PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCCP2032</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: CalAIM Enhanced Care Management (ECM)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 03/09/2022
Effective Date: 01/01/2022 vs. DHCS</td><td colspan="4">Next Review Date: 11/13/2025
Last Review Date: 11/13/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 11/13/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports
B. MPCD2013 – Care Coordination Program Description
C. MCCP2007 – Complex Case Management
D. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
E. MCND9001 – Population Health Management Strategy & Program Description.
F. MPCR100 – Credential and Re-credential Decision Making Process
G. MPPR200 – Partnership Provider Contracts
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
I. MCCP2024 – Whole Child Model for California Children's Services (CCS)
J. MCUP3037 – Appeals of Utilization Management / Pharmacy Decisions
K. CMP36 – Delegation Oversight and Monitoring
L. MCCP2033-Community Health Worker (CHW) Services Benefit
M. MCCP2034 Transitional Care Services (TCS)

II. IMPACTED DEPTS:

A. Claims
B. Configuration
C. Compliance
D. Enhanced Health Services
E. Finance
F. Grievance and Appeals
G. Utilization Management
H. Member Services
I. Project Management Office
J. Provider Relations

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Closed Loop Referral: means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and

format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and/or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.

C. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

D. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(C) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

E. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).

F. 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.

G. Enhanced Care Management (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.

H. Individualized Care Plan (ICP): A Member-focused care plan designed to optimize the Member's health, function, and well-being.

I. Lead Care Manager (LCM): A Member's designated care manager for ECM, who works for the ECM Provider organization. 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 Community Support (CS). 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.

J. Point Click Care (PCC) A contracted external vendor platform designated as Partnership HealthPlan of California (Partnership)'s ECM data sharing and information exchange system. The use of the platform will be to advance communication and share information between ECM Members' care teams, integrate services, improve health outcomes, and streamline the ECM benefit delivery.

K. Release of Information (ROI): The process of providing access to Protected Health Information (PHI) to an individual or entity authorized to receive or review it.

L. Release of Information (ROI) Consent Form for ECM: A valid ROI form including the Member's signature and specified time frame to allow Partnership, ECM provider(s), lead case manager, community organizations, and relevant affiliates or entities of the Member's care team to share their health information.

M. Substance Use Disorder (SUD): A complex condition in which there is the uncontrolled recurrent use of a substance, which causes harmful consequences such as clinically significant impairment, health problems, and disabilities.
N. Serious Mental Health (SMH): A diagnosed mental, behavioral, or emotional disorder resulting in serious functional impairment that interferes with or limits the quality of life.
O. Whole Child Model (WCM): A comprehensive program for the whole child encompassing care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member insured by Partnership.
P. Whole Person Care (Whole Person Care): A five-year pilot program under California's 1115 Medicaid waiver to service high-risk populations using a collaborative approach across public and private entities to integrate and coordinate health, behavioral health, and social services. Partnership's Counties participating in the WPC pilot program were Marin, Mendocino, Napa, Shasta, and Sonoma.

IV. ATTACHMENTS:

A. Individualized Care Plan Example
B. Enhanced Care Management (ECM) Release of Information Form (ROI)

V. PURPOSE:

To describe Partnership HealthPlan of California's (Partnership's) Enhanced Care Management (ECM) benefit for Partnership Medi-Cal eligible Members, and to outline the collaboration between Partnership, ECM providers, and other community partners in the delivery of ECM services pursuant to the California Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032. The ECM benefit is unique and distinct from other care management programs. ECM builds on both the design and the learning from California's Whole Person Care Pilots (WPC) and Health Home Program (HHP). ECM, with Community Supports (CS), replaces both models, scaling up the interventions to a statewide care management approach. ECM offers comprehensive, "whole person" care management to high-need, high-cost Partnership Members. ECM services primarily:

A. Are delivered in-person to Members and/or their caregivers, Authorized Representative (AR), parents/guardians wherever Members may live, seek care, or prefer to access services within their community.
B. Focus largely on Social Determinants of Health (SDOH) such as housing/shelter, food instability, transportation and community supports to improve medical health outcomes and healthcare costs.
C. Populations of Focus within Partnership's membership that often need to access six or more separate delivery systems for care, benefits and/or support (e.g. Partnership, Medi-Cal fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.).
D. Have goals and interventions that aim to improve care coordination, integrate the delivery of services, facilitate community resources and improve health outcomes, while decreasing inappropriate health care utilization.

VI. POLICY / PROCEDURE:

A. ECM ELIGIBILITY
   1. Member must be assigned to Partnership for Medi-Cal benefits.
   2. ECM is voluntary, Members can decline or end ECM services upon initial outreach and engagement, or at any other time.
   3. Member must be identified as meeting criteria in one of the following Populations of Focus eligible for ECM benefits:
      a. Adult Populations of Focus: Homelessness, At Risk for Avoidable Hospital or ED Utilization, Serious Mental Health (SMH) or Substance Use Disorder (SUD),

Transitioning from Incarceration, At Risk of Institutionalization / Eligible for Long-Term Care Services, Nursing Facility Residents Transitioning to the Community, and/or Pregnant and Postpartum; Birth Equity.

b. Children & Youth Populations of Focus: Homelessness, At Risk for Avoidable Hospital or ED Utilization, Serious Mental Health (SMH) and/or Substance Use Disorder (SUD), Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond CCS Condition, Involved with Child Welfare, Intellectual or Developmental Disability (I/DD), and/or Pregnant and Postpartum; Birth Equity.

