of the ECM Provider Certification Process is to certify that prospective ECM Providers have the experience and expertise necessary to provide intensive, in-person care management services to the Population(s) of Focus that the ECM Provider is interested in serving. Certification is the process used by the MCPs to evaluate and verify the potential ECM Provider's ability to comply with ECM requirements as outlined by DHCS, including the provision of ECM core services and the ability to submit data files and claims.

To become an ECM Provider, organizations must meet the criteria described in the DHCS ECM Policy Guide and formally submit a Letter of Interest (LOI) to the MCPs with whom they intend to engage in contractual agreements. Upon review of the LOI L.A. MCPs will extend invitations to select organizations to complete an ECM Provider Certification Application and submit accompanying documentation to support their application. Working collaboratively with the MCPs, prospective ECM Providers will review the ECM requirements, including services offered, populations served, staffing, and system readiness.

Together, the prospective ECM Provider and L.A. MCP will determine where additional effort(s) will be necessary to meet the contracted ECM Provider requirements.

MCPs will contract with ECM Providers specializing in each of the specific Populations of Focus who have a footprint in the community they serve. The appropriate ECM Provider assignment will vary depending on the specific needs of the Member and Member preferences.

The L.A. MCP and the prospective ECM Provider must discuss, document, and agree on a Readiness and Gap Closure Plan to ensure the prospective ECM Provider's readiness by the agreed upon go-live date and expectations following the go-live date into ECM administration. The key areas of focus for the Readiness and Gap Closure Plan are driven by the Required Areas in the ECM Certification Application:

Area of Focus
Overview of ECM Structure
Overview of ECM Structure/Staffing
Overview of ECM Structure/Outreach & Engagement
Comprehensive Assessment and Care Management Plan/Member and Family Supports/ Administration & Operations
Enhanced Coordination of Care/Member and Family Supports/ Enhanced Coordination of Care/ Coordination of and Referral to Community and Social Support Services/ Member and Family Supports
Health Promotion
Transitional Care Services
File Data Exchange
Claims/Encounters
Oversight & Monitoring

The L.A. MCP and the prospective ECM Provider will connect regularly to evaluate progress made towards addressing the identified gap(s) as outlined in the Readiness and Gap Closure Plan. Should the prospective ECM Provider be unable to meet the ECM requirements or determines their inability to do so, certification by the MCP will be withheld, consequently disqualifying them from contracting with the MCP to deliver ECM services under the ECM benefit. Additionally, the L.A. MCP may retain the authority to request an on-site visit with the prospective ECM Provider during both the certification process and ECM administration period as deemed necessary.[1] Once all gap closures are resolved provider will move to the credentialing and contracting process.

4.3 National Provider Identifier (NPI)

A National Provider Identifier (NPI) is required for Medi-Cal enrollment. All ECM Providers, as a part of their enrollment process as Medi-Cal providers, must obtain an NPI. This ensures that the ECM Provider is recognized and able to participate in the Medi-Cal program. For more information on how to set up an organizational NPI please refer to DHCS's A Step-by-Step Guide for Providers Participating in the ECM and Community Supports Programs.

[1] On-site visits will be subject to the standard public health protocols and may need to occur virtually.

4.4 Medi-Cal Enrollment

In accordance with relevant DHCS guidance and DHCS *APL 19-004 Provider Credentialing / Recredentialing and Screening / Enrollment*, MCP Network Providers, including those that will operate as ECM Providers, are required to enroll as a Medi-Cal provider.

ECM Providers without a state-level pathway to Medi-Cal enrollment will undergo vetting by the L.A. MCP in order to participate as ECM Providers. The ECM Provider, including its affiliated individuals delivering services on its behalf, must adhere to the L.A. MCP's vetting process outlined in Section 4.2 Provider Certification to ensure compliance with the requisite capabilities and standards expected of an ECM Provider. The L.A. MCP will request pertinent information from the ECM Provider to satisfy this requirement.

4.5 ECM Provider Care Team

It is imperative for ECM Providers to assemble a highly qualified and skilled multi-disciplinary team to effectively execute the seven ECM Core Services. This entails establishing and sustaining a comprehensive care team that encompasses all the roles and functions necessary to deliver ECM services to Members. The ECM Provider is responsible for maintaining adequate staff and ensuring their ability to carry out responsibilities for each assigned Member that is consistent with the DHCS Provider Standard Terms and Conditions, the DHCS-MCP ECM Contract, the DHCS ECM Policy Guide, and any other related DHCS guidance. The L.A. MCP will work with the ECM Provider to ensure the ECM Provider's ECM staffing model emphasizes and optimizes the roles of different team members, meets required ECM staffing ratios, and meets the ECM requirements necessary to serve all Populations of Focus.

According to DHCS guidelines, each ECM provider is required to appoint a Lead Care Manager. An ECM Lead Care Manager is a Member's designated care manager for ECM, who works for the ECM Provider organization. L.A. MCPs are required to ensure that each Member receiving ECM has a dedicated Lead Care Manager with responsibility for interacting directly with the Member and/or family, Authorized Representatives, caretakers, and/or other authorized support person(s), as appropriate.

The assigned Lead Care Manager operates as part of the Member's multi-disciplinary care team and is responsible for engaging with the multi-disciplinary care team to identify gaps in the Member's care and ensure appropriate input is obtained to effectively coordinate all primary, behavioral, developmental, oral health, LTSS, Community Supports and other services that address SDOH, regardless of setting, at a minimum. The Lead Care Manager is also responsible for coordinating all aspects of ECM and coordination with Community Supports Provider(s), as applicable. For instances in which a Member has multiple care managers, the Lead Care Manager is considered to be the primary care manager for the Member and will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and preventing service duplication.

ECM Providers must have protocols in place outlining how clinical supervision is provided to non-licensed (i.e., paraprofessional) staff members serving as Lead Care Managers to ensure continued guidance, training, and clinical support to oversee the ECM Member's Care Plan and care coordination appropriately.

The ECM Provider assumes responsibility for maintaining specific roles and positions within its multi-disciplinary care team. At a minimum, the team must be comprised of:

- Lead Care Manager(s)

- ECM Director
- ECM Clinical Consultant(s)

Many multi-disciplinary care team models also include Community Health Workers (CHWs). CHWs can be included in the multi-disciplinary care team at the ECM Provider's discretion.

The table below describes the DHCS ECM multi-disciplinary care team requirements. As DHCS may provide additional guidance regarding staffing, this section of the guide may be updated in the future.

ECM Team Member	Qualifications	Role
Lead Care Manager	Professional (i.e., licensed mental health or behavioral health professional/clinician, social worker, or nurse) *or* Paraprofessional (with appropriate training and oversight)	• Member Engagement: Engage eligible Members through personalized interaction and utilize motivational interviewing, trauma-informed care, and harm-reduction techniques. • Coordination: Work with individuals and entities to ensure a seamless experience for the Member, avoiding service duplication. • Service Oversight: Oversee the provision of ECM services and ensure the implementation of the Comprehensive Assessment and Care Management Plan. • Service Delivery: Offer services where the Member lives, seeks care, or is most convenient, in line with MCP guidelines. • Social Services Connection: Facilitate connections between Members and other social services, including transportation. • Advocacy: Advocate on behalf of the Member with healthcare professionals. • Discharge Coordination: Collaborate with hospital staff on discharge planning and act as the single point of contact for the member. • Accompaniment: Accompany Members to office visits as needed, following MCP guidelines. • Monitoring: Monitor treatment adherence, including medication. • Health Promotion: Provide health promotion and self-management training. • POF-Specific Roles: Fulfill any Population of Focus-specific roles as stipulated by DHCS in the DHCS ECM Policy Guide and related guidance.
ECM Director	Ability to manage multi-disciplinary care teams	• Management: Oversee and manage the multi-disciplinary care team.

