State of California—Health and Human Services Agency
Department of Health Care Services

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CalAIM Enhanced Care Management and Community Supports Frequently Asked Questions (FAQ)

Introduction

California Advancing and Innovating Medi-Cal, or CalAIM, is a new initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal Members by implementing broad delivery system, program, and payment reform across the Medi-Cal program. CalAIM establishes the framework to address social determinants of health and improve health equity *statewide* rather than on a pilot basis. A key feature of CalAIM is the introduction of Enhanced Care Management (ECM) in the Medi-Cal managed care delivery system, as well as a new menu of Community Supports, or in lieu of services (ILOS), which can serve as cost-effective alternatives to covered Medi-Cal services. Medi-Cal managed care plans (MCPs) will be responsible for administering both ECM and Community Supports. For more information about CalAIM, see DHCS' Revised CalAIM Proposal released on 1/8/21.[1]

ECM and Community Supports are ambitious reforms that will take time and support to implement. DHCS recognizes that California MCPs and communities will be working to operationalize these new initiatives and transition smoothly from existing initiatives, most notably the Whole Person Care (WPC) Pilots and Health Home Program (HHP), even as they continue to manage and recover from the COVID-19 Public Health Emergency. DHCS will offer a range of technical assistance and support, including new implementation material posted on the DHCS CalAIM ECM & Community Supports website, webinars, and other opportunities for discussion. This FAQ provides up-to-date information about the ECM/Community Supports implementation and will be updated regularly.

Please submit questions about ECM and Community Supports to: CalAIMECMILOS@dhcs.ca.gov.

Questions about CalAIM generally should be submitted to CalAIM@dhcs.ca.gov.

[1] Revised CalAIM Proposal. Available: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-Updated-1-8-21.pdf.

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ECM/Community Supports (ILOS) Frequently Asked Questions

Enhanced Care Management (ECM)

1. **How will MCPs know that someone is experiencing homelessness in order to identify them as eligible for ECM?**
   There are a few ways for MCPs to know that a Member is homeless. First, MCPs are encouraged to coordinate with shelters, homeless services providers, recuperative care providers, community partners and other service Providers, to receive direct referrals. MCPs are also encouraged to coordinate with counties and Continuum of Care regional planning organizations to access data from Homeless Management Information Systems (HMIS). Some MCPs are also identifying members experiencing homelessness through the use of ICD-10-CM Z-codes.

2. **Is there flexibility in how the MCPs can interpret the ECM Populations of Focus definitions?**
   No. ECM is a statewide, standardized benefit that is designed to be available to all who meet the Populations of Focus definitions. MCPs may not narrow the Populations of Focus definitions. The Adult High Utilizer Population of Focus definition allows MCPs to authorize ECM services for individual high utilizers who would benefit from ECM but who may not meet the numerical thresholds, but this flexibility does not displace the numerical thresholds and MCPs must use the numerical thresholds to identify members in this Population of Focus.

3. **Are ECM Providers required to serve all eligible ECM Populations of Focus?**
   No. ECM Providers may serve one or more of the ECM Populations of Focus or a subset of Populations of Focus with which they have experience and expertise. MCPs must contract with ECM Providers to ensure they have an adequate ECM Provider network in place to meet the needs of all ECM Populations of Focus.

4. **Is ECM available for individuals dually eligible for Medicare and Medicaid in 2022?**
   ECM is generally available to individuals dually eligible for Medicare and Medicaid if they meet ECM Populations of Focus criteria and are enrolled in an MCP. MCPs are encouraged to work with Medicare plans to coordinate care. However dual-eligible Members enrolled in Cal MediConnect (CMC) plans, Fully Integrated Dual-Eligible Special Needs Plans (FIDE-SNPs), and Program for All-Inclusive Care for the Elderly (PACE) plans are not eligible from ECM, on the basis that these plans offer comprehensive care management that is duplicative of ECM services.

5. *(Updated May 2022)* **Will Dual Eligible Special Needs Plans (D-SNP) members be eligible for ECM when D-SNPs phase in Coordinated Care Initiative counties in 2023?**

   It depends on the type of D-SNP. For dual eligible Members eligible for ECM and also enrolled in a D-SNP, DHCS recognizes there is significant overlap across the D-SNP Model of Care and ECM requirements. As a result, there is potential for

duplication and confusion for Members and care teams if both D-SNP care coordination and ECM are in place simultaneously, particularly for Members in D-SNPs with LTSS needs. To avoid duplication and confusion, beginning in 2023 DHCS will strengthen expectations for D-SNPs to provide comprehensive care coordination. **Thus, from 2023 onwards, DHCS will phase out Medi-Cal ECM eligibility for Medi-Cal MCP Members who are also enrolled in D-SNPs, as summarized below.** Over time, DHCS state-specific D-SNP model of care requirements will be more closely aligned with ECM requirements.

- The 2023 D-SNP Policy Guide will reflect the intent for Exclusively Aligned Enrollment (EAE) D-SNPs to provide sufficient care management so that members that would otherwise qualify for ECM receive an equivalent level of care coordination through their D-SNP.

- 2024 state-specific Model of Care Requirements for all D-SNPs will contain additional requirements for integrating elements of ECM into the D-SNP model of care, to be developed collaboratively with stakeholders.

DHCS will issue forthcoming guidance regarding continuity of care requirements for dual eligible Members engaged in ECM and who subsequently enroll in an EAE D-SNP, PACE, or FIDE-SNP.

Policies on availability of ECM to all other dually eligible Medi-Cal MCPs will remain unchanged from 2022.

6. *(Updated May 2022)* **Who provides ECM?**

ECM is offered primarily through in-person interaction where Members and their families and support networks live, seek care, and prefer to access services. MCPs are required to contract with ECM Providers to deliver ECM to Members.

MCPs must contract with Whole Person Care (WPC) Lead Entities and/or Health Home Program (HHP) Community-Based Care Management Entities (CB-CMEs) to be ECM Providers in counties with WPC and/or HHP, except under permissible exceptions defined in DHCS-MCP ECM and Community Supports (ILOS) Contract Template Provision: 6.b.

