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



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Enhanced Care Management (ECM) Definitions

1. **Enhanced Care Management (ECM):** a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
2. **ECM Provider:** community-based entities with experience and expertise providing intensive, in-person care management services to Members in one or more of the Populations of Focus for ECM.
3. **ECM Care Manager:** a Member's designated ECM care manager, who works for the ECM Provider organization, or as staff of Contractor, and is responsible for coordinating all aspects of ECM and any Community Supports as part of the Member's multi-disciplinary care team, which may include other care managers.
4. **Model of Care:** Contractor's framework for providing ECM and Community Supports, including its Policies and Procedures for partnering with ECM and Community Supports Providers.
5. **Population of Focus:** a subset of Medi-Cal Managed Care Health Plan Members that meet eligibility criteria, as defined by DHCS, by which they are eligible to receive the ECM benefit.

ECM Scope of Services

1. Contractor's Responsibility for Administration of ECM

- A. Contractor must take a whole-person approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-need and high-cost Members in distinct Populations of Focus, as defined in Provision 3, Populations of Focus for ECM of this Attachment, through systematic coordination of services and Comprehensive Case Management. Contractor must ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.
- B. Contractor must ensure ECM is available throughout its Service Area.
- C. Contractor must ensure ECM is offered primarily through in-person interaction where Members and their family members, guardians, authorized representatives, caregivers, and authorized support persons live, seek care, or prefer to access services in their local community. Contractor must ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and telehealth, when appropriate and with the Member's consent.
- D. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor must follow the same requirements as a contracted ECM Provider.

- E. In counties with operating Health Homes Program (HHP) and Whole Person Care (WPC) pilots, Contractor must enter into Subcontractor Agreements with WPC Lead Entities and HHP Community-Based Care Management Entities (CB-CMEs) for the provision of ECM, as described in Provision 7, Member Identification for ECM of this Attachment.
- F. Contractor must follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract.
- G. Contractor must ensure ECM provided to each Member encompasses the ECM core service components described in Provision 12, Core Service Components of ECM of this Attachment.
- H. Contractor must ensure a Member receiving ECM is not receiving duplicative services from other sources, including by not limited to county-specific Targeted Case Management (TCM) services administered by Local Governmental Agencies (LGAs).
- I. For Members who are dually eligible for Medicare and Medi-Cal and enrolled in a Medicare Advantage Plan, including a Dual-Eligible Special Needs Plan (D-SNP), Contractor must coordinate with the Medicare Advantage Plan for the provision of ECM for those Members.
- J. Contractor must develop Member-facing written material about ECM for use across its network of ECM Providers. The written material must be submitted for DHCS review and approval prior to use. This material must include the following:
 - 1) Explain ECM and how a Member may request it;
 - 2) Explain that ECM participation is voluntary and can be discontinued at any time;
 - 3) Explain that the Member must authorize ECM-related data sharing;
 - 4) Describe the process by which the Member may choose a different ECM Lead Care Manager or ECM Provider; and
 - 5) Meet standards for culturally and linguistically appropriate communication outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program and in Exhibit A, Attachment 13, Provision 3, Written Member Information.

2. Populations of Focus for ECM

- A. Subject to the phase-in and Member transition requirements described in Provision 7, Member Identification for ECM of this Attachment.
- B. Contractor must provide ECM Members that meet the eligibility criteria for the following Populations of Focus:
 - 1) Members over the age of 21 who are:
 - a) Experiencing homelessness;
 - b) High utilizers;
 - c) Experiencing Serious Mental Illness (SMI) or Substance Use Disorder (SUD);
 - d) Transitioning from incarceration;
 - e) At risk for institutionalization who are eligible for Long-Term Care services; and
 - f) Nursing facility residents transitioning to the community.
 - 2) Children who are:
 - a) Experiencing homelessness;
 - b) High utilizers;
 - c) Experiencing Serious Emotional Disturbance (SED) or identified to be at Clinical High Risk (CHR) for psychosis or experiencing a first episode of psychosis;
 - d) Enrolled in California Children's Services (CCS)/CCS Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition;
 - e) Involved in, or with a history of involvement in, child welfare (including individuals involved in foster care ages 26 and under); and
 - f) Transitioning from incarceration.

- C. Contractor may offer ECM to Members who do not meet Population of Focus criteria in full, but may benefit from ECM.
- D. Contractor must follow all DHCS policies and guidance including All Plan Letters (APLs) and ECM Policy Guide that further defines the approach to ECM for each Population of Focus, including the eligibility criteria for each Population of Focus and the phase-in timeline for Populations of Focus.
- E. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs:
 - 1) 1915(c) waiver programs including:
 - a) Multipurpose Senior Services Program (MSSP);
 - b) Assisted Living Waiver (ALW);
 - c) Home and Community-Based Alternatives (HCBA) Waiver;
 - d) Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver;
 - e) HCBS Waiver for Individuals with Developmental Disabilities (DD);
and
 - f) Self-Determination Program for Individuals with intellectual and DD.
 - 2) Fully integrated programs for Members dually eligible for Medicare and Medi-Cal including:
 - a) Cal MediConnect (CMC);
 - b) Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs);
and
 - c) Program for All-Inclusive Care for the Elderly (PACE).
 - 3) Family Mosaic Project
 - 4) California Community Transitions (CCT) Money Follows the Person (MFTP)
 - 5) Basic Case Management (BCM) or Complex Care Management (CCM)

