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Department of Health Care Services



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DATE: September 15, 2021

ALL PLAN LETTER 21-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: ENHANCED CARE MANAGEMENT REQUIREMENTS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to all Medi-Cal managed care health plans (MCPs) regarding the provision of the Enhanced Care Management (ECM) benefit.

BACKGROUND:

The Department of Health Care Services (DHCS) released its California Advancing and Innovating Medi-Cal (CalAIM) proposal on October 29, 2019, in anticipation of the expiration of its Medi-Cal 2020 1115 Demonstration and 1915(b) Specialty Mental Health Services Waiver authorities. DHCS postponed the planned implementation of the CalAIM initiative, which was originally scheduled for January 1, 2021, due to the COVID-19 public health emergency, and released a revised CalAIM proposal on January 8, 2021. DHCS also submitted its CalAIM Section 1115 Demonstration and 1915(b) Waiver applications to the Centers for Medicare and Medicaid Services on June 30, 2021.¹ DHCS obtained statutory authority to establish the CalAIM initiative to support the stated goals of identifying and managing the risks and needs of Medi-Cal beneficiaries, transitioning and transforming the Medi-Cal program to a more consistent and seamless system, and improving quality outcomes.²

CalAIM is a multi-year initiative to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of broad delivery system, program, and payment reforms across the Medi-Cal program. The ECM benefit is a component of the CalAIM initiative that will be delivered through Medi-Cal managed care.

¹ Information regarding CalAIM, including updates regarding the implementation of various components of CalAIM, can be found at:

<https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx>.

² Assembly Bill 133 (Committee on Budget, Chapter 143, Statutes of 2021) can be accessed at: https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=20210220AB133.

ECM is a whole-person, interdisciplinary approach to comprehensive care management intended to address the clinical and non-clinical needs of high-cost, high-need managed care members through systematic coordination of services that is community-based, interdisciplinary, high-touch, and person-centered. ECM will build on the Whole Person Care (WPC) Pilots and Health Homes Program (HHP) efforts and activities.^{3,4} The care coordination and care management services that are currently being provided under WPC Pilots and HHP will transition to and be replaced by ECM. The ECM benefit will be phased in over time and available statewide through the managed care delivery system starting January 1, 2022. The WPC Pilots and HHP are scheduled to conclude on December 31, 2021.

POLICY:

Effective upon the DHCS determined ECM implementation date for each MCP in its respective county of operation, the MCP must administer ECM and provide the following seven core ECM services to eligible Members in applicable ECM Populations of Focus: 1) Outreach and Engagement; 2) Comprehensive Assessment and Care Management Plan; 3) Enhanced Coordination of Care; 4) Health Promotion; 5) Comprehensive Transitional Care; 6) Member and Family Supports; and 7) Coordination of and Referral to Community and Social Support Services.⁵

ECM Core Service Components:

The requirements under each core service component are described below.

1) Outreach and Engagement:

- a. The MCP is responsible for reaching out to and engaging Members who are identified to be eligible for ECM.

³ The WPC Pilots webpage can be accessed at the following link:

<https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx>.

⁴ The HHP webpage can be accessed at the following link:

<https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx>.

⁵ The ECM and In Lieu of Services (ILOS) implementation timelines are available in the ECM and ILOS Model of Care Cover Note, released in June 2021, and subject to any subsequent updates, which is available on the ECM and ILOS webpage at the following link:

<https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx>.

- 2) 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 must 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 their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, 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, substance use disorders (SUD), Long Term Services and Supports (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, 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.
- 3) Enhanced Coordination of Care**, which must 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 since their input is

necessary for successful implementation of the Member's goals and needs;

- c. Ensuring care is continuous and integrated among all service Providers and refers to and follows 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 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 members, legal guardians, authorized representatives, caregivers, and authorized support persons, as appropriate, consistent with the Care Management Plan.
- 4) Health Promotion**, which must include, but is not limited to:
- a. Working with the Member to identify and build on successes and potential family and/or support networks;
 - b. Providing services to encourage and support the Member to make lifestyle choices based on healthy behavior, with the goal of supporting the Member's 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.
- 5) Comprehensive Transitional Care**, which must 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 the Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions to,

from, and among treatment facilities, including admissions and discharges;

- iii. Tracking each Member's admission and 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 and reconciliation; and
- v. Providing adherence support and referral to appropriate services.