A wide range of entities may operate as ECM Providers, including ***but not limited to***:

- Counties
- Behavioral Health Providers
- Primary Care Providers (PCPs)
- Federally Qualified Health Centers (FQHCs)
- Community Health Centers
- Hospitals or hospital-based physician groups or clinics (including public hospitals and district and/or municipal public hospitals)

- Rural Health Clinics
- Local Health Departments

- Indian Health Service Programs
- Behavioral health entities
- Community mental health centers
- Substance use disorder (SUD) treatment providers
- Organizations serving individuals experiencing homelessness
- Community Based Adult Services (CBAS) providers
- In Home Supportive Services (IHSS) providers
- Organizations serving justice-involved individuals
- California Children's Services (CCS) providers
- Other community-based organizations

An ECM Lead Care Manager who works for the ECM Provider organization as an employee or contractor, is required to be assigned to each Member accessing ECM services and will serve as the point of contact for the Member. The ECM Lead Care Manager will be responsible for developing a comprehensive Care Management Plan with input from a multidisciplinary care team, as well as the Member, to ensure a whole-person approach is taken in identifying any gaps in treatment or gaps in available and needed services. The MCP must hold the ECM Provider responsible for the provision of all six ECM Core Services. See DHCS-MCP ECM and Community Supports (ILOS) Contract Template Provisions: 13. Core Service Components of ECM for more information.

All entities serving as ECM Providers must have experience and expertise with the services they propose to provide under ECM and must be able to comply with all applicable ECM program requirements. See ECM and Community Supports (ILOS) Standard Provider Terms and Conditions: 2. ECM Provider Requirements for more information.

MCPs will not be permitted to offer or administer ECM directly, unless approved by DHCS under the limited exceptions set forth in the DHCS-MCP ECM and Community Supports (ILOS) Contract Template Provision: 4.f.

7. **Can a person receive both Specialty Mental Health Services (SMHS) Targeted Case Management and ECM?**
   Yes. MCP Members can be enrolled in both SMHS Targeted Case Management and ECM. ECM can enhance case management services and/or help coordinate across the whole person, including physical health needs. The MCP must ensure nonduplication of services for Members enrolled in both programs.

8. **Must individuals consent to ECM before they can receive it?**
   There are no formal requirements for the ECM Provider or MCP to document the individual's consent before beginning to provide services. DHCS removed documentation requirements to streamline and simplify implementation of the

benefit. However, an individual may decline to engage in or continue ECM at any time.

9. **Will DHCS provide required staffing ratios for ECM?**
   No. MCPs will be provided with assumed average caseloads as part of rates but these are not required maximums for the number of Members who can be served by each care manager.

10. **For the Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD) ECM Population of Focus, does "at high risk for institutionalization" mean at risk of institutionalization specifically for the SMI or SUD condition?**
    No. Institutionalization in this context is broad and means any type of inpatient, SNF, long-term or emergency department setting.

11. **Will there be a required annual reassessment for all Members under ECM?**
    No. There is not a required annual reassessment for Members under ECM. MCPs must ensure that Members are reassessed at a frequency appropriate for their individual progress or changes in needs and/or as identified in the Care Management Plan. MCPs should explain the reassessment approach in detail as part of their MOC.

12. **Is ECM subject to standard utilization management medical authorization timeframes, Notice of Action (NOA) requirements, and Grievance and Appeals processes?**
    Yes. ECM is a managed care benefit for Members who meet specific Population of Focus Criteria. MCPs must ensure that authorization requests for ECM occurs in accordance with federal and state regulations for processing Authorizations as well as Grievances and Appeals. MCP medical authorization timeframes, Notice of Action (NOA) requirements, and standard Grievance and Appeals processes apply to ECM for all Members. For more information, please refer to ECM and Community Supports MCP Contract Section 7, Authorizing Members for ECM, MCP Boilerplate Contract Exhibit A, Attachment 13, Provision 8, Denial, Deferral or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeal System, as well as APL 17-006.

    MCPs are expected to develop Policies and Procedures that explain how they will authorize ECM for eligible Members in an equitable and non-discriminatory manner. Several main pathways for enrollment into ECM include: the MCP's internal process for proactively identifying eligible Members who may benefit from ECM and meet the ECM eligibility criteria; referrals from Providers and community-based entities, Member self-referrals, or family/care taker referrals; and, preauthorization by select ECM Providers as defined in Section 7.E. of the ECM and Community Supports MCP Contract.

A NOA should be issued only when 1) Services are in place and are being discontinued; and/or 2) the Member or Provider explicitly states that ECM is desired. Examples of applicable NOA scenarios are listed below. DHCS expects MCPs to further consult internal compliance and legal departments for particular circumstances for which a NOA must be issued.

- **Scenario 1**: 28-year-old man with serious mental illness and substance use disorder is already enrolled and receiving services in ECM. However, the ECM Provider is unable to establish contact. After the time established in MCP's policies and procedures has elapsed, the MCP and the ECM Provider agree to disenroll the Member due to lack of participation.
    - Action: Issue NOA for discontinuation of ECM because the services are being discontinued.
- **Scenario 2:** A 60-year-old woman experiencing homelessness, with history of frequent hospital stays in a six-month period, automatically transitions from Whole Person Care to ECM. At the six-month mark, she is due to be reassessed for continuation of ECM, but the ECM Provider cannot reach her after the number of attempts established in the MCP's Policies and Procedures.
    - Action: Issue NOA for discontinuation of ECM because the services are being discontinued.
- **Scenario 3:** A 30-year-old woman with mild depression (controlled with medication) requests ECM from her MCP directly. The MCP determines that she does not meet ECM Population of Focus criteria.
    - Action: Issue NOA for ECM (because ECM is desired but not offered) and refer her to alternative services.
- **Scenario 4:** A 45-year-old man with unstable housing and frequent ED visits for Fentanyl use complications and COPD declines ECM after outreach from his PCP who is an ECM Provider attempting to engage him in ECM.
    - Action: Do not issue NOA as Member has declined services.

