	Enhanced Care Management (ECM)	**In Lieu of Services (ILOS)**
Definition	Systematic coordination of "whole person care" svcs. and comprehensive care management – interdisciplinary, high-touch, provided primarily through in-person interactions where beneficiaries live or seek services	Medically appropriate and cost effective alternatives to covered state plan services, intended to address social determinants of health.
Benefit vs. option	• **Mandatory benefit** that must be available to all who meet eligibility criteria for mandatory populations. • Plans can choose to add additional populations. • DHCS has not specified eligibility criteria for each target population – will plans establish? • DHCS reserves right to narrow/refine populations.	• **Optional** for each MCP and coverage area, and for the beneficiary • MCPs must specify which ILOS they will offer • If an ILOS is made available, must be offered to all beneficiaries who are eligible • MCPs can add ILOS every 6 mos. or remove annually
Implementation dates	• Jan. 2022 (begin WPC & HH counties) • July 2022 (begin all other counties) • Jan. 2023 (full implementation for all target populations in all counties) **See below for additional nuance: ECM may be available to some populations earlier than others depending on WPC and HH coverage. ECM coverage for individuals transitioning from incarceration planned for Jan. 2023.*	• Jan. 2022 (at MCP discretion; highly encouraged) • MCPs may add services every 6 months or remove services once per year.
Detail (see p. 3 for more detailed description of ECM service components)	**Mandatory ECM Populations:** • Children or youth with complex physical, behavioral, or developmental health needs • Individuals experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions; • High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits; • Individuals at risk for institutionalization who are eligible for long-term care services; • Nursing facility residents who want to transition to the community; • Individuals who are at risk for institutionalization who have co-occurring chronic health conditions and: o Serious Mental Illness (SMI, adults); o Serious Emotional Disturbance (SED, children and youth); or o Substance Use Disorder (SUD); • Individuals	**ILOS Service Menu:** Housing Transition Navigation Services; • Housing Deposits; • Housing Tenancy and Sustaining Services; • Short-Term Post-Hospitalization Housing; • Recuperative Care (Medical Respite); • Respite Services; • Day Habilitation Programs; • Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF); • Community Transition Services/Nursing Facility Transition to a Home; • Personal Care and Homemaker Services; • Environmental Accessibility Adaptations (Home Modifications); • Meals/Medically Tailored Meals; • Sobering Centers; and • Asthma Remediation.

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<tr><th></th><th><u>Enhanced Care Management (ECM)</u></th><th><u>In Lieu of Services (ILOS)</u></th></tr>
<tr><td></td><td>transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.</td><td></td></tr>
<tr><td>Whole Person Care & Health Homes transitions</td><td>Populations & individuals receiving WPC or HH services must be enrolled in ECM
Health Homes: 3 populations are mandatory at implementation (homeless, high utilizers, and SMI/SED/SUD); others must be added by Jan. 2023
WPC: Populations currently receiving WPC services must be enrolled in ECM in Jan. 2022; other mandatory target populations added beginning July 2022 and complete by Jan. 2023 (If WPC pilot already served individuals transitioning from incarceration it must offer them ECM in 2022.)
Reassess all WPC/HH enrollees within six months to determine if ECM remains appropriate
MCPs <u>must</u> contract with WPC lead entities and HH CB-CMEs, <u>unless limited exceptions apply</u>
MCPs must offer ECM to all eligible members of target populations, including those who were not previously identified to receive WPC or HH svcs.</td><td>DHCS encourages MCPs to also offer appropriate ILOS for all populations/individuals previously enrolled in WPC or HH.
ECM contractors may also provide ILOS and will be expected to coordinate available and appropriate ILOS</td></tr>
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<tr><th></th><th>Additional Specifications – ECM & ILOS (Proposed as of March 2021)</th></tr>
<tr><td>ECM core service components</td><td>

Comprehensive Assessment and Care Management Plan

Includes individualized assessment of risks and needs and development of goals
Inclusive of needs related physical health, developmental disabilities, mental health/SUD, dementia, oral health, palliative care, housing and social services

Enhanced Coordination of Care

Implement care plan (organize care) in coordination with service providers and care team members
Manage referrals for specialty care, housing, social services
Support member treatment adherence: scheduling, medication reconciliation, accompaniment to appointments

Health Promotion

Work with member and family/community to identify and build on resiliencies; strengthen skills members need to manage their own conditions and needs
Support health mgmt. and healthy behaviors

Comprehensive Transitional Care

Strategies to reduce avoidable admissions and readmissions, including tracking admissions and ED visits
Develop real-time tools/alerts to ID members who experience ED visits or admissions to inpatient facilities, residential treatment, or incarceration and track status changes in housing or employment
Manage care transition planning and coordination of transition supports

Member and Family Supports

Document members' chosen caregivers or family/community supports
Inform and coordinate with family members; Lead Care Manager should be primary point of contact for member and for family/support persons
Member and family education and supports designed to help manage member's condition

Coordination of and Referral to Community and Social Support Services

Identify services needed to address social determinants of health, including housing
Coordinate referrals and follow-up

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<tr><td>ECM/ILOS Model of Care (MOC) templates</td><td>

Six months before implementation: MCPs submit MOC templates to describe transition plans (narrative descriptions and policies/procedures) and information on planned ILOS
Three months before implementation: MCPs submit detailed info on ECM/ILOS provider capacity and contract language, including detailed list of contracted providers
Periodic 6-month updates required by DHCS through January 2023; after that DHCS will rely on monitoring of encounter data and other reporting
Other modifications to MOC, or to P&P after Jan. 2023, require 60-day notifications and approval by DHCS

