DHCS-MCP Enhanced Care Management and In Lieu of Services Contract Template Provisions

DRAFT FOR PUBLIC COMMENT

2/12/2021

Table of Contents

Enhanced Care Management (ECM) Definitions

1. **Enhanced Care Management (ECM):** a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
2. **ECM Provider:** a Provider of ECM. ECM Providers are community-based entities, with experience and expertise providing intensive, in-person care management services to individuals in one (1) or more of the target populations for ECM, as described in ECM Section 3: ECM Providers.
3. **Lead Care Manager:** a Member's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be on staff with Contractor, as described in ECM Section 4: ECM Provider Capacity). The Lead Care Manager operates as part of the Member's care team and is responsible for coordinating all aspects of ECM and any In Lieu of Services (ILOS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.
4. **Model of Care:** the ECM and ILOS Model of Care (MOC) is Contractor's framework for providing ECM and ILOS, including its Policies and Procedures for partnering with ECM and ILOS Providers. The ECM and ILOS Model of Care Template (MOC Template) is the document that details the MOC. Contractor must submit its MOC Template to DHCS for review and approval prior to ECM and ILOS implementation. ECM and ILOS Provider contracts must incorporate the MOC requirements as described in ECM Section 5: Model of Care.

ECM Scope of Services

1. Contractor's Responsibility for Administration of ECM

a. Contractor shall ensure Enhanced Care Management (ECM) is a whole-person approach that addresses the clinical and non-clinical needs of high-cost and/or high-need Members in distinct target populations as defined in ECM Section 2: Target Populations for ECM, through systematic coordination of services and comprehensive care management. Contractor shall ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.

b. Contractor shall ensure ECM is available throughout Contractor's service area.

c. Contractor shall ensure ECM is offered primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services. Contractor may substitute secure teleconferencing when appropriate to meet the Member's needs and with consent of the Member.

i. As described in ECM Section 3: ECM Providers, Contractor must contract with ECM Providers for the provision of ECM.

a. Under limited circumstances defined in ECM Section 4: ECM Provider Capacity, Contractor may perform ECM functions using its own staff, with prior written approval from DHCS.

b. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor shall follow the same requirements as a contracted ECM Provider.

ii. Contractor shall ensure it has contracts in place to ensure its ECM Provider capacity meets the needs of all ECM target populations in a setting consistent with all the requirements in this Contract amendment, as described in ECM Section 4: ECM Provider Capacity.

iii. In Counties with operating Health Homes Programs (HHP) and Whole Person Care (WPC) pilots, Contractor shall contract with WPC Lead Entities and HHP Community-Based Care Management Entities (CB-CMEs) for the provision of ECM, as described in ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM.

d. Contractor shall follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract amendment.

i. Contractor shall inform Members about ECM and how to access it. Contractor shall identify Members within the ECM target populations who may benefit from ECM, as defined in ECM Section 2: Target Populations for ECM. Contractor shall manage and respond promptly to requests for ECM directly from Members and on behalf of Members from ECM Providers, other Providers and community entities, and the Member's guardian or authorized representative, where applicable, as described in ECM Section 7: Identifying Members for ECM.

ii. Contractor shall be responsible for authorizing ECM for Members, whether they are identified by Contractor or if the Member or a family member, guardian, caregiver, authorized support person or external entity requests that the Member receive ECM, as described in ECM Section 8: Authorizing Members for ECM.

iii. Contractor shall be responsible for assigning all Members authorized to receive ECM to an appropriate ECM Provider, as described in ECM Section 9: Assignment to an ECM Provider.

iv. Contractor shall ensure ECM Providers conduct outreach to engage Members who are authorized to receive ECM, as described in ECM Section 10: Outreach and Engagement into ECM.

v. Contractor shall ensure the assigned ECM Provider obtains and documents consent for each assigned Member to initiate ECM, as described in ECM Section 11: Initiating Delivery of ECM and ECM Section 12: Discontinuation of ECM.

e. Contractor shall ensure ECM provided to each Member encompasses the ECM Core Service Components described in ECM Section 13: Core Service Components of ECM.

i. Contractor shall ensure each Member authorized to receive ECM has 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), any In Lieu of Services (ILOS), and other services that address social determinants of health needs, regardless of setting.

f. Contractor shall ensure a Member receiving ECM is not receiving duplicative services both through ECM and outside of ECM, including by working with Local Governmental Agencies to ensure ECM services do not duplicate Targeted Case Management services.
g. Contractor shall complete an ECM MOC Template and submit for DHCS to review and approve as described in ECM Section 5: Model of Care.
h. Contractor shall comply with all data system and data sharing requirements to support ECM, as described in ECM Section 14: Data System Requirements and Data Sharing to Support ECM.
i. Contractor shall be responsible for overseeing the delivery of ECM to authorized Members through its contracted ECM Providers, as described in ECM Section 15: Oversight of ECM Providers. Contractor shall ensure all Subcontractors participating in any aspect of ECM administration uphold all applicable requirements as described in ECM Section 16: Delegation of ECM to Subcontractor(s) and in accordance with Exhibit A, Attachment 6, Provision 14, Subcontracts.
j. Contractor shall pay contracted ECM Providers for the provision of ECM, including for outreach to assigned Members, as described in ECM Section 17: Payment.
k. Contractor shall report ECM encounters, performance metrics, and supplemental information as specified by DHCS to allow DHCS appropriate oversight of ECM, as described in ECM Section 18: DHCS Oversight of ECM.
l. For Members who are dually eligible for Medicare and Medi-Cal, when the Member is enrolled in a Medicare Advantage Plan, including a Dual-Eligible Special Needs Plan, Contractor shall coordinate with the Medicare Advantage Plan in the provision of ECM.

2. Target Populations for ECM

a. Subject to the phase-in and member transition requirements described in ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM, Contractor shall provide ECM to highest-risk Members who utilize multiple delivery systems and services, need ongoing coordination across medical, behavioral, and social needs, and are part of the following mandatory target populations:
    i. Children or youth with complex physical, behavioral, or developmental health needs (e.g., California Children's Services, foster care, youth with Clinical High-Risk Syndrome, or first episode of psychosis).
    ii. Individuals experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions.
    iii. High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
    iv. Individuals at risk for institutionalization who are eligible for Long-Term Care services.
    v. Nursing facility residents who want to transition to the community.

vi. Individuals at risk for institutionalization who have co-occurring chronic health conditions and:
    - Serious Mental Illness (SMI, adults);
    - Serious Emotional Disturbance (SED, children and youth); or
    - Substance Use Disorder (SUD).
vii. Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition to the community.

b. Contractor shall follow all DHCS guidance that further defines the approach to ECM for each target population and/or further refines target population criteria.
c. Contractor may identify additional unique target populations that may benefit from ECM, subject to DHCS' prior approval within the process described in ECM Section 5: Model of Care.

