Enhanced Care Management Oversight, Monitoring, and Auditing

Purpose: As part of the Department of Health Care Services' (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) initiative and the Enhanced Care Management (ECM) benefit, Partnership HealthPlan of California is required to perform oversight of ECM providers and hold them accountable to all ECM requirements.

Process: Partnership will perform audits and oversight of ECM providers to ensure their performance meets all ECM requirements contained in the DHCS contract amendment, ECM policy guide and DHCS All Plan Letter (APL) 23-032. An internal oversight audit tool will be used to track each audit element and document compliance, comments, findings, if correction(s) are needed in the specific area, and date of correction(s) completed.

Frequency: Audits will occur every other year, or more frequently as needed, to evaluate ECM provider performance and compliance to ensure State and contractual requirements are met. Additionally, onsite visits may be conducted as needed.

ECM Record Selection: Providers with 10 or more enrolled ECM members will be subject to ECM oversight. Partnership will pull a sample of eight charts of the ECM provider's assigned enrolled ECM members. Partnership will review ECM Treatment Authorization Record (TAR) records, as well as the provider's applicable ECM folder for valid release of information, care plans, and reporting files.

Once sample files are identified, Partnership will review care plans and then request the provider to attach additional member file information or records via Point Click Care (PCC) for review. Use the following naming convention when you upload documents: Last NameCIN. If any of the eight charts show any problems, Partnership may audit additional charts.

Scoring: The review score is based on a review standard of eight sample files of Partnership members enrolled with the ECM provider. Partnership will review ECM TAR records, as well as the provider's valid release of information (ROI), care plans, and reporting files. Compliance levels are:

- 90% = Pass
- 80-89% = Conditional Pass
- 79% and below = Failure

The minimum passing score is 80%. A corrective action plan (CAP) is required for a total audit score below 80%.

Performance Improvement (PIPs) and Corrective Action Plans (CAPs): If a provider scores below 80%, a PIP will be sent to the provider and the provider will have 90 days to correct action(s). Should a provider fail to correct action(s) within 90 days, they will receive a Corrective Action Plan (CAP) and will not be able to enroll new ECM members nor submit authorizations until 100% compliant. The provider will have 30 days to correct action (s) and should a provider fail to correct action(s), the provider may be administratively terminated or de-credentialed and would not be able to provide services to nor bill for Partnership members.

Audit Tracking and Documentation: Designated Partnership staff will send the ECM provider the Oversight Template. Partnership staff will conduct the ECM audit using the ECM Audit Tool. All oversight audits will be recorded for historical purposes and reference.

- **ECM Provider Oversight Template**
- **Audit Scorecard**

Duplication of Services Prevention: Partnership will work with the ECM provider and the member's multi-disciplinary care team to ensure there is no duplication of services. Partnership will conduct ongoing analysis using internal and external data.

- External DHCS reports, such as Targeted Case Management (TCM)
- Internal TAR reports, including ECM, CS, Behavioral Health, Care Coordination programs and ECM referrals
- Partnership's additional reports may include Complex Case Management (CCM), Assisted Living Waiver (ALW), Medi-Cal Waiver Program (MCWP) (formerly named the HIV/AIDS Waiver), Multipurpose Senior Services Program (MSSP), and HCBS Waiver for Individuals with Developmental Disabilities (I/DD)

Designated Staff: Auditing will be overseen by the Enhanced Health Services clinical manager. Both clinical (medical) and non-clinical (program staff) will conduct these ECM audits.