ECM Team Member	Qualifications	Role
		• **Compliance:** Ensure adherence to quality measures and reporting requirements for the multi-disciplinary care team. • **Community Engagement:** Lead efforts in community engagement, networking, and relationship-building to generate referrals. • **Primary Contact:** Serve as the primary point of contact for the plan, addressing case escalations and other operational needs.
ECM Clinical Consultant	Clinician consultant(s), independently licensed clinician who may be a primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, licensed clinical social worker, or other licensed behavioral health care professional	• **Clinical Oversight:** Ensure that clinical assessment elements leading to the creation of the plan of care are completed under the direction of an independently licensed clinician. • **Team Support:** Review and provide guidance to the multi-disciplinary care team. • **Clinical Resource:** Serve as a clinical resource for the multi-disciplinary care team, as needed, including supporting medication reconciliation where necessary. • **Facilitation**: Assist in facilitating access to primary care and behavioral health providers, supporting the care coordinator and the multi-disciplinary team.
Community Health Worker	Paraprofessional or peer advocate	• **Member Engagement:** Connect with and support members in navigating the healthcare system. • **Support:** Accompany members to visits, arrange transportation, and link to services. • **Health Promotion:** Offer basic health education and self-management training. • **Social Services Linkage:** Connect members to community supports. • **Outreach:** Facilitate visits with care coordinators. • **Routine Advocacy:** Advocate in routine situations and support treatment adherence.

4.6 Staffing and Capacity

To ensure that the LA MCPs understand the organization's staffing capacity, measure network adequacy, observe growth over time, and identify staff who will need to complete required training, ECM Providers are required to submit an ECM Provider Staffing and Capacity Report to the L.A. MCP as part of the ECM Provider Certification process. After ECM go-live, ECM Providers will be required to submit Staffing and Capacity reports on a monthly basis, at a minimum. L.A. MCPs will provide ECM Providers a standard ECM Provider & Staffing Capacity reporting template for the ECM Providers to use.

All L.A. MCPs will use the data from the Staffing and Capacity reports to report network capacity to DHCS and ensure that ECM Provider caseloads remain within the thresholds specified by the L.A. MCPs. The individual Lead Care Manager's caseload count is the cumulative count of members regardless of the Member's MCP assignment. Lead Care Managers can serve Members from different MCPs, but the individual Lead Care Manager's caseload capacity count cannot exceed the caseload threshold for each individual Care Manager as a whole.

When establishing caseload ratios for Lead Care Managers, L.A. MCPs require ECM providers to prioritize acuity and population of focus. The ratio should not exceed fifty (50) ECM enrolled patients per one (1) Lead Care Manager. ECM providers will be asked to provide the rationale for their chosen caseload ratios

4.7 ECM Staff Training

ECM Providers must participate in all mandatory trainings as outlined in the UPM and Contract, as well as provider-focused ECM training and technical assistance provided by the L.A. MCP. This includes in-person sessions, webinars, and calls as necessary.

5 ECM Member Eligibility

This section outlines information regarding ECM Member eligibility. Medi-Cal managed Care Members are eligible for the ECM benefit if they meet the following eligibility criteria as Members of the ECM Populations of Focus. The ECM Populations of Focus seek to improve the health outcomes of a group by monitoring and identifying Members within that group. ECM Providers can serve one or more Populations of Focus.

5.1 Adult and Youth Definitions

In the Populations of Focus definitions, "adult" is defined as an individual who is 21 years of age or older, and a "child or youth" is defined as an individual under 21. Consequently, the Children and Youth-specific definitions for ECM apply up to age 21, with limited exceptions as called out below for youth with a history of involvement with the child welfare system. When a Member under 21 is served in ECM and does not meet the adult ECM criteria upon turning 21, the Member should not be disenrolled from ECM due to aging out alone; rather, the ECM Provider should apply the L.A. MCP graduation criteria to determine when the Member is ready to disenroll.

ECM Population of Focus	Eligibility Criteria
Individuals Experiencing Homelessness*:* *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	A. Adults (whether or not they have dependent children/youth living with them) who: 1. Are experiencing homelessness, defined as meeting one or more of the following conditions: i. Lacking a fixed, regular, and adequate nighttime residence; ii. Having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; iii. Living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by federal, state, or local government programs for low

ECM Population of Focus	Eligibility Criteria
	income individuals or by charitable organizations, congregate shelters, and transitional housing); iv. Exiting an institution into homelessness (regardless of length of stay in the institution); v. Will imminently lose housing in next 30 days; vi. Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence; ***AND*** 2. Have at least one complex physical, behavioral, or developmental need, with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high cost services. DHCS defines homelessness as one of the following[2]: • An individual or family who lacks a fixed, regular, and adequate nighttime residence; • An individual or family 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; • An individual or family living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotel and motels paid for by federal, state, or local government programs for low income individuals or by charitable organizations, congregate shelters, and transitional housing); • An individual exiting an institution into homelessness (regardless of length of stay in the institution); • An individual or family who will imminently lose housing in next 30 days; Individuals fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence.
Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	B. Children, Youth, and Families with members under 21 years of age who: 1. Are experiencing homelessness, as defined above in (a) under the modified HHS 42 CFR Section 11302 "Homeless" definition; ***OR***

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

ECM Population of Focus	Eligibility Criteria
	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 shelter; 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". Notes on the (B) definition: • Children, youth, and families do not need to meet the additional "complex physical, behavioral, or developmental need" criteria noted above in Clause (2) for adults in (A). • Clause (2) for children, youth, and families in (B) is modified from the 45 CFR 11434a McKinney-Vento Homeless Assistance Act definition of "at risk of homelessness" and is included in this Population of Focus to ensure ECM captures the breadth of unsafe, substandard, and insecure living conditions that Members, particularly children and youth, may experience. DHCS defines homelessness as one of the following[3]: • An individual or family who lacks a fixed, regular, and adequate nighttime residence; • An individual or family 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; • An individual or family living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotel and motels paid for by federal, state, or local government programs for low income individuals or by charitable organizations, congregate shelters, and transitional housing); • An individual exiting an institution into homelessness (regardless of length of stay in the institution); • An individual or family who will imminently lose housing in next 30 days; • Individuals fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence.

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

ECM Population of Focus	Eligibility Criteria
Individuals At Risk for Avoidable Hospital or ED Utilization *(Formerly "High Utilizers")*	A. Adults At Risk for Avoidable Hospital or ED Utilization Adults who meet one or more of the following conditions: 1. Five or more emergency room visits in a six-month period that could been avoided with appropriate outpatient care or improved treatment adherence; 2. Three or more unplanned hospital and/or short-term skilled nursing facility (SNF) stays in a six-month period that could have been avoided with appropriate outpatients care or improved treatment adherence. B. Children and Youth At Risk for Avoidable Hospital or ED Utilization Children and youth who meet one or more of the following conditions: 1. Three or more ED visits in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence; 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. For this POF, MCPs may choose to authorize ECM for individuals who are at risk for avoidable hospital or ED utilization and who would benefit from ECM but who may not meet the numerical thresholds specified above.
Individuals with Serious Mental Health and/or SUD Needs	A. Adults with Serious Mental Health and/or SUD Needs Adults who: 1. Meet the eligibility criteria for participation in, or obtaining services through: i. SMHS delivered by MHPs; ii. The Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program; *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, overdoes, and/or suicide; ii. Use crisis services, EDs, urgent care, or inpatient stays as the primary source of care;

