Intrepid Ascent

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STEP UP / STEP DOWN:

A GUIDE TO THE NON-DUPLICATIVE INTERSECTIONS OF ECM & CHW SERVICES

Overview

This resource was developed using content generated by the Contra Costa California Advancing and Innovating Medi-Cal (CalAIM) PATH CPI Enhanced Care Management (ECM) – Community Health Worker (CHW) Work Group and is intended to support case management service providers in navigating when and how Medi-Cal members may move between ECM and CHW services. It is designed to help providers think through these transitions in a way that is intentional, member-centered, and aligned with Medi-Cal policy. The toolkit focuses on clarifying the key differences and similarities between ECM and CHW services, identifying where the two models naturally complement one another, and supporting organizations in considering how ECM and CHWs can be deployed together as part of a broader service delivery and sustainability strategy.

Policy Background

CalAIM is California's most recent Medi-Cal transformation effort, designed to make care more coordinated, person-centered, and equitable. Care coordination is a cornerstone of the initiative's efforts, particularly for individuals with complex medical, behavioral health, housing, and social needs. CalAIM also makes care coordination and case management activities reimbursable, creating new opportunities for community-based organizations (CBOs) and non-traditional healthcare workforces to sustain and strengthen the work they have long provided. Within CalAIM, there are two main types of service categories that have a strong emphasis on supporting Medi-Cal members holistically; the first is ECM, which provides whole-person, ongoing support for Medi-Cal members with complex needs. The second is service-specific activities delivered through Community Supports, which focuses on helping members access and stay connected to particular services, such as housing supports. As California providers think about long-term sustainability, especially as CalAIM funding and policies evolve, many are exploring other case management reimbursable activities that align with the skill set and populations of focus of ECM. The main of which is CHW services; both ECM and CHW models center relationship-based support, and, when thoughtfully aligned, can complement one another by supporting members as their needs change over time.

Enhanced Care Management

ECM is a statewide benefit designed to provide a centralized person-centered community-based approach for member needs and coordination across the care continuum. While ECM is tied to the efforts of the CalAIM 1115 waiver, the California Department of Health Care Services (DHCS) has indicated that ECM services are not dependent upon the continuation of the waiver period so may continue beyond 2026 under Medicaid managed care authority.[1]

Community Health Worker

CHW services were cemented as a Medi-Cal benefit in July 2022 and are preventative health services to prevent disease, disability, and other health conditions or their progression, and promote physical and mental well-being. CHW professionals may be individuals known by a variety of job titles such as promotores, community health representatives, navigators, and other non-licensed public health workers.

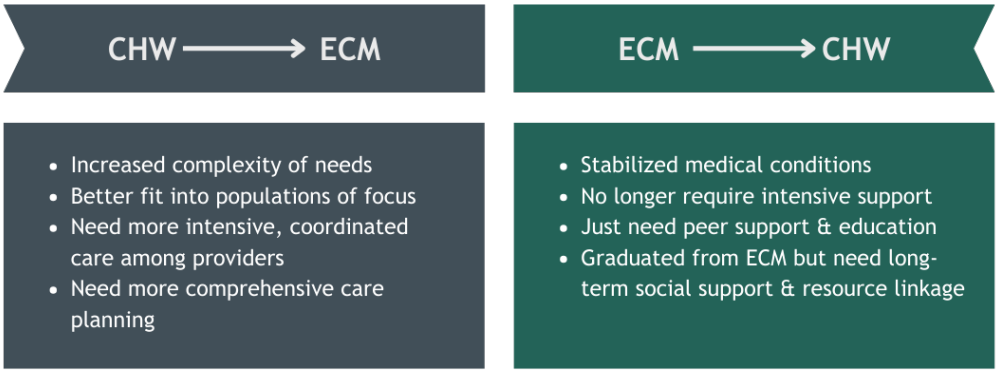
Important Considerations

The similarities between ECM and CHW services highlight why organizations that provide one model are often well positioned to provide the other. Both ECM and CHW services place strong emphasis on lived experience, cultural competence, and deep community knowledge, particularly within the geographic areas served. While CHW professionals must complete required certification and ongoing training to deliver services, the overall

[1] Medi-Cal Transformation Concept Paper

barrier to entry for organizations to operate both ECM and CHW programs is relatively low, especially for CBOs already engaged in care coordination and navigation work.