3. ECM Providers

- A. Contractor must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member, such as where the Member lives, seeks care, or prefers to access services in their local community.
- B. ECM Providers may include, but are not limited to, the following entities:
- 1) Counties;
 - 2) County behavioral health Providers;
 - 3) Primary Care Physician (PCP), Specialist, or Physician groups;
 - 4) Federally Qualified Health Centers (FQHCs);
 - 5) Community health centers;
 - 6) Community-based organizations;
 - 7) Hospitals or hospital-based Physician groups or clinics (including public hospitals and district or municipal public hospitals);
 - 8) Rural Health Clinics (RHC) and American Indian Health Service (AIHS) Programs;
 - 9) Local Health Departments (LHDs);
 - 10) Behavioral health entities;
 - 11) Community mental health centers;
 - 12) SUD treatment Providers;
 - 13) Community Health Workers;
 - 14) Organizations serving individuals experiencing homelessness;
 - 15) Organizations serving justice-involved individuals;
 - 16) CCS Providers; and
 - 17) Other qualified Providers or entities that are not listed above, as approved by DHCS.
- C. For the Population of Focus for eligible individuals with SMI or SUD and the Population of Focus for eligible individuals with SED, Contractor must prioritize county behavioral health staff or behavioral health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus, not just their behavioral health services.

- D. Contractor must attempt to enter into a Subcontractor Agreement with each AIHS Facility as set forth in 22 CCR sections 55110 through 55180 to provide ECM, when applicable, as described in Exhibit A, Attachment 8, Provision 7, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and American Indian Health Service Programs, Paragraph C.
- E. Contractor must ensure ECM Providers meet the requirements set forth in all applicable APLs including, but not limited to, the requirements regarding the use of a care management documentation system.
- F. Care management documentation systems may include certified electronic health record technology, or other documentation tools that can:
 - 1) Document Member goals and goal attainment status;
 - 2) Develop and assign care team tasks;
 - 3) Define and support Member care coordination and care management needs;
 - 4) Gather information from other sources to identify Member needs and support care team coordination and communication; and
 - 5) Support notifications regarding Member health status and transitions in care such as discharges from a hospital or LTC Facility, and housing status.
- G. Contractor must also comply with requirements on data exchange pursuant to Provision 13, Data System Requirements and Data Sharing to Support ECM of this Attachment.
- H. Contractor must ensure all ECM Providers for whom a State-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 19-004. If APL 19-004 does not apply to an ECM Provider, Contractor must have a process for verifying qualifications and experience of ECM Providers, which must extend to individuals employed by or delivering services on behalf of the ECM Provider. Contractor must ensure that all ECM Providers meet the capabilities and standards required to be an ECM Provider.
- I. Contractor must not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of entering into a Subcontractor Agreement.

4. ECM Provider Capacity

- A. Contractor must develop and manage a Network of ECM Providers.
- B. Contractor must ensure sufficient ECM Provider capacity to meet the needs of all ECM Populations of Focus.

- C. Contractor must meet DHCS' requirements regarding ECM Provider capacity separately from general Network adequacy; ECM Provider capacity does not alter the general Network adequacy provisions in Exhibit A, Attachment 6, Provider Network.
- D. Contractor must report on its ECM Provider capacity to DHCS initially in its ECM MOC Template as referenced in Provision 6, ECM Model of Care (MOC) of this Attachment, and on an ongoing basis pursuant to DHCS reporting requirements in a form and manner specified by DHCS.
- E. Contractor must report to DHCS any significant changes in its ECM Provider capacity as soon as possible but no later than 60 days from the occurrence of the change, in accordance with DHCS reporting requirements in a form and manner specified by DHCS.
- F. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus through contracts with community-based ECM Providers, Contractor may submit a written request to DHCS for an exception that authorizes Contractor to use Contractor's own personnel for ECM. Any such request must be submitted in accordance with DHCS guidelines and must meet at least one (1) of the following criteria:
 - 1) There are insufficient ECM Providers, or a lack of ECM Providers with qualifications and experience, to provide ECM for one (1) or more of the Populations of Focus in one (1) or more counties in;
 - 2) There is a justified quality of care concern with one (1) or more of the otherwise qualified ECM Providers;
 - 3) Contractor and the ECM Providers are unable to agree on rates;
 - 4) ECM Providers are unwilling to contract;
 - 5) ECM Providers are unresponsive to multiple attempts to contract;
 - 6) ECM Providers who have a State-level pathway to Medi-Cal enrollment but are unable to comply with the Medi-Cal enrollment process or Contractor's verification requirements for ECM Providers; or
 - 7) ECM Providers without a State-level pathway to Medi-Cal enrollment that are unable to comply with Contractor's verification requirements for ECM Providers.
- G. During any exception period approved by DHCS, Contractor must take steps to continually develop and increase its ECM Provider network capacity. After expiration of an exception period, Contractor must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis.

- H. Contractor's failure to provide network capacity that meets the needs of all ECM Populations of Focus in a community-based manner may result in imposition of corrective action proceedings, and may result in sanctions pursuant to Exhibit E, Attachment 2, Program Terms and Conditions, Provision 16, Sanctions.