ECM Population of Focus	Eligibility Criteria
	iii. Experienced two or more ED visits or two or more hospitalizations due to serious mental health or SUD in the past 12 months; B. Children and Youth with Serious Mental Health and/or SUD Needs Children and youth who: 1. Meet the eligibility criteria for participation in, or obtaining services through one or more of: i. SMHS delivered by MHPs; ii. The DMC-ODS OR the DMC program No further criteria are required to be met for children and youth to qualify for this ECM Population of Focus.
Individuals Transitioning from Incarceration	A. Adults Transitioning from Incarceration Adults who: 1. Are transitioning from a correctional facility (e.g., prison, jail, or youth correctional facility) or transitioned from correctional facility within the past 12 months; *AND* 2. Have at least one of the following conditions: 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 B. Children and Youth Transitioning from a Youth Correctional Facility or transitioned from being in a youth correctional facility within the past 12 months. No further criteria are required to be met for Children and Youth to qualify for this ECM Population of Focus.
Adults Living in the Community and At Risk for LTC Institutionalization	Adults who: 1. Are living in the community who meet the SNF Level of Care (LOC) criteria; 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*

ECM Population of Focus	Eligibility Criteria
	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.
Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition	Children and youth who: 1. Are enrolled in CCS OR CCS WCM; *AND* 2. Are experiencing at least one complex social factor influencing their health. Examples includes (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 and Youth Involved in Child Welfare	Children and youth who meet one or more of the following conditions: 1. Are under age 21 and are currently receiving foster care in California; 2. Are under age 21 and previously received foster care in California or another state within the last 12 months; 3. Have aged out of foster care up to age 26 (having been in foster care on their 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.
Birth Equity Population of Focus	Adults and youth who: 1. Are pregnant OR are postpartum (through 12 months period); *AND* 2. Are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality

5.2 Continuity of ECM Services for Members Who Change Managed Care Plans

The L.A. MCPs will preserve continuity of ECM services for members who were receiving ECM with a prior health plan and have changed health plans. Members and/or their family member or authorized representative may request enrollment into ECM upon the transfer of their care from a prior Managed Care Plan where they were receiving the ECM benefit. Members will be requested to provide the name of

the prior Managed Care Plan and/or the prior ECM Provider to facilitate continuity and mitigate gaps in care.

Requests should be submitted via referral to the new Managed Care Plan using the ECM referral form and identifying ECM eligibility as Continuity of Care, in addition to any applicable ECM Populations of Focus.

Managed Care Plans will also conduct a retrospective review of data supplied by DHCS to identify members who have changed health plans and received ECM services with their prior health plan. These members, when identified through the L.A. MCP's data, will be identified as ECM enrolled and included on the Member Information File (MIF) for outreach and engagement.

5.3 ECM Program Overlaps and Exclusions

ECM will coordinate all care for the highest-risk Members with complex medical and social needs, including across the physical and behavioral health delivery systems. DHCS conducted a thorough analysis of existing programs incorporating care management and/or care coordination to devise effective coordination strategies and prevent duplication across programs. DHCS categorized three potential approaches to ECM coordination and preventing duplication, outlined below, along with programs falling within each category.

Approach	Explanation	Programs
ECM and the other Program	MCP Members can be enrolled in **both** ECM and the other program. ECM enhances and/or coordinates across the case/care management available in the other program. MCP must ensure non-duplication of services between ECM and the other program. These Programs are considered to be complementary of ECM.	**Services Carved Out of Managed Care** • California Children's Services (CCS) • Specialty Mental Health Services (SMHS) Targeted Case Management (TCM) • SMHS Intensive Care Coordination (ICC) for Children • Drug Medi-Cal Organized Delivery System (DMC-ODS) and Drug Medi-Cal (DMC) Care Coordination & Management Programs • Fall Service Partnership (FSP) • Health Care Program for Children in Foster Care (HCPCFC) • In Home Supportive Services (IHSS) • Genetically Handicapped Person's Program (GHPP) **Services Carved into Managed Care** • CCS Whole Child Model (WCM) • Community-Based Adult Services (CBAS) **Dual-Eligible Members** • Medi-Cal MCP + Medicare FFS • Medi-Cal MCP + Other MA **Other Programs** • California Wraparound • Regional Centers for Individuals with I/DD **Programs Serving Pregnant & Postpartum Individuals** • Comprehensive Perinatal Services Program (CPSP)

		• Black Infant Health (BIH) Program • California Perinatal Equity Initiative (PEI) • American Indian Maternal Support Services (AIMSS) • CDPH California Home Visiting Program (CHVP) • CDSS CalWORKs Home Visiting Program (HVP)
Either ECM or the other Program	MCP Members can be enrolled in ECM **OR** in the other Program, not in both at the same time. These Programs are considered to be duplicative of ECM.	**1915(c) 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 (I/DD) • Self-Determination Program for Individuals with I/DD **Services Carved Out of Managed Care** • Local Governmental Agencies (LGAs) County-based Case Management (TCM) **Services Carved into Managed Care** • Complex Care Management (CCM) **Other Programs** • California Community Transitions (CCT) Money Follows the Person (MFTP)
Excluded from ECM	Medi-Cal beneficiaries enrolled in the other program are excluded from ECM. These Programs are ECM exclusionary criteria.	**Dual-Eligible Members** • Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) • Program for All Inclusive Care for the Elderly (PACE) • EAE D-SNP and Non EAE D-SNP **Other Programs** • Family Mosaic Project Services • Hospice

Members with a share of cost, excluding Long Term Care share of cost, are excluded from Managed Care and thus not eligible for ECM.

Given the number of care management and care coordination programs, initiatives, or waivers in existence today, the exclusion and overlapping criteria are intended to ensure that the most appropriate individuals who would benefit from ECM can participate.

5.3.1 Non Duplication of Services

If a Member is receiving care management from multiple sources or systems of care, ECM Providers are responsible for coordinating across all these sources to deliver comprehensive care management. It is the responsibility of ECM Providers, and the role of the Lead Care Manager, to ensure that services provided through ECM do not duplicate those offered by other programs.

ECM Providers should establish clear processes to ensure that Lead Care Managers inquire about a member's participation in other programs during the in-person comprehensive assessment and care planning process. Providers are also encouraged to review the latest DHCS guidance for detailed information on exclusion criteria and overlapping programs.

In instances where a member is receiving care management or overlapping services from multiple sources or systems, ECM Providers are expected to notify the L.A. MCP to prevent service duplication.

6 Member Identification

This section outlines how ECM provider and the L.A. MCPs identify Members eligible for ECM, using a "no wrong door" approach that allows Members to be identified and referred through multiple channels:

6.1 Community-Based Referrals:

Members can be identified through referrals from a variety of sources, including community-based organizations (CBOs), non-contracted providers, PCPs, hospitals, shelters, correctional facilities, and other social service organizations. ECM Providers and L.A. MCPs must ensure that Members, their families, guardians, caregivers, and community partners are informed about ECM, the Populations of Focus (POF), and the process to request ECM. These referrals are a key method for identifying eligible Members.

6.2 ECM Provider-Initiated Referrals:

ECM Providers are encouraged to identify potentially eligible Members during their regular interactions. After identifying a Member who may benefit from ECM, the ECM Provider submits an ECM Service Authorization Request (SAR) Form or Member referral form to the L.A. MCP using the designated process outlined in Section 7 ECM Provider Referrals: Submission Processes and Eligibility Determination.

6.3 Member Self-Referral:

Members can self-refer to ECM Providers or L.A. MCPs after receiving information about the ECM benefit through Member-informing materials. This supports the "no wrong door" approach, allowing Members to enter ECM through various pathways.

6.4 ECM Member Information File (MIF):

L.A. MCPs provide ECM Providers with a monthly ECM Member Information File (MIF), which includes a list of potentially eligible Members identified through data analysis. This list is a crucial tool for ECM Providers to screen, enroll, and deliver core services to Members.

By leveraging these identification pathways, ECM Providers ensure that eligible Members have access to the necessary services, regardless of how they are identified.

7 ECM Provider Referrals: Submission Processes and Eligibility Determination

7.1 LA County Enhanced Care Management (ECM) Benefit Referral Form

The L.A. MCPs have developed the LA County Benefit Referral Form, which can be utilized by ECM Providers, community partners, and other relevant service providers to refer ECM-eligible member into ECM program.

