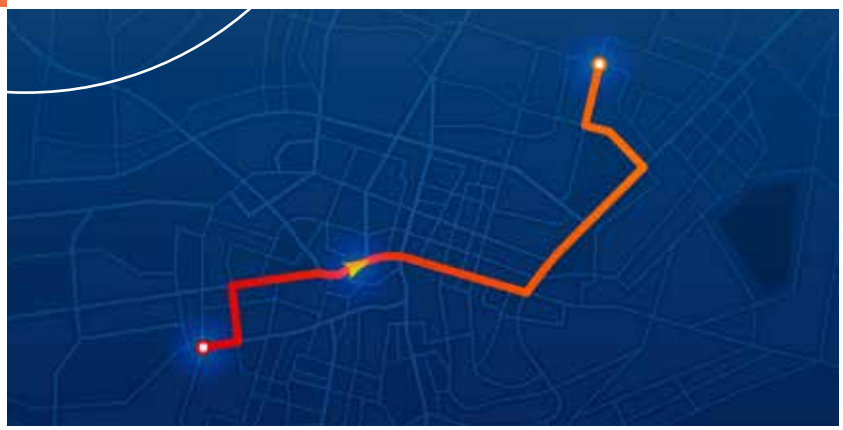
CHCF

CalAIM and Health Data Sharing:
A Road Map for Effective Implementation of Enhanced Care Management and In Lieu of Services

MAY 2021



AUTHORS
Jonah Frohlich, Kevin McAvey, and Jonathan DiBello
Manatt Health Strategies

About the Authors

This paper was authored by the following team of individuals at Manatt Health Strategies: Jonah Frohlich, MPH, managing director; Kevin McAvey, MA, MPP, director; and Jonathan DiBello, MPH, consultant. **Manatt Health Strategies** is a consulting subsidiary of Manatt, Phelps & Phillips, and combines legal excellence, firsthand experience in shaping public policy, strategy insight, and deep analytic capabilities to provide professional services to the full range of health industry players.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Contents

Executive Summary

In 2022, the California Department of Health Care Services (DHCS) will launch an ambitious and innovative program designed to address the complex physical, behavioral, and social needs of Medi-Cal's most vulnerable members. The California Advancing and Innovating Medi-Cal (CalAIM) program will build upon the plan-based Health Homes Program (HHP) and county-based Whole Person Care (WPC) pilots that use whole-person care approaches to address underlying social determinants of health (SDOH). CalAIM envisions enhanced coordination, integration, and information exchange among managed care plans (MCPs); physical, behavioral, community-based, and social service providers; and county agencies by establishing new benefits and services including:

- **Enhanced Care Management (ECM)** benefit, which will provide intensive whole-person care management and coordination to address the clinical and nonclinical needs of Medi-Cal members with complex needs. MCPs will administer and oversee ECM benefits, identifying members in each of the ECM target populations and assigning them to "ECM providers" who will be responsible for conducting outreach and for coordinating and managing care across a broad spectrum of physical, behavioral, and social service providers. ECM services will be community-based, with high-touch, on-the-ground, face-to-face, and frequent interactions between members and ECM providers.

- **In Lieu of Services (ILOS)**, which are cost-effective, health-supporting services that may be substituted for existing State Plan–covered services to reduce hospitalization and institutionalization, reduce cost, and address underlying drivers of poor health. DHCS will allow 14 ILOS categories, including housing transition and navigation services, respite care, day habilitation programs, and nursing facility transition support to assisted living facilities or a home. MCPs may choose which ILOS to cover, in which counties, and to which members.

The ECM and ILOS programs will engage a broad set of MCPs, providers, county agencies, and community-based organizations (CBOs). Many of these organizations, especially CBOs, do not currently interact extensively with the health care system and have limited information technology capacity. Nevertheless, their participation in the program and ability to share and use administrative, health, and social service information will be vital in carrying out ECM and ILOS program functions including:

- **ECM member identification, review, and authorization**, where MCPs will identify target ECM populations by compiling and analyzing data and information received from counties, providers, members, and others.

- **ECM assignment and member engagement**, where MCPs will assign members to an ECM provider based on their previous provider relationships, health needs, and known preferences, and ECM providers will use available information to reach and engage members into the ECM benefit.

- **ECM care plan development, sharing, and use**, where ECM providers will develop care plans using data acquired from the MCP, the member, and other sources, and make the care plan available for use by a member's care team.

- **ECM care coordination and referral management**, where ECM providers will support coordinated and transitional care, and engage MCPs' referral network for community and social services, including ILOS.

- **ECM and ILOS billing and encounter reporting practices**, where ECM and ILOS providers will record and report services rendered to MCPs, and MCPs will report complete and accurate encounters of all services provided by contracted ECM and ILOS providers to DHCS.

- **ECM and ILOS quality measure and performance reporting**, where MCPs will report DHCS-specified quality and performance metrics to demonstrate ECM and ILOS program impact on member health, well-being, and costs.
- **ILOS needs assessment and referral management**, where MCPs and ECM and ILOS providers will identify members requiring ILOS benefits, and MCPs, primary care physicians, or ECM providers will connect members to ILOS through a closed-loop referral process.

This implementation road map identifies data, data exchange, and information system barriers to implementing ECM and ILOS program functions, and offers a set of recommendations and actions for policymakers, government agencies, MCPs, and providers (see Table 1 on page 5). As the road map describes, whole-person approaches to care require all parties in a community to step outside of their traditional boundaries to provide a level of collaboration and coordination that addresses drivers of health. These road map recommendations address three categories of data sharing barriers and the steps necessary to mitigate them, including:

- **Regulations and policies** to facilitate safe and secure information sharing
- **Technical infrastructure and standards** to support the efficient collection, exchange, and use of member information
- **Financing, contracting, and operations**, where aligning incentives, contracting, and tactics is crucial to institutionalizing the programs and ensuring their long-term success

Each recommendation offers a proposed set of actions, including their sequence and timing for implementation. Road map development was informed by over two dozen interviews and an advisory group composed of DHCS, MCPs, county agencies, providers, and community-based organizations.

Table 1. Road Map Recommendations Overview: CalAIM and Health Data Sharing

RECOMMENDATIONS LEGEND ➤ Regulations/Policies ➤ Technical Infrastructure/Standards ➤ Financing/Contracting/Operations	ROAD MAP ACTIONS		
	2021	2022–24	2025+
1. Legal and regulatory alignment for data exchange: Sharing physical, behavioral, and social service information implicates a broad cross-section of federal and state privacy rules and regulations, with differing levels of associated consent policies, and financial and criminal penalties.			
➤ Extend WPC authorizing legislation to apply to all entities participating in ECM, ILOS, and other Medi-Cal care management programs.	State lawmakers should work with DHCS to develop legislation and subsequent guidance that permits information exchange activities in support of CalAIM and Medi-Cal program objectives.		
➤ Develop "universal consent" guidance.	DHCS should establish a workgroup to support the development of standard consent form elements and case examples.	The DHCS workgroup should develop recommendations that address federal law and refine state law to create a statewide universal consent form. Depending on the findings of the workgroup, the California Health & Human Services Agency (CHHS) should work with stakeholders and the legislature to craft legislation or an executive order to facilitate creation of a universal consent form.	
➤ Remove statutory barriers to a universal consent form.	CHHS should establish a multi-department workgroup to assess statutory barriers to implementing a universal consent form, and required actions to resolve them.[1]		
➤ Develop legal guidance for health information exchange (HIE) for ECM and ILOS stakeholders.	California Office of Health Information Integrity (CalOHII) should work closely with DHCS to draft and refine State Health Information Guidance (SHIG) to clarify laws and regulations that affect disclosure of physical, behavioral, and social service information, and should offer technical assistance to advise when various data may be shared to support program functions.		
➤ Develop member condition or status identifiers to reduce unnecessary sensitive data sharing.	MCPs should work with ECM/ILOS providers to determine where standard proxy indicators may be shared in lieu of full patient data.	MCPs and ECM/ILOS data sharing providers should implement proxy measures where DHCS/CalOHII exchange tactics indicate that full release of patient data may not be feasible.	
➤ Implement electronic consent management systems.	MCPs should develop and test data sharing consent management systems with ECM, ILOS, county, and other providers.	MCPs should implement consent management systems, refining access and utilities as needed.	
➤ Integrate ECM participation and data sharing consent in the Medi-Cal enrollment application.	DHCS should assess options to acquire ECM and other program and data sharing member consents during enrollment.	DHCS should implement collection of ECM participation and data sharing consent during enrollment and redetermination and share consent information with MCPs.	

Table 1. Road Map Recommendations Overview: CalAIM and Health Data Sharing, *continued*

RECOMMENDATIONS LEGEND ➤ Regulations/Policies ➤ Technical Infrastructure/Standards ➤ Financing/Contracting/Operations	ROAD MAP ACTIONS		
	2021	2022–24	2025+
2. Statewide infrastructure for data exchange: Many ECM and ILOS participants including providers, county agencies, CBOs, and payers do not have information technology capabilities necessary to support robust cross-sector data exchange. Standards, data sharing specifications, and infrastructure are needed, especially for housing, justice, and other social data. ECM and ILOS program participants will build on the WPC pilot infrastructure to advance ECM and ILOS objectives.			
➤ Develop a legislative mandate requiring participation in HIE activities and care transition notifications.	The governor's office, DHCS, CalPERS (California Public Employees' Retirement System), Covered California, and other stakeholders should work with the legislature to craft legislation that defines a vision for statewide information exchange, including use cases, financing mechanisms, and types of data and providers that should be required to share information.	➤ State agencies should be required to implement and enforce legislative requirements that specify goals, funding and incentives program opportunities, reporting requirements, and penalties in subsequent regulatory guidance. ➤ State agencies should report progress against goals and identify remaining barriers and additional actions that can be taken. ➤ State agencies should provide additional implementation guidance and support development of necessary amendments.	
➤ Develop requirements for correctional facilities to send health information to the next provider of record upon member release.	CHHS, the Board of State Community Corrections (BSCC), the California Department of Corrections and Rehabilitation (CDCR), county jails and sheriff's departments, and other stakeholders should work together to identify funding sources and define HIE requirements for correctional facilities to share health information with community providers.	CHHS, BSCC, and CDCR should implement HIE funding programs for correctional facilities and enforce data sharing requirements.	
➤ Develop standards and guidance for the exchange of SDOH information.	DHCS, CalOHII, and other stakeholders should establish standards for the collection and sharing of SDOH information.	➤ DHCS and CalOHII should develop SDOH coding guidance. ➤ MCPs should provide training on how to use new standards and ILOS billing codes.	
➤ Establish working groups to develop state standards and recommend guidance for nonmedical event notifications (e.g., housing, incarceration, employment status changes).	CHHS, CalOHII, DHCS, and other stakeholders should establish a workgroup to define requirements for sharing nonmedical event notifications and develop plans to test nonmedical event notification.	➤ CHHS, CalOHII, and DHCS should develop California-specific implementation guides, guidance, and case studies. ➤ The state and workgroup participants should test event notification protocols.	

Table 1. Road Map Recommendations Overview: CalAIM and Health Data Sharing, *continued*

RECOMMENDATIONS LEGEND ➤ Regulations/Policies ➤ Technical Infrastructure/Standards ➤ Financing/Contracting/Operations	ROAD MAP ACTIONS		
	2021	2022–24	2025+
➤ Develop Homeless Management Information System (HMIS) and correctional facility data exchange contracting requirements and financing programs.	CHHS should convene state and county agencies and stakeholders to develop template contract language requirements for data sharing.	➤ State and county health agencies including HMIS Lead Agencies and correctional facilities should incorporate data exchange requirements into vendor contracts. ➤ Agencies should identify and use funding to defray HMIS and state and county correctional facility HIE implementation costs.	
➤ Develop financing and incentive payment programs to invest in delivery system infrastructure, build care management and In Lieu of Services capacity, and improve quality performance and measurement reporting that can inform future policy decisions.	➤ DHCS should establish an incentive payment program and provide MCPs with guidance for plans to include incentive payments in their program structure. ➤ DHCS should work with legislators, MCPs, and other stakeholders to identify additional funding for needed HIE, ECM and ILOS providers, HMIS Lead Agencies, correctional facilities, and others to support capacity building and infrastructure investments.	DHCS, MCPs, and other stakeholders should enable identified incentive and funding programs.	
➤ Develop contractual requirements to participate in data exchange.	DHCS, CalPERS, and Covered California should define contractual obligations for MCPs that require contracted providers to participate in data sharing activities.	➤ DHCS, CalPERS, and Covered California should incorporate requirement into MCP contract language, providing a glide path for implementation, and assess whether further expansion of requirements is warranted. ➤ Public and private payers should develop patient visit summary, ADT (admission, discharge, transfer), and other nonmedical alert notification requirements into MCP contracts. ➤ MCPs should develop processes for sharing patient visit summary and ADT data with ECM providers and support training on use of ADT data.	
3. Care management, shared care plans, and assessment capabilities: Many ECM providers will not have robust system capabilities to unify and share care plans and to receive, aggregate, and integrate care management and care coordination information.			
➤ Develop minimum necessary care management documentation system capabilities and guidance.	DHCS should work with MCPs to develop care management documentation system expectations and requirements, and further define MCP responsibilities for ensuring ECM providers have access to such systems.		
➤ Develop shared care plan policy guidance.	DHCS should work with stakeholders to define a minimum set of sharable care plan data elements, formats, and exchange methods required to be exchanged by MCPs and their contracted ECMs.		
➤ Implement common care plan standards.		MCPs should implement DHCS guidance on minimum care plan data elements and transmission standards.	

Table 1. Road Map Recommendations Overview: CalAIM and Health Data Sharing, *continued*

RECOMMENDATIONS LEGEND ➤ Regulations/Policies ➤ Technical Infrastructure/Standards ➤ Financing/Contracting/Operations	ROAD MAP ACTIONS		
	2021	2022–24	2025+
➤ Develop accessible care management documentation systems for ECM providers lacking internal capabilities capacity.	MCPs should test care management documentation systems and options for sharing care plans with ECM providers.	➤ MCPs should deploy care management and care plan sharing platforms. ➤ MCPs should provide ongoing technical assistance (TA) to ECM and other providers to help implement care plan systems and sharing technologies and services.	
➤ Assess development of a statewide care plan repository.	DHCS, MCPs, and ECM providers should assess options to create regional or state care plan repositories.	Depending on assessment, establish regional or statewide shared care planning infrastructure.	
➤ Develop care management documentation systems and care plans training and TA programs.	MCPs should develop training program to support ECM provider adoption and use of shared care plans and care management documentation systems.		
➤ Develop financing programs to build technical capabilities for ECM and ILOS providers.	DHCS and MCPs should develop plans to access funding that supports ECM and ILOS information technology (IT) capacity.	DHCS and MCPs should implement financing programs.	
4. Community resource closed-loop referrals for social and human services: Many ILOS providers lack access to a technical platform, infrastructure, and capabilities to receive referrals and to access demographic, eligibility, and authorization information from MCPs and referring providers. Also, referring providers often do not have access to electronic directories and associated workflows to close the loop on ILOS referrals.			
➤ Develop guidance for referral and information sharing among MCPs and ECM and ILOS providers.	DHCS should develop guidance to help MCPs and providers establish closed-loop referral platforms and processes.		
➤ Develop and deploy referral service standards and platforms accessible to contracted ECM and ILOS providers.	MCPs should collaborate and deploy a standard set of closed-loop referral data elements and processes.	MCPs should test and roll out closed-loop referral platforms.	
➤ Provide training and TA to ECM and ILOS providers to support workflow changes and access to systems used to authorize, track, and close referrals.	MCPs should develop training for ECM and ILOS providers on ILOS referral processes and systems.	MCPs should update trainings to reflect evolving system designs and program requirements.	

