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Department of Health Care Services

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CalAIM Enhanced Care Management and In Lieu of Services 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 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 ILOS. For more information about CalAIM, see DHCS' Revised CalAIM Proposal released on 1/8/21.[1]

ECM and ILOS 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 & ILOS website, webinars, and other opportunities for discussion. This FAQ provides up-to-date information about the ECM/ILOS implementation and will be updated regularly.

Please submit questions about ECM and ILOS 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/ILOS Frequently Asked Questions

Enhanced Care Management (ECM)

1. What is Enhanced Care Management (ECM)?

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal managed care health plan (MCP) Members through systematic coordination of services and comprehensive, community-based care management. ECM is part of a broader population health system design within CalAIM, under which MCPs will systematically risk-stratify their enrolled populations and offer a menu of care management interventions at different levels of intensity, with ECM at the highest intensity level. See the CalAIM Proposal for more information.

What sets ECM apart from the existing managed care approaches is that:

- ECM is "high touch" and must include a level of in-person contact in a place where the Member lives, seeks care, and prefers to access services.
- ECM must be provided by community providers rather than health plan staff, unless exceptional circumstances apply. This requirement is designed to ensure that ECM is as connected as possible with the Member's medical care and social services, not something separate and apart.
- ECM is "whole person" – meaning it spans all medical, behavioral, social, oral, and long-term services and supports (LTSS) needs that Members experience.

ECM implementation will begin January 1, 2022, with full implementation by January 1, 2023 (see ECM Implementation Timelines in CalAIM ECM and ILOS Model of Care Template for more information).

2. *(Updated June 3, 2021)* **Who will be eligible to receive ECM?**

ECM will be available statewide to individuals enrolled in Medi-Cal MCPs who are Members of ECM Populations of Focus, as defined by DHCS.

DHCS has created distinct Populations of Focus for adults and children/youth. There are six (6) Populations of Focus for adults; DHCS will launch further stakeholder work to define the children/youth Populations of Focus prior to 2023. MCPs must proactively identify and offer ECM to their high-need, high-cost Members who meet the Populations of Focus criteria. These Populations of Focus are listed below. For detailed definitions, please refer to the ECM Key Design & Implementation Decisions document posted on the ECM & ILOS website.

- Individuals Experiencing Homelessness
- Adult High Utilizers
- Adult with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)
- Adults Transitioning from Incarceration
- Adults at Risk for Institutionalization and Eligible for Long-Term Care
- Nursing Facility Residents Who Want to Transition to the Community

3. *(New July 30, 2021)* **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.

4. *(New July 30, 2021)* **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.

5. **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.

6. *(Updated June 3, 2021)* **Will ECM be available for individuals dually eligible for Medicare and Medicaid?**
   ECM will be 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 will be excluded from ECM, on the basis that these plans offer comprehensive care management that is duplicative of ECM services.

7. *(New July 30, 2021)* **Will Dual Eligible Special Needs Plans (D-SNP) members be eligible for ECM when D-SNPs phase in Coordinated Care Initiative counties in 2023?**
   Yes, D-SNP members who meet ECM Populations of Focus criteria will remain eligible for ECM. DHCS is working on policies for required coordination between ECM and D-SNPs.

8. *(Updated June 3, 2021)* **Who will provide ECM?**
   ECM will be offered primarily through in-person interaction where Members and their families and support networks live, seek care, and prefer to access services. MCPs will be 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 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
   - Indian Health Service Programs
   - Local health departments
   - Behavioral health entities
   - Community mental health centers
   - Substance use disorder (SUD) treatment Providers
   - Organizations serving individuals experiencing homelessness
   - Managed Care Plans
   - 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 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 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 ILOS Contract Template Provision: 4.f.

9. *(Updated July 30, 2021)* **Is ECM subject to standard utilization management medical authorization timeframes, Notice of Action (NOA) requirements, and Grievance and Appeals processes?**
   Yes. 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 requirements, and standard Grievance and Appeals processes apply to ECM for all Members. For more information, please refer to DHCS-MCP ECM ILOS Contract Template Provision: 8. Authorizing Members for ECM.

10. *(New June 3, 2021)* **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.

11. *(New July 30, 2021)* **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.