3. ECM Providers

a. Contractor shall ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member (i.e., where the Member lives, seeks care, or prefers to access services).
b. Contractor shall contract with ECM Providers to provide ECM.
c. ECM Providers may include, but are not limited to, the following entities:
    i. Counties
    ii. County behavioral health Providers
    iii. Primary Care Physician or Specialist or Physician groups
    iv. Federally Qualified Health Centers
    v. Community Health Centers
    vi. Hospitals or hospital-based Physician groups or clinics (including public hospitals and district and/or municipal public hospitals)
    vii. Rural Health Clinics and/or Indian Health Service Programs
    viii. Local health departments
    ix. Behavioral health entities
    x. Community mental health centers
    xi. Substance use disorder treatment Providers
    xii. Organizations serving individuals experiencing homelessness
    xiii. Organizations serving justice-involved individuals
    xiv. Other qualified Providers or entities that are not listed above, as approved by DHCS
d. For the SMI, SED and SUD ECM target population, Contractor shall consider County behavioral health staff for the ECM Provider role, provided they agree to coordinate all services needed by those target populations, not just their behavioral health services.
e. Contractor shall attempt to contract with each American Indian Health Service Program set forth in Title 22 CCR Sections 55120-55180 to provide ECM, when applicable, as described in Exhibit A, Attachment 8, Provision 7(C).
f. To provide Members with ongoing care coordination previously provided in HHP and WPC Pilot counties, Contractor shall contract with each WPC Lead Entity or HHP CB-CME as an ECM Provider unless there is an applicable exception *[See ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM].*

g. Contractor shall ensure ECM Providers:
    i. Are experienced in serving Medi-Cal Members including the ECM target population(s) they propose to serve;
    ii. Have experience and expertise with the services they propose to provide;
    iii. Comply with all applicable ECM program requirements in this Contract and associated guidance;
    iv. Have the capacity to provide culturally appropriate and timely in-person care management activities in accordance with Exhibit A, Attachment 6, Provision 13, Ethnic and Cultural Composition, including accompanying Members to critical appointments when necessary;
    v. Are able to communicate in culturally and linguistically appropriate and accessible ways, in accordance with Exhibit A, Attachment 9, Provision 14, Cultural and Linguistic Program;
    vi. Have in place agreements and processes to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, such as ILOS Providers, to coordinate care as appropriate to each Member; and
    vii. Use a care management documentation system or process that is capable of integrating physical, behavioral, social service and administrative information from other entities in order to manage and maintain a care plan that can be shared with other Providers and organizations involved in each Member's care *[See ECM Section 14: Data System Requirements and Data Sharing to Support ECM* for more detailed requirements on data exchange].
h. Contractor shall use standard terms and conditions provided by DHCS, in addition to Contractor's own terms, to develop its contracts with ECM Providers, as described in ECM Section 15: Oversight of ECM Providers.
i. Contractor shall ensure all ECM Providers are Medicaid-enrolled where a State-level enrollment pathway exists and is required by Federal law.
    i. If no Medicaid enrollment pathway exists, Contractor must either credential ECM Providers or conduct background checks, as applicable and pursuant to relevant DHCS All Plan Letters (APL) including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
j. Contractor shall not require eligible ECM Providers to be NCQA certified or accredited as a condition of contracting for ECM.

4. ECM Provider Capacity

a. Contractor shall develop and manage a Network of ECM Providers.
b. Contractor shall ensure sufficient ECM Provider capacity to meet the needs of all ECM target populations *[See ECM Section 2: Target Populations for ECM]*.
c. DHCS will evaluate ECM Provider capacity separately from general Network Adequacy; ECM Provider capacity does not alter general Network Adequacy provisions in Exhibit A, Attachment 6, Provider Network.
d. Contractor shall report on its ECM Provider capacity to DHCS initially within its MOC Template *[See ECM Section 5: Model of Care],* and on an ongoing basis pursuant to DHCS reporting requirements.

i. Within the MOC Template and pursuant to ongoing reporting requirements, Contractor shall report to DHCS:
    a. Target populations, by county;
    b. The ECM Providers that will serve each county's target populations;
    c. Contractor's approach and metrics for ensuring there is sufficient ECM Provider capacity in each county to meet the needs of Contractor's ECM target populations; and
    d. Other information as specified by DHCS.
ii. Contractor shall report 60 days in advance on its ECM Provider capacity whenever there are significant changes, pursuant to DHCS reporting requirements.

e. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM target populations in a community-based manner through Contracts with ECM Providers, Contractor may request written approval for an exception to the ECM Provider contracting requirement from DHCS that authorizes Contractor to use Contractor's own staff for ECM. Any such request must be submitted in accordance with DHCS guidelines and must evidence one (1) or more of the following:
    i. There are insufficient Providers with experience and expertise to provide ECM for one (1) or more of the target populations in one or more counties;
    ii. There is a justified quality of care concern with one (1) or more of the otherwise qualified Providers;
    iii. Contractor and the Provider(s) are unable to agree on contracted rates;
    iv. Provider(s) is/are unwilling to contract;
    v. Provider(s) is/are unresponsive to multiple attempts to contract; and/or
    vi. Provider(s) is/are unable to comply with the Medi-Cal enrollment or Contractor credentialing or background check process.
f. During any exception period approved by DHCS, which shall be in effect no longer than one (1) year, Contractor shall take steps to develop the capacity of the ECM Provider network. Extension requests after the initial one (1) year period will be reviewed on a case by case basis.
g. Unless Contractor has DHCS approval, based on one of the exceptions defined above, failure of Contractor to provide ECM Provider capacity to meet the needs of all ECM target populations in a community-based manner shall result in corrective action proceedings, leading to sanctions as defined in Exhibit E, Attachment 2, Provision 16, Sanctions.