There is also significant overlap in the types of reimbursable activities allowed under ECM and CHW services. For instance, both include reimbursable activities related to health promotion, individual support, and advocacy, helping members make lifestyle changes and take an active role in managing their health and well-being. Additionally, both ECM and CHW serve similar populations, the distinction being the intensity of support, which illustrates why incorporating both models can offer a more holistic approach to supporting members through different stages of need over time, while also creating a sustainability pathway for organizations by expanding the range of reimbursable services they can provide.



ECM populations of focus include Medi-Cal members with high and complex needs who require intensive, wraparound support to coordinate care across multiple systems and providers. CHW services, by contrast, can be understood as a lighter-touch form of support. They are well suited for members who no longer require intensive case management but would still benefit from ongoing assistance with preventive care, health education, and social needs. **DHCS has issued guidance indicating that while it anticipates and encourages CHW services to be delivered by CBOs that may also be ECM providers, CHW services cannot be provided to members who are actively enrolled in ECM at the same time.**[2] However, organizations may provide CHW services before a member begins ECM and again after ECM services end, allowing for continuity of support across transitions.

Despite these similarities, there are two key differences between ECM and CHW services that organizations must account for. The first is the supervision requirement for CHW services; CHWs must operate under the supervision of an enrolled Medi-Cal provider, referred to as a supervising provider. This supervising provider is responsible for ensuring the CHW is qualified to deliver services, overseeing the services provided either directly or indirectly, and submitting claims for CHW services.[3] This supervision structure differs from ECM, which is delivered through an organizational, team-based model rather than a licensed-provider supervision framework.

The second major difference is the billing structure. ECM is reimbursed through a per-member-per-month rate that covers two core activities: outreach and engagement, and ongoing care management planning. ECM services are typically authorized for a 12-month period, with reauthorization required in six-month increments to continue services.[4] CHW services are billed on a fee-for-service basis in 30-minute increments, with a maximum of four units per member per day.[3] **DHCS has issued a standing recommendation that Medi-Cal members who meet eligibility criteria would benefit from receiving up to six hours, or 12 units, of CHW services annually[5], with additional units allowable when recommended by a licensed provider as part of the member's care plan**. This standard recommendation fulfills the requirement for CHW services to be

[2] DHCS Frequently Asked Questions for Medi-Cal Community Health Worker Services
[3] DHCS Community Health Worker Preventative Services
[4] DHCS ECM Policy Guide
[5] DHCS Recommendations for Community Health Workers (CHW) Services for Eligible Medi-Cal Members