13. **Does the ECM Lead Care Manager need to be a licensed clinical staff person (e.g., RN, LCSW)?**
No. DHCS will not set licensing requirements for ECM Care Managers. For more information, please refer to ECM Policy Guide. For ECM rate setting purposes, salary costs assumptions for certain licensure categories were included but this does not mean that licensure is required.

14. **When WPC Pilot Members transition to ECM and are reassessed within six months, how should MCPs determine if they are still eligible to receive ECM?**
MCPs should use the reassessment process to evaluate whether Members are ready to transition out of ECM. MCPs should assess transitioning Members against their ECM discontinuation criteria; specifically, as outlined in Section 10.B of the ECM and Community Supports MCP Contract Template, when any of the following circumstances are met, ECM should be discontinued:

    - The Member has met all care plan goals;

- The Member is ready to transition to a lower level of care;
- The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
- The ECM Provider has not been able to connect with the Member after multiple attempts.

In their MOC, MCPs are required to provide Policies and Procedures for discontinuing ECM and must elaborate on the specific graduation criteria they will apply to transition a Member to a lower level of care management or coordination.

15. Can an MCP assess a member transitioning from WPC or HHP to ECM sooner than six months?
Yes. Six months is the latest that reassessment must occur, but it may occur earlier.

ECM Rates and Contracting

16. How will plans offer ECM if they are unable to contract with community-based ECM Providers for all Members receiving ECM?
ECM is intended to be provided by community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the ECM Populations of Focus. However, DHCS recognizes that there may not be sufficient providers to provide ECM to all members of all Populations of Focus in all regions, particularly when ECM is first implemented. Therefore, if an MCP makes a good faith effort but is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus in a community-based manner through contracts with ECM Providers, the MCP may request written approval for an exception to the ECM Provider contracting requirement from DHCS that authorizes the MCP to use its own staff to provide ECM.[2] DHCS' expectation is that MCPs will work toward moving more Lead Care Manager capacity to the community-based Provider level over time.

During the period when the MCP serves as an ECM Provider, the MCP is required to 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, Authorized Representative (AR), caregiver, and/or other authorized support person(s) as appropriate. The MCP is also required to deliver ECM in a community-based, Member-centered manner to the greatest extent possible. Examples include meeting with Members in the community or in places where Members live, seek care, or prefer to access services in order to provide the majority of ECM core services. Public health precautions and recommendations should be used to accomplish the community-based, in-person approach of ECM.

[2] For more information on permissible exceptions, see the ECM and Community Supports MCP Contract Template Section: 4.F. ECM Provider Capacity.

17. Will DHCS publish ECM capitation rate information?
No. DHCS does not publish capitation rate information at the benefit level.

18. Will the cost of delivering ECM be incorporated into MCP capitation rates?
Yes. The MCP capitation rates will consider a number of factors associated with the cost of delivering ECM, including but not limited to projections of the number of Member anticipated to transition from the WPC Pilots and HHP, the number of new enrollees expected to begin receiving services in 2022 and average caseload and average outreach necessary for each new Member.

Community Supports (ILOS)

19. What are Community Supports?
Community Supports, or in lieu of services (ILOS), are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. Federal regulation allows states to offer Community Supports as an option for Medicaid managed care organizations.[3] These can be highly valuable services to Members and, as such, DHCS strongly encourages MCPs to offer a robust menu of Community Supports to comprehensively address the needs of Members with the most complex health issues, including conditions caused or exacerbated by lack of food, housing, or other social drivers of health. Community Supports are optional services for MCPs to offer and are optional for managed care Members to receive.

Starting on January 1, 2022, DHCS will pre-approve the following Community Supports:[4]

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF); Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Tailored Meals/Medically Supportive Foods
- Sobering Centers
- Asthma Remediation

[3] 42 CFR 438.3(e)(2).
[4] See Appendix J of the Revised CalAIM Proposal for more detail about each Community Supports option.

These pre-approved Community Supports are based upon the work done in the WPC Pilots and HHP to address unmet social needs that intensify or make it costlier to address health conditions. Further, pre-approved Community Supports will set the stage for Medi-Cal MCPs to be prepared to offer similar services as a benefit in future years and supports the state's overarching managed long-term services and supports (MLTSS) strategy. As such, the pre-approved Community Supports are designed to help avert or substitute hospital or nursing facility admissions, discharge delays, and emergency department use when provided to eligible Members.

20. How are Community Supports paid for in MCP rates?

MCPs operating in WPC counties will receive an adjustment to their capitation payments to account for the anticipated cost and utilization changes due to the WPC Pilots ending. DHCS expects MCPs to provide the Community Supports that correspond to WPC and HHP services. The proposed Governor's budget contains $115M for this rate adjustment.

In future years, consistent with federal Medicaid managed care rate-setting requirements, the utilization and actual costs of Community Supports, once available, will be considered in developing the component of the MCP rates that represents the covered State Plan Covered Service(s), unless a statute or regulation explicitly requires otherwise.[5]

21. What are the requirements for MCP authorization of Community Supports?

MCPs are required to validate Member eligibility for Community Supports using the same methodology for all Members that is based on approved Community Supports service definitions and eligibility criteria. All service authorization processes must be non-discriminatory and equitably applied – including when Provider capacity for a particular Community Support is limited. MCPs will develop Policies and Procedures for the authorization of Community Supports as part of their Part 2 submission of the Model of Care (MOC).

22. What does it mean for the pre-approved Community Supports to be "optional"?

MCPs are strongly encouraged to offer some or all of the pre-approved Community Supports but are not required to do so. DHCS expects MCPs in WPC and HHP counties to provide Community Supports that correspond to WPC and HHP services. Given the importance of Community Supports to the CalAIM initiative, MCPs should expect that DHCS will integrate consideration of a plan's experience and effectiveness in offering Community Supports into future initiatives, including MCP procurement. In the event an MCP discontinues a Community Support, they must notify members consistent with existing requirements related to changes in

[5] 42 CFR 438.3(e)(2)(iv).

availability or location of covered services and notifications of changes in access to covered services.[6]

MCPs may choose to offer different Community Supports in different counties. However, MCPs are not permitted to limit Community Supports only to those Members who received WPC or HHP services or to those receiving ECM. Subject to approval by DHCS, MCPs may add or remove Community Supports at defined intervals: every six (6) months for an addition and annually for a removal.