5. Model of Care

a. Contractor shall develop a MOC, which shall be Contractor's framework for providing ECM, including its ECM Providers and Policies and Procedures for partnering with ECM Providers.
b. DHCS will review and approve the MOC using the DHCS defined MOC Template, which shall contain:
    i. Contractor's ECM Providers, in accordance with ECM Section 4: ECM Provider Capacity;

ii. Contractor's approach to ensuring ECM is offered primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services;
iii. Contractor's approach to engagement and initiation of ECM for identified Members following the requirements in ECM Section 10: Outreach and Engagement into ECM;
iv. Contractor's requirements to be placed on ECM Providers to ensure adherence to the MOC, including key Provider Contract terms not otherwise provided in ECM Provider Standard Terms and Conditions;
v. Contractor's approach to data sharing to support ECM in accordance with ECM Section 14: Data System Requirements and Data Sharing to Support ECM;
vi. Contractor's approach to transitioning Members to lower levels of care management or graduating them from ECM described in ECM Section 12: Discontinuation of ECM;
vii. Description of any aspects of the MOC that differ substantially from Contractor by Subcontractor;
viii. Any collaboration with other MCPs within the same County about how ECM will be implemented to mitigate burden on ECM Providers *[See ECM Section 15: Oversight of ECM Providers]*; and
ix. Details of Contractor's approach to the transition from Whole Person Care and Health Homes Program, to ECM and ILOS, when applicable *[See ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM].*

c. In developing and executing ECM Contracts with ECM Providers, Contractor must incorporate requirements described in the MOC, in addition to the ECM Provider Standard Terms and Conditions.
d. Contractor is encouraged to collaborate on its MOC with other MCPs within the same County.

6. Transition of Whole Person Care and Health Homes Program to ECM

a. Contractor shall promote continuity from Whole Person Care (WPC) Pilots and the Health Homes Program (HHP) to ECM and ILOS.
b. Contractor shall make ECM available to Members in HHP and WPC counties, on an ECM target populations implementation schedule defined by DHCS. ECM must be offered to all Members within the target populations identified in the ECM target populations implementation schedule, not just those transitioning from HHP or WPC.
c. To ensure continuity between HHP and ECM, Contractor shall:
    i. Automatically authorize ECM for all Members of ECM target populations who are enrolled in or are in the process of being enrolled in HHP.
    ii. Ensure that each Member automatically authorized for ECM under this provision is assessed within six (6) months to determine the most appropriate level of services for the Member, whether that is ECM or a lower level of care coordination.
d. To ensure continuity between WPC Pilots and ECM, Contractor shall:

i. Automatically authorize all Members enrolled in a WPC Pilot who are identified by the WPC Lead Entity as belonging to an ECM target population.
ii. Ensure each Member automatically authorized under this provision is assessed within six (6) months to determine the most appropriate level of services for the Member, whether that is ECM or a lower level of care coordination.

e. Contractor shall contract with each WPC Lead Entity and/or HHP CB-CME as an ECM Provider to provide Members with ongoing care coordination previously provided in HHP and WPC Pilot counties, except under circumstances defined below.
f. Contractor shall submit to DHCS for prior approval any requests for exceptions to the contracting requirement with a WPC Lead Entity or HHP CB-CME as an ECM Provider. Permissible exceptions to contracting are:
    i. There is a justified quality of care concern with one or more of the otherwise qualified Providers;
    ii. Contractor and Provider(s) are unable to agree on contracted rates;
    iii. Provider(s) is/are unwilling to contract;
    iv. Provider(s) is/are unresponsive to multiple attempts to contract; and/or
    v. Provider(s) is/are unable to comply with the Medi-Cal enrollment or Contractor credentialing or background check process.

7. Identifying Members for ECM

a. Contractor shall proactively identify Members who can benefit from ECM and who meet the criteria for the ECM target populations described in ECM Section 2: Target Populations for ECM.
b. To identify such Members, Contractor must consider Members' health care utilization; needs across physical, behavioral, developmental, and oral health; health risks and needs due to social determinants of health; and LTSS needs.
c. Contractor shall identify Members for ECM through the following pathways:
    i. Analysis of Contractor's own enrollment, claims, and other relevant data and available information. Contractor shall use data analytics to identify Members who can benefit from ECM and who meet the ECM target population criteria. Contractor shall consider all Members who can benefit from ECM using the following data sources:
        a. Enrollment data
        b. Encounter data
        c. Utilization/claims data
        d. Pharmacy data
        e. Laboratory data
        f. Assessment data
        g. Clinical information on physical and/or behavioral health
        h. Health Information Form (HIF)/Member Evaluation Tool (MET)
        i. DHCS standardized "Staying Healthy" assessment tools or alternative Individual Health Education Behavioral Assessment (IHEBA) tools approved by DHCS and utilized by Primary Care Providers

j. Health Risk Stratification and Assessment survey for Seniors and Persons with Disabilities (SPD)
k. Risk stratification information for children in County Organized Health System (COHS) counties with Whole Child Model programs
l. Information about social determinants of health and/or Adverse Childhood Experiences (ACEs),
    i. Using ICD-10 codes for social determinants of health (SDOH) needs as applicable
m. Other cross-sector data and information, including housing, social services, foster care, criminal justice history and other information relevant to the ECM target populations

ii. Receipt of requests from ECM Providers and other Providers or community-based entities:
    a. Contractor shall accept requests for ECM on behalf of Members from:
        i. ECM Providers;
        ii. Other Providers in Contractor's contracted Network;
        iii. Community-based entities, including those contracted to provide ILOS, as described in ILOS Section 3: ILOS Providers; and
        iv. Other Providers not listed above.

d. Contractor shall directly engage with Network Providers and County agencies to inform these entities of ECM, the ECM target populations, and how to request ECM for Members.
e. Contractor shall encourage ECM Providers to identify Members who may benefit from receipt of ECM and develop a process for receiving and responding to requests from ECM Providers.
f. Contractor shall have a process for allowing Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) to request ECM on a Member's behalf, and shall provide information to Members regarding its Member and/or family ECM request and approval process.
g. Contractor shall develop and disseminate Member-facing written material about ECM for use across its ECM Provider Network. This material must:
    i. Explain ECM and how to request it;
    ii. Explain that ECM participation is voluntary;
    iii. Describe the consent process and the process by which the Member may choose to participate;
    iv. Describe the process by which the Member may choose a different Lead Care Manager or ECM Provider; and
    v. Meet standards for culturally and linguistically appropriate communication outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program and in Exhibit A, Attachment 13, Provision 3, Written Member Information.

