DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

ENHANCED CARE MANAGEMENT FOR CHILDREN AND YOUTH

A POPULATIONS OF FOCUS SPOTLIGHT

This **Enhanced Care Management Populations of Focus Spotlight** illustrates how ECM is delivered for children and youth, as a way to support young Californians with varied and unique needs, their caregivers and families, and the providers who care for them. It is intended to help future ECM Providers get started and current ECM Providers refine their ECM program for Medi-Cal managed care plan Members across the state.

Enhanced Care Management (ECM) is a Medi-Cal managed care plan (MCP) benefit available in all California counties to support comprehensive care management for MCP Members with complex needs. It launched in 2022, is the highest MCP-administered care management tier in the Medi-Cal Population Health Management continuum, and is delivered in the community by community-based providers.

From July 1, 2023, forward, ECM is available to children and youth with the highest social and clinical risk enrolled in Medi-Cal managed care plans. For these young Members, ECM is intended to identify and close gaps in needed services, as well as ensure closed loop care coordination occurs between a child's or youth's medical care, behavioral health care, and social services delivery systems. Because children and youth with complex needs are often already served by one or more case managers or other service providers within a fragmented delivery system, ECM offers coordination between systems. Instead of duplicating work already being done, ECM facilitates effective communication and timely and necessary data sharing to make sure that the child or youth and their caregivers' needs are being met with a whole person care approach.

In the following sections, readers will find ECM operational guidance for the **Children and Youth Populations of Focus (POFs)**, vignettes showing how ECM might support two Medi-Cal Members, and extensive resources for assessing your organization's capacity to contract with managed care plans as an ECM provider.

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The strategies and Member vignettes included in this Spotlight are informed in part by a series of informational interviews conducted with the following ECM Providers and MCPs in various stages of contracting for the Children and Youth POFs.

- Alameda County, CCS Department
- Edgewood Center for Children and Families
- Health Plan of San Mateo
- HealthySteps Program at 6M Children's Health Center (UCSF)
- Novel Interventions in Children's Healthcare (NICH) at UCSF
- Pacific Clinics
- San Mateo County, CCS Program
- Santa Clara Family Health Plan (SCFHP)
- Seneca Family of Agencies

DHCS thanks these organizations for their insights and contribution to this resource.

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What Is ECM for Children and Youth?

The Department of Health Care Services (DHCS), Medi-Cal MCPs, and providers across the state are launching ECM in phases, by "Population of Focus" (POF), from 2022 to 2024. Each POF requires a unique model, referral pipeline, and provider network to meet the needs of eligible Members, but the key features of ECM across POFs include:

COMMUNITY-BASED PROVIDERS

Medi-Cal MCP Members are matched to community-based ECM Providers with expertise supporting their needs and experience in intensive care management. Wherever possible, the ECM Provider should have an existing, trusted relationship with the Member.

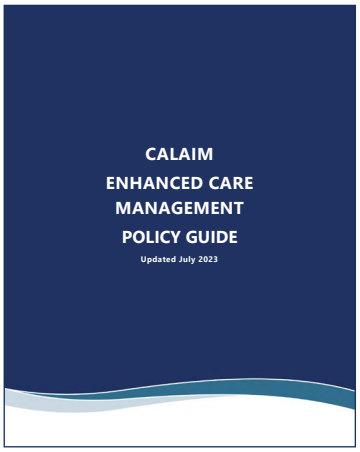
PERSON-CENTERED CARE

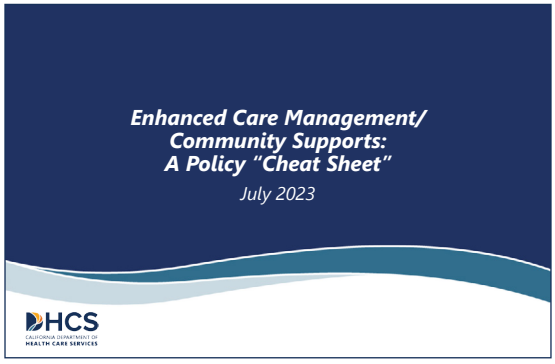
ECM Providers develop individualized care plans based on Members' needs and coordinate all medical care, behavioral health support, and social services across the continuum.

HIGH-TOUCH, IN-PERSON SUPPORT

ECM entails high-touch support provided by a Lead Care Manager primarily through in-person interactions with Members where they live, seek care, or prefer to access services.

DHCS has published an ECM Policy Guide containing comprehensive details about the benefit, as well as a policy "cheat sheet." The subsequent sections highlight key aspects of ECM specific to the Children and Youth POFs.