Table 1. Road Map Recommendations Overview: CalAIM and Health Data Sharing, *continued*

RECOMMENDATIONS LEGEND ➤ Regulations/Policies ➤ Technical Infrastructure/Standards ➤ Financing/Contracting/Operations	ROAD MAP ACTIONS 2021	 2022–24	 2025+
5. Performance reporting and ECM and ILOS billing: Many ECM and ILOS providers will not have the technical capabilities or capacity to submit claims to MCPs in compliance with state and national standards, and their systems will not be configured to capture and store clinical data in a structured, standardized format to support performance reporting.			
➤ Develop guidance to support standardized ECM and ILOS invoicing and billing.	DHCS should convene MCPs and ECM and ILOS providers to develop a minimum set of data elements for invoicing and billing, including minimum requirements for ECM/ILOS providers unable to submit compliant claims.	MCPs should implement minimum billing data element requirements.	
➤ Establish clear ECM and ILOS quality and performance improvement goals, objectives, and performance metrics.	DHCS should review program goals and objectives with ECM and ILOS stakeholders and define measures to assess program efficacy.	➤ DHCS should finalize measure selection and provide MCP reporting guidance. ➤ DHCS should evaluate ECM/ILOS programs by selected measures and refine measure selection, as needed.	
➤ Develop standard ECM and ILOS billing templates.	MCPs should collaborate with other plans and providers to develop and test a standardized set of minimum billing data elements and requirements and to develop invoicing templates and processes for ECM and ILOS providers.	MCPs should implement and refine billing templates, as needed.	
➤ Define performance metric technical specifications.	DHCS should develop and refine existing performance measure specifications, as needed.	DHCS should update measure specifications, as needed.	
➤ Develop ECM and ILOS provider training and TA to support billing and reporting.	MCPs should develop ECM and ILOS training programs on coding and billing practices.	MCPs should update training programs as needed to reflect updates and changes to billing guidelines and practices.	

CalAIM ECM and ILOS Background

Medi-Cal is the nation's largest Medicaid program as measured by enrollment and spending, providing health care coverage for over 13 million Californians.[2] The California Department of Health Care Services (DHCS), which administers Medi-Cal, has used its 1115(a) waiver authority to test novel initiatives aimed at improving outcomes and managing costs for its members. In 2015, the Centers for Medicare & Medicaid Services (CMS) approved DHCS's "Medi-Cal 2020" waiver, including its county-based Whole Person Care (WPC) pilots, to transform and improve the quality of care, access, and efficiency of health care services. WPC is focused on improving the coordination of physical health, behavioral health, and social services for vulnerable members with poor health outcomes who were identified as high users of multiple systems.[3] Concurrently, DHCS, through State Plan Amendment 16-007, established a plan-based Health Homes Program (HHP) to serve eligible Medi-Cal members with complex medical needs and chronic conditions.[4] The HHP was designed to support members who could benefit from stronger care management and coordination services for a full range of physical health, behavioral health, and community-based long-term services and supports (LTSS).[5]

Social determinants of health (SDOH) — the conditions in the environments where people are born, live, learn, work, play, worship, and age — are estimated to be up to 80% responsible for a health outcome.

In 2022, DHCS is sunsetting the HHP and WPC pilots, drawing lessons from that experience, and transitioning critical program elements into its California Advancing and Innovating Medi-Cal (CalAIM) program. CalAIM builds upon these initiatives to manage member care and need through whole-person care approaches, while addressing social determinants of health.[6] CalAIM envisions enhanced coordination, integration, and information exchange across managed care plans (MCPs); physical, behavioral, community-based, and social service providers; and county agencies to provide members with a comprehensive array of health and social services to address the underlying drivers of poor health outcomes, including inequity. Two primary elements of the new CalAIM program include:

Enhanced Care Management (ECM). The ECM benefit will provide whole-person care management to help address the clinical and nonclinical needs of Medi-Cal MCPs' highest-risk members. MCPs will administer and oversee ECM benefits, identifying members in ECM target populations who would benefit from long-term coordination of physical health, behavioral health, and social services across delivery systems. ECM services will be community-based and locally provided, with high-touch, on-the-ground, face-to-face, and frequent interactions between members and "ECM providers," which will be responsible for the coordination and management of patient care.[7] MCPs and the ECM providers with whom they contract will need to collaborate with a broad contingent of physical, behavioral, and social service providers, county and state agencies, and others to securely share member data to support care coordination and management. DHCS expects that MCPs will build on the expertise and health information technology (HIT) infrastructure developed through the WPC pilots and HHP to support ECM implementation.

In Lieu of Covered Services (ILOS). MCPs will have the option to offer ILOS, which are cost-effective, health-supporting — though generally nonmedical — activities that may substitute for State Plan–covered services to reduce hospitalization and institutionalization or that otherwise address underlying drivers of poor health. If states choose to opt to provide ILOS and receive federal funds to support them, federal law requires that they are optional for MCPs to provide and for enrollees to accept.[8]

MCPs may choose to offer ILOS in counties they serve and if they do, they must offer them to all members in the county who qualify. If MCPs elect to offer ILOS, they must also establish and maintain networks

of community-based organizations to provide services, and integrate those services with their ECM approaches.[9] Offered ILOS will be accounted for in MCP rate setting.

DHCS expects MCP implementation of ILOS will support the transition of its WPC pilot and HHP, covering previously provided services that may not otherwise be included under the State Plan benefits.

CalAIM's ECM and ILOS programs will engage a broad set of providers, county agencies, and community-based organizations, many of whom have not extensively interacted with the health care system, creating unique challenges to implementation.

This road map defines the program information system, data sharing, and data use activities that will be necessary for ECM and ILOS stakeholders to carry out core program functions, as well as potential barriers to implementation across three dimensions:

- *Technical infrastructure to support information sharing and use.* Most ILOS and some ECM providers will not be integrated with their partner health care systems and may lack necessary information technology capacity to effectively participate in the program. Further, most communities in California lack the robust data exchange infrastructure necessary to support access to and sharing of physical, behavioral, and social service data needed to coordinate complex care.

- *Legal and policy environment to facilitate information sharing.* Sharing information to coordinate care and improve access to behavioral health and social services implicates an extensive and complex set of federal and state rules that extend beyond traditional governing statutes (e.g., HIPAA [Health Insurance Portability and Accountability Act]). Understanding these rules and developing responsive policies to obtain and manage consent has proven difficult for WPC pilot and HHP program participants and will likely prove similarly difficult for ECM and ILOS stakeholders.

- *Business drivers, incentives, and financing to sustain the program.* Building technical infrastructure and providing support for CBOs not integrated with the health care system will require alignment of contracting incentives and funding sources to underwrite and sustain necessary investments.

Each actor — from policymakers, to state and county agencies, to CBO — will have an important role to play in successfully launching and sustaining the ECM and ILOS programs in California. Whole-person approaches to care require whole-community approaches to care, necessitating that all parties step outside of their traditional service boundaries to collaborate and coordinate care to effectively address root drivers of health.

DHCS has proposed covering 14 ILOS, including:

1. Housing transition and navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Short-term post-habilitation housing
5. Recuperative care (medical respite)
6. Respite care
7. Day habilitation programs
8. Nursing facility transition support to assisted living facilities
9. Community transition services / nursing facility transition to a home
10. Personal care and homemaker services
11. Environmental accessibility adaptations (home modifications)
12. Meals / medically tailored meals
13. Sobering centers
14. Asthma remediation

Methodology

In 2020, Manatt worked with DHCS and WPC pilot and HHP stakeholders including counties, MCPs, providers, and CBOs to assess the data, data exchange, and information systems that DHCS and future ECM and ILOS providers, MCPs, counties, and other participating organizations will need to support critical ECM and ILOS program functions. Manatt further assessed the current capabilities of prospective ECM and ILOS stakeholders to identify potential challenges and gaps in technology, data exchange infrastructure, standards, policy, and business drivers. Manatt's assessment was informed by the following activities:

- *Research and analysis of the WPC pilots and HHP.* Manatt reviewed published reports on lessons learned from these foundational pilot programs.
- *Stakeholder interviews.* Manatt interviewed over 50 people across a diverse set of two dozen organizations from August through October 2020 to understand and document lessons from California's WPC pilots and HHP and to discuss potential barriers to ECM and ILOS program implementation. (See Appendix A for a list of interviewees.)
- *DHCS ECM/ILOS data strategy workgroup.* Manatt facilitated meetings with DHCS program and operational staff from August 2020 through January 2021 to discuss ECM and ILOS stakeholder data use expectations for specific program functions, and potential mitigation strategies for identified issues.
- *ECM/ILOS data strategy advisory committee.* Manatt convened a stakeholder advisory committee of 14 WPC and HHP organizations to advise on potential ECM and ILOS stakeholder data use expectations, potential barriers to program implementation, and resolution strategies. The advisory committee met three times between October 2020 and January 2021. (See Appendix B for a list of committee members.)

Manatt supplemented stakeholder feedback with original legal, policy, and program research.

ECM and ILOS Program Data Functions

Manatt, DHCS, and the advisory group identified seven critical data-dependent use cases required to support the ECM and ILOS programs. Each function describes the activities that need to be carried out by program participants to ensure program success, as explicitly required in DHCS or MCP contracts or implied but not mandated through policy guidance or contracting. These functions include:

1. **ECM member identification, review, and authorization.** MCPs will identify target ECM populations by compiling and analyzing data and information received from counties, providers, and members, among other sources.
2. **ECM assignment and member engagement.** MCPs will assign members to an ECM provider based on their previous provider relationships, health needs, and known preferences. Member outreach and engagement into the ECM benefit will be conducted by ECM providers to the extent possible.
3. **ECM care plan development, sharing, and use.** ECM providers will develop care plans using data acquired from the MCP, the member, and other sources, and make the care plan available for use by a member's care team.
4. **ECM care coordination and referral management.** ECM providers will support coordinated and transitional care and engage MCPs' referral networks for community and social services, including ILOS.
5. **ECM and ILOS billing and encounter reporting practices.** ECM and ILOS providers will record and report services rendered to MCPs in standard formats, as specified by DHCS (e.g., claims, invoices). MCPs will be expected to report complete and accurate encounters of all services provided by contracted ECM and ILOS providers to DHCS using identified codes.

6. **ECM and ILOS quality measure and performance reporting.** MCPs will report DHCS-specified quality and performance metrics to demonstrate ECM and ILOS program impact on member outcomes and MCP operational performance.
7. **ILOS needs assessment and referral management.** MCPs, ECM providers, and ILOS providers will identify members requiring ILOS benefits, and MCPs, PCPs, or ECM providers will connect members to ILOS through a closed-loop referral process.

Stakeholders should review the latest DHCS guidance to understand their organization's exact data use and reporting expectations.

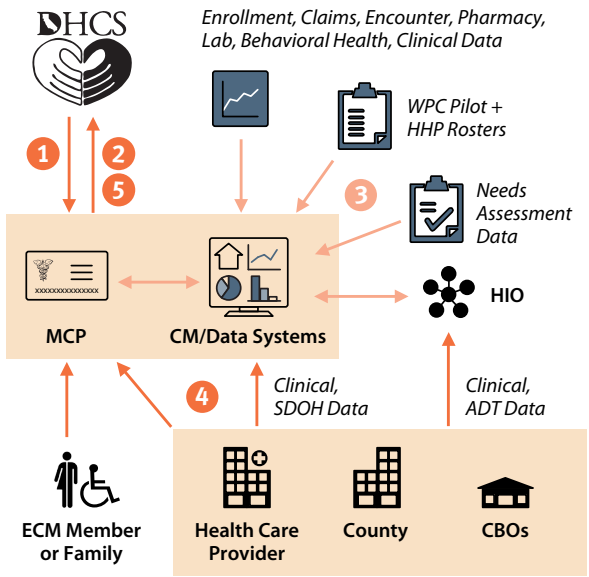
1. ECM Member Identification, Review, and Authorization

MCPs will be responsible for identifying high-cost, high-needs members eligible for the ECM benefit who could gain the most from the program's comprehensive, high-touch, interdisciplinary, and community-based care management services, particularly as they move through significant health and social transitions. The identification of members within each of the DHCS-defined "target populations" will be supported by providers, county agencies, and community-based organizations who have physical, behavioral health, and social service information and insights. Target populations shall include:

- Children or youth with complex physical, behavioral, developmental, and oral health needs
- People experiencing chronic homelessness or who are at risk of becoming homeless
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits
- Nursing facility residents seeking to transition to the community
- Those at risk for institutionalization who are eligible for long-term care services
- People at risk for institutionalization with serious mental illnesses, children with serious emotional disturbances, or substance use disorders (SUDs) with co-occurring chronic health conditions
- People transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition to the community
- Additional target populations identified by an MCP and approved by DHCS.[10]

MCPs will be expected to identify members for ECM through a combination of data sources, including enrollment, Medi-Cal fee-for-service, and encounter data they receive from DHCS and generate and

Potential Data Exchanges



1. Member enrollment and encounter files
2. Methodology for identifying ECM members
3. Risk stratification and analytics using available data (e.g., claims/encounters, clinical data)
4. Identification or requests from providers, counties, other CBOs, and members/families
5. "Supplemental" reporting (to be determined)

Note: See Appendix C for a glossary of abbreviations.

manage themselves; other administrative, clinical, social service, and care needs; and assessment information they can securely access through partnerships with county agencies, providers, community and social service providers, and health information organizations (HIOs). MCPs will also be required to assess requests for the ECM benefit from providers, members, and member caretakers.

Implementation of ECM and ILOS will be phased in beginning in counties with a HHP or a WPC pilot. MCPs will authorize the ECM benefit for all members enrolled or in the process of enrolling in the HHP and will develop an approach for transitioning members enrolled or in the process of enrolling in WPC pilots that includes consideration of which members would benefit from ECM. MCPs will determine whether other members meet ECM authorization criteria and will include them in member assignment files distributed to ECM providers.[11] MCPs will report to DHCS, based on provided specifications, the members that have been authorized and are receiving the ECM benefit.

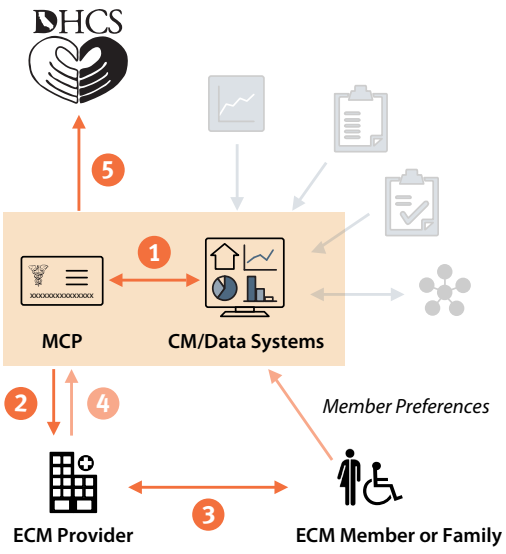
2. ECM Assignment and Member Engagement

Once members are identified and authorized for the ECM benefit, MCPs will identify the providers each member has engaged with and determine the most appropriate provider for ECM assignment based on that member's physical, behavioral health, and social needs. ECM providers may include primary care providers (PCPs), behavioral health specialists, county behavioral health providers, and community clinics, among others. If a member's preferences for a specific ECM provider are known to the MCP, it will assign the member to that ECM provider to the extent practicable. If the member's assigned PCP is an ECM provider, the MCP will assign the member to the PCP, unless the member has expressed a different preference or a more appropriate ECM provider is identified, given the member's individual needs and conditions (e.g., a behavioral health entity).