5. Model of Care

- A. Contractor must develop an ECM Model of Care (MOC) template in accordance with the DHCS-approved ECM MOC template. The ECM MOC must specify Contractor's framework for providing ECM, including a listing of its ECM Providers and policies and procedures for partnering with ECM Providers for the provision of ECM.
- B. In developing and executing Subcontractor Agreements with ECM Providers, Contractor must incorporate all requirements and policies and procedures described in its ECM MOC, in addition to all applicable APLs.
- C. Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on the development of its ECM MOC.
- D. Contractor must submit its ECM MOC for DHCS review and approval. Contractor must also submit any significant changes to its ECM MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable APLs. Significant changes may include, but are not limited to, changes to the Health Homes Program (HHP), ECM Contractor's approach to administer or deliver ECM services, approved policies and procedures, and Subcontractor Agreements boilerplates.

6. Identifying Members for ECM

- A. Contractor must promote continuity from the HHP and WPC pilots to ECM.
- B. Contractor must authorize ECM for Members in HHP and WPC pilot counties, following the DHCS implementation schedule.
- C. To ensure continuity between HHP and ECM, Contractor must:
 - 1) Automatically authorize ECM for all Members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in HHP; and
 - 2) Ensure that each Member automatically authorized for ECM under this Provision is assessed within six (6) months, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.
- D. To ensure continuity between WPC Pilots and ECM, Contractor must:

- 1) Automatically authorize all Members enrolled in a WPC pilot who are identified by the WPC Lead Entity as belonging to an ECM Population of Focus; and
 - 2) Ensure each Member automatically authorized under this Provision is assessed within six (6) months, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.
- E. Contractor must enter into a Subcontractor Agreement with each WPC Lead Entity or HHP CB-CME as an ECM Provider to provide Members with ongoing care coordination previously provided in HHP and WPC pilot counties, except under the permissible exceptions set forth in Paragraph F below.
- F. Contractor must submit to DHCS for prior approval any requests for exceptions to the Subcontractor Agreement requirement with a WPC Lead Entity or HHP CB-CME as an ECM Provider. Permissible exceptions to the Subcontractor Agreement requirement, include, but are not limited to:
- 1) There is a justified quality of care concern with the ECM Provider(s);
 - 2) Contractor 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 Contractor; or
 - 6) For ECM Provider(s) without a State-level pathway to Medi-Cal enrollment, ECM Provider(s) is/are unable to comply with Contractor processes for vetting qualifications and experience.
- G. Contractor must proactively identify Members who may benefit from ECM and who meet the eligibility criteria for the ECM Populations of Focus, as described in Provision 3, Populations of Focus for ECM of this Attachment.
- H. To identify such Members, Contractor must consider the following:
- 1) Members' health care utilization;
 - 2) Needs across physical, behavioral, developmental, and oral health;
 - 3) Health risks and needs due to social determinants of health; and,
 - 4) Long-term services and supports (LTSS) needs.

- I. Contractor must identify Members for ECM through the following pathways:
 - 1) Analysis of Contractor's own Enrollment, claims, and other relevant data and available information. Contractor must use data analytics to identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus. Contractor must consider data sources, including but not limited to:
 - a) Enrollment data;
 - b) Encounter Data;
 - c) Utilization/claims data;
 - d) Pharmacy data;
 - e) Laboratory data;
 - f) Screening or assessment data;
 - g) Clinical information on physical and behavioral health;
 - h) SMI/SUD data, if available;
 - i) Risk stratification information for Members under 21 years of age in Contractor's Whole Child Model (WCM) program;
 - j) Information about Social Determinants of Health, including standardized assessment tools including Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) and International Classification of Diseases, Tenth Revision (ICD-10) codes;
 - k) Results from any available Adverse Childhood Experience (ACE) screening; and
 - l) Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM Populations of Focus such as Homeless Management Information System (HMIS), and available data from the education system.
 - 2) Receipt of requests from ECM Providers and other Providers or community-based entities.
 - a) Contractor must accept requests for ECM on behalf of Members from:
 - i. ECM Providers;

- ii. Other Providers; and
 - iii. Community-based entities, including those contracted to provide Community Supports, as described in Provision 20, Community Supports Providers of this Attachment.
- b) Contractor must directly engage with Network Providers, Subcontractors and county agencies to inform these entities of ECM, the ECM Populations of Focus, and how to request ECM for Members.
 - c) Contractor must encourage ECM Providers to identify Members who meet the criteria for the ECM Populations of Focus, and must develop a process for receiving and responding to requests from ECM Providers.
- 3) Requests from Members.

Contractor must have a process for allowing Members to request ECM and for Members' parents, family members, legal guardians, authorized representatives, caregivers, and authorized support persons to request ECM on a Member's behalf. Contractor must provide information to Members regarding the Member initiated ECM request and approval process.

