Children Now

Enhanced Care Management:
Implementation Barriers & Observations

This document is an excerpt from a project Children Now undertook to research, explore, and better understand the early implementation experience of the Medi-Cal Enhanced Care Management (ECM) benefit for children and youth, as of Summer/Fall 2024. This project has been informed by a number of activities prior to the launch of the ECM benefit for children and youth, and throughout the first year-plus of implementation, including dozens of stakeholder interviews. Visit the full project site here.

During interviews with ECM stakeholders, we heard many common themes about challenges with referral processes and contracting arrangements that have also been documented for adult populations. These implementation challenges were exacerbated for children and youth populations because of unclear and inconsistent population definitions and eligibility criteria for child/youth POFs, poor understanding of the interaction of the ECM benefit with other programs & systems that exist exclusively for children and youth, and lack of minimum qualifications for ECM providers to meet the complex needs of children and families. Based on our research of the first year of ECM implementation for children and youth POFs, we offer the following 10 observations:

1 Children and youth populations are an ECM policy after-thought.

The ECM benefit was designed based on experience and pilots with adult populations. In fact, the ECM benefit for children and youth populations was launched 18 months after the benefit went live for adult populations. Five months after the ECM benefit went live for kids, DHCS released a "spotlight" document explaining how the benefit might work for kids. Among stakeholders knowledgeable about ECM, there still appears to be significant confusion about the ECM benefit for kids, particularly around eligibility criteria, provider qualifications & matching, and intended outcomes from ECM for children and youth. DHCS leaders have conceded that ECM for adults is "not the same model that works for children and youth." For example, one provider shared that the assessment tool used to refer adult members for ECM was not appropriate for children and youth populations, so they had to create their own. This burden of adapting ECM for kids often falls on providers and case managers.

2 Reliable and robust networks of qualified ECM providers for children and youth do not exist (yet).

Reliable and robust networks of qualified ECM providers for children and youth do not exist (yet), due to the intense focus on ECM member and provider enrollment numbers has eclipsed conversations of quality or outcomes for children and youth. As a result, ECM implementation efforts thus far seem entirely driven by numbers – that is, the numbers of ECM members enrolled and the numbers of ECM providers on paper. This comes at the expense of attention to the quality of providers, whether in terms of knowledge of child-serving systems and programs, sufficient skillset, cultural competency, etc. Many interviewees expressed concerns about the quality and realized access of ECM provider networks for children and youth. Some adult-serving ECM providers – for good reason – do not want to expand services to children and youth who aren't in their specific population, and some don't want to serve children at all, even if they contracted with an MCP and in so doing bolstered the appearance of a network. The lack of standardization across providers has resulted in varying quality of care across MCPs. In addition, the language diversity of ECM providers for children and youth is extremely limited and may pose unique language accessibility challenges in terms of matching families with providers.

Continued →

Enhanced Care Management:

Implementation Barriers & Observations

3 For current & potential ECM providers, contracting is a big challenge and MCP payment schemes are not sustainable.

For current & potential ECM providers, contracting is a big challenge and MCP payment schemes are not sustainable. Both ECM providers and MCP staff reported challenges in contracting for the ECM child-serving network. MCPs seemed unsure how to find qualified providers; for example, we heard from a few stakeholders that awareness of CCS among some ECM providers may be limited even though they are contracted to serve children in CCS. Potential ECM providers who were new to contracting with MCPs took on a risk to become ECM providers and invest in new processes for data-sharing, communication, IT, and workflows across ECM and other providers. It is especially difficult for small providers and Community Based Organizations (CBOs) to contract with MCPs, and even larger institutions are challenged by having to navigate multiple MCP contracts, systems, data platforms, assessment tools, and referral forms. Because of the significant financial and personnel startup costs, coupled with the variation in payment levels/protocols across MCPs and uncertain caseloads, it is not entirely clear if all ECM providers will be able to sustainably provide services. At least one ECM provider noted that the reimbursement structure, which requires three contact meetings with ECM members each month, including one in person, was not sustainable because families have complex and competing scheduling needs. Leadership also matters, and several potential ECM providers are choosing not to become ECM providers because their executive or leadership team does not consider it worthwhile to do so from an organizational perspective – at least not without more clarity and certainty about the financial feasibility. Access to technical assistance supports and resources (via the PATH TA Marketplace) has also been noted as a challenge for potential ECM provider organizations, and the vast majority of available resources are not specific to child and youth populations.

4 There are many outstanding questions and challenges about the role Community Health Workers (CHWs) can play as ECM providers.

It is clear that the CHW workforce will be an important way for MCPs to meet the spectrum of care coordination needs of their members and for providers to create financially sustainable models. However, as it relates to ECM, there is significant confusion among MCPs and providers including fear of duplicating services (which is not allowed) with CHW services, CCS case management, Targeted Case Management, or other existing care navigation program (such as the Home and Community Based Services waiver program). ECM providers may not be aware or understand the other care management programs that could be duplicative, and some ECM providers do not know if a member is already enrolled in ECM or receiving CHW services. Because of the lack of clarity around the role CHWs can – and should – play in the ECM network, particularly for families with children, the confusion may result in families being given false choices about the services available to them. For example, a family may misunderstand that enrolling in ECM does not affect CCS case management, but CHW services could be considered duplicative with ECM.