After assignment is confirmed, MCPs will be required to share member assignment files with ECM providers. Files will include a list of members authorized for the ECM benefit, and available encounter and/or claims data; physical, behavioral, administrative, and SDOH (e.g., housing) data; and reports of performance on quality measures. ECM providers will be expected to reach out to assigned members and use data from the MCP and other sources to support member engagement.[12] Specifically, ECM providers will:

- Notify the member of ECM benefit and authorization, and allow the member to choose a different ECM provider, if desired
- Obtain member consent to participate in the ECM program

Potential Data Exchanges



1. MCP analysis of available member data to determine ECM provider assignment
2. MCP assignment files
3. ECM provider outreach to members; request for consent confirmation
4. ECM provider reports member engagement activity and consent (+ change requests) to MCPs
5. MCP sends supplemental reports to DHCS

Note: See Appendix C for a glossary of abbreviations.

The ECM benefit will be initiated once verbal or written consent is obtained from authorized members. ECM providers will communicate member consent to the MCP, which will manage consent records across its ECM population.[13] ECM providers will inform MCPs of members they could not reach, who may be incorrectly assigned, or who declined to participate in the benefit. MCPs will send supplemental reports that DHCS will define and that describe member engagement activity to DHCS.

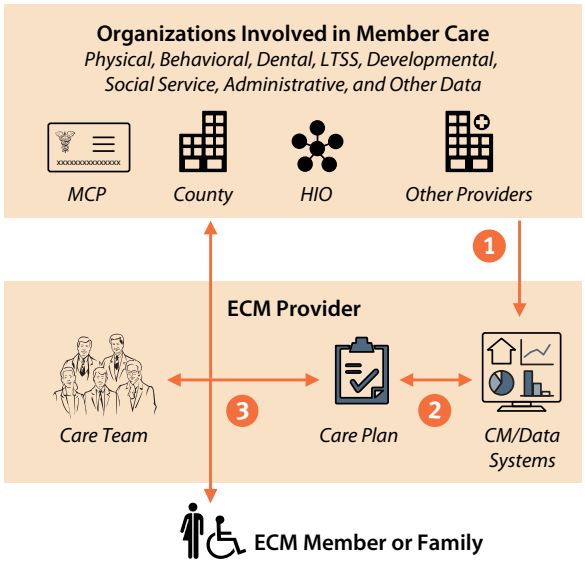
3. ECM Care Plan Development, Sharing, and Use

Once a member is assigned to and engaged by an ECM provider, the provider will work directly with the member to perform a comprehensive assessment and develop an individualized, person-centered care plan that documents the member's health risks, needs, goals, and preferences for care. To develop care plans, ECM providers will use member data acquired from MCPs, directly from members and caretakers, and from other sources including state and county agencies (e.g., behavioral health, substance use disorder, justice data), other health care providers directly or through HIOs (e.g., clinical data, care plans), and community-based and social service providers.

ECM providers will be expected to use a care management documentation system or process that aligns with MCPs' Model of Care and is capable of integrating physical, behavioral, dental, LTSS, developmental, social service, and administrative information from other entities in order to create, manage, and maintain a care plan that can be shared with other providers and organizations involved in a member's care.

ECM providers will be expected to engage members directly and, where feasible in person, proactively monitor member progress against care plan goals, and, along with the rest of a member's care team, update progress toward goals and any changes in the member's needs and goals. Members will have access to their care plans, among other information "created, gathered, managed, and consulted by authorized health care clinicians and staff" per proposed federal Individual Right of Access requirements.[14]

Potential Data Exchanges



1. ECM provider acquires member information from MCP, county, other providers and/or HIO
2. Care plan developed using information available to the ECM provider care team
3. Care plan shared with and updated by care team and shared with member; care plan may also be shared with other organizations involved in member's care

Note: See Appendix C for a glossary of abbreviations.

4. ECM Care Coordination and Referral Management

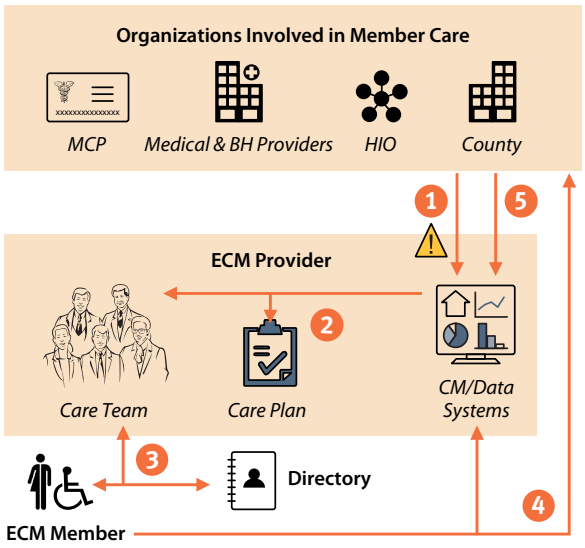
MCPs will be required to ensure that members authorized for ECM benefits receive enhanced care coordination services, including:

- Coordinated, continuous, and integrated patient care, as outlined in the care plan and facilitated through care team information exchange
- Support for member treatment adherence
- Tracking member admissions and discharges
- Developing care transition plans and performing engagement activities that seek to reduce avoidable member admissions and readmissions
- Communicating and sharing of member care needs preferences and other necessary information with the member's care team

Most of these activities will likely be assigned to ECM providers. ECM providers will be expected to proactively monitor assigned members' health and well-being and provide responsive care management interventions, using alerts from a variety of sources that signal changes in assigned members' situations and health status. Upon receiving notification of a member clinical or nonclinical event — including admission to a hospital, changes to incarceration status, and changes that would otherwise necessitate outreach and action — and as the care team identifies other member changes or needs that necessitate follow-up, the ECM provider will seek to engage and connect the member to the appropriate providers, services, and resources, consulting the MCP's provider directory as needed to make referrals, coordinating care, and supporting care transitions. Referrals that require prior authorization from MCPs will follow established MCP authorization processes and policies. ECM providers will be notified or will follow up to confirm that their assigned members received the referred services (i.e., will "close the loop").

MCPs will establish parameters for ECM providers to maintain care management documentation systems or processes that can track and elevate changes in member health status, support care team notification of relevant health status changes, and manage referrals to physical and behavioral health, and social service providers. Information gathered through member engagement and referral processes will be used to update the member's care plan.

Potential Data Exchanges



1. ECM provider will monitor changes to member health using a variety of data and referral sources
2. ECM provider updates care plan
3. ECM provider engages care team and member, and refers member to appropriate provider
4. Member referred to appropriate medical or ILOS provider; referral noted in CM system
5. Completed referral noted in CM system by ILOS provider or through ECM provider follow-up

Note: See Appendix C for a glossary of abbreviations.

5. ECM and ILOS Billing and Encounter Reporting Practices

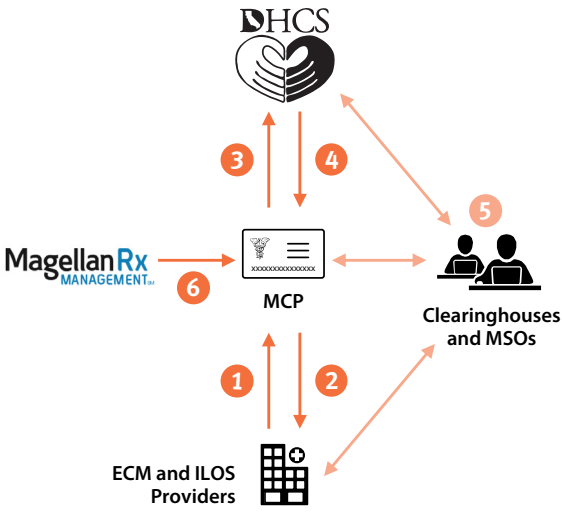
ECM and ILOS providers will generate and submit claims/invoices to MCPs, either directly or through clearinghouses or managed services organizations using DHCS-defined billing codes, standard specifications (ANSI ASI x12 837P), and electronic data interchange transmission methods.[15] Some ECM and ILOS providers will not have the technical capabilities and systems to submit a compliant 837 claim, and will be permitted to submit invoices to MCPs for generating payments and encounter data to submit to DHCS. Minimum data elements will include:

- Member demographic and identifier information (e.g., Medi-Cal managed care plan member ID)
- Services provided with relevant HCPCS (Healthcare Common Procedure Coding System) and modifier codes[16]
- Units or number of services provided
- Date service rendered and end date, if applicable

MCPs will review ECM and ILOS provider claims and invoices for accuracy and completeness, will generate "error reports" back to submitters (e.g., incorrect coding, syntax, or submission), and will request remediation as needed. Error reports may be transmitted as standard x12 999 error reports for providers able to receive and process them, and in an alternative, simplified format for providers that cannot. MCPs will be prohibited from imposing additional reporting requirements on ECM and ILOS providers.[17]

MCPs will be responsible for submitting ECM and ILOS encounters to DHCS and ensuring those encounters are complete and accurately coded per DHCS specifications. MCPs will also be responsible for submitting supplemental reports to DHCS that may include ECM and ILOS engagement and service use data, which DHCS may use to verify encounter data completeness. DHCS will process MCP encounters and supplemental reports, and generate and send error and other response reports to MCPs.

Potential Data Exchanges



1. ECM/ILOS provider invoices, claims, and encounters
2. MCP transmits error reports for ECM/ILOS provider resolution
3. MCP submits ECM/ILOS provider encounters, supplemental reports
4. DHCS transmits error reports for MCP resolution
5. ECM/ILOS providers may submit claims to clearinghouses/MSOs for MCP submission may do similarly for DHCS file submission
6. Magellan Rx pharmacy encounter data transmitted to MCPs

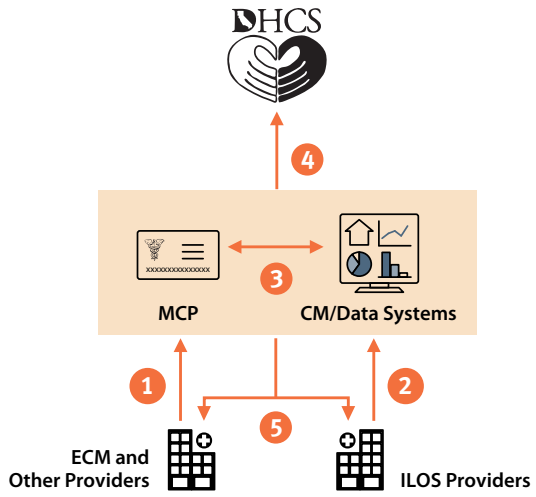
Note: See Appendix C for a glossary of abbreviations.

6. ECM and ILOS Quality Measure and Performance Reporting

DHCS will establish ECM and ILOS quality improvement and performance requirements for MCPs based on existing Medi-Cal managed care measure sets. MCPs will calculate measures using available claims/encounter, clinical, and social data as required by DHCS. Should metrics include hybrid measures, MCPs will be expected to acquire the necessary administrative, clinical, and social service data from ECM and ILOS providers to support measure calculation, aggregation, and reporting. DHCS may choose to separately compile and analyze submitted claims/encounter, clinical, and social service data to calculate quality measures and report results back to MCPs. DHCS may integrate measures into its managed care quality strategy and performance improvement programs.[18]

MCPs will conduct oversight of participation in the ECM benefit and ILOS with respect to all subcontractors to ensure benefit quality and ongoing compliance with program requirements. DHCS expects MCPs will share reports with ECM and ILOS providers of performance on quality measures, as requested. To the extent metrics attributed to ECM and ILOS providers are shared by MCPs, MCPs may set expectations that they use this information to enhance and improve their processes, workflows, and outcomes.

Potential Data Exchanges



1. ECM and other providers transmit administrative and clinical data
2. ILOS provider transmits claims and invoices
3. MCP calculates quality and performance measures
4. MCP reports ECM and ILOS quality and performance measures (through External Quality Review Organization process)
5. MCP transmits quality measure reports for assigned members back to ECM and ILOS providers

Note: See Appendix C for a glossary of abbreviations.

7. ILOS Needs Assessment and Referral Management

An MCP will be responsible for coordinating ILOS for members, to the extent the MCP offers ILOS. Coordination of and referral to community and social support services will include determining appropriate services to meet member needs, including services that address social determinants of health, housing, and other ILOS offered by the MCP.

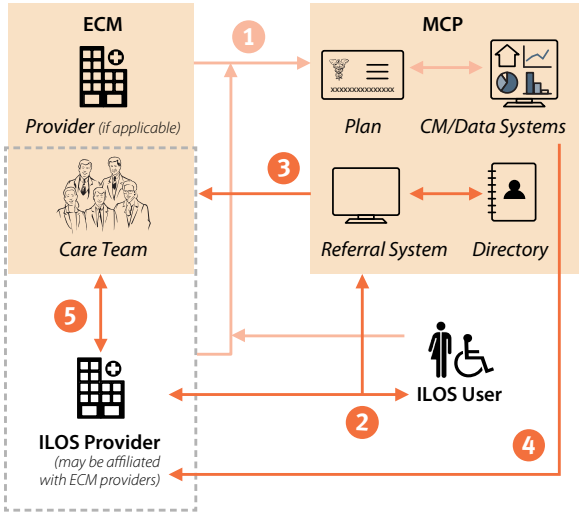
Many of these obligations will be assigned by the MCP to ECM providers, which may use available claims/encounter, clinical, housing, social service, admission, discharge and transfer (ADT), and other data to identify members in need of offered ILOS. ECM providers will also assess ILOS referral requests from members, the member's family, or providers, and will evaluate alerts they may receive that signal a change in health status, admission or discharge from a facility, or a transition between care settings (e.g., discharge from a short-term residential facility stay) to determine if that member would benefit from available ILOS.[19]

ILOS authorization requests will be submitted to MCPs to assess appropriateness and member eligibility. MCPs may authorize ILOS where they are determined to be a medically appropriate and cost-effective substitute for covered services or settings. When authorization decisions are reached, MCPs will notify members and their ECM and ILOS provider or other requesting provider of the decision. The member will be referred to an ILOS provider within the established MCP-ILOS network, and the MCP will securely share the member's:

- Demographic and administrative information confirming the member's eligibility and authorization status
- Administrative, clinical, and social service information, as appropriate and necessary to help the ILOS provider understand the member's needs
- Billing information to support invoicing

ILOS providers will accept referrals, conduct outreach to referred members (as needed), and confirm whether members receive the referred service. ILOS providers will provide updates to members' MCP and ECM providers upon outreach and service delivery and may request that additional ILOS be authorized depending on member need. MCPs will be required to ensure that referral loops are "closed," confirming whether services were rendered.

Potential Data Exchanges



1. MCP analyzes data to identify member who may benefit from ILOS services; ECM and ILOS providers may identify members who may benefit from ILOS
2. Members may self-identify
3. MCP refers member to ILOS provider via closed-loop referral process
4. MCP notifies member's ECM provider/PCP of referral
5. ILOS provider communicates with members' ECM providers / care teams

Note: See Appendix C for a glossary of abbreviations.