4. Adult Specific ECM Population of Focus Eligibility Criteria are defined as:
   a. Effective through June 30, 2023, Individuals Experiencing Homelessness – Adults 21 years of age or older and their families who:
      1) Have at least one complex physical, behavioral, or developmental health need with an inability to successfully self-manage for whom coordination of services would likely result in improved health outcomes and/or decrease in utilization of high-cost services, and
      2) Are experiencing homelessness defined as meeting one or more of the following conditions defined by the U.S. Department of Health and Human Services (HHS) 42 CFR §11302 criteria:
         a) Lacking adequate nighttime residence
         b) Having a primary residence that is a public or private place not designed for or ordinarily used for habitation
         c) Living in a shelter
         d) Exiting an institution into homelessness
         e) Will imminently lose housing in next 30 days
         f) Fleeing domestic violence, dating violence, sexual assault, stalking and other dangerous, traumatic, or life-threatening conditions relating to such violence
   b. Effective July 1, 2023, Individuals Experiencing Homelessness – Adults 21 years of age or older without dependent children/youth living with them who:
      1) Have at least one complex physical, behavioral, or developmental health need with an inability to successfully self-manage for whom coordination of services would likely result in improved health outcomes and/or decrease in utilization of high-cost services, and
      2) Are experiencing homelessness defined as meeting one or more following conditions defined by the U.S. Department of Health and Human Services (HHS) 42 CFR § 11302 criteria:
         a) Lacking adequate nighttime residence
         b) Having a primary residence that is a public or private place not designed for or ordinarily used for habitation
         c) Living in a shelter
         d) Exiting an institution into homelessness
         e) Will imminently lose housing in next 30 days
         f) Fleeing domestic violence, dating violence, sexual assault, stalking and other dangerous, traumatic, or life-threatening conditions relating to such violence
         g) Defined as homeless under other federal statutes
   c. At risk for Avoidable Hospital or ED Utilization – Adults, 21 years of age or older who:
      1) Have five (5) or more Emergency Department (ED) visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence, and/ or

2) Have three (3) or more unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

d. SMH or SUD – Adults, 21 years of age or older who:
   1) Meet the eligibility criteria for participation in or obtaining services through:
      a) Specialty mental health services (SMHS) delivered by the county's Mental Health Plan (MHP)
   2) The Drug Medi-Cal Organized Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) program, and are actively experiencing at least one complex social factor influencing their health, and
   3) Are experiencing at least one complex social factor influencing their health, and
   4) Meet one or more of the following criteria:
      a) High risk for institutionalization, overdose and/or suicide
      b) Use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care
      c) Two or more ED visits or two or more hospitalizations due to SMH or SUD in the past 12 months
      d) Pregnant and post-partum Members (12 months from delivery)

e. Transitioning from Incarceration – Adults 21 years of age or older who:
   1) Are transitioning from a correctional facility or transitioned from a correctional facility within the last 12 months, and
   2) Have at least one (1) of the following conditions:
      a) Mental illness
      b) Substance Use Disorder (SUD)
      c) Chronic Condition/Significant Clinical Condition
      d) Intellectual or Developmental Disability (I/DD)
      e) Traumatic Brain Injury (TBI)
      f) HIV/AIDS
      g) Pregnancy or Postpartum

f. At Risk for Institutionalization & Eligible for Long-Term Care – Adults, 21 years of age or older who are:
   1) Living in the community who meet the Skilled Nursing Facility (SNF) Level of Care (LOC) criteria; or who require a lower-acuity skilled nursing, such as a time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury; and
   2) Actively experiencing at least one complex social or environmental factor influencing their health; and
   3) Able to reside continuously in the community with wraparound supports

g. Nursing Facility Residents Who Want to Transition to the Community – Adults, 21 years of age or older who are:
   1) Interested in moving out of the institution, and
   2) Likely candidates to do so successfully, and
   3) Able to reside continuously in the community

h. Birth Equity – Adults, who are:
   1) Pregnant or Postpartum (through 12-month period); and
   2) Meet one of more of the following conditions:
      a) Eligible in any other adult or youth ECM Population of Focus;
      b) Effective January 1, 2024 - Subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

5. Children and Youth Specific ECM Population of Focus Eligibility Criteria are defined as:
   a. Effective July 1, 2023, Individuals Experiencing Homelessness – Homeless Families or Unaccompanied Children/Youth who:
      1) Are experiencing homelessness as defined by the U.S. Department of Health and Human Services (HHS) 42 CFR § 11302 criteria:
         a) Lacking adequate nighttime residence
         b) Having a primary residence that is a public or private place not designed for or ordinarily used for habitation
         c) Living in a shelter
         d) Exiting an institution into homelessness
         e) Will imminently lose housing in next 30 days
         f) Fleeing domestic violence, dating violence, sexual assault, stalking and other dangerous, traumatic, or life-threatening conditions relating to such violence
      2) Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;
         a) Living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations
         b) Living in emergency or transitional shelters
         c) Abandoned in hospitals or unable to discharge from the hospital to a safe place
   b. At Risk for Avoidable Hospital or ED Utilization – children and youth under the age of 21 who:
      1) Have three (3) or more Emergency Department (ED) visits in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence, and/ or
      2) Have two (2) or more unplanned hospital and/or short-term skilled nursing facility stays in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.
   c. SMH or SUD – Children and youth under the age of 21 who:
      1) Meet the eligibility criteria for participation in, or obtaining services through:
         a) SMHS delivered by MHPs
         b) The DMC-ODS or the DMC program.
   d. Transitioning from Incarceration – Children and youth under the age of 21 who are:
      1) Transitioning from a youth correctional facility or transitioned from being in a youth correctional facility within the past 12 months.
   e. Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition – Children and youth under the age of 21 who are:
      1) Enrolled in CCS or CCS WCM; and
      2) Experiencing at least one complex social factor influencing their health.
         a) Lack of access to food,
         b) Lack of access to stable housing,
         c) Difficulty accessing transportation
         d) Have a high measure (four or more) of ACEs screening;
         e) History of recent contacts with law enforcement, or crisis intervention services related to mental health and/or substance use symptoms.
   f. Children and Youth Involved in Child Welfare – children and youth who meet one or more of the following conditions:
      1) Under age 21 and are currently receiving foster care in California;
      2) Under age 21 and previously received foster care in California or another state within the last 12 months;

