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Department of Health Care Services
CalAIM Enhanced Care Management (ECM) and
In Lieu of Services (ILOS)
Contract Template Provisions



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Enhanced Care Management (ECM) Definitions

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

ECM Scope of Services

1. Contractor's Responsibility for Administration of ECM

- a. Contractor shall take a whole-person approach to offering Enhanced Care Management (ECM), ensuring that ECM addresses the clinical and non-clinical needs of high-need and/or high-cost Members in distinct Populations of Focus, as defined in ECM Section 2: Populations of Focus for ECM, through systematic coordination of services and comprehensive care management. Contractor shall ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.
- b. Contractor shall ensure ECM is available throughout its service area.
- c. Contractor shall ensure ECM is offered primarily through in-person interaction where Members and/or their family member(s), guardian, Authorized Representative(s) (AR), caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their local community. Contractor shall ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and telehealth, when appropriate and with the Member's consent.
 - i. As described in ECM Section 3: ECM Providers, Contractor must contract with ECM Providers for the provision of ECM.
 - a. Under limited circumstances defined in ECM Section 4: ECM Provider Capacity, Contractor may perform ECM functions using its own staff, with prior written approval from DHCS.

- b. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor shall follow the same requirements as a contracted ECM Provider.
 - ii. Contractor shall use ECM Provider Standard Terms and Conditions provided by DHCS to develop its contracts with ECM Providers, as described in Section 14: Oversight of ECM Providers.
 - iii. Contractor shall ensure it has a sufficient number of contracts in place to ensure its ECM Provider capacity meets the anticipated needs of all ECM Populations of Focus in a setting consistent with all the requirements in this Contract, as described in ECM Section 4: ECM Provider Capacity.
 - iv. In counties with operating Health Homes Program (HHP) and Whole Person Care (WPC) pilots, Contractor shall contract with WPC Lead Entities and HHP Community-Based Care Management Entities (CB-CMEs) for the provision of ECM, as described in ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM.
 - d. Contractor shall follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract amendment.
 - i. Contractor shall inform Members about ECM and how to access it. Contractor shall manage and respond promptly to any requests for ECM directly from Members and on behalf of Members from ECM Providers, other Providers, and community entities, and the Member's guardian or AR, where applicable, as described in ECM Section 7: Identifying Members for ECM.
 - ii. Contractor shall identify Members within the ECM Populations of Focus who may benefit from ECM, as defined in ECM Section 2: Populations of Focus for ECM.
 - iii. Contractor shall be responsible for authorizing ECM for Members, whether they are identified by Contractor or the Member or a family member, guardian, AR, caregiver, authorized support person, or external entity requests that the Member receive ECM, as described in ECM Section 8: Authorizing Members for ECM.
 - iv. Contractor shall be responsible for assigning all Members authorized to receive ECM to an appropriate ECM Provider, as described in ECM Section 9: Assignment to an ECM Provider.
 - v. Contractor shall ensure the Member is able to decline or end ECM at any time, as described in ECM Section 10: Initiating Delivery of ECM and ECM Section 11: Discontinuation of ECM.
 - e. Contractor shall ensure ECM provided to each Member encompasses the ECM Core Service Components described in ECM Section 12: Core Service Components of ECM.
 - i. Contractor shall ensure each Member authorized to receive ECM has a Lead Care Manager who interacts directly with the Member and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any In Lieu

of Services (ILOS), and other services that address social determinants of health needs, regardless of setting.

- f. Contractor shall ensure a Member receiving ECM is not receiving duplicative services both through ECM and outside of ECM, including by working with Local Governmental Agencies to ensure ECM services do not duplicate county-specified Targeted Case Management services for a Member.
- g. Contractor shall complete an MOC Template and submit for DHCS to review and approve as described in ECM Section 5: Model of Care.
- h. Contractor shall comply with all data system and data sharing requirements to support ECM, as described in ECM Section 13: Data System Requirements and Data Sharing to Support ECM.
- i. Contractor shall be responsible for overseeing the delivery of ECM to authorized Members through its contracted ECM Providers, as described in ECM Section 14: Oversight of ECM Providers.
- j. Contractor shall ensure all Subcontractors participating in any aspect of ECM administration uphold all applicable requirements as described in ECM Section 15: Delegation of ECM to Subcontractor(s) and in accordance with Exhibit A, Attachment 6, Provision 14, Subcontracts.
- k. Contractor shall pay contracted ECM Providers for the provision of ECM in accordance with contracts established between Contractor and ECM Provider, including for outreach to assigned Members, as described in ECM Section 16: Payment of ECM Providers.
- l. Contractor shall report ECM encounters, performance metrics, and supplemental information as specified by DHCS to allow DHCS appropriate oversight of ECM, as described in ECM Section 17: DHCS Oversight of ECM.
- m. Contractor shall coordinate with the Medicare Advantage Plan in the provision of ECM for Members who are dually eligible for Medicare and Medi-Cal, when the Member is enrolled in a Medicare Advantage Plan, including a Dual-Eligible Special Needs Plan.
- n. Contractor shall develop, submit for DHCS approval, and disseminate Member-facing written material about ECM for use across its ECM Provider Network. This material must:
 - i. Explain ECM and how to request it;
 - ii. Explain that ECM participation is voluntary and can be discontinued at any time;
 - iii. Explain that the Member must authorize ECM-related data sharing;
 - iv. Describe the process by which the Member may choose a different Lead Care Manager or ECM Provider; and
 - v. Meet standards for culturally and linguistically appropriate communication outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program and in Exhibit A, Attachment 13, Provision 3, Written Member Information.