ECM File Review: **Information from the TAR, Care Plans, ECM Provider Reporting Files, ROIs, Claims/Invoice Billing, and ECM Provider materials such as program description, organizational charts, etc.**	
Outreach and Engagement	
Member Visit Documentation *Source: Snip from case management documentation system*	Member visit documentation showing a minimum number of visits, dependent upon care plan and set goals.
Engagement Requirements Met *Source: Snip from case management documentation system, IOT*	Engaging non-enrolled members: three times per 30 days. Engaging enrolled members: a minimum of once per 30 days (note duration of meeting[s]).
Using Multiple Strategies for Engagement *Source: Materials, best practices and/or desktops*	Using multiple strategies for engagement, as appropriate and to the extent possible, including direct communications with the member (and/or their parent, caregiver, guardian), such as in-person meetings where the member lives, seeks care or is accessible; 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 claims data to contact providers the member is known to use.
Utilizing Education Materials *Source: Materials, best practices and/or desktops*	Utilizing educational materials and scripts developed for outreaching and engaging members, as appropriate.
Sharing Information with MCP *Source: IOT, RTF*	Sharing information between the MCP and ECM providers, to ensure that the MCP can assess members for other programs if they cannot be reached or decline ECM.
Culturally and Linguistically Appropriate *Source: Member specific materials, best practices and/or desktops*	Providing culturally and linguistically appropriate communications and information to engage members (and/or their parent, caregiver, guardian).
Comprehensive Assessment and Care Management Plan	
Care Plans and Goal Progress *Source: Care Plan*	Care plan filed and goal progress documented. Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess member health status and gaps in care.

	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, risks, needs, and goals. The care plan must also leverage member strengths and preferences and make recommendations for service needs.
Identifying Needs *Source: 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.
Timely Updates *Source: Care plan*	Updates made to member's ECM care plan. Ensuring 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 management plan.Ensuring the care management plan is reviewed, maintained, and updated under appropriate clinical oversight.
Valid ROI *Source: ROI in PCC*	ROI in member's file.
Enhanced Coordination of Care	
Organizing Patient Care Activities *Source: Care plan*	Organizing patient care activities, as laid out in the care management plan; sharing information with those involved as part of the member's multi-disciplinary care team; and implementing activities identified in the member's care management plan.
Regular Contact with Care Team *Source: Care plan and/or case management platform, RTF*	Maintaining regular contact with all providers that are identified as being a part of the member's multi-disciplinary care team, whose 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 primary care provider (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.

Support for Member Treatment Coordination *Source: Care plan and/or case management platform*	Providing support to engage the member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to member engagement in treatment. Communicating the member's needs and preferences in a timely manner to the member's multi-disciplinary care team to ensure safe, appropriate and effective person-centered care.
Ensure Regular Contact with Enrollee *Source: Claims, RTF, and/or case management platform*	Ensuring regular contact with the member (and/or their parent, caregiver, guardian) when appropriate, consistent with the care plan and to ensure information is shared with all involved parties to monitor the member's conditions, health status, care planning, medications usages, and side effects.
Health Promotion	
Working with Members to Identify and Build Networks *Source: Member specific materials, best practices and/or desktops*	Providing services, such as coaching, to encourage and support members to make lifestyle choices based on healthy behavior, with the goal of supporting members' ability to successfully monitor and manage their health. Supporting members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions. Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage.
Comprehensive Transitional Care	
Timely Manner of Member's Admission, Transfer or Discharge *Source: Care plan and/or case management platform*	Knowing, in a timely manner, each member's admission, discharge, or transfer to or from an emergency department (ED), hospital inpatient facility, Skilled Nursing Facility (SNF, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members.
Re-Admission Strategies Developed *Source: Care plan, case management platform, materials,*	Developing strategies to reduce avoidable member admissions and readmissions. Examples include using PCC to review discharges and admissions; establishing agreements and processes to promptly notify to the member's lead care manager, who will ensure all transitional care services are complete, including but not limited to: ensuring

best practices and/or desktops	discharge risk assessment and discharge planning document is created and shared with appropriate parties; planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners; conducting medication reconciliation or closed loop referrals, developing policies to arrange transportation for transitional care, including to medical appointments, as per Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) policy and procedures; and easing the member's transition by addressing their understanding of rehabilitation activities, self- management activities and medication management.
Member and Family Supports	
Documentation of Member's Authorized Family and/or Caregiver *Source: Care plan and/or case management platform*	Documenting member's authorized parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM providers; the member and/or member's authorized parent, caregiver, guardian, other family member(s), and/or other authorized support person(s), as applicable.
Primary Point of Contact *Source: Care plan and/or case management platform*	Ensuring the member's ECM lead care manager serves as the primary point of contact for the member and/or parent, caregiver, guardian, other family member(s), and/or other authorized support person(s). Ensuring that the member parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) has a copy of his/her care plan and information about how to request updates.
Appropriate Education and Activities *Source: Care plan, case management platform, materials, best practices and/or desktops*	Providing appropriate education of the member parent, caregiver, guardian, other family member(s), and/or other authorized support person(s) about care instructions for the member. 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 condition(s), 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.