Which Children and Youth Are Eligible for ECM?

ECM Is Available for Children and Youth in the Following Populations of Focus (POFs):	
	Children and Youth Experiencing Homelessness
	Children and Youth at Risk for Avoidable Hospital or Emergency Department (ED) Utilization
	Children and Youth With Serious Mental Health and/or Substance Use Disorder (SUD) Needs
	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) With Additional Needs Beyond the CCS Condition
	Children and Youth Involved in Child Welfare

Note: In January 2024, ECM will also launch for Individuals Transitioning from Incarceration and Birth Equity POFs, which are inclusive of children and youth.

The individual needs of Members in each of these POFs vary significantly, as does the existing landscape of services available to those Members. Therefore, each POF requires:

- Its own **referral pipeline and process for leveraging existing relationships with Members in each POF to identify and refer eligible Members to ECM**, as well as using existing data sets to identify eligible Members.
- A **provider network** that is community-based and *uniquely* experienced and expert in addressing the needs of Members in the POF.
- An **interdisciplinary team composition and high-touch model** that positions the ECM Provider as "air traffic control" and additional support across the existing clinical and nonclinical service delivery systems for Members.
- A **detailed plan ("Model of Care")** addressing how each MCP will implement ECM, covering each of these issues.

How Do Children and Youth Access ECM?

Access to ECM can be created in multiple ways.

- Eligible Members may be referred to the Medi-Cal MCP by a **provider, case manager, or other professional already serving the child or youth**.
  - DHCS expects MCPs to source most ECM referrals in this way. Since children and youth with complex needs are usually already being served by at least one health care or social service delivery system, DHCS expects almost all children and youth to access ECM this way in the first few years of the program.

  - Community-based service providers are encouraged to identify and refer eligible children and youth to their MCPs for ECM, whether or not referring providers are themselves serving as ECM Providers within the MCP contracted network and/or service area.
  - MCPs should work with their ECM Providers to receive ECM referrals from the Provider's current clients who have qualifying conditions or who are already receiving other services aligned with ECM eligibility criteria.
  - **Presumptive authorization** arrangements with trusted providers can help streamline access for children and youth who automatically qualify for ECM, including those enrolled in foster care and/or receiving specialty mental health services (SMHS). Therefore, MCPs are strongly encouraged to allow trusted providers to screen Members for ECM eligibility, attest to the Member's presumed eligibility, and begin offering ECM services at the point of care.
- Families, caregivers, legal guardians, and youth may **self-refer** to the MCP.
- MCPs must also have a process for **using data to proactively identify Members who may benefit from ECM and meet POF criteria**. This process should supplement, and not replace, community-based provider referral sources.

How Is a Child or Youth Matched With an ECM Provider?

After the MCP authorizes an ECM referral from the community or identifies a Member's eligibility for ECM services from MCP data, the MCP assigns the child or youth to an ECM Provider. ECM Providers are defined as community-based provider organizations that have contracted with an MCP to provide ECM for a specific POF based on their expertise and experience caring for that population. The table below outlines a list of organizations that may be particularly well positioned to serve as ECM Providers for each of the Children and Youth POFs. This list is non-exhaustive and should be understood to be in addition to organizations that serve multiple POFs, such as federally qualified health centers (FQHCs).

Children and Youth POFs	**Well-Positioned ECM Providers** *(Non-Exhaustive List)*
Children and Youth Experiencing Homelessness	Street medicine providers, school-based clinics, transitional housing programs, homeless shelters and navigation centers that serve children and youth, early education programs (Head Start, First5, community-based organizations (CBOs)), public health and social service programs (HealthySteps, Help Me Grow, WIC, Black Infant Health Program, etc.)
At Risk for Avoidable Hospital or ED Utilization	School-based clinics, FQHCs, medical providers
With Serious Mental Health and/or SUD Needs	School-based clinics, behavioral health providers, county behavioral health services, public health and social service programs, CBOs serving children and families with social needs
Enrolled in CCS or CCS WCM With Additional Needs Beyond the CCS Condition	California Children's Services (CCS) paneled providers, including specialty care centers, and pediatric acute care hospitals
Involved in Child Welfare	CBOs, public health and social service programs (First5, Help Me Grow, WIC, Black Infant Health Program, etc.)

Once assigned a child or youth Member, the ECM Provider assigns them to an individual "ECM Lead Care Manager" to work directly with them and the family. Serving as the consistent point of contact for the Member and their family, the Lead Care Manager meets the Member wherever they are—at school, in a shelter, in their doctor's office, or at home. They are responsible for coordinating all aspects of ECM and any Community Supports as part of the Member's multidisciplinary care team, which may include other care managers.