3) Aged out of foster care up to age 26 in California or another state
4) Under age 18 and are eligible for and/or in California's Adoption Assistance Program;
5) Under age 18 and currently receiving or have received services from California's Family Maintenance program within the last 12 months.

g. Intellectual and Developmental Disability (I/DD) – children and youth who are:
1) Diagnosed I/DD
2) Eligible in any other adult ECM Population of Focus

h. Pregnancy, Postpartum and Birth Equity – children and youth who are:
1) Pregnant or Postpartum (through 12-month period); and
2) Meet one of more of the following conditions:
a) Eligible in any other adult or youth ECM Population of Focus;
b) Effective January 1, 2024 - Subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

6. ECM may be offered to Members who do not meet DHCS' Population of Focus criteria but would benefit from the services. Partnership will handle these requests on a case-by-case basis.

B. JUSTICE INVOLVED MANAGED CARE TRANSITION
1. Partnership will use the DHCS Member assignment data when the Member's pre-release service aid code is activated and identified to ensure the Member receives coordination of care.
2. Partnership will support the creation and development of the reentry care plan for individuals as requested by the pre-release care management provider and/or their team of the ECM provider. This includes the following but is not limited to:
a. Receiving Member data
b. Warm handoff
c. Pre-release and post release
d. Receipt of person-centered care
e. Behavioral health links
f. Ensuring post-release ECM provider participates in behavioral health transition meetings, warm handoffs, follow-up planning, and ensure that warm handoffs include follow up-planning, including confirming transportation.
g. Assist with appointment scheduling for behavioral health services.
3. Partnership will ensure that the ECM provider supports scheduling for required post-release physical, behavioral health, and social services.
4. Partnership will ensure that the ECM provider connects individuals with needed services such as Community Supports, and benefits like Non-Emergency Medical Transportation, to assist the Member with reentering the community.

C. ECM EXCLUSION CRITERIA:
1. The following Members are excluded from receiving ECM benefit:
a. Member is sufficiently well managed through self-management or through another care management program.
b. Member is enrolled in Hospice or Intensive Outpatient Palliative Care.
c. Member enrolled in County-based Target Case Management (TCM) programs.
1) DHCS has allowed a one-year exception from July 1, 2024 to June 30, 2025 for cases where the member is receiving County-based TCM for addressing a communicable disease or for the sole purpose of receiving a home visiting program supporting the healthy development and well-being of children and families.
d. The Member is unresponsive to outreach attempts.
e. The Member displays unsafe or threatening behavior.
f. Member's physical environment poses a safety or security risk.

g. The member is receiving the Community Health Worker services benefit.
h. The Member is currently enrolled in duplicative care management waiver or DHCS demonstration programs such as:
   1) Multipurpose Senior Services Program (MSSP)
   2) Assisted Living Waiver
   3) Home and Community-Based Alternatives (HCBA) Waiver;
   4) HIV/AIDS Waiver
   5) HCBS Waiver for Individuals with Developmental Disabilities (DD)
   6) Self-Determination Program for Individuals with I/DD
   7) Cal MediConnect
   8) Fully Integrated Dual Eligible Special Needs Plans (FIDESNPs)
   9) Program for All-Inclusive Care for the Elderly (PACE)
   10) Family Mosaic Project
   11) California Community Transitions (CCT) Money Follows the Person (MFTP)
i. The Member is currently enrolled in Partnership's Basic Case Management or Complex Case Management Programs. For these Members, Partnership Care Coordination staff will work with the Member, their caregiver, Authorized Representative, and/or interdisciplinary care team to evaluate and coordinate the appropriate level of case management support.

D. ECM CORE SERVICE COMPONENTS:
1. The ECM benefit is to be delivered primarily in-person where a Member seeks or receives care. If the ECM provider is unable to connect with the Member in-person, or the Member has expressed an alternative communication method, outreach and engagement may be performed by teleconferencing, telehealth, televideo, or other protected communication tool in an effort to help build relationships as a supplement to in-person visits.
2. An assigned Lead Care Manager will act as the Members' primary point of contact and is responsible for coordinating care, at minimum, across the following delivery systems, including but not limited to; medical, behavioral, developmental, dental, long-term care supports and community resources/supports, Community Supports, regardless of setting or payor.
3. The ECM Provider will designate a Lead Care Manager who may be any of following: a nurse, a social worker, a care navigator, a housing navigator, or a community health worker. The Lead Care Manager is responsible for the delivery of ECM services as outlined in the ECM core services components below, and shall possess the appropriate experience and expertise in servicing the Member's Population of Focus.
4. If the Member has other Care Managers assisting or supporting them, it is the responsibility of the Member's ECM Lead Care Manager to coordinate with those individuals and/or entities to ensure a seamless experience for the Member, and to ensure non-duplication of services.
5. Partnership will ensure all ECM enrolled Members receive the following ECM core service components from their assigned ECM provider:
   a. Outreach and engagement
      1) The ECM provider shall use available data to prioritize outreach and engagement of Members addressing Members with the most immediate needs first.
      2) The ECM provider will maintain regular contact with Members to ensure there are not gaps in the activities designed to address an individual's health and social service needs. Upon engagement, the ECM Provider shall obtain the Member's, the Member's parent/guardian or authorize representative's written consent for ECM services using the attached ROI form in Attachment B.

