CHCF PERSPECTIVES FROM THE FIELD

Up Close with Enhanced Care Management Program Providers

In January 2022, the California Department of Health Care Services (DHCS) launched the Enhanced Care Management (ECM) program, an essential component in the state's ambitious plan known as CalAIM (California Advancing and Innovating Medi-Cal), which aims to transform Medi-Cal and improve outcomes for the millions of Californians it covers.

The ECM program implements comprehensive care management and interventions for nine populations of focus (POFs). These populations include adults and children with complex medical, behavioral, and/or social needs. Through a network of community-based providers contracted with Medi-Cal managed care plans (MCPs), eligible ECM recipients are assigned a dedicated lead care manager who helps coordinate and connect them to clinical and nonclinical services addressing their individual challenges and social determinants of health.

Rollout of the program has been gradual and staggered across counties and populations. It began with just three populations (people experiencing homelessness, people at risk of avoidable hospitalization or emergency department use, and people with serious mental health and/or substance use disorder) across 25 counties in January 2022, providing a bridge from two prior programs, Whole Person Care and Health Homes. The program expanded to become statewide six months later, and more POFs were added in 2023, including children and youth, and adults transitioning out of long-term care (LTC) facilities or at risk of entering LTC facilities. The final two POFs — birth equity and people transitioning from incarceration — were launched in January 2024.

Methodology

During the summer of 2023, the UCSF Health Systems Leadership Pathway chose to assess the implementation status of ECM across the different POFs, in collaboration with DHCS. The team, a cohort of UCSF residents and fellows and pathway adviser Edgar Pierluissi, MD, worked under the guidance of a team from DHCS to interview 18 ECM stakeholder organizations across the state. The stakeholders included 16 single-county and multicounty ECM provider organizations, one intermediary supporting community-based organizations in contracting with health plans, and one MCP. The team focused on involvement with three newer POFs: those at risk of LTC institutionalization, children and youth, and the birth equity POF. However, most organizations worked with multiple POFs, and it was difficult for the study team to parse out specific details for each. Also, only one organization had received referrals for the birth equity POF. The team asked questions about their implementation efforts, impact of the program so far, and rollout challenges.

About the Perspective from the Field Series

As California's Department of Health Care Services administers changes to the Medi-Cal program, especially those that are part of the CalAIM initiative, CHCF is intermittently publishing short reports that highlight the perspectives of those who are implementing the changes. These "Perspectives from the Field" seek to inform policymakers and other health care leaders about insights and experiences from people on the ground who work directly with patients.

The team also conducted a literature review to identify promising key performance indicators (KPIs) for DHCS to consider implementing for assessment of the ECM program moving forward.

From the insights and feedback gleaned from the interviews, four main takeaways emerged:

- **Delivering ECM is complex.** Implementation of ECM has been complicated by factors such as provider experience and capacity, the quality of data provided by health plans, the different needs and challenges of working with the various POFs, variability in health plan requirements, and a lack of established protocols and quality measures due to the newness of the program.
- **Variation is the norm.** There is no uniform approach for implementing and delivering ECM across the state. This lack of standardization has resulted in significant administrative burden for ECM providers.
- **Success is possible, and it's happening.** Despite the challenges, ECM providers are having success supporting patients in navigating a fragmented system and helping patients get what they need.
- **More measurement standards would help.** ECM providers currently have no KPIs to target outside of enrollment and engagement, which makes measuring impact a challenge.

What follows is a more detailed summary of findings that serve as useful guidance for providers, MCPs, and DHCS administrators as they continue to build out the ECM program as an important benefit for Californians with complex needs.

The ECM Journey

Here's how organizations are tackling the various steps of ECM implementation.

Identification

"We have a really robust outreach program. You know, we are mining the heck out of that data. . . . We're casting a really wide net. . . . If you think about a lot of the very vulnerable folks that we're working with, they're not the kind of people who think about calling up the health plan and saying, I need help."

— A multicounty LTC ECM provider

Most providers used a combination of methods to identify people eligible for ECM, both from their existing client base (for organizations already providing social or medical services) and from the broader community.

- New client identification strategies
  - **Health plan member information files (MIFs).** Almost all provider organizations used MIFs from participating health plans to identify eligible ECM members. However, many representatives reported that these lists were often out of date and thus only partially useful. Improving the quality and standardization of the data provided by health plans could improve outreach and enrollment efforts.
  - **Third-party referrals.** Some organizations accepted referrals from community providers such as hospitals, skilled nursing facilities, social workers, physicians, and childcare programs. Referrals from internal providers were also common.

- **Direct community engagement.** This included hiring Spanish- and Vietnamese-speaking outreach workers, visiting nursing facilities to educate staff and identify eligible patients, and engaging with California Children's Services (CCS) providers to tell families about ECM. One organization used data-mining techniques to reach people who may not have sought help through traditional referral methods.