12. *(New July 30, 2021)* **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.

ECM Rates and Contracting

13. *(Updated June 3, 2021)* **When will ECM rate information be available to MCPs?** DHCS is releasing draft ECM rate information for the CY 2022 rating period to MCPs at the end of May 2021 and final rate information in August 2021.

14. *(Updated June 3, 2021)* **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.

15. *(New July 30, 2021)* **Will DHCS publish ECM capitation rate information?** No. DHCS does not publish capitation rate information at the benefit level.

16. *(New July 30, 2021)* **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.

[2] For more information on permissible exceptions, see DHCS-MCP ECM and ILOS Contract Template Provision: 4.f. ECM Provider Capacity.

In Lieu of Services (ILOS)

17. What are in lieu of services (ILOS)?

In lieu of services, or 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 ILOS 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 ILOS 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. ILOS 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 ILOS:[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

These pre-approved ILOS 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 ILOS 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 ILOS are designed to help avert or substitute hospital or nursing facility admissions, discharge delays, and emergency department use when provided to eligible Members.

18. How are ILOS 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 ILOS that correspond to WPC

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

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 ILOS, 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]

19. *(New June 3, 2021)* **What are the requirements for MCP authorization of ILOS?**
MCPs are required to validate Member eligibility for ILOS using the same methodology for all Members that is based on approved ILOS service definitions and eligibility criteria. All service authorization processes must be non-discriminatory and equitably applied – including when Provider capacity for a particular ILOS is limited. MCPs will develop Policies and Procedures for the authorization of ILOS as part of their Part 2 submission of the Model of Care (MOC).

20. *(Updated June 3, 2021)* **What does it mean for the pre-approved ILOS to be "optional"?**
MCPs are strongly encouraged to offer some or all of the pre-approved ILOS but are not required to do so. DHCS expects MCPs in WPC and HHP counties to provide ILOS that correspond to WPC and HHP services. Given the importance of ILOS to the CalAIM initiative, MCPs should expect that DHCS will integrate consideration of a plan's experience and effectiveness in offering ILOS into future initiatives, including MCP procurement. In the event an MCP discontinues an ILOS, they must notify members consistent with existing requirements related to changes in availability or location of covered services and notifications of changes in access to covered services.[6]

MCPs may choose to offer different ILOS in different counties. However, MCPs are not permitted to limit ILOS 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 ILOS at defined intervals: every six (6) months for an addition and annually for a removal.

21. *(New June 3, 2021)* **Do ILOS need to be offered countywide?**
No. MCPs are encouraged but not required to offer ILOS on a countywide basis. If an MCP is unable to offer an elected ILOS 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:

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

- Policies and Procedures describing how the MCP will prioritize the equitable delivery of ILOS 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 ILOS 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.

22. Who will be eligible to receive pre-approved ILOS?

MCPs must determine eligibility for a pre-approved ILOS using the DHCS ILOS service definitions, which contain specific eligibility criteria for each ILOS. The MCP also is expected to determine that an ILOS 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 ILOS only to individuals who previously were enrolled in the HHP or a WPC Pilot. ILOS are always voluntary for the Member to use. If a Member refuses ILOS, the MCP must still ensure the Member receives Medically Necessary Covered Services.

23. Is it possible for an MCP to provide an ILOS that is not on the pre-approved list?

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

24. *(New June 3, 2021)* **What does it mean to "expedite" the authorization of an ILOS?**

Some ILOS 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 ILOS 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 ILOS Providers to define a process and appropriate circumstances for presumptive authorization of ILOS. Under these

circumstances, select ILOS Providers of pre-determined, urgent ILOS (e.g., sobering center visits or discharges to recuperative care) would be able to directly authorize an ILOS, potentially only for a limited period of time or under specified circumstances, when a delay would be harmful to the Member.

25. *(Updated June 3, 2021)* **Who will provide the pre-approved ILOS?**
The pre-approved ILOS will typically be provided by community-based organizations and providers. MCPs that elect to offer ILOS are expected to contract with community-based organizations with expertise and training in the ILOS they are contracted to provide. ECM Providers may also serve as ILOS Providers if they have appropriate experience. To assist with the development of payment models and facilitate contracting between MCPs and ILOS Providers, DHCS plans on releasing non-binding pricing guidance for ILOS in late June 2021.