Implementation Road Map

The implementation road map identifies potential ECM and ILOS program implementation challenges based on research, interviews with previous WPC pilot and HHP participants, and advisory group feedback. Each issue includes a description of the challenges that ECM or ILOS providers, MCPs, DHCS, or other stakeholders are likely to face before outlining the actions that can be taken to overcome them. Five barrier categories have been identified as being of paramount importance requiring resolution including:

1. **Legal and regulatory alignment for data exchange.** Sharing physical, behavioral, and social service information implicates a broad cross-section of federal and state privacy rules and regulations, with differing levels of associated consent policies, and financial and criminal penalties.
2. **Statewide infrastructure for data exchange.** Many ECM and ILOS participants, including providers, county agencies, CBOs, and MCPs, will not have the HIT capabilities necessary to support robust cross-sector data exchange. Data sharing infrastructure, standards, and specifications are needed — especially for data domains including housing and justice facilities — to enable safe and secure information exchange.
3. **Care management, shared care plans, and assessments.** Many ECM providers will not have robust system capabilities to unify, manage, and share care plans or to receive, aggregate, and integrate care management and care coordination information.
4. **Community resource closed-loop referrals for social and human services.** Many ILOS providers lack access to a technical platform, infrastructure, and capabilities to receive referrals and to access demographic, eligibility, and authorization information from MCPs and referring providers. Referring providers also often do not have access to electronic provider directories or workflows to support closed-loop referrals.
5. **Performance reporting and ECM and ILOS billing.** Many ECM and ILOS providers will not have the technical capabilities or capacity to submit claims to MCPs in compliance with state and national standards, or systems to capture, store, and share health and social data needed to support performance reporting.

For each issue, the road map proposes strategies for overcoming these barriers, along with specific actions that the state, MCPs, counties, health care providers, and other community-based organizations can take to resolve them. The strategies are segmented into three categories: regulatory and policy; technical; and financing, contracting, and operations. The road map concludes with a discussion of the potential funding sources available to support the recommended approaches.

1. Legal and Regulatory Alignment for Data Exchange

CHALLENGES

Coordinated efforts to address health disparities and to promote health equity for vulnerable populations require the secure exchange of sensitive information subject to a large and complex set of federal and state privacy laws, most of which were not written with broad multisectoral and electronic data exchange in mind. Also, California's health privacy laws do not always align with federal rules. State law can be more restrictive than federal rules in certain instances, such as allowing patient information to be disclosed for treatment purposes only if the recipient is a health care provider, while HIPAA (Health Insurance Portability and Accountability Act) does not have this limitation.[20] HIPAA, for example, envisions disclosures of protected health information being made between "covered entities," while federal rules regulating Medicaid and the Supplemental Nutrition Assistance Program allow personal information being disclosed for program operations purposes, and criminal history privacy laws typically assume that such information will be used exclusively for criminal justice purposes and for background checks.[20] The lack of an established framework that enables health, social service, and other providers

Key Legal and Privacy Challenges to Data Sharing

For most health care providers, **HIPAA** is the foundational regulation governing data sharing, access, and use. Broadly, HIPAA safeguards patient privacy by limiting the sharing of PHI by plans and providers (covered entity)* and their contractors (business associates)† to only treatment, payment and operations, and a limited number of other specific purposes, such as public health. **California's Confidentiality of Medical Information Act (CMIA)** also protects an individual's medical Information by stipulating additional consent requirements in select cases, though generally these rules have not stymied efforts to securely share information.‡ HIPAA and the CMIA apply to government agencies to the extent they take on a role subject to these laws. For example, a government agency that operates a health care clinic is generally treated as a provider under HIPAA, while a Medicaid agency is treated as a health plan.

Behavioral health providers — those who treat patients for substance use disorders (SUD) and mental illness — must abide by additional federal and state rules that govern the sharing and use of specific sensitive health information, including:

- **42 C.F.R. Part 2**, which regulates certain SUD records and provides narrower data sharing allowances than HIPAA (with no exceptions for treatment, payment, or health care operations)
- **California Health & Safety Code § 11845.5**, which largely follows the rules of 42 C.F.R. Part 2, although it alters the scope of records covered by its requirements
- The **Lanterman-Petris-Short (LPS) Act**, which applies to records held by private, state, and county mental hospitals and hospitals for the developmentally disabled, and includes distinct disclosure and consent requirements

A patchwork of federal and state laws and regulations similarly applies to other types of information that may be shared among government agencies and their partners. To support care coordination for people discharged from jails and prisons, the sharing of correctional records managed by state and local sheriff's offices and probation departments is governed by federal regulations (**28 C.F.R. Part 20**) and state regulations (e.g., the disclosure and consent requirements of Criminal Offender Record Information, including state and local summary criminal history information, arrestee/inmate rosters, and individually identifiable information held by probation departments).

Social service records are also governed by a combination of federal and state laws. Medi-Cal, for example, must comply with **Social Security Act 1902(a)(7)**, which requires the state Medicaid program, and any local government organizations and contractors that implement the program, to ensure that Medi-Cal applicants' and beneficiaries' individually identifiable information is only disclosed for purposes directly related to the administration of the plan. State law (**Welf. & Inst. Code § 12100.2(a)**) reinforces this requirement, though individual state-local agreements may include more limiting data sharing rules.

Health plans and ECM providers may also need to obtain employment, food security, and welfare program information to determine benefits that patients might need and qualify for in order to facilitate referrals and help them access services. Rules that govern information sharing under CalWORKs§ limit disclosure of beneficiary data without consent to purposes directly related to program administration, unless excepted (**45 C.F.R. 205.50(a)(1)(i)**). California state law similarly allows disclosure without consent to welfare, social service, other public agencies, and housing authorities to aid in the administration of their duties; though where consent is required, the form must be signed and dated, and expires within one year of signature (**Welf. & Inst. Code § 10850**). Supplemental Nutrition Assistance Program (SNAP), or "CalFresh," is subject to the same state statutes, along with federal statutes that limit information disclosure to federal assistance programs, federally assisted state programs, and others directly connected with the administration of SNAP (**7 U.S.C. 2020(e)(8)(a)**).

Access to housing information will be important to support both ECM and ILOS programs: Those at risk of or currently homeless are an ECM target population, and ILOS include housing support services. Housing and homeless information is governed by yet another set of federal and state rules. Housing records held in the Homeless Management Information System (HMIS) are federally protected by rules that limit the sharing of protected personal information (PPI) without consent to support the provision of services, payment or reimbursement of services, or carrying out of administrative functions (**69 Fed. Reg. 45888, 45928**).# Locally, individual counties may promulgate laws and regulations further restricting or governing the disclosure and consent requirements for housing data. California's Assembly Bill 210 notably waives a number of state laws to allow for data sharing between members of the individual's Homeless Multi-Disciplinary Team so long as the information meets certain criteria (Welf. & Inst. Code § 18999.8), though federal laws still apply.

*A health plan, a health care clearinghouse, or a health care provider that electronically transmits PHI to a health plan in a manner regulated by HIPAA.

† A person or entity that performs certain functions or activities that involve the use or disclosure of HIPAA PHI on behalf of, or provide services to, a covered entity.

‡ Information that contains any element of personal identifying information sufficient to allow identification of the individual or other information that, alone or in combination with other publicly available information that reveals the individual's identity, as possessed by or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment. The CMIA also requires that health care providers seeking Medical Information related to an individual's outpatient treatment with a psychotherapist, the provider must submit specific information on the nature of the request, except for the purposes of diagnosis and treatment.

§ CalWORKs is California Work Opportunity and Responsibility to Kids; a public assistance program that provides cash aid and services to eligible families that have a child(ren) in the home. The program serves all 58 counties in the state and is operated locally by county welfare departments.

Or for creating de-identified PPI.

to disclose sensitive member information presents a challenge to ECM and ILOS payers and providers.

Medi-Cal's ECM and ILOS programs are rooted in addressing social needs, and will necessitate the exchange of physical, behavioral, and social service data among stakeholders who must comply with complex and at times ambiguous and conflicting federal and state privacy law and data sharing rules. Given these challenges, and despite enabling legislation (see sidebar), many counties, providers, and other stakeholders participating in the WPC pilots and HHP have been reluctant to comprehensively share information, preventing participants from accessing the information they needed to fully realize each program's respective goals.[21] As described in the WPC pilot Performance Year 4 report: "[WPC pilots] emphasized partner and staff hesitation to data integration and/or use of new data systems (e.g., due to beliefs about risks associated with data sharing)."[22] Sixty-four percent of WPC pilot sites (16) cited "patient privacy and confidentiality regulations as a major barrier to data-sharing," with 9 sites explicitly noting 42 C.F.R. Part 2 as "complicating efforts to share data on substance abuse treatment."[23]

Enabling California Legislation

Notwithstanding any other law, including, but not limited to, Section 5328 of this code, and Sections 11812 and 11845.5 of the Health and Safety Code, the sharing of health information, records, and other data with and among WPC lead entities and WPC participating entities shall be permitted to the extent necessary. . . . This provision shall also apply to the sharing of health information, records, and other data with and among prospective WPC lead entities and WPC participating entities in the process of identifying a proposed target population and preparing an application for a WPC pilot.

— California Welf. and Inst. Code § 14184.60

Without changes to state policy and guidance, many MCPs, counties, providers, and other ECM and ILOS stakeholders will be reluctant to share data and continue to protect themselves from potential liability amid the labyrinth of ambiguous rules and regulations.

Technical challenges to data sharing will also arise as stakeholders wrestle with two types of consent:

- *Consent to engage members in ECM benefits.* Consent to participate in ECM benefits may be obtained by MCPs, providers, or even DHCS at the time of member enrollment in Medi-Cal. Technical tools and processes are needed to manage and convey member consent to all affected stakeholders.
- *Consent to share sensitive data.* Members may be willing to allow certain types of information to be shared (e.g., behavioral health data) while prohibiting others from being shared (e.g., incarceration data). Data stewards and those that participate in its sharing will need to know a member's choices, and have the capabilities to filter or prevent certain types of data from being shared based on their preferences.

OPPORTUNITIES

Given these legal and regulatory complexities, an informed consent-based model is likely needed to support ECM and ILOS data sharing needs to mitigate privacy and data sharing barriers. Member data sharing informed consent should be acquired as early in Medi-Cal and/or ECM or ILOS program enrollment as possible, and collected, stored, and shared in a uniform manner that allows all ECM or ILOS partners access for consent verification purposes.

DHCS, MCPs, providers, and counties should work collaboratively to clarify legal and regulatory concerns and opportunities to overcome data exchange barriers, and establish clear pathways to enable safe, secure information exchange. Although enabling legislation sanctioned WPC pilot participants to securely share sensitive member information, records, and other data to carry out program activities — and several pilot participants noted its value in starting data sharing discussions with partner organizations — many participants expressed that more guidance and legislative action is needed to encourage ECM and

ILOS program participants to enter into data sharing agreements without putting their organizations at risk of unauthorized disclosures.[24]

Marin County, for example, developed a universal consent form that includes hospitals, health clinics, CBOs, and other organizations involved in the provision of the whole-person care program. The San Francisco Department of Public Health, as of September 2020, was also working on establishing an "umbrella agreement" among several county agencies and contracted nonprofits to share data in support of the whole-person care program. These and other cases may serve as a foundation for developing template consent language that can be adopted and adapted as needed to address any local concerns statewide.

Table 2. Road Map Recommendations to Support Legal and Regulatory Data Exchange Alignment

	ROAD MAP ACTIONS		
	2021	2022–24	2025+
REGULATORY AND POLICY			
Extend WPC pilot authorizing legislation to apply to all entities participating in the ECM, ILOS, and other Medi-Cal care management programs. California's WPC pilot legislation (see sidebar, page 23) provided participants with authority to share patient relevant health information, records, and other data to carry out program activities including population identification, real-time care coordination, data sharing between systems, and population health management. WPC pilot organizations cited this as critical when crafting data sharing agreements and consent language with partner organizations, indicating state permission and encouragement to exchange information where possible. Legislation should be expanded to support ECM and ILOS program data sharing activities, among other Medi-Cal care management programs.	The state should develop legislation and DHCS should develop subsequent guidance that defines permissible information exchange activities that support CalAIM and Medi-Cal program objectives.		
Develop "universal informed consent" guidance. DHCS should establish a working group to develop guidance to support the development of standard consent documents and data sharing agreements that could be used by MCPs, providers, CBOs, and counties, and identify processes to grant specific authority to collect and exchange data for specified purposes among participating organizations to support member care. Template consent and data sharing agreement language could both lower the burden associated with multiple individual stakeholders obtaining member consent to share member data and facilitate more seamless information exchange.	DHCS should establish a workgroup to develop standard consent form elements and case examples.	The DHCS workgroup should review updates to federal and state law that may require changes to consent form language, steps, and process. Depending on the findings of the workgroup, the California Health & Human Services Agency (CHHS) should work with stakeholders and the legislature to craft legislation or an executive order to facilitate creation of a universal consent form.	
Remove statutory barriers to a universal consent form. Lawmakers, policy leaders, and stakeholders should work collaboratively to identify California physical, behavioral, and social service consent, privacy, and information exchange law that conflicts with federal law and harmonize discordant state law with federal rules to help remove ambiguities and provide a clear pathway to developing a universal consent framework by: ➤ Updating state and local laws that require an authorization to expire within a relatively short period. ➤ Clarifying that a single authorization form can apply to many different forms of data (e.g., health, criminal, and social service data) under California law. ➤ Clarifying that California law permits authorizations to apply to multiple disclosures ➤ Requiring organizations to recognize a universal consent form developed by the state (i.e., they cannot insist that people sign their own forms in additional to the universal form).	CHHS should establish a multi-department work group to assess all statutory barriers to implementing a universal consent form, considering whether each may be addressed by executive order or legislative action.	California legislature should enact new law, harmonizing conflicting and outdated state law with federal rules.	

Table 2. Road Map Recommendations to Support Legal and Regulatory Data Exchange Alignment, *continued*

	ROAD MAP ACTIONS		
	2021	2022–24	2025+
Develop explicit operating guidance for ECM and ILOS stakeholders advising when various data may be shared to support specific program functions. The State Health Information Guidance (SHIG) program of the California Office of Health Information Integrity (CalOHII) previously provided WPC pilot and HHP participants guidance in its report *State Health Information Guidance: Sharing Behavioral Health Information in California* (PDF) and can build on this work to clarify federal and state laws that affect disclosure and data exchange in support of the ECM and ILOS programs. CalOHII's "SHIG 2.0" efforts, which will provide additional clarification around federal and state housing and food insecurity regulations, could be expanded to take on this broader scope.	CalOHII should work closely with DHCS and stakeholders to draft and refine SHIG technical advice that clarifies law that affects disclosure of physical, behavioral, and social service information, and should offer technical assistance to advise when various data may be shared to support program functions.		
TECHNICAL			
Develop condition or status identifiers for members, reducing the need to exchange greater volumes of potentially sensitive data. Counties and other stewards of sensitive information may develop methods of flagging a person's records with indicators of health risk, social service needs, or status changes (e.g., incarceration, housing insecurity), reducing the volume of identifiable data needed to be shared and potentially providing pathways to disclose needed information without disclosing prohibited data. For example, the San Francisco Department of Public Health developed a "high utilizer" indicator from an analysis of the data available to it that indicated potential SUD-based needs, without disclosing whether a given person had an SUD.	MCPs should work with ECM/ILOS data sharing partners to determine where standard proxy indicators may be shared with MCPs in lieu of full patient data.	MCPs and ECM/ILOS data sharing partners should implement proxy measures where DHCS/CalOHII exchange tactics cannot release full data.
Implement local and regional electronic consent management systems and processes accessible to MCPs; ECM, ILOS, and other providers; county agencies; and data stewards of member health and social information. MCPs should develop member consent management systems or platform that ECM, ILOS, and other providers can access to verify member data sharing consent preferences.	MCPs should design and test an accessible consent management system with provider partners.	MCPs should implement accessible consent management systems.
FINANCING, CONTRACTING, AND OPERATIONS			
Integrate ECM participation and data sharing consent in the Medi-Cal enrollment application. WPC stakeholders recommended that both member consent to participate in ECM and authorization to share sensitive data may be acquired during the Medicaid enrollment and redetermination process. The process should ensure that members understand the implications for authorizing data sharing, and that consent to share data is not a requirement for Medicaid enrollment.	➤ DHCS should assess options to acquire ECM participation and data sharing consents during enrollment. ➤ Depending on the assessment, DHCS should develop plans to implement consent at enrollment.	➤ DHCS should implement collection of ECM participation and data sharing consent during enrollment and redetermination, and share consent information with MCPs. ➤ DHCS should begin collecting care management program participation and data sharing consents at Medi-Cal enrollment. ➤ DHCS should work with MCPs to develop processes to share member consents obtained at enrollment.