7. Authorizing Members for ECM

- A. Contractor must authorize ECM for each eligible Member identified through any of the pathways described in Provision 7, Member Identification for ECM of this Attachment.
- B. Contractor must develop policies and procedures that explain how it will authorize ECM for eligible Members in an equitable and non-discriminatory manner.
- C. For requests from Providers and other external entities, Members, Member's parent, family member, legal guardian, authorized representative, caregiver, or authorized support person:
 - 1) Contractor must ensure that authorization or a decision to not authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization and APL 21-011;
 - 2) If Contractor does not authorize ECM, Contractor must ensure the Member and the requesting individual or entity who requested ECM on a Member's behalf, as applicable, are informed of the Member's right to an Appeal and the Appeals process by way of the Notice of Action (NOA) as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or

Modification of Prior Authorization Requests, Exhibit A, Attachment 14, Member Grievance and Appeal System, and APL 21-011; and

- 3) Contractor must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 21-011.
- D. Contractor must follow requirements for transitioning Members previously served by WPC pilots or HHP contained in Provision 7, Member Identification for ECM of this Attachment.
 - E. Contractor may collaborate with its ECM Providers to develop a process and identify possible circumstances under which presumptive authorization or preauthorization of ECM may occur, where select ECM Providers may directly authorize ECM for a limited period of time until Contractor authorizes or denies ECM.
 - F. To inform Members that ECM authorization, Contractor must follow its standard notice process outlined in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests and APL 21-011.

8. Assignment to an ECM Provider

- A. Contractor must assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS-approved exception to the ECM Provider contracting requirement as described in Provision 5, ECM Provider Capacity of this Attachment.
- B. Contractor must develop a process to disseminate information of assigned Members to ECM Providers on a regular basis.
- C. Contractor must ensure communication of Member assignment to the designated ECM Provider occurs within ten (10) Working Days of authorization or on an agreed upon schedule.
- D. If a Member prefers a specific ECM Provider, Contractor must assign the Member to that Provider, to the extent practicable.
- E. If a Member's assigned PCP is a contracted ECM Provider, Contractor must assign the Member to the PCP as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
- F. If a Member receives services from a behavioral health Provider for SED, SUD, or SMI and the Member's behavioral health Provider is a contracted ECM Provider, Contractor must assign that Member to that behavioral health Provider as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

- G. If a Member is enrolled in CCS and the Member's CCS Case Manager is affiliated with a contracted ECM Provider, Contractor must assign that Member to the CCS Case Manager as the ECM Provider, unless the Member or parent, legal guardian, or authorized representative has indicated otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
- H. Contractor must notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider assignment, within ten (10) Working Days of the date of assignment.
- I. Contractor must document the Member's ECM Lead Care Manager in its system of record.
- J. Contractor must permit Members to change ECM Providers at any time. Contractor must implement any Member's request to change their ECM Provider within 30 calendar days to the extent practicable, but no later than within 90 days of receiving the original request.

9. Initiating Delivery of ECM

- A. Contractor must not require Member authorization for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM, unless such authorization is required by federal law.
- B. Contractor must develop policies and procedures for its Network of ECM Providers that meet the following requirements, including but not limited to:
 - 1) Where required by law, ECM Providers must obtain Member's authorization to share information with Contractor and all others involved in the Member's care to maximize the benefits of ECM; and
 - 2) ECM Providers must provide Contractor with Member-level records of any obtained authorizations for ECM-related data sharing as required by federal law and to facilitate ongoing data sharing with Contractor.
- C. Contractor must ensure that upon the initiation of ECM, each Member receiving ECM has a Lead Care Manager with responsibility for interacting directly with the Member and the Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate.

The assigned ECM Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify gaps in Member's care and at a minimum, ensure effective coordination of all primary, behavioral, developmental, oral health, LTSS, Community Supports, and other services to address Social Determinants of Health, regardless of setting.

- D. Contractor must ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

10. Discontinuation of ECM

- A. Contractor must ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.
- B. Contractor must require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met:
 - 1) The Member has met all care plan goals;
 - 2) The Member is ready to transition to a lower level of care;
 - 3) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or
 - 4) The ECM Provider has not been able to connect with the Member after multiple attempts.
- C. Contractor must develop processes to determine if the Member is no longer authorized to receive ECM and, if so, to notify ECM Provider to initiate discontinuation of services in accordance with the NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests; Exhibit A, Attachment 14, Member Grievance and Appeal System; and APL 21-011.
- D. Contractor must develop processes for transitioning Members from ECM to lower levels of care management to provide coordination of ongoing needs.
- E. Contractor must notify the ECM Provider when ECM has been discontinued by Contractor.
- F. Contractor must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to an Appeal and the Appeals process by way of a NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, Exhibit A, Attachment 14, Member Grievance and Appeal System, and APL 21-011.

11. Core Service Components of ECM

- A. Contractor must ensure all Members receiving ECM benefits receive all of the following seven (7) ECM core service components, as further defined in applicable APLs:
 - 1) Outreach and engagement
 - 2) Comprehensive assessment and care management plan;
 - 3) Enhanced coordination of care;
 - 4) Health promotion;

- 5) Comprehensive transitional care;
- 6) Member and family supports; and
- 7) Coordination of and referral to community and social support services.

