Policy:	GG.1353
Title:	**CalAIM Enhanced Care Management Service Delivery**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 09/05/2024*
Effective Date:	01/01/2022
Revised Date:	08/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the process for provision of Enhanced Care Management (ECM) under the California Advancing and Innovating Medi-Cal for All (CalAIM) initiative.

II. POLICY

A. CalOptima Health shall implement ECM in phases for Populations of Focus (POF), as prescribed by the Department of Health Care Services (DHCS) and in accordance with CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management – Eligibility and Outreach.

B. An ECM Provider shall:

1. Conduct outreach and engagement services to all ECM-eligible Members for ECM services in accordance with CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management – Eligibility and Outreach;

2. Assign each Member enrolled in ECM a Lead Care Manager (LCM), with responsibility for interacting directly with the Member and/or family, Authorized Representative, caretakers, and/or other authorized support person(s), as appropriate;

3. Ensure accurate and up-to-date Member-level records in their Medical Management System (MMS) for Members authorized for ECM;

4. Ensure all ECM Members receive all ECM core service components described below:

   a. Outreach and engagement;

   b. Comprehensive assessment and Care Management Plan (CMP);

   c. Enhanced coordination of care;

   d. Health promotion;

   e. Transitional Care Services (TCS);

f. Member and family supports; and

g. Coordination of and referral to community and social support services.

5. Ensure ECM Members are able to decline or discontinue ECM upon initial outreach and engagement, or at any other time;

6. Discontinue ECM for Members when case closure criteria are met;

7. For all Members authorized to receive ECM, the initial authorization period will be twelve (12) months, and the reauthorization period will be six (6) months.

8. An ECM Provider shall assign an LCM to each Member, with expertise and skills to meet each Member's needs.

9. An ECM Provider shall ensure Transitional Care Services (TCS) are provided to support transfers from one (1) setting or level of care to another as outlined in Section III.B-E of this Policy and in accordance with CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS) .

10. An ECM Provider shall ensure Basic Population Health Management (BPHM) is provided to Members enrolled in ECM, in accordance with CalOptima Health Policy GG.1667: CalAIM Population Health Management Program.

C. CalOptima Health Member eligibility for participation in ECM shall be determined in accordance with CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management – Eligibility and Outreach.

D. CalOptima Health shall conduct oversight of ECM Providers in accordance with CalOptima Health Policy GG.1356: CalAIM Enhanced Care Management Administration.

E. CalOptima Health shall coordinate Continuity of Care for Members transitioning from other Medi-Cal Managed Care Plans (MCP) who were receiving ECM services, in accordance with CalOptima Health Policy GG.1356: CalAIM Enhanced Care Management Administration

F. A Member or Provider shall be entitled to appeals and grievance procedures in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint, HH.1102: Member Grievance, GG.1510: Appeal Process, and HH.1108: State Hearing Process and Procedures, as applicable.

III. PROCEDURE

A. Enhanced Care Management (ECM) Lead Care Manager (LCM)

1. An ECM Provider shall assign each Member enrolled in ECM an ECM LCM, with responsibility for interacting directly with the Member and/or family, Authorized Representative, caretakers, and/or other authorized support person(s), as appropriate.

a. An ECM Provider shall document the ECM LCM in its MMS;

b. The ECM LCM shall be responsible for engaging with a multi-disciplinary care team to:

i. Identify gaps in the ECM Member's care;

ii. Ensure appropriate input is obtained to effectively coordinate all primary, medical, behavioral, developmental, and oral health needs, Long Term Services and Supports (LTSS), Community Supports offered by CalOptima Health, and other services that address Social Drivers of Health regardless of setting, at a minimum;

iii. Develop a Person-Centered Plan of Care built around Member goals, needs, and choices including:

a) Member-centric goals;

b) Measurable outcomes; and

c) Interventions to achieve Member goals.

iv. Ensure the Person-Centered Plan of Care is updated as a Member's needs change and goals are achieved or altered.

c. The multi-disciplinary care team may be composed of the ECM Member, authorized support person, ECM LCM, primary care provider, specialty medical providers, Community Supports Providers, and providers of other disciplines, and/or other authorized individuals per the Member's needs and choice.

B. ECM Provider Responsibilities

1. An ECM Provider shall ensure that accurate and up-to-date Member-level records related to the provision of ECM services are maintained in their MMS, in accordance with CalOptima Health Policy GG.1301: Comprehensive Case Management, for Members authorized for ECM, including:

a. Documentation of Member outreach attempts;

b. Documentation of Member assessments;

c. Member care plan; and

d. Care management notes.