Continued →

Enhanced Care Management:

Implementation Barriers & Observations

5 Administrative approvals and authorizations for ECM can delay access to care, or entirely block an opportunity to engage a child, youth, or family.

MCP administrative approval and authorizations are a barrier in getting Medi-Cal members connected to ECM services. Opportunities are lost when members and providers have to wait three or four weeks for approval of ECM services; the provider may no longer be able to contact the member, or the member may have lost interest or trust in ECM during that time. Although MCPs are required to review and adjudicate ECM approvals "within five working days for routine authorizations and within 72 hours for expedited requests," there are reports that many ECM referrals are not acted upon in that time frame. The upcoming presumptive authorization policy for ECM providers may help alleviate some of the delay, but only if the appropriate providers (e.g., CCS paneled providers) are contracted to also provide ECM.

6 Some families of kids with medical complexity – especially in CCS Whole Child Model counties – are turned off from ECM because it introduces another care manager into their lives.

The vision of ECM is to offer Medi-Cal members a single Lead Care Manager, but that is especially complicated for the CCS population that, by way of being in CCS, have a clinical case manager for their CCS condition. The ECM programs at Rady Children's Hospital in San Diego and at Children's Hospital Los Angeles are two examples of very intentional design where ECM is integrated within the network of primary and specialty medical care that CCS children already rely on. The integrated team design of these models ensures that ECM providers have an understanding and line of sight into the member's clinical management in order to provide the range of support and navigation assistance families need and can build on the trust families have already established with their health providers. Given the deep trust that many families already have with their care team and case managers, there is understandable hesitance to add a new and potentially underqualified ECM care manager into the picture. This seems especially true in Whole Child Model counties where CCS has already been integrated within the MCP, and a new outside care coordinator feels redundant to families. Some ECM providers are also fearful of being unequipped to serve children with medical complexity.

Continued →

Enhanced Care Management:

Implementation Barriers & Observations

7 For the half of the children/youth involved in child welfare who are eligible for ECM, quality is a major concern.

DHCS has still not made clear where ECM fits into the larger landscape of care coordination for children and youth in child welfare. Navigating child welfare systems and cases requires a unique understanding possessed by only certain CBOs and agencies. It has been especially challenging for MCPs to recruit providers for ECM who are familiar with and trained in dealing with the trauma history and unique legal situations of children and youth in child welfare. ECM can be a particularly valuable benefit for older foster youth who will be leaving the system and newly required to navigate care on their own, but success will hinge on having competent and qualified ECM providers to support them. Another concern is that because foster youth are a highly mobile population and roughly half are not enrolled in an MCP, the ECM benefit may have limited reach/impact for this population.

8 Even with knowledge about the ECM benefit, referrals to ECM may simply not happen.

The ECM benefit is new and still unknown to families, although receptivity to ECM might increase if families hear about or get referred to ECM from organizations or agencies they already know and trust. But not enough providers (clinical and non-clinical), educators, and community members know about ECM. If they don't know about it, they can't refer, and if they don't understand or trust it, they won't refer. In fact, one CBO shared that they no longer refer families to ECM if they are members of a certain MCP, because families who were in need of support and appeared eligible for ECM were getting denied ECM services by that MCP. Even when a member might be eligible, there are discrepancies in how some of the ECM eligibility criteria are interpreted, leading to members missing out on critical services and finding reasons to be skeptical or mistrustful of Medi-Cal. Poor experiences with ECM referrals and connection to providers will erode trust that the ECM benefit can be realized. There are also concerns that referral processes and ECM provider networks are limited in terms of diversity of language access and congruency; for example, most ECM providers speak only English and the standardized referral template will launch in English only.

Continued →

Enhanced Care Management:

Implementation Barriers & Observations

9 Nobody's talking about dental care within the context of ECM for kids.

In focus groups prior to the launch of ECM, parents identified to us that dental care coordination is a high need, however dental care rarely seems to be part of the ECM discussion and most stakeholders did not know that DHCS had a Medi-Cal Dental Care Coordination Referral Form. It is not clear if dental need is regularly captured at intake or as part of ECM care plans, or if there is a clearly articulated role for ECM to navigate MCP members to dental services, which are primarily delivered through a fee-for-service system. In one case where ECM enrollment was triggered by a child's hospitalization for an emergency tooth extraction, the ECM care manager was only able to offer the parent a phone number, and was not able to help the parent find a dental provider who could coordinate with her child's medical specialists to ensure the child could safely receive dental care services. In other words, even when oral health care was central to the child's needs for ECM, the system was unable to deliver on the benefit.

