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ECM and CHW Coordination
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IMPROVING COORDINATION BETWEEN ENHANCED CARE MANAGEMENT AND COMMUNITY HEALTH WORKERS

Purpose: The purpose of this document is to highlight the opportunities to improve alignment between Enhanced Care Management (ECM) and Community Health Worker (CHW) benefits, which taken together can assist high-risk members in improving their health and maintaining gains. This can be especially important for high-risk children and families, and children that screen positive for Adverse Childhood Experiences (ACEs) to ensure they have access to coordinated and sustained services. The framework below is intended to assist managed care plans, ECM and CHW providers and community-based organizations to identify approaches, processes and financing strategies to enhance provider networks that lead to more effective care, improved outcomes and continuity for members.

Background

The California Department of Health Care Services implemented both the ECM and CHW benefits in 2022, with the goal of improving health outcomes by providing more effective care management and coordination with other health and supportive services to eligible Medi-Cal enrollees with qualifying health and social needs. Although both benefits can be complimentary to one another, the structure of each benefit, development of provider networks and payment guidelines have often resulted in distinct and siloed provider networks for patients. For children and families, these challenges can be especially difficult. For example, a child may be enrolled in ECM, but their guardian/parent is eligible for CHW services but not enrolled, and the family is missing needed support. Alternatively, a child may be receiving CHW services and a triggering event results in ECM eligibility that requires a change with a trusted provider and likely a disruption in care.

As Medi-Cal managed care plans and community-based organizations stand up these services, opportunities exist for stronger coordination across ECM and CHW that could contribute to greater efficiency for patients and health plans. These

opportunities also enable additional financial security for providers, and help achieve and maintain better health outcomes for eligible members.

ECM and CHW Overview

	ECM[1]	CHW[2]
Eligibility	DHCS identified populations of focus with complex medical and social needs (e.g., homeless, positive for 4+ ACEs, SMI/SUD, etc.). The ECM benefit is available to individuals enrolled in Medi-Cal managed care.	Eligibility includes but is not limited to: Presence of medical indicators or risk of chronic disease (e.g., childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition. Any stressful life event prevented via the Adverse Childhood Events (ACEs) screening. The CHW benefit is available to Med-Cal enrollees in both fee-for-service and managed care.
Services	Enrollees receive comprehensive care management from a lead care manager (LCM) who is responsible for coordinating their health and health-related care, including physical, mental, and social services. The LCM may attend medical visits, assist with transition from hospital, jail, etc.	Enrollees can receive health education, health navigation, screening and assessment and individual support and advocacy to assist members in meeting health needs, preventing worsening health conditions and achieving care plan goals.

[1]CALAIM ENHANCED CARE MANAGEMENT POLICY GUIDE
[2]Community Health Workers

Provider Requirements	Members are assigned an LCM that serves as the main point of contact and works closely with a multi-disciplinary team of licensed providers and non-licensed community staff or family members to support a member's needs. ECM LCMs must have appropriate training and relevant experience but there are no state certification requirements. Many LCMs are also CHWs.	CHW providers must have lived experience that aligns with the population they are serving and fulfill DHCS training, experience and/or certification requirements. CHWs must be supervised by a licensed provider, hospital, clinic or CBO that can submit claims for Medi-Cal services and confirm CHWs have met necessary requirements.
Payment	ECM payments are set by MCPs, which could include capitated payments for engaged members or fee-for-service payments based on utilization.	CPT code: 98960 - 30 minutes of self-management and education and training: $26.66 for an individual CPT codes 98961 and 98962 - 30 minutes of self-management and education and training: $9.46-12.66 group visits; payment varies depending on size of group visit. Additional payment via G0019 and G0022 are also available with an initiating visit with a licensed provider.

Service duration	Initial authorization is 12 months, with opportunity to renew every six months, if needed. Once member's health improves and care plan goals are achieved, provider and member can assess if patient is eligible to graduate from ECM.	Eligible members can receive 12 units (6 hours) annually without prior authorization. Max is 2 hours per day. Additional services can be provided with approved prior authorization.[3]

Common Questions About ECM and CHW

- **Can Medi-Cal enrollees receive both ECM and CHW services at the same time?** No, members can receive either ECM or CHW. Billing for both services would be considered duplicative.
- **Can members transition from ECM to CHW or from CHW to ECM?** Yes, depending on member needs, they can transition between both benefits.
- **Can family members enroll in ECM and CHW?** Individuals cannot be enrolled in both benefits at the same time; however, a child can enroll in ECM and their guardian(s) can receive CHW services or visa-versa if the child is fee-for-service and the guardian is in managed care.
- **Does ECM or CHW require a referral for services?** ECM does require a referral but eligible individuals for CHW can receive up to 6 hours of services per year without a referral[1].
- **Can individuals in both Medi-Cal fee-for-service and managed care access ECM and CHW benefits?** No, only the CHW benefit is available in both fee-for-service and managed care. ECM benefit is only available for Medi-Cal managed care members that meet eligibility criteria.
- Can CHW staff provide services in both the CHW and ECM benefits? Yes, if staff meet relevant training, experience and certification requirements. CHW benefit staff must have lived experience that aligns with the population they are serving and fulfill DHCS training, experience and/or certification requirements. Lead Care Managers in ECM must have appropriate training and experience; however, at this time there are no certification requirements. Providers may employ staff for ECM that are CHWs who do not have a certificate; however, they would not be able to provide the CHW benefit services.