The LA County Enhanced Care Management (ECM) Benefit Referral Form and LA County Enhanced Care Management (ECM) Benefit Eligibility Screening Checklist can be found here: LA County Enhanced Care Management (ECM) Benefit Member Eligibility Checklists/Referral Forms.

7.2 ECM Eligibility Determination

Once the completed Standard Referral Form is received and reviewed, the L.A. MCP may follow up with the referring entities (e.g., ECM and non-ECM Providers, Members, other organizations) to request supporting documentation and/or evidence to facilitate making a benefit determination. The L.A. MCP will ensure that a benefit determination occurs as soon as possible (i.e., within five (5) working days for routine authorizations and within seventy-two (72) hours for expedited requests). If the L.A. MCP does not authorize ECM services, they will ensure the Member and the requesting individual or entity (as applicable) who requested ECM on a Member's behalf are informed of the Member's right to appeal and the appeals process by way of the Notice of Action (NOA) process as described in DHCS *APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates*.

7.3 Electronic Presumptive Authorization Tool

L.A. Care offers contracted ECM Providers the ability to submit referrals through the Service Authorization Request (SAR) e-Form, commonly known as the E-Form, which serves as an electronic presumptive authorization tool. This tool is designed to streamline the referral process, allowing ECM Providers to receive automatic presumptive authorization for services immediately upon submission of the E-Form.

Unlike the Standard ECM Referral Form, which adheres to standard turnaround times, the E-Form expedites the process by enabling real-time authorization. Once the E-Form is completed and submitted, it is processed automatically, allowing providers to proceed with delivering necessary ECM services without delay. This ensures that members can access care more quickly, and providers can efficiently manage their caseloads.

7.4 Member Assignment to ECM Providers

L.A. MCPs will consider the member's POF, prior relationship, location, and the provider's capacity when making the assignment. L.A. MCPs will process referrals and disseminate information about member assignment to the designated ECM Provider in alignment with the authorization timeframes: a standard five (5) business day turnaround for routine requests or a seventy-two (72) hour turnaround for expedited requests.

Upon notification of an assigned member the ECM Provider is responsible for assigning the member to an ECM Lead Care Manager to begin outreach and engagement within seventy-two (72) hours.

The ECM Provider is responsible for immediately accepting all members assigned by the L.A. MCP for ECM, except when the ECM Provider has reached its pre-determined capacity. If the ECM Provider has reached capacity, they are allowed to decline member assignment. However, the ECM Provider must notify the L.A. MCP within one business day if they are unable to accept the referral.

7.5 Assign Lead Care Manager

The ECM Provider must assign each Member a Lead Care Manager who interacts directly with the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any Community Supports, and other services that address social determinants of health (SDOH) needs, regardless of setting.

7.6 Member Ability to Change Provider

ECM Members can request to change their ECM Provider at any time.

Provider Expectations

- ECM Providers must inform Members about the process for changing ECM Providers, which can be done at any time.
- If a Member expresses the desire to switch ECM Providers, the ECM Provider must notify the L.A. MCP.
- Members may also initiate a provider change by contacting the L.A. MCP Member Services line. The Member's right to choose between the ECM benefit and other duplicative programs must always be upheld.

The L.A. MCP must implement any requested ECM Provider change within thirty (30) calendar days.

8 ECM Core Services

ECM is designed to be interdisciplinary, high-touch, and person-centered, primarily provided through in-person interactions with Members where they live, seek care, and prefer to access services. Eligible Members are expected to be among the most vulnerable and highest-need Medi-Cal Managed Care Members. It is critical for ECM Providers to establish strong relationships with these Members (and, if applicable, their parent, caregiver, or guardian). This is most effectively achieved through in-person interactions in locations most convenient for the Member.

When in-person communication is not available or does not meet the Member's needs, ECM Providers may use alternative methods, including telehealth, to provide culturally appropriate and accessible communication according to the Member's preferences. DHCS and the L.A. MCPs will monitor the efficacy of location-based in-person interactions versus community or home-based interactions.

This section describes the seven ECM core services, which are universal for all Populations of Focus:

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

8.1 Outreach and Engagement

ECM Providers are expected to actively and progressively engage assigned members in ECM using a variety of methods. Providers must utilize at least five different outreach methods over a 30-day period, including at least one in-person attempt. The in-person attempt should focus on the member's preferred location, such as where they live, seek care, or are otherwise accessible. Outreach should be conducted on different days and at varying times to maximize the likelihood of contact, utilizing multiple engagement strategies as appropriate.

All outreach efforts, including the dates, times, methods used, and the member's response, must be thoroughly documented in the member's record. This documentation should also include the member's choice and contact preferences for receiving ECM services.

Providers are required to report evidence of all outreach activities via ECM claims and as part of the monthly Outreach Tracker File (OTF). If a member is not reachable after five attempts, including at least one in-person attempt within the initial 30-day period, or if the member declines to participate, continues

to disengage, or meets exclusion criteria, the ECM Provider may exclude the member from further outreach and report this in the Return Transmission File (RTF) submission to the L.A. MCP.

L.A. MCPs expect ECM Providers to have the capacity and strong commitment to conduct in-person outreach for all members identified as eligible for ECM, whether identified by L.A. MCPs ECM Member Information File (MIF), or via ECM Referral. Providers must also comply with all non-discrimination requirements as per State and Federal law and the contract with the MCP.

The Outreach and Engagement core service can include, but is not limited to, the following activities:

- Locating and Engaging Members: Attempting to locate, contact, and engage Members (and/or their parent, caregiver, guardian) who have been identified as good candidates for ECM services, promptly after assignment.
- Multiple Engagement Strategies: Utilizing a variety of engagement strategies, including direct communication with the Member (and/or their parent, caregiver, guardian) through in-person meetings where the Member lives, seeks care, or is accessible; as well as through mail, email, texts, and telephone; community and street-level outreach; follow-up if the Member presents to another partner in the ECM network; or using MIF and Pharmacy data to contact Providers the Member is known to use.
- Active and Progressive Outreach: Employing an active and progressive approach to outreach and engagement until the Member (and/or their parent, caregiver, guardian) is successfully engaged.
- Documentation: Documenting all outreach and engagement attempts and the modalities used.
- Educational Materials: Utilizing educational materials and scripts developed for outreaching and engaging Members, as appropriate.
- Culturally Appropriate Communication: Providing culturally and linguistically appropriate communications to engage Members (and/or their parent, caregiver, guardian), ensuring that these approaches build trust with historically underserved communities in the Medi-Cal program.

8.1.1 Confirm Member Eligibility and Opt-In

At the time of outreach, if a Member expresses interest in opting into the ECM benefit, ECM Providers are required to confirm the Member's eligibility and appropriateness for ECM. The L.A. MCPs will provide the ECM Providers with the L.A. County Enhanced Care Management (ECM) Benefit Eligibility Screening Checklist, which covers Populations of Focus, Program Overlaps, and Exclusion criteria. ECM Providers are encouraged to integrate this checklist into their initial engagement workflow.

To determine eligibility, ECM Providers may use the following:

- Reviewing available data or reports provided by the MCP
- Reviewing Member Electronic Health Records (EHR), Health Information Exchange (HIE), and admit-discharge-transfer (ADT) data
- Engaging in discussions with the Member

ECM Providers must notify the MCP of any Members interested in enrolling in the ECM benefit, as well as those who may not be eligible. If there are questions regarding a Member's eligibility, the ECM Provider

should contact the MCP, which may request supporting documentation to assist in the eligibility determination.

ECM is an opt-in benefit, requiring the Member's informed consent to participate. Opt-in can be provided verbally, but all verbal opt-ins must be documented by the ECM Provider and maintained in the Member's record. MCPs may request evidence of Member opt-in as needed, particularly in response to any DHCS monitoring requests.

As participation in ECM is voluntary, Members have the right to opt out at any time by notifying their ECM Provider or contacting a customer service representative.

