



Enhanced Care Management: OPPORTUNITY FOR CHANGE

Under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS) has established a new statewide Enhanced Care Management (ECM) care coordination benefit. The ECM program began serving targeted adult populations in January 2022, and will launch in July 2023 for youth populations with high needs where social and emotional conditions have a profound impact on their healthy development.

DHCS has an ambitious vision to center managed care plans as part of its efforts to knit together fragmented safety net systems. This vision faces a number of challenges as demonstrated by the complexities of successfully delivering on the ECM benefit. ECM represents an unprecedented opportunity for DHCS to align—in a culturally concordant and accessible manner—the multiple delivery systems serving targeted populations of children, and to do so in partnership with youth and their families and caregivers.

The purpose of this document is to detail commitments and design features that must be incorporated into the development of ECM in order to improve outcomes for youth and families with high needs.

What Is ECM?

ECM is a managed care benefit that addresses the clinical and non-clinical needs of high-need individuals through the coordination of services and comprehensive care management.¹ The ECM program is being designed to sustain the Whole Person Care (WPC) model and will be implemented by community-based organizations (CBOs) contracted through managed care plans (MCPs).

To successfully design ECM for children and youth, it is first critical to note that WPC was exclusively targeted to adults at risk of or experiencing homelessness, or adults coming out of incarceration. Some of the challenges DHCS and stakeholders have experienced in planning for ECM for young people are due in no small part to the reality that children's unique needs (utilization patterns and qualifying criteria) for more intensive case management were not considered in the design and development of WPC.

¹ ECM Provider Toolkit—December 2021, developed by Aurrera HealthGroup for CA DHCS

Although ECM eligibility criteria has not yet been finalized, it will at a minimum include the following groups of children and youth under the age of 21:

- » Experiencing homelessness
- » Have serious behavioral health or substance use disorder needs
- » Enrolled in California Children's Services (CCS) with additional needs beyond their [CCS condition](#)
- » Involved in child welfare (up to age 26)
- » Involved in the justice system

ECM is designed to be an extension of Whole Person Care programming, focusing on children and youth with the highest needs who are already receiving care through some or many of California's existing care coordination and care management programs. These programs are inconsistently implemented and monitored, and have their own administrative and service delivery mechanisms, thus creating challenges for the rollout of ECM.

- » California Children's Services (CCS)
- » CCS Whole Child Model (WCM)
- » Specialty Mental Health Services (SMHS) Targeted Case Management (TCM)
- » SMHS Intensive Care Coordination (ICC)
- » California Wraparound
- » CBO approaches directly contracted by child welfare and probation departments

Coordinating the above programs with ECM presents both challenges and opportunities for the many system players who will be called upon to cross siloes and create a seamless continuum of care. The complexity of these considerations is [starting to be addressed for the CCS program](#).

Of particular interest to the implementation of ECM is the nexus of the new benefit with child-serving systems and the recently approved 1915 b waiver (covering the county Specialty Mental Health Services). The waiver approved on January 1, 2022, specifies that all children in the juvenile justice and child welfare systems qualify for SMHS under [new criteria for access to Medi-Cal SMHS for beneficiaries under age 21](#).

Why ECM Matters

First and foremost, ECM represents an opportunity to engage caregivers and youth in the co-creation of an assets-based care coordination benefit that shifts from problem-focused, siloed interventions to a responsive, community-based continuum of care.

While a number of care coordination initiatives exist, as noted above, they are not consistently meeting the needs of some of the most vulnerable children and their families. This results in inefficiencies and delays, and ultimately in unnecessary suffering. Furthermore, the persistently high costs associated with ineffectual care of high-needs youth are well known, and distort and limit efforts to provide a comprehensive continuum of care.

ECM presents an opportunity to create a system change that "gets it right" for a manageable, targeted population. It also provides an opportunity to ensure that assigned rates are adequate to support a skilled workforce and that data drives continuous improvement processes to facilitate timely program improvements and adjustments. This can inform ongoing efforts to improve and align other care coordination approaches offered at scale, including the mandated care coordination benefit provided in the EPSDT program, which should be available to support the success of all 6 million children and youth enrolled in California's Medi-Cal program.