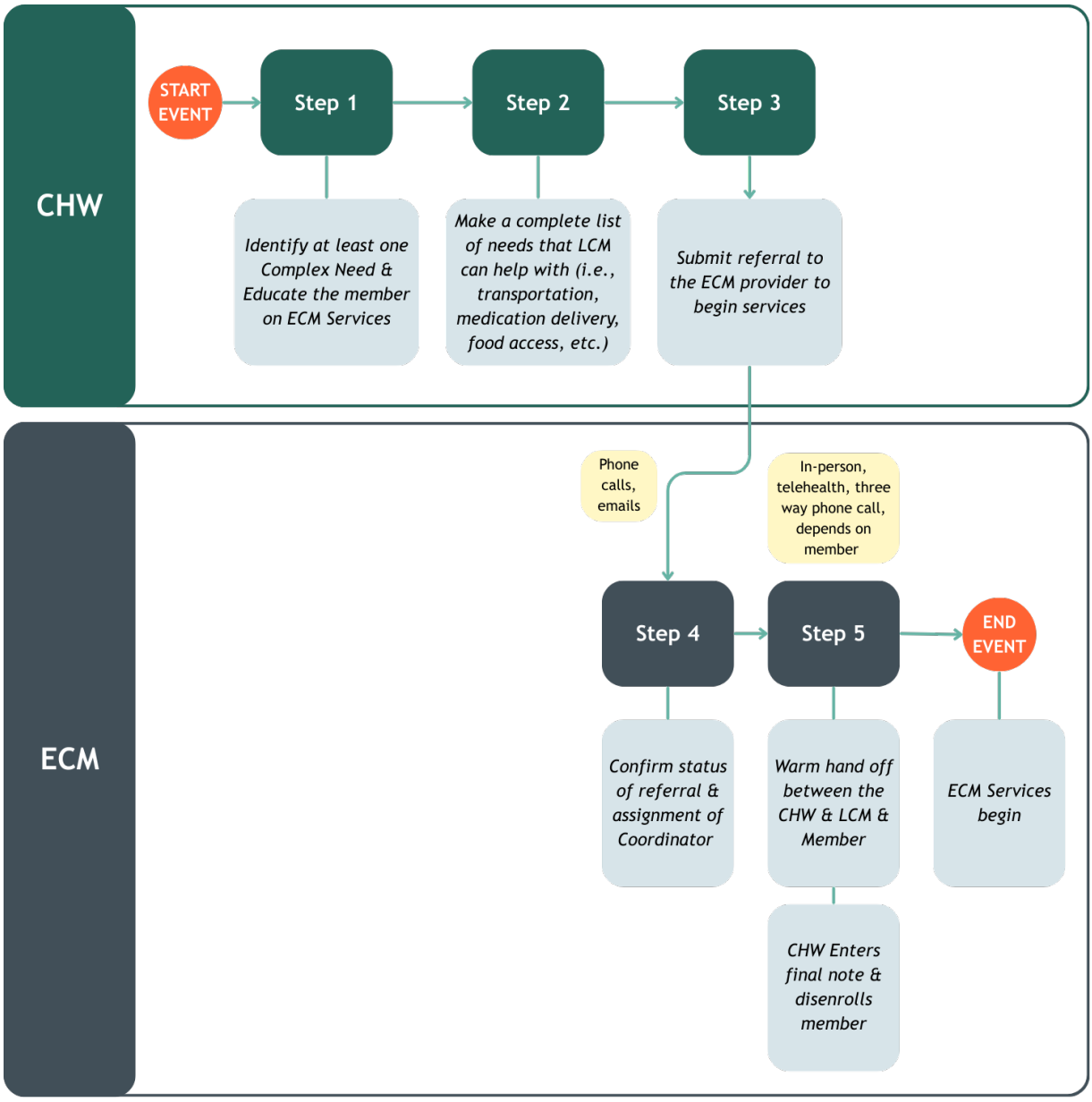
recommended by a licensed provider, for up to 12 units. For a further breakdown of details comparing ECM and CHW service components, please refer to Appendix A.

Step-Up & Step-Down Scenarios

The following scenarios illustrate just two examples on how organizations can thoughtfully use both ECM and CHW services to support members more holistically as their needs evolve over time, while also maximizing appropriate reimbursement opportunities. It is important to note that there are numerous other scenarios that may better align with your organization's infrastructure.