2. Populations of Focus for ECM

- a. Subject to the phase-in and Member transition requirements described in ECM Section 6: Transition of Whole Person Care and Health Homes

Program to ECM, Contractor shall provide ECM to the following Populations of Focus:

- i. Adult Populations of Focus
 - a. Experiencing Homelessness;
 - b. High Utilizers;
 - c. Serious Mental Illness (SMI) or Substance Use Disorder (SUD);
 - d. Transitioning from Incarceration;
 - e. Individuals At Risk for Institutionalization who are Eligible for Long-Term Care Services;
 - f. Nursing Facility Residents Transitioning to the Community.
- ii. Children/Youth (up to Age 21) Populations of Focus
 - a. Experiencing Homelessness;
 - b. High Utilizers;
 - c. Serious Emotional Disturbance (SED) or Identified to be At Clinical High Risk (CHR) for Psychosis or Experiencing a First Episode of Psychosis;
 - d. Enrolled in California Children's Services (CCS)/CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Qualifying Condition;
 - e. Involved in, or with a History of Involvement in, Child Welfare (Including Foster Care up to Age 26);
 - f. Transitioning from Incarceration.
- b. Contractor may, but is not required to, offer ECM to Members who do not meet Population of Focus criteria in full, but may benefit from ECM.
- c. Contractor shall follow all DHCS guidance that further defines the approach to ECM for each Population of Focus, including the criteria for each Population of Focus and the phase-in timeline for Populations of Focus.
- d. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs:
 - i. 1915(c) waivers:
 - a. Multipurpose Senior Services Program (MSSP);
 - b. Assisted Living Waiver;
 - c. Home and Community-Based Alternatives (HCBA) Waiver;
 - d. HIV/AIDS Waiver;
 - e. HCBS Waiver for Individuals with Developmental Disabilities (DD); and
 - f. Self-Determination Program for Individuals with I/DD.
 - ii. Fully integrated programs for Members dually eligible for Medicare and Medicaid:
 - a. Cal MediConnect;
 - b. Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs); and
 - c. Program for All-Inclusive Care for the Elderly (PACE).
 - iii. Family Mosaic Project
 - iv. California Community Transitions (CCT) Money Follows the Person (MFTP)
 - v. Basic or Complex Case Management

3. ECM Providers

- a. Contractor shall ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member (i.e., where the Member lives, seeks care, or prefers to access services in their local community).
- b. ECM Providers may include, but are not limited to, the following entities:
 - i. Counties;
 - ii. County behavioral health Providers;
 - iii. Primary Care Physician or Specialist or Physician groups;
 - iv. Federally Qualified Health Centers;
 - v. Community Health Centers;
 - vi. Community-based organizations;
 - vii. Hospitals or hospital-based Physician groups or clinics (including public hospitals and district and/or municipal public hospitals);
 - viii. Rural Health Clinics and/or Indian Health Service Programs;
 - ix. Local health departments;
 - x. Behavioral health entities;
 - xi. Community mental health centers;
 - xii. SUD treatment Providers;
 - xiii. Organizations serving individuals experiencing homelessness;
 - xiv. Organizations serving justice-involved individuals;
 - xv. CCS Providers; and
 - xvi. Other qualified Providers or entities that are not listed above, as approved by DHCS.
- c. For the adult Population of Focus with SMI or SUD and children/youth Population of Focus with SED, Contractor shall prioritize county behavioral health staff or behavioral health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus, not just their behavioral health services.
- d. Contractor shall attempt to contract with each Indian Health Service Facility as set forth in Title 22 CCR Sections 55110-55180 to provide ECM, when applicable, as described in Exhibit A, Attachment 8, Provision 7(C).
- e. To provide Members with ongoing care coordination previously provided in HHP and WPC Pilot Counties, Contractor shall contract with each WPC Lead Entity or HHP CB-CME as an ECM Provider unless there is an applicable exception [*See ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM*].
- f. Contractor shall ensure ECM Providers:
 - i. Are experienced in serving the ECM Population(s) of Focus they will serve;
 - ii. Have experience and expertise with the services they will provide;
 - iii. Comply with all applicable state and federal laws and regulations and all ECM program requirements in this Contract and associated guidance;
 - iv. Have the capacity to provide culturally appropriate and timely in-person care management activities in accordance with Exhibit A, Attachment 6, Provision 13, Ethnic and Cultural Composition, including accompanying Members to critical appointments when necessary;

- v. Are able to communicate in culturally and linguistically appropriate and accessible ways, in accordance with Exhibit A, Attachment 9, Provision 14, Cultural and Linguistic Program;
 - vi. Have formal agreements and processes in place to engage and cooperate with area hospitals (when not serving as the ECM Provider), primary care practices, behavioral health Providers, Specialists, and other entities, including ILOS Providers, to coordinate care as appropriate to each Member; and
 - vii. Use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a Member care plan that can be shared with other Providers and organizations involved in each Member's care. Care management documentation systems may include Certified Electronic Health Record 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) *[See ECM Section 13: Data System Requirements and Data Sharing to Support ECM for more detailed requirements on data exchange]*.
- g. Contractor shall ensure all ECM Providers for whom a state-level enrollment pathway exists enroll in Medicaid, pursuant to relevant DHCS All Plan Letters (APLs), including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
- i. If APL 19-004 does not apply to an ECM Provider, Contractor shall have a process for vetting qualifications and experience of ECM Providers, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.
- h. Contractor shall not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of contracting as an ECM Provider.

4. ECM Provider Capacity

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

- e. Contractor shall report 60 days in advance or as soon as possible on its ECM Provider capacity whenever there are significant changes, pursuant to DHCS reporting requirements.
- f. If Contractor 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, Contractor may request written approval for an exception to the ECM Provider contracting requirement from DHCS that authorizes Contractor to use Contractor's own staff for ECM. Any such request must be submitted in accordance with DHCS guidelines and must evidence one or more of the following:
 - i. There are insufficient ECM Providers, or a lack of ECM Providers with experience and expertise to provide ECM for one or more of the Populations of Focus in one or more counties;
 - ii. There is a justified quality of care concern with one or more of the otherwise qualified ECM Providers;
 - iii. Contractor and the ECM Provider(s) are unable to agree on contracted rates;
 - iv. ECM Provider(s) is/are unwilling to contract;
 - v. ECM Provider(s) is/are unresponsive to multiple attempts to contract;
 - vi. For ECM Providers who have a state-level pathway to Medi-Cal enrollment: Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the Contractor; and/or
 - vii. For ECM Providers without a state-level pathway to Medi-Cal enrollment: Provider(s) is/are unable to comply with Contractor's processes for vetting ECM Providers.
- g. During any exception period approved by DHCS, Contractor shall take steps to continually develop and increase the capacity of its ECM Provider Network. The initial exception period will be in effect no longer than one year. After the initial one-year period, Contractor must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis.
- h. Unless Contractor has DHCS approval, based on one of the exceptions defined above, failure of Contractor to provide ECM Provider capacity to meet the needs of all ECM Populations of Focus in a community-based manner shall result in imposition of corrective action proceedings, which may lead to sanctions as set forth in Exhibit E, Attachment 2, Provision 16, Sanctions.