2. An ECM Provider shall ensure all ECM Members receive all ECM core service components described below:

a. Outreach and Engagement

i. The ECM Provider is responsible for reaching out and engaging ECM-eligible Members in accordance with CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management – Eligibility and Outreach;

b. Comprehensive Assessment and Care Management Plan (CMP)

i. The ECM Provider shall conduct a comprehensive assessment that includes DHCS standardized Long Term Support Services (LTSS) referral questions to identify and refer Members who may have LTSS needs.

ii. The ECM Provider shall develop a CMP which may include case conferences to ensure that care is continuous and integrated among all service providers across all delivery systems.

iii. The comprehensive assessment and CMP shall consider and address the ECM Populations of Focus as outlined in CalAIM Enhanced Care Management Policy Guide. Activities may include, but are not limited to:

a) Engaging with each Member (and/or their parent, caregiver, guardian) authorized to receive ECM primarily through in-person contact.

b) When in-person communication is not available or does not meet the ECM Member's needs, the ECM Provider shall use alternative methods, such as Telehealth or telephonic communication, to provide culturally appropriate and accessible communication in accordance with Member choice and availability.

1) An ECM Provider may implement telephonic and video call assessments and follow-up contact, in compliance with CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services, DHCS All Plan Letter (APL) 23-007: Telehealth Services Policy, and APL 20-004: Emergency Guidance for Medi-Cal Managed Care Plans Health Plans in Response to COVID-19, including subsequent revisions of such APLs.

c) 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 CMP.

d) The ECM Provider shall develop a comprehensive, individualized, person-centered CMP with input from the ECM Member and/or family member(s), guardian, Authorized Representative, caregiver, and/or other authorized support person(s), as appropriate, to assess Member strengths, risks, needs, goals, and preferences as well as make recommendations for service needs.

e) The care plan will incorporate identified needs and strategies to address those needs, including, but not limited to:

1) Physical and developmental health;

2) Mental health;

3) Dementia;

4) Substance use disorder;

5) LTSS;

6) Oral health;

7) Palliative Care needs;

8) Necessary community based and social services; and

9) Housing.

f) The ECM Provider shall reassess ECM Members' progress toward their goals on a regular basis at a frequency appropriate for the Member's individual progress, changes in needs, and/or as identified in the CMP.

g) The ECM Provider shall ensure the CMP is reviewed, maintained, and updated under appropriate clinical oversight.

c. Enhanced Coordination of Care

i. The ECM Provider will contact the ECM Member and/or support persons regularly to organize care plan activities as laid out in the CMP, sharing information with those involved as part of the Member's multi-disciplinary care team, and implementing activities identified in the Member's CMP.

ii. The ECM Provider will maintain regular contact with all providers that are identified as being part of the ECM Member's multi-disciplinary care team since their input is necessary for successful implementation of the Member's goals and needs. Enhanced coordination of care may include case conferences or other means of communication, as appropriate, in order to ensure that the Member's care is continuous and integrated among all service providers.

iii. The ECM Provider will work to ensure care is continuous and integrated among all service providers and refer to and follow 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.

iv. The ECM Provider will engage the ECM Member in their treatment, including coordination for medication review and/or medication reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, as appropriate, and identifying and helping to address other barriers to Member engagement in treatment.

v. The ECM Provider will communicate the ECM Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care.

vi. The ECM Provider will ensure regular contact with the ECM Member and their family members, legal guardians, Authorized Representatives, caregivers, and authorized support persons, as appropriate, consistent with the CMP and to ensure information is shared with all involved parties to monitor the ECM Member's conditions, health status, care planning, medications usages and side effects.

d. Health Promotion: Encourage and support Members receiving ECM to make lifestyle choices based on healthy behavior, with the goal of motivating Members to successfully monitor and manage their health.

i. The ECM Provider shall work with the ECM Member to identify and build on successes and potential family and/or support networks.

ii. The ECM Provider shall provide the ECM Member with services and coaching to encourage and support healthy lifestyle behavior choices, with the goal of creating self-sufficiency and supporting the Member's ability to successfully monitor and manage their health.

iii. The ECM Provider shall support the ECM Member in strengthening skills that enable the Member to identify and access resources to assist them in managing existing conditions and preventing the emergence of additional Chronic Health Conditions.