23. Do Community Supports need to be offered countywide?

No. MCPs are encouraged but not required to offer Community Supports on a countywide basis. If an MCP is unable to offer an elected Community Supports to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, it must include the following as part of its Part 2 submission of the MOC:

- Policies and Procedures describing how the MCP will prioritize the equitable delivery of Community Supports when capacity is limited, and how it will ensure such Policies and Procedures are non-discriminatory.
- A three-year plan DHCS detailing how it will build Community Supports network capacity over time within the county with annual updates.
- Commitment to participate in regular meetings with DHCS to review progress toward expanding network capacity.

24. Who will be eligible to receive pre-approved Community Supports?

MCPs must determine eligibility for a pre-approved Community Supports using the DHCS Community Supports service definitions, which contain specific eligibility criteria for each Community Support. The MCP also is expected to determine that a Community Support is a medically appropriate and cost-effective alternative to a State Plan Covered Service. When making such determinations, MCPs must apply a consistent methodology to all Members within a particular county and cannot limit the Community Supports only to individuals who previously were enrolled in the HHP or a WPC Pilot. Community Supports are always voluntary for the Member to use. If a Member refuses Community Supports, the MCP must still ensure the Member receives Medically Necessary Covered Services.

25. Is it possible for an MCP to provide a Community Support that is not on the pre-approved list?

Yes. MCPs are permitted to submit a request to DHCS for review and approval to offer Community Supports that are not on the pre-approved list. Subject to DHCS approval, MCPs may add or remove Community Supports at defined intervals: every six (6) months for an addition and annually for a removal. Any discontinuation of a Community Support is considered a change in the availability of services and

[6] See Medi-Cal Managed Care Boilerplate Contract, Exhibit A, Attachment 9, Provision 10, Changes in Availability or Location 20 of Covered Services and Exhibit A, Attachment 13, Provision 5, Notification of Changes in Access to Covered Services.

requires the MCP to adhere to existing requirements related to changes in availability or location of Covered Services and notifications of changes in access to Covered Services.[7] MCPs will be expected to report to DHCS on utilization of elected Community Supports.

26. What does it mean to "expedite" the authorization of a Community Support?

Some Community Supports are designed to meet urgent Member needs, and as such should be authorized on an expedited basis. To meet this goal, MCPs are required to have Policies and Procedures in place to expedite the authorization of certain Community Supports for urgent needs. For example, if a Member is using a 24-hour sobering center stay in lieu of an emergency room visit, the service should be approved on an expedited basis (e.g., 12 hours) as opposed to standard authorization timelines (e.g., 5 business days). This requirement is distinct from the timeframe requirements in 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.

MCPs may consider working with Community Supports Providers to define a process and appropriate circumstances for presumptive authorization of Community Supports. Under these circumstances, select Community Supports Providers of pre-determined, urgent Community Supports (e.g., sobering center visits or discharges to recuperative care) would be able to directly authorize a Community Support, potentially only for a limited period of time or under specified circumstances, when a delay would be harmful to the Member.

27. Who will provide the pre-approved Community Supports?

The pre-approved Community Supports will typically be provided by community-based organizations and providers. MCPs that elect to offer Community Supports are expected to contract with community-based organizations with expertise and training in the Community Supports they are contracted to provide. ECM Providers may also serve as Community Supports Providers if they have appropriate experience. To assist with the development of payment models and facilitate contracting between MCPs and Community Supports Providers, DHCS released the Community Supports Non-Binding Pricing Guidance in August 2021.

28. How will Community Supports Provider Capacity be determined?

MCPs that elect to offer Community Supports are responsible for developing and managing a network of Providers with sufficient capacity to meet the needs of all Members authorized to receive a Community Support offered in their service area. Traditional Medi-Cal provider network adequacy standards do not apply to Community Supports, but MCPs must submit information to demonstrate current Community Supports Provider capacity and the plan to increase capacity in their Model of Care Template for DHCS review and approval prior to ECM and

Community Supports implementation,[8] as well as on an ongoing basis pursuant to DHCS reporting requirements.[9]

29. Does the Nursing Facility Transition/Diversion to Assisted Living Facilities Community Supports cover ongoing assisted living expenses for individuals served?

Yes. The Nursing Facility Transition/Diversion Community Supports covers ongoing expenses for Members receiving it in an assisted living facility. This service can be used to support ongoing assisted living activities, including assistance with activities of daily living or instrumental activities of daily living (ADLs and IADLs) for individuals who have transitioned from a nursing facility to an assisted living facility, as well as other wraparound services such as companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment.

For individuals who transition from a nursing facility to home, MCPs may elect to offer the "Personal Care/Homemaker" Community Supports to support ongoing ADLs/IADLs.

30. Will the Community Supports that MCPs elect to offer be posted publicly?

Yes. DHCS intends to make publicly available on its website the list of Community Supports that each MCP is offering. This list will be updated at regular intervals, when MCPs change their Community Supports offerings. MCPs should also make Community Supports offerings publicly available.

31. How should MCPs calculate the cost-effectiveness of a Community Support?

DHCS has reviewed each of the pre-approved Community Supports and has determined that these services are cost-effective alternatives to State Plan Covered Services, as required by federal regulation. Prior to electing Community Supports, each MCP also should make its own determination as to whether a Community Support represents a medically appropriate and cost-effective alternative to one or more State Plan services. In making such a determination, the MCP may evaluate cost-effectiveness at an aggregate level for potentially eligible Members. When implementing Community Supports, MCPs must apply a consistent methodology, regardless of whether it is based on a population or individual-level assessment, to determine cost-effectiveness to all potentially eligible beneficiaries within a particular county and cannot limit the Community Supports only to individuals who previously were enrolled in the HHP or a WPC Pilot. MCPs will describe how they will monitor cost-effectiveness as part of their Part 2 submission of the MOC.

