Enhanced Care Management (ECM)

1. ECM Definitions

Key terms are defined as follows:

a. **Enhanced Care Management (ECM):** a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
b. **ECM Provider: a Provider of ECM.** ECM Providers are community-based entities, with experience and expertise providing intensive, in-person care management services to individuals in one (1) or more of the target populations for ECM.
c. **Lead Care Manager:** a Member's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be on staff with a Contractor). The Lead Care Manager operates as part of the Member's care team and is responsible for coordinating all aspects of ECM and any In Lieu of Services (ILOS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

2. ECM Provider Requirements

Provider Experience and Qualifications

a. ECM Provider shall be experienced in serving Medi-Cal Members including the ECM target population(s) it proposes to serve;
b. ECM Provider shall have experience and expertise with the services it proposes to provide;
c. ECM Provider shall comply with all ECM program requirements specified in this Contract and in any related DHCS guidance;
d. ECM Provider shall have capable and engaged organizational leadership;
e. ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Members to critical appointments when necessary;
f. ECM Provider shall have the capacity to communicate to Members in culturally and linguistically appropriate and accessible ways;
g. ECM Provider shall have agreements and processes in place to engage and cooperate with area hospitals, Primary Care Providers, behavioral health

Providers, Specialists, and other entities, including ILOS Providers, to coordinate care as appropriate to each Member; and

h. ECM Provider shall use a care management documentation system or process that is capable of integrating physical, behavioral, dental, long-term services and supports (LTSS), developmental, social service, and administrative information from other entities in order to manage and maintain a care plan that can be shared with other Providers and organizations involved in each Member's care.

Medicaid Enrollment/Credentialing for ECM Providers

a. ECM Provider shall be Medicaid-enrolled where a State-level enrollment pathway exists, as is required by Federal law.
b. If no State-level Medicaid enrollment pathway exists, ECM Provider shall be credentialed by the Medi-Cal managed care plan (MCP) and/or undergo a background check, as applicable *[fE].*

3. Identifying Members for ECM

a. ECM Provider is encouraged to identify Members who would benefit from ECM and send a request to the MCP for authorization of ECM.

4. Member Assignment to an ECM Provider

a. MCP shall communicate new Member assignments to ECM Provider as soon as possible, but in any event no later than ten (10) business days after ECM authorization.
b. ECM Provider shall immediately accept all Members assigned by MCP for ECM, with the exception that an ECM Provider shall be permitted to decline a Member assignment if ECM Provider is at its pre-determined capacity.
    i. ECM Provider shall immediately alert MCP if it does not have the capacity to accept a Member assignment.
c. Upon initiation of ECM, ECM Provider shall ensure each Member assigned has a Lead Care Manager.
d. ECM Provider shall advise the Member on the process for changing ECM Providers, which is permitted at any time.
    i. ECM Provider shall advise the Member on the process for switching ECM Providers, if requested.
    ii. ECM Provider shall notify MCP if the Member wishes to change ECM Providers.

5. ECM Provider Staffing

a. At all times, ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each assigned Member consistent with this Contract and any other related DHCS guidance.

6. ECM Provider Outreach and Member Engagement

a. ECM Provider shall be responsible for conducting outreach to each assigned Member in order to obtain consent from the Member to initiate ECM.
    i. ECM Provider shall obtain and document from each assigned Member either verbal or written consent to receipt of ECM and authorization for related data sharing, including sharing of personal health information between all ECM entities, Contractor, and others involved in the ECM Member's care, in accordance with DHCS guidance and Federal, State, and local laws.
b. ECM Provider shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.
c. ECM Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services. ECM Provider may substitute secure teleconferencing when appropriate to meet the Member's needs and with consent of the Member.
    i. ECM Provider shall use the following modalities, as appropriate, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences:
        a. Mail
        b. Email
        c. Texts
        d. Telephone calls
        e. Other
d. ECM Provider shall comply with non-discrimination requirements set forth in State and Federal law and the Contract with MCP.

7. Initiating Delivery of ECM

a. ECM Provider shall initiate delivery of ECM for each authorized Member as soon as verbal or written consent to receive ECM and authorization for related data sharing, including sharing of personal health information in accordance with Federal, State, and local laws, is obtained from the Member.
b. ECM Provider shall document Member's consent to receive ECM and authorization for related data sharing, and shall communicate this information to the MCP.
c. ECM Provider shall obtain and document Member authorization to communicate electronically with the Member and/or family member(s), guardian, caretaker, and/or authorized support person(s), if it intends to do so.
d. ECM Provider shall notify the MCP to discontinue ECM under the following circumstances:
    i. The Member has met their care plan goals for ECM;
    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. ECM Provider has not had any contact with the Member despite multiple attempts.

e. When ECM is discontinued, or will be discontinued for the Member, MCP is responsible for notifying the Member of the discontinuation of ECM and ensuring the Member is informed of their right to appeal and the appeals process by way of the Notice of Action (NOA) process. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Coordinated Care Management, Basic Care Management, etc.).