8.1.2 Member Authorization for Data Sharing

The ECM Provider is required to obtain, document, and manage Member authorization for the sharing of Personally Identifiable Information between MCP and ECM, Community Supports, and other Providers involved in the provision of Member care to the extent required by federal law.

Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law. When federal law requires authorization for data sharing, the ECM Provider must communicate that it has obtained Member authorization for such data sharing back to the MCP. For more information on data sharing requirements and guidance please see the DHCS CalAIM Data Sharing Authorization Guidance.

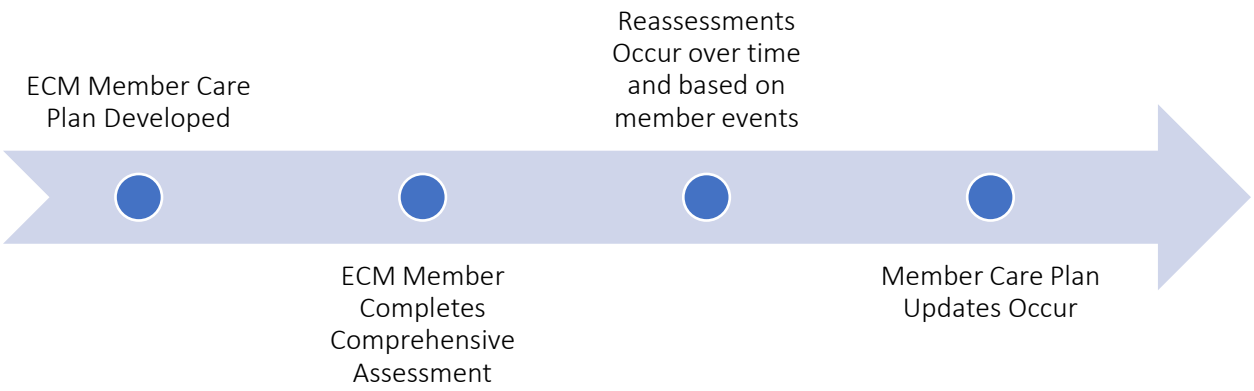
8.2 Comprehensive Assessment and Care Plan

After the initial step of successful engagement with an ECM member, a Comprehensive Assessment should be conducted, and a Care Plan developed. ECM Providers are required to provide person-centered care management by working with the Member to assess risk, needs, goals, and preferences, and have a care management plan that coordinates and integrates all of the Member's clinical and non-clinical health care related needs. Key components to this core service provision include, but are not limited to:

- Engaging with each Member (and/or their parent, caregiver, guardian) authorized to receive ECM primarily through in-Person contact and communication
- When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider must use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member (and/or their parent, caregiver, guardian) choice.
- Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan.
  Comprehensive assessment
- Developing a comprehensive, individualized, person-centered Care Plan with input from the Member (and/or their parent, caregiver, guardian) as appropriate to prioritize, address, and communicate strengths, risk, needs, and goals. The care plan must also leverage Member strengths and preferences and make recommendations for service needs.
- In the Member's care plan, incorporating identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing.

ECM Providers are required to engage with each Member authorized to receive ECM primarily through in-person contact. Public health precautions and recommendations should be used to accomplish the

community-based, in-person approach of ECM. ECM Members will have varying levels of acuity and will require different levels of service intensity and frequency of contact with the ECM Provider's multi-disciplinary care team. The diagram below illustrates the order of operations in developing and maintain the Member's Care Plan:



8.2.1 Comprehensive Assessment

The Comprehensive Assessment is used to assess an ECM Member's current health status, identifies a member's physical, mental health, substance use, palliative, community-based LTSS, oral health, trauma-informed care, social supports and SDOH needs. The ECM Assessment is used to establish a platform to begin building care management and coordination goals, and develop an individualized Care Plan. ECM Providers are required to identify necessary clinical and non-clinical resources that may be needed to appropriately address the Member's health status and gaps in care that supports the development of an individualized Care Plan.

ECM Providers are required to start a member's Comprehensive Assessment immediately following ECM enrollment. ECM Providers must begin a member's Comprehensive Assessment within thirty (30) days and complete it within sixty (60) days from enrollment, unless a delay is requested by the member. Upon a requested delay by the Member, ECM Providers are required to document the reasons for the delay within their care management systems. For best practice, ECM Providers are recommended to begin the ECM assessment within seven (7) days from ECM enrollment.

DHCS does not require an annual reassessment for members, however ECM Providers must ensure the Member is reassessed at a frequency appropriate for the member's individual progress or changes in needs as determined in collaboration with the ECM Provider, and/or as identified in the Care Plan. For example, ECM Providers must reassess the member throughout the continuum of care, when clinically indicated or when new needs are identified, such as but not limited to after a transition of care of an inpatient/facility admission, change in health status, etc. L.A. MCPs recommend Care Plans also be updated during reassessments to address any changes in the member's condition.

In addition to the Member assessment, ECM Providers are encouraged to review health plan data and reports, electronic health records, medications, and other available clinical and non-clinical data sources to inform the assessment. This includes leveraging any existing Comprehensive Assessments and Care Plans initiated and developed by other existing programs involved in the Member's care to minimize duplication of questions and inform the ECM assessment process.

The L.A. MCPs provide a standardized L.A. County ECM Adult Comprehensive Assessment Template and a Children/Youth ECM Comprehensive Assessment Template for ECM Providers to adopt as their Comprehensive Assessment and incorporate into their workflows and systems. The L.A. MCPs require the ECM Providers to adopt the L.A. County ECM Common Assessment Templates. It should be noted that the L.A. MCPs may release revised and/or updated editions of the ECM Adult and/or Children/Youth Assessments in the future

8.2.2 Care Plan

The Care Plan is a dynamic and person-centered plan of care that is maintained by ECM Providers, and includes comprehensive input from the Member (and/or their parent, caregiver) and care team members as appropriate and in accordance with the Member's wishes. ECM Providers are required to develop a comprehensive, individualized, person-centered Care Plan by working with the Member to assess strengths, risks, needs, goals, and document member's preferences and to make recommendations for services needed. This includes collaborating and developing the Member's Care Plan together with appropriate stakeholders, including the Member, the Member's providers, and the Member's family or support persons. The Care Plan is based on the needs and desires of the member. ECM Providers are expected to incorporate into the Member's Care Plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing.

ECM providers must develop a Member's Care Plan including problems (opportunities), interventions, goals, and barriers. This includes documenting the Member's preferred goals in SMART format (Specific, Measurable, Achievable, Realistic, and Time-bound). The Care Plan is a living document; the ECM Provider should update and review the Care Plan together with the member on a continual basis and not limited to when goals are modified, new needs or goals are identified, after transition of care, or when a Member's health is reassessed or changes in Member health, functional, or social status occur. This includes documenting dates of care plan update and dates the Care Plan is reviewed with the member. The Care Plan will track and coordinate information on referrals, follow-ups, member outcomes, coordination with other delivery systems (i.e., agencies, Community Supports, other programs) and transitions in care. The ECM Provider will document Member acuity as part of the Care Plan and will maintain an appropriate level of contact with ECM Members for their health status and goals.

ECM Providers are required to create the Member's Care Plan with a minimum of 2-3 goals within fourteen (14) days of member starting ECM Comprehensive Assessment. The ECM Providers must ensure the Care Plan is reviewed, maintained, and updated under appropriate clinical oversight.

ECM Providers are required to submit Care Plans to the L.A. MCP at a frequency communicated by the L.A. MCP.

8.3 Enhanced Coordination of Care

Enhanced Coordination of Care includes the services necessary to implement the care plan. ECM Providers are responsible for the ongoing care coordination for ECM authorized Members. Regular and frequent Member support and coordination services are essential to the success of ECM. Key components of this service provision include, but are not limited to:

- **Organizing patient care activities** as laid out in the Care Plan.
- **Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team.** The care team's input is necessary for successful implementation of

Member goals and needs. The assigned ECM Lead Care Manager is responsible for ensuring that the Member has an assigned PCP and that they are engaging with that PCP for appropriate care.