8. Authorizing Members for ECM

a. Contractor shall be responsible for authorizing ECM for each Member identified through any of the pathways described in ECM Section 7: Identifying Members for ECM.
b. For requests from Providers and other external entities, and for Member or family requests:
    i. Contractor shall ensure authorization or a decision not to authorize occurs as soon as possible and in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (i.e., within (5) working days for routine authorizations and within 72 hours for expedited requests).
    ii. If Contractor does not authorize ECM, Contractor shall 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 Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeal System and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
    iii. Contractor shall follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments from Members who were not authorized to receive ECM.
c. Contractor shall follow requirements for transitioning Members previously served by WPC Pilots or HHP contained in ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM.
d. To inform Members that ECM has been authorized, Contractor shall follow its standard notifications process outlined in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
e. Contractor is encouraged to apply a six (6) month minimum initial authorization period for ECM for all Members transitioning into ECM to provide stability for Members and ECM Providers.

9. Assignment to an ECM Provider

a. Contractor shall assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS approved exception to the ECM Provider contracting requirement *[See ECM Section 4: ECM Provider Network Capacity].*
b. Contractor shall ensure communication of the assignment to the assigned ECM Provider occurs within ten (10) business days of authorization.
c. If the Member's preferences for a specific ECM Provider are known to Contractor, Contractor shall follow those preferences, to the extent practicable.

d. If the Member's assigned Primary Care Provider (PCP) is a contracted ECM Provider, Contractor shall assign the Member to the PCP as the ECM Provider, unless the Member has expressed a different preference or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
e. If a Member receives services from a Specialty Mental Health Plan for SED, SUD, and/or SMI and the Member's Behavioral Health Provider is a contracted ECM Provider, Contractor shall assign that Member to that Behavioral Health Provider as the ECM Provider, unless the Member has expressed a different preference or the Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
f. Contractor shall notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider.
g. Contractor shall document the Member's ECM Lead Care Manager in its system of record.
h. Contractor shall permit Members to change ECM Providers at any time. Contractor shall implement any requested ECM Provider change within thirty (30) days.

10. Outreach and Engagement into ECM

a. Contractor shall require all ECM Providers to assume responsibility for conducting outreach and engaging each assigned Member into ECM.
b. Contractor shall, as part of its MOC described in ECM Section 5: Model of Care, have policies and procedures for its ECM Providers with respect to requirements for outreach to and engagement of ECM-authorized Members, including how ECM Providers will be required to:
    i. Conduct outreach prioritizing in-person contact where the Member lives, seeks care, or is accessible;
    ii. Conduct outreach promptly after ECM authorization;
    iii. Engage all target populations for which each ECM Provider is responsible;
    iv. Prioritize engagement of those with the most immediate needs;
    v. Establish contact with the Member through multiple community-based modalities as appropriate to each Member;
    vi. Use the following modalities, as appropriate, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences:
        a. Mail
        b. Email
        c. Texts
        d. Telephone calls
        e. Other
    vii. Make a required number of attempts to engage the Member;
    viii. Adhere to Contractor's time limits on the outreach process;
    ix. Provide culturally and linguistically appropriate Member communication as described in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program; and
    x. Share information and data between Contractor and ECM Providers on a real-time or frequent basis to ensure when Members cannot be

engaged or choose not to participate in ECM, Contractor can reassess them for other care management programs.

11. Initiating Delivery of ECM

a. Contractor shall initiate delivery of ECM for each authorized Member, at the time the Member gives verbal or written consent to receipt of ECM and authorization of related data sharing, including sharing of personal health information in accordance with Federal, State, and local laws.
b. Contractor shall ensure the assigned ECM Provider assumes responsibility for obtaining and documenting consent from each assigned Member to receipt of ECM and authorization of related data sharing, and shall develop policies and procedures for its ECM Providers (to be contained in its MOC) to:
    i. Obtain and document Member consent to the receipt of ECM and authorization of related data sharing between Contractor and all ECM Providers involved in administering the Member's ECM, including sharing of protected health information;
    ii. Communicate Member-level record of consent to ECM and authorization of data sharing, when obtained, back to Contractor; and
    iii. Obtain Member authorization to communicate electronically with the Member and/or family member(s), guardian, caretaker, and/or authorized support person(s), if it intends to do so.
c. Contractor shall ensure that upon the initiation of ECM, each Member receiving ECM has a Lead Care Manager with responsibility for interacting directly with the Member and/or family, caretakers or authorized support person(s) as appropriate, and coordinating all covered primary, behavioral, developmental, oral health, LTSS, any ILOS, and other services that address social determinants of health needs, regardless of setting, at a minimum.
d. Contractor shall ensure accurate and up-to-date Member-level records are maintained for the Members authorized for ECM.

12. Discontinuation of ECM

a. Contractor shall ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.
b. Contractor shall ensure the ECM Provider notifies Contractor to discontinue ECM for Members when any of the following circumstances are met:
    i. Contractor determines the Member is no longer authorized to receive ECM;
    ii. The Member has met all care plan goals;
    iii. The Member is ready to transition to a lower level of care;
    iv. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
    v. The ECM Provider has not been able to connect with the Member after multiple attempts.
c. Contractor shall develop processes for transitioning Members from ECM to lower levels of care management to provide coordination of ongoing needs.
d. Contractor shall notify the ECM Provider when ECM has been discontinued.

e. Contractor shall notify the Member of the discontinuation of ECM and ensure the Member is informed of their right to appeal and the appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

13. Core Service Components of ECM

a. Contractor shall ensure all Members receiving ECM receive all core service components described below:
    i. Comprehensive Assessment and Care Management Plan, which shall include, but are not limited to:
        a. Engaging with each Member authorized to receive ECM primarily through in-person contact;
            i. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider shall use alternative methods to provide culturally appropriate and accessible communication.
        b. Developing a comprehensive, individualized, person-centered care plan by working with the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
        c. Incorporating 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; and
        d. Ensuring the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and as identified in the care plan.
    ii. Enhanced Coordination of Care, which shall include, but is not limited to:
        a. Organizing patient care activities, as laid out in the care plan, sharing information with the Member's key care team, and implementing the Member's care plan;
        b. 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, necessary community-based and social services including housing, as needed;
        c. Providing support for Member engagement in 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;

d. Communicating the Member's needs and preferences timely to the Member's care team in a manner that ensures safe, appropriate, and effective person-centered care; and
e. Ensuring regular contact with the Member and their family member(s), guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

iii. Health Promotion, which shall include, but is not limited to:
   a. Working with Members to identify and build on resiliencies and potential family and/or support networks;
   b. Providing services 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; and
   c. Supporting the Member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

iv. Comprehensive Transitional Care, which shall include, but is not limited to:
   a. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;
   b. For Members who are experiencing or are likely to experience a care transition:
      i. Developing and regularly updating a transition plan for the Member;
      ii. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;
      iii. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;
      iv. Coordinating medication review/reconciliation; and
      v. Providing adherence support and referral to appropriate services.