12. Data System Requirements and Data Sharing to Support ECM

- A. Contractor must have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:
 - 1) Consume and use claims and Encounter Data, as well as other data types listed in Provision 7, Member Identification for ECM of this Attachment;
 - 2) Assign Members to ECM Providers;
 - 3) Keep records of Members receiving ECM and authorizations necessary for sharing Protected Health Information and Personal Identifying Information between Contractor and ECM and other Providers, among ECM Providers and family member(s) or support person(s), whether obtained by ECM Provider or by Contractor;
 - 4) Securely share data with ECM Providers and other Providers in support of ECM;
 - 5) Receive, process, and send Encounter Data from ECM Providers to DHCS;
 - 6) Receive and process supplemental reports from ECM Providers;
 - 7) Send ECM supplemental reports to DHCS; and
 - 8) Open, track, and manage referrals to Community Supports Providers.
- B. In order to support ECM, Contractor must follow DHCS guidance on data sharing and provide the following information to all ECM Providers:
 - 1) Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
 - 2) Encounter Data and claims data;
 - 3) Physical, behavioral, administrative, and Social Determinants of Health data, such as HMIS data, for all Members assigned to the ECM Provider; and
 - 4) Reports of performance on quality measures and metrics, as requested.
- C. Contractor must 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.

13. Oversight of ECM Providers

- A. Contractor must perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract, DHCS policies and guidance, including all applicable APLs, and Contractor's ECM MOC.
- 1) Contractor must evaluate the prospective Subcontractor's ability to perform services;
 - 2) Contractor must ensure the Subcontractor's ECM Provider capacity is sufficient to serve all Populations of Focus;
 - 3) Contractor must report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment 6, Provision 12, Subcontractor Reports; and
 - 4) Contractor must make all Subcontractor Agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements.
- B. Contractor must hold ECM Providers responsible for the same reporting requirements as those Contractor has with DHCS.
- 1) Contractor must not impose mandatory reporting requirements that differ from or are additional to those required for Encounter and supplemental reporting; and
 - 2) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on oversight of ECM Providers.
- C. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.
- D. Contractor must provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, or calls, as necessary, in addition to Network Provider training requirements described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.
- E. Contractor must ensure the Subcontractor Agreement mirrors the requirements set forth in this Contract and in accordance with all applicable APLs, as applicable to Subcontractor.

Contractor may collaborate with its Subcontractors on the approach to administration of ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractors, and to ensure a streamlined,

seamless experience for ECM Providers and Members.

14. Payment of ECM Providers

- A. Contractor must pay ECM Providers for the provision of ECM in accordance with contracts established between Contractor and each ECM Provider.
- B. Contractor must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as defined in Provision 10, Initiating Delivery of ECM of this Attachment.
- C. Contractor may tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.
- D. Contractor must utilize the claims timeframes as described in Exhibit A, Attachment 8, Provision 5, Claims Processing.

15. DHCS Oversight of ECM

- A. Contractor must submit the following data and reports to DHCS to support DHCS oversight of ECM:
 - 1) Encounter Data
 - a) Contractor must submit all ECM Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS.
 - b) Contractor must be responsible for submitting to DHCS all Encounter Data for ECM services to its Members, regardless of the number of levels of delegation or sub-delegation between Contractor and the ECM Provider.
 - c) In the event the ECM Provider is unable to submit ECM Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor is responsible for converting the ECM Provider's Encounter Data information into the national standard specifications and code sets, for submission to DHCS.
 - 2) ECM supplemental reports, on a schedule and in a format to be defined by DHCS.
- B. Contractor must track and report to DHCS, on a schedule and in a format specified by DHCS, information about outreach efforts related to Members who could potentially be enrolled in ECM.

- C. In the event of underperformance by Contractor in relation to its administration of ECM, DHCS may impose sanctions as described in Exhibit E, Attachment 2, Provision 17, Sanctions.

16. ECM Quality and Performance Incentive Program

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

Community Supports (formerly In Lieu of Services)

Community Supports Definitions

1. **Community Supports:** substitute services or settings to those required under the California Medicaid State Plan that Contractor may select and offer to their Members when the substitute service or setting is and are medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.
2. **Community Supports Provider:** a contracted Provider of DHCS-approved Community Supports. Community Supports Providers are entities with experience and expertise providing one or more of the Community Supports approved by DHCS.

Community Supports

1. Contractor's Responsibility for Administration of Community Supports

- A. Contractor may provide DHCS pre-approved Community Supports as described in Provision 19, DHCS Pre-Approved Community Supports of this Attachment.

The remainder of Exhibit A, Attachment 22 refers only to Community Supports that Contractor may choose to offer, unless otherwise specified.

- B. In accordance with 42 CFR section 438.3(e)(2), all applicable APLs, and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the State Plan. See Provision 19, DHCS Pre-Approved Community Supports below for list.
 - 1) Contractor must ensure medically appropriate State Plan services are available to the Member regardless of whether the Member has been offered a Community Supports, is currently receiving a Community Supports, or has received a Community Supports in the past.
 - 2) Contractor may not require a Member to utilize a Community Supports. Members always retain their right to receive the California Medicaid State Plan Covered Services on the same terms as would apply if a Community Supports was not an option in accordance with regulatory requirements.
 - 3) Contractor must not use Community Supports to reduce, discourage, or jeopardize Members' access to State Plan services.
 - 4) Contractor may submit a request to DHCS to offer Community Supports in addition to the pre-approved Community Supports.
- C. With respect to pre-approved Community Supports, Contractor must adhere to DHCS' guidance on service definitions, eligible populations, code sets, potential

Community Supports Providers, and parameters for each Community Supports, referenced in APL 21-017 and the Community Supports Policy Guide, that Contractor chooses to provide. Upon approval from DHCS, Contractor may adopt a more narrowly defined eligible population than outlined in the Community Supports Policy Guide.