Because outreach and engagement in care management is known to be most successful when it is based on a preexisting trusted relationship, DHCS' preferred model—wherever possible—is for the trusted provider already serving the child or youth to enter into a contract with the MCP to extend its role and become the ECM Provider in addition to continuing its preexisting role. When a child/youth is referred to ECM, the MCP should prioritize assignment of that Member to an ECM Provider that is already known and trusted by that child/youth, or work with the child/youth's existing and non-contracted trusted Provider to become an ECM Provider when possible. It is possible that the MCP will not always know about these relationships in advance, so there should be a streamlined process to immediately (re)assign Members if another ECM Provider is found to be preferred.

ECM does not supplant or displace other care management, case management, or care coordination programs serving children and youth. Rather, ECM enhances the potential of these programs to work more synergistically by assigning a dedicated ECM Lead Care Manager to remove the navigational burden from children and their families, while helping coordinate providers from varied delivery systems around a family-centered plan of care. While Members can be enrolled in ECM and other case/care management programs, MCPs are responsible for ensuring non-duplication of services provided through ECM and any other program(s). ECM Providers also should ask Members about their participation in other programs as part of the in-person comprehensive assessment and care planning process.

For organizations already established in the community providing services to children and youth, partnering with MCPs to serve as ECM Providers can provide a new source of revenue without displacing preexisting funding.

Connecting the Dots: The ECM, CHW Services, and Dyadic Services Benefits

Providers who are well suited to deliver ECM services also may consider participating in the following Medi-Cal MCP benefits:

Benefits	Description of Benefit	When Providers Can Bill for This Benefit vs. ECM
Community Health Worker (CHW) Services Benefit	Through the CHW Services Benefit, eligible providers may bill Medi-Cal MCPs for CHW services. CHWs are trusted Members of their community and may include individuals such as promotores, community health representatives, navigators, and other non-licensed public health workers. CHW services are preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression, prolong life, and promote physical and mental health well-being. They may be provided in an individual or group setting, and may include health education services and health navigation.	A CHW who has been assigned as a Member's ECM Provider cannot bill for the CHW Benefit for those Members while they are receiving the ECM benefit. However, providers can deliver ongoing support to Members who have graduated from ECM through the CHW Benefit.
Dyadic Services Benefit	Through the Dyadic Services Benefit, eligible providers may bill Medi-Cal MCPs for dyadic services. The Dyadic Services benefit is a family- and caregiver-focused model of care intended to address developmental and behavioral health conditions of children. It is designed to support implementation of comprehensive models of dyadic care, such as HealthySteps and Dulce, that work within the pediatric clinic and other settings to identify and address caregiver and family risk factors for the benefit of the child. Through dyadic services, a child and their caregiver(s) or parent(s) can be screened for behavioral health problems, interpersonal safety, tobacco and substance misuse, and social drivers of health, as well as be provided with referrals for appropriate care.	While dyadic providers may be good candidates for delivering ECM, dyadic services are distinct from and do not duplicate ECM services. Dyadic services providers can bill Medi-Cal for dyadic services provided to children and to families/caregivers of Members who are also enrolled in ECM. The Non-Specialty Mental Health Services Manual includes more information on dyadic services billing codes, modifiers, and screenings.

What Does ECM Delivery Look Like for Children and Youth?

While ECM will look different for children and youth with different needs, the **seven ECM core services** described on the right are common to all ECM, and ECM Providers are required to offer all seven services. For detailed information on each of these services, as well as other details of the ECM model, consult the **ECM Policy Guide**.

ECM Lead Care Managers are strongly encouraged to screen ECM Members for needs for **Community Supports**—services provided by MCPs as cost-effective alternatives to traditional medical services or settings—and refer to those Community Supports when eligible and available. Children and youth may benefit from many of the **14 pre-approved services**, including asthma remediation, housing navigation, medical respite, and sobering centers.

See the **Community Supports Policy Guide** to learn more about eligibility and services, and consult the **MCP Community Supports Elections Summary** to see which services are available in your county.

ECM Core Services

- Outreach and Engagement
- Comprehensive Assessment and Care Management Plan
- Enhanced Coordination of Care
- Health Promotion
- Comprehensive Transitional Care
- Member and Family Supports
- Coordination of and Referral to Community and Social Support Services

How ECM Helps Coordinate Care Across Existing Systems and Services for Children and Youth

In California, existing programs with a care coordination/care management component serve many of the same children and youth who will be served in ECM. **Members enrolled in programs with an existing care coordination/care management component are still eligible for ECM.** These programs include, but are not limited to:

- Intensive Care Coordination (ICC): ICC is a statewide SMHS targeted case management program that facilitates the assessment of, care planning for, and coordination of services for children and youth who are in or at risk of placement in residential or hospital settings but could be effectively served in the home and community.
- Dyadic Services: Dyadic Services is a family- and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified. It is a covered benefit for children enrolled in Medi-Cal managed care.