The California Children's Trust (The Trust) is a statewide initiative to reimagine our state's approach to children's social, emotional, and developmental health. We work to transform the administration, delivery, and financing of child-serving systems to ensure that they are equity driven and accountable for improved outcomes. The Trust regularly presents its Framework for Solutions and policy recommendations in statewide and national forums. For more information, visit www.cachildrenstrust.org.

✓ What Needs to Be Addressed to Make ECM Successful

Meeting the Moment

To address the immediate needs of children and families, ECM must:

1. Design a Child-Focused Benefit

- a. ECM must be structured for children with unique needs, not treat children as “little adults.”

2. Align Eligibility Criteria

- a. ECM eligibility criteria must be inclusive and reflect the true causes of poor health outcomes, including school performance and other social drivers of health (SDOH) such as ACEs or housing instability.

3. Center Youth and Caregiver Experience

- a. Parents and caregivers need to co-create the benefit and be engaged to evaluate program effectiveness, referral, and cultural congruence of services and supports.

4. Deliver Culturally Responsive Services

- a. Culturally concordant CBOs need to have a prominent role in the implementation of the program, with rate structures that allow hiring, training, and retaining skilled staff.

Broader Systems Change

To impact expansive systems change, ECM implementation must:

1. Clarify the Role of ECM

- a. DHCS should specify the role of ECM in relation to CCS and other existing care management programs, including the existing obligations of managed care organizations to provide care coordination supports for all members.

2. Expand Access for System-Involved Youth

- a. Use ECM to facilitate access to other essential benefits, including IEPs/504s, regional center services, caregiver respite, transportation, food security, housing support, home health, medical nutrition resources, and Specialty Mental Health Services.
- b. ECM should expand access to wraparound and other existing best practices, such as dyadic therapy, peer-to-peer support and mutual aid, and minimum per child spending.

3. Establish Baselines and Accountability

- a. DHCS should clarify how many children will receive the benefit and at what anticipated cost given an adequate rate structure that will support family-sustaining employment of staff with relevant lived experience.



How Do We Get There

Meeting the Moment

To address the immediate needs of children and families, ECM must:

1. DESIGN A CHILD-FOCUSED BENEFIT

We must differentiate the utilization patterns and care coordination needs of children, youth, and families from those of adults to ensure that the ECM benefit meets needs specific to children’s care and developmental stages and is a benefit welcomed by beneficiaries.

The ECM benefit was originally created to support adults with patterns of high cost, high utilization of their health benefits. Kids are not little adults, and a health benefit program built from a structure for high acuity adults experiencing homelessness, substance abuse, and chronic illness is not the best model for a benefit for children and youth with special health and highly complex care coordination needs.

Children and youth receive supports and services in different settings than adults; have evolving and different developmental needs than adults; rely on caregivers and guardians to design, implement, and support care coordination activities; have different indicators for complexity of care than adults; have different utilization patterns; and ultimately have different resourcing and service delivery needs.

Some of the settings and programs unique to children and youth—CCS and Foster Care, for example—are included in the current policy conversations about the pediatric version of ECM but other significant stakeholders are notably missing, including schools and regional centers.

Schools are high and trusted touch points with the families of almost 6 million children enrolled in California District and Charter schools in the 21-22 school year.² Thirteen percent of students, or over 800,000, have IEPs.³



Current statewide initiatives and reform efforts, including CalAIM and the Child and Youth Behavioral Health Initiative, have recognized the critical roles of schools as venues for and providers of child and adolescent behavioral health services. ECM should be part of these conversations, and these efforts should be informed by the development of the ECM benefit.

Another 20,000 children in California are served by Regional Centers. Clients of Regional Centers by definition have complex healthcare and care coordination needs. Thus, Regional Centers should be included in all ECM design conversations.