5. Model of Care

- a. Contractor shall develop and submit to DHCS for review and approval an MOC, which must detail Contractor's framework for providing ECM, including a listing of its ECM Providers and Policies and Procedures for partnering with ECM Providers.
- b. Contractor shall detail its MOC using the DHCS-approved MOC Template for DHCS review.
- c. In developing and executing contracts with ECM Providers, Contractor must incorporate all requirements and Policies and Procedures described in its MOC, in addition to the ECM Provider Standard Terms and Conditions.

- d. Contractor is encouraged to collaborate on development of its MOC with other Medi-Cal Managed Care Health Plans within the same county, if applicable.
- e. Contractor shall submit to DHCS any significant updates to its MOC for review and approval 60 days in advance of any changes or updates, consistent with DHCS guidance.

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

- a. Contractor shall promote continuity from WPC Pilots and the HHP to ECM.
- b. Contractor shall authorize ECM for Members in HHP and WPC Pilot Counties, following DHCS' implementation schedule.
- c. To ensure continuity between HHP and ECM, Contractor shall:
 - i. Automatically authorize ECM for all Members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in HHP; and
 - ii. Ensure that each Member automatically authorized for ECM under this provision is assessed within six months, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.
- d. To ensure continuity between WPC Pilots and ECM, Contractor shall:
 - i. Automatically authorize all Members enrolled in a WPC Pilot who are identified by the WPC Lead Entity as belonging to an ECM Population of Focus; and
 - ii. Ensure each Member automatically authorized under this provision is assessed within six months, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.
- e. Contractor shall contract with each WPC Lead Entity and/or HHP CB-CME as an ECM Provider to provide Members with ongoing care coordination previously provided in HHP and WPC Pilot Counties, except under the permissible exceptions set forth in f. below.
- f. Contractor shall submit to DHCS for prior approval any requests for exceptions to the contracting requirement with a WPC Lead Entity or HHP CB-CME as an ECM Provider. Permissible exceptions to contracting are:
 - i. There is a justified quality of care concern with the ECM Provider(s);
 - ii. Contractor and ECM Provider(s) are unable to agree on contracted rates;
 - iii. ECM Provider(s) is/are unwilling to contract;
 - iv. ECM Provider(s) is/are unresponsive to multiple attempts to contract;
 - v. ECM Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the Contractor; and/or
 - vi. For ECM Provider(s) without a state-level pathway to Medi-Cal enrollment, ECM Provider(s) is/are unable to comply with Contractor processes for vetting qualifications and experience.

7. Identifying Members for ECM

- a. Contractor shall proactively identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus described in ECM Section 2: Populations of Focus for ECM.
- b. To identify such Members, Contractor must consider Members' health care utilization; needs across physical, behavioral, developmental, and oral health; health risks and needs due to social determinants of health; and LTSS needs.
- c. Contractor shall identify Members for ECM through the following pathways:
 - i. Analysis of Contractor's own enrollment, claims, and other relevant data and available information. Contractor shall use data analytics to identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus. Contractor shall consider data sources, including but not limited to:
 - a. Enrollment data;
 - b. Encounter data;
 - c. Utilization/claims data;
 - d. Pharmacy data;
 - e. Laboratory data;
 - f. Screening or assessment data;
 - g. Clinical information on physical and/or behavioral health;
 - h. SMI/SUD data, as available;
 - i. Risk stratification information for children in County Organized Health System (COHS) counties with Whole Child Model (WCM) programs;
 - j. Information about social determinants of health, including standardized assessment tools (e.g., PRAPARE) and/or ICD-10 codes;
 - k. Results from any available Adverse Childhood Experience (ACE) screening; and
 - l. Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM Populations of Focus (e.g., Homeless Management Information System (HMIS), available data from the education system).
 - ii. Receipt of requests from ECM Providers and other Providers or community-based entities.
 - a. Contractor shall accept requests for ECM on behalf of Members from:
 - i. ECM Providers;
 - ii. Other Providers;
 - iii. Community-based entities, including those contracted to provide ILOS, as described in ILOS Section 3: ILOS Providers.
 - b. Contractor shall directly engage with Network Providers and county agencies to inform these entities of ECM, the ECM Populations of Focus, and how to request ECM for Members.
 - c. Contractor shall encourage ECM Providers to identify Members who meet the criteria for the ECM Populations of

Focus, and shall develop a process for receiving and responding to requests from ECM Providers.

- iii. Receipt of requests from Members.
 - a. Contractor shall have a process for allowing Members and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s) to request ECM on a Member's behalf, and shall provide information to Members regarding the Member and/or family ECM request and approval process.

8. Authorizing Members for ECM

- a. Contractor shall be responsible for authorizing ECM for each Member identified through any of the pathways described in ECM Section 7: Identifying Members for ECM.
- b. Contractor shall develop Policies and Procedures that explain how it will authorize ECM for eligible Members in an equitable and non-discriminatory manner.
- c. For requests from Providers and other external entities, and for Member or family requests:
 - i. Contractor shall ensure that authorization or a decision not to authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (i.e., within five working days for routine authorizations and within 72 hours for expedited requests);
 - ii. If Contractor does not authorize ECM, Contractor shall ensure the Member and the requesting individual or entity (as applicable) who requested ECM on a Member's behalf are informed of the Member's right to appeal and the appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeal System and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments; and
 - iii. Contractor shall follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments for Members who were not authorized to receive ECM.
- d. Contractor shall follow requirements for transitioning Members previously served by WPC Pilots or HHP contained in ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM.
- e. Contractor is encouraged to work with ECM Providers to define a process and appropriate circumstances for presumptive authorization or preauthorization of ECM, whereby select ECM Providers would be able to directly authorize ECM and be paid for ECM services for a fixed period of time until Contractor validates or denies ECM based on a complete assessment of Member eligibility for ECM consistent with Population of Focus criteria.