[3] Standing Recommendation for CHW Services
[1] CALAIM ENHANCED CARE MANAGEMENT POLICY GUIDE

Getting Started: Aligning ECM and CHW Activities

For providers and MCPs that want to explore ways to improve continuity for members across ECM and CHW benefits, below are a few suggested areas to focus on:

ECM and CHW eligibility and transition between benefits. Develop criteria and processes for ECM and CHW eligibility and an agreed upon approach for when members can transition from one benefit to another. In particular:

What change in health status or achievement in care plan goals would trigger a graduation from ECM to CHW services, and under what circumstances would a CHW member require more intensive care coordination via ECM?

a. Develop a checklist to determine when it is appropriate for an individual to transition from ECM to CHW or CHW to ECM.[4] This will help facilitate a clear distinction between MCPs and providers about when a change may be needed. Key questions could include:
    i. Transition to ECM:
        1. Does the individual meet ECM eligibility for a population of focus and require more intensive services?
        2. Has a triggering event occurred that warrants movement from CHW to ECM? If so, please describe.
    ii. Transition to CHW:
        1. Has the individual achieved a certain percentage of the goals established in the ECM care plan?
        2. Does the member have safe and stable housing?
        3. Does the member know how to reach their doctor to schedule an appointment or communicate a concern?
        4. What ongoing support is needed that necessitates CHW assistance?

What data/communication is required to demonstrate when an individual is transitioning from ECM to CHW or from CHW to ECM?

a. If referrals and oversight for ECM and CHW are in the same department at the managed care plan, establish processes with all parties involved to ensure streamlined transitions from one benefit to another

[4]Some managed care plans have developed ECM graduation questionnaires that help assess the completion of care plan goals and what additional supports might be needed going forward. Such questionnaires could be used to support the transition from ECM to CHW, and a similar framework could be developed to accompany a referral from CHW into ECM.

b. Assess how referrals are submitted and approved within the health plan for ECM and CHW services (beyond initial 6 hours) and develop streamlined referral processes to support a seamless transition and reduce the burden on referring providers and MCPs.
c. How is the MCP already utilizing ECM bulk referrals, standing orders for CHW or other tools that could assist with a smooth transition and ensure continued access to care?

Provider engagement. Clarify MCP requirements for organizations interested in providing both ECM and CHW services.

1. Can the member see the same provider for both ECM and CHW services? If they retain the same provider, would the patient be transitioned to a separate Lead Care Manager or CHW within that provider organization?[5]
2. What minimum provider requirements are needed to service both ECM and CHW?
3. How is the provider utilizing staff that have lived experience with populations of focus and meet requirements for both ECM and CHW?
4. How can managed care plans streamline provider onboarding, credentialling and contracting with organizations that are interested in offering both benefits?

Delivery of services and staff resources. Establish a clear delineation of types of services, provider requirements and clinical oversight to ensure compliance with MCP and DHCS rules, reporting, and billing for all ECM and CHW services. Consider how both benefits will be staffed and establish clear lines of distinction about what services and time are billed to one benefit versus another so that it is clear to the MCP and any other partners.

1. How is the provider delineating between ECM and CHW services (e.g., are services being provided by different staff, other guardrails in place, etc.)?
2. If the transition between ECM and CHW results in a change in the member's provider, develop processes and procedures across the MCP and providers to support a warm handoff.
   a. Create a checklist to articulate what information can be shared (e.g., care plan goals, summary of recent medical visits, etc.) and encourage coordination between providers.

[5] CHW-Qualifications-and-Supervising-Provider-Requirements-FAQ

Payment for services. Delineate payment and billing for both ECM and CHW and identify what, if any, additional funding opportunities may be available.

1. What would be required within the MCP to ensure timely and accurate provider billing and payment for both services?
2. Capacity building: Does the MCP provide capacity building grants to support provider network expansion, cross training of staff, etc.?
3. Quality incentives: What quality incentive programs are available via the MCP? Are ECM or CHW providers eligible and how can they contribute to achieving and sustaining broader MCP quality and equity goals?
4. What community or local government funding is available to support ECM and CHW activities? How can these resources address current gaps and improve the sustainability of services?

Quality and data reporting

1. Improve internal MCP coordination to align ECM/CHW more efficiently with broader quality/equity priorities. If the oversight for CHW, ECM and quality are all in separate areas of the organization, how can leaders/staff across the MCP work together to meet quality and equity priorities?
2. How is the MCP tracking quality data on CHW benefit recipients?
3. How is the MCP quality data being shared with ECM and CHW providers to collectively monitor progress, identify gaps and align on shared priorities?

How could this coordination work in practice?

Below are a few examples of individuals and families that are eligible for ECM and CHW services and suggested steps that providers and MCP could implement to maintain and support families to improve and sustain health outcomes.