a) The ECM Provider shall store a copy of this executed ROI form with the Member's ICP in the Point Click Care Platform to communicate back to Partnership the Member's data sharing preferences.

b. Comprehensive Assessment
   1) The ECM provider will perform a comprehensive assessment and/or risk screening to determine ECM engagement level and to inform the Member's ICP.
   2) Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care
   3) For Members with long-term services and supports (LTSS) needs, the Lead Care Manager shall utilize approved assessments and tools to develop care plans in accordance with federal requirements under 42 CFR 438.208(c), including:
      a) The ability for the Member to include people of their choosing to participate in the care planning process;
      b) The necessary information and support to ensure that the Member/individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
      c) Reflects cultural considerations of the Member and is conducted by providing information in plain language and in a manner that is accessible to the Member with disabilities and persons who are limited English proficient;
      d) Includes strategies for solving conflict or disagreement between Members and their care managers within the process, and also includes or references clear conflict-of-interest guidelines for all planning participants;
      e) Offers choices regarding the services and/or supports the Member may receive and from whom;
      f) Includes a method for the Member/individual to request updates to the plan as needed
      g) Records the alternative home and community-based settings that were considered in the care planning process with the Member/individual
      h) When available, Partnership shall share the results of the Health Risk Assessment (HRA), which includes the required LTSS referrals questions, with ECM providers when a Member is assigned to them.
      i) The ECM provider shall use the Members' responses to the HRA in developing the Members' Individualized Care Plan (ICP).

c. Individualized Care Plan (ICP)
   1) The ECM provider shall work with the Member, guardian, caregiver, AR, and/or other authorized person(s) as appropriate to assess strengths, risks, needs, goals and preferences to make recommendations for service needs.
   2) The Lead Care Manager is responsible for documenting and updating the Member's ICP as needed to ensure there are no gaps in care.
   3) The ICP shall contain at minimum, needs, strategies, and patient prioritized goals surrounding care coordination needs for services including but not limited to the following
      a) Physical health
      b) Mental health
      c) Developmental health
      d) Substance Use Disorder (SUD)
      e) Long Term Support Services (LTSS)
      f) Oral health

g) Necessary community-based and/or social services
h) Health Promotion
i) Transitional Care Needs
j) Member and/or Family Supports

4) The Lead Care Manager shall make available to the Member a copy of the ICP upon enrollment in ECM and/or upon Member request.
5) The ECM Provider shall ensure that the Member's ICP contains appropriate clinical oversight.

d. Enhanced Coordination of Care
1) Organizing patient care activities, as laid out in the ICP, and sharing information with those involved as part of the Member's multi-disciplinary care team.
2) Implementing activities identified in the Member's ICP.
3) 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.
4) 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, long-term support services (LTSS), oral health trauma-informed care, and necessary community-based and social services, including housing, as needed.
5) 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.
6) 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.
7) Ensuring regular contact with the Member and their family member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s), when appropriate, consistent with the Individualized Care Plan (ICP).

e. Health Promotion
1) Working with Members to identify and build on successes and potential family and/or support networks
2) 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
3) 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.

f. Transitional Care Services
1) Develop strategies to reduce avoidable Member admissions and/or readmissions to acute or skilled settings.
a) For Members who are currently hospitalized, the ECM Lead Care Manager shall provide Transitional Care Services pursuant to the DHCS Population Health Management (PHM) Strategy Guide. At minimum, the ECM Lead Care Manager shall:
1) Prior to discharge, compete a discharge assessment to assess the Member's risk of re-institutionalization, re-hospitalization, and risk of SMHI and/or SUD;
2) Ensure that medication reconciliation is conducted pre- and post-transition;

3) Ensure Closed Loop Referrals to Community Supports and coordination with county social service agencies and waiver agencies for In-Home Support Services (IHSS) and/or other Home and Community Based Services are coordinated as appropriate;
4) When applicable, ensure Members with SUD and mental health needs receive treatment for those conditions upon discharge;
5) Provide a discharge planning document to the Member, Member's parents, legal guardians, or authorized representatives, as appropriate, when being discharged from a hospital, institution or facility. This discharge plan must include information about the hospital, institution or facility to which the Member was admitted; the Member's pre-admission status (ex: living arrangements, physical and mental function, SUD needs, social support, DME uses, etc.); pre-discharge factors (ex: medical condition(s), physical and mental function, financial resources, social supports at the time of discharge, etc.); recommendations made for the Member after discharge (ex: placement, DME, follow-up, etc.); summary of the nature and outcome of participation of Member, Member's parents, legal guardians, or authorized representatives in the discharge planning process; anticipated problems in implementing post-discharge plans, and information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.
6) 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.
7) Coordinating medication review/reconciliation
8) Providing adherence support and referral to appropriate services.

g. Member and Family Supports, which shall include, but are not limited to:
1) Documenting a Member's authorized family member(s), guardian, Authorized Representative, 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), Authorized Representative, guardian, caregiver, and/or authorized support person(s)
2) Activities to ensure the Member and/or their family member(s), guardian, Authorized Representative, 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.
3) Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and/or family member(s), guardian, Authorized Representative, caregiver, and/or other authorized support person(s)
4) Identifying supports needed for the Member and/or their family member(s), Authorized Representative, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services
5) Providing for appropriate education of the Member and/or their family member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s) about care instructions for the Member
6) Ensuring that the Member has a copy of their ICP and information about how to request

updates

h. Coordination of and Referral to Community and Social Support Services
   1) 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 Community Supports (CS) under CalAIM, see Partnership Policy MCUP3142 CalAIM Community Supports.
   2) Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

6. Members enrolled in the ECM benefit shall participate in differing levels of engagement as determined by both the Member and ECM Provider through the development of the Member's ICP. At minimum, Partnership expects that the ECM provider attempts and/or makes successful engagement with the Member once a month via in-person, telehealth, telephonic or televideo where appropriate.
7. Through the delivery of ECM both the ECM provider and/or Member's Lead Care Manager shall use culturally and linguistically appropriate methods of communication with the Member.
8. Partnership shall recruit ECM Providers that have diverse care management staff reflecting the populations they serve.