- f. To inform Members that ECM has been authorized, Contractor shall follow its standard notice process outlined in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments.

9. Assignment to an ECM Provider

- a. Contractor shall assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS-approved exception to the ECM Provider contracting requirement [See ECM Section 4: ECM Provider Network Capacity].
- b. Contractor shall develop a process to disseminate information of assigned Members to ECM Provider(s) on a regular cycle.
- c. Contractor shall ensure communication of Member assignment to the designated ECM Provider occurs within ten business days of authorization.
- d. If the Member’s preferences for a specific ECM Provider are known to Contractor, Contractor shall follow those preferences, to the extent practicable.
- e. If the Member’s assigned Primary Care Provider (PCP) is a contracted ECM Provider, Contractor shall assign the Member to the PCP as the ECM Provider, unless the Member has expressed a different preference or Contractor identifies a more appropriate ECM Provider given the Member’s individual needs and health conditions.
- f. If a Member receives services from a Specialty Mental Health Plan for SED, SUD, and/or SMI and the Member’s behavioral health Provider is a contracted ECM Provider, Contractor shall assign that Member to that behavioral health Provider as the ECM Provider, unless the Member has expressed a different preference or Contractor identifies a more appropriate ECM Provider given the Member’s individual needs and health conditions.
- g. For children enrolled in CCS and when the Member’s CCS Case Manager is affiliated with a contracted ECM Provider, Contractor shall assign that Member to the CCS Case Manager as the ECM Provider, unless the Member or family has expressed a different preference or Contractor identifies a more appropriate ECM Provider given the Member’s individual needs and health conditions.
- h. Contractor shall notify the Member’s PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten (10) business days of the date of assignment.
- i. Contractor shall document the Member’s ECM Lead Care Manager in its system of record.
- j. Contractor shall permit Members to change ECM Providers at any time. Contractor shall implement any requested ECM Provider change within thirty days.

10. Initiating Delivery of ECM

- a. Contractor shall not require Member authorization for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM, unless such authorization is required by federal law.

- b. Contractor shall develop Policies and Procedures for its Network of ECM Providers to:
 - i. Where required by federal law, ensure that Members authorize information sharing with the Contractor and all others involved in the ECM Member's care as needed to support the Member and maximize the benefits of ECM.
 - ii. Communicate Member-level record of any authorization required by federal law, to allow data sharing (once obtained) back to Contractor.
- c. Contractor shall ensure that upon the initiation of ECM, each Member receiving ECM has a Lead Care Manager with responsibility for interacting directly with the Member and/or family, AR, caretakers, and/or other authorized support person(s) as appropriate.
 - i. The assigned Lead Care Manager shall be responsible for engaging with a multi-disciplinary care team to identify gaps in Member's care and ensure appropriate input is obtained to effectively coordinate all primary, behavioral, developmental, oral health, LTSS, ILOS, and other services that address social determinants of health, regardless of setting, at a minimum.
- d. Contractor shall ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

11. Discontinuation of ECM

- a. Contractor shall ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.
- b. Contractor shall require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met:
 - 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.
- c. Contractor shall develop processes to determine if the Member is no longer authorized to receive ECM and notify ECM Provider to initiate discontinuation of services in accordance with the NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
- d. Contractor shall develop processes for transitioning Members from ECM to lower levels of care management to provide coordination of ongoing needs.
- e. Contractor shall notify the ECM Provider when ECM has been discontinued.
- f. Contractor shall notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to appeal and the appeals process by way of the NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior

Authorization Requests, and Attachment 14, Member Grievance and Appeals and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments.

12. Core Service Components of ECM

- a. Contractor shall ensure all Members receive all ECM core service components described below:
 - i. Outreach and Engagement
 - a. Contractor shall develop Policies and Procedures for its ECM Providers with respect to outreach to and engagement of ECM-authorized Members.
 - ii. Comprehensive Assessment and Care Management Plan, which must include, but is 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 (including use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
 - b. Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan;
 - c. Developing a comprehensive, individualized, person-centered Care Management Plan with input from the Member and/or their family member(s), guardian, AR, caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
 - d. Incorporating into the Member’s Care Management 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;
 - e. Ensuring the Member is reassessed at a frequency appropriate for the Member’s individual progress or changes in needs and/or as identified in the Care Management Plan; and
 - f. Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight.
 - iii. Enhanced Coordination of Care, which shall include, but is not limited to:
 - a. Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Member’s multi-disciplinary care team, and

- implementing activities identified in the Member's Care Management Plan;
 - b. Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of Member goals and needs;
 - c. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
 - d. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;
 - e. Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
 - f. Ensuring regular contact with the Member and their family member(s), guardian, AR, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.
- iv. Health Promotion, which shall include, but is not limited to:
- a. Working with Members to identify and build on successes 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 Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.
- v. 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.
- c. Member and Family Supports, which shall include, but are not limited to:
- i. Documenting a Member's authorized family member(s), guardian, AR, caregiver, and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM Providers; the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s); and Contractor, as applicable;
 - ii. Activities to ensure the Member and/or their family member(s), guardian, AR, 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;
 - iii. Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and/or family member(s), guardian, AR, caregiver, and/or other authorized support person(s);
 - iv. Identifying supports needed for the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services;
 - v. Providing for appropriate education of the Member and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s) about care instructions for the Member; and

- vi. Ensuring that the Member has a copy of his/her care plan and information about how to request updates.
- d. Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:
 - i. Determining appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services offered by Contractor as ILOS; and
 - ii. Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., “closed loop referrals”).