- 1) Contractor is not permitted to extend a Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate, as indicated in the DHCS guidance on eligible populations.
 - 2) Contractor must provide public notice of any limitations on Community Supports when Contractor requests an alternate approach involving narrowing eligible populations, including specifying such limitations in the Member Services Guide/EOC and on Contractor's website, in addition to receiving DHCS' written approval.
- D. If Contractor elects to offer one (1) or more pre-approved Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth below in Provision 21, Community Supports Provider Capacity.
- E. Contractor must identify Members who may benefit from Community Supports and for whom Community Supports will be a medically appropriate and cost-effective substitute for Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described below in Provision 23, Identifying Members for Community Supports.
- F. Contractor must authorize Community Supports for Members deemed eligible in accordance below with Provision 24, Authorizing Members for Community Supports and Communication of Authorization Status.
- G. Contractor may elect to offer value-added services in addition to offering one (1) or more Community Supports. Offering Community Supports does not preclude Contractor from offering value-added services.
- H. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment 9, Provision 10, Changes in Availability or Location of Covered Services, and Exhibit A, Attachment 13, Provision 4, Notification of Changes in Access to Covered Services.
- I. When Members are dually eligible for Medicare and Medi-Cal, and enrolled in a Medicare Advantage Plan, including a D-SNP, Contractor must coordinate with the Medicare Advantage Plan in the provision of Community Supports.
- J. Contractor must not require Members to use Community Supports.

2. DHCS Pre-Approved Community Supports

- A. Contractor may choose to offer Members one (1) or more of the following pre-approved Community Supports, and any subsequent Community Supports additions pre-approved by DHCS, in each county:
- 1) Housing Transition Navigation Services;
 - 2) Housing Deposits;
 - 3) Housing Tenancy and Sustaining Services;
 - 4) Short-Term Post-Hospitalization Housing;
 - 5) Recuperative Care (Medical Respite);
 - 6) Respite Services;
 - 7) Day Habilitation Programs;
 - 8) Nursing Facility Transition/Diversion to Assisted Living Facilities;
 - 9) Community Transition Services/Nursing Facility Transition to a Home;
 - 10) Personal Care and Homemaker Services;
 - 11) Environmental Accessibility Adaptations;
 - 12) Medically Tailored Meals/Medically Supportive Food;
 - 13) Sobering Centers; and
 - 14) Asthma Remediation.
- B. Contractor must list all Community Supports it offers in its Contractor's Community Supports MOC template and Community Supports MOC amendments.
- C. Contractor must ensure Community Supports are provided in accordance with all applicable APLs, unless DHCS has provided written approval of an alternate approach requested by Contractor.
- D. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports.

- E. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date.

Contractor must ensure Community Supports that were authorized for a Member prior to the discontinuation of those specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet the Member's needs.

- F. At least 30 calendar days before discontinuing Community Supports, Contractor must notify Members affected by the discontinuation of the Community Supports of the following:

- 1) The change and timing of discontinuation, and
- 2) The procedures that will be used to ensure completion of the authorized Community Supports or a transition into other comparable Medically Necessary services.

- G. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of Provision 18, Contractor's Responsibility for Administration of Community Supports, through Provision 31, Community Supports Quality and Performance Incentive Program, and are subject to the limitations of 42 CFR section 438.3(e)(1).

3. Community Supports Providers

- A. Community Supports Providers are entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program.
- B. Contractor must enter into Subcontractor Agreements with Community Supports Providers for the delivery of elected Community Supports elected by Contractor.
- C. Contractor must ensure all Community Supports Providers for whom a State-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 19-004. If APL 19-004 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.

- D. In accordance with Provision 26 below, Data System Requirements and Data Sharing to Support Community Supports, Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum:
- 1) Obtain and document Member information including eligibility, Community Supports authorization status, Member authorization for data sharing to the extent required by law, and other relevant demographic and administrative information; and
 - 2) Contractor must also support Community Supports Provider notification to Contractor and ECM Providers and Member's PCP, as applicable, when a referral has been fulfilled, as described below in Provision 26, Data System Requirements and Data Sharing to Support Community Supports.
- E. To the extent Contractor elects to offer Community Supports, Contractor may coordinate its approach with other Medi-Cal Managed Care Health Plans offering Community Supports in the same county.

4. Community Supports Provider Capacity

- A. Contractor must develop a robust network of Community Supports Providers to deliver all elected Community Supports.
- B. If Contractor is unable to offer its elected Community Supports to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, Contractor must submit ongoing progress reports to DHCS in a format and manner specified by DHCS.
- C. Contractor must ensure its contracted Community Supports Providers have sufficient capacity to receive referrals for Community Supports and provide the agreed-upon volume of Community Supports to Members who are authorized for such services on an ongoing basis.