26. How will ILOS Provider Capacity be determined?
MCPs that elect to offer ILOS are responsible for developing and managing a network of Providers with sufficient capacity to meet the needs of all Members authorized to receive an ILOS offered in their service area. Traditional Medi-Cal provider network adequacy standards do not apply to ILOS, but MCPs must submit information to demonstrate current ILOS Provider capacity and the plan to increase capacity in their Model of Care Template for DHCS review and approval prior to ECM and ILOS implementation,[8] as well as on an ongoing basis pursuant to DHCS reporting requirements.[9]

27. *(New June 3, 2021)* **Does the Nursing Facility Transition/Diversion to Assisted Living Facilities ILOS cover ongoing assisted living expenses for individuals served?**
Yes. The Nursing Facility Transition/Diversion ILOS 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" ILOS to support ongoing ADLs/IADLs.

28. *(New June 3, 2021)* **Will the ILOS that MCPs elect to offer be posted publicly?**
Yes. DHCS intends to make publicly available on its website the list of ILOS that each MCP is offering. This list will be updated at regular intervals, when MCPs change their ILOS offerings. MCPs should also make ILOS offerings publicly available.

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

29. *(New June 3, 2021)* **How should MCPs calculate the cost-effectiveness of an ILOS?**
DHCS has reviewed each of the pre-approved ILOS and has determined that these services are cost-effective alternatives to State Plan Covered Services, as required by federal regulation. Prior to electing an ILOS, each MCP also should make its own determination as to whether an ILOS 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 an ILOS, 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 ILOS 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.

30. (*New June 3, 2021*) **Can MCPs contract with ILOS Providers in neighboring counties?**
Yes. MCPs are permitted to contract with ILOS Providers in neighboring counties to increase network capacity for the provision of a particular ILOS.

31. **Will all MCPs in the same county be required to implement the same ILOS?**
Each MCP may elect to offer one or more ILOS 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 ILOS offered within that county.

32. (*New July 30, 2021*) **Must individuals consent to ILOS 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 ILOS at any time.

33. (*New July 30, 2021*) **Can an MCP limit the provision of ILOS to a sub-set of the eligible individuals defined by the ILOS service definitions?**
In addition to transitioning all WPC Members as described above, DHCS strongly encourages MCPs to offer any ILOS that they have opted to provide to all individuals who are eligible, as outlined in the "Eligibility (Population Subset)" section of the detailed ILOS service definitions (available INSERT). DHCS carefully established these eligibility criteria to reflect the populations to whom it would likely be cost effective to provide each ILOS. 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 an ILOS will be cost effective. However, DHCS does recognize that MCPs may need time to build their ILOS 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 ILOS, including proposals to limit ILOS to a subset of the eligible

population or county, to offer ILOS only through some subcontractors, or any other limitation on eligibility for or access to the ILOS 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 ILOS when an ILOS 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 ILOS.

When considering such limitations, MCPs should note that the performance incentive program will be designed to reward broader deployment of ILOS. 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.

34. (*New July 30, 2021*) **Can an MCP modify the services that are defined in each of the ILOS service definitions?**

No. MCPs may not modify the services that are defined in the ILOS 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 ILOS, 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 ILOS service definitions for more details on services that must be provided as part of a given ILOS. 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.

35. (*New July 30, 2021*) **What utilization management protocols can an MCP implement for ILOS?**

MCPs should develop appropriate and non-discriminatory utilization management and authorization procedures for ILOS. These procedures should include ILOS

discontinuation criteria for all ILOS enrollees, including those who have transitioned from corresponding WPC Pilot services. Because MCPs have limited experience to date in the provision of most ILOS, MCPs should consult with WPC lead entities and other ILOS providers to understand the appropriate and average utilization and duration of each ILOS, as well as any discontinuation criteria in use today, to inform these policies. Utilization management procedures should consider the goals of each ILOS and MCPs should not categorically deny or discontinue an ILOS 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 ability to transfer to stable housing or availability of caregiver support; rather than discontinuing the service after 14 calendar days regardless of Member circumstances. Upon discontinuing an ILOS for a Member, the MCP is expected to provide them with any appropriate alternative services or referrals.