13. Data System Requirements and Data Sharing to Support ECM

- a. Contractor shall have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:
 - i. Consume and use claims and encounter data, as well as other data types listed in ECM Section 7: Identifying Members for ECM, to identify Populations of Focus;
 - ii. Assign Members to ECM Providers;
 - iii. Keep records of Members receiving ECM and authorizations necessary for sharing Personally Identifiable Information between Contractor and ECM and other Providers, among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by Contractor;
 - iv. Securely share data with ECM Providers and other Providers in support of ECM;
 - v. Receive, process, and send encounters from ECM Providers to DHCS;
 - vi. Receive and process supplemental reports from ECM Providers;
 - vii. Send ECM supplemental reports to DHCS; and
 - viii. Open, track, and manage referrals to ILOS Providers.
- b. In order to support ECM, Contractor shall follow DHCS guidance on data sharing and provide the following information to all ECM Providers, at a minimum:
 - i. Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
 - ii. Encounter and/or claims data;
 - iii. Physical, behavioral, administrative, and social determinants of health data (e.g., HMIS data) for all Members assigned to the ECM Provider; and
 - iv. Reports of performance on quality measures and/or metrics, as requested.
- c. Contractor shall use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS, to the extent practicable.

14. Oversight of ECM Providers

- a. Contractor shall perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract amendment and associated guidance and Contractor's MOC.
- b. Contractor shall use ECM Provider Standard Terms and Conditions to develop its ECM contracts with ECM Providers and shall incorporate all of its ECM Provider requirements, reviewed and approved by DHCS as part of its MOC, including all monitoring and reporting expectations and criteria.
- c. To streamline ECM implementation:
 - i. Contractor shall hold ECM Providers responsible for the same reporting requirements as those the Contractor has with DHCS.
 - ii. Contractor shall not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting; and
 - iii. Contractor is encouraged to collaborate with other Medi-Cal Managed Care Health Plans within the same county on oversight of ECM Providers.
- d. Contractor shall not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.
- e. Contractor shall provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, and/or calls, as necessary, in addition to Network Provider training requirements described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

15. Delegation of ECM to Subcontractor(s)

- a. Contractor may subcontract with other entities to administer ECM in accordance with the following:
 - i. Contractor shall maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting, as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
 - ii. Contractor shall be responsible for developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
 - iii. Contractor shall be responsible for evaluating the prospective Subcontractor's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
 - iv. Contractor shall remain responsible for ensuring the Subcontractor's ECM Provider capacity is sufficient to serve all Populations of Focus;
 - v. Contractor shall report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment 6, Provision 12, Plan Subcontractors; and
 - vi. Contractor shall make all Subcontractor agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment 6, Provision 14, Subcontracts.

- b. Contractor shall ensure the agreement between Contractor and Subcontractor mirrors the requirements set forth in this Contract and the ECM Provider Standard Terms and Conditions, as applicable to Subcontractor.
- c. Contractor is encouraged to collaborate with its Subcontractors on the approach to ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractor(s) and/or across multiple Subcontractors and ensure a streamlined, seamless experience for ECM Providers and Members.

16. Payment of ECM Providers

- a. Contractor shall pay contracted ECM Providers for the provision of ECM in accordance with contracts established between Contractor and each ECM Provider.
- b. Contractor shall ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as defined in ECM Section 10: Initiating Delivery of ECM.
- c. Contractor is encouraged to tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.
- d. Contractor shall utilize the claims timeline as dictated in Exhibit A, Attachment 8, Provision 5, Claims Processing.

17. DHCS Oversight of ECM

- a. Contractor shall submit the following data and reports to DHCS to support DHCS' oversight of ECM:
 - i. Encounter data.
 - a. Contractor must submit all ECM encounters to DHCS using national standard specifications and code sets to be defined by DHCS.
 - b. Contractor shall be responsible for submitting to DHCS all encounter data for ECM services to its Members, regardless of the number of levels of delegation and/or sub-delegation between Contractor and the ECM Provider.
 - c. In the event the ECM Provider is unable to submit ECM encounters to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor shall be responsible for converting the ECM Provider's encounter information into the national standard specifications and code sets, for submission to DHCS.
 - ii. Supplemental reporting. Contractor shall submit ECM supplemental reports, on a schedule and in a format to be defined by DHCS.
- b. Contractor shall track and report to DHCS, in a format to be defined by DHCS, information about outreach efforts related to potential Members to be enrolled in ECM.
- c. In the event of underperformance by Contractor in relation to its administration of ECM, DHCS may impose sanctions as described in Exhibit E, Attachment 2, Provision 16, Sanctions.

18. ECM Quality and Performance Incentive Program

- a. Contractor shall meet all quality management and quality improvement requirements in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements set forth in associated guidance from DHCS for ECM.
- b. Contractor may participate in a performance incentive program related to building Provider capacity for ECM, related health care quality and outcomes, and/or other performance milestones and measures, to be defined in forthcoming DHCS guidance.

In Lieu of Services

In Lieu of Services Definitions

1. **In Lieu of Services (ILOS):** Pursuant to 42 CFR 438.3(e)(2), ILOS are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. ILOS are optional for both Contractor and the Member and must be approved by DHCS. DHCS already has authorized the list of ILOS included in Section 2: DHCS-Approved ILOS (“pre-approved ILOS”) services [*See ILOS Section 2: DHCS Pre-Approved ILOS*].
2. **ILOS Provider:** a contracted Provider of DHCS-approved ILOS. ILOS Providers are entities with experience and expertise providing one or more of the ILOS approved by DHCS.