5. Community Supports Model of Care

- A. Contractor must develop a Community Supports MOC in accordance with the DHCS-approved Community Supports MOC template. The Community Supports MOC must specify Contractor's framework for providing Community Supports, including a listing of its Community Supports Providers and policies and procedures for partnering with Community Supports Providers for the provision of Community Supports.
- B. In developing and executing Subcontractor Agreements with Community Supports Providers, Contractor must incorporate all requirements and policies and procedures described in its Community Supports MOC, in addition to all applicable APLs.

- C. Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county, on the development of its Community Supports MOC.
- D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must submit to DHCS any Significant Changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable APLs. Significant Changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services, approved policies and procedures, and Subcontractor Agreement boilerplates.

6. Identifying Members for Community Supports

- A. Contractor must utilize a variety of methods to identify Members who may benefit from Community Supports, in accordance with all applicable APLs.
- B. Contractor must develop policies and procedures for Community Supports, and submit its policies and procedures to DHCS for review and approval prior to its implementation. Contractor's policies and procedures must address the following, at a minimum:
 - 1) How Contractor will identify Members eligible for Community Supports;
 - 2) How Contractor will notify Members; and
 - 3) How Contractor will accept requests for Community Supports from Providers, other community-based entities, and Member or Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons.
- C. Contractor must submit all Member notices to DHCS for review and approval prior to implementation.
- D. Contractor must ensure that Member identification methods for Community Supports are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.
- E. Transition of WPC and HHP to Community Supports
 - 1) In HHP and WPC pilot counties, Contractor may offer Community Supports to HHP and WPC Members who receive similar services through WPC or HHP for continuity of the services being delivered as part of those programs.
 - 2) In HHP and WPC pilot counties, Contractor must enter into Subcontractor Agreements with all WPC Lead Entities and HHP CB-CMEs as Community Supports Providers, regardless of whether Contractor offers Community Supports on a county-wide basis, unless Contractor receives prior written approval from DHCS, through the Community Supports MOC review process, based on one (1) or more of the following exceptions:
 - a) The Community Supports Provider does not provide the Community Supports that Contractor elected to offer;
 - b) There is a justified quality of care concern with the Community Supports Provider;
 - c) Contractor and the Community Supports Provider are unable to agree on contracted rates;

- d) The Community Supports Provider is unwilling to enter into a Subcontractor Agreement;
- e) The Community Supports Provider is unresponsive to multiple attempts to enter into a Subcontractor Agreement;
- f) The Community Supports Provider is unable to comply with the Medi-Cal enrollment process or vetting by Contractor; or
- g) The Community Supports Provider without a State-level pathway to Medi-Cal enrollment is unable to comply with Contractor's processes for vetting qualifications and experience.

7. Authorizing Members for Community Supports and Communication of Authorization Status

- A. Contractor must develop policies and procedures that explain how Contractor will authorize Community Supports for eligible Members in an equitable and non-discriminatory manner. Contractor's policies and procedures must be submitted to DHCS for review and approval prior to implementation.
- B. Contractor must monitor and evaluate Community Supports authorizations to ensure they are equitable and non-discriminatory. Contractor must have policies and procedures in place for immediate actions that will be undertaken if monitoring/evaluation processes reveal that service authorizations have had an inequitable effect.
- C. For Members with an assessed risk of incurring other California Medicaid State Plan services, such as inpatient hospitalizations, skilled nursing facility stays, or emergency department visits, Contractor must develop policies and procedures to ensure appropriate clinical support authorization of Community Supports for Members. Contractor's policies and procedures must include detailed documentation that a Network Provider using their professional judgement has determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in accordance with all applicable APLs and to be defined in forthcoming guidance.
- D. Contractor must not restrict the authorization of Community Supports only to Members transitioning from WPC or HHP.
- E. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports.
 - 1) If Medically Necessary, Contractor must make available the California Medicaid State Plan services that the Community Supports replaces, pending authorization of the requested Community Supports.

- 2) Contractor must evaluate and document whether a service is medically appropriate and cost-effective when determining whether to provide Community Supports to a Member. Providing particular Community Supports to a Member in one (1) instance does not automatically mean that providing other Community Supports to the same Member, the same Community Supports to another Member, or the same Community Supports to the same Member in a different instance would be medically appropriate and cost-effective.
- F. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with all applicable APLs.
 - G. When a Member has requested Community Supports, directly or through a Provider, community-based organization, or other entity, Contractor must notify the requesting entity and Member of Contractor's decision regarding Community Supports authorization, in accordance with all applicable APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.
 - H. Member always retains the right to file Appeals and/or Grievances if they request one (1) or more Community Supports offered by Contractor, but were not authorized to receive the requested Community Supports because of a determination that it was not medically appropriate or cost effective.
 - I. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 21-011.

8. Referring Members to Community Supports Providers for Community Supports

- A. Contractor must develop and maintain policies and procedures to define how Community Supports Provider referrals will occur. Contractor's policies and procedures must be submitted to DHCS for review and approval prior to implementation.
 - 1) For Members enrolled in ECM, policies and procedures must address how Contractor will work with the ECM Provider to coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider, such as using closed loop referrals.
 - 2) Contractor's policies and procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.

- B. If the Member prefers a particular Community Supports Provider are known, Contractor must follow those preferences, to the extent practicable.
- C. Contractor must track referrals to Community Supports Providers to verify if the authorized service has been delivered to the Member.