iv. The ECM Provider shall link ECM Members with resources for management and prevention of chronic conditions, self-help recovery resources, smoking cessation, and other services depending on Member's needs and preferences.

v. The ECM Provider shall use evidence-based practices, such as motivational interviewing, to engage and help the ECM Member participate in and manage their care.

e. Transitional Care Services (TCS)

i. The Member's ECM LCM must provide all TCS as the single point of contact.

a) The ECM LCM is responsible for ensuring that the discharging facility and the Member has their name and contact information, including phone number, in the discharge planning document.

ii. The ECM LCM must offer direct assistance to Members, but Members may choose to have limited to no contact with the LCM while hospitalized.

a) In these cases, at a minimum, the ECM LCM must act as a liaison coordinating care among the discharging facility, the PCP, and CalOptima Health.

iii. The ECM LCM is responsible for communicating in a timely manner with the responsible facility care manager and with the facility where the ECM Member is admitted in order to participate in discharge planning and support access to available services.

iv. The ECM LCM is also responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions from one setting or level of care to another, including:

a) Discharge Risk Assessment;

b) Discharge planning documentation that includes facilitating discharge instructions developed by a hospital discharge planner or discharge facility staff; and

c) Post-discharge services and follow-ups:

1) Providing adherence support and referral to appropriate services.

2) Coordinating of medication review and/or reconciliation

f. Member and Family Supports: Activities that ensure the ECM Member and family/support are knowledgeable about the Member's conditions, with the overall goal of improving their adherence to treatment and medication management.

i. The ECM Provider shall document the ECM Member's authorized family members, legal guardians, Authorized Representatives, caregivers, and/or other authorized support persons, as applicable.

ii. The ECM Provider shall ensure all required authorizations are in place to ensure effective communication between the ECM Provider, CalOptima Health, and the ECM Member and their family members, Authorized Representatives, legal guardians, caregivers, and authorized support persons, as applicable.

iii. The ECM Provider shall conduct activities, including educating the ECM Member and their family members, legal guardians, Authorized Representatives, caregivers, and authorized support persons, as applicable, to ensure they are knowledgeable about the Member's conditions, with the goal of improving the Member's care planning and follow up, adherence to treatment regimens, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.

iv. The ECM Provider shall ensure that the ECM Member's assigned ECM LCM serves as the primary point of contact for the ECM Member and their family members, legal guardians, Authorized Representatives, caregivers, and other authorized support persons, as applicable.

v. The ECM Provider shall identify and assess the supports needed for the ECM Member and/or their family members, legal guardians, Authorized Representatives, caregivers, and authorized support persons, as applicable, to manage the Member's condition and assist them in accessing needed support services and with making informed choices.

vi. The ECM Provider shall provide for appropriate education for the ECM Member and their family members, legal guardians, Authorized Representatives, caregivers, and/or authorized support persons regarding Member care instructions and needs.

vii. The ECM Provider shall share a copy of the ECM Member's CMP and information on the process for requesting updates with the ECM Member and, as appropriate and if the ECM Member is in agreement, with the ECM Member's legal guardians, Authorized Representatives, family members, caregivers, and authorized support persons, as applicable.

g. Coordination of and Referral to Community and Social Support Services: 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.

i. The ECM Provider shall determine appropriate community and social support services that are available to meet ECM Members' needs, including those that address Social Drivers of Health, such as housing support and other Community Supports offered by CalOptima Health according to CalOptima Health Policy GG.1355: CalAIM Community Supports.

ii. The ECM Provider shall coordinate and refer ECM Members to available community resources and follow up with such Members to ensure that services were rendered, and the Member is engaged with community service providers, as appropriate.

h. ECM Providers that integrate Community Health Workers into ECM services shall ensure that they do not bill for both Community Health Worker Services and ECM services for the same Member for the same time period in accordance with Department of Health Care

Services (DHCS) All Plan Letter (APL) 24-006 Community Health Worker Services Benefit.

C. Discontinuation of ECM

1. An ECM Provider shall ensure ECM Members are able to decline or discontinue ECM upon initial outreach and engagement, or at any other time.

    a. If a Member declines or requests to discontinue ECM at any time, the ECM Provider shall close the Member's ECM case.