D. MEMBER IDENTIFICATION & AUTHORIZATION OF ECM SERVICES

1. In accordance with Partnership's Population Health Management Program and activities, Partnership proactively screens, stratifies, segments and assigns risk tiers for Partnership's Membership population using Partnership's proprietary Risk Score Model and additional Member demographic, utilization, and social data. Through this process, Partnership identifies and prioritizes those Members who present with the highest needs and risks and directs them to appropriate interventions and services; including the Enhanced Care Management benefit. See policy MCND 9001 Population Health Management Strategy & Program Description.
2. Partnership will also proactively analyze data and/or information received directly from DHCS, counties, providers, members and/or others to identify additional Members eligible for the ECM benefit. Sources may include, but are not limited to:
   a. Enrollment data
   b. Utilization/claims data including
      1) Encounter data
      2) Pharmacy data
      3) TAR clinical data (ex: Minimum Data Set Survey data from LTCs, CBAS Individualized Plan of Care, etc.)
      4) Laboratory data, as available
   c. Screening or assessment data (ex: Health Risk Assessment for Seniors or Persons with Disabilities (SPD), etc.)
   d. Clinical information on physical and/or behavioral health
   e. ~~SMH~~/SUD data, as available Risk stratification information for children in Partnership's Whole Child Model (WCM) program
   f. Information about social determinants of health, including standardized assessment tools and/or current ICD codes
   g. Regional Center data feeds
   h. Results from any available Adverse Childhood Experience (ACE) screening
   i. Other cross-sector data and information, including housing, social services, foster care, criminal justice history, school absentee or truancy and other information relevant to the ECM Populations

of Focus (e.g., Homeless Management Information System (HMIS), available data from the education system, etc.).

j. Plan Data Feed from DHCS
k. 1915c waiver wait lists
l. Claims, laboratory, request for services and/or encounters shall be used to internally identify Members who are pregnant or postpartum and meet other ECM Population of Focus criteria.
m. Other data and/or risk stratification reports

3. Partnership shall compile a monthly report of potentially eligible ECM Members based upon Partnership's available data and analysis.
   a. The list of Members on this report shall be prioritized; with the Members believed to have the immediate needs and in need of outreach and engagement listed first.
   b. This prioritized report shall be shared and assigned to the appropriate ECM provider(s) so that outreach and engagement with Members can be initiated.
4. In addition to using available data, Partnership encourages direct referrals for Members to access ECM services. Information on directly referring Members to ECM, along with Partnership's ECM referral form can be found on Partnership's website as well as information in the Partnership Member/provider newsletter. In addition, Partnership shares information about how to refer Members for ECM services at community partner meetings, provider roundtables and/or community events.
5. Direct referrals for ECM can come from a multitude of sources, including but not limited to:
   a. Providers, ECM providers, and/or community-based organizations via phone, mail, or fax.
   b. Members and/or their family Member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s) via phone, mail, or Partnership Member portal.
   c. Partnership Care Coordination Department
   d. Internal Partnership Department (ex: Claims, Utilization Management, Pharmacy, Member Services, Population Health Management, etc.)
   e. County partners (ex: Health and Human Services, Behavioral Health, Public Health, Social Services, Child Welfare, Continuums of Care, etc.)
   f. Hospitals, including CCS Specialty Care Centers
   g. Probation and/or parole departments
   h. Nursing Homes / Skilled Nursing Facilities
   i. Home Health Agencies
   j. Community Based Adult Services (CBAS) providers
   k. Home and Community Based Waiver Providers
   l. Area Agencies on Aging
   m. Centers for Independent Living
   n. Regional Centers
   o. Schools
   p. Local Foster Care Offices
   q. First 5
   r. Community Based Organizations
   s. Local Perinatal Programs
   t. Community Supports Providers
   u. Correctional facilities, prisons, jails, youth/juvenile facilitates
6. Upon receipt of a direct ECM referral, Partnership's designated staff shall conduct an initial screening for ECM services, and assign Members who may qualify for ECM to an in-network ECM provider for a Comprehensive Assessment and ICP.
   a. For Members who meet the initial screening criteria, Partnership's designated staff shall:
      1) Inform the Member and/or their AR of the Member's referral assignment via

telephone, mail and/or Member portal when appropriate, and

2) Electronically inform the ECM provider of the referral assignment in the electronic systems denoted below in section VI.H.

7. Partnership will require specific ECM referral information from entities in accordance with DHCS ECM referral standards and form template guidance.
   a. Partnership will acknowledge receipt of the ECM referral.
   b. Partnership will notify the individual or entity if there are errors that must be corrected before submission.
8. For Members who do not meet initial screening criteria, Partnership's Care Coordination Department shall offer other available case management and/or care coordination services (e.g. Complex Case Management, etc.) For Members who qualify for the ECM benefit, Partnership requires that a Treatment Authorization Request (TAR) be submitted to Partnership for review and approval of ECM services. See Partnership policies MCUP3041 - Treatment Authorization Request (TAR) Review Process and MCUP3143 Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS).