If the Member receiving the Community Support is also receiving ECM, Contractor must monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the Community Supports Provider.

- D. Contractor must not require Member authorization for Community Supports-related data sharing as a condition of initiating delivery of Community Supports, unless such authorization is required by federal law.
- E. Contractor must develop and maintain policies and procedures for its network of Community Supports Providers to:
 - 1) Ensure the Member agrees to receive Community Supports;
 - 2) Where required by law, ensure that Members authorize information sharing with Contractor and all others involved in the Member's care as needed, to support the Member and maximize the benefits of Community Supports, in accordance with all applicable APLs;
 - 3) Provide Contractor with Member-level records of any obtained authorization for Community Supports related data sharing which are required by law, and to facilitate ongoing data sharing with Contractor; and
 - 4) Obtain Member authorization to communicate electronically with the Member, Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons, if Contractor intends to do so.

9. Data System Requirements and Data Sharing to Support Community Supports

- A. Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals.

Contractor must support Community Supports Provider access to systems and processes allowing them to track and manage referrals for Community Supports and Member information.

- B. Consistent with federal, State, and if applicable, local privacy and confidentiality laws, Contractor must ensure Community Supports Providers have access to the following as part of the referral process to the Community Supports Providers:

- 1) Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;
 - 2) Appropriate administrative, clinical, and social service information that Community Supports Providers might need to effectively provide the requested service; and
 - 3) Billing information necessary to support the Community Supports Providers' ability to submit claims or invoices to Contractor.
- C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

10. Contractor's Oversight of Community Supports Providers

- A. Contractor must comply with all State and federal reporting requirements.
- B. Contractor must perform oversight of Community Support Providers, holding them accountable to all Community Supports requirements contained in this Contract and all applicable APLs.
- C. Contractor must use all applicable APLs to develop its Subcontractor Agreements with Community Support Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Subcontractor Agreements with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS.
- D. To streamline Community Supports implementation, Contractor must ensure the following:
- 1) Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS.
 - 2) Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter and supplemental reporting.
 - 3) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on reporting requirements and oversight.
- E. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of Community Supports Providers, unless by mutual consent with the Community Supports Provider.
- F. Contractor must provide Community Supports training and technical assistance to Community Supports Providers, including in-person sessions, webinars, and calls, as necessary, in addition to Network Provider training requirements as described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

11. Delegation of Community Supports Administration to Subcontractor(s)

- A. Contractor may enter into Subcontractor Agreements with other entities to administer Community Supports in accordance with the following:
- 1) Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;
 - 2) Contractor is responsible for developing and maintaining DHCS-approved policies and procedures to ensure Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;
 - 3) Contractor must evaluate the prospective Subcontractor's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;
 - 4) Contractor must ensure the Subcontractor's Community Supports Provider capacity is sufficient to serve all Populations of Focus;
 - 5) Contractor must report to DHCS the names of all Subcontractors by type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment 6, Provision 12, Subcontractor Reports; and
 - 6) Contractor must make all Subcontractor Agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements.
- B. Contractor must ensure that the Subcontractor Agreement mirror the requirements set forth in this Contract and all applicable APLs, as applicable to the Subcontractor.
- C. Contractor may collaborate with its Subcontractors on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Subcontractor(s) and ensure a streamlined, seamless experience for Community Supports Providers and Members.

12. Payment of Community Supports Providers

- A. Contractor must pay contracted Community Supports Providers for the provision of authorized Community Supports to Members in accordance with established Subcontractor Agreements between Contractor and each Community Supports Provider.

- B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment 8, Provision 5, Claims Processing.
- C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for an individual who is homeless and being discharged from the hospital.

For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the Community Supports Provider is expedited. Contractor must submit these policies and procedures to DHCS for review and approval prior to implementation.

- D. Contractor shall ensure Community Supports Providers submit a claim for rendered Community Supports, to the greatest extent possible.
 - 1) If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider documents services rendered using an invoice approved by DHCS.
 - 2) Upon receipt of such invoice, Contractor must document the Encounter for the Community Supports rendered.

13. DHCS Oversight of Community Supports

- A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers, in accordance with all applicable APLs.
- B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:
 - 1) Encounter Data
 - a) Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor must be compliant with DHCS guidance on invoicing standards for Contractor to use with Community Supports Providers.
 - b) Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under Subcontractor Agreements.

- c) In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor must convert Community Supports Providers' invoice data into the national standard specifications and code sets, for submission to DHCS.
 - d) Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS.
 - 2) Supplemental reporting on a schedule and in a form to be defined by DHCS.
- C. Contractor must timely submit any related data requested by DHCS, CMS, or an independent entity conducting an evaluation of Community Supports including, but not limited to:
- 1) Data to evaluate the utilization and effectiveness of a Community Supports.
 - 2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.
 - 3) Data necessary to monitor Member Appeals and Grievances associated with Community Supports.
- D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions in accordance with Exhibit E, Attachment 2, Provision 17, Sanctions.

14. Community Supports Quality and Performance Incentive Program

- A. Contractor must meet all quality management and Quality Improvement requirements described in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.
- B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and outcomes, and other

performance milestones and measures, in accordance with DHCS policies and guidance.