2. Statewide Infrastructure for Data Exchange

CHALLENGES

The ability to consume, integrate, and use member data from clinical and nonclinical sources was critical to WPC pilot success, with effective sites able to "work through the legal requirements around how to share beneficiary data… invest in developing data infrastructure and help partners recognize opportunities created by more expansive data-sharing."[25] And while a majority of pilot sites (13) participated in an HIE, less than half of those that did (5) were able to leverage such connections to acquire nonclinical information (e.g., member social service needs and utilization) to support engagement, and only two sites had local probation departments and CBOs actively participating in such exchanges.[26]

MCPs, providers, county agencies, CBOs, and other ECM and ILOS stakeholders will similarly not have immediate access to the robust cross-sector data exchange technical infrastructure needed to efficiently administer and support ECM and ILOS programs, and will likely need to make significant individual and collective investments to build them.[27] States, MCPs, and providers have traditionally relied on local administrative data — physical, behavioral health, and pharmacy claims — combined with clinical data, where available, to identify member health risks and inform ongoing care management.[28] These local sources may be supplemented with data collected from health information organizations (HIOs). However, these traditional data sources rarely contain social determinant information needed to broaden health care stakeholders' view into critical needs, issues, and transitions that occur outside of the health system (e.g., incarceration, housing). In addition, social determinants data generally lack structure, have not been standardized across electronic health record (EHR) platforms, and are not shared using standardized health data exchange such as Consolidated Clinical Data Architecture (C-CDA) or Fast Healthcare Interoperability Resource (FHIR).[29]

Technical infrastructure to support exchange of a broader complement of administrative, physical, behavioral, and social service information is needed to support ECM and ILOS participants. While California's existing regional and statewide HIOs can serve as a strong foundation upon which to build additional data sharing capabilities, today California's HIOs are generally limited to sharing administrative and physical health information, do not serve all providers in the communities in which they operate, and do not cover the entire state: 23 counties lack any significant community HIO presence.[30] While investments in promising "community information exchanges" (CIEs) were made to support the sharing of nonclinical social and human service organization information under the WPC pilot and HHP, most communities do not have mature or scaled services that can meet all local needs. Without more extensive local, regional, or statewide aggregators of physical, behavioral, social, and human service organizations, MCPs, providers, and county agencies will be left with the prohibitive task of independently establishing technical, operational, and governance infrastructure necessary to securely share comprehensive member information across their service areas.

In addition to the limited regional and statewide capacity to aggregate clinical and nonclinical data, most ECM and ILOS providers that need access to these data do not have the technical capabilities necessary to consume and use it.[31] Nontraditional data sources will bring new data standards, exchange specifications, and funding needs that need to be addressed. For example, Marin County reported difficulty in linking its acquired Homeless Management Information System (HMIS)[32] data with its member data due to a lack of a consistent, unique patient identifier. HMIS data have not necessarily been designed for separate analytic purposes or to be shared with non-housing agencies.[33] Understanding how to consume and meaningfully use clinical and nonclinical data will be critical to ensuring ECM and ILOS success.

OPPORTUNITIES

Developing a statewide environment and infrastructure to facilitate a meaningful cross-sector information exchange can be supported by regulatory, contracting, and financing programs that require and incentivize specified health information exchange activities between clinical and nonclinical organizations. Technical solutions can be developed to test and implement data standards and technical infrastructure to facilitate data exchange.

Contracting requirements can be implemented to require and institutionalize information sharing expectations and goals. Incorporating health information exchange and alert notification requirements into MCP and provider contracts has been done in other states. North Carolina, for example, will require its Medicaid MCPs to "have access to an ADT data source that correctly identifies when members are admitted, discharged or transferred to/from an emergency department or hospital in real time or near real time."[34] The contract further specifies the process and timelines for responding to ADT alerts depending on their urgency.[35] North Carolina also requires certain Advanced Medical Home (i.e., PCP/care management) practices to have access to ADT feeds.[36]

Some cities and counties in California have developed infrastructure requirements for SDOH and other nonmedical information exchange. Alameda County developed a Social Health Information Exchange that collects health and SDOH data to create a Community Health Record. It facilitates the collection of physical health information with housing and social service information, while helping manage the consent process and member identification.[37] Merced and San Joaquin Counties have used contracting authority to require data sharing. They revised their contracts with EHR vendors serving their county jails, requiring that they share health information with local HIOs upon inmate release.

Many financing programs in California and elsewhere have supported HIE implementation and can be expanded to fill remaining HIE gaps. The California Health Information Exchange Onboarding Program (Cal-HOP), for example, was initiated using state and federal funding to cover some of the HIO onboarding costs for providers to connect to qualified HIOs.[38]

Policy, contracting, technology, and financing initiatives should take into consideration and align with federal rules and programs, including the 21st Century Cures Act Final Rule released by CMS and ONC (Office of the National Coordinator for Health Information Technology) in March 2020, which will significantly change the ways in which patients, providers, and payers exchange information.[39]

Table 3. Road Map Recommendations to Expand Statewide Infrastructure for Data Exchange

	ROAD MAP ACTIONS		
	2021	2022–24	2025+
REGULATORY AND POLICY			
Develop a legislative mandate requiring MCP and provider participation in qualified health information exchange activities, including requiring specified providers to send patient visit summaries, and to notify care team members when a patient has been admitted or discharged from their facility. A number of states have passed legislation requiring information sharing and/or participation in a state or "qualified" health information exchange.[40] States with more robust HIE initiatives reinforce mandates with incentives and funding to participate in data sharing activities and payer contracting requirements.[41] Funding is also needed to enable affected organizations to build the technical capacity to connect, and to enable HIOs or CIEs to develop the capacity to serve every region across California. North Carolina, for example, advanced HIE between physical and behavioral health providers, and MCPs through a mandate, supported by state funding.[42] The Statewide HIE Act requires almost all enrolled providers to connect to the state-designated HIO, NC HealthConnex, or risk losing payments for state-funded health care services. The Statewide HIE Act also charged the North Carolina Health Information Exchange Authority (NC HIEA), a public-private partnership composed of diverse stakeholders, with carrying out the HIE Act and overseeing NC HealthConnex. Nebraska's Nebraska Health Information Initiative offers another example of a successful state-designated HIO supported by state funding.[43]	The state, working with DHCS, CalPERS, Covered California, and other stakeholders should: ➤ Define HIE goals, priorities, HIE use cases, activities, and types of providers that would be subject to data sharing mandates. ➤ Identify funding sources to support HIE implementation costs and incentivize HIE participation. ➤ Develop and pass data sharing legislative requirements.	➤ State agencies should implement and enforce legislative requirements that specify goals, funding, incentives, and reporting requirements and penalties through subsequent regulatory guidance. ➤ State agencies should report progress against goals and identify remaining barriers and additional actions that can be taken. ➤ State agencies should provide additional implementation guidance and support development of necessary amendments to state law (as needed).
Develop a legislative mandate requiring correctional facilities to send health information to the next provider of record upon member release. State prisons and county jails provide health care for incarcerated residents but aren't required to share health information exchange electronically upon discharge. The state should develop legislative requirements for state prisons and county jails to securely share electronic health information upon discharge to support care coordination and continuity with community health providers.	The state, along with CHHS, the Board of State Community Corrections (BSCC), CDCR, county jails and sheriff's departments, and other stakeholders should work together to: ➤ Define specific HIE requirements for correctional facilities to share health information with community providers. ➤ Identify funding sources to support implementation costs.	➤ CDCR, BSCC, and CHHS should implement and enforce requirements and funding programs through subsequent regulatory guidance. ➤ State and county agencies should report progress against goals and identify remaining barriers and additional actions that may need to be taken to support information exchange. ➤ State agencies should provide additional implementation guidance and support development of necessary amendments to state law (as needed).

Table 3. Road Map Recommendations to Expand Statewide Infrastructure for Data Exchange, *continued*

	ROAD MAP ACTIONS		
	2021	2022–24	2025+
TECHNICAL			
Develop standards and guidance for the exchange of social determinant information. Having access to timely, structured social needs and risk information is critically important to deliver whole-person care through ILOS and ECM benefits. Technical standards are needed to support the exchange of SDOH data into EHRs and care management documentation systems. Building off standardization efforts supported by HL7's Gravity Project, California stakeholders should work together to test and implement housing, food insecurity, transportation, and other SDOH data code sets, terminologies, and implementation guides, and the use of federal FHIR API exchange protocols.[44] The state, in collaboration with industry stakeholders, should proactively develop guidance — in the form of California-specific implementation guides, best practices in data governance models, and case studies — to support regional implementation.[45]	CHHS, DHCS, CalOHII, and other stakeholders should review and establish standards for the collection and sharing of SDOH information based on national efforts for implementation in the ECM and ILOS programs.	▶ CHHS, DHCS, and CalOHII should develop guidance for SDOH coding standards. ▶ MCPs should support ECM provider training on the use of the new standards.	
Establish working groups to develop state standards and to recommend guidance for nonmedical event notifications (e.g., housing, incarceration, employment status changes). Housing, incarceration, employment, and other electronic notifications lack standards, are less accessible and automated than medical ADT notifications, and infrastructure for these types of notifications is underdeveloped. The state should establish a workgroup to develop standards for nonmedical notifications. The workgroup should consider the availability of data sources, formats, and transmission, and necessary provider workflows changes. The workgroup should also explore other state and regional case studies where non-ADT notifications have been used; for example, New York's Healthix is capable of sharing alerts when patients are incarcerated or released from New York City correctional facilities.[46]	CHHS, DHCS, CalOHII, and other stakeholders should establish a workgroup composed of MCPs, HIOs, providers, government agencies, and social service entities to define the needs and potential requirements for sharing nonmedical event notifications.	▶ Workgroup participants should test SDOH data standards exchange protocols, evaluate efficacy of exchange standard tests, and adapt and expand the scale of testing. ▶ DHCS and CalOHII should develop California-specific implementation guides and additional guidance and best practice case studies.	

Table 3. Road Map Recommendations to Expand Statewide Infrastructure for Data Exchange, *continued*

	ROAD MAP ACTIONS		
	2021	2022–24	2025+
FINANCING, CONTRACTING, AND OPERATIONS			
Develop HMIS and incarceration data exchange contracting requirements and funding programs. City and county agencies, regional Continuum of Care housing collaboratives, community-based organizations, HMIS Lead Agency and Joint Powers Authorities use Homeless Management Information Systems (HMIS) to enable centralized, coordinated homeless status data entry and receive federal funding to support their efforts. Through reprocurement processes and contract amendments, HMIS Lead Agencies should contractually require HMIS vendors to share information with health care providers and to adopt federal and state data sharing standards and requirements to facilitate data exchange.[47] To improve the transfer of information from state prisons and county jails to the next provider of record when a member is released, state and county correctional facilities should add contracting requirements with prison and jail EHR vendors to share health information with community providers. Template contract language should be developed that can be incorporated into EHR and HMIS reprocurement efforts. The state should identify funding sources to support HMIS Lead Agency and state and county correctional facility implementation of data sharing requirements.	CHHS should convene BSCC, CDCR, DHCS, county jails and sheriff's departments, HMIS Lead Agencies and Joint Power authorities, and others to: ▸ Develop template model HIE requirement contract language for EHR and HMIS systems. ▸ Identify funding sources (e.g., BSCC construction and grant programs, federal Housing and Urban Development funding) to support HIE implementation costs.	State and county health and housing agencies, including HMIS Lead Agencies and correctional facilities, should: ▸ Incorporate contracting requirements into vendor contracts requiring that they participate in specified data exchange activities. ▸ Implement funding programs to defray HIE implementation costs.
Develop financing and incentive payment programs to invest in HIE infrastructure. Lack of Initial and ongoing funding to support information exchange is a significant barrier impeding provider, community-based organization, county, and local health department participation in HIE.[48] Incentive programs can also stimulate and help sustain HIE participation and build ECM and ILOS provider information system, data exchange, and performance reporting capacity. State and private payer funding and incentive programs should be created to support ECM and ILOS provider, county, and other HIE onboarding and participation, and build administrative, clinical, and social service data management capabilities.	DHCS should design incentive programs with MCPs that invest in ECM and ILOS provider, county agency, CBO, and other care team member data sharing capacity.	DHCS and MCPs should implement HIE incentive payment and funding programs.
Develop contractual requirements to participate in data exchange. DHCS should contractually obligate MCPs to require specific contracted providers to provide patient visit summaries, ADT alert, and other notifications. Contractual obligations would be more effective if they are aligned across other government and private payers including CalPERS, managed care plans participating in Covered California, and commercial health plans.	DHCS, CalPERS, and Covered California should work together to define contractual obligations for managed care plans that require specified providers to provide patient visit summaries, ADT, and other care transition alert notifications to ECM providers.	▸ DHCS, CalPERS, and Covered California should incorporate requirements into MCP contract language, providing a glide path for implementation for MCPs and their contacted providers. ▸ DHCS, CalPERS, and Covered California should consider requiring attestation for implementation and assess whether further expansion of requirements is warranted. ▸ DHCS should develop MCP contracting requirements that specify provider network, data sharing, and alert notification expectations. ▸ DHCS and MCPs should develop technical assistance programs to support ECM and ILOS data sharing and alert notification workflow changes.

3. Care Management, Shared Care Plans, and Assessments

CHALLENGES

Patients with complex health and social needs require both medical and social services and support from a wide range of providers and caregivers. Factors that increase the complexity of care include multiple chronic and acute physical health problems, social vulnerability, care delivered by multiple unaffiliated providers, patient preferences, and the patient's ability to manage their care.[49]

Care coordination and care management programs designed to support patients with complex needs start with a comprehensive assessment of each member to identify care needs and preferences and to support care plan development. Care plans capture physical, behavioral health, and social needs; reflect how patients function in their daily lives and with their family and other social supports; and clarify patients' preferences regarding community participation and goals for care. Physical, social and behavioral health providers involved in the patient's care should have access to and periodically update this information, including when new medical problems or other changes in health or functional status arise, to ensure care plans remain reflective of needs.[50]

The integration of social service information into physical health care planning and care coordination is a relatively new phenomenon in the United States.[51] Investments made through the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 and current-day health information technology capabilities make it possible for the integration of health, behavioral, and social service information into EHR and care management documentation system care plans. However, lack of agreed-upon standards, terminologies, and definitions for basic shared care plan social determinants of health (SDOH) elements, compounded by disjointed and uncoordinated health and social service sector workflows and interprofessional communication practices, continue to stymie integration efforts.[52]

ECM providers will be expected to have care management documentation systems and processes capable of consuming, integrating, analyzing, and using this broad swath of member health and social service information, including demographic, claims and encounter, clinical, social service, care needs screening, and member-generated data. ECM providers will be expected to use integrated data to support member engagement, manage consent, document care needs, develop and curate comprehensive care plans, receive and respond to event and care transition notifications, and manage and track referrals. Care managers and other ECM care team members will be expected to develop and maintain comprehensive care plans that ensure each member's "physical, behavioral, long-term care, developmental, oral, social, and psychosocial needs are met in the safest, least restrictive way possible, while considering the most cost-effective way to address those needs."[53] Experience from the WPC pilots and HHP exemplified the challenges future ECM participants will likely face in compiling, synthesizing, and sharing care plans and care needs information.[54]

ECM provider system capacity to oversee robust care management and care coordination efforts and support assessment and care plan sharing will be highly variable at program launch.[55] While many ECM providers will be clinics with robust care management documentation systems — including federally certified electronic health records (EHRs) — some ECM providers, including smaller clinics, behavioral health, housing, and other providers will not have access to systems capable of receiving data transmitted from MCPs upon member assignment; managing consent; analyzing, sharing, and integrating data with other care team members; developing care plans using data from a variety of sources; or receiving and integrating incoming patient notifications. Based on the WPC pilot and HHP experience, ECM providers will face several technical and operational challenges to accomplishing this task, including these:

- *Identifying existing care plans.* ECM providers will find that some assigned members have a multitude of discordant care plans. Without a centralized

resource to compile member care plans, ECM providers will need to solicit information from each member's providers to identify where a care plan has been developed and may be shared.