In Lieu of Services

1. Contractor’s Responsibility for Administration of ILOS

- a. Contractor is authorized and encouraged to provide DHCS pre-approved ILOS [*See ILOS Section 2: DHCS-Pre-Approved ILOS*].
 - i. The remainder of this section refers only to ILOS that the Contractor elects to offer unless otherwise specified.
- b. To offer ILOS in accordance with 42 CFR 438.3(e)(2), Contractor may select from the list of ILOS “pre-approved” by DHCS as medically appropriate and cost-effective substitutes for covered services or settings under the State Plan [*See ILOS Section 2: DHCS Pre-Approved ILOS*].
 - i. Contractor shall ensure the underlying State Plan services are made available to the Member if medically necessary for the Member, or if the Member declines the ILOS.
 - ii. Contractor may submit a request to DHCS to offer ILOS in addition to the pre-approved ILOS [*See ILOS Section 2: DHCS Pre-Approved ILOS*].
- c. With respect to pre-approved ILOS, Contractor shall adhere to DHCS guidance on eligible populations, code sets, potential ILOS Providers, and parameters for each ILOS that Contractor chooses to provide.
- d. Contractor need not offer elected ILOS in each county it serves. Contractor shall report to DHCS the counties in which it intends to offer the ILOS. [*For requirements regarding the extent to which ILOS must be provided throughout a county selected by Contractor, see Section 4: ILOS Provider Network Capacity*].
- e. Contractor shall identify individuals who may benefit from ILOS and for whom ILOS will be a medically appropriate and cost-effective substitute for State Plan Covered Services, and accept requests for ILOS from Members and on behalf of Members from Providers and organizations that serve them, including community-based organizations [*See ILOS Section 7: Identifying Members for ILOS*].
- f. Contractor shall authorize ILOS for Members deemed eligible [*See ILOS Section 8: Authorizing Members for ILOS and Communication of Authorization Status*].

- g. Electing to offer one or more ILOS shall not preclude Contractor from offering value-added services (VAS).
- h. Any discontinuation of an ILOS is considered a change in the availability of services and therefore requires Contractor to adhere to the requirements of Exhibit A, Attachment 9, Provision 10, Changes in Availability or Location of Covered Services and Exhibit A, Attachment 13, Provision 5, Notification of Changes in Access to Covered Services.
- i. Contractor shall coordinate with the Medicare Advantage Plan in the provision of ILOS for Members dually eligible for Medicare and Medi-Cal, when the Member is enrolled in a Medicare Advantage Plan, including a Dual-Eligible Special Needs Plan.
- j. Contractor shall not require Members to use ILOS.

2. DHCS Pre-Approved ILOS

- a. Contractor can choose to offer Members one or more of the following pre-approved ILOS, and any later DHCS-approved ILOS additions, in each county:
 - i. Housing Transition Navigation Services;
 - ii. Housing Deposits;
 - iii. Housing Tenancy and Sustaining Services;
 - iv. Short-Term Post-Hospitalization Housing;
 - v. Recuperative Care (Medical Respite);
 - vi. Respite Services;
 - vii. Day Habilitation Programs;
 - viii. Nursing Facility Transition/Diversion to Assisted Living Facilities;
 - ix. Community Transition Services/Nursing Facility Transition to a Home;
 - x. Personal Care and Homemaker Services;
 - xi. Environmental Accessibility Adaptations;
 - xii. Medically Tailored Meals/Medically Supportive Food;
 - xiii. Sobering Centers; and/or
 - xiv. Asthma Remediation.
- b. Contractor shall indicate in Contractor's MOC Template and through MOC amendments which ILOS it will offer.
- c. Contractor shall ensure ILOS are provided to Members in as timely a manner as possible, and shall develop Policies and Procedures outlining its approach to managing Provider shortages or other barriers to timely provision of ILOS.
- d. Contractor is permitted to begin offering new pre-approved ILOS every six months upon notice and submission of an updated MOC to DHCS.
- e. Contractor is permitted to discontinue offering ILOS annually with notice to DHCS.
 - i. Contractor shall ensure ILOS that were authorized for a Member prior to the discontinuation of that specific ILOS are not disrupted by a change in ILOS offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet their needs.
- f. Contractor shall notify Members affected by a decision to discontinue an ILOS of 1) the change and timing of discontinuation, and 2) the procedures

that will be used to ensure completion of the authorized ILOS or a transition into other Medically Necessary services.

- g. Contractor is not restricted from providing voluntary services that are neither State-approved ILOS nor Covered Services when medically appropriate in accordance with 42 CFR 438.3(e)(1). Such voluntary services are not subject to the terms of this Provision and are subject to the limitations of 42 CFR 438.3(e)(1).

3. ILOS Providers

- a. Contractor shall contract with ILOS Providers for the delivery of elected ILOS.
- b. ILOS Providers are entities that Contractor has determined can provide the ILOS to eligible Members in an effective manner consistent with culturally and linguistically appropriate care.
- c. Contractor shall ensure all ILOS Providers with which it contracts have sufficient experience and/or training in the provision of the ILOS being offered.
 - i. ILOS Providers can include but are not limited to those listed in the In Lieu of Services – Service Description section of the ILOS Program Guide under “Licensing/Allowable Providers.” Other entities that have training and/or experience providing ILOS in a culturally and linguistically competent manner may also serve as contracted ILOS Providers.
- d. Contractor shall ensure ILOS Providers for whom a state-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
 - i. If APL 19-004 does not apply to an ILOS Provider, Contractor shall have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.
- e. Contractor shall support ILOS Provider access to systems and processes allowing them to obtain and document Member information including eligibility, ILOS authorization status, Member authorization for data sharing (to the extent required by federal law), and other relevant demographic and administrative information, and to support notification to Contractor and ECM Provider and PCP, as applicable, when a referral has been fulfilled [*See ILOS Section 10: Data System Requirements and Data Sharing to Support ILOS*].
- f. To the extent Contractor elects to offer ILOS, Contractor is encouraged to coordinate its approach with other Medi-Cal Managed Care Health Plans offering ILOS in the same county.

