KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Enhanced Care Management Member Authorization				POLICY #: 18.20-P	
DEPARTMENT: Enhanced Care Management					
Effective Date: 1/2022	Review/Revised Date: 2/12/2024	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date_____
Emily Duran
Chief Executive Officer

_____ Date_____
Chief Medical Officer

_____ Date _____
Director of Enhanced Care Management

_____ Date _____
Senior Director of Claims

_____ Date _____
Senior Director of Provider Network

POLICY:

Kern Health Systems (KHS) will authorize Members for the Enhanced Care Management (ECM) benefit in compliance with all Department of Health Care Services (DHCS) requirements.

PROCEDURE:

A. KHS will proactively identify Members who can benefit from ECM and who meet the criteria for the ECM Populations of Focus as described in the DHCS ECM guidelines.

1. KHS will identify eligible Members through monthly stratification of the KHS population. Populations of Focus will be identified through defined criteria and methodologies utilizing

data elements including but not limited to medical and pharmacy claims, DHCS fee for service claims, care management program information, Adjusted Clinical Group (ACG) modeler files, Electric Medical Record (EMR) data, Health Risk Assessment (HRA) results, and other external supplemental data. Please see data matrix for additional methodologies related to individual Populations of Focus.

2. To be eligible for ECM, a Member must fall into one of the mandatory Populations of Focus.
    a. Members that are identified as eligible for the KHS ECM program will be auto authorized for a period of 12 months.
3. Contracted ECM Providers may directly or presumptively pre-authorize Members that preliminarily meet the criteria and will benefit from ECM for a 60-day period. KHS will validate or deny ECM based on a complete assessment of Member eligibility and proceed with the standard authorization and denial procedure.
4. Members receiving ECM in a previous plan are considered ECM-eligible upon enrollment at KHS. KHS will automatically authorize ECM eligibility for such Members in the new plan.
    a. KHS may receive requests directly from the Member, the Member's family, or authorized representative (AR) requesting ECM. Upon Member request and attestation, KHS will automatically authorize such Member requests and reassess Members based on their ECM discontinuation criteria.
        i. KHS ECM Care Team will work with the previous Managed Care Plan (MCP), the Member or ECM Provider to obtain access to the Member's Care Management Plan to mitigate any gaps in care.
        ii. KHS will follow the standard process outlined in Section D. Assignment to ECM Provider of the ECM Outreach and Engagement Policy for assigning Members to ECM Providers and take steps to re-assess Members based on their discontinuation criteria.
    b. KHS will receive ECM encounter data as part of the 12-month historical utilization data set under the Plan Data Feed. KHS will assign any "new" ECM Members who have historical ECM service utilization within the prior 90 days using their standard ECM outreach and engagement process.
        i. The presence of ECM service HCPCS codes contained within the prior 90 days of historical utilization data KHS receives is sufficient to add the Member to the KHS existing ECM outreach and engagement process and assign to an ECM Provider.
        ii. KHS will initiate the standard ECM assignment process with Members that are identified through this process as soon as we become aware of this information.
5. Members transitioning from WPC (Whole Person Care) Pilot and HHP (Health Homes Program) will be auto authorized for a period of 6 months. During the 6-month period, Members will need to be reevaluated for continued participation in the ECM program by the following:
    a. ECM Provider assessment of medical, behavioral, dental, and social needs.
    b. ECM Provider assessment for discontinuation as required in Section 11 of the ECM CalAIM ECM and Community Supports Contract. ECM Providers will notify KHS to discontinue ECM for Members if any of the following circumstances are met:

i. The Member has met all care plan goals.
ii. The Member is ready to transition to a lower level of care.
iii. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
iv. The ECM Provider has not been able to connect with the Member after multiple attempts.

c. Members who are not discontinued will receive an additional 12-month authorization of the ECM benefit and will be notified of continued participation via letter.
d. ECM Providers will be notified of Members reauthorization, or ECM discontinuation, to include ECM graduation to a lower level of care using disenrollment reasons and codes via an Enrollment File accessed via Secure File Transfer Protocol (SFTP).

6. Self-referrals or referrals by family members, caregivers or support networks will be evaluated by the KHS ECM Care Team to determine eligibility. KHS will determine eligibility within 5 working days for routine authorizations and within 72 hours for expedited requests.
    a. If a Member meets eligibility, an authorization for a period of 12 months will be given. Authorized Member notifications will be sent to the ECM provider(s) and PCP within 10 business days of authorization.
    b. If a Member does not meet eligibility criteria, the Member's referral will be reviewed by a KHS medical director for approval or denial.
    c. Notification of approval or denial will be sent to the referring Member.
        i. If approved, the ECM Provider will receive an outpatient notification form identifying the approved authorization. The ECM Provider will outreach and enroll the authorized Member.
        ii. If denied, the Member will receive a Notice of Action from KHS and be provided with notification of grievance and appeal rights.
    d. Denials will go through the KHS appeals and grievance processes.