[8] See CalAIM ECM and COMMUNITY SUPPORTS Model of Care Template: Part 1 and Part 3.
[9] See DHCS-MCP ECM and COMMUNITY SUPPORTS Contract Template: Part 1 and Part 3.

32. Can MCPs contract with Community Supports Providers in neighboring counties?
Yes. MCPs are permitted to contract with Community Supports Providers in neighboring counties to increase network capacity for the provision of a particular Community Supports.

33. Will all MCPs in the same county be required to implement the same Community Supports?
Each MCP may elect to offer one or more Community Supports in each county it serves. While not required, DHCS strongly encourages MCPs to coordinate their approach with other MCPs operating in a given county to align Community Supports offered within that county.

34. Must individuals consent to Community Supports before they can receive them?
There are no formal requirements for the ECM Provider or MCP to document the individual's consent before beginning to provide services. DHCS removed documentation requirements to streamline and simplify implementation of the benefit. However, an individual may decline or discontinue Community Supports at any time.

35. Can an MCP limit the provision of Community Supports to a sub-set of the eligible individuals defined by the Community Supports service definitions?
In addition to transitioning all WPC Members as described above, DHCS strongly encourages MCPs to offer any Community Supports that they have opted to provide to all individuals who are eligible, as outlined in the "Eligibility (Population Subset)" section of the detailed Community Supports service definitions. DHCS carefully established these eligibility criteria to reflect the populations to whom it would likely be cost effective to provide each Community Supports. DHCS made these determinations based on experience with WPC Pilots, HCBS waivers, stakeholder input, and a review of available research and data on when offering Community Supports will be cost effective. However, DHCS does recognize that MCPs may need time to build their Community Supports provider networks to serve the entire eligible population, and that it may not be feasible for an MCP to serve every eligible person in a given county upon launch. As such, MCPs are asked to clarify in their MOC responses any proposed limitations on the delivery of each Community Supports, including proposals to limit Community Supports to a subset of the eligible population or county, to offer Community Supports only through some subcontractors, or any other limitation on eligibility for or access to the Community Supports that the MCP is requesting to impose. DHCS will review and must approve these requests and may engage with MCPs to discuss the specifics of any proposed limitations.

MCPs proposing limitations should also be prepared to describe in their MOC responses:

- Details of subcontracted arrangements, clearly describing how roles and responsibilities will be divided between and among the MCP and subcontracting plans or network Providers.
- Policies and procedures for prioritizing Community Supports when a Community Support is not going to be offered to all eligible members in the county. These policies and procedures must be equitable and non-discriminatory and ensure members' care is not disrupted.
- The high-level overview of their 3 Year Plan detailing approach to building network capacity over time for their selected Community Supports (ILOS).

When considering such limitations, MCPs should note that the performance incentive program will be designed to reward broader deployment of Community Supports. Moreover, in WPC counties, MCPs will receive additional funding through their rates that recognizes the projected impact of termination of the WPC Pilots. This additional funding reflects the anticipated higher utilization of medical services that will occur in the absence of WPC services.

36. Can an MCP modify the services that are defined in each of the Community Supports service definitions?

No. MCPs may not modify the services that are defined in the Community Supports service definitions, including to offer only some components of a service and not others, or to change standards around provision of a given service. For example, if an MCP elects to offer the Asthma Remediation Community Support, it may not only provide de-humidifiers to qualifying Members. It must commit to providing a comprehensive suite of remediation services to the home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. While any given individual may not need every elements of the service, the MCP should be prepared to offer all elements when and if appropriate for an individual's circumstances. MCPs should reference the Community Supports service definitions for more details on services that must be provided as part of a given Community Support. Adhering to the standardized service definitions promotes consistency across the state and prepares key stakeholders (e.g., MCPs, Counties, and Providers) to offer these services as a statewide benefit in the future.

37. What utilization management protocols can an MCP implement for Community Supports?

MCPs should develop appropriate and non-discriminatory utilization management and authorization procedures for Community Supports. These procedures should include Community Supports discontinuation criteria for all Community Supports enrollees, including those who have transitioned from corresponding WPC Pilot services. Because MCPs have limited experience to date in the provision of most Community Supports, MCPs should consult with WPC lead entities and other Community Supports providers to understand the appropriate and average utilization and duration of each Community Support, as well as any discontinuation criteria in

use today, to inform these policies. Utilization management procedures should consider the goals of each Community Support and MCPs should not categorically deny or discontinue a Community Support irrespective of Member outcomes or circumstance. For example, when considering appropriate discontinuation criteria for individuals in recuperative care, the MCP should consider Member medical stability, likelihood of readmission to the hospital, and other factors such as ability to transfer to stable housing or the availability of caregiver support; rather than discontinuing the service after 14 calendar days regardless of Member circumstances. Upon discontinuing a Community Support for a Member, the MCP is expected to provide them with any appropriate alternative services or referrals.

38. Are Community Supports available to individuals dually eligible for Medicare and Medicaid?

Yes.

39. Which medically-supportive food and nutrition services must be covered under the Medically-Supportive Food/Meals/Medically Tailored Meals Community Support?

Medically supportive foods can be a valuable service that supports the health and wellbeing of qualifying Medi-Cal enrollees. The provision of medically supportive foods can improve the diets of individuals, families, and children by increasing the quantity and range of nutritious foods (e.g., fruits and vegetables) they are able to access.

MCPs electing to offer the Medically-Supportive Food/Meals/Medically Tailored Meals Community Support should ensure that the services provided under this Community Support align with the service definition. As such, MCPs should be prepared to offer a range of food and nutrition services that will "help individuals achieve their nutrition goals at critical times to help them regain and maintain their health." However, consistent with the service definition specifically for this Community Support, MCPs "have the discretion to define criteria for the level of services determined to be both medically appropriate and cost-effective for Members."