² CDE

³ EdSource, <https://edsource.org/2022/parents-guide-to-504-plans-and-ieps-what-they-are-and-how-theyre-different/669493#:~:text=In%20California%2C%20about%20800%2C000%20students,require%20specialized%20help%20with%20school.>

2. ALIGN ELIGIBILITY CRITERIA

ECM eligibility criteria must be inclusive and reflect the true causes of poor health outcomes, which requires aligning eligibility criteria, creating shared definitions, and clarifying how terminology is used to identify and trigger the eligibility of benefits for children and youth across child-serving systems.

In order to improve access, ECM eligibility criteria and underlying definitions need to be better aligned.

The development of the pediatric ECM benefit has cast light on how different systems of care—DHCS, HHS, Child Welfare, CCS, Juvenile Justice, schools, Regional Centers, etc.—have dramatically different definitions and eligibility criteria for the very same children. These inconsistencies create confusion and prevent children from accessing and maintaining care coordination benefits.

A benefit that by design cuts across youth-serving sectors, ECM represents an opportunity for the system to engage and align these various stakeholders to streamline the divergent definitions and language used for the targeted youth populations. ECM also represents an opportunity for beneficiaries to inform the language and interpretation of the criteria for ECM inclusion. As a new benefit, ECM also presents an opportunity to fulfill DHCS's commitment to promoting equity and inclusion in MediCaid programs.

3. CENTER YOUTH AND CAREGIVER EXPERIENCE

The ECM design process must engage youth and caregivers in co-creating the design of the ECM eligibility criteria, benefits, baselines, and accountability structures.

From developing eligibility criteria to determining the competencies needed by newly hired ECM care coordinators, parents and youth should participate in the development of the ECM benefit.

[Family Voices Matter: Listening to the Real Experts in Medi-Cal Children's Health](#), a report created by The California Children's Trust in partnership with [The Children's Partnership](#), captures parent and caregiver input about why and how they want to be involved in the



development and delivery of their children's health care, and includes recommendations for how to actively engage families and caregivers.

An important way to measure how or if youth and caregiver experience is centered is to develop mechanisms for beneficiaries to seek access to ECM directly through self-referral, and to develop evaluation metrics that directly ask caregivers and young people about the scope, nature, and quality of the services they receive.

4. DELIVER CULTURALLY RESPONSIVE SERVICES

The data is indisputable that children and youth populations targeted by ECM benefit from comprehensive, continuous, and culturally concordant care management.

MCOs are charged with overseeing and implementing ECM through partnerships with CBOs best suited to address social determinants of health and the health care disparities that serve as barriers to accessing and receiving care. Rate structures and MCO contracts will need to be adequate to compensate staff who possess cultural proficiency and the expertise needed to braid together fragmented service streams to support children and families.

Broader Systems Change

To impact expansive systems change, ECM implementation must:

1. CLARIFY THE ROLE OF ECM IN THE SYSTEM OF CARE

Specify how ECM enhances and intersects with other care coordination and care management efforts.

Existing care management and care coordination programs serving the populations targeted by ECM lack consistent monitoring and implementation. The landscape analysis of the assessment data and the measurable impact of those programs on children and youth is vague. The mechanisms that will be used to identify additional benefits needed by families and the additional coordination support ECM will provide need to be determined. It is imperative that ECM for children is informed by stakeholders who understand the nuances and intricacies of the care coordination programs the new benefit is slated to enhance.

2. EXPAND ACCESS FOR SYSTEM-INVOLVED YOUTH

Done right, ECM should improve access to other required benefits and services, including for systems-involved youth. With wraparound, there is an opportunity for the ECM benefit to shift from a problem-based program to an assets-based benefit.

Over 20 years of evidence shows that the wraparound process has become a compelling and highly visible method for working with youth and families with intensive needs. Wraparound allows teams to center around the child and to unify a fragmented service delivery system to create and implement a unified plan of care. Wraparound provides an “on the ground” mechanism for ensuring that the process and the care plans are individualized, family-driven, and youth-guided as well as built on community-based and culturally competent resources.