8. ECM Requirements and Core Service Components of ECM

a. ECM Provider shall ensure 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 Members enrolled in managed care. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally relevant.
    i. If the ECM Provider subcontracts with other entities to administer functions of ECM, the ECM Provider shall ensure agreements with such Subcontractors for the provision of ECM contain the exact terms and conditions that are enumerated here.
b. To the extent MCP offers ILOS or other coordinated services, the ECM Provider shall:
    i. Ensure each Member receiving ECM has a Lead ECM Care Manager;
    ii. Coordinate across all sources of care management in the event that a Member is receiving care management from multiple sources;
    iii. Alert MCP to ensure non-duplication of services in the event that a Member is receiving care management from multiple sources; and
    iv. Follow MCP instruction and participate in efforts to ensure care management services are not duplicated.
c. ECM Provider shall collaborate with area hospitals, Primary Care Providers, behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and developmental populations, and other associated entities, such as ILOS Providers, as appropriate, to coordinate Member care.
d. ECM Provider shall provide all core service components of ECM to each assigned Member, as follows:
    i. Comprehensive Assessment and Care Management Plan, which shall include, but are not limited to:
        a. Engaging with each Member authorized to receive ECM primarily through in-person contact;
            i. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider

shall use alternative methods to provide culturally appropriate and accessible communication.

b. Developing a comprehensive, individualized, person-centered care plan by working with the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
c. Incorporating into the Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing; and
d. Ensuring the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and as identified in the care plan.

ii. Enhanced Coordination of Care, which shall include, but is not limited to:
    a. Organizing patient care activities, as laid out in the care plan, sharing information with the Member's key care team, and implementing the Member's care plan;
    b. Ensuring care is continuous and integrated among all service providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, necessary community-based and social services including housing, as needed;
    c. Providing support for Member engagement in treatment including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;
    d. Communicating the Member's needs and preferences timely to the Member's care team in a manner that ensures safe, appropriate, and effective person-centered care; and
    e. Ensuring regular contact with the Member and their family member(s), guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.
iii. Health Promotion, which shall include, but is not limited to:
    a. Working with Members to identify and build on resiliencies and potential family and/or support networks;

b. Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health; and
c. Supporting the Member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

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

v. Member and Family Supports, which shall include, but are not limited to:
   a. Documenting a Member's designated family member(s), guardian, caregiver, and/or authorized support person(s) and ensuring all appropriate authorizations are in place to ensure effective communication between the ECM Providers, the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) and Contractor, as applicable;
   b. Activities to ensure the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s) with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in

accordance with Federal, State and local privacy and confidentiality laws;

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

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

9. Training

a. ECM Providers shall participate in all ECM training and technical assistance provided by MCP, including in-person sessions, webinars, and/or calls, as necessary.

10. Data Sharing to Support ECM

a. MCP will provide to ECM Provider the following data at the time of assignment and periodically thereafter:
   i. Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
   ii. Encounter and/or claims data;
   iii. Physical, behavioral, administrative and SDOH data (e.g., HMIS data) for all assigned Members; and
   iv. Reports of performance on quality measures and/or metrics, as requested.

11. Claims Submission and Reporting

a. ECM Provider shall submit claims for the provision of ECM-related services to MCP using the national standard specifications and code sets to be defined by DHCS.
b. In the event ECM Provider is unable to submit claims to MCP for ECM-related services using the national standard specifications and code sets, ECM Provider shall submit to MCP the minimum data elements identified by the MCP that allow MCP to convert ECM Provider's data into the national standard specifications and code sets for submission to DHCS.

12. Quality and Oversight

a. ECM Provider acknowledges MCP will conduct oversight of its participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include audits and/or corrective actions.
b. ECM Provider shall respond to all MCP requests for information and documentation to permit ongoing monitoring of ECM.

13. Payment

a. MCP shall pay contracted ECM Providers for the provision of ECM.
b. MCP payment to ECM Providers shall meet the following requirements:
    i. ECM Provider is paid when ECM is initiated for any given Member;
    ii. Payment to ECM Provider, made when ECM is initiated, includes compensation for outreach efforts that occurred prior to the initiation of services; and
    iii. ECM Provider has financial incentives to engage hard-to-reach populations.
c. MCP is encouraged to tie ECM Provider payments to achieving outcomes related to high-quality care and improved health status.
d. MCP shall pay 90% of all clean claims from practitioners who are individual or group practices or who practice in shared health facilities within 30 days of date of receipt and 99% of all clean claims within 90 days. The date of receipt shall be the date MCP receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

In Lieu of Services (ILOS)