- California Children's Services (CCS): CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with eligible medical conditions, such as cystic fibrosis, cancer, and others. In some counties, CCS services are administered through MCPs via the Whole Child Model.

- Health Care Program for Children in Foster Care (HCPCFC): HCPCFC is a statewide public health nursing program that provides care management and coordination of medical, dental, developmental, and behavioral health for foster children, probation youth, and non-minor dependents.

ECM provides whole-child care management **above and beyond** the scope of the individual services and coordination capacity of many preexisting programs. Working closely with other programs, the ECM Provider serves as the **single point of accountability** to ensure care management across multiple systems and programs—this is sometimes called the "air traffic control" or "quarterback" role.

How To Coordinate With Other Programs: Tips for ECM Providers

DHCS conducted interviews with ECM Providers in May–June 2023 to gather the following tips on how to establish an ECM Lead Care Manager in the "air traffic control" or "quarterback" role for Members served by multiple programs.

1. **Generate a list of all potential programs serving similar clients**. Acknowledging that available programs and services can vary significantly by geography, ECM Providers can start with the list above, add other known programs in their area, and complete their inventory by (a) asking ECM-eligible families about services they receive and (b) comparing lists with similar providers within their region.
2. **Get to know those programs**. To do this, ECM Providers recommend meeting with key partner programs, providing an opportunity to both introduce the ECM benefit to their team and learn about their services. During this phase, ECM Lead Care Managers can collect and document key information about the program, such as details of services provided and their documentation system (e.g., whether the program's documentation is visible to the ECM team).
3. **Scope out roles and responsibilities**. ECM Providers suggest working directly with key partners to delineate program/staff roles. In doing this, it can be helpful to jointly create a document that describes what each program does—and does not do.
4. **Revisit regularly**. Finally, care management programs with a long history of coordinating across services and programs recommend circling back with partner programs on a regular basis. This may be accomplished via regular joint meetings, with the frequency depending on the extent of the overlap in Members.

ECM in Action

Andrea, a Teen in Foster Care Receiving Intensive Care Coordination

The following vignette describes how a fictional Member named Andrea might experience ECM from a fictional nonprofit agency—Compass Clinics—that provides behavioral health services and support. Compass Clinics has traditionally contracted primarily with county Mental Health Plans and has recently become an ECM Provider under contract with Andrea's local MCP. This vignette was developed based on interviews with community-based providers considering becoming ECM Providers, current ECM Providers, providers who participated in CalAIM Whole Person Care or Health Homes Program pilots, and MCPs; see page 2 for additional information.

Andrea is a 15-year-old girl living in the Central Valley region and a Medi-Cal MCP Member. A year ago, she was removed from her biological mother's home due to severe neglect and her mother's substance use issues, and was placed in foster care with a nonrelative resource family.

Andrea recently came to Compass Clinics after her foster parents and the county social worker appointed to represent Andrea realized she was struggling with anxiety and depression due to the trauma experienced in her biological mother's home. At Compass Clinics, she began receiving California Wraparound and ICC support through a team of behavior specialists, peer partners, and Jason, her Compass Clinics ICC and Wraparound Coordinator. Jason established a Child and Family Team (CFT) with Andrea and her caregivers, comprised of her foster parents, her biological grandmother, her pediatrician, and her county social worker.

Accessing ECM

After a couple of weeks of working with Andrea's county social worker on issues related to her foster care placement and coordinating her behavioral health care, Jason determines that Andrea would benefit from a central point of contact to coordinate care across all systems and programs, including staying on top of her primary care needs, scheduling dental care visits, coordinating her psychiatric appointments, and navigating her MCP benefits including nonemergency transportation services when her foster parents need help. Jason works with his colleagues at Compass Clinics to submit a referral to Andrea's MCP for ECM. Andrea automatically qualifies for ECM as a youth enrolled in foster care. Under its "presumptive authorization" policy for the Youth Involved in Child Welfare POF, the MCP automatically approves Andrea to receive 12 months of ECM because she meets the criteria for the following two POFs:

- Youth With Serious Mental Health and/or SUD Needs
- Youth Involved in Child Welfare

Assigning an ECM Provider

Understanding the importance of existing relationships with providers, Andrea's MCP assigns Compass Clinics to serve as Andrea's ECM Provider.