ECM represents an opportunity to embody the equity goals of DHCS and the State of California by shifting towards an assets-based model that moves the focus away from a problem-based, service-driven approach to care to one that builds on individual and family strengths. ECM can facilitate families achieving positive goals and improved well-being by leveraging multiple system players to create a continuum of care. The wraparound model offers an important strategy

for uniting multiple system and community entities around the explicit care needs of the child and family. Successful templates are already in place for creating the partnerships that allow trusted and culturally concordant care providers to work with children and families to safely access care. MCOs need to be prepared to create continuity of care for highly mobile populations, especially those children and youth—common in the targeted populations—who move from county to county.

ECM should be braided into existing contracts for wraparound services with community-based providers under contract to county Mental Health Plans, and used with other funding streams in MHPs and CW to dramatically expand access to high-fidelity wraparound services.

Further fragmenting providers to this vulnerable population makes no sense—and will not work in the face of dire workforce shortages. We know what works for system-involved youth and ECM should be used to scale those strategies.

3. ESTABLISH BASELINES AND ACCOUNTABILITY

Establish a minimum guaranteed spending for every child or youth enrolled in ECM. Provide utilization projections and rate structures so that meaningful planning and preparation can occur.

California too often fails to spend what it takes to meet the needs of children. Only 14% of Medi-Cal expenditures are on children, yet they represent nearly 40% of all beneficiaries.

The ECM benefit is intended to be delivered by community-based providers, and to extend beyond standard care coordination and disease management to concentrate on coordination and monitoring of cost-effective health care services, as well as making connections for community needs. And yet, a year out, local CCS departments, MCOs, and CBOs don’t have access to a proposed rate structure.

Does it make sense to create a new benefit for the most vulnerable of the children enrolled in Medi-Cal with a goal to further contain costs? Medi-Cal is the primary form of coverage for California’s children, particularly Black and Latinx children. How will outcomes for children with unmet complex care needs be met through ECM?

Calls to Action

How to Create a Successful ECM Benefit for Children and Families

1) Meeting the Moment

- » Develop eligibility criteria that reflects the impact of social determinants of health (SDOH).
- » Center schools and other uniquely youth-serving entities in the ECM model.
- » Clarify how ECM recipients will be made aware of the options they have to select culturally concordant ECM coordinators and alternate agencies.
- » Create a referral mechanism for caregivers, parents, and providers that can help children access ECM.
- » Create meaningful accountability, monitoring, and data sharing plans for ECM that include and center beneficiary experience and expertise.
- » Recognize and account for the role of, and burden on, caregivers in ECM service delivery.
- » Revise language in the ECM provider toolkit to provide more agency and narrative space for beneficiaries.

2) Broader Systems Change

- » Focus on enhancing and expanding access to wraparound for system-involved children/youth enrolled in ECM.
- » Specify the number of children and the minimum amount plans should be expected to spend on ECM.
- » Create a cycle of inquiry and continuous improvement, through DHCS, that engages ECM beneficiaries, ECM coordinators, and service implementers to assess whether the benefit is “beneficial” from their perspective.
- » Engage people with lived and/or on-the-ground professional experience in creating policy language and toolkits for implementation.

Resources

- » **DHCS ECM Guidance Documents** <https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices>
- » **NHELP 1915b Waiver** <https://healthlaw.org/resource/principles-for-1915bc-waivers/>
- » **ECM Provider Toolkit** https://www.aurrerahealth.com/wp-content/uploads/2021/12/Provider-Toolkit_FINAL.pdf
- » **Key Components of Children’s Care Coordination Issue Brief**
<https://cachildrenstrust.org/our-work/finance-reform/#whole-child-approach-care-coordination>
- » **Care Coordination for Children in Medi-Cal Issue Brief**
https://cachildrenstrust.org/wp-content/uploads/2021/06/cct_carecoordination.pdf
- » **Family Engagement for Children’s Health Equity**
<https://cachildrenstrust.org/our-work/finance-reform/#family-engagement-for-child-health-equity>