- **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.
- **Providing support to engage the Member in their treatment adherence**, 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.
- **Communicating the member's needs and preferences in a timely manner** to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care.
- **Ensuring regular and on-going contact with Member** (and/or their parent, caregiver, guardian) when appropriate consistent with the care plan and to insure information is shared with all involved parties to monitor the member's condition, health status, care planning, medications usages and side effects. Member contact should be in person wherever feasible and possible.

Stakeholders, which include but not limited to: Providers, Community based organizations, PCP's, Counties or internal MCP business units, may outreach to ECM Providers to help coordinate care or follow up with Members.

8.4 Health Promotion

ECM Providers are responsible for Health Promotion, following the federal care coordination and continuity of care requirements stipulated in 42 CFR 438.208(b). Key components of this service provision include, but are not limited to:

- Working with the member to identify and build upon member strengths and potential family and/or support networks.
- Member skill development such as coaching to support lifestyle choices based on healthy behavior with the goal of supporting the Member's ability to monitor and manage their health.
- Strengthening member skills that enable them to identify and access resources to assist them in managing their conditions.
- Linking Members to resources for smoking cessation, management of Member chronic conditions, self-help recovery resources and other services based on Member needs and preferences.
- Promoting self-management by utilizing evidence-based practices, such as motivational interviewing, to engage and help the Member participate in their care.

8.5 Transitional Care Services (TCS)

Transitional Care Services (TCS) include services intended to support Members and their families and/or support networks as Members transfer from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings. Although it is not a required component of TCS at this time, ECM Providers are strongly encouraged to provide Emergency Department (ED) follow up as part of TCS.

ECM providers are responsible for ensuring ECM Members receive Transitional Care Services to support Members and their families and/or support networks as Members transfer from one setting or level of care to another. Transitional Care Services for ECM members should always extend at least thirty (30) days post-discharge to help avoid unnecessary readmissions.

L.A. Care will provide daily Admission, Discharge, and Transfer (ADT) feeds to ECM Providers to ensure timely notification for implementing TCS. ECM Providers are also encouraged to utilize Health Information Exchange (HIE) platforms that offer additional critical clinical ADT information to further support the implementation of TCS.

ECM Provider and Lead Care Manager Responsibilities

ECM Providers are expected to support Members' transitions from discharge planning until they have been successfully connected to all needed services and supports. The ECM Lead Care Manager is responsible for ensuring collaboration, communication, and coordination with Members and their families/support persons/guardians, hospitals, LTSS, physicians (including the Member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions.

While the ECM Lead Care Manager does not need to perform all activities directly, they must coordinate and ensure completion of the TCS tasks. The ECM Lead Care Manager is responsible for ensuring all Transitional Care Services are completed including, but not limited to:

1. Coordinating with Discharge Facility: Upon notification of a member's transition, the ECM Lead care manager must begin outreach to the member and the discharging facility within twenty-four (24) hours to begin coordination and understanding of the potential needs and the needed follow-up plans for the member. ECM Providers should provide information to the hospital discharge planners or discharging facility staff about ECM so that collaboration on behalf of the Member can occur in a timely manner and that the member does not receive two different discharge planning documents. The ECM Lead Care Manager must also coordinate with the discharging facility to ensure the member participates in the discharge plan and receives and understands information about their needed care from the discharging facility.

2. Discharge Risk Assessment: The Discharge Risk Assessment supports the discharge planning process by helping to assess a member's risk of re-institutionalization, re-hospitalization, destabilization of a mental health condition, and/or SUD relapse following an admission. It also helps to identify interventions/services that benefit the member.
   The ECM Lead Care Manager must ensure a Discharge Risk Assessment is completed at any time during the inpatient admission or after discharge if the member has discharged prior to ECM outreach. This must include reviewing information from the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary). The ECM lead Care Manager must also ensure the Discharge Risk Assessment is shared with appropriate parties such as the PCP, the Member, and other service providers involved in the Member's care.
   It is recommended that the ECM Provider consider the use of the Modified LACE Tool. This tool will yield a risk score of (Low, Moderate, or High) indicating the Member's risk for re-admission. Members who score at a high risk of readmission are considered to be high acuity. The ECM Provider is expected to identify interventions and services that benefit the member and address their needs.

3. Discharge Summary/Planning Document: The ECM Lead Care Manager must ensure a discharge summary/planning document is created and shared with the member (if the Member accepts a copy), PCP, and if applicable, receiving facility (e.g., skilled nursing facility (SNF), long-term care (LTC), or acute rehab unit). This includes ensuring the member has the ECM Lead Care Manager's contact information.

   A best practice is for the ECM Lead Care Manager to work with the discharging facility to ensure that the ECM Lead Care Manager's name and contact information are integrated into the discharge summary documents that the Member receives. The ECM Lead Care Manager may consider faxing a TCS Admission Notification Letter to the discharge facility that will inform the facility and PCP about the member's enrollment in ECM services and the assigned ECM Lead Care Manager's name and contact information. The TCS Admission Letter explains the purpose of TCS and requests the facility to share the ECM Lead Care Manager's contact information directly with the member and include it in the discharge document. The ECM Lead Care Manager should also request that the facility send a copy of the discharge summary when it becomes available along with medical records relevant to coordination.

4. Medication Reconciliation: Lack of medication reconciliation presents a significant risk for adverse drug events, especially for the highest risk populations. Accurate and timely medication reconciliation is a critical element of TCS for ensuring patient safety during transitions of care.

   The ECM Lead Care Manager must ensure medication reconciliation is completed post-discharge. This means medication reconciliation should be completed upon discharge by the discharging facility (pre-discharge) and a second reconciliation must be completed after discharge once the member is in their new setting (post-discharge). This can be done by the follow-up provider, such as the PCP, home health provider, or by the ECM Lead Care Manager if they hold an appropriate license, or by another team member on the ECM care team that has an appropriate license, in a manner that is consistent with California's licensing and scope of practice requirements, as well as applicable federal and state regulations.

5. Closed Loop Referrals: The ECM Lead Care Manager must ensure member is connected to Community Supports as needed. This includes ensuring completion of referrals to social service organizations, and referrals to necessary at-home services (Durable Medical Equipment (DME), home health, along with others) and follow-up on referrals made with internal and external providers to ensure services were rendered.

6. Transportation: The L.A. MCP may require the ECM Lead Care Manager to be responsible for arranging transportation for transitional care, including the use of Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT). The ECM Provider is responsible for developing policies to arrange transportation for transitional care.

7. Post-discharge Follow-up: The ECM Lead Care Manager must ensure needed post-discharge services are provided and follow-ups are completed. The ECM Lead Care Manager is responsible for contacting the Member no later than seven (7) days of discharge depending on the needs and acuity of the member.

   The Lead Care Manager must continue to support the member in all needed Transitional Care Services identified at discharge, as well as any new needs identified through engagement with

the Member or their care providers. As a best practice, it is recommended that the ECM Provider follow the member closely during the first thirty (30) days post-discharge.

Post-discharge services include:

- Reviewing the discharge instructions with the Member.
- Ensuring the Member understands the process of navigating any resources or referrals initiated during their admission and addressing the potential delays with accessing these services.
  Supporting the Member in addressing barriers that prevent the member from following up with the discharge orders. This includes timely scheduling of follow-up appointments with recommended outpatient Providers and/or community partners, arranging transportation to any follow-up appointments and connecting the member to the PCP within seven (7) days post-discharge.

8.6 Member and Family Supports

Member and Family supports include activities to ensure both the Member and their family/support are knowledgeable about the Member's conditions, Care Plan, and follow-up with the goal of improving their adherence to treatment and medication management.