DHCS strongly encourages MCPs to offer medically supportive food services, including medically tailored groceries, healthy food vouchers, and access to food pharmacies, as part of this Community Support; however, it is not a prerequisite to being able to offer the service. MCPs who propose not to do so in Year 1 will be expected to develop a 3-year plan to expand their service offerings as detailed in FAQ #25.

40. What are the differences between the Community Supports Coding Guidance and Community Supports Pricing Guidance?

The Community Supports Coding Options Guidance (included in the Community Supports Policy Guide) lists the codes that providers should consider using when documenting Community Supports encounters, but it is not intended to be pricing

guidance. MCPs may pay providers using units other than those indicated in the coding guidance (such as those in the Community Supports Pricing Guidance), as long as individual encounters are documented per the coding guidance. The Coding Guidance may also be used for claiming/invoicing for payment when appropriate. For example, an MCP might pay a PMPM rate to a Housing Navigation provider, as suggested by the Community Supports pricing guidance, while still requiring the provider to code each Housing Navigation encounter with a per diem or 15-minute increment and submit claims documenting these encounters.

41. **Are Community Supports subject to standard Notice of Action (NOA) requirements?**
MCP standard Notice of Action (NOA) requirements apply to Community Supports. A NOA should be issued only when 1) Services are in place and are being discontinued; and/or 2) the Member or Provider explicitly states that the Community Support is desired. For more information, please refer to the MCP Boilerplate Contract Exhibit A, Attachment 13, Provision 8, Denial, Deferral or Modification of Prior Authorization Requests.

42. (*Updated May 2022*) **If a Member's stay at a short-term post-hospitalization facility was interrupted due to Member's injuries worsening, resulting in readmission to a hospital, does that hinder their ability to return to the short term facility?**
If a Member's stay in a Short-Term Post-Hospitalization setting is unexpectedly cut short or interrupted and the MCP makes the determination that this alternative setting would continue to be both medically appropriate for the Member and cost-effective for the Plan, the continuation of the service may be offered to the Member so long as the overall duration does not exceed six months.

ECM and Community Supports Providers

43. **Do ECM and Community Supports Providers have to be Medi-Cal enrolled Providers?**
No. MCP Network Providers (including those who will operate as ECM or Community Supports Providers) are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so. However, many ECM and Community Supports Providers (e.g., housing agencies, medically tailored meal Providers) may not have a corresponding state-level enrollment pathway and are not required to enroll in the Medi-Cal program, but they still must be vetted by the MCP in order to participate as ECM and/or Community Supports Providers.

44. **What is the process for Medi-Cal enrollment for ECM/Community Supports Providers with a state-level Medi-Cal enrollment pathway?**
For ECM/Community Supports Providers with a state-level Medi-Cal enrollment pathway, the process for enrolling will be the same as applies to other Medi-Cal

Providers. The Provider will have to enroll through the DHCS Provider Enrollment Division, or the MCP can choose to have a separate enrollment process.

45. **Do all ECM and Community Supports Providers have to be "credentialed," consistent with the requirements of APL 19-004?**
No. The credentialing requirements articulated in APL 19-004 only apply to Providers with a state-level pathway for Medi-Cal enrollment. ECM and Community Supports Providers without a state-level pathway to Medi-Cal enrollment are not required to meet the credentialing requirements in APL 19-004 in order to become "in-network" ECM and/or Community Supports Providers, but they must be vetted by the MCP in order to participate as ECM and/or Community Supports Providers.

46. **If there is no state-level Medi-Cal enrollment pathway for a Provider seeking to become an ECM and/or Community Supports Provider, what are the MCP requirements related to Medi-Cal screening and enrollment, credentialing, and background checks that the ECM/Community Supports Provider must meet?**
If there is no state-level Medi-Cal enrollment pathway, ECM and Community Supports Providers are not subject to APL 19-004 related to Medi-Cal screening and enrollment, credentialing, and background checks. To include an ECM/Community Supports Provider in their networks when there is no state-level Medi-Cal enrollment pathway, MCPs are required to vet the qualifications of the Provider or Provider organization to ensure they meet the standards and capabilities required to be an ECM or Community Supports Provider. MCPs must submit Policies and Procedures for how they will vet the qualifications of ECM and Community Supports Providers in their Part 2 submission of the MOC. MCPs must create and implement their own processes to do so. Criteria MCPs may want to consider as part of their process include, but are not limited to:

    - Ability to receive referrals from MCPs for ECM or the authorized Community Supports.
    - Sufficient experience to provide services similar to ECM for Populations of Focus and/or the specific Community Supports for which they are contracted to provide.
    - Ability to submit claims or invoices for ECM or Community Supports using standardized protocols.
    - Business licensing that meets industry standards.
    - Capability to comply with all reporting and oversight requirements.
    - History of fraud, waste, and/or abuse.
    - Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families.
    - History of liability claims against the Provider.

    The same principles would apply to any ECM or Community Supports Provider for whom there is no state-level enrollment pathway.

47. **Must ECM and Community Supports Providers have experience serving Medi-Cal MCP Members?**
No. ECM and Community Supports Providers do not have to have experience serving Medi-Cal MCP Members specifically, though it may increase their effectiveness if they do. However, Providers should have experience with the population(s) they plan to serve and expertise in the services they plan to offer.

48. **What are the licensing requirements for ECM care managers?**
DHCS will not set licensing requirements for ECM care managers. MCPs are required to have a process for vetting qualifications and experience of ECM Providers.

49. **Can primary MCP and subcontractors have different networks of ECM and/or Community Supports Providers?**
DHCS understands that where a primary MCP delegate to a subcontractor, they may contract with different providers. However, DHCS will hold the primary MCP accountable for the requirements of ECM and Community Supports. DHCS will assess the combined network of the primary MCP and subcontractors for sufficiency and will hold the primary MCP responsible.