2. An ECM Provider shall discontinue ECM for Members when any of the following case closure criteria are met and shall notify CalOptima Health via the monthly eligibility and activity file in accordance with CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting:

    a. The Member has met all care plan goals.

    b. The Member is ready to transition to a lower level of care.

    c. The Member states they no longer wish to receive ECM.

    d. The ECM Provider has not been able to connect with the Member after multiple attempts.

    e. The Member is incarcerated.

    f. The Member declined to participate.

    g. The Member enrolled in a duplicative program.

    h. The Member lost Medi-Cal coverage.

    i. The Member switched health plans.

    j. The Member moved out of the county.

    k. The Member moved out of the country.

    l. The Member has unsafe behavior or environment.

    m. The Member is not reauthorized for ECM services.

    n. The Member is deceased.

    o. The Member has other discontinuation reason not defined.

D. Reassessment and Transitioning Members from ECM:

1. ECM Provider must ensure that Members are reassessed at a frequency appropriate for their individual progress or changes in needs and/or as identified in the CMP.

2. ECM Provider should reassess Members against their ECM discontinuation criteria, not the ECM Population of Focus eligibility criteria, to evaluate whether Members are ready to transition out of ECM.

3. Members who have engaged in ECM services and no longer require this service, the ECM Provider will work with Member to agree on transition.

    a. Member has met all care plan goals;

    b. Member is ready to transition to a lower level of care management;

4. ECM Provider shall evaluate the Member to determine if the Member would benefit from a less intensive care management program.

    a. If the Member would benefit from a less intensive care management program, the care manager will come to an agreement with the Member regarding the appropriate level of care management support and will transition the Member to the less intensive program, as appropriate, and with Member agreement.

    b. The ECM Provider shall transition the Member to the lower intensity program at CalOptima Health or the assigned Health Network, with warm handoff as available.

5. ECM care managers shall complete training in accordance with GG.1356: CalAIM Enhanced Care Management Administration.

6. An ECM Provider shall consider Member preference in the event a Member wishes to change their LCM.

    a. If an ECM Member requests a new LCM, the ECM Provider shall consider the following factors in determining whether a new LCM will be assigned:

        i. Member's clinical needs;

        ii. Member's preferred language;

        iii. Social and therapeutic considerations; and

        iv. Staff availability and appropriateness

    b. If reassignment is appropriate and staff is available, the ECM Provider shall change the LCM.

    c. If reassignment is not clinically appropriate, or staff is unavailable, the ECM Provider shall work with the Member and LCM to address the Member's concerns.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
B. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process
C. CalOptima Health Policy GG.1301: Comprehensive Care Management Process
D. CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management – Eligibility and Outreach

E. CalOptima Health Policy GG.1355: CalAIM Community Supports
F. CalOptima Health Policy GG.1356: CalAIM Enhanced Care Management Administration
G. CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS)
H. CalOptima Health Policy GG.1510: Member Appeal Process
I. CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services
J. CalOptima Health Policy GG.1667: CalAIM Population Health Management Program
K. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
L. CalOptima Health Policy HH.1102: Member Grievance
M. CalOptima Health Policy HH.1108: State Hearing Process and Procedures
N. CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-004: Emergency Guidance for Medi-Cal Managed Care Plans Health Plans in Response to COVID-19
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program Guide (Supersedes APLs 17-012 and 17-013)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-007: Telehealth Services Policy (Supersedes APL 19-009)
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-018: Managed Care Health Plan Transition Policy Guide
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032: Enhanced Care Management Requirements (Supersedes APL 21-012)
T. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)
U. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS) Contract Template Provisions
V. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) and Community Supports Model of Care Template
W. Department of Health Care Services (DHCS) 2024 Medi-Cal Managed Care Plan Transition Policy Guide, Issued 03/22/2024
X. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) Policy Guide, February 2024
Y. Department of Health Care Services (DHCS) CalAIM Population Health Management (PHM) Policy Guide, January 2024
Z. Department of Health Care Services (DHCS) Conflict of Interest