ECM Providers are responsible for documenting a Member's authorized parent, caregiver, guardian, other family member(s) and/or other authorized support person(s). Additional responsibilities include, but are not limited to:

- Ensuring all required authorizations are in place to ensure effective communication between the ECM Providers, the Member and/or their family member/s, guardian, caregiver, and/or authorized support person/s and L.A. MCP, as applicable.
- Ensuring all required authorizations are in place to ensure effective communication between the ECM Providers, the Member and/or their family member/s, guardian, caregiver, and/or authorized support person/s and L.A. MCP, as applicable.
- Conducting activities to ensure the Member and/or parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) are knowledgeable about the Member's conditions with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State, and local privacy and confidentiality laws.
- Serving as the primary point of contact for the Member and their supports, which can include the Member and/or their parent, caregiver, guardian, other family member(s) and/or other authorized support person(s).
- Identifying supports needed for the Member and/or their parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) to manage the Member's condition and assist them in accessing needed support services.
- Providing appropriate education to Member and/or their parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) about care instructions for the Member.
- Ensuring that the Member and/or their parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) has a copy of their Care Plan within their preferred language and format including information about how to request updates.

8.7 Coordination of and Referral to Community and Social Support Services

Coordination of and Referral to Community and Social Support Services involves determining appropriate services to meet the needs of Members receiving ECM, to ensure that any present or emerging social factors can be identified and properly addressed. The ECM Provider is responsible for the coordination of and referral to Community and Social Support Services.

The ECM Provider must determine the appropriate services to meet the needs of ECM Members, including the services that address SDOH needs, such as housing and services offered by the L.A. MCP as Community Supports. Additionally, the ECM Provider is responsible for coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

ECM Providers are encouraged to build and reinforce strong relationships with community members to support this service provision. ECM Providers are encouraged to maintain a Community Resource Directory and/or actively utilize the online Community Resource Referral Platform offered by the L.A. MCPs.

9 Discontinuing and Reauthorizing ECM

9.1 Discontinuation and Graduation

DHCS has identified ECM as the most intensive level of care management services to be Members. Newly enrolled members are given an initial 12- month authorization period for ECM and a subsequent reauthorization 6-month period after that. Prior to the end of the member's ECM authorization period, or sooner, each member must be assessed for readiness to complete ECM or ongoing need for the ECM benefit. ECM Providers are to reassess Members against the MCP ECM discontinuation criteria, not the ECM POF eligibility criteria, to evaluate whether Members are ready to transition out of ECM. To support this requirement, the ECM Program Completion Questionnaire (PCQ) serves as a standardized tool that ensures all contracted ECM providers are using the same set of criteria to assess a member's readiness for ECM completion or ongoing need for ECM services.

ECM Providers must notify MCPs to discontinue ECM for Members when any of the following conditions are met:

- The Member has met all care plan goals.
- The Member is ready to transition to a lower level of care.
- The Member no longer wishes to receive ECM, is unresponsive, or unwilling to engage.
- The Member's behavior or environment is unsafe for the ECM Provider.
- The ECM Provider has been unable to connect with the Member and/or their parent, caregiver, or guardian after multiple attempts.
- The Member is no longer eligible for the benefit.

Members are generally considered ready to graduate from ECM when they have completed their Care Plan goals and shown improvement in self-management of physical and behavioral health, social determinants of health (SDOH), and activities of daily living. ECM Lead Care Managers are required to use the PCQ with the Member to help determine readiness for program completion or transition out of ECM.

When an ECM Provider identifies a Member who is ready to graduate from ECM, they will conduct an ECM case conference with the multidisciplinary team to review the recommendation for stepping down

from ECM and transitioning to another setting. This ensures that any resources, warm handoffs, and care coordination needs are in place, including community-based services and other care management programs available within and outside of the L.A. MCP.

The ECM Provider must notify the MCP to discontinue ECM for a Member and communicate the discontinuation to the Member. The ECM Provider should also inform the Member about any other available benefits or programs, including other care management programs (e.g., Basic Care Management). If assistance is needed, the Provider should refer to the Community Link or contact the L.A. MCP.

Members currently receiving ECM services through a Model 1 ECM Provider may continue receiving services with their assigned ECM Provider even if they change their Primary Care Physician (PCP) or Participating Provider Group (PPG) assignment. ECM Providers should not discontinue ECM services due to a PCP or PPG change unless the Member specifically requests to be disenrolled or requests an ECM provider change.

Members can contact their ECM Provider or L.A. MCP Member Services to request disenrollment from ECM at any time if they no longer wish to receive the benefit. The L.A. MCP will notify ECM Providers via the regular ECM Member Information File (MIF) if a Member no longer qualifies for the ECM benefit.

9.2 Reauthorization

Members who are not ready for graduation can receive an additional six months of ECM services. The ECM Provider must submit the PCQ documenting the need for continued ECM interventions to L.A. Care via the referral pathways within 30 - 14 days before the ECM authorization end date. L.A. Care staff will review the PCQ, determine if continued ECM services are warranted, and notify both the provider and the member of the outcome.

9.3 Member's Behavior or Environment is Unsafe for the ECM Provider

L.A. Care defines **disruptive behavior** as a member whose behavior substantially impairs the ECM Provider's ability to arrange for or provide services to the member. An individual cannot be considered disruptive if such behavior is related to the compliance or non-compliance with medical advice or treatment. Members who behave in a disruptive way and make it difficult for the ECM Provider to provide care management services will be given an opportunity to correct the behavior to allow them to continue participating in ECM.

Disruptive behavior consists of intimidating, hostile, or harassing behavior and threatening or any other behavior that makes the member unable to participate in the ECM process and/or interferes with the ECM Providers' business operations. This may include, but is not limited to the following:

- Verbal abuse such as outbursts, yelling, swearing, or cursing directed at ECM staff.
- Harassing or intimidating telephone calls, letters, or other forms of written or electronic communications directed at the ECM staff.
- Verbal, written, or physical intimidation or harassment of ECM staff.

L.A. Care defines **threatening behavior** as a credible threat of violence or the manifestation of violence or harm to oneself, another individual, or a provider, Participating Provider Group (PPG), Plan Partner, or health plan property.

Threatening behavior consists of a threat of violence or the manifestation of violence or harm to ECM staff. This may include, but is not limited to the following:

- Making a threat of violence, considered as a knowing and willful statement or course of conduct that would place a reasonable person in fear for his or her safety, or the safety of others.
- Unlawful violence.
- Intentional destruction or threat of destruction of property owned, operated, or controlled by the ECM Provider.
- Harassing surveillance, also known as "stalking," which is the willful, malicious, and repeated following of ECM staff.
- Threatening telephone calls, letters, or any other form of communication directed at ECM staff.
- Inappropriate use of a firearm, weapon, or any other dangerous device within proximity of ECM staff.

ECM Providers are required to develop a policy & procedure on how to manage disruptive/threatening members. The L.A. MCPs encourage hosting ad-hoc case conferences if additional support is needed.

9.4 The Notice of Action (NOA)

The L.A. MCPs will notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of the Member's Right to Appeal and the Appeals process by way of the NOA process outlined in DHCS APL 21-011 *Grievance and Appeal Requirements, Notice and "Your Rights" Templates*.

- The standard grievance and appeals processes apply to ECM for all Members. If a Member has concerns or complaints, the Member can contact the L.A. MCP's Member Services. If the Member feels that they have been wrongfully denied enrollment or wrongfully disenrolled from ECM, the Member can initiate an appeal via the L.A. MCP's existing complaints, grievances, and appeals process.

10 Care Management Documentation System

The ECM Provider must use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities – including MCPs, ECM providers, Community Supports, and other county and community-based Providers – to support the management, maintenance, and sharing of a Member Care Plan that can be shared with other providers and organizations involved in each Member's care. Care management documentation systems may include Certified Electronic Health Record (EHR) Technology, or other documentation tools that can support the documentation of:

- Member's enrollment into ECM
- Member's authorization/approval to release information to other providers in the care team and anyone involved in execution of the Care Plan
- Member's goals and goal attainment status
- Member's care coordination and care management needs (e.g., allow for documenting closed looped referrals to ensure the follow up with the Member is tracked and completed)
- Information from other sources to identify Member needs which support care team coordination and communication
- The development and assignment of care team tasks
- Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status)

- Referrals to other providers and support persons
- Screenings and assessments (e.g., Comprehensive Assessment, PHQ-9, etc.)