4. ILOS Provider Capacity

- a. Contractor shall make best efforts to develop a robust network of ILOS Providers to deliver all elected ILOS.
- b. If Contractor is unable to offer its elected ILOS to all eligible Members for whom it is medically appropriate and cost-effective, it shall do the following:

- i. Develop Policies and Procedures describing how Contractor will prioritize the delivery of ILOS when capacity is limited to avoid wait lists, including how it will ensure those Policies and Procedures are non-discriminatory in their application(s);
 - ii. Submit a three-year plan to DHCS detailing how it will build Network capacity over time, and update the plan annually; and
 - iii. Participate in regular meetings with DHCS to review progress towards expanding ILOS network capacity.
- c. Contractor shall ensure its contracted ILOS Providers have sufficient capacity to receive referrals for ILOS and provide the agreed-upon volume of ILOS to Members who are authorized for such services on an ongoing basis.

5. Model of Care

- a. Contractor shall develop and submit to DHCS for review and approval an MOC that shall be Contractor's framework for providing ILOS, which details:
 - i. Which ILOS Contractor plans to offer;
 - ii. Contractor's network of ILOS Providers; and,
 - iii. All Policies and Procedures for the delivery of elected ILOS.
- b. Contractor shall detail its MOC using the DHCS-developed MOC Template for DHCS review.
- c. In developing and executing ILOS contracts with ILOS Providers, Contractor must incorporate requirements and Policies and Procedures described in its MOC, in addition to the ILOS Provider Standard Terms and Conditions.
- d. Contractor is encouraged to collaborate on its MOC with other Medi-Cal Managed Care Health Plans within the same county, if applicable.
- e. Contractor shall submit to DHCS any significant updates to its MOC for review and approval 60 days in advance of any changes or updates, consistent with DHCS guidance.

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

- a. In HHP and WPC Pilot Counties, Contractor is strongly encouraged to offer ILOS to HHP and WPC participants who are being provided similar services through WPC or HHP to provide continuity of the services being delivered as part of those programs.
- b. In HHP and WPC Pilot Counties, Contractor shall contract with all WPC Lead Entities and HHP CB-CMEs as ILOS Providers unless Contractor receives prior written approval from DHCS, through the MOC review process, based on one or more of the following exceptions.
 - i. ILOS Provider(s) does not provide the ILOS that Contractor has elected to offer;
 - ii. There is a justified quality of care concern with the ILOS Provider(s);
 - iii. Contractor and the ILOS Provider(s) are unable to agree on contracted rates;
 - iv. ILOS Provider(s) is/are unwilling to contract;
 - v. ILOS Provider(s) is/are unresponsive to multiple attempts to contract;
 - vi. ILOS Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the Contractor; and/or

- vii. For ILOS Provider(s) without a state-level pathway to Medi-Cal enrollment, ILOS Provider(s) is/are unable to comply with Contractor processes for vetting qualifications and experience.
- c. The requirement to contract with WPC Lead Entities and HHP CB-CMEs except as allowed under requirements b.i – vii of this section applies regardless of whether a Contractor offers an ILOS on a county-wide basis or not.

7. Identifying Members for ILOS

- a. Contractor shall utilize a variety of methods to identify Members who may benefit from ILOS, including:
 - i. Working with ECM Providers to identify Members receiving ECM who could benefit from ILOS;
 - ii. Proactively identifying Members who may benefit from the DHCS-authorized ILOS that Contractor is offering;
 - iii. Accepting requests from Providers and other community-based entities; and
 - iv. Accepting Member and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s) requests.
- b. Contractor shall develop Policies and Procedures for how Contractor will identify Members, and how it will accept requests for ILOS from Providers, other community-based entities, and Member and/or their family.
- c. Contractor shall submit its Policies and Procedures to DHCS for review and approval.
- d. Contractor shall develop Policies and Procedures to inform Members of ILOS for which they may be eligible and shall submit those Policies and Procedures and all Member notices to DHCS for review and approval prior to implementation.
 - i. Contractor shall ensure that Member identification methods for ILOS are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.

8. Authorizing Members for ILOS and Communication of Authorization Status

- a. Contractor shall develop Policies and Procedures that explain how it will authorize ILOS for eligible Members in an equitable and non-discriminatory manner [*See ILOS Section 4: ILOS Provider Capacity*].
- b. Contractor shall monitor and evaluate ILOS authorizations to ensure they are equitable and non-discriminatory. Contractor shall have Policies and Procedures for what immediate actions will be taken if monitoring/evaluation processes identify that service authorizations have had an inequitable effect.
- c. Contractor shall validate Member eligibility for ILOS using a consistent methodology and authorize ILOS for Members for whom the ILOS is determined to be a medically appropriate and cost-effective alternative to services and settings covered under the State Plan.
 - i. Contractor shall not restrict the authorization of ILOS only to Members who are transitioning from WPC and/or HHP.
- d. Contractor shall submit Policies and Procedures to ensure Members do not experience undue delays pending the authorization process for ILOS.

- i. If Medically Necessary, Contractor shall make available the State Plan Covered Services that the ILOS replaces, pending authorization of the requested ILOS.
 - ii. Contractor shall evaluate medical appropriateness and cost-effectiveness when determining whether to provide ILOS to a Member. Providing a particular ILOS to a Member in one instance does not automatically mean that providing another ILOS to the same Member, the same ILOS to another Member, or the same ILOS to the same Member in a different instance would be medically appropriate and cost-effective.
- e. Contractor shall have Policies and Procedures for expediting the authorization of certain ILOS for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply.
 - i. Contractor is encouraged to work with ILOS Providers to define a process and appropriate circumstances for presumptive authorization of ILOS whereby select ILOS Providers would be able to directly authorize an ILOS, potentially only for a limited period of time, under specified circumstances when a delay would be harmful to the Member or inconsistent with efficiency and cost-effectiveness.
- f. Contractor shall permit Members who sought one or more ILOS offered by Contractor but were not authorized to receive the ILOS to submit a Grievance and/or Appeal to Contractor.
- g. When a Member has requested an ILOS, directly or through a Provider, community-based organization, or other entity [See *ILOS Section 7: Identifying Members for ILOS*], Contractor shall notify the requesting entity of Contractor's decision regarding ILOS authorization. If the Member is enrolled in ECM, Contractor shall ensure the ECM Provider is informed of the ILOS authorization decision.