E. ECM PROVIDER ASSIGNMENT

1. The Member's assigned ECM provider must meet the following standards:
   a. Must be experienced in serving the ECM Population(s) of Focus they will serve. For Members with long-term services and supports (LTSS) needs, the Lead Care Manager will be experienced and/or have received training in person-centered planning as required by federal law.
   b. Have experience and expertise with the services they provide.
   c. Comply with all applicable state and federal laws and regulations and all ECM program requirements.
   d. 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.
2. Members will be assigned to their approved ECM provider after taking into account their known preferences, previous provider relationships, and/or health needs.
   a. If the Member's assigned Primary Care Provider (PCP) is a contracted ECM Provider, Partnership shall assign the Member to the PCP as the ECM Provider, unless the Member has expressed a different preference or Partnership identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
   b. If a Member receives services from a Specialty Mental Health Plan for severe emotional disturbance (SED), substance use disorder (SUD), and/or serious mental health (SMH) and the Member's behavioral health Provider is a contracted ECM Provider, Partnership shall assign that Member to that behavioral health Provider as the ECM Provider, unless the Member has expressed a different preference or Partnership identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
   c. For Members enrolled in Partnership's Whole Child Model for CCS, Partnership shall assign that Member to a CCS Case Manager affiliated with a contracted ECM provider for ECM services, unless the Member or family has expressed a different preference or Partnership identifies a more appropriate ECM Provider given the Member's individual needs and health conditions. For more information on case management and care coordination services provided under the Whole Child Model for CCS, see Partnership Policy MCCP2024.
3. Members can request to change their assigned ECM provider by contacting Partnership's Care Coordination department via phone, mail or Partnership's Member Portal. Upon receipt of a Member's request for reassignment, Partnership's Care Coordination department shall contact the Member to acknowledge the request, and to work

collaboratively with the Member for reassignment to a new ECM provider within 30 days of the request date.

4. Partnership will ensure that ECM provider communication of a Member's assignment to designated ECM provider occurs within ten (10) business days of authorization. Partnership shall communicate the Member's assignment using the information platform described in section VI. H.
5. Partnership will document the Member's ECM Lead Care Manager in its internal electronic platform and systems.
6. As contracted network providers, both ECM providers and PCPs alike can work with Partnership's Provider Relations Department representatives to provide feedback regarding ECM referrals or concerns they may have about ECM Member assignments.

F. DISCONTINUATION OF ECM

1. The ECM provider shall notify Partnership, and the interdisciplinary care team, when a Member discontinues ECM services. Examples of discontinuation include:
   a. The Member has graduated and is no longer in need of intensive case management or care coordination services. Graduation criteria for ECM shall include:
      1) The Member has met all identified goals on their ICP addressing any needs for their medical, behavioral health, dental, long-term supports, or community referral needs as indicated. (e.g. connection to primary/specialty care, appropriate utilization of health care services, connection to mental health, connection to dental care, connection to Community Based Adult Services (CBAS) or In-Home Support Services (IHSS), referrals and linkages to Community Supports, etc.).
      2) The Member has demonstrated an ability to self-manage their health. (e.g. able to make their own appointments, understands warning signs or triggers for their medical and/or mental health conditions and can implement strategies to prevent acute exacerbations, ability to manage their medications or treatment regimens, verbalizes an understanding of who to call if new health problems arise, has obtained all necessary durable medical equipment (DME), etc.).
      3) The Member is connected to appropriate community service(s) and/or Community Supports to address their short-term and long-term needs (e.g. housing, meal delivery, transportation, disease management programs/classes, support groups, etc.).
   b. The Member expresses that they no longer wish to receive ECM
   c. The Member is unresponsive or unwilling to engage in ECM outreach & engagement attempts by the ECM provider
   d. The Member, who was previous enrolled in ECM, no longer responds to the ECM provider's attempts to contact, locate or engage the Member
   e. The Member is deceased
   f. The Member loses Partnership Medi-Cal eligibility
   g. The Member moves out of Partnership's service area
   h. The Member becomes incarcerated for more than 30 days
   i. After attempts to reassign the Lead Care Manager or remedy ECM service delivery, the ECM provider can no longer provide services. (ex: patient behavior, unsafe environment, etc.)
   j. The Member is transitioned to an alternative care management or care coordination program/services that can better meet the Member's goals, preferences and care needs.
      1) In order to prevent gaps in care or duplication of ECM services, ECM providers are to plan and coordinate to transfer a Member's care needs within 30 days to an alternative care management or care coordination provider. Examples of such

providers/programs include, but are not limited to:
   a) Hospice
   b) Partnership's Intensive Outpatient Palliative Care Program
   c) Long-Term Dialysis
2) When appropriate, the ECM provider and care team are to coordinate services and transition the Member to a lower level or alternative care management program based on the Member's needs, goals, preferences and progress on ICP, including but not limited to Partnership's Complex Case Management Program.

2. Upon discontinuation of ECM, Partnership shall:
   a. Notify the ECM provider
   b. Issue a Notice of Action (NOA) to the Member regarding discontinuation of ECM services. The notification will serve to inform the Member of their rights per DHCS, including their right to appeal the decision 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 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates. For more information, see policy MCUP3037 Appeals of Utilization Management / Pharmacy Decisions.