- Existing client population
  - **Chart reviews.** Some providers did manual chart reviews. Others enlisted third-party organizations to help.
  - **Repurposing existing staff and structures into ECM programs.** This allowed some organizations to engage a subset of their existing clients in ECM.

Enrollment

"We'll start to build relationships with the front staff or even a pharmacy. Or we might just say, when is their next refill? We'll show up if they're consistently there, and we meet them in the lobby while they're waiting for a refill or their next appointment and we can enroll them. If we can get with them face-to-face, we'll enroll them."

— An LTC ECM provider in San Francisco

Providers used a variety of outreach strategies, including phone calls, emails, letters, home visits, group education sessions, and text messages. These were typically performed by dedicated outreach specialists or care managers.

To engage enrollees, providers sent introductory letters, repeated contact attempts over several months, used customer relationship management systems to manage data, and sometimes visited locations their clients frequent. One organization used claims data to locate hard-to-reach clients at their local pharmacy or provider office.

Enrollment procedures typically involve doing assessments, signing necessary documents like consent forms and service agreements, and scheduling an initial appointment with the ECM lead care manager.

Risk Stratification and Intake

"The health plans are variable. Some provide us with risk stratification or acuity tiering. Others require that we reach out to ALL patients within the first 10 days. Our team will also layer on their own assessment based on medical and social circumstances."

— A multicounty LTC ECM provider

Most organizations used prestratified lists from health plans but found these only partially helpful. Some used mini-assessments, a proprietary algorithm or — in the case of two larger organizations — an integrated call center to screen for high-risk enrollees. Some providers did not do stratification because they didn't have enough volume to need it.

Follow-Up

"We've even had some that were daily interactions, or as they start to get settled and be stable, maybe we back off a little bit because we can feel that we're doing too much, like we're bothering them. We're calling too much, we're showing up too much, so then we adjust and pull back a little bit based on their preferences."

— An LTC ECM provider in San Francisco

Most health plans require provider organizations to follow up with patients a minimum number of times after the initial assessment, although there are no requirements for how long this should take. ECM providers tackled these follow-ups in different ways:

- **Time-based.** Most plans followed up frequently with members, such as weekly or biweekly, particularly in the first 1 to 3 months of enrollment.
- **Tier-based.** At least two organizations used tiers to risk-stratify patients and determine follow-up intervals.
- **Event-based.** Some organizations followed up more frequently if an event occurred, such as hospital admission.

Documentation

The assessments "could take up to an hour to two hours, and that's… assessing, completing the assessment, really having a conversation around what [are] the needs that they want to identify in the care plan, developing that care plan, providing intervention, and then sending out the referrals for that member."

— A multicounty LTC ECM provider

Several organizations used electronic health record (EHR) systems for documentation, billing, and tracking outcomes. However, data sharing was made difficult by differences in the EHRs organizations use. Also, while ECM providers saw documentation as important, they also perceived it as a high administrative burden, often requiring hours of work per day.

How ECM Organizations Operate

"ECM is, at this time, a secondhand thing that we're doing one day a week out of our normal schedule. . . . I know we do have plans as well to bring on some more people. . . . We are in the end stages of hiring a case manager. We will be hiring a full-time ECM RN/case manager here real soon. So, we're building capacity to facilitate the growing needs of this program."

— An LTC and children/youth ECM provider in Kern County

The paths that organizations took to becoming ECM providers varied. Many were previously involved in ECM-like activities such as Whole Person Care or the Health Homes Program, making the transition to ECM easier. Others grew into ECM providers incrementally.

This variation makes it difficult to identify best practices for becoming an ECM provider.

Similarly, staffing arrangements, performance measures, and support from health plans varied significantly among organizations.

Team Staffing

- **Different credentials.** For case manager roles, many organizations employed nonlicensed college graduates. Licensed professionals such as RNs and LCSWs were hired for more supervisory or specialized clinical roles. Organization representatives said they preferred to hire staff from the community with lived experience, but this wasn't always possible. Unpredictable launch timelines for POFs created staffing challenges for some.
- **Huge variation in staffing ratios.** Lead care manager-to-patient ratios varied greatly across organizations, from as low as 1:8 to as high as 1:150. Some organizations didn't track these ratios. This is an area of concern, because acuity-adjusted ratios are crucial for ensuring that case managers can effectively meet the needs of their clients while maintaining quality care, and such variation suggests very different intensity of service.
- **Larger organizations had more specialized roles.** While all organizations employed ECM case managers, bigger organizations were able to hire people for more specialized positions, such as outreach and enrollment, supervisory tasks, and quality management. Staff at smaller organizations often wore multiple hats.

Accountability and Performance Measurement

There was no standard approach to measuring success or accountability within organizations or their patient populations. However, a few common practices and themes emerged.

- **All organizations measured enrollment.** Most also measured enrollment success. Among those that did, success rates ranged from 1% to 60% of the population targeted.
- **Internal dashboards and self-audits were used by many organizations to check that case worker teams were on the right track.** One group used a standard internal measure to assess employee productivity, assigning a set amount of time per activity. Only one organization surveyed patient satisfaction.
- **Lead Care Managers were often in charge of the performance of their group.** Many met frequently with other staff to discuss cases and problem-solve.