Outreach and Engagement

In their next CFT meeting, Jason talks with Andrea and her team about the ECM services that will be offered to Andrea. He introduces them to Leslie, a former foster youth herself and ECM Lead Care Manager at Compass Clinics who works closely with the Wraparound/ICC team. Leslie is a nonclinical, high school-educated "system navigator" at Compass Clinics, working under the supervision of a licensed clinician. Leslie joins two CFT meetings to build a relationship with Andrea and her support team before beginning to develop her ECM care plan.

Comprehensive Assessment and Care Management Plan

Leslie coordinates with Jason to understand the assessments that Andrea and her CFT have completed to date and identify additional screenings that might be useful to ensure a 360-degree approach to care planning, such as assessing her caregivers' needs and identifying key social drivers of health. Based on these assessments, Leslie, Andrea, and the CFT Members develop an ECM care plan that builds on both formal supports (such as her foster family and school counselor) and natural supports (including her soccer coach and team).

Enhanced Coordination of Care

Understanding the complexity of Andrea's care, Leslie connects with each of the key providers and coordinators caring for Andrea to establish clear roles and responsibilities. For example, Leslie and Jason agree that Leslie will take point on organizing the CFT meetings (a decision that is Member-specific at Compass Clinics), while Jason will focus on scheduling Andrea's outpatient behavioral health appointments and addressing any needs related to her foster care placement, including ongoing visitation with her biological mother.

To help create a safe space for Andrea, Leslie moves CFT meetings to Andrea's home and schedules them in the evening after school whenever possible. Leslie establishes consistent communication with each Member of the CFT and Andrea's care team, in addition to following up with her natural supports (e.g., her soccer coach) to keep them engaged in Andrea's progress. With this cross-system, CFT-focused lens, Leslie is able to identify and help address gaps in care as they emerge.

Comprehensive Transitional Care

Andrea becomes increasingly distressed when her biological mother becomes unresponsive over text. Andrea begins to exhibit self-harming behavior, and her foster parents admit her to the hospital for a short-term psychiatric hold. After being alerted to the event through a preexisting notification process with the hospital, Leslie and Jason join the discharge planning meetings at the hospital and set up a CFT meeting immediately once Andrea returns home. During Andrea's stay, Leslie also works to ensure that a renewed safety plan is in place with key roles and responsibilities identified.

Health Promotion

After developing the ECM care plan, Leslie connected Andrea to Compass Clinics' health promotion series designed to help her improve sleep and manage stress. She also connected with Andrea's MCP to make sure Andrea was connected to the appropriate MCP educational offerings.

Member and Family Supports

Leslie connects Andrea's foster parents with training on trauma reactions and behaviors, including reactive attachment work to help ensure a sustainable, secure placement for Andrea. Leslie also reaches out to Andrea's biological grandmother, who has recently missed a month of her CFT meetings after falling ill, and engages her in Andrea's recovery.

Community and Social Support Services

With Andrea about to turn 18, Leslie coordinates with Jason and the Wraparound team to make sure Andrea is building independent living skills and exploring educational or job options after high school. Leslie also helps Andrea get her first driver's license.

Sam, a Child With Cerebral Palsy Enrolled in California Children's Services

The following vignette describes how a fictional Member named Sam might experience ECM services from a county CCS provider. This vignette was developed based on interviews with community-based providers considering becoming ECM Providers, current ECM Providers, providers who participated in CalAIM Whole Person Care or Health Homes Program pilots, and MCPs; see page 2 for additional information.

Sam is a 5-year-old boy living with cerebral palsy in the Bay Area and is a Medi-Cal MCP Member.

About three years ago, Sam began receiving services from the county California Children's Services (CCS) team in a Bay Area county where he was enrolled in the Medical Therapy Program (MTP) to support him and his family as they learn how to help Sam thrive with cerebral palsy. MTP is a special CCS program that provides physical therapy and occupational therapy to children with disabling conditions like Sam's.

Sam and his parents, Julia and Kim, worked telephonically with a CCS Nurse Case Manager, Caitlin, to manage Sam's cerebral palsy care. A few times a month, Sam visits with Inez, an Occupational Therapist (OT), to help build his motor skills.