G. CONTINUITY OF CARE
1. Beginning January 1, 2022 for Members who are in process or currently enrolled in a Whole Person Care Pilot program, who are identified by the WPC Lead Entity as belonging to an ECM Population of Focus, Partnership will automatically authorize ECM services for six (6) months pursuant to DHCS implementation schedule.
   a. Transitioning Members must be assessed within six (6) months of their initial authorization, or other timeframes provided by DHCS, to determine most appropriate level of care management services and ECM benefit eligibility per the criteria as outlined above. ECM providers shall:
      1) Complete a comprehensive assessment, ICP and submit to Partnership a Treatment Authorization Request (TAR) pursuant to Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process for continued ECM services.
      2) Transition Members who no longer meet the criteria for ECM services as outlined in section VI.F. Discontinuation of ECM.
      3) Notify Partnership of transitioning Members who have been discharged as outlined in section VI.F. above.
   b. Partnership shall utilize existing data exchange platforms described in section VI.H. to coordinate with WPC Lead Entities to ensure a smooth transition and warm hand-off for mutual Members entering into or being discharged from the ECM benefit.
   c. Both the WPC Lead Entity and Partnership shall work collaboratively to inform Members via written notice of the transition to the ECM benefit pursuant to DHCS' guidance.
2. Partnership shall attempt to contract with each WPC Lead Entity as an ECM provider to provide Members with ongoing care coordination and continuity of care in WPC Pilot Counties.
   a. Partnership shall submit to DHCS for prior approval any requests for exceptions to the WPC contracting requirement. Permissible exceptions to contracting are:
      1) There is a justified quality of care concern with the ECM Provider(s)
      2) Partnership and ECM Provider(s) are unable to agree on contracted rates
      3) ECM Provider(s) is/are unwilling to contract
      4) ECM Provider(s) is/are unresponsive to multiple attempts to contract
      5) ECM Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the Contractor; and/or

6) For ECM Provider(s) without a state-level pathway to Medi-Cal enrollment, ECM Provider(s) is/are unable to comply with the Partnership processes for vetting qualifications and experience

b. For transitioning Members for whom Partnership is not able to enter into a contract with the WPC Lead Entity, Partnership shall authorize ECM services with an in-network ECM provider.

3. Members transitioning to Partnership from another managed care plan and /or fee-for-service Medi-Cal who are currently enrolled in ECM, shall automatically be authorized for ECM services. For these Members:
   a. Partnership shall use available utilization data to proactively identify any new Members who are in receipt of ECM within the previous 6 months of their assignment to Partnership, and initiate continued ECM authorization.
   b. Newly assigned Partnership Members or their AR may contact Partnership directly to request continued ECM benefits and Partnership shall expedite this request.
   c. If a pre-existing relationship has been established and the ECM provider is part of Partnership's ECM network or agrees to a letter of agreement until an agreement is reached, Partnership will assign the Member to their existing ECM provider to ensure the Member's relationship is not disrupted.
   d. Partnership shall contact and work with the Member's previous health plan and/or ECM provider to obtain access to the Member's ICP and ensure services are connected appropriately.
   e. ECM services shall be authorized for up to six (6) months. At which time, the Member shall be reassessed for services in accordance to the policy criteria shared above in sections VI. A, B, and F.

H. DATA SHARING TO SUPPORT ECM
1. Partnership has an Information Technology (IT) and data analytic infrastructure to support the delivery of the ECM benefit. Key features of Partnership's systems include, but are not limited to:
   a. Systems and agreements with agencies that support the information captured for ECM Member identification as outlined in section VI.D.
   b. Secure data sharing between, Partnership, ECM provider, the Member, and other providers in support of ECM.
   c. The ability to receive, process, and send encounters from ECM providers to DHCS.
   d. The ability to receive and process supplemental reports from ECM providers.
2. ECM providers shall use the "Point Click Care" module of the cloud-based Point Click Care Platform (see III. B) in the delivery of ECM services. This platform shall allow Partnership and ECM providers to:
   a. Share real-time information between ECM Members' care teams and providers.
   b. Serve as a mechanism for Partnership and ECM providers to share ECM Member assignment files (e.g. targeted engagement lists, referrals, discontinuation or disenrollment from ECM services, etc.)
   c. Track Emergency Department and Inpatient Hospital Admissions as they are occurring.
   d. Perform and run periodic reports of performance on certain quality measures and/or metrics.
3. Partnership will 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.

I. ECM PROVIDER NETWORK DEVELOPMENT
1. Partnership will contract with providers that meet DHCS' and Partnership requirements
2. Partnership will collaborate with other Managed Care Plans (MCP) in the applicable county to identify qualified ECM providers with which to contract.

3. Partnership will make every effort to contract and build a sufficient network of ECM providers
4. Partnership will collaborate with other MCPs in the county/counties in which it operates to achieve mandatory overlap of the provider network

J. ECM PROVIDER OVERSIGHT & QUALITY MONITORING

1. Partnership will perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the DHCS Contract amendment and DHCS APL 21-012: Enhanced Care Management Requirements.
    a. Partnership will perform quarterly audits, or more frequently as needed, to evaluate ECM provider performance and compliance to ensure State, Federal, and contractual requirements are met. At a minimum, the following shall be reviewed:
        1) ECM Files:
            a) Visit documentation showing minimum number of visits
            b) Delivery of the Core Services components of ECM
            c) Release of Information (ROI)
        2) ECM provider's policies and procedures as they relate to the delivery of ECM, including but not limited to:
            a) Internal policies
            b) Job descriptions
            c) Training Materials
            d) Organizational charts
            e) Model of Care for Justice Involved providers that includes:
                i. Provisions for a "warm handoff" between ECM providers within the correctional facility and those who will provide ECM services upon release at least 2 weeks prior to date of expected release.
                ii. Ensuring the ECM provider meets the Member within 1-2 days of release wherever possible
                iii. A second follow up ECM appointment occurs within 1 week of release.
                iv. The ECM provider leverages the reentry plan that was developed in the pre-release period as the post-release care management plan.
        3) Quality and monitoring reports to guide improvement across the network
            a) Point Click Care reports
            b) Partnership internal monitoring reports & dashboards
            c) Member experience surveys
            d) Referral patterns
            e) ECM Provider Capacity Reports
    b. Partnership has developed its ECM contracts using the DHCS ECM Provider Standard Terms and Conditions and incorporated all of its ECM provider requirements, including all monitoring and reporting expectations and criteria.
2. Partnership shall support ECM Provider peer sharing meetings to report on activities at a frequency of every two (2) months for new sites, during the first six (6) months of services, and at a frequency of every six (6) months for existing sites or at a frequency deemed appropriate for support as monitored by Partnership.
    a. Topics shall include, but not be limited to: billing, authorizations, best practices for operational efficiencies, successful strategies to improve outreach and engagement efforts, case management and care coordination approaches for complex populations, health equity, ECM policy updates, etc.
3. ECM providers shall conduct Member experience surveys of enrolled Members at least once annually and share a summary of this survey with Partnership.
4. Over time, Partnership shall review key performance indicators of ECM providers