1. ILOS Definitions

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

2. Overview

a. As defined in this section, pursuant to 42 CFR 438.3(e)(2), ILOS are services or settings that are not covered under the California Medicaid State Plan but are medically appropriate, cost-effective alternatives to State Plan Covered Services. ILOS are optional for both MCPs and Members.
b. Under DHCS requirements, if an MCP elects to offer ILOS, MCP must offer them to all Members in the County who are approved by MCP to receive an ILOS.
c. The ILOS Provider shall provide the following DHCS-authorized ILOS to Members (check as appropriate):
    i. ☐ Housing Transition Navigation Services
    ii. ☐ Housing Deposits
    iii. ☐ Housing Tenancy and Sustaining Services
    iv. ☐ Short-Term Post-Hospitalization Housing
    v. ☐ Recuperative Care (Medical Respite)
    vi. ☐ Respite Services
    vii. ☐ Day Habilitation Programs
    viii. ☐ Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
    ix. ☐ Community Transition Services/Nursing Facility Transition to a Home
    x. ☐ Personal Care and Homemaker Services
    xi. ☐ Environmental Accessibility Adaptations (Home Modifications)
    xii. ☐ Meals/Medically Tailored Meals
    xiii. ☐ Sobering Centers
    xiv. ☐ Asthma Remediation

xv. ☐ Other: _____, as approved by DHCS

3. ILOS Provider Requirements

a. Medicaid Enrollment/Credentialing for ILOS Providers
    i. The ILOS Provider shall be Medicaid-enrolled where a State-level enrollment pathway exists, as is required by Federal law.
        a. If no State-level Medicaid enrollment pathway exists, the ILOS Provider shall be credentialed by MCP or undergo a background check, as applicable *[See APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment].*
b. Experience and Expertise
    i. The ILOS Provider shall have sufficient experience and expertise in the provision of the ILOS being offered.
    ii. The ILOS Provider shall have a history of serving Medi-Cal Members in a community-based manner.
c. If the ILOS Provider subcontracts with other entities to administer functions of the ILOS, the ILOS Provider shall ensure agreements with such Subcontractors for the provision of ILOS bind all Subcontractors to the terms and conditions enumerated here.

4. Delivery of ILOS

a. ILOS Provider shall deliver the ILOS services it is contracted to provide in accordance with DHCS-developed service definitions.
b. ILOS Provider shall maintain staffing that allows for timely, high-quality service delivery of the ILOS that it is contracted to provide.
c. ILOS Provider shall:
    i. Accept Member referrals from MCP for authorized ILOS, up to ILOS Provider's pre-determined capacity;
    ii. Conduct outreach to the referred Member for authorized ILOS as soon as possible, including by conducting initial outreach within 24 hours of assignment;
    iii. Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week;
    iv. Coordinate with other Providers in the Member's care team, including ECM Provider, as applicable, and the Member's MCP;
    v. Comply with cultural competency and linguistic requirements set forth by MCP; and
    vi. Comply with non-discrimination requirements set forth in State and Federal law and the Contract with MCP.
d. ILOS Provider shall obtain and document consent from each assigned Member to receipt of ILOS and authorization of related data sharing, including

sharing of personal health information, in accordance with Federal, State and local laws, and shall communicate this information to the MCP.

e. ILOS Provider shall obtain and document Member authorization to communicate electronically with the Member and/or family member(s), guardian, caretaker, and/or authorized support person(s), if it intends to do so.
f. ILOS Provider will be reimbursed only for services that are authorized by MCP. In the event of a Member requesting services not yet authorized by MCP, ILOS Provider shall send the request(s) to MCP for authorization.
g. If an ILOS is discontinued for any reason, ILOS Provider shall support transition planning for the Member into other programs or services that meet their needs.
h. ILOS Provider is encouraged to identify additional ILOS the Member may benefit from and send any additional request(s) for ILOS to MCP for authorization.

5. Payment for ILOS

a. ILOS Provider shall record, generate, and send a claim or invoice to MCP for ILOS rendered.
    i. If ILOS Provider submits claims, ILOS Provider shall submit claims to MCP using specifications based on national standards and code sets to be defined by DHCS.
    ii. In the event ILOS Provider is unable to submit claims to MCP for ILOS-related services using DHCS-defined standard specifications and code sets, ILOS Provider shall submit invoices with minimum necessary data elements defined by DHCS, which includes information about the Member, the ILOS services rendered, and ILOS Providers' information to support appropriate payment by MCPs, that will allow MCPs to convert ILOS invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.
b. ILOS Provider shall not receive payment from MCP for the provision of any ILOS services not authorized by MCP.
c. ILOS Provider shall be able to accept payment from MCP for ILOS rendered.
    i. MCP shall pay 90% of all clean claims and invoices within 30 days of receipt and 99% of clean claims and invoices within 90 days of receipt.
    ii. MCP will provide expedited payments for urgent ILOS (e.g., recuperative care services for an individual who no longer requires hospitalization, but still needs to heal from an injury or illness, including behavioral health conditions, and whose condition would be exacerbated by an unstable living environment), pursuant to its Contract with DHCS and any other related DHCS guidance.

6. Data Sharing to Support ILOS

a. As part of the referral process, MCP will ensure ILOS Provider has access to:
    i. Demographic and administrative information confirming the referred Member's eligibility for the requested service;
    ii. Appropriate administrative, clinical, and social service information the ILOS Provider might need in order to effectively provide the requested service; and
    iii. Billing information necessary to support the ILOS Provider's ability to submit invoices to MCP.

7. Quality and Oversight

a. ILOS Provider acknowledges MCP will conduct oversight of its delivery of ILOS to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both the MCP and the ILOS Provider have, including but not limited to, required reporting, audits, and corrective actions, among other oversight activities.