Example 1: Child screens positive for 5 ACE's and is eligible for ECM and specialty mental health services. Child enrolls in ECM and is later transitioned to the CHW benefit.

ECM enrollment:

- ·Child is enrolled in ECM and together with the child's family, they begin working with a Lead Care Manager (LCM) to outline goals and establish a care plan. The LCM attends regular doctor and behavioral health visits and submits referrals for additional Community Supports to assist the family.

- After 9 months, the child demonstrates considerable progress and completes 80% of the goals outlined in the care plan.

Transition to CHW:

- LCM and child/family determine the child can graduate from ECM and transition to CHW.
- LCM/ECM provider notifies the MCP of the change to CHW and member is disenrolled from ECM.
- LCM provides a warm handoff to CHW provider; both staff are part of the same organization but supervised by different managers.
    - As part of the MCP contracting and onboarding process, provider organization supplied information to MCP to delineate ECM and CHW staffing and supervision across the organization.
- CHW provider and child/family develop a new care plan through the CHW benefit (in partnership with the CHW supervising provider)

Oversight, documentation and billing:

- ECM disenrollment is documented in the Return Transmission File (RTF).
    - ECM provider also submits progress reports, completion of care plan, checklist or supporting documentation to indicate completion of ECM goals and transition to CHW.
- CHW provider initiates services the following month after the date of ECM disenrollment and CHW services are billed via CHW benefit.[6]
- CHW provider submits provider a referral (if needed) for additional CHW services beyond the 12 units.
- MCP expands eligibility for quality performance program to include ECM and CHW providers and shares quality data with providers to monitor gains in health outcomes and how members sustain improvements over time.

[6]Many managed care plans pay ECM providers on a per member per month basis and providers are assigned for that month. Therefore, transitioning and billing for CHW services would likely start at the beginning of the following month after ECM disenrollment.

Example 2: Child has been receiving CHW services for 6 months, hasn't seen substantial improvement and then experiences an ECM triggering event. Child transitions from CHW to the ECM benefit.

ECM enrollment:

- Child is enrolled in ECM. The ECM LCM is the same non-licensed staff that the child was previously working with under the CHW benefit. LCM now provides more enhanced coordination and support.
- Together, the child/family and LCM create a new care plan with updated goals to monitor progress.

Oversight, documentation and billing:

- CHW provider submits a referral for ECM noting the change in circumstances, need for additional support and eligibility under relevant ECM population of focus.
- ECM provider includes the child on all monthly file submissions and maintains an up-to-date care plan.
- As part of the MCP contracting and onboarding process, provider organization supplied information to MCP to delineate how they determine the available capacity for staff that are serving individuals receiving services through both ECM and CHW in order to ensure staff have a reasonable panel of members that they can serve at one time.
- Provider begins billing for ECM following approval of the ECM referral and ensures there is no subsequent billing under the CHW benefit.
- Over time, the child/family and LCM will assess completion of care plan goals and determine if the child should continue receiving the ECM benefit, step down to the CHW benefit or warrant additional community services and supports.

Example 3: Child is enrolled in ECM and the parent is eligible but not enrolled in CHW. The child continues to receive ECM services and the parent begins receiving CHW support. After one year, the child graduates from ECM and is transitioned to the CHW benefit.

CHW and ECM enrollment:

- ECM provider for the child speaks with the parent and sends a referral for CHW services. The parent receives CHW services from a separate provider.

- CHW and ECM LCM collaborate with the family to establish 3-5 family goals that are included in the separate care plans for the child and parent. The child's goals focus on school attendance and meeting behavioral health goals. The parent's goals prioritize better maintenance of a chronic condition, improving housing stability and support for substance use. The goals for the child and family work together to improve individual health and wellbeing as well as the sustainability and security for the household.
- The CHW provider supports the parent at subsequent primary and specialty care visits and assists the parent with accessing housing support and substance use services.
- ECM LCM coordinates with the child's primary care and behavioral health provider(s) and maintains regular communication with CHW provider to ascertain additional family needs.
- After one year, several of the family goals have been achieved along with sustained health improvements for the child and the parent. The child graduates from ECM and transitions to the CHW benefit to help maintain progress to ensure continued improvement. The parent retains their CHW provider for additional support on an as-needed basis.

Oversight, documentation and billing:

- ECM provider is not contracted by the MCP to provide the CHW benefit. LCM sends a referral for CHW services and the MCP assigns a separate CHW provider to the parent.
- ECM and CHW providers separately bill for services for their assigned family member.
- After one year, ECM provider submits the agreed upon MCP checklist demonstrating the child has completed many care plan goals and is eligible to graduate. ECM provider notes disenrollment in the Return Transmission File.
- ECM provider facilitates a warm hand off to CHW provider to support the development of a new care plan and maintain improvements in health.

Conclusion

The ECM and CHW benefits offer significant opportunities for patients, providers and managed care plans to expand and maintain care coordination and improve health outcomes for families experiencing adverse health and social circumstances. However, in order to realize these benefits, managed care plans and providers will need to work together to delineate how these services can more effectively partner, streamline communication, reporting and billing practices and expand outreach and engagement to eligible members.