Accessing ECM

Ahead of a telephonic check-in with Sam and his parents, Caitlin sees in the notes from Sam's latest physician visit that he had lost four pounds and was experiencing gastrointestinal problems. After speaking with Sam's parent, Julia, she realizes the family is having serious financial issues. Julia shares that she recently left her job to take care of Sam full time, and groceries are not lasting until the end of the month. Caitlin recognizes that Sam and his parents need help navigating these financial issues and food insecurity to ensure that they remain healthy. She discusses options, including ECM, with the family. Following the training provided by the MCP, Caitlin contacts Sam's MCP to place a referral for ECM. Sam's MCP reviews the referral and authorizes Sam for the standard 12 months of ECM because he meets the POF criteria for:

- Enrolled in CCS or CCS WCM With Additional Needs Beyond the CCS Condition

Assigning an ECM Provider

Understanding the importance of existing relationships with providers, Sam's MCP assigns the CCS team in a Bay Area county, a contracted ECM Provider, to serve as Sam's ECM Provider.

Outreach and Engagement

The CCS team assigns Alef as Sam's Lead Care Manager for ECM. They considered Alef to be a strong fit for Sam's care team because of his lived experience; he is a Family Support Care Manager in the CCS department who grew up with an aunt who had cerebral palsy. Alef calls Sam's parents to introduce himself and describe the ECM benefit, and explains how he will partner with Julia and Kim to create a care plan to address Sam's health care and social service needs, including those stemming from their growing financial issues. Alef further describes his role in assisting with care coordination, referrals, health care navigation, and health education. Sam's parents agree that ECM sounds like what Sam needs. Wanting to build a connection with the family before proposing a home visit, Alef offers to meets them in person at their next occupational therapy visit at the CCS MTP Unit. Alef also lets them know that he will be reaching out to Sam's Primary Care Provider (PCP) and the MCP to work on identifying the family's needs and connecting the family with the Medically Tailored Meals Community Support.

Comprehensive Assessment and Care Management Plan

During the first visit at the MTP Unit, Alef begins to build a rapport with the family and reviews the program's consent forms, which Julia and Kim sign. Since the family's food needs are urgent, Alef helps the family fill out the paperwork to apply for CA Work Opportunity and Responsibility to Kids (CalWORKs) financial assistance and the CalFresh Program. Before Sam and his family leave, they agree that Alef will call them next week to find out if their CalWORKs and CalFresh applications have been approved and begin the comprehensive assessment to learn more about the family's strengths and needs.

After a couple of phone and MTP Unit meetings, Sam's family invites Alef to visit them at home, where Alef completes the comprehensive assessment. In addition to food insecurity and weight loss, Alef finds that the family's financial difficulties have had other impacts on Sam's health too. For example, the family had to sell their car, and they are now struggling to get Sam to all his medical appointments on time. Moreover, Sam's parents are feeling overwhelmed with all of Sam's appointments for cerebral palsy, and they have fallen behind on his dental care. Alef and the family begin to develop a care plan to address key needs stemming from the family's financial difficulties. During the assessment, Sam's parents identify providers on Sam's care team who they would like to participate in Sam's ECM care plan.

Enhanced Coordination of Care

Back at the office, Alef shares the care plan with Sam's care team. With a better sense of Sam's needs and a care plan mapped out, Alef connects with Sam's CCS team to coordinate his cerebral palsy care and with Sam's primary and dental care providers to coordinate all his other care. The teams establish clear roles and processes for coordinating Sam's care, with a focus on how they can reduce the burden of coordination that's currently on Sam's parents.

During his meetings with Sam and his parents, Alef helps with the tasks of coordinating Sam's care, including scheduling appointments and setting up appointment reminders. As part of this, he works with the MCP to coordinate nonemergency transportation services to make sure Sam can get to his varying appointments, including occupational therapy. Sam's family is also relieved that Alef has provided his contact information so they can reach him if they have trouble accessing the services or when they aren't sure where to turn for support.

As needed, Alef will connect with Sam's CCS care team for problem-solving, for example, regarding transportation to appointments. He will reach out to Sam's medical providers as needs arise and continue sharing updated care plans.

Comprehensive Transitional Care

Sam experiences a fever and severe cough and misses his OT appointment with Inez. As his symptoms worsen, his mother suspects he is developing a chest infection, which brought him to the hospital a year earlier, and he is admitted as a precaution. Because the MCP knows that Alef is Sam's ECM Lead Care Manager, they assign him to the role of Sam's Transitional Care Services manager while he is in the hospital. Together, Alef and Caitlin work with the hospital staff and Sam's parents to ensure a discharge risk assessment and discharge plan of care are developed, and that it meets all the needs of Sam's family and full care team before he returns home to follow up with his health and social service providers in the community.