Identify Supports *Source: Care plan and/or case management platform*	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 and assist them with making informed choices.
Coordination of/and Referral to Community and Social Support Services	
Coordination and Referrals to Appropriate Services *Source: Care plan and/or case management platform*	Determining appropriate services to meet the needs of members, including services that address SDOH needs, housing, and services offered by contractor as community supports. Coordinating and referring members to available community resources and following up with members (and/or parent, caregiver, guardian) to ensure services were rendered (i.e., "closed-loop referrals").
Quality and Monitoring Reports	
ECM Provider's Reporting Files	• Return Transmission File *Source: RTF* • Initial Outreach Tracker File *Source: IOT* • Capacity *Source: Capacity Survey*
Partnership Internal Monitoring Reports *Source: Care Plan and/or case management platform*	Member-level outcomes related to utilization to evaluate ECM benefit and transitions of care success.
Quality Incentive Reports *Source: RTF, IOT, Capacity*	Reports from Partnership's Quality Incentive Program
Treatment Authorization Reports *Source: TAR data*	• TARs are submitted in a timely manner. Partnership Policy MCUP3041: TARs must be received by Partnership within 15 business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. Renewal TARs to be submitted at least 10 days prior to end of the prior approval. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.) • TARs are submitted correctly for payment purposes (i.e., correct codes, quantities, modifiers, dates, diagnosis codes.) • TARs correctly identify a POF.

Member Experience Surveys	2025/2026
ECM Provider Peer Sharing Support	• Every two months for new sites • During the first six months of services • Every six months for existing sites or as needed
Program Narrative Description	Review of provider program narrative as shared six months after first member enrolled and annually thereafter. Will include description of program, staffing, enrollment, barriers, challenges, successes, and recommendations for improvement of program.
Onsite Visits	
Onsite Visits	Onsite Visits

ECM Review Tool

Provider Name: _____ Review Date: _____

Partnership No: _____ Site NPI: _____

Address: _____ Reviewer name/title: _____

City and Zip Code: _____ Reviewer name/title: _____

Phone: _____ Fax: _____

Contact person/title: _____

Email: _____

Provider Name	NPI

Number of Records Reviewed: _____

Visit Purpose	Populations of Focus	
□ Initial Audit □ Monitoring □ Follow-up □ Technical Assistance □ Other	□ Adults and Families - Homelessness □ Adults – At Risk for Avoidable Hospital or ED Utilization □ Adults – SMH and/or SUD □ Adults – At Risk for LTC □ Adults – Transitioning from Incarceration □ Adults and Youth – Pregnancy and Postpartum □ Adults and Youth – Birth Equity	□ Children and Youth – Homelessness □ Children and Youth – SMH and/or SUD □ Children and Youth – At Risk for Avoidable Hospital or ED Utilization □ Children and Youth – Transitioning from Youth Correctional Facility □ Children and Youth – Involved in Child Welfare □ Children and Youth – Enrolled in CCS

ECM Record Scores					Scoring Procedure	Compliance Rate
	Yes	No	N/A	Section Score %	**Scoring is based on first 8 records pulled. If any of the first 8 pulled fails, another 8 records will be pulled for a total of 16 records.** 1) Add points given for all 8 sections. 2) Divide total points given by total points possible.	**Note:** Any section score < 80% requires a PIP. **___ Pass: 90% or above** (Total score is ≥ 90% ***and*** all section scores are 80% or above) **___ Conditional Pass: 80-89%** (Total is 80-89% ***OR*** any section(s) score is < 80%) **___ PIP: 79% and Below** **___ Other follow-up** **Next Review Due: _____**
Outreach and Engagement						
Comprehensive Assessment and Care Management Plan						
Enhanced Coordination of Care						
Health Promotion						
Comprehensive Transitional Care						
Member and Family Supports						
Coordination/Referral to Community and Social Support Services						
Quality and Monitoring Reports						
	Yes Points	**No Points**	**N/A**			

ECM Records Reference:

ECM Record	CIN	Age (Year/Month)	Gender	Member's Health Plan Code	Member's Enrollment Date or Effective Date Assigned to Member*
1					
2					
3					
4					
5					
6					
7					
8					

*More recent date should be noted in column.