9. Referring Members to ILOS Providers for ILOS

- a. Contractor shall develop Policies and Procedures to define how ILOS Provider referrals will occur.
 - i. For Members enrolled in ECM, Policies and Procedures must address how Contractor will work with the ECM Provider to coordinate the ILOS referral and communicate the outcome of the referral back to the ECM Provider (i.e., using closed loop referrals).
 - ii. Policies and Procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.
- b. If the Member's preferences for an ILOS Provider are known, Contractor shall follow those preferences, to the extent practicable.
- c. Contractor shall track referrals to ILOS Provider(s) to verify if the authorized service has been delivered to the Member.
 - i. If the Member receiving the ILOS is also receiving ECM, Contractor shall monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the ILOS Provider.
- d. Contractor shall not require Member authorization for ILOS-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ILOS, unless such authorization is required by federal law.

- e. Contractor shall develop Policies and Procedures for its Network of ILOS Providers to:
 - i. Ensure the Member agrees to the receipt of ILOS;
 - ii. Where required by federal law, ensure that Members authorize information sharing with the Contractor and all others involved in the Member's care as needed to support the Member and maximize the benefits of ILOS; and
 - iii. Communicate Member-level record of any authorization required by federal law, to allow data sharing (once obtained) back to Contractor.

10. Data System Requirements and Data Sharing to Support ILOS

- a. Contractor shall use systems and processes capable of tracking ILOS referrals, access to ILOS, and grievances and appeals to Contractor.
 - i. Contractor will support ILOS Provider access to systems and processes allowing them to track and manage referrals for ILOS and Member information.
- b. As part of the referral process to ILOS Providers and consistent with federal, state and, if applicable, local privacy and confidentiality laws, Contractor shall ensure ILOS Providers have access to:
 - i. Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;
 - ii. Appropriate administrative, clinical, and social service information the ILOS Providers might need to effectively provide the requested service; and
 - iii. Billing information necessary to support the ILOS Providers' ability to submit claims or invoices to Contractor.
- c. Contractor shall use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ILOS Providers and with DHCS, to the extent practicable.

11. Oversight of ILOS Providers

- a. Contractor shall perform oversight of ILOS Providers, holding them accountable to all ILOS requirements contained in this Contract amendment and associated guidance and Contractor's MOC.
- b. Contractor shall use ILOS Provider Standard Terms and Conditions to develop its ILOS contracts with ILOS Providers and shall incorporate all of its ILOS Provider requirements, reviewed and approved by DHCS as part of its MOC, including all monitoring and reporting expectations and criteria.
- c. To streamline ILOS implementation:
 - i. Contractor shall hold ILOS Providers responsible for the same reporting requirements as those that Contractor must report to DHCS.
 - ii. Contractor shall not impose mandatory reporting requirements that are alternative or additional to those required for encounter and supplemental reporting.
 - iii. Contractor is encouraged to collaborate with other Medi-Cal Managed Care Health Plans within the same county on reporting requirements and oversight.

- d. Contractor shall not utilize tools developed or promulgated by NCQA to perform oversight of ILOS Providers, unless by mutual consent with the ILOS Provider.
- e. Contractor shall provide ILOS training and technical assistance to ILOS Providers, including in-person sessions, webinars, and/or calls, as necessary, in addition to Network Provider training requirements described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

12. Delegation of ILOS to Subcontractor(s)

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

13. Payment of ILOS Providers

- a. Contractor shall pay contracted ILOS Providers for the provision of authorized ILOS to Members in accordance with established contracts between Contractor and each ILOS Provider.
- b. Contractor shall utilize the claims timeline and process as described in Exhibit A, Attachment 8, Provider Compensation Arrangements, 5. Claims Processing, B.

- c. Contractor shall identify any circumstances under which payment for an ILOS must be expedited to facilitate timely delivery of the ILOS to the Member (e.g., recuperative care for an individual who is homeless and being discharged from the hospital) *[See ILOS Section 8: Authorizing Members for ILOS and Communication of Authorization Status]*.
 - i. For such circumstances, Contractor shall develop Policies and Procedures to ensure payment to the ILOS Provider is expedited, and share such Policies and Procedures with DHCS for prior approval.
- d. Contractor shall ensure ILOS Providers submit a claim for ILOS rendered, to the greatest extent possible.
 - i. If an ILOS Provider is unable to submit a claim for ILOS rendered, Contractor shall ensure the ILOS Provider documents services rendered using an invoice.
 - ii. Upon receipt of such an invoice, Contractor shall be responsible for documenting the encounter for the ILOS rendered.

14. DHCS Oversight of ILOS

- a. Contractor shall include details on the ILOS Contractor plans to offer in its MOC, including in which counties ILOS will be offered and its Network of ILOS Providers *[See Section 5: ILOS Model of Care]*.
- b. After implementation of ILOS, Contractor shall submit the following data and reports to DHCS to support DHCS' oversight of ILOS:
 - i. Encounter data.
 - a. Contractor must submit all ILOS encounters to DHCS using national standard specifications and code sets to be defined by DHCS. DHCS will provide guidance on invoicing standards for Contractor to use with ILOS Providers.
 - b. Contractor shall be responsible for submitting to DHCS all ILOS encounter data, including encounter data for ILOS generated under subcontracting arrangements.
 - c. In the event the ILOS Provider is unable to submit ILOS encounters to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor shall be responsible for converting ILOS Providers' invoice data into the national standard specifications and code sets, for submission to DHCS.
 - ii. Supplemental reporting. Contractor shall submit supplemental reports, on a schedule and in a format to be defined by DHCS.
- c. In the event of underperformance by Contractor in relation to its administration of ILOS, DHCS may administer sanctions as set out in Exhibit E, Attachment 2, Provision 16, Sanctions.

15. ILOS Quality and Performance Incentive Program

- a. Contractor shall meet all quality management and quality improvement requirements described in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements set forth in associated guidance from DHCS for ILOS offered.

- b. Contractor may participate in a performance incentive program related to adoption of ILOS, building infrastructure and Provider capacity for ILOS, related health care quality and outcomes, and/or other performance milestones and measures, to be defined in forthcoming DHCS guidance.