v. Member and Family Supports, which shall include, but are not limited to:

a. Documenting a Member's designated family member(s), guardian, caregiver, and/or authorized support person(s) and ensuring all appropriate 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 Contractor, as applicable;
b. Activities to ensure the Member and/or their family member(s), guardian, caregiver, and/or 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;
c. Ensuring the Member's ECM Provider serves as the primary point of contact for the Member and/or family member(s), guardian, caregiver, and/or authorized support person(s);
d. Identifying supports needed for the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services;
e. Providing for appropriate education of the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) about care instructions for the Member; and
f. Ensuring that the Member has a copy of his/her Care Plan and information about how to request updates.

vi. Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:
a. Determining appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services offered by Contractor as ILOS; and
b. Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

14. Data System Requirements and Data Sharing to Support ECM

a. Contractor shall comply with all State and Federal reporting requirements.
b. Contractor shall have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:
i. Consume and use claims and encounter data, as well as other data types listed in ECM Section 7: Identifying Members for ECM to identify target populations;
ii. Assign Members to ECM Providers;

iii. Keep records of all Members receiving ECM who have given consent to receive ECM and have completed all authorizations necessary for sharing personal information among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by Contractor;
iv. Securely share data with ECM Providers;
v. Receive, process and send claims, encounters and invoices from ECM Providers to DHCS;
vi. Receive and process supplemental reports from ECM Providers;
vii. Send ECM supplemental reports to DHCS; and
viii. Open, track and manage referrals to ILOS Providers.

c. In order to support ECM, Contractor shall follow DHCS guidance on data sharing and provide the following information to all ECM Providers, at a minimum:
   i. Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
   ii. Encounter and/or claims data;
   iii. Physical, behavioral, administrative and SDOH data (e.g., HMIS data) for all assigned Members; and
   iv. Reports of performance on quality measures and/or metrics, as requested.
d. Contractor shall use defined Federal and State standards, specifications, code sets and terminologies when sharing physical, behavioral, social and administrative data with ECM and ILOS Providers, to the extent practicable, and with DHCS.

15. Oversight of ECM Providers

a. Contractor must ensure ECM Providers are in compliance with all aspects of ECM requirements in this Contract amendment, associated ECM guidance, and Contractor's MOC.
b. Contractor shall use ECM Provider Standard Terms and Conditions to develop its ECM Contracts with ECM Providers and shall incorporate all of its ECM Provider requirements, reviewed and approved by DHCS, as part of its MOC.
c. To streamline ECM implementation:
   i. Contractor shall hold ECM Providers responsible for the same reporting requirements as those Contractor must report to DHCS and shall not impose reporting requirements that are alternative or additional to those required for encounter and supplemental reporting.
   ii. Contractor is encouraged to collaborate with other Managed Care Plans (MCPs) within the same County on oversight of ECM Providers.
d. Contractor shall not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.
e. Contractor shall provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, and/or calls, as necessary, in addition to Network Provider training requirements described in Exhibit A, Attachment 7, Provision 5. Network Provider Training.

16. Delegation of ECM to Subcontractor(s)

a. Contractor may Subcontract with other entities to administer ECM in accordance with the following:
    i. Contractor shall be responsible for and oversee all Contract provisions and Covered Services, regardless of the number of layers of subcontracting as described in Exhibit A, Attachment 6, Provision 14, Subcontracts.
    ii. Contractor shall be responsible for developing and maintaining Policies and Procedures, approved by DHCS, to ensure Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment 6, Provision 14, Subcontracts.
    iii. Contractor shall be responsible for evaluating the prospective Subcontractor's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Subcontracts.
    iv. Contractor shall remain responsible for ensuring the ECM Provider capacity is sufficient to serve all target populations.
    v. The Contractor shall report to DHCS the names of all Subcontractors by Subcontractor type and indicating the County or Counties in which Members are served as described in Exhibit A, Attachment 6, Provision 12, Plan Subcontractors.
    vi. Contractor shall make all Subcontractor agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment 6, Provision 14, Subcontracts.
b. Contractor shall ensure the Contract between Contractor and Subcontractor mirrors the requirements set forth in this Contract and the standard ECM Provider Terms and Conditions, as applicable to Subcontractor.
c. Contractor is encouraged to collaborate with its Subcontractors on the approach to ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractor(s) and/or across multiple Subcontractors and ensure a streamlined, seamless experience for ECM Providers and Members.

17. Payment

a. Contractor shall pay contracted ECM Providers for the provision of ECM.
b. Initial Contractor payment to ECM Providers shall meet the following requirements:
    i. ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as defined in ECM Section 11: Initiating Delivery of ECM;
    ii. Payment to ECM Providers, made when ECM is initiated, takes into account outreach efforts that occurred prior to the initiation of services; and
    iii. Contractor establishes financial incentives to engage hard-to-reach populations.
c. Contractor is encouraged to tie ECM Provider payments to achieving outcomes related to high-quality care and improved health status.

d. Contractor shall utilize the claims timeline as dictated in Exhibit A, Attachment 8, Provision 5, Claims Processing.

18. DHCS Oversight of ECM

a. Contractor shall submit the following data and reports to DHCS to support DHCS' oversight of ECM:
    i. **Encounter data.** Contractor must submit all ECM encounters to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor shall be responsible for submitting to DHCS all encounter data for ECM services to its Members, regardless of the number of levels of delegation and/or sub-delegation between Contractor and the ECM Provider. In the event the ECM Provider is unable to submit ECM encounters to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor shall be responsible for converting ECM Provider's encounter information into the national standard specifications and code sets, for submission to DHCS.
    ii. **Supplemental reporting.** Contractor shall submit ECM supplemental reports, on a schedule and in a format to be defined by DHCS.
b. Contractor shall submit to DHCS any significant updates to its MOC for review and approval 60 days in advance of any changes or updates *[See ECM Section 5: Model of Care],* consistent with DHCS guidance.
c. In the event of underperformance by Contractor in relation to its administration of ECM, DHCS may administer sanctions as described in Exhibit E, Attachment 2, Provision 16, Sanctions.