and ECM benefit to provide benefit monitoring and oversight as well as address quality standards and to identify areas of improvement. Examples include, but are not limited to:

a. ECM Member-level outcomes related to medical cost, utilization and/or health status'
b. ECM referral sources and patterns
c. ECM provider key performance indicators, including but not limited to: Member capacity, successful outreach attempts, # of FTEs providing ECM, etc.
d. Results of ECM Member surveys

5. Partnership will inform PCPs, Members, family Member(s) guardian, caregiver, and/or other authorized support person(s) and community partners about the ECM benefit through routine Member communication pathways, including but not limited to:
   a. Partnership Member Handbook
   b. Partnership Website
   c. Required DHCS notices
   d. Webinars
   e. Member/Provider newsletters

J. HEALTH EQUITY FOR ENHANCED CARE MANAGEMENT (ECM)
1. Health Equity is a priority for DHCS and Partnership. Partnership shall ensure that ECM services are delivered in a culturally relevant, person-centered manner by:
   a. Encouraging ECM providers to hire and train care management staff with experience and expertise in serving the unique Population of Focus' under ECM.
   b. Screen potential ECM providers through Partnership's ECM Readiness Assessment and contracting process
   c. Include Health Equity measures as part of Partnership's oversight and quality monitoring of ECM, such as disparities in engagement, disparities in access and/or patterns of utilization of ECM services for the health plan.

K. ECM SUBCONTRACTOR DELEGATION
1. Partnership may allow an ECM provider to subcontract with other entities to administer ECM services under the following conditions:
   a. The ECM provider maintains the responsibility for oversight and compliance of all of its subcontractors for the delivery of ECM as set forth in this policy and in DHCS APL 21-012. Examples of compliance include, but are not limited to:
      1) Ensure the subcontractor meets the DHCS required provider experience thresholds for the delivery of ECM for the Population(s) of Focus.
      2) Ensure the subcontractor has appropriate staffing ratios and capacities.
      3) Partnership shall provide oversight and monitoring of the ECM provider's ability to perform delegation of the ECM benefit.
      4) Maintain current contracts and make available to Partnership any subcontractor agreements upon DHCS request. Such agreements will contain minimum required information specified by DHCS, including the method and amount of compensation, Population(s) of Focus served, service area, case ratios and ECM capacity.
   b. Partnership will ensure the agreement between ECM delegated entity and subcontractor mirrors the requirements outlined in the DHCS Contract and the ECM provider Standard Terms and Conditions, as applicable to the subcontractor.
   c. Partnership will make every effort to collaborate with its ECM provider delegated entities and subcontractors on the best approach to streamline the ECM experience and minimize the divergence for ECM Members and providers.
2. Partnership will hold ECM entities and subcontractors to the same ECM provider requirements.

3. Partnership shall maintain appropriate structures and mechanisms to ensure delegation oversight, including pre-delegation evaluation as applicable, no less than annual review of delegation agreement/grid, monitoring of performance data, and oversight auditing of delegated functions. Partnership's delegation oversight is designed to effectively review, evaluate, and verify satisfactory performance and compliance with regulatory and accreditation standards.

L. DHCS ECM OVERSIGHT
1. Partnership will submit the following data and reports to DHCS to support DHCS' oversight of ECM:
   a. Encounter data using national standard specifications and code sets defined by DHCS.
      1) Partnership is responsible for submitting all encounter data to DHCS for ECM services to its Members, regardless of the number of levels of delegation and/or sub-delegation between Partnership and the ECM provider.
      2) In the event the ECM provider is unable to submit the ECM encounters to Partnership using the national standard specifications and codes set by DHCS, Partnership will be responsible for converting the ECM provider's data information before DHCS submission.
   b. Supplemental reporting on a schedule and in the DHCS specified format.
2. Partnership will track and report to DHCS in a DHCS specified format, information about outreach efforts related to potential ECM Members.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment 5 Utilization Management and Attachment 6, Provision 13, Ethnic and Cultural Composition
B. DHCS All Plan Letter (APL)23-032 Enhanced Care Management Requirements(12/22/2023 *supersedes APL 21-012*)
C. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2021)
D. DHCS All Plan Letter (APL) 22-013 Provider Credentialing / Recredentialing and Screening / Enrollment (07/19/22 *supersedes APL 19-004*).
E. Title 42 Code of Federal Regulations (CFR) Section 438.208(c).
F. Title 42 Code of Federal Regulations (CFR) Section 441.301(c).
G. DHCS ECM Policy Guide (August 2024)
H. DHCS ECM Referral Standards and Form Templates (August 2024)

VIII. DISTRIBUTION:

E. Partnership Department Directors
F. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 10/12/22; 11/08/23; 11/13/24

PREVIOUSLY APPLIED TO:

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.