- *Acquiring existing care plan information in a consumable format.* While ECM providers will request existing care plans from providers, plans may not be in electronic, structured, sharable, or machine-readable formats, placing a significant burden on ECM providers to consume and integrate care plan data into a unified, electronic, and sharable format.
- *Unstructured and unstandardized care plan data.* Care plan data elements, structures, formats, and requirements will differ among providers and MCPs. While federal care plan standards continue to gain adoption, standards and consistent data exchange requirements for sharing care plans are not well established and will make shared access and use of member care plans difficult.[56]

These challenges present significant barriers for the sharing of physical, behavioral, and social information; assessments; and the development of actionable care plans that can easily be shared across providers.

OPPORTUNITIES

Having robust care management document systems in place that integrate data from a variety of sources and that support care planning is fundamental for providing integrated whole-person care. Barriers to overcome challenges will require broad understanding of system requirements and stakeholder responsibilities in satisfying those requirements, and financing mechanisms to build and implement systems and data sharing capabilities.[57] Investment will also be required to standardize the exchange of care plan information, which can often be unstructured and siloed in various provider systems. Some WPC pilot programs made investments in care management documentation system and data exchange capacity that, for example, matched data access to a member's permission settings and used simple cloud-based forms and document sharing capabilities.[58] Inland Empire Health Plan granted contracted providers access to its care management documentation system through a portal allowing CB-CMEs to review and transmit clinical notes, document outreach efforts, complete enrollment assessments, and perform other care management and care plan tasks.[59] Other WPC pilots participants benefited from technical assistance to support care management documentation system use and workflow integration.[60]

Table 4. Road Map Recommendations to Build Care Management Documentation, Shared Care Plans, and Assessments

	ROAD MAP ACTIONS		
	2021	2022–24	2025+
REGULATORY AND POLICY			
Define minimum necessary care management documentation system requirements. DHCS and MCPs should clearly define expectations regarding basic care management documentation systems capabilities and requirements.	DHCS should work with MCPs to develop care management documentation system expectations and requirements, and further define MCP responsibilities for ensuring ECM providers have access to such systems.		
Develop policy guidance defining a minimum set of sharable care plan data elements, formats, and exchange methods. DHCS should work with MCPs and ECM providers to develop guidance that specifies a minimum set of care plan data elements and expectations.[61] Guidance should include expected care plan domains, such as physical health, behavioral health, and social needs. Each domain should contain elements that include care plan goals, action steps, and other elements. Guidance should acknowledge and align with federal standards, including those specified in the Argonaut Data Query Implementation Guide's standards for care plans.[62]	DHCS should work with stakeholders to define a common set of shared care plan data elements, formats, and exchange methods that should be adopted and used for providers managing and sharing care plans.		
TECHNICAL			
Develop accessible care management documentation systems for ECM providers. Many ECM providers will not have care management documentation systems capable of managing care plans for patients with complex needs. Managed care plans should develop, test, and deploy care management documentation systems and shared care plan services for ECM providers lacking capabilities.	MCPs should develop and test care management documentation systems and care plan sharing options that can be deployed to ECM providers.	▶ MCPs should deploy care management documentation systems and care plan sharing platforms. ▶ MCPs should implement the minimum set of sharable care plan data elements, formats, and exchange methods included in DHCS policy guidance. ▶ MCPs should provide ongoing technical assistance to ECM and other providers to help implement care management documentation systems and care plan sharing services.	
Assess development of a statewide care plan repository. To facilitate sharing of member care plans, DHCS should assess the development of a statewide care plan repository for the ECM program and requirements that all MCPs and ECM providers use it to share and update ECM member care plans.	DHCS, MCPs, and ECM providers should assess options to create regional or statewide care plan and data sharing	Depending on the outcome of the assessment, DHCS and MCP partners should establish regional or statewide shared care planning infrastructure.	
FINANCING, CONTRACTING, AND OPERATIONS			
Develop care management data systems and care plan training and technical assistance programs for ECM providers. MCPs in coordination with DHCS should develop programs to support ECM care management documentation system implementation, and technical assistance programs to support workflow changes.	MCPs should develop training programs to support ECM provider adoption and use of standard care plans and care management documentation systems.		
Develop financing programs to build technical capabilities for ECM and ILOS providers. Working with MCPs, DHCS should explore, leverage, and develop financing programs that can leverage sources including Medicaid Performance Improvement Program, State Medicaid Health IT Plan, Section 1115 waivers, Medicaid Enterprise System (MES) funding, and others to fund care management documentation systems capacity building and implementation.	DHCS should identify funding sources with MCPs and other partners to support ECM care management documentation system implementation, adoption, and training.	DHCS should implement financing programs with MCPs and other partners to support ECM implementation, adoption, training, and use of care management documentation systems.	

4. Community Resource Closed-Loop Referrals for Social and Human Services

CHALLENGES

Social determinants of health have a profound impact on health outcomes, particularly for low-income populations.[63] Evidence suggests that those with complex and unmet physical, behavioral, and social needs typically consume a large share of health care resources and have poor health outcomes.[64] Providing supportive housing and other support services that address unmet social needs has been found to reduce emergency department utilization, inpatient admissions, and total cost of care.[65] Social services providers, however, have historically been disconnected from the health care delivery system and are not integrated to effectively support the management of patients with multiple chronic diseases and complex social needs such as food, housing, and respite care.[66]

MCPs will be expected to develop and engage a network of community-based social and human services organizations to deliver ILOS to patients with complex health and social needs. Many of these organizations lack access to a technical platform, infrastructure, and capabilities to access demographic, eligibility, and authorization information from MCPs or to receive information from a referring provider.[67] Providers referring members to these health and social service organizations often do not have access to electronic directories integrated into their workflows to generate MCP referral and authorization requests or to receive notifications regarding status and fulfillment of referral requests. Specific challenges that MCPs and providers are expected to confront as ECM benefits and ILOS are implemented include:

- *ILOS provider capabilities and workflows.* Information technology and data governance challenges represent one of the most significant barriers to integrating health and social services with community partners.[68] Without access to integrated technical solutions, ILOS providers cannot easily receive referrals, determine eligibility, check authorization status, or notify referring providers and other care team members of referral status. ILOS providers may not know what information they are expected to share back with referring MCPs or ECM providers or have the internal systems or workforce to support extensive reporting. ILOS providers need access to systems and training to be responsive to referring providers, access information they need about referred members, and transmit notifications to communicate referral status.
- *Referring provider technical capabilities and workflows.* Many providers are burdened with inefficient workflows and protocols when using social service referral resource platforms that aren't integrated with their EHRs.[69] Referring providers need access to systems that are more integrated with their EHR workflows to facilitate referrals, and training to incorporate new processes into clinical workflows.
- *Provider directory and member information.* MCPs need to equip referring providers with accurate and up-to-date information on ILOS and other providers in their networks, and information on members' eligibility and referral authorization status. Provider directories are notoriously difficult and burdensome for MCPs to maintain.

OPPORTUNITIES

Numerous efforts are already underway in California to share information and support referrals between social service and health care providers. 2-1-1 San Diego is one of the most advanced efforts in the state that includes a multidisciplinary partner network and technology platform centered on a resource directory, bidirectional referrals, and shared longitudinal patient records.[70]

Other activities in California may help and could be leveraged to address gaps. These include Senate Bill 137 (2016) requiring health plans to maintain accurate provider directories, and the Integrated Healthcare Association's Symphony provider directory, which was launched to develop a statewide platform for plans and providers to exchange and update provider information.[71]

Table 5. Road Map Recommendations to Build Community Resource Closed-Loop Referrals Services

	ROAD MAP ACTIONS		
	2021	2022–24	2025+
REGULATORY AND POLICY			
Develop guidance for referral and information sharing among MCPs and ECM and ILOS providers. Additional DHCS guidance should be developed to align efforts to develop closed-loop referral platforms so that MCPs do not create conflicting workflows, standards, and data definitions for the ECM and ILOS providers they contract with. Guidance may include definitions, data elements, and requirements for the type of information that referral systems should include.		DHCS should develop guidance in consultation with industry stakeholders, including vendors, to help MCPs and providers coordinate efforts to establish closed-loop referral platforms and processes.	
TECHNICAL			
Develop and deploy referral service standards and platforms accessible to contracted ECM and ILOS providers. MCPs operating in regions with multiple plans should collaboratively develop community resource referral platforms that reduce inefficiencies and support connectivity and integration with ILOS and ECM providers. Plans and providers should work together to develop consistent data definitions, ECM and ILOS provider-facing workflows, notification processes, and necessary directory information, and member and referral tracking information.		DHCS should work with MCPs to develop and deploy a consistent set of closed-loop referral platform standards, data elements, and processes. MCPs should test and roll out closed-loop referral platforms that adhere to DHCS guidance.	
FINANCING, CONTRACTING, AND OPERATIONS			
Provide training and technical assistance to ECM and ILOS providers to support workflow changes and access to systems used to authorize, track, and close referrals. Processes associated with issuing ILOS referrals and authorizations, alerting providers to referral notifications and status changes, and updating referral statuses will be new to many ECM and ILOS providers. MCPs should provide training to its contracted ECM and ILOS providers on the use of referral systems and to support integration into their workflows to maximize efficiency and utility.	MCPs should develop training with ECM and ILOS providers on ILOS referral processes and systems.	MCPs should update trainings to reflect evolving system designs and program requirements.	

5. Performance Reporting and ECM and ILOS Billing

CHALLENGES

ECM benefits and In Lieu of Services will be administered by MCPs and paid by MCPs using capitated payments received from DHCS. DHCS will set MCP payment rates annually based on plan-specific and risk-adjusted utilization measures directly reported by plans and derived from MCP encounter data.[72] In accordance with federal regulations, DHCS contractually requires MCPs to submit encounter data to it following national standards and reflecting the full experience of the member.[73] The complete and accurate capture of compliant encounters by MCPs is an important ingredient for rate setting, and one that DHCS plans to increase over time.[74]

Federal rules also require that DHCS implement a quality strategy to assess and improve the quality of the health care services provided through MCPs, and that DHCS conduct external quality reviews to evaluate the care provided to enrollees through MCPs.[75] DHCS has focused on the use of data for performance monitoring and transparency efforts and uses encounter data to construct performance metrics from the Centers for Medicare & Medicaid Services (CMS) Adult and Child Core Measures Set.[76] These measures are intended to be used to "incentiviz[e] provider performance in new [Value Based Payment] Program… and [Quality Improvement Program] initiatives… to create synergistic quality improvement initiatives, support goals to decrease reporting burden, and focus on processes and outcomes that assess integration of services across delivery systems."[77] DHCS requires MCPs to report on and be held accountable to meeting performance measure targets, the majority of which are dependent on MCP claim and encounter data; the remaining are hybrid or clinical/EHR measures that require access to clinical information.

Many ECM and ILOS providers — particularly those who have historically operated outside of the traditional health care delivery system, including social and human service organizations serving the homeless, food insecure, and justice-involved populations — will not have technical capabilities to submit claims to MCPs in compliance with state and national standards. Their systems will not generally be configured to capture and store clinical data in a structured, standardized format so that it may be used to support performance reporting. Without complete ECM and ILOS encounter and clinical data, MCPs cannot report complete encounter, quality, and performance information to DHCS, and DHCS performance metrics will not reflect the full experience of the member.

The specific challenges MCPs and ECM and ILOS providers are expected to face to meet billing, encounter, and performance reporting requirements and expectations include these:

- *Accurate coding.* ILOS providers will need to match the nontraditional health care services they provide to newly created DHCS billing codes to invoice MCPs for services they render. DHCS has incorporated stakeholder feedback on the proposed ILOS billing code set to make them as practicable as possible (e.g., eliminating many 15-minute billing requirements). However, the process of invoicing against these new codes will require staff training and workflow changes at many organizations that are understaffed and underresourced.[78] ILOS providers will require uniform, consistent, and easy-to-understand guidance on how to crosswalk the services they provide to DHCS billing codes, and the resources to support staff training.
- *Technical billing capacity and administrative simplification.* Some ECM and ILOS providers will be technically ill-equipped to generate and send DHCS-compliant electronic claims for rendered services to MCPs. Without practice management systems in place, they will not be able to compile, format, and submit an invoice as a standard ANSI ASC X12N 837P claim. And most counties will also have multiple MCPs administering benefits; ECM and ILOS providers with technical capacity will be further challenged if billing standards vary by health plan in these regions.

- *Performance reporting.* DHCS's Comprehensive Quality Strategy may include ECM and ILOS metrics using CMS's Core Measure Set to the maximum extent possible.[79] Metrics assessing the impact of ECM benefits and ILOS may require hybrid administrative and clinical measures as well as different measures for different ECM and ILOS target populations. MCPs will need clear guidance on ECM and ILOS program goals, objectives, and metrics, and the underlying data needed to generate each measure. Given the limited technical capacity of many ECM and ILOS providers, MCPs may find it difficult to accurately and completely report ECM and ILOS performance metrics based on administrative and clinical data.

ECM and ILOS providers unable to meet MCP billing requirements will need alternative pathways to electronically submit claims to MCPs and consistent and easy-to-use systems and processes. These may include standard billing templates and simplified transmission methods, such as a web-based portal that can be used to submit invoices to MCPs. MCPs will also need to ensure all billing information received is validated for accuracy and completeness, and they will need to develop processes to transform invoices into compliant encounters for submission to DHCS.

ECM and ILOS providers will also need training and technical assistance to orient them to coding requirements and use of invoicing templates, tools, and portals to support effective billing practices. Training and technical support will also be needed to help providers curate data needed to construct measures.

