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-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.

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 or more of the Populations of Focus for ECM.

2. **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 MCP, as described in the DHCS-MCP ECM and ILOS Contract, 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.

2. ECM Provider Requirements

Provider Experience and Qualifications

a. ECM Provider shall be experienced in serving the ECM Population(s) of Focus it will serve;

b. ECM Provider shall have experience and expertise with the services it will provide;

c. ECM Provider shall comply with all applicable state and federal laws and regulations and all ECM program requirements in the DHCS-MCP ECM and ILOS Contract and associated guidance;

d. 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;

e. ECM Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways;

f. ECM Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral

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

g. ECM Provider shall 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).

Medicaid Enrollment/Vetting for ECM Providers

h. If a State-level enrollment pathway exists, ECM Provider shall enroll as a Medi-Cal provider, 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 ECM Provider, the ECM Provider must comply with the MCP's process for vetting the ECM Provider, 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.

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, to determine if the Member is eligible for ECM, consistent with the MCP's process for such request.

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 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 who interacts directly with the Member and/or their

family member(s), guardian, 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 (SDOH) needs, regardless of setting.

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.
    iii. MCP must implement any requested ECM Provider change within thirty days.

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 Provider Standard Terms and Conditions, the DHCS-MCP ECM ILOS 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 and engaging each assigned Member into ECM, in accordance with MCP's Policies and Procedures .

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 in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the Member's consent.
    i. ECM Provider shall use the following modalities, as appropriate and as authorized by the Member, 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. Telehealth

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 obtain, document, and manage Member authorization for the sharing of Personally Identifiable Information between MCP and ECM, ILOS, and other Providers involved in the provision of Member care to the extent required by federal law.
b. Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law.
c. When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to the MCP.
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 sending a Notice of Action (NOA) notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the NOA. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex 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-need and/or high-cost Medi-Cal Members enrolled in managed care. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.
    i. If the ECM Provider subcontracts with other entities to administer ECM functions, the ECM Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth here and that its Subcontractors comply with all requirements in these Standardized Terms and Conditions and the DHCS-MCP ECM ILOS Contract.
b. ECM Provider shall:
    i. Ensure each Member receiving ECM has a Lead 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 or duplication of services from multiple sources; and
iv. Follow MCP instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

c. ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS 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, in compliance with MCP's Policies and Procedures, as follows:
    i. Outreach and Engagement of MCP Members into ECM.
    ii. Comprehensive Assessment and Care Management Plan, which shall 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 innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
        b. Identify 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 plan by working with the Member and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or 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 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 care plan 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, who's 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), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

iv. Health Promotion, which shall adhere to federal care coordination and continuity of care requirements (42 CFR 438.208(b)) and 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 who are likely to experience a care transition:

i. Developing and regularly updating a transition of care 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.

vi. Member and Family Supports, which shall include, but are not limited to:

a. Documenting a Member's designated family member(s), AR, 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 MCP, as applicable;

b. Activities to ensure the Member and/or their family member(s), AR, 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), AR, guardian, caregiver, and/or authorized support person(s);
d. 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;
e. Providing for appropriate education of the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care instructions for the Member; and
f. Ensuring that the Member has a copy of their Care Plan and information about how to request updates.

vii. 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 SDOH needs, including housing, and services offered by MCP 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 mandatory, Provider-focused 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, and following DHCS guidance for data sharing where applicable:
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., Homeless Management Information System (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 DHCS-defined code sets, ECM Provider shall submit an invoice to the MCP with a minimum set of data elements (to be defined by DHCS) necessary for the MCP to convert the invoice to an encounter 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 for ECM

a. MCP shall pay contracted ECM Providers for the provision of ECM in accordance with contract established between MCP and ECM Provider.
b. ECM Provider is eligible to receive payment when ECM is initiated for any given MCP Member.
c. MCP shall pay 90 percent 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 percent 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

Key terms are defined as follows:

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 are medically appropriate, cost-effective alternatives to services or settings under the State Plan. ILOS are optional for both the MCP and the Member and must be approved by DHCS. DHCS already has pre-approved the list of ILOS included in Section 2: DHCS-Approved ILOS ("pre-approved ILOS"). services *[See ILOS Section 2: DHCS Pre-Approved ILOS].*

b. **ILOS Provider:** a contracted Provider of DHCS-approved ILOS. ILOS Providers are entities with experience and/or training providing one or more of the ILOS approved by DHCS.

2. Overview

a. The ILOS Provider may elect to offer the following DHCS-authorized ILOS to Members (check as applicable):

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

3. ILOS Provider Requirements

a. ILOS Providers for whom a State-level enrollment pathway exists, shall 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, the ILOS Provider will comply with the MCP's 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.
b. Experience and training in the elected ILOS.
    i. The ILOS Provider shall have experience and/or training in the provision of the ILOS being offered.
    ii. The ILOS Provider shall have the capacity to provide the ILOS in a culturally and linguistically competent manner, as demonstrated by a successful history of providing such services, training or other factors identified by the MCP.
c. If the ILOS Provider subcontracts with other entities to administer its functions of ILOS, the ILOS Provider shall ensure agreements with each entity bind each entity to applicable terms and conditions set forth here.

4. Delivery of ILOS

a. ILOS Provider shall deliver contracted ILOS services in accordance with DHCS service definitions and requirements.
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 and act upon Member referrals from MCP for authorized ILOS, unless the ILOS Provider is at pre-determined capacity;
    ii. Conduct outreach to the referred Member for authorized ILOS as soon as possible, including by making best efforts to conduct initial outreach within 24 hours of assignment, if applicable;
    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 Providers, other ILOS Providers and the MCP;
    v. Comply with cultural competency and linguistic requirements required by federal, State and local laws, and in contract(s) with the MCP; and
    vi. Comply with non-discrimination requirements set forth in State and Federal law and the Contract with MCP.
d. When federal law requires authorization for data sharing, ILOS Provider shall obtain and/or document such authorization from each assigned Member,

including sharing of protected health information (PHI), and shall confirm it has obtained such authorization to the MCP.

i. Member authorization for ILOS-related data sharing is not required for the ILOS Provider to initiate delivery of ILOS unless such authorization is required by federal law. 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 prior authorization request(s) to MCP, unless a different agreement is in place (e.g., if the MCP has given the ILOS Provider authority to authorize ILOS directly).

e. 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.

f. 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 specifications based on national standards or 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 reimbursement 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 must have a system in place to accept payment from MCP for ILOS rendered.

i. MCP shall pay 90 percent of all clean claims and invoices within 30 days of receipt and 99 percent 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.