19. ECM Quality and Performance Incentive Program

a. Contractor shall meet all quality management and quality improvement requirements in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements set forth in associated guidance from DHCS for ECM.
b. Contractor may participate in a performance incentive program related to building capacity for ECM and ILOS, to be defined in DHCS guidance.

In Lieu of Services

In Lieu of Services (ILOS) Definitions

1. **In Lieu of Services (ILOS):** Pursuant to 42 CFR 438.3(e)(2), ILOS are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized ILOS offered are included in development of Contractor's capitation rate and count toward the medical expense component of Contractor's Medical Loss Ratio (MLR) in accordance with 42 CFR 438.8. ILOS are optional for both Contractor and the Member and must be approved by DHCS.
2. **ILOS Provider:** a contracted Provider of DHCS-approved ILOS. ILOS Providers are entities with experience and expertise providing one (1) or more of the ILOS approved by DHCS to individuals with complex physical, behavioral, developmental and social needs.

In Lieu of Services (ILOS)

1. Contractor's Responsibility for Administration of ILOS

a. Contractor is authorized and encouraged to provide the ILOS listed in ILOS Section 2: DHCS-Approved ILOS.
b. Contractor shall not require Members to use ILOS.
c. To offer pre-authorized ILOS in accordance with 42 CFR 438.3(e)(2), Contractor may select from the list of ILOS authorized by DHCS as medically appropriate and cost-effective substitutes for covered services or settings under State Plan services *[See ILOS Section 2: DHCS-Approved ILOS].*
    i. Contractor shall ensure the underlying State Plan services are made available to the Member if Medically Necessary for the Member, or if the Member declines the ILOS.
    ii. Contractor may submit a request to DHCS to offer ILOS in addition to those listed above.
d. Contractor shall adhere to DHCS guidance on eligible populations, code sets, potential ILOS Providers, and limitations for each ILOS that Contractor chooses to provide.
e. If Contractor elects to offer one (1) or more DHCS-authorized ILOS, it need not offer the ILOS in each County it serves. Contractor shall report to DHCS the Counties in which it intends to offer the ILOS.
f. Contractor shall identify individuals who may benefit from ILOS and for whom ILOS will be a medically appropriate and cost-effective substitute for State Plan Covered Services, and accept requests for ILOS on behalf of Members from Providers, including community-based organizations *[See ILOS Section 6: Identifying Members for ILOS].*
g. Contractor shall authorize ILOS for Members deemed eligible *[See ILOS Section 7: Authorizing Members for ILOS and Communication of Authorization Status].*
h. Electing to offer one (1) or more ILOS shall not preclude Contractor from offering value-added services (VAS).
i. Any discontinuation of an ILOS is considered a change in the availability of services and therefore requires Contractor to adhere to the requirements of Exhibit A, Attachment 9, Provision 10, Changes in Availability or Location

of Covered Services and Exhibit A, Attachment 13, Provision 5, Notification of Changes in Access to Covered Services.

j. For members dually eligible for Medicare and Medi-Cal, when the Member is enrolled in a Medicare Advantage Plan, including a Dual-Eligible Special Needs Plan, Contractor shall coordinate with the Medicare Advantage Plan in the provision of ILOS.

2. DHCS-Approved ILOS

a. Contractor can choose to offer Members one (1) or more of the following DHCS-authorized ILOS, and any subsequent revisions made by DHCS, in each County:
   i. Housing Transition Navigation Services;
   ii. Housing Deposits;
   iii. Housing Tenancy and Sustaining Services;
   iv. Short-Term Post-Hospitalization Housing;
   v. Recuperative Care (Medical Respite);
   vi. Respite Services;
   vii. Day Habilitation Programs;
   viii. Nursing Facility Transition/Diversion to Assisted Living Facilities;
   ix. Community Transition Services/Nursing Facility Transition to a Home;
   x. Personal Care and Homemaker Services;
   xi. Environmental Accessibility Adaptations;
   xii. Meals/Medically Tailored Meals;
   xiii. Sobering Centers; and/or
   xiv. Asthma Remediation.
b. Contractor shall indicate in Contractor's ECM MOC Template, and through ongoing reporting requirements, which ILOS it will offer.
c. Contractor shall ensure ILOS are provided in accordance with the DHCS ILOS service definitions.
d. If a Contractor elects to offer ILOS in a County, Contractor must ensure those ILOS are available to all Members in the County who qualify, regardless of Members' location within the County, coverage of Members by Subcontractor(s), whether Members are receiving ECM or other factors. Contractor may offer different ILOS in the different Counties covered by this Contract, if applicable.
e. Contractor shall ensure all ILOS are provided to Members in a timely manner, including by developing any contingency plans for provider shortages or other barriers to timely provision of ILOS.
f. Contractor is permitted to add new ILOS every six (6) months.
g. Contractor is permitted to remove ILOS annually.
   i. Contractor shall ensure ILOS that were authorized for a Member(s) prior to the removal of that specific ILOS are not disrupted by a change in ILOS offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that adequately meet their needs.
   ii. Contractor shall notify Members receiving an ILOS that will be discontinued of the change.