OPPORTUNITIES

In WPC and HHP pilots in California, some lead entities and health plans established portals, secure email, and other web-based services to support reporting and invoicing functions for providers with limited technical capabilities. Anthem, for example, established a web-based portal that allowed providers to submit and track the status of invoices and to look up patient eligibility and benefit information. In New Jersey, the Camden Coalition Accountable Care Organization, implemented a web-based clinical portal (TrackVia) for primary care practices to use to track engagement and select clinical information.[80]

Table 6. Road Map Recommendations to Support Performance Reporting and ECM and ILOS Billing Requirements

	ROAD MAP ACTIONS		
	2021	2022–24	2025+
REGULATORY AND POLICY			
Develop guidance to support standardized ECM and ILOS invoicing and billing, including minimum data requirements for ECM and ILOS providers unable to submit compliant 837 claims. DHCS in coordination with MCPs should develop minimum data requirements for ECM and ILOS invoicing and billing that should be maintained across MCPs from which they can generate compliant encounters for submission to DHCS. Guidance may include recommendations regarding standardization of transmission methods and modalities (e.g., submissions through portals or secure email) to minimize provider administrative burden.	DHCS should convene MCPs and ECM and ILOS providers to develop a minimum set of data elements for ECM and ILOS invoicing and billing, including minimum requirements for ECM/ILOS providers unable to submit compliant claims.		MCPs should implement minimum billing data element requirements following DHCS guidance.
Establish clear ECM and ILOS program quality and performance improvement goals, objectives, and performance metrics. DHCS should define program goals and objectives for ECM target populations and members authorized for ILOS and adopt appropriate metrics accordingly. DHCS should also convene a stakeholder group composed of MCPs and ECM and ILOS providers to advise on the development of metrics for the ECM and ILOS programs.	➤ DHCS should review program goals and objectives with ECM and ILOS stakeholders and define a set of existing or new measures to assess program efficacy. ➤ DHCS should finalize measure selection and provide guidance to MCPs regarding reporting of quality and performance metrics.		DHCS should evaluate ECM/ILOS programs by selected measures and refine measure selection as needed.
TECHNICAL			
Develop standardized data requirements, templates, and processes for ECM and ILOS invoicing and billing systems that can be used by ECM and ILOS providers with limited billing capabilities. MCPs should work together to develop standard templates, forms, and accessible submission methods to facilitate billing processes for ECM and ILOS providers with limited capabilities.	MCPs should work with providers to implement and test a standardized set of minimum billing data elements and requirements based on DHCS guidance and develop invoicing templates and processes that can be used by ECM and ILOS providers.	➤ MCPs should implement billing templates and services and make them available to ECM and ILOS providers to submit invoices.	
Define performance metric technical specifications. DHCS should develop technical specifications for each identified performance measure to support consistent managed care plan implementation.	DHCS should develop or refine existing performance metric specifications that align with policy objectives and performance measure guidance.	DHCS should update measure specifications, as warranted.	
FINANCING, CONTRACTING, AND OPERATIONS			
Develop ECM and ILOS provider training and technical assistance to support complete and accurate billing/invoicing and other data reporting. ECM and ILOS providers unable to electronically submit a compliant claim or encounter would benefit from training on how to crosswalk standardized codes to provided services and best practices for integrating new MCP billing procedures and invoice submission processes into their workflows. ECM and ILOS providers may also need to transmit additional data to support quality and performance reporting.	MCPs should develop ECM and ILOS training programs on coding and billing practices.	MCPs should update training programs as needed to reflect updates and changes to billing guidelines and practices.	

Funding Considerations

DHCS can work collaboratively with MCPs and other ECM and ILOS stakeholders to explore various federal, state, and local funding mechanisms — including the state's 1115 waiver authority — to build needed system HIT capacity to support program implementation.[81] Several additional potential funding sources follow.

Medicaid Enterprise Systems 90/10 funding. Section 1903(a)(3) of the Social Security Act allows states to receive enhanced federal funding for activities related to their Mechanized Claims Processing and Information Retrieval Systems — the IT that supports eligibility and enrollment and the array of Medicaid program management and administration.[82] These systems are collectively referred to as a state's Medicaid Enterprise System (MES). Under this authority, states may receive 90% federal matching funds for the design, development, installation, or enhancement of these system, and a 75% federal match for system maintenance and operation.[83]

California could submit Advance Planning Documents for CMS approval to draw down matching federal funds to help MCPs and ECM and ILOS providers enhance their HIE capabilities to meet program objectives. For example, MES 90/10 funding could potentially support ECM providers in acquiring or accessing a care management documentation system. It could also be used to support enhancements to ECM and ILOS providers' billing systems to enable providers without electronic billing systems to submit claims and encounters in the formats specified by DHCS.

90/10 Health Information Technology (HITECH) Act administrative funding. Through HITECH, funding is available to states at a 90% federal match for some activities related to interoperability, such as:[84]

- HIE onboarding and outreach
- Facilitating connections between providers and HIOs
- Promoting Medicaid providers' use of EHRs and HIOs

HITECH administrative funding is available at a 90% match through September 2021, and states must submit an HIE Implementation Advanced Planning Document to CMS for approval to receive funding. CMS recently sent notifications to Medicaid agencies requesting that they submit a final State Medicaid HIT Plan to update understanding of the current HIE landscape and that could be used to submit additional funding requests.

California's Health Information Exchange Onboarding Program (Cal-HOP) is using HITECH administrative funding to provide up to $50 million in state ($5 million) and federal ($45 million) funding to qualified HIOs to support Medi-Cal providers' access to and use of HIE technology through September 2021.[85] Specifically, qualified HIOs can use Cal-HOP funding to support Medi-Cal providers and hospitals in connecting their EHRs to qualified HIOs to enable ADT notifications, connect to the Controlled Substance Utilization Review and Evaluation System (CURES), and implement advanced data exchange interfaces. Notably, Cal-HOP funding can be used only for initial onboarding activities and may not be used for ongoing HIE operations, such as HIO subscription fees.[86]

To the extent that Cal-HOP funds are still available, qualifying Medi-Cal providers that intend to participate in the ECM or ILOS programs may be able to partner with an HIO participating in Cal-HOP to enhance their HIE capabilities. Cal-HOP funding may be especially helpful in improving California's data exchange infrastructure by increasing the number of Medi-Cal providers that can exchange patient data via HIOs, and expanding the data exchange capabilities of potential ECM and ILOS providers that currently participate in HIOs (e.g., facilitating exchange of ADT and other types of data). However, the utility of Cal-HOP funding may be limited, since funds will be available only through September 2021, and it provides for limited opportunities to bolster the exchange of behavioral health or SDOH data.

Delivery system and provider payment incentives. 42 C.F.R. § 438.6(c) and its subsequent Informational Bulletins provide states with the flexibility to implement delivery system and provider payment initiatives through contracted MCPs with funds over and above capitation payments.[87] States have wide latitude in making such incentive payments as long as payments:

- Do not exceed 5% of annual managed care plan capitation payments
- Are for a fixed period with performance measured during that contract period
- Are available to public and private managed care organizations under the same terms of performance
- Meet certain other requirements[88]

For example, California's Quality Incentive Payment program currently uses this strategy in the Quality Incentive Program, which directs MCPs to make payments to designated public hospitals based on performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization.[89] Washington's Medicaid Quality Improvement Program provides Medicaid MCPs with incentive dollars to use, in collaboration with partnering public hospitals, to improve the quality of care delivery and to support community health.[90]

Incentive payments could be harnessed to fund capacity-building initiatives in the ECM and ILOS programs. MCPs could develop incentives and share incentive payments with ECM and ILOS providers to build or enhance data systems and sharing capabilities. These incentive payments could also potentially be used for MCP-level technical assistance and training for ECM and ILOS providers on a variety of programmatic features and requirements.

Mental Health Services Act. The state could leverage existing funding sources, such as the 2004 Mental Health Services Act, which funds a broad continuum of service needs including improving or replacing behavioral health provider technology systems.[91]

CMS Promoting Interoperability Programs. The American Recovery and Reinvestment Act of 2009 established the EHR Incentive Program for Medicaid and Medicare providers. In 2011, eligible Medi-Cal professionals and hospitals began receiving incentive payments to assist in purchasing, installing, and using electronic health records in their practices.[92] ECM and ILOS providers that meet eligibility criteria for the Promoting Interoperability Programs may be eligible to receive incentive payments to adopt or upgrade their EHRs, which may enhance their capabilities to exchange event notifications and to share care plans. ECM providers may also be able to use an EHR as a care management documentation system if it offers the required functionality.

Philanthropic funding support. Philanthropies can fund pilots and test programs to build an evidence base on approaches to address implementation barriers. For example, philanthropic funding could support a pilot program that tests the implementation of a centralized care plan directory in a region or for a small number of participants statewide. Philanthropies can also provide the state's 10% federal funding match requests if the funding is not otherwise authorized by the California legislature or state budget.

Private sources. Individual stakeholder groups including managed care plans and providers could make capacity-building investments if there is a long-term prospect of returns or if other lines of business and activities could concurrently benefit from Medi-Cal related investments.

Appendix A. Interviewees, by Organization

	INTERVIEWEES	INTERVIEW DATE(S)
Alameda County WPC	Jennifer Martinez, Program Development Director Cristi Ianuzzi, HIT Consultant (C&C Advisors)	Aug. 24, 2020
Anthem	Beau Henneman, Director, Special Programs	Aug. 27, 2020
Bay Area Community Services	Jamie Almaza, Executive Director	Sept. 30, 2020
California Health & Wellness (Centene)	Abbie Totten, Medi-Cal Program Officer	Aug. 27, 2020
California Office of Health Information Integrity	Jennifer Schwartz, Chief Privacy Officer Elaine Scordakis, Assistant Director Courtney Hansen, Attorney	Sept. 25, 2020
California Mental Health Services Authority	Amie Miller, Executive Director	Sept. 25, 2020
Central California Alliance for Health	Stephanie Sonnenshine, CEO Dale Bishop, MD, Chief Medical Officer Jennifer Mockus, Community Care Coordination Director Gina Rhoads, Program Development Manager	Nov. 4, 2020
Community Health Center Network	Laura Miller, MD, Chief Medical Officer Xiao Chen, CHCN Director, Analytics Angela O'Brien, Community Social Worker	Sept. 14, 2020
Contra Costa County WPC	Bhumil Shah, Chief Analytics Officer Sue Crosby, Director, Whole Person Care Emily Parmenter, Whole Person Care Program Manager Rachael Birch, Health Services Administrator, Whole Person Care Program Rajiv Pramanik, Chief Medical Information Officer	Sept. 3, 2020
Health Plan of San Mateo	Maya Altman, Chief Executive Officer Amy Scribner, Director, Behavioral Health	Oct. 13, 2020
Homebase	Nikka Rapkin, Executive Director Julie Silas, Deputy Director	Nov. 20, 2020
Inland Empire Health Plan	Elise Pomerance, Senior Medical Director, Practice Transformation Leslie Brooks, Senior Consultant, Health Management Associates Shawna Sanchez, Integration Department Matthew Wray, Operational Manager, Practice Transformation	Oct. 7, 2020
Intrepid Ascent	Mark Elson, Principal Alex Horowitz, Principal Technology Strategist Jennifer Kaufer, Managing Consultant, Health Care Improvement	Sept. 17, 2020

	INTERVIEWEES	INTERVIEW DATE(S)
Kaiser	Sarita Mohanty, Vice President, Care Coordination, Medicaid and Vulnerable Populations, National Medicaid Elizabeth Reno, Executive Director, Medi-Cal Regulatory and Special Programs Vidya Iyengar, Executive Director, NCAL Medi-Cal Strategy and Operations Kyle Murphy, Executive Director, Medi-Cal Strategy and State Programs, Southern California Bayley Raiz, National Director, Care Coordination, Medicaid and Vulnerable Populations Kevin Isbell, Executive Director, Data and Analytics Services Walter Suarez, Executive Director, Health IT Strategy and Policy	Sept. 11, 2020
L.A. Care Health Plan	Cynthia Carmona, Sr. Director, Safety Net Initiatives Mary Zavala, Health Homes Director Rich Seidman, Chief Medical Officer Alison Kerfeld, Director, Safety Net Programs and Partnerships	Sept. 4, 2020
LA County WPC	Clemens Hong, Director, WPC Belinda Waltman, Medical Director, WPC Henna Asad Zaidi, Director, Delivery System Integration, WPC	Aug. 25, 2020
LifeLong Medical Care	Brenda Goldstein, Chief, Integrated Services Sonny Nguyen, Care Neighborhood Community Health Worker Jeff Heath, Community Health Worker Tirzah Riley, Care Neighborhood Community Health Worker	Sept. 23 and Oct. 1, 2020
Marin County	Charis Baz, Director of Whole Person Care	Sept. 25, 2020
Partnership HealthPlan	Robert Moore, Chief Medical Officer Amy Turnipseed Arun Saligame	Aug. 27, 2020
San Francisco County WPC	Kiersten Robertson, Whole Person Care Operations Manager Dara Papo, Director, Whole Person Integrated Care Colleen Lynch, Medical Director, Care Coordination in Primary Care Carol Chapman, Health Program Administrator Spencer Williams	Sept. 10, 2020
San Francisco Health Plan	Lucinda Dei Rossi, Manager, Whole Person Care Peter Shih, Senior Manager, Delivery System Planning	Sept. 3, 2020
San Mateo County WPC	Fiona Donald, Senior Medical Director Courtney Gray, Director, Care Management	Sept. 3, 2020
Shasta County WPC	Josette McKrola, Senior Staff Services Analyst Katie Cassidy, Program Manager Rhonda Schultz, Community Development Coordinator	Sept. 1, 2020
WellSpace Health	Ben Avey, Chief Public Affairs Officer	Sept. 23, 2020

Appendix B. Advisory Committee Members, by Organization

	MEMBER/INDIVIDUAL	TITLE
Industry Stakeholders		
Alameda County WPC	Jennifer Martinez	Program Development Director
Bay Area Community Services	Jamie Almanza	Executive Director
California Health & Wellness	Abbie Totten	Medi-Cal Program Officer
Community Health Center Network	Laura Miller Xiao Chen Angela O'Brien	Chief Medical Officer Director, Analytics Community Social Worker
Contra Costa County WPC	Rajiv Pramanik	Chief Medical Information Officer
Intrepid Ascent	Alex Horowitz	Principal Technology Strategist
Kaiser	Kyle Murphy	Executive Director, Medi-Cal Strategy and State Programs, SoCal
L.A. Care Health Plan	Mary Zavala	Director, Health Homes
LA County WPC	Belinda Waltman	Medical Director, WPC
Partnership HealthPlan	Robert Moore	Chief Medical Officer
San Francisco Health Plan	Fiona Donald Courtney Gray	Senior Medical Director Director, Care Management
San Francisco County WPC	Spencer Williams Kiersten Robertson Dara Papo	Interagency Data Sharing Coordinator WPC Operations Manager Director, Whole Person Integrated Care
DHCS and CHCF		
California Department of Health Care Services	Aaron Toyama Brian Hansen Nathan Nau	Senior Advisor, Health Care Programs Health Program Specialist — Health Care Delivery Systems Chief, Managed Care Quality and Monitoring
California Health Care Foundation	Melissa Buckley Hong Truong Michelle Schneidermann	Director, Innovation Fund Senior Program Investment Officer Director, High-Value Care

Appendix C. Glossary of Abbreviations

ADT	Admission, discharge, and transfer
BH	Behavioral health
BSCC	Board of State Community Corrections
CalAIM	California Advancing and Innovating Medi-Cal
Cal-HOP	California Health Information Exchange Onboarding Program
CalOHII	California Office of Health Information Integrity
CalPERS	California Public Employees' Retirement System
CB-CME	Community-Based Care Management Entities
CBO	Community-based organization
C-CDA	Consolidated Clinical Data Architecture
CDCR	California Department of Corrections and Rehabilitation
CHHS	California Health & Human Services
CIE	Community information exchange
CM	Care management
CMIA	California's Confidentiality of Medical Information Act
CMS	Centers for Medicare & Medicaid Services
CURES	Controlled Substance Utilization Review and Evaluation System
DHCS	Department of Health Care Services
ECM	Enhanced Care Management
EHR	Electronic health record
FHIR	Fast Healthcare Interoperability Resource
HHP	Health Homes Program
HIE	Health information exchange
HIF	Health information form
HIO	Health information organization
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health information technology
HITECH	Health Information Technology for Economic and Clinical Health
HMIS	Homeless Management Information System
ILOS	In Lieu of Services
IT	Information technology
LTSS	Long-term services and supports
MCP	Managed care plans
MES	Medicaid Enterprise System
MET	Medical evaluation tool
MSO	Management services organization
ONC	Office of the National Coordinator for Health Information Technology
PCP	Primary care provider
SDOH	Social determinants of health
SHIG	State Health Information Guidance
SNAP	Supplemental Nutrition Assistance Program
SUD	Substance use disorder
TA	Technical assistance
WPC	Whole Person Care