50. **Can MCPs delegate ECM or Community Supports to entities such as Independent Physician/Provider Associations (IPAs), Medical Groups, and Management Service Organizations (MSOs), and may IPAs and MSOs serve as ECM or Community Supports Providers?**
Yes. MCPs may choose to delegate ECM and/or Community Supports to IPAs, Medical Groups, and/or MSOs. MCPs must describe these arrangements in the MOC for DHCS approval. IPAs and MSOs must meet all requirements. DHCS will hold the MCP accountable for the requirements of ECM and Community Supports.

51. **Will Community Support Providers be subject to the Medi-Cal managed care 10–day new provider orientation process requirement?**
Yes. Community Support providers are required to undergo new provider orientation training within 10 working days of the MCP places a newly contracted Community Support Provider on active status. MCPs must provide training in select Medi-Cal provider training areas including but not limited to cultural competency, policies and procedures, Member rights and responsibilities, as outlined in all Medi-Cal managed care boilerplate contracts and can require other trainings specific to Community Support Providers as outlined in the DHCS–MCP ECM and Community Supports Contract Template.

52. **Are all ECM and Community Supports Providers required to have a National Provider Identifier (NPI)?**
Yes. All ECM and Community Support Provider Organizations and individuals or sole proprietorships that have a contract with an MCP and that submit claims to an MCP for reimbursement must have an NPI. Employees and subcontractors of ECM and Community Support Providers that deliver ECM and Community Support services and do not otherwise have a contract with or are billing to an MCP, are

encouraged to obtain an NPI, but are not required to have one at this time. Organizations can apply for an NPI online or by mail through the CMS website on the NPI Application/Update Form webpage. Please see the CalAIM NPI Application Guidance for additional information on the NPI application process, including guidance on provider taxonomy code selection for ECM and Community Supports providers.

53. *(Updated May 2022)* **Is it possible for a Member to simultaneously receive ECM and the care management included in certain Community Supports?**
Yes. A Member can receive ECM and also simultaneously receive the care management included in the following Community Supports services:

- Housing Transition Navigation Services
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home

The care management included in these Community Supports services is focused on securing and transitioning Members into community-based housing, such as assessing a Member's housing needs and presenting options, assisting with securing and moving into housing, and connecting the Member to other complementary services needed for the Member to be safely and stably housed. ECM is broadly focused on coordinating all primary, acute, behavioral, oral, social needs, and long-term services and supports for Members, and includes administering a comprehensive assessment and care management plan. As such, the type of care management provided by ECM and these Community Supports services is distinct and complimentary, and a Member can receive both. The member's ECM Lead Care Manager remains primarily responsible for the overall coordination of the member's care across the physical and behavioral health delivery systems and social supports.

54. *(Updated May 2022)* **Is it possible for a Provider serving as an ECM and Community Supports Provider to simultaneously receive payment for ECM and for the care management included in certain Community Supports?**
Yes. A Provider can receive payment for ECM and also simultaneously receive payment for the care management included in the following Community Supports services:

- Housing Transition Navigation Services
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home

The care management included in these Community Supports services is focused on securing and transitioning Members into community based housing, including communicating and advocating on behalf of the Member with landlords coordinating with landlords, Assessing the Member's housing needs and presenting options, and Coordinating with the Medi-Cal managed care plan to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services. ECM is broadly focused on coordinating all primary, acute, behavioral, oral, social needs, and long-term services and supports for Members, and includes administering a comprehensive assessment and care management plan. As such, the type of care management provided by ECM and these Community Supports services is distinct and complimentary, and a Provider can receive payment for doing both. The member's ECM care manager remains primarily responsible for the overall coordination of the member's care across the physical and behavioral health delivery systems and social supports.

ECM and Community Supports Data

55. What HCPCS codes and modifiers will be used to track ECM and Community Supports encounters?

DHCS requires MCPs to submit encounter data in accordance with the requirements in the MCP contract and All Plan Letter 14-019. For ECM and Community Supports, MCPs will be required to submit encounter data for services provided through the existing encounter data reporting mechanisms for all covered services for which they have incurred any financial liability, whether directly or through subcontracts or other arrangements, using federal and state standards. The ECM & Community Supports Coding Guidance document, which is posted on the ECM & Community Supports website, describes the set of HCPCS codes and modifiers that will be used to bill for ECM and Community Supports services, and will become effective January 1, 2022.

56. How will ECM and Community Supports Providers submit invoices if they don't have a compliant billing system?

DHCS expects that some ECM and Community Supports Providers will not have access to billing systems that can generate a compliant ASC X12 837 version 5010 x223 claim. DHCS will be working with MCPs and other stakeholders to develop billing guidance that includes minimum necessary data elements that ECM and Community Supports Providers need to provide to MCPs in order to submit invoices to MCPs, and for MCPs to translate those invoices into a compliant encounter for submission to DHCS.

57. What is required in a "care management documentation" system or process that MCPs must ensure ECM Providers use?

A care management documentation system is an information management system that is capable of using physical, behavioral, social service, and administrative data and information from other entities – including MCPs, ECM, Community Supports

and other county and community-based Providers – in order to support the management and sharing of a Member's care plans. Care management documentation systems may include Certified Electronic Health Record (EHR) technology or other documentation tools that can document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication; and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status, etc.). A care management documentation system need not be a certified EHR technology, and it may include systems that are securely managed and hosted by third parties, including MCP partners.

58. **Do ECM and Community Supports Providers have to submit encounter data?**
DHCS' expectation is that ECM and Community Supports Providers will submit encounters to MCPs for transmission to DHCS. Providers that do not have these capabilities will be allowed to submit invoices to MCPs, and MCPs will then convert the invoices to encounters for submission to DHCS. DHCS is developing guidance that describes the minimum set of data elements required to be included in an invoice. ECM/Community Supports Providers and MCPs may need to reconfigure their existing systems to meet these requirements.