3. ILOS Providers

a. If Contractor is offering ILOS, Contractor shall contract with ILOS Providers for the delivery of the ILOS. ILOS Providers can include:
    i. Homeless service providers
    ii. Housing authorities
    iii. Medically tailored meal providers
    iv. ECM Providers (as defined in ECM Section 3: ECM Providers)
    v. Other entities that are qualified Providers of Medicaid services or benefits and are able to provide the DHCS-approved ILOS.
b. To the extent Contractor is offering ILOS, Contractor is encouraged to coordinate its approach with other MCPs offering ILOS in the same County.
c. Contractor shall ensure all ILOS Providers have sufficient experience and expertise in the provision of the ILOS being offered.
d. Contractor shall ensure ILOS Providers are Medicaid-enrolled providers where a State-level enrollment pathway exists. If no Medicaid enrollment pathway exists, Contractor must either credential ILOS Providers or conduct background checks, as applicable and pursuant to relevant DHCS All Plan Letters (APL) including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
e. Contractor shall support ILOS Provider access to systems and processes allowing them to obtain and document Member information including eligibility, ILOS authorization status, Member authorization for data sharing and other relevant demographic and administrative information, and to support notification to Contractor and ECM Provider and PCP, as applicable, when a referral has been fulfilled *[See ILOS Section 9: Data System Requirements and Data Sharing to Support ILOS].*

4. ILOS Provider Capacity

a. Contractor shall ensure in each County in which Contractor elects to offer ILOS, Contractor develops contracts with ILOS Providers to provide ILOS to all authorized Members residing in that County, regardless of any subcontracting agreements in place.
b. Contractor shall ensure its contracted ILOS Providers have sufficient capacity to receive referrals for ILOS and provide the agreed upon ILOS to Members who are authorized for such services.

5. Transition of Whole Person Care and Health Homes Program to ILOS

a. If Contractor elects to offer ILOS in Health Homes Program (HHP) and Whole Person Care (WPC) Pilot counties, Contractor is encouraged to offer ILOS to HHP and WPC participants to provide continuity of the services being delivered as part of those programs. Once ILOS is offered in a County, the ILOS must be offered to all Members who meet criteria, not just those transitioning from HHP and WPC.
b. If Contractor is offering ILOS in HHP and WPC Pilot counties, Contractor shall provide continuity of services in HHP and WPC Pilot counties by contracting with WPC Lead Entities and HHP Community-Based Care Management Entities (CB-CMEs) as ILOS Providers unless the exceptions below apply.
c. Contractor shall submit to DHCS for prior approval through the Model of Care process any exceptions to contracting with a WPC Lead Entity or

HHP CB-CME as an ILOS Provider. Permissible exceptions to contracting are:

i. Provider does not provide the ILOS the Contractor has elected to offer;
ii. There is a justified quality of care concern with one or more of the otherwise qualified providers;
iii. Contractor and the provider(s) are unable to agree on contracted rates;
iv. Provider(s) is/are unwilling to contract;
v. Provider(s) is/are unresponsive to multiple attempts to contract; and/or
vi. Provider(s) is/are unable to comply with the Medi-Cal enrollment or Contractor credentialing or background check process.

6. Identifying Members for ILOS

a. Contractor shall utilize a variety of methods to identify Members for ILOS including:
   i. Working with ECM Providers to identify Members receiving ECM who could benefit from ILOS;
   ii. Proactively identifying Members who will benefit from the DHCS-authorized ILOS it is offering;
   iii. Accepting requests from providers and other community-based entities; and
   iv. Accepting Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) requests.
b. Contractor shall develop Policies and Procedures for how Contractor will identify Members, and how it will accept requests for ILOS from Providers, other community-based entities, and Member and/or family requests. Contractor shall submit its Policies and Procedures to DHCS for review and approval.
c. Contractor shall develop Policies and Procedures to inform Members of ILOS for which they may be eligible and shall submit those Policies and Procedures and all Member notices to DHCS for review and approval before they are put in use.

7. Authorizing Members for ILOS and Communication of Authorization Status

a. Contractor shall validate Member eligibility for ILOS using a standardized methodology across counties, and, based on the DHCS-defined service definitions, authorize ILOS for Members for whom the ILOS is determined to be a medically appropriate and cost-effective alternative to a State Plan Covered Service.
b. Contractor shall ensure Members do not experience delays pending the authorization process for ILOS.
   i. If Medically Necessary, Contractor shall make available the State Plan Covered Service that the ILOS replaces, pending authorization of the requested ILOS.
   ii. Contractor shall evaluate medical appropriateness and cost-effectiveness when determining whether to provide ILOS to a Member. Providing a particular ILOS to a Member in one instance does not automatically mean that providing another ILOS to the

same Member, or the same ILOS to the same Member in a different instance, would be medically appropriate and cost-effective.

c. Contractor shall expedite the authorization of certain ILOS for urgent needs and shall have Policies and Procedures identifying the circumstances in which the expedited authorization processes apply.
d. Contractor shall follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System for any Member who sought one or more ILOS offered by the Contractor in the Member's County but was not authorized to receive the ILOS.
e. In cases of a Provider, community-based entity or other *[See ILOS Section 6: Identifying Members for ILOS]* request for ILOS, Contractor shall notify the requesting Provider, entity or Member (as applicable) of Contractor's decision regarding ILOS service authorization. If the Member is enrolled in ECM, Contractor shall ensure the ECM Provider is informed of the ILOS service authorization decision.

8. Referring Members to ILOS Providers for ILOS

a. Contractor shall develop Policies and Procedures to define how ILOS Provider referrals will occur.
    i. For Members enrolled in ECM, Policies and Procedures must address how Contractor will work with the ECM Provider to coordinate the referral and communicate the outcome of the referral back to the ECM Provider, using closed loop referrals whenever possible.
    ii. Policies and Procedures must include timeline expectations to ensure referrals occur in a timely manner after service authorization.
b. If the Member's preferences for an ILOS Provider are known, or if there is an opportunity to provide continuity of care to a Member, Contractor shall follow those preferences, to the extent practicable.
c. Contractor shall track referrals to ILOS Provider(s) to verify if the authorized service has been delivered to the Member.
    i. If the Member receiving the ILOS is also receiving ECM, Contractor shall ensure that the ECM Provider tracks whether the Member receives the authorized service from the ILOS Provider.
d. Contractor shall initiate delivery of ILOS for each authorized Member, at the time the Member gives either verbal or written consent to receipt of ILOS and authorization of related data sharing, including sharing of personal health information in accordance with Federal, State, and local laws.
e. Contractor shall ensure the assigned ILOS Provider assumes responsibility for obtaining and documenting consent from each assigned Member to receipt of ILOS and authorization of related data sharing, and shall develop Policies and Procedures for its Network of ECM Providers (to be contained in its MOC) to:
    i. Obtain and document Member consent to the receipt of ILOS and authorization of related data sharing between Contractor and all ILOS Providers involved in administering the Member's ILOS, including sharing of protected health information;

ii. Communicate Member-level record of consent to ILOS and authorization of data sharing, when obtained, back to Contractor; and
iii. Obtain Member authorization to communicate electronically with the Member and/or family member(s), guardian, caretaker, and/or authorized support person(s), if it intends to do so.