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/17/2021	Department of Health Care Services (DHCS)	Approved as Submitted
06/01/2022	Department of Health Care Services (DHCS)	Approved as Submitted
12/13/2022	Department of Health Care Services (DHCS)	Approved as Submitted
08/18/2023	Department of Health Care Services (DHCS)	Approved as Submitted
12/14/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/26/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2022	GG.1353	Enhanced Care Management Service Delivery	Medi-Cal
Revised	03/03/2022	GG.1353	Enhanced Care Management Service Delivery	Medi-Cal
Revised	01/01/2023	GG.1353	CalAIM Enhanced Care Management Service Delivery	Medi-Cal
Revised	07/01/2023	GG.1353	CalAIM Enhanced Care Management Service Delivery	Medi-Cal
Revised	10/01/2023	GG.1353	CalAIM Enhanced Care Management Service Delivery	Medi-Cal
Revised	08/01/2024	GG.1353	CalAIM Enhanced Care Management Service Delivery	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Basic Population Health Management (BPHM)	An approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).
Care Management Plan (CMP)	A written plan that is developed with input from the member and/or their family member(s), guardian, authorized representative, caregiver, and/or other authorized support person(s), as appropriate, to assess strengths, risks, needs, goals, and preferences, and make recommendations for service needs.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Community Health Worker (CHW) Services	Preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified in CalOptima Health's contract with the Department of Health Care Services (DHCS) for Medi-Cal.
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR section 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.
Community Supports Provider	Entities that CalOptima Health has determined can provide Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in the DHCS Contract.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Cultural Competency or Culturally Competent	The ability to actively apply knowledge of cultural behavior and linguistic issues when interacting with members from diverse cultural and linguistic backgrounds. Essential elements of Cultural Competency include: 1. An unbiased attitude and organizational policy that values and respects cultural diversity and respect for the multifaceted nature and individuality of Members; 2. Awareness that culture and cultural beliefs may influence health and health care delivery; knowledge about, and respect for

Term	Definition
	diverse attitudes, beliefs, behaviors, and practices about preventive health, illness and diseases, as well as differing communication patterns; 3. Recognition of the diversity among Members (e.g., religion, socioeconomic status, physical or mental ability, age, gender, sexual orientation, social and historical context, generational, and acculturation status); 4. Skills to communicate effectively with diverse Member populations and application of those skills in cross-cultural interactions to ensure equal access to quality health care; 5. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, or disability; 6. Programs and policies that address the health needs of diverse Member populations; and 7. Ongoing program and service delivery evaluation with regard to cultural and linguistic needs of Members.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
Enhanced Care Management (ECM) Lead Care Manager (LCM)	A Member's designated Enhanced Care Management (ECM) care manager who works for the ECM Provider organization or as staff of CalOptima Health and is responsible for coordinating all aspects of ECM and any Community Supports as a part of the Member's multi-disciplinary care team, which may include other care managers.
Enhanced Care Management (ECM) Member	A Member that is authorized for, continuously participating in, and receiving Enhanced Care Management, and assigned to a Health Network or CalOptima Health Direct.
Enhanced Care Management (ECM) Provider	Community-based entities with experience and expertise providing intensive, in-person care management services to Members in one or more of the Populations of Focus for Enhanced Care Management (ECM).
Health Homes Program (HHP)	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks, and CMS approves for the provision of HHP Services that provide supplemental services to eligible Members coordinating the full range of physical health, behavioral health, and community-based MLTSS needed for chronic conditions.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.

Term	Definition
Interdisciplinary Care Team (ICT)	A team comprised of the Primary Care Provider and Care Coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Palliative Care	Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.
Person-Centered Plan of Care	An ongoing process designed to develop an individualized care plan specific to each person's needs, desires, and abilities. A Person-Centered Plan of Care includes consideration of the current and unique bio-psycho-social and medical history of the individual Member, as well as the Member's functional level, support systems and continuum of care needs. A Person-Centered Plan of Care is an integral part of basic and complex care management, ECM, and discharge planning.
Populations of Focus (POF)	Subject to the phase-in requirements prescribed by DHCS and Member transition requirements for HHP and WPC, Members eligible to participate in ECM under the CalAIM initiative include the following, as defined by DHCS: 1. Adult Populations of Focus include the following: a. Individuals and families experiencing Homelessness; b. Individuals At Risk for Avoidable Hospital or emergency department utilization; c. Adults with Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD); d. Individuals transitioning from incarceration; e. Individuals who are at risk for institutionalization and are eligible for long-term care (LTC); f. Nursing facility residents who want to transition to the community; and g. Birth Equity Population of Focus. 2. Populations of Focus for Children and Youth include the following: a. Children (up to age 21) experiencing Homelessness; b. Individuals At Risk for Avoidable Hospital or emergency department utilization; c. Children (up to age 21) with Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD); d. Individuals transitioning from incarceration; e. Enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition; f. Involved in, or with a history of involvement in, child welfare (including foster care up to age 26); and g. Birth Equity Population of Focus.

Term	Definition
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health Related Social Needs.
Telehealth	A method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.