Health Promotion

As part of Sam's discharge instructions, the hospitalist sends a referral for a specialized dietitian, and Alef helps follow up on the referral to get the appointment scheduled. Sam and his parents attend the appointment, and Alef follows up with the dietitian, who shares Sam's new meal plan and tools (e.g., interactive charts, a food diary) to help them adhere to his care plan.

Member and Family Supports

Alef supports Sam and his family with scheduling the at-home specialized exercises and the dietician's recommended meal plan. He also supports the family with any follow-up questions about the tools provided by the dietitian and makes sure they know where to access the ingredients through CalFresh.

Community and Social Support Services

Having initiated the Medically Tailored Meals referral during their first visit, Alef follows up once a Community Supports Provider is assigned to ensure the start of the service and coordinate deliveries. He also calls the family to confirm their CalWORKs and CalFresh applications have been approved.

How Providers Can Get Started in Partnership With MCPs

The following section summarizes key steps for providers interested in participating in ECM. They are based on interviews conducted by DHCS with ECM Providers and their MCP partners in May–June 2023.

1. Determine If ECM Is Right for Your Organization

The first step for any interested provider is determining whether they have the relevant experience and the ability to access the necessary infrastructure to become an ECM Provider. Here are some elements to consider:

- ☐ **Do you have the expertise and experience to provide ECM?**

  Providers of ECM must have capacity to provide intensive, in-person, timely care management; person-centered care coordination; and services to the specific POFs they would serve, in a culturally and linguistically competent manner. For Pacific Clinics, a nonprofit behavioral health services provider, this was a major factor in their decision to provide ECM, noting that "care management, intensive care management, and team planning are hallmarks of all the services we do."

  - Consult the ECM Policy Guide to learn more about the experience requirements for ECM Providers.

- ☐ **Do you have the necessary infrastructure to provide ECM—or could you create it?**

  Providers of ECM must be able to either submit claims to MCPs or use a DHCS invoicing template to bill MCPs if unable to submit claims and must have a documentation system for care management. They also must bidirectionally share data with their MCP partners about ECM referrals and Members.

DHCS Resources for Prospective and Contracted ECM Providers

DHCS is committed to supporting prospective and contracted ECM Providers through myriad resources that support their participation in the benefit. Please click the links below to learn more about these resources.

- ☐ The **Providing Access and Transforming Health (PATH)** Initiative provides $1.85 billion over five years to support ECM and **broader CalAIM implementation**. It includes a **TA Marketplace** through which providers, CBOs, counties, and others can access a range of off-the-shelf and hands-on technical assistance resources needed to implement ECM.
- ☐ **Capacity and Infrastructure Transition, Expansion, and Development (CITED) grants** for ECM Providers.
- ☐ Regional **Collaborative Planning and Implementation (CPI)** groups that support local information sharing and collaborative implementation among MCPs, providers, counties, and other local stakeholders.

- Review the data guidance documents from DHCS.
- Watch DHCS webinars that provide an overview of the data sharing and billing requirements and showcase how ECM Providers have implemented those requirements.
- The TA Marketplace provides resources to help providers understand and implement the documentation, data sharing, billing requirements, and other infrastructure needed for ECM.

The **Incentive Payment Program (IPP)** supports the implementation and expansion of ECM by providing incentives to MCPs. MCPs are incentivized to use those funds to help providers build capacity and infrastructure for ECM.

DHCS-hosted ECM & Community Supports **webinar series** provides policy guidance, spotlights provider models for ECM, and lifts up other critical technical assistance to promote ECM Program success.

☐ **Does ECM make financial sense for your organization?**

Organizations are encouraged to consider the financial impact of participating in ECM. For the UCSF Novel Interventions in Children's Healthcare (NICH) program, they saw "ECM funding [as] a pathway to expand from a philanthropy and hospital-based funding model into more operational, consistent funding."

- The TA Marketplace provides both off-the-shelf and hands-on resources to help providers gauge their potential to implement ECM.
- The ECM Provider Toolkit offers guidance on how to talk with an MCP about ECM provider payment rates, which are not set by DHCS.

Providers are encouraged to consider how they can participate in the CHW and/or Dyadic Service benefits to supplement ECM payment, as described in the "Connecting the Dots" section of this Spotlight.

2. Determine Which POFs To Serve

For organizations that are a good fit for ECM, there are several steps they may consider in determining which POF to serve, including:

- ☐ **Identify where you have specific expertise and experience within the defined POFs and communities your organization serves.**
  Members in each POF have distinct and unique needs, and the providers who serve them must have expertise and experience addressing those needs to ensure trust and engagement with these populations. Prospective providers are encouraged to review this Spotlight and the ECM Policy Guide and compare these elements to determine which POFs they are equipped to serve.