10 Accountability for ECM for children and youth is elusive.

DHCS is not yet carefully monitoring or holding plans accountable for ECM enrollment or for Closed Loop Referrals to ECM. Plans have received millions of dollars in incentive payments specifically for the purpose of building ECM networks, but there is little transparency or accountability that those funds have been used to prepare to deliver ECM for children and youth. As noted above, with so much focus on enrolling as many members as possible, there has been little foresight or consideration of what "graduating" or transitioning out of ECM looks like for children and youth, especially for children in CCS who often have chronic, lifelong conditions. An individual child or youth's ECM care goals cannot be successfully met if there are local service gaps and restrictions. Community Supports services may not be available for children/youth in some areas – for example, one northern California ECM provider shared about a case where no housing provider was available or willing to serve a family with a special needs child who was at risk of homelessness. Moreover, MCPs may have too much discretion to reject approvals for interventions – for instance, an MCP rejected one request for asthma-safe cleaning supplies but approved a nearly identical one for a different member with no clear reason given for the discrepancy. Without a Closed Loop Referral system that tracks children and youth referred to ECM and the outcomes of those referrals, it is difficult to tell who has received the ECM services they were referred for and whether they had a positive experience. It is still not clear what successful implementation of ECM looks like or what outcomes the State would like to see for kids (e.g. fewer Emergency Department (ED) visits, reduced school absenteeism, less care coordination support needs, etc.)

Enhanced Care Management:

Recommendations for the Department of Health Care Services (DHCS)

It is widely acknowledged that the roll out of the ECM benefit for kids has been slow, which is often the case when new benefits are launched. But more than a year into availability of the ECM benefit for child and youth populations, MCPs and CBOs are still working extremely hard to figure out ECM for kids, and at the same time DHCS is course-correcting the overall ECM policy through streamlining and standardizing. While the vision of ECM holds much promise for supporting children, youth, and families, there is much room for improvement in the actual implementation. To that end, we offer the following recommendations for DHCS and MCPs to improve the ECM benefit for children and youth.

We recommend that the Department of Health Care Services (DHCS):

Develop an action plan and schedule for streamlining and course-correcting around the ECM benefit policy for children and youth. Streamlining strategies should be developed that are specific to children and youth POFs, for example:

- Developing ECM assessments that are specifically tailored to child/youth populations;
- Clarifying the role of CHWs in delivering ECM for children/youth rather than describing CHWs as a separate workforce;
- Considering allowances for Whole Child Model CCS case managers to be ECM providers;
- Standardizing billing processes and reimbursements; and
- Addressing uncompensated long travel times for ECM services delivered in the community.

Enforce compliance with MCPs' ECM provider directories and perform an audit as it relates to ECM provider network robustness for all MCPs to ensure there are qualified providers available and willing to serve child and youth populations.

- Each provider directory should clearly differentiate between pediatric and adult-serving providers.
- Provider directories should have at least one qualified provider who serves CCS populations, and MCPs should build out provider networks if not.

Track Closed Loop Referrals to ECM for children/youth and enforce compliance with ECM authorization timelines so that children and youth can access ECM services more quickly.

Develop and vet comprehensive guidance and standards to hold MCPs accountable for:

- Timely action on ECM referrals involving child/youth members;
- Connecting child/youth members to an appropriately qualified ECM provider;
- Ensuring adequacy and quality control of ECM providers and measurement of consumer experience/satisfaction with ECM; and
- Supporting child/youth member ECM care plans, including access to dental care and filling gaps in service availability for Community Supports available to children and youth.

Continued →

Enhanced Care Management:
Recommendations for Managed Care Plans (MCPs)

We recommend that Managed Care Plans (MCPs):

More flexibly contract and engage with potential ECM providers serving children and youth populations – for example, on-the-street outreach and in-home billing requirements may not respect or reflect the care relationship families have with trusted providers, nor may it be needed given the level that some families are engaged in care. Focused in-person contracting convenings or workshops could also be a way to support potential ECM providers for children and youth, and better understand their concerns around issues like data-sharing and sustainability. ECM provider recruitment efforts should be targeted to meet the cultural and linguistic needs of children and caregivers eligible for ECM. MCPs should also reimburse ECM providers in a timely way that reflects the reality of delivering ECM services and the cost of outreach.

Improve compliance with ECM provider directory requirements and improve directory usability with respect to accuracy and accessibility. All plans should have easily accessible, downloadable PDFs with populations of focus clearly spelled out and languages listed, not just search portals. For example, it should be easy to identify the ECM providers serving children in CCS and if they are accepting new clients.

Improve timeliness of ECM authorizations for children and youth by tracking referrals, streamlining referral processes, increasing authorization staff, and/or expanding presumptive authorizations so that children and youth can access ECM services more quickly.

Play a proactive role in ECM implementation by establishing regular meetings with providers, proactively connecting providers serving the same populations of focus, and assigning an MCP liaison to be a point of contact with providers.

Construct local ECM child/youth referral networks by embarking on trust-building, educational "promo tours" about ECM for kids that intentionally educate and connect with child-serving providers who can refer members to ECM, including obvious and eager partners such as:

- Pediatric and other clinical training and residency programs;
- Head Start/Early Head Start sites;
- School nurses;
- Pediatric day health centers;
- Local oral health programs; and
- Local or regional pediatric/medical/dental societies.
- An MCP could also develop training curriculum and invest in a parent "ambassadors" program for ECM.