9. Data System Requirements and Data Sharing to Support ILOS

a. If Contractor elects to offer ILOS, Contractor shall use systems and processes capable of tracking ILOS referrals.
   i. If Contractor elects to offer ILOS, Contractor will support ILOS Provider access to systems and processes allowing them to track and manage referral and Member information.
b. As part of the referral process to ILOS Providers, Contractor shall ensure ILOS Providers have access to:
   i. Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;
   ii. Appropriate administrative, clinical and social service information the ILOS Providers might need to effectively provide the requested service; and
   iii. Billing information necessary to support the ILOS Providers' ability to submit invoices to Contractor.
c. Contractor shall use defined Federal and State standards, specifications, code sets and terminologies when sharing physical, behavioral, social and administrative data with ILOS Providers and with DHCS.

10. Oversight of ILOS Providers

a. Contractor shall comply with all State and Federal reporting requirements.
b. Contractor shall perform oversight of ILOS Providers, holding them accountable to all ILOS requirements contained in this Contract amendment and associated guidance.
c. Contractor shall use ILOS Provider Standard Terms and Conditions, to be released by DHCS, to develop Contractor's ILOS Contracts with ILOS Providers.
d. Contractor shall submit Contractor's ILOS Provider Contracts for review and approval by DHCS as part of the Model of Care (MOC) process as defined in ECM Section 5: Model of Care.
e. To streamline ILOS implementation:
   i. Contractor shall hold ILOS Providers responsible for the same reporting requirements as those Contractor must report to DHCS and shall not impose reporting requirements that are alternative or additional to those required for encounter and supplemental reporting.
   ii. Contractor is encouraged to collaborate with other MCPs within the same County on reporting requirements and oversight.
f. Contractor shall not utilize tools developed or promulgated by NCQA to perform oversight of ILOS Providers, unless by mutual consent with the ILOS Provider.
g. Contractor shall provide ILOS training and technical assistance to ILOS Providers, including in-person sessions, webinars, and/or calls, as

necessary, in addition to Network Provider training requirements described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

11. Delegation of ILOS to Subcontractor(s)

a. Contractor may Subcontract with other entities to administer ILOS in accordance with the following:
    i. Contractor shall oversee and remain responsible for all Contract provisions and Covered Services, regardless of the number of layers of subcontracting as described in Exhibit A, Attachment 6, Provision 14, Subcontracts.
    ii. Contractor shall be responsible for developing and maintaining Policies and Procedures, approved by DHCS, to ensure Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment 6, Provision 14, Subcontracts.
    iii. Contractor shall be responsible for evaluating the prospective Subcontractors' ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Subcontracts.
    iv. Contractor shall remain responsible for ensuring the ECM Provider Network is sufficient to serve all target populations.
    v. Contractor shall report to DHCS the names of all Subcontractors by Subcontractor type and indicating the County or Counties in which Members are served as described in Exhibit A, Attachment 6, Provision 12, Plan Subcontractors.
    vi. Contractor shall make all Subcontractor agreements available to DHCS upon request and must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment 6, Provision 14, Subcontracts.
b. Contractor shall ensure the Contract between Contractor and Subcontractor mirrors the requirements set forth in this Contract and the standard ILOS Provider Terms and Conditions, as applicable to the Subcontractor.
c. Contractor shall be responsible for the provision of any aspect of the ILOS it chooses to offer in each County if a Subcontractor cannot provide the ILOS in its entirety.
d. Contractor is encouraged to collaborate with its Subcontractors on the approach to ILOS to minimize divergence in how the ILOS will be implemented between Contractor and its Subcontractor(s) and/or across multiple Subcontractors and ensure a streamlined, seamless experience for ILOS Providers and Members.

12. DHCS Oversight of ILOS

a. Contractor shall include details on the ILOS Contractor plans to offer, including in which Counties ILOS will be offered and its network of ILOS Providers within its MOC as described in ECM Section 5: Model of Care.
b. After implementation of ILOS, Contractor shall submit the following data and reports to DHCS to support DHCS' oversight of ILOS:
    i. **Encounter data.** Contractor must submit all ILOS encounters to DHCS using national standard specifications and code sets to be defined by DHCS. DHCS will develop and provide a standardized

invoice template Contractor will be required to use with ILOS Providers.

a. Contractor shall be responsible for submitting to DHCS all ILOS encounter data, including encounter data for ILOS generated under subcontracting arrangements.
b. In the event the ILOS Provider is unable to submit ILOS encounters to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor shall be responsible for converting ILOS Providers' invoice data into the national standard specifications and code sets, for submission to DHCS.

ii. **Supplemental reporting.** Contractor shall submit supplemental reports, on a schedule and in a format to be defined by DHCS.

c. In the event of underperformance by Contractor in relation to its administration of ILOS, DHCS may administer sanctions as set out in Exhibit E, Attachment 2, Provision 16, Sanctions.

13. Payment for ILOS

a. Contractor shall reimburse contracted ILOS Providers for the provision of authorized ILOS services to Members.
b. Contractor shall utilize the claims timeline and process as described in Exhibit A, Attachment 8, Provider Compensation Arrangements, 5. Claims Processing, B.
c. Contractor shall identify circumstances under which payment for an ILOS must be expedited to facilitate timely delivery of the ILOS to the Member (e.g., recuperative care for an individual who is homeless and being discharged from the hospital) *[See ILOS Section 7: Authorizing Members for ILOS and Communication of Authorization Status].*
    i. For such circumstances, Contractor shall develop Policies and protocols to ensure payment to the ILOS Provider is expedited, and share such Policies with DHCS for prior approval.
d. Contractor shall ensure ILOS Providers submit a claim for ILOS services rendered to the greatest extent possible.
    i. In the case an ILOS Provider is unable to submit a claim for ILOS services rendered, Contractor shall ensure the ILOS Provider uses a required invoice template to document services rendered, to be issued by DHCS.
    ii. Upon receipt of such an invoice, Contractor shall be responsible for developing an encounter for the ILOS service rendered.

14. ILOS Quality and Performance Incentive Program

a. Contractor shall meet all quality management and quality improvement requirements described in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements set forth in associated guidance from DHCS for ILOS offered.
b. Contractor may participate in a performance incentive program related to building capacity for ILOS, to be defined in DHCS guidance.