- ☐ **Talk with your potential MCP partner to understand potential referral volumes and what they are looking for in their network.**
  In their conversations with one MCP, Seneca Family Agencies learned that the MCP was especially focused on building their network for a specific POF they already serve. Seneca shared, "The MCP expressed they had a shortage of providers with expertise in child welfare. Despite having the expertise to serve broader POFs, [we] chose to focus on the child welfare POF in this MCP's region, given the need identified."

- ☐ **If you have capacity constraints, determine whether it may be more feasible for your organization to launch with a smaller subset of POFs based on your capacity.**
  For HealthySteps at UCSF, the team opted to start with just one POF because they did not have sufficient capacity to serve a wider set of POFs at the time. They said, "We could easily provide services to all of the children and youth ECM POFs, but because we [had only] one person in the Family Navigator role … we wanted to narrow to some of our biggest gaps, which is the wraparound support for families to connect to their Regional Centers and to their school districts." Another provider, Edgewood Center for Children and Families, is leveraging its internal staff first and plans to expand its program over time. The team there explained, "We're trying to [launch] the program using the existing resources and expertise we have in-house, knowing that once we build expertise in delivering ECM and figure out how to work with the revenue stream, we'll be able to hire an expanded ECM team."

3. Become an ECM Provider

For organizations that decide to become an ECM Provider, there are several steps to implementation.

- ☐ **Connect with local partners working on ECM implementation in your area.**
  - Joining your regional **CPI groups** will connect you with local partners—including MCPs, county departments, and local TA providers—who can facilitate your entry into ECM.
- ☐ **Reach out to your local MCP(s) to discuss contracting for ECM.**
  - The **ECM Provider Toolkit** offers guidance on how to approach contracting with MCPs.
  - The **TA Marketplace** provides both off-the-shelf and hands-on resources to help providers with becoming Medi-Cal providers and contracting for ECM.
- ☐ **Determine the ECM model of care for each POF you'll serve.**

  Providers for the Children and Youth POFs are encouraged to work closely with other providers in their county to design their model and establish roles, data sharing, and referral systems with other care management and social service programs. In Alameda, for example, the CCS team brought together experts in CCS and experts in home visiting to develop their ECM model of care. In San Mateo, the county CCS team said, "Our driver was about what was best for our clients and recognizing how we could leverage our existing relationships to provide [ECM] in the best way possible."

  - **DHCS webinars** spotlight various ECM models of care across the state and **provide an overview** of **approaches to partnerships between MCPs, counties, and CBOs for Children and Youth POFs**.
  - The **TA Marketplace** has resources that help providers build models of care for specific POFs.
- ☐ **Build the capacity and infrastructure—including data sharing and billing workflows—needed to launch ECM.**
  - The **TA Marketplace** provides resources to support staff training, billing/coding, data sharing, and more.
  - Applying for a **CITED grant** could help you build capacity and infrastructure to provide ECM.
  - Your MCP may offer **IPP** funding opportunities to provider.

Your patients may be ready for ECM today.

All providers—prospective, contracted, or neither—are strongly encouraged to reach out to their local MCP to learn how to refer eligible Members to the ECM benefit.

Key ECM Resources

- **ECM Policy Materials**
  - ECM Policy Guide
  - ECM and Community Supports Policy Cheat Sheet
- **ECM Technical Assistance**
  - TA Marketplace
  - Collaborative Planning and Implementation (CPI)
  - ECM Provider Toolkits
  - ECM Member Toolkit
  - ECM Outreach Toolkit
  - ECM & Community Supports Webinar Series
- **ECM Billing and Data Guidance**
  - ECM Member-Level Information Sharing Guidance
  - ECM & Community Supports Coding Options
  - Billing & Invoicing Guidance
  - National Provider Identifier (NPI) Application Guidance
  - Social Determinants of Health (SDOH) Coding Guidance
  - CalAIM Data Sharing Authorization Guidance (DSAG) 2.0
  - Quarterly Implementation Monitoring Report

- **ECM Model of Care Template**
  - ECM and Community Supports Model of Care Legacy Template
  - ECM Model of Care Template Addendum I for Long-Term Care POFs
  - ECM Model of Care Template Addendum II for Children and Youth Populations of Focus and Birth Equity POFs
- **Funding Opportunities**
  - Funding Opportunities Cheat Sheet
  - Incentive Payment Program (IPP)
  - Providing Access and Transforming Health (PATH)
  - PATH Capacity and Infrastructure Transition, Expansion, and Development (CITED) Grants