36. *(New July 30, 2021)* **Are ILOS available to individuals dually eligible for Medicare and Medicaid?**

Yes.

Timelines for Implementing ILOS and ECM

37. What is the ILOS implementation timeline?

MCPs in all counties may begin offering pre-approved ILOS on January 1, 2022. MCPs are strongly encouraged to offer ILOS that allow for continuity of services offered through the WPC Pilots and HHP, when applicable. Please see pages 8-13 in the Model of Care Cover Note for a comprehensive overview of the timelines.

38. What is the ECM implementation timeline?

ECM will be implemented in a phased approach throughout 2022 and 2023. For a detailed implementation schedule, please refer to the ECM Key Design & Implementation Decisions document posted on the ECM & ILOS website.

Transition of WPC and HHP to ECM and ILOS

39. How will the transition from WPC/HHP to ECM and ILOS work?

DHCS is focused on ensuring a smooth transition for Members and ensuring that the successful work that MCPs, counties, cities, community-based organizations, and Providers have done to implement the WPC Pilots and HHP is leveraged and transitioned to ECM and ILOS. As described in detail below, MCPs in counties with WPC and/or HHP will implement ECM in those counties first, with additional counties implementing six (6) months later. MCPs in all counties may begin offering pre-approved ILOS on January 1, 2022. Please see pages 8-13 in the Model of Care Template for a comprehensive overview of the timelines.

40. *(New June 3, 2021)* **Are MCPs specifically required to contract with WPC Lead Entities (LEs) and/or HHP Community-Based Care Management Entities (CB-CMEs) as an ECM Provider for ECM and ILOS?**

Yes. MCPs must contract with WPC LEs and/or HHP CB-CMEs as ECM Providers (and ILOS Providers, if the MCP elects to offer ILOS) unless a justifiable reason can

be demonstrated as defined in DHCS-MCP ECN and ILOS Contract Template Provisions, 6.b:

- There is a justified quality of care concern with the ECM Provider(s).
- MCP and ECM Providers are unable to agree on contracted rates.
- ECM/ILOS Provider(s) is/are unwilling to contract.
- ECM/ILOS Provider(s) is/are unresponsive to multiple attempts to contract.
- ECM/ILOS Provider(s) is/are unable to comply with the Medi-Cal enrollment, MCP credentialing, background check process.
- For ECM/ILOS Providers without a state-level pathway to Medi-Cal enrollment: ECM Provider(s) is/are unable to comply with MCP processes for vetting qualifications and experience.
- (ILOS only) Provider does not provide the ILOS the MCP has elected to offer.

MCPs must attempt to contract with WPC LEs and/or HHP CB-CMEs to ensure continuity of services for Members enrolled in a WPC Pilot and/or HHP transitioning to ECM or ILOS in January 2022. Plans may choose to contract with additional individual Providers to extend network capacity. DHCS will monitor the efforts MCPs are making through the Model of Care process to contract with WPC LEs and/or HHP CB-CMEs. For WPC LEs and/or HHP CB-CMEs that are not direct service Providers but do play a role in organizing and paying community-based organizations that offer WPC and/or HHP services, MCPs are encouraged to contract with the LEs and/or CB-CMEs when effective and efficient to continue such services.

41. *(New June 3, 2021)* **How may an MCP request an exception to contracting with a WPC LE and/or HHP CB-CME?**
MCPs may request an exception to contracting with a WPC LE through the MOC process. Any exception request must adhere to the provisions outlined in Section 6 of the DHCS-MCP ECM and ILOS Contract Template.

42. *(New June 3, 2021)* **Can non-WPC/HHP MCPs offer ILOS starting in January 2022?**
Yes. DHCS strongly encourages all plans to offer ILOS beginning in January 2022. Non-WPC/HHP health plans that elect to offer ILOS starting in January 2022 should submit an MOC according to the schedule and requirements for January 2022 implementation.