Endnotes

1. The multidepartment workgroup should also include California Department of Corrections and Rehabilitation and representatives from county sheriff's offices.
2. "Medi-Cal Enrollment," California Dept. of Health Care Services (DHCS), last modified March 12, 2021.
3. "Whole Person Care Pilots," DHCS, last modified February 26, 2021.
4. See California SPA Transmittal Number 16-007 (PDF), CMS, December 19, 2017. Authorized under Section 2703 of the Patient Protection and Affordable Care Act.
5. "Health Homes Program," DHCS, last modified February 17, 2021.
6. "Social Determinants of Health," US Office of Disease Prevention and Health Promotion; and Deborah Bachrach, "Addressing Patients' Social Needs: An Emerging Case for Provider Investment," Commonwealth Fund, May 29, 2014.
7. ECM providers may include, but are not limited to, counties; county behavioral health providers; primary care physician or specialist or physician groups; Federally Qualified Health Centers; community health centers; hospitals or hospital-based physician groups or clinics (including public hospitals and district/municipal public hospitals); Rural Health Centers/ Indian Health Centers; local health departments; behavioral health entities; community mental health centers; substance use disorder treatment providers; organizations serving people experiencing homelessness; organizations serving justice-involved people; and other qualified providers or entities not listed above, as approved by DHCS.
8. Gabriel Petek, "The 2020-21 Budget: Re-Envisioning Medi-Cal — The CalAIM Proposal," Legislative Analyst's Office, February 28, 2020.
9. "Enhanced Care Management and In Lieu of Services Workgroup," DHCS, March 6, 2020.
10. *Enhanced Care Management Target Population Descriptions: Children and Youth* (PDF), DHCS, December 2019.
11. If an MCP determines that a member is not authorized to receive the benefit, the MCP will ensure that the member and the entity requesting the benefit is appropriately informed of the decision and of the member's right to appeal it. See contract provisions for complete and latest authorization data requirements, including treatment of WPC pilot and HHP members.
12. MCPs will define within the ECM Model of Care the specific policies and procedures under which ECM providers will notify and engage members.
13. The ECM benefit is considered to be initiated when verbal or written consent is obtained.
14. Notice of Proposed Rulemaking: *Proposed Modifications to the HIPAA Privacy Rule to Support, and Remove Barriers to, Coordinated Care and Individual Engagement* (PDF), US Dept. of Health and Human Services, December 10, 2020.
15. *Enhanced Care Management and In Lieu of Services: Coding Options* (PDF), DHCS, February 7, 2020; and "Medi-Cal Managed Care Encounter Data Reporting," DHCS, last modified February 3, 2020. Some MCPs may establish prospective per-member per-month payment arrangements with ECMs. In February 2020, DHCS released proposed ECM and ILOS HCPCS coding options for public comment.
16. If the ILOS provider is unable to utilize relevant HCPCS and/ or modifier codes, it will provide a description of the service rendered so that the MCP is able to map the service provided to the appropriate HCPCS code.
17. MCPs will be expected to hold ECM providers responsible for the same reporting requirements as those it must report to DHCS and shall not impose reporting requirements that are alternative or additional to the required encounter and supplemental reporting.
18. *Comprehensive Quality Strategy: Draft Report for Public Comment* (PDF), DHCS, November 2019.
19. ILOS are not limited to members authorized for ECM; not all ECM members are eligible for ILOS.
20. Alex Dworkowitz and Cindy Mann, *Data Sharing and The Law: Overcoming Healthcare Sector Barriers to Sharing Data on Social Determinants* (PDF), Manatt Health, July 2020.
21. Cal. Welf. and Inst. Code § 14184.60.
22. Nadereh Pourat et al., *Whole Person Care (WPC) Pilot Program Challenges and Successes: January 2017–December 2019* (PDF), UCLA Center for Health Policy Research, September 2020.
23. Emmeline Chuang et al., "Integrating Health and Human Services in California's Whole Person Care Medicaid 1115 Waiver Demonstration," *Health Affairs* 39, no. 4 (April 2020): 639–48.
24. WPC pilot interviews. While enabling legislation included language encouraging WPC and HHP participants to appropriately and securely share sensitive member information in order to meet program goals, it did not carry with it legal standing to trump other conflicting federal or other state law.
25. Lucy Pagel, Carol Backstrom, and Hilary Haycock, *Whole Person Care: A Mid-Point Check-In*, California Health Care Foundation (CHCF), March 2019.
26. Chuang et al., "Integrating Health and Human Services."

27. Sharon Hewner et al., "Integrating Social Determinants of Health into Primary Care Clinical and Informational Workflow during Care Transitions," *Journal for Electronic Health Data and Methods* 5, no. 2 (July 2017). ECM providers will benefit from having access to event notifications for care transitions and critical physical, behavioral, and social status changes, including discharges from jails and acute and post-acute care facilities, housing and employment status changes, and other relevant life status changes in order to coordinate care and to facilitate and manage referrals.

28. *Using Risk Stratification to Understand Medicaid Beneficiaries with Complex Care Needs and High Costs* (PDF), Medicaid Innovation Accelerator Program, January 2018; and Leonard W. D'Avolio, "Beyond Racial Bias: Rethinking Risk Stratification In Health Care," *Health Affairs Blog*, January 15, 2020.

29. *Advancing Interoperability: Social Determinants of Health* (PDF) (presentations from the ONC workshop, online, September 21, 2020).

30. *Expanding Payer and Provider Participation in Data Exchange: Options for California*, CHCF, November 2019.

31. Nir Menachemi et al., "The Benefits of Health Information Exchange: An Updated Systematic Review," *Journal of the American Medical Informatics Assn. (AMIA)* 25, no. 9 (September 2018): 1259–65.

32. "Homeless Management Information System," US Dept. of Housing and Urban Development. HMIS is a local information technology system used to collect client-level data and data on the provision of housing and services to individuals and families experiencing homelessness and those at risk of homelessness.

33. *Addressing Homelessness in the San Francisco Bay Area: A Framework for Regional Data Sharing* (PDF), Homebase. Housing programs receiving federal and state funding are required to enter certain standardized data into their HMIS to identify, deduplicate, aggregate, and report information to local, state, and federal agencies, and with other regional housing agencies.

34. North Carolina prepaid health plan contract (PDF), Section V.6.a.v.c.8, North Carolina Dept. of Health and Human Services (NCDHHS), January 25, 2019.

35. North Carolina contract, NCDHHS.

36. *Becoming Certified as an Advanced Medical Home: A Manual for Primary Care Providers* (PDF), NCDHHS, August 27, 2018.

37. "Alameda County Community Health Record Delivering Consumer-Centered, Data-Informed Care," Alameda County Care Connect, July 26, 2018.

38. "Cal-HOP," DHCS, last modified December 4, 2020.

39. In particular, the ONC rule adopted HL7 FHIR APIs as the foundational standard for application-based exchange of health information. The CMS rule requires, beginning in 2021, a broad suite of payers to implement patient access APIs based on the ONC rule's standards that permit, upon direction by an enrollee, third-party applications to access the enrollee's adjudicated claims, encounters, clinical data, and patient drug benefit information. The CMS rule also requires that, beginning in 2021, certain hospitals, as a condition of participation in Medicare or Medicaid, transmit electronic notifications of enrollees' ED and inpatient ADTs to all applicable providers and other practitioners. See 85 Fed. Reg. 25510 (May 1, 2020) and 85 Fed. Reg. 25642 (May 1, 2020).

40. "State Health IT Policy Levers Compendium," ONC, December 2015; Statewide Health Information Exchange Act (PDF), N.C. Gen. Stat. §§ 90.414.1–12 (2015); and *Expanding Payer and Provider*, CHCF.

41. Brittany L. Brown-Podgorski et al., "The Association Between State-Level Health Information Exchange Laws and Hospital Participation in Community Health Information Organizations," *AMIA Symposium Proceedings* (Dec. 5, 2018): 313–20; and *Expanding Payer and Provider*, CHCF.

42. NC HealthConnex is supported by $9 million in annual state funding.

43. CyncHealth (website).

44. "Gravity Project," HL7.

45. Non-health-care stakeholders (e.g., HMIS Lead Agencies and vendors) should be engaged in the consideration of new measure development (e.g., housing / housing stability, measured by placement into permanent housing and/or a minimum amount of time retaining housing).

46. "Clinical Alerts," Healthix.

47. Changes to data sharing will also impact user agreements, data sharing agreements, and releases of information, which will impact service providers and clients, and which should be addressed across activities outlined in this recommendation.

48. *2018 Report to Congress: Annual Update on the Adoption of a Nationwide System for the Electronic Use and Exchange of Health Information* (PDF), ONC; and Karmen S. Williams et al., "Overcoming Barriers to Experience Benefits: A Qualitative Analysis of Electronic Health Records and Health Information Exchange Implementation in Local Health Departments," eGEMS 5, no. 1 (2017): 18.

49. Eugene Rich et al., *Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions* (PDF), AHRQ, January 2012.

50. Chad Boult and G. Darryl Wieland, "Comprehensive Primary Care for Older Patients with Multiple Chronic Conditions: 'Nobody Rushes You Through,'" *JAMA* 304, no. 17 (Nov. 3, 2010): 1936–43. In addition to helping providers better manage patients, MCP care managers will be able to use the data to preemptively divert unnecessary ED visits by offering lower-cost services like telehealth visits or a same-day appointment at a nearby clinic.

51. Alex Baker et al., "Making the Comprehensive Shared Care Plan a Reality," *NEJM Catalyst*, May 18, 2016.

52. Suzanne S. Sullivan et al., "Integrating Social Context into Comprehensive Shared Care Plans: A Scoping Review," *Nursing Outlook* 65, no. 5 (Sept. 1, 2017): 597–606; and Margareta Rämgård, Kerstin Blomqvist, and Pia Petersson, "Developing Health and Social Care Planning in Collaboration," *Journal of Interprofessional Care* 29, no. 4 (Jan. 30, 2015): 354–58.

53. California Advancing & Innovating Medi-Cal (CalAIM) Proposal (PDF), DHCS, October 28, 2019.

54. Stakeholder interviews and advisory committee feedback, August–November 2020.

55. Clemens S. Hong, Allison L. Siegel, and Timothy G. Ferris, *Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?* (PDF), Commonwealth Fund, August 2014.

56. "Final ONC Interoperability Regulation: What You Need to Know," HIMSS, March 19, 2020.

57. *Coordinating Care for Adults*, AHRQ.

58. Amanda Clarke, "After Some Hurdles, California Whole Person Care Pilots Hit Stride," Healthforce Center at UCSF, November 5, 2018; and *Whole Person Care*, CHCF.

59. *Health Homes Program: Year One Implementation Report, 2019* (DOWNLOADS PDF), Inland Empire Health Plan, 2020.

60. *Whole Person Care*, CHCF.

61. Guidance should also acknowledge existing local HIT capacity (e.g., WPC investments) and provide guidance on how such capacity may be used to advance current requirements.

62. "Welcome to the Argonaut Project," HL7, last modified August 31, 2020; and "Argonaut Data Query Implementation Guide Version 1.0.0: StructureDefinition-argo-careplan," HL7, February 15, 2017. The Argonaut Project is a private sector initiative to advance industry adoption of modern, open interoperability standards. The purpose of the Argonaut Project is to rapidly develop a first-generation FHIR-based API and Core Data Services specification to enable expanded information sharing for electronic health records and other HIT based on internet standards and architectural patterns and styles.

63. Caitlin Thomas-Henkel and Meryl Schulman, *Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations*, Center for Health Care Strategies, October 2017.

64. Seth A. Berkowitz et al., "Addressing Basic Resource Needs to Improve Primary Care Quality: A Community Collaboration Programme," *BMJ Quality & Safety* 25, no. 3 (Mar. 2016): 164–72.

65. Laura M. Gottlieb, "A Systematic Review of Interventions on Patients' Social and Economic Needs," *American Journal of Preventive Medicine* 53, no. 5 (Nov. 1, 2017): 719–29.

66. Ruben Amarasingham et al., *Using Community Partnerships to Integrate Health and Social Services for High-Need, High-Cost Patients* (PDF), Commonwealth Fund, January 2018.

67. *Using Community Partnerships*, Commonwealth Fund.

68. Jody Ranck, "Addressing Social Determinants of Health: IT Solutions to Engage Community Resources," Chilmark Research, November 9, 2020.

69. Yuri Cartier, Caroline Fichtenberg, and Laura Gottlieb, *Community Resource Referral Platforms: A Guide for Health Care Organizations* (PDF), Social Interventions Research & Evaluation Network (SIREN), April 16, 2019.

70. Cartier, Fichtenberg, and Gottlieb, *Community Resource Referral Platforms*.

71. "Symphony Provider Directory," Integrated Healthcare Assn.

72. *Intended Consequences: Modernizing Medi-Cal Rate-Setting to Improve Health and Manage Costs*, CHCF, March 2018.

73. ANSI ASC X12 837 5010 and NCPDP standards and reporting requirements were implemented to meet state and federal Medicaid monitoring and reporting requirements and to accommodate receipt of ICD-10 diagnosis codes in accordance with HIPAA requirements.

74. *Medi-Cal Encounter Data: Landscape Assessment* (PDF), Manatt Health, August 12, 2019.

75. 42 C.F.R. § 438.340 – Managed Care State Quality Strategy, (2016).

76. "Core Set Measures Reporting," DHCS, last modified December 6, 2019.

77. *Comprehensive Quality Strategy* (PDF), DHCS, November 2019.

78. *Enhanced Care Management and In Lieu of Services: Coding Options* (PDF), DHCS, February 12, 2021.

79. *Comprehensive Quality Strategy* (PDF), DHCS, November 2019.

80. *Camden Coalition Accountable Care Organization Gainsharing Plan* (PDF), Camden Coalition of Healthcare Providers.

81. Madeline Guth et al., "The Landscape of Medicaid Demonstration Waivers Ahead of the 2020 Election," KFF, October 30, 2020. Section 1115 allows states to use federal matching funds in ways that federal rules might not ordinarily allow.

82. Such as encounter data processing, interoperability, claims adjudication and payment, provider management, clinical decision support, care management, plan management, program integrity, and registries (Medicaid Management Information Systems, or MMIS).

83. *Strategies for Supporting and Strengthening Medicaid Information Technology During the COVID-19 Crisis* (PDF), State Health and Value Strategies, May 2020.

84. "Federal Financial Participation for HIT and HIE," CMS, last updated September 2020.

85. Jim Pettersson et al., *Approved Medicaid State Directed Payments: How States Are Using §438.6(c) 'Preprints' to Respond to the Managed Care Final Rule*, Milliman, October 2018.

86. "Cal-HOP," DHCS.

87. 42 C.F.R. § 438.6(b) (2016) (PDF).

88. 42 C.F.R. § 438.6(b) (2016).

89. "Directed Payments DPH Quality Incentive Program," DHCS, last modified November 6, 2020.

90. *Medicaid Quality Improvement Program (MQIP)* (PDF), Washington State Health Care Authority, January 2020.

91. "MHSA Components," DHCS, last modified November 25, 2020; *Fact Sheet: How Can MHSA Be Used To Support Homeless Individuals?* (PDF), DHCS, March 23, 2020; and Williams et al., "Overcoming Barriers."

92. "Promoting Interoperability Programs," CMS, last modified December 3, 2020; and "Promoting Interoperability Programs Registration System: Overview of Eligible Professional (EP) and Eligible Hospital Types," CMS, December 2020.