Care management documentation systems also need to be able to:

- Assist with informing the ECM Provider's regular reporting to the L.A. MCPs, as requested.
- Support and track the ECM services provided to the Member to enable ECM Providers to appropriately submit claims to the L.A. MCPs.

A care management documentation system is not required to be a certified EHR technology, and may include systems that are securely managed and hosted by third parties, including L.A. MCP partners.

11 Data Sharing Requirements for MCPs

The L.A. MCP and the ECM Provider will exchange data on Members on a regular basis.

The MCP will provide the following data to the ECM Provider at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable:

- Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider (referred to as the Member Information File (MIF))
- Encounter and/or claims data
- ADT data feeds
- Physical, behavioral, administrative and SDOH data for all assigned Members
- Reports of performance on quality measures and/or metrics, as requested.

12 Data Sharing Requirements for ECM Providers

ECM Providers ECM Providers are responsible for submitting required reports to the L.A. MCP monthly. These reports include, but are not limited to:

- ECM Return Transmission File (RTF)
- ECM Outreach Tracker File (OTF)
- Staffing and Capacity Reports

ECM Providers must regularly retrieve the ECM Member Information File (MIF) via a secure file transfer protocol (SFTP) site or portal. This file contains information on assigned ECM Members eligible to receive ECM services, including both new and existing Members.

Monthly, ECM Providers must update and report back to the L.A. MCPs via SFTP file upload or through the L.A. MCP's portal. The updates should include:

- The services provided and the status of each eligible and enrolled ECM Member, as reported in the **Return Transmission File (RTF).**
- The outreach services provided to assigned ECM Members, as reported in the **Outreach Tracker File (OTF).**

L.A. MCPs may also use the SFTP site or their portals to exchange additional data files to support ECM Provider service delivery, such as ADT reports, capitation reports, and others.

13 Quality, Monitoring, and Oversight

L.A. MCPs are required to perform Monitoring & Oversight of ECM Providers, holding ECM Providers accountable to all applicable state and federal laws and regulations and all ECM program requirements in the DHCS-MCP ECM and CS contract, MCP's Model of Care (MOC), and any associated guidance issued by DHCS. ECM requirements contained in the ECM and Community Supports Template, DHCS ECM Policy Guide, the MCP's Model of Care (MOC), and any associated guidance issued by DHCS.

MCPs are responsible to implement an ECM Monitoring and Oversight Program that informs how they will be conducting oversight activities for all contracted ECM Providers. As part of the ECM Monitoring and Oversight Program, L.A. Care will regularly monitor ECM Provider performance and compliance with ECM requirements using a variety of methods including but not limited to Monthly Provider calls, on-site visits, progress reports, Audit reviews, Gap closures and/or Corrective Action Plans, as needed. ECM Providers are subject to more frequent oversight activities as deemed necessary by the MCP.

13.1 Audits Overview

ECM Audit Reviews are part of L.A. Care's ongoing Monitoring & Oversight Program to ensure the highest quality of service for members and compliance with regulatory requirements. As such, L.A. Care is responsible for scheduling regular audit reviews of their ECM Provider Network. L.A. Care will ensure that Audits include clinical review of Comprehensive ECM Assessments, Care Plans, Clinical Documentation and other forms of documentation requested and submitted by the ECM Provider. To ensure ECM providers are complying with ECM requirements, L.A. Care will ensure Audit reviews include but are not limited to the seven ECM core services:

1. Outreach and Engagement
2. Comprehensive Assessment and Care Plan
3. Enhanced Care Coordination
4. Health Promotion
5. Transitional Care Services
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

13.2 MCP Responsibility:

MCPs will not utilize tools developed or promulgated by NCQA to perform oversight of ECM providers unless by mutual consent with the ECM Provider, thus MCP tools and processes may vary by MCPs. L.A. Care will establish operational processes to support with Audit Reviews which may include but not limited to the development of Audit tools, ECM Provider trainings, Provider Reference Guides and/or other tools to support the ECM provider during the Audit review process. L.A. Care will be responsible for audit time frames to reflect adequate program and case maturity for a comprehensive review, this includes determining random member cases that are eligible for an audit review and criteria for an ECM provider's readiness to participate. L.A. Care will ensure L.A. Care ECM clinical staff participate in the audit review process which may include but not limited to, sharing Audit review results and scoring expectations with the ECM provider. L.A. Care may establish their own score cards and Gap Closures that will inform the ECM provider of the final results and findings including areas of strengths and areas of improvement. MCP may establish their own thresholds to determine if an ECM provider has passed, failed and/or is in need for a Corrective Action Plan (CAP). MCPs are responsible for developing and implementing a

Corrective Action Plan process including but not limited to escalations to Sanction Review Committee and ECM contract termination.

13.3 ECM Provider Responsibility:

The ECM Provider is responsible to acknowledge that the MCPs will conduct Monitoring & Oversight Activities to ensure adherence with state regulatory requirements and ensure ECM members are receiving the highest quality of service by the ECM Provider. ECM Providers are required to comply with all MCP requests related to Audit Reviews and submission of all documents requested in a timely manner including but not limited to:

- ECM Comprehensive Assessment(s)
- Care Plan(s)
- Progress Notes

ECM Providers are responsible for including any additional documentation such as Referrals, Discharge Summaries, Encounter notes, multidisciplinary meeting notes, etc. to support in reviewing the coordination efforts by the ECM provider during the case review.

ECM Provider is also responsible for developing and/or update their own internal workflows and system processes that will help them meet this requirement and be successful with all audit requests. ECM providers will be required to train ECM staff at their organization around Audits, developing a process for responding to MCPs in a timely manner, and meeting all Audit document submission deadlines. Failure to meet the pre-defined deadlines set by the MCP, with the exception of extenuating circumstances, may result in failing the audit review with escalation of a Corrective Action Plan (CAP) and/or Sanctions Committee Review. ECM Providers will be required to identify and share the point of contact(s) for their organization responsible for the oversight of the audit process with the MCP and identify alternative point of contact(s) should the primary contact be unavailable. MCP will hold ECM Providers responsible for communicating any changes in their point of contact(s) to ensure a successful ongoing audit review process.

14 Claims Submission

The ECM Provider is required to submit claims within 60 days of the last day of the service month for all ECM-related services provided to ECM Members. These claims should be submitted to the L.A. MCP using the national standard specifications and code sets defined by DHCS, as evidence of services rendered. DHCS coding guidance is available on the DHCS' Resources Page. Timely submission of claims ensures that the L.A. MCP can effectively monitor the volume and frequency of ECM services and accurately reflect the true cost of providing these services to both the L.A. MCP and DHCS.

In the event the ECM Provider is unable to submit claims to the L.A. MCP for ECM-related services using the national standard specifications and DHCS-defined code sets, the ECM Provider can submit an invoice to the MCP with a minimum set of data elements defined by DHCS in the *CalAIM Data Guidance: Billing and Invoicing between ECM/Community Supports Providers and MCPs*.

For further assistance, ECM Providers should refer to the **L.A. Care ECM Claims Guidance Document** or contact the account manager for additional support regarding the claims or invoice submission process.

15 MCP Payment to Providers

The L.A. MCP will pay contracted ECM Providers for the provision of ECM in accordance with contract established between L.A. MCP and ECM Provider. MCP shall pay ninety percent (90%) of all clean claims within thirty (30) days of date of receipt and ninety-nine percent (99%) of all clean claims within ninety (90) days. The date of receipt shall be the date the L.A. MCP receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.