To address the lack of standards for ECM accountability or performance, the UCSF team recommended several KPIs that DHCS could build into the program's reporting requirements. These include population-specific KPIs as well as general quality measures such as enrollment and discontinuation of benefits, requests for service and outreach, and provider capacity.

Health Plan Support

"Some MCPs are even now paying for outreach, which is an acknowledgment to [the] onerous and time-consuming work that it entails. Some of them are doing reverse referrals and doing bulk authorizations and presumptive eligibility. The ones that are doing presumptive eligibility are very appreciated. The ones that are reviewing every single one and beyond the authorization turnaround time are not appreciated."

— A multicounty children/youth ECM intermediary

In general, the organizations viewed health plans as supportive of ECM implementation, although representatives from only five organizations spoke about

this. They highlighted specific efforts they found helpful, including using gift cards to incentivize enrollment and retention, and process-related interventions to expedite service delivery such as bulk authorizations and streamlined eligibility.

Implementation Challenges

Organizations shared multiple success stories about how ECM had benefited patients, including providing much-needed wraparound care coordination, connecting clients with critical housing resources, preventing evictions, and addressing multiple practical needs such as medication delivery and transportation.

Nevertheless, organizations also identified several challenges that have complicated ECM implementation. These challenges include the following:

- **Lack of standardization among health plans.** Many organization representatives reported high administrative burden with documentation, billing, and overall tracking of outcomes. This was especially true for organizations that worked across multiple counties or with multiple health plans.
- **Housing insecurity.** Helping clients find and maintain stable housing was a frequent challenge facing ECM providers.

> *"Housing is the number one barrier once we have them engaged."*
>
> — An LTC ECM provider in San Francisco

- **Inadequate data from health plans.** Some organization representatives reported that they had received poor-quality data from health plans. This included MIFs with incorrect phone numbers, clients already assigned to another ECM provider, and out-of-date medical information.

> *"One issue we've encountered pertains to technical problems with the files received from the health plan. Our enterprise application department is collaborating with their IT department to address these issues. For example, our files may still include members who have opted out or relocated, which erroneously inflates our membership count and hinders enrollment of new members."*
>
> — An LTC ECM provider in San Francisco

- **Incongruous policy and payment structures.** Representatives from organizations serving children and youth and LTC populations said outreach, staffing, payment and outcome measurement models need to be better tailored to the specific needs of those populations.

> *"Some managed care plans still want us to make sure there is an LVN or RN on each team . . . but our providers are social service providers and behavioral health providers . . . the current model is very much designed for adult complex care."*
>
> — A multicounty children/youth ECM intermediary

"We think CalAIM hasn't quite caught up yet to the right model of care [for] the care management needs for someone as they transition out of a nursing home or out of an institutional setting . . . [these needs] are much more significant in those first 3 to 6 months than they are in month 7 through 12. . . . Yet the policy and the payment structure does not necessarily follow that."

— A multicounty LTC ECM provider serving San Mateo and Santa Clara counties

- **Billing difficulties.** Some providers said they did not have the capital to build up infrastructure to bill and implement ECM at a high volume and thus ensure financial sustainability. A lack of upfront reimbursement and infrastructure, along with delays in referral approvals, contributed to this challenge.

"We have yet to be able to bill for anything because . . . we don't have an actual billing department. . . . So, we have not had any kind of monetary return."

— An LTC and children/youth ECM provider in Kern County

"We don't have a specific admin person or a billing team, and billing for ECM is [a] very precise and tedious process. It's not just billing for each client but it's also you need to know about how many encounters you've had and keep track of a lot of data too, including in addition to our performance measures."

— A multicounty children/youth ECM provider serving San Mateo and Alameda counties

- **Coordination hurdles.** Some providers struggled to coordinate care because of complex system and family dynamics, especially for clients in LTC and under conservatorship.

"I would . . . try to get buy-in and responsiveness, and then there was like this other layer of people [such as] conservators or family members making decisions . . . and the health plan and a local hospital [would be] duking it out about who was going to pay for these services . . . and it didn't feel very collaborative."

— A multicounty LTC and children/youth ECM provider

Next steps

The DHCS team greatly appreciated the work of the UCSF Health Systems Leadership Pathway team. Their structured conversations with ECM providers offered deep insights into some of the challenges faced by providers and plans as the DHCS team seeks to improve implementation and oversight of the ECM program. In particular, it helped inform the ECM monitoring program, which was launched in January 2025. Although the KPIs researched by the UCSF team were not used in the monitoring program, the literature review was very helpful and will inform the development of future monitoring plans, including supporting further communication and feedback between provider and plan personnel. Future monitoring will also be supported by Medi-Cal Connect, the Population Health Management service being rolled out by DHCS.

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About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

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