43. *(New July 30, 2021)* **Does DHCS expect MCPs in WPC counties to transition all individuals who would have received a comparable benefit under the WPC Pilot to ILOS services?**
Yes, it is DHCS' expectation that MCPs will transition all WPC Pilot Members to ILOS that the MCP elects to offer corresponding to the WPC service each individual is receiving. The Member Transition List (MTL) will identify these individuals who should be transitioned. DHCS will review and may request justification or rationale for any deviation from this expectation.

44. *(New July 30, 2021)* **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 11.a of the Contract Template, when any of the following circumstances are met, ECM should be discontinued:

I. The Member has met all care plan goals;
II. The Member is ready to transition to a lower level of care;
III. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
IV. 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.

45. *(New July 30, 2021)* **Can an MCP assess a member transitioning from WPC or HHP to ECM sooner than 6 months?**

Yes. 6 months is the latest that reassessment must occur, but it may occur earlier.

46. *(New July 30, 2021)* **What are Basic and Complex Case Management?**

MCPs are required to offer Basic and Complex Case Management for Medi-Cal managed care members. Please refer to Medi-Cal Managed Care Boilerplate Contract Exhibit A, Attachment 11, Provision 1. Comprehensive Care Management Including Coordination of Care Services.

Basic Case Management Services are provided by the Primary Care Provider, in collaboration with the MCP, which include:

- Initial Health Assessment (IHA);
- Individual Health Education Behavioral Assessment (IHEBA);
- Identification of appropriate Providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs;
- Direct communication between the Provider and Member/family;
- Member and family education, including healthy lifestyle changes when warranted; and
- Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

Complex Case Management Services are provided by the MCP, in collaboration with the Primary Care Provider, which include, at a minimum:

- Basic Case Management Services

- Management of acute or chronic illness, including emotional and
- social support issues by a multidisciplinary case management team
- Intense coordination of resources to ensure member regains
- optimal health or improved functionality
- With Member and PCP input, development of care plans specific to
- individual needs, and updating of these plans at least annually

For Members transitioning from the WPC Pilots and HHP, the MCP must ensure that each Member is reassessed to determine the most appropriate level of care management or coordination of services. Basic or complex case management may be alternatives to ECM that meet the needs of a Member who does not need the intensity of services offered by ECM.

ECM and ILOS Providers

47. *(Updated June 3, 2021)* **Do ECM and ILOS Providers have to be Medi-Cal enrolled Providers?**
No. MCP Network Providers (including those who will operate as ECM or ILOS 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 ILOS 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 ILOS Providers.

48. *(New June 3, 2021)* **What is the process for Medi-Cal enrollment for ECM/ILOS Providers with a state-level Medi-Cal enrollment pathway?**
For ECM/ILOS 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.

49. *(New June 3, 2021)* **Do all ECM and ILOS 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 ILOS 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 ILOS Providers, but they must be vetted by the MCP in order to participate as ECM and/or ILOS Providers.

50. *(New June 3, 2021)* **If there is no state-level Medi-Cal enrollment pathway for a Provider seeking to become an ECM and/or ILOS Provider, what are the MCP requirements related to Medi-Cal screening and enrollment, credentialing, and background checks that the ECM/ILOS Provider must meet?**
If there is no state-level Medi-Cal enrollment pathway, ECM and ILOS Providers are not subject to APL 19-004 related to Medi-Cal screening and enrollment, credentialing, and background checks. To include an ECM/ILOS 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 ILOS Provider. MCPs must submit Policies and Procedures for how they will vet the qualifications of ECM and ILOS 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 ILOS.
- Sufficient experience to provide services similar to ECM for Populations of Focus and/or the specific ILOS for which they are contracted to provide.
- Ability to submit claims or invoices for ECM or ILOS 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 ILOS Provider for whom there is no state-level enrollment pathway.

51. *(New June 3, 2021)* **Must ECM and ILOS Providers have experience serving Medi-Cal MCP Members?**
No. ECM and ILOS 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.

52. *(New July 30, 2021)* **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.

53. *(New July 30, 2021)* **Can primary MCP and subcontractors have different networks of ECM and/or ILOS 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 ILOS. DHCS will assess the combined network of the primary MCP and subcontractors for sufficiency and will hold the primary MCP responsible.

