KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Enhanced Care Management Member Authorization	**Policy #**	18.20-P
Policy Owner	Enhanced Care Management	**Original Effective Date**	01/2022
Revision Effective Date	12/2025	**Approval Date**	01/08/2026
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

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.

II. POLICY

KHS will 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.

III. DEFINITIONS

TERMS	DEFINITIONS
N/A	

IV. PROCEDURES

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. To be eligible for ECM, a Member must fall into one of the mandatory Populations of Focus.

    a. Members that are initially identified as eligible for the KHS ECM program will be authorized for a period of twelve (12) months.

B. Stratification Management:

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 available medical and pharmacy claims, DHCS fee for service claims, care management program information, Adjusted Clinical Groups (ACG) modeler files, Electronic Medical Record (EMR) data, Health Risk Assessment (HRA) results, and other external supplemental data.

C. **Referral Management:**

1. Contracted ECM Providers may submit "Streamlined" authorizations for members that preliminarily meet the criteria and will benefit from ECM for a thirty (30)-day period of ECM services. KHS will validate or deny ECM based on a complete assessment of Member eligibility and proceed with the standard authorization and denial procedure.

2. Self-referrals or referrals by family members, caregivers or support networks will be evaluated by KHS to determine eligibility. KHS will determine eligibility within seven (7) calendar days for routine authorizations and within seventy-two (72) hours for urgent requests.

    a. If a Member meets eligibility, an initial authorization for a period of twelve (12) months will be given. Authorized Member notifications will be sent to the ECM provider(s) and the member's assigned Primary Care Physician (PCP) within ten (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 intended member.
        i. If approved, the ECM Provider will receive an outpatient notification form identifying the approved authorization.
        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, pursuant to KHS Utilization Management policy 3.22-P Referral and Authorization Process §4.3.

3. Requests or referrals from contracted 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 the 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 five (5) working days for routine authorizations and within seventy-two (72) hours for urgent requests.

a. These referrals will be reviewed by the ECM Team and if eligible, members will receive an initial authorization for twelve (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 ten (10) business days.
d. Members will also be notified of the decision with notification of grievance and appeal rights.

4. Effective January 1, 2026, all Managed Care Plans (MCPs) will be required to provide Transitional Rent (TR) as a standard benefit. In conjunction with this, members authorized to receive TR are automatically eligible for Enhanced Care Management (ECM) services. Kern Health Systems (KHS) will be responsible for authorizing eligible members into ECM if they are not already enrolled. KHS will uphold and respect the rights of members to decline ECM services even in the presence of TR enrollment.

D. Closed Loop Referral Management

l. ECM referrals are required to be tracked, supported, and monitored by Kern Health Systems through the Closed-Loop Referral (CLR) process as per DHCS guidelines. CLR requirements aim to improve information collection, supportive actions on individual referrals, and system-level improvements that will result in Members being connected more quickly to priority services for their health and well-being.

a. ECM member referrals must be tracked by KHS to ensure the referrals are complete and that necessary information is shared timely and accurately. ECM program providers must engage in data exchange with KHS to receive referrals timely, accurately, and must return referral status information to KHS in a timely, accurate manner, to ensure that the referral has been responded to.
b. KHS will support member referrals by such methods as intervening to support individual referrals that experience barriers, initiating re-referrals, closing the loop, and/or informing Members and Referring Entities of a referral's progress, etc. Strategies may include working with individual ECM program providers to escalate referrals that have not been responded to timely and/or assisting ECM program providers with any barriers they may be experiencing, etc. Should a referral be denied by an ECM program provider due to eligibility or capacity of the ECM program provider, KHS will either follow-up with the ECM program provider for more information and/or will reassign the referral to ensure the member receives timely ECM outreach and/or services.

c. KHS will monitor trends in the ECM Closed-Loop Referral process regarding the timely connection of Members to services. KHS will take data-driven action to support the CLR process, including but not limited to sharing the volume of Members that an ECM program provider continues to have pending referrals for and identifying ECM program providers with higher rates of Referral Loop Closure due to 'Member Unable to Reach.'
d. It is expected that all ECM program providers will respond to assigned ECM referrals in a timely and accurate manner. KHS will reassign referrals as needed to different ECM program providers based on overall referral-closure rates and/or an ECM program provider's failure to respond timely to referrals on an ongoing basis. Should there be multiple failures to respond timely and appropriate technical assistance has been provided by KHS, an ECM program provider could be at risk of losing their assigned eligibility list(s) for reassignment to other available ECM program providers.

   KHS will submit data as required back to DHCS for the overall monitoring of Closed-Loop Referrals.

E. Reauthorization Process

1. 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. Review of all active plan of care goals, problems and related interventions necessitating continued ECM services.
   c. 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.