7. Requests or referrals from Network Providers including, but not limited to, Primary Care, Specialists, County behavioral health agencies, Tribal Partners, and local agencies such as Primary or Secondary care facilities servicing the KHS population, Tertiary centers servicing KHS population, Skilled Nursing Facilities/Sub Acute Facilities/ In-Patient Rehabilitation Services, Home Health Agencies, Community Based Adult Services (CBAS) Providers, Home and Community Based Waiver Providers, Area Agencies on Aging, and Centers for Independent Living) will submit referrals via the provider portal. KHS will determine eligibility within 5 working days for routine authorizations and within 72 hours for expedited requests.
    a. These referrals will be reviewed by the ECM Team and if eligible, Members will receive an authorization for 12 months.
    b. If a Member does not meet eligibility criteria, the Member's referral will be reviewed by a KHS medical director for approval or denial.

c. Notification of approval or denial will be sent to the referring Provider. If authorized, the Member's PCP will be notified within 10 business days.
d. Members will also be notified of decision with notification of grievance and appeal rights.

8. KHS will work with the ECM providers in monitoring Members that are due for reevaluation for authorization.

B. Reauthorization Process

1. Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.
2. Upon expiration of the initial 12-month authorization, Members will need to be reevaluated for continued participation in the ECM program by the following:
    a. ECM Provider assessment of medical, behavioral, dental, and social needs.
    b. ECM Provider assessment for discontinuation as required in Section 11 of the ECM CalAIM ECM and Community Supports Contract. ECM Providers will notify KHS to discontinue ECM for Members if any of the following circumstances are met:
        i. The Member has met all care plan goals.
        ii. The Member is ready to transition to a lower level of care.
        iii. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
        iv. The ECM Provider has not been able to connect with the Member after multiple attempts.
3. Members who are not discontinued will receive an additional 6-month authorization of the ECM benefit and will be notified of continued participation via letter.
4. ECM Providers will be notified of Members reauthorization, or ECM discontinuation, to include ECM graduation to a lower level of care using disenrollment reasons and codes via an Enrollment File accessed via SFTP.
5. At the time of reassessment, Care Team members will evaluate appropriateness of other KHS programs and necessary level of care based on ongoing needs including cessation of all case management services. Cases are typically closed 60–90 days after Members have reached their goals. The ECM Provider will document each graduation from Enhanced Care Management and submit a disenrollment request to KHS. The KHS Care Team will document each graduation within the KHS system.
6. KHS will apply the following graduation criteria:
    a. The Member is well managed and has met all care plan goals.
    b. The appropriate risk assessment tool(s) has/have been completed and actionable issues have not been identified.
7. Interdisciplinary Care Team (ICT) meeting has occurred, and ECM Care Team members have mutually agreed Member has met goals and does not have further needs to be addressed.
        i. Member should participate in the ICT and agree with graduation. If Member is not in agreement, ECM services will continue for 60 days with the care plan goal of transitioning to an appropriate KHS Population Health

Management Program (lower level of care). Before the end of the 60 days the ECM Care Team will have an ICT review, including the Member, to assess if graduation is still appropriate or if ECM services should continue. If the Care Team determines graduation is appropriate, the Member will be referred to KHS and be screened for an appropriate KHS Population Health Management Program (lower level of care).

8. All KHS members are stratified on a monthly basis to determine if they are appropriate for any available Population Health programs. Members graduating from ECM will be referred to KHS to be screened and offered enrollment in the appropriate KHS Population Health Management Program (lower level of care).
9. Members no longer authorized to receive the ECM benefit and who quality for ECM discontinuation will receive a Notice of Action (NOA) identifying their disenrollment from KHS. This includes information of their right to appeal, and the appeals process by way of the DHCS outlined NOA process. Notification of disenrollment will be sent to each Member's Provider.

C. Continuity of Care (CoC)

1. KHS will demonstrate policies, procedures, and processes ensuring Medi-Cal members with authorizations to receive Enhanced Care Management (ECM) do not experience disruptions to the ECM authorization, provider relationships, or services in accordance with the 2024 MCP Transition Policy Guide.
2. KHS will honor all of the previous MCP's authorizations for ECM.
3. KHS will maintain all authorizations for no less than the length of time originally authorized by the previous MCP, regardless of whether members are actively receiving ECM.
4. If a previous MCP's ECM Provider does not wish to enter into a contract with KHS' network or if both parties cannot come to an agreement, KHS will offer a CoC for Provider agreement with the ECM Provider for up to 12 months.
5. If KHS's efforts do not result in an agreement with the ECM Provider, KHS will explain in writing to DHCS why the Provider and the KHS could not execute a contract or CoC for Provider agreement.
6. If KHS confirms that the member's existing ECM Provider is part of its network, agrees to join its network, or participates under a CoC for Provider agreement, KHS will assign the member to their existing ECM Provider to ensure the member's relationship with their ECM Provider is not disrupted.
7. If KHS does not bring the ECM provider into its network or establish an agreement with the ECM Provider, KHS will transition the member to an in-network ECM Provider for outreach activity and continuation of ECM.

REFERENCE:

Revision 2023-09: Policy updated to include requirements of 2024 Medi-Cal Managed Care Plan Transition Policy Guide - Chapter VI Enhanced Care Management. DHCS approval 11/13/2023. **Update 2023-01:** On 1/20/2023, the policy received approval for Prime & Subcontractor Authorization Alignment. **Revision 2022-12:** Policy received DHCS approval on

12/8/2022 per ECM MOC Addendum 1. **Revision 2022-06:** Policy received DHCS approval on 6/20/2022 per MOC 2022. **Revision 2021-12:** General approval for MOC Part 1-3 received by DHCS to implement ECM on January 1, 2022.

- ECM Outreach and Engagement Policy, 18.21-P.