59. **How does the requirement to submit encounter data relate to payment by the MCP for ECM and Community Supports?**
DHCS is not specifying the payment model between MCPs and Providers for either ECM or Community Supports, though it will be issuing non-binding Community Supports pricing guidance that MCPs and Providers may use as a source of information on potential pricing strategies and amounts. DHCS encourages plans and Providers to adopt or progress to value-based payment (VBP) models for ECM and Community Supports.

    If the ECM/Community Supports Provider is paid by the MCP on a fee-for-service (FFS) basis, they will be expected to generate a claim and send it to the MCP for payment processing. If the ECM/Community Supports Provider is unable to send a compliant 837P claim to the MCP, they will be expected to send an invoice with a minimum set of data elements (to be defined by DHCS in subsequent guidance) necessary for the MCP to convert that information into a compliant 837P encounter that they will subsequently submit to DHCS according to current DHCS policy.

    If an ECM/Community Supports Provider is paid by the MCP on a capitated basis, then the Provider will still be expected to generate encounters and submit them to MCPs. In the event that the ECM/Community Supports Provider is unable to submit a compliant 837P encounter, they will be expected to send a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that the plan will subsequently submit to DHCS according to current DHCS policy.

60. How will ECM and Community Support Providers document Member social needs?

APL 21-009 was recently released and includes a recommended set of Z-codes to help guide all Medi-Cal providers and the plans who contract with them to support their coding needs. Since we anticipate that many of these providers will be unfamiliar with health care coding; we believe that providing some guidance as to what codes might be used when submitting invoices would be helpful.

ECM and Community Supports (ILOS) Financing

61. *(Updated April 2022)* Does a Community Supports provider have to exhaust other available funding sources before being reimbursed for a Community Supports service by a Managed Care Plan?

No. State and federal Medi-Cal funds have been authorized as the ongoing, sustainable source of funding for Community Supports. While a provider may have other sources of funds that could be used for similar services, MCPs may not require providers to exhaust or seek reimbursement from other sources of funding before the MCPs authorize Community Supports, consistent with the DHCS Policy Guide and the Section 1115 CalAIM demonstration special terms and conditions (STCs).

The STCs and DHCS guidance establish the following principles for all Community Supports that an MCP is providing:

1) Community Supports are designed to be medically appropriate, cost-effective substitutes for other Medicaid state plan services, typically avoiding or preventing institutional care such as emergency department, inpatient hospital care, or nursing home care. The member always has a right to receive the underlying state plan services instead of the Community Supports.

2) Medicaid payment is the source of financing for all approved Community Support services that an MCP authorizes for eligible members. Consistent with the federal "free care" guidance with respect to third party payment, other sources of funding do not have to be exhausted before an authorized provider bills an MCP for an approved Community Supports service that the MCP has elected to offer. For example, where a county or local provider may access funding for comparable housing support services under another program, the MCP may not require the county or local provider to use that funding before providing and seeking Medi-Cal reimbursement for a Community Supports housing support service to an eligible Medi-Cal enrollee. MCPs should not deny an individual a Community Supports service because other related funding might be available in the locale, as long as the individual is eligible per the service definition and the Community Supports service would be medically appropriate and cost effective. Nothing in the STCs permits such denials.

3) As is true generally in Medi-Cal, a provider cannot get paid twice (in full or in part) for a Community Supports service provided to an individual. Double billing or duplicative reimbursement for the same delivered service is not permitted. Other available funding should be used to provide additional and complementary services or supports that may benefit Medi-Cal members or other community residents depending on the purposes of the funds.

62. *(Updated May 2022)* **Can FQHCs receive ECM and Community Support reimbursement in addition to their prospective payment system (PPS) payments?**
Yes. FQHCs may receive ECM and Community Supports' reimbursement payments in addition to PPS payments, and those reimbursements are not subject to the annual reconciliation process. This process aligns with the payment policy for FQHCs that participated in WPC Pilots and the HHP.

Process for Implementing ECM and Community Supports

63. What is the ECM and Community Supports Model of Care (MOC)?
The ECM and Community Supports MOC is each MCP's plan for providing ECM and pre-approved Community Supports to Members. Each MCP's MOC will include its overall approach to ECM and Community Supports; its detailed Policies and Procedures for partnering with Providers, including non-traditional Providers, for the administration of ECM and Community Supports; the capacity of its ECM and Community Supports Providers; and the contract language that will define key aspects of its arrangements with its ECM and Community Supports Providers. The MOC also contains specific "Transition and Coordination" questions for MCPs operating in WPC and/or HHP counties, in which these MCPs must describe how they will ensure smooth transitions for their Members in counties with existing initiatives. DHCS will use the MOC Template to determine each MCP's readiness to meet ECM and Community Supports requirements.

In order to balance statewide consistency with the ability of MCPs to innovate in their design of ECM and any Community Supports, DHCS is standardizing certain design aspects of ECM and pre-approved Community Supports, while allowing MCPs the flexibility to develop a plan that will best meet the needs of their Members and communities.

64. What is the DHCS approval process for the MOC?
DHCS will review and provide feedback on the MOC submissions using its deliverable review process. DHCS will provide final approval of each MOC no later than 30 days prior to each go-live date.

65. Will DHCS publish the MCPs' Model of Care submissions?
Managed care plans' (MCP) final Community Supports selections, submitted by MCPs as part of their "Part 2" MOC Submission, will be published on DHCS' CalAIM and ECM and Community Supports websites. DHCS will make updates to this list

every 6 months. DHCS will not publish other MOC information. Providers and other stakeholders can request to access each MCP's MOC through that MCP.

66. What kind of support will be available for implementing this initiative?

DHCS will offer a number of implementation supports for this work in the coming months. DHCS will publish APLs for ECM and Community Supports, and attachments with additional guidance are expected to be released on a rolling basis. In addition, there will be a number of core Technical Assistance resources and activities provided throughout the year, including informational webinars, convenings with MCPs and Associations, support for counties and MCPs transitioning from WPC, and this FAQ.

The most up-do-date information about ECM and Community Supports can be accessed on the ECM & Community Supports website.

For any questions, please reach out to CalAIMECMILOS@dhcs.ca.gov.