2. Members who are not discontinued will receive an additional six (6) month authorization of the ECM benefit and will be notified of continued participation via letter.

3. ECM Providers will be notified of Member's 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 Safe File Transfer Protocol (SFTP).

4. KHS will leverage the internal auditing team to complete focused sampled membership to vet if active plan of care is present for member being requested to be reauthorized by, but not limited to, remote access to vendor electronic health record data, member contact, provider contact and formal in-person site audits to ensure relevant plan of care data is present to warrant reauthorization of ECM services.

5. Members no longer authorized to receive the ECM benefit and who qualify for ECM discontinuation will receive a Notice of Action (NOA) identifying their disenrollment from ECM. 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.

6. All KHS Members are stratified monthly 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).

F. 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.

2. KHS will honor all the previous Managed Care Plan's (MCP's) authorizations for ECM and comply with the outlined DHCS guidance to automatically authorize newly enrolled Member in the following scenarios:

    a. The previous MCP informs the new MCP that the Member received ECM during the last ninety (90) days of enrollment in the previous MCP and did not subsequently either meet graduation criteria or choose to discontinue ECM.
    b. Historical utilization data provided to the new MCP by DHCS (referred to as the Plan Data Feed) reveals one or more ECM Healthcare Common Procedure Coding System (HCPCS) codes for ECM services delivered during the last ninety (90) days of enrollment in the previous MCP.
    c. The Member, family, or Authorized Representative notifies the new MCP that the Member received ECM during the last ninety (90) days of enrollment in the previous MCP and wishes to continue to do so.
    d. The Member's previous ECM Provider notifies the new MCP that the Member received ECM during the last ninety (90) days of enrollment in the previous MCP and recommends continuation of ECM: or
    e. The new MCP becomes aware that a newly enrolled Member received ECM during the last ninety (90) days of enrollment in the previous MCP, in any other way.

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 KHS confirms that the Member's existing ECM Program Provider is part of its contracted network, KHS will assign the member to the same ECM program provider unless the member chooses a different ECM program provider. If the existing ECM program provider is not already contracted with KHS, KHS will explore potential contracting as appropriate.

5. Ultimately, if a member is receiving ECM services from a non-contracted ECM program provider and potential contracting is either not an option or the contracting process will delay any ECM provision of services, KHS will transition the member to an in-network ECM Provider for outreach activity and continuation of ECM.

6. Effective January 1, 2026, Dual Eligible Special Needs Plans (D-SNPs) must ensure up to 12 months of continuity of care with existing Medi-Cal Enhanced Care Management (ECM) providers for members transitioning into Kern Health System's D-SNP program, when feasible. To promote seamless care coordination and minimize service disruption, duplication, and maintain continuity, KHS will align with the established Department of Health Care Services (DHCS) framework that transitions members into the KHS D-SNP-led care management. KHS will assume responsibility for care management upon member transition while adhering to additional state-specific standards outlined in California Integrated Care Management (CICM).

V. ATTACHMENTS

N/A	

VI. REFERENCES

Reference Type	Specific Reference
Regulatory	CalAIM Addendum to the PHM Policy Guide: Closed-Loop Referral Implementation Guidance
Other KHS Policies	3.22-P Referral and Authorization Process §4.3.

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	12/2025	Minor revision made to referral management	D.D. Enhanced Care Management

Revised	09/2025	Policy updated for upcoming Transitional Rent and D-SNP program requirements.	D.D. Enhanced Care Management
Revised	04/2025	Policy updated for annual review. Policy approved by DHCS for Post OR R.0072.	D.D. Enhanced Care Management
Revised	09/2024	Policy updated for annual review	D.D. Enhanced Care Management
Revised	09/2023	Policy updated to include requirements of 2024 Medi-Cal Managed Care Plan Transition Policy Guide - Chapter VI Enhanced Care Management.	-
Revised	01/2023	On 1/20/2023, the policy received approval for Prime & Subcontractor Authorization Alignment	-
Created	01/2022	General approval for MOC Part 1-3 received by DHCS to implement ECM on January 1, 2022.	-

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
N/A		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Department of Health Care Services (DHCS)	6/6/2025, DHCS for Post OR D.0342 (R.0072)	7/3/2025
Department of Health Care Services (DHCS)	2024 Medi-Cal Managed Care Plan Transition Policy Guide - Chapter VI Enhanced Care Management	11/13/2023
Department of Health Care Services (DHCS)	Prime & Subcontractor Authorization Alignment	01/2023
Department of Health Care Services (DHCS)	ECM MOC Addendum 1	12/8/2022
Department of Health Care Services (DHCS)	MOC 2022	06/20/2022
Department of Health Care Services (DHCS)	MOC Part 1-3	12/2022
Department of Health Care Services (DHCS)	2024 Contract Readiness R.0072, Under & Overutilization	09/15/2022