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	Additional Specifications – ECM & ILOS (Proposed as of March 2021)
	• MCPs that operate in multiple counties will submit a single MOC template. Implementation may differ by county (or not). MOC submissions should include multiple responses account for any planned differences between counties and specific provider capacity info for each county

ECM provider contracts, capacity requirements, and assignment of ECM clients	• ECM provider capacity will be assessed separately from MCP network adequacy
	  ○ In Part 2 of MOC submission, MCP expected to report how many members each ECM provider is expected to serve and describe contractor's experience working with identified target populations
	  ○ Must include mandatory provider types (Indian Health Care Providers)
	• Required to contract with WPC lead entities and HH CB-CMEs unless specified exceptions apply:
	  ○ There is a justified quality-of-care concern with one or more of the otherwise qualified Providers; o Contractor and Provider(s) are unable to agree on contracted rates; o Provider(s) is/are unwilling to contract; o Provider(s) is/are unresponsive to multiple attempts to contract; and/or o Provider(s) is/are unable to comply with the Medi-Cal enrollment or Contractor credentialing or background check process.
	• MCPs may use their own staff for ECM only if:
	  ○ There are insufficient Providers with experience and expertise to provide ECM for one (1) or more target populations in one (1) or more Counties; o There is a justified quality-of-care concern with one or more of the otherwise qualified Providers; o MCP and Provider(s) are unable to agree on contracted rates; o Provider(s) is/are unwilling to contract; o Provider(s) is/are unresponsive to multiple attempts to contract; and/or o Provider(s) is/are unable to comply with the Medi-Cal or MCP Provider enrollment process.
	• MUST explain efforts to coordinate with Local Gov't Agency TCM programs in MOC submissions
	  ○ "Encouraged" to contract with Public Health in these counties
	• *Currently no requirement to address coordination or transition planning with county BH
	  ○ "Encouraged" to contract with Behavioral Health
	• May contract with an ECM entity that also subcontracts with other providers
	  ○ P&P to explain accountability procedures
	• In counties with multiple MCPs: MOC must describe how the MCP will coordinate with other MCPs to align ECM provider requirements

Member eligibility and enrollment for ECM	• MCPs must proactively identify eligible members of each target population via data analysis
	• Must establish a process for receiving ECM referrals from external sources
	  ○ Including ECM providers and other providers serving members (e.g., county BH)
	• Must establish a process for members or family/caregivers to request ECM
	• MCP authorizations for ECM must follow existing processes/timeframes for prior authorizations: 5 working days for routine authorizations and 72 hours for expedited requests
	  ○ MCPs encouraged to authorize ECM in six-month increments at minimum

ECM provider assignment	• Individuals authorized for ECM should be assigned to a participating provider within 10 days of authorization

	Additional Specifications – ECM & ILOS (Proposed as of March 2021)
	• MCP must “follow” members’ “known preferences” in ECM provider assignment • If PCP is a provider, member must be assigned to PCP unless member wants a different provider or MCP identifies a more appropriate placement based on members’ needs • If member receives BH services and their BH provider is contracted, MCP must assign them to BH provider unless member has a different preference or MCP identifies a more appropriate placement based on needs • Members may request change of ECM providers at any time; MCP must make the change within 30 days of request
Outreach and engagement – ECM provider role	• All ECM providers responsible for outreach and engagement to their assigned target populations • Outreach and engagement should take place in person wherever possible • Required number of engagement attempts for members identified as eligible (defined by MCPs) • Must offer culturally and linguistically appropriate communications

Additional responsibilities for ECM providers & MCPs	• Real-time or frequent information-sharing between MCP and ECM providers on status of enrollment, outreach, and engagement in ECM, along with encounter and claims data and other data for QI purposes
	    ◦ MOC template includes additional specificity on data to be shared between MCPs/ECM providers
	    ◦ MCP must provide ECM provider with “physical, behavioral, administrative and SDOH data (e.g. HMIS)
	    ◦ MCPs may not impose additional reporting requirements on ECM providers beyond DHCS requirements
	• ECM Provider responsible for documenting member consent for participation and data-sharing
	• ECM Provider assigns Lead Care Manager for each member; members may request changes to LCMs
	• MCP must establish policies/procedures for ECM providers to periodically assess need for ECM and support a transition to alternative case management services if appropriate (NOA required if ECM is discontinued)
	• MCP must develop policies and procedures to ensure that ECM interactions are primarily in-person (with defined contingencies to mitigate COVID-19 risk, including use of audio/video technologies)
	• P&P to ensure services are culturally relevant & linguistically appropriate, & MCP recruits culturally diverse providers
	• MCPs must provide training and TA to ECM providers

Payment for ECM	• MCPs may use variable models to reimburse ECM providers – e.g., FFS or capitation • Rates must cover outreach as well as ECM services • Financial incentives to engage hard-to-reach populations • MCPs encouraged to tie payments to outcomes • DRAFT DHCS coding guidance available here
Additional ILOS requirements	• MCPs choose which ILOS to offer and must make their lists public • MCPs must ensure sufficient provider capacity for identified ILOS • ILOS available to all eligible members in county • MCPs must prioritize contracts with WPC entities and CB-CMEs, or must explain why not