54. *(New July 30, 2021)* **Can MCPs delegate ECM or ILOS 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 ILOS Providers?
Yes, MCPs may choose to delegate ECM and/or ILOS 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 ILOS.

ECM and ILOS Data

55. *(Updated June 3, 2021)* **What HCPCS codes and modifiers will be used to track ECM and ILOS 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 ILOS, 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 & ILOS Coding Guidance document, which is posted on the ECM & ILOS website, describes the set of HCPCS codes and modifiers that will be used to bill for ECM and ILOS services, and will become effective January 1, 2022.

56. How will ECM and ILOS Providers submit invoices if they don't have a compliant billing system?
DHCS expects that some ECM and ILOS 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 ILOS 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. *(New June 3, 2021)* **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, ILOS 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. *(New June 3, 2021)* **Do ECM and ILOS Providers have to submit encounter data?**
DHCS' expectation is that ECM and ILOS 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/ILOS Providers and MCPs may need to reconfigure their existing systems to meet these requirements.

59. *(New June 3, 2021)* **How does the requirement to submit encounter data relate to payment by the MCP for ECM and ILOS?**
DHCS is not specifying the payment model between MCPs and Providers for either ECM or ILOS, though it will be issuing non-binding ILOS 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 ILOS.

If the ECM/ILOS 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/ILOS 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/ILOS 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/ILOS Provider is unable to submit a compliant 837P encounter, they will be expected to send 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 the plan will subsequently submit to DHCS according to current DHCS policy.

ECM and ILOS Financing

60. *(New June 3, 2021)* **Are MCPs required to "make counties whole" in the transition from WPC/HHP to ECM/ILOS?**
No. MCPs are not required to "make WPC Pilots whole" financially. Payments for ECM/ILOS will reflect the services provided to Medi-Cal Members by Providers and will be in accordance with established contracts between the MCPs and ECM/ILOS Providers. DHCS recognizes that investments are needed to facilitate the transition to ECM/ILOS and is developing separate strategies to provide capacity-building investment for ECM and ILOS Providers.

61. *(New June 3, 2021)* **How will DHCS support capacity-building investment for ECM and ILOS Providers?**
In addition to payments for services to ECM and ILOS Providers in accordance with established contracts between MCPs and each ECM/ILOS Provider, DHCS plans to make additional funding available to support the implementation of ECM and ILOS, including:

- A performance incentive program
- Pending CMS approval, funding in the CalAIM 1115 waiver to support delivery system reform through an initiative known as "Providing Access and Transforming Health (PATH) Supports"
- Shared risk/savings models through a multipronged risk strategy to incentivize MCPs to fully engage in ECM, ILOS, and the statewide carve-in of long-term care (LTC)

Process for Implementing ECM and ILOS

62. What is the ECM and ILOS Model of Care (MOC)?
The ECM and ILOS MOC is each MCP's plan for providing ECM and pre-approved ILOS to Members. Each MCP's MOC will include its overall approach to ECM and ILOS; its detailed Policies and Procedures for partnering with Providers, including non-traditional Providers, for the administration of ECM and ILOS; the capacity of its ECM and ILOS Providers; and the contract language that will define key aspects of its arrangements with its ECM and ILOS 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 ILOS requirements.

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

63. 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. DHCS will begin a monthly check-in process with each MCP following Part 1 of the MOC Template submissions to gauge each MCP's provider capacity development for ECM.

64. *(New July 30, 2021)* **Will DHCS publish the MCPs' Model of Care submissions?**
Managed care plans' (MCP) final ILOS selections, submitted by MCPs as part of their "Part 2" MOC Submission, will be published on DHCS' CalAIM and ECM and ILOS 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.

65. *(New July 30, 2021)* **Will Medi-Cal Members who have been served by WPC Pilots be required to enroll in Medi-Cal Managed Care in 2022?**
Medi-Cal members who have been served by WPC Pilots and are not yet enrolled in Medi-Cal Managed Care are not required, but are strongly encouraged, to enroll before January 2022 if they are eligible to do so. WPC Pilots are also encouraged to assist Medi-Cal members to enroll in Medi-Cal Managed Care. ECM and ILOS will be available only in Medi-Cal Managed Care.

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 ILOS, 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 ILOS can be accessed on the ECM & ILOS website.

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