6) Member and Family Supports, which must include, but are not limited to:

- a. Documenting the Member's authorized family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as applicable;
- b. Ensuring all required authorizations are in place to ensure effective communication between the ECM Providers, MCP, and the Member and their family members, authorized representatives, legal guardians, caregivers, and authorized support persons, as applicable;
- c. Activities to ensure the Member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, are knowledgeable about the Member's conditions, 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;
- d. Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as applicable;
- e. Identifying supports needed for the Member and/or their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, to manage the Member's condition and assist them in accessing needed support services;
- f. Providing appropriate education for the Member and their family members, legal guardians, authorized representatives, caregivers, and/or authorized support persons, as applicable, about care instructions for the Member; and,
- g. Ensuring that the Member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, have a copy of the Member's Care Management Plan and information about how to request updates.

- 7) Coordination of and Referral to Community and Social Support Services,** which must include, but is not limited to:
- a. Determining appropriate services to meet the needs of the Member, including services that address social determinants of health needs, such as housing, and services offered by the MCP as ILOS; and
 - b. Coordinating and referring the Member to available community resources and following up with the Member to ensure services were rendered (i.e., “closed loop referrals”).

Additional Guidance:

ECM Populations of Focus (POF)

MCPs must proactively identify and offer ECM to their high-need, high-cost Members who meet the POF criteria listed in the Contract and detailed in Attachment 1 of this APL.

ECM Provider Standard Terms and Conditions (STCs)

MCPs must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for Members and, to this end, must contract with ECM Providers to provide ECM services in a community based, in-person manner. MCPs are required to incorporate STCs provided by DHCS, in addition to their own terms, to develop their contracts with ECM Providers.⁶

ECM Model of Care (MOC)

MCPs must develop and submit to DHCS for review and approval an ECM MOC, which is the MCP’s framework for providing ECM. MCPs must complete and submit their MOCs in accordance with the DHCS approved MOC Template.⁷ MCPs must submit to DHCS any significant updates to their MOCs for DHCS review and approval at least 60 calendar days in advance of significant changes or updates. Significant changes may include, but are not limited to, changes to the MCP’s approach to administer or deliver ECM services, approved P&Ps, and Subcontractor Agreement(s) boilerplates.

ECM Encounter Data Reporting

MCPs must report all ECM encounters to DHCS, using the defined set of ECM

⁶ The finalized ECM and ILOS Provider STCs document, released in June 2021, and subject to any subsequent updates, is available on the ECM and ILOS webpage that can be accessed at the following link: <https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx>.

⁷ The finalized MOC Template document, released in June 2021, and subject to any subsequent updates, is available on the ECM and ILOS webpage that can be accessed at the following link: <https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx>.

Healthcare Common Procedure Coding System codes and modifiers.⁸

ECM Policy Guide

The ECM Policy Guide outlines ECM policies and contains details of MCPs' contractual requirements for ECM. The ECM Policy Guide includes operational guidelines, including reporting requirements for ECM. MCPs must use the ECM Policy Guide as a key resource for implementation and administration of ECM. The ECM Policy Guide is posted to the ECM and ILOS webpage.⁹ The ECM Policy Guide also contains information related to MCPs' use of DHCS ECM/ILOS Billing & Invoicing Guidance as well as ECM Member Information File Guidance. DHCS may update the ECM Policy Guide to reflect the latest ECM requirements and guidelines. DHCS will notify MCPs whenever the ECM Policy Guide is updated.

ECM Rates:

For the Calendar Year 2022 rating period, a two-sided, symmetrical risk corridor will be in effect for applicable revenues and expenditures associated with ECM, as determined by DHCS. Further details of this risk corridor will be incorporated into this APL via a subsequent revision, or into the Contract via an amendment. DHCS reserves the right to continue the risk corridor for subsequent rating periods, subject to actuarial judgment and consultation with affected MCPs.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, ECM requirements, contract requirements, and other DHCS guidance, including APLs and Policy Letters.¹⁰ These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

⁸ The finalized ECM and ILOS Coding Options document, released in June 2021, and subject to any subsequent updates, is available on the ECM and ILOS webpage that can be accessed at the following link: <https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx>.

⁹ The ECM Policy Guide released in September 2021, and subject to any subsequent updates, is available on the ECM and ILOS webpage that can be accessed at the following link: <https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx>.

¹⁰ For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

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If you have any questions regarding this APL, please contact your MCO Contract Manager and the DHCS CalAIM mailbox at CalAIM@dhcs.ca.gov.

Sincerely,

Original signed by Bambi Cisneros

Bambi Cisneros, Acting Chief
Managed Care Quality and Monitoring Division