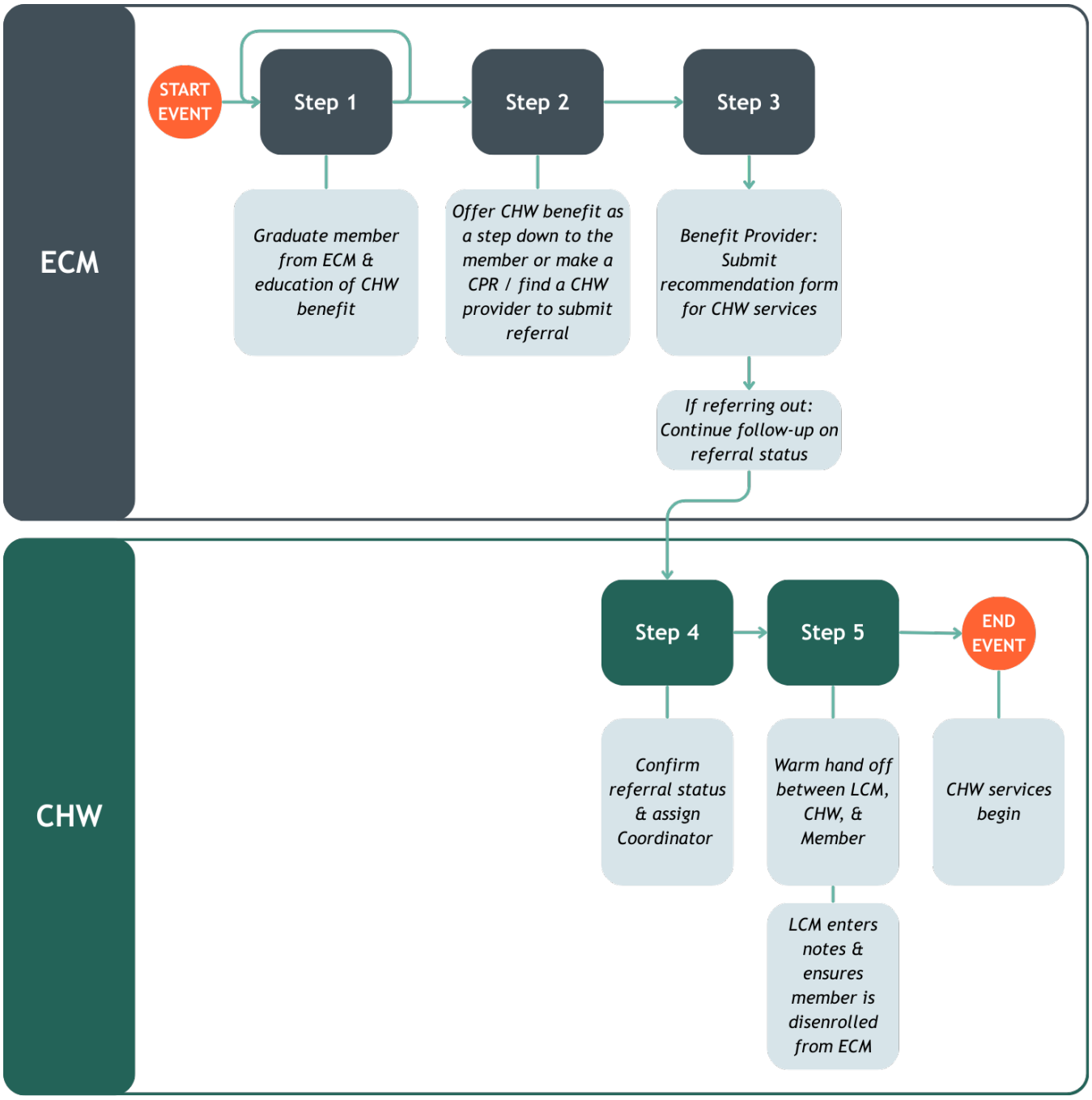
Scenario 1: Stepping Up Case Management Supports

Pamela is a CHW who has been supporting James, a 58-year-old man recently discharged from the hospital after complications from congestive heart failure. Over the past few weeks, Pamela has helped James's schedule follow-up appointments, refill his medications, and access food assistance. However, James's condition has become more complex, resulting in him missing several appointments due to worsening mobility issues and has been in and out of the emergency room. Pamela realizes that James needs more intensive, coordinated care than she can provide and refers him to an ECM provider within her agency.



Scenario 2: Stepping Down Case Management Supports

Natasha is an ECM provider who has been working with Louise, a 43-year-old woman with a history of chronic asthma and housing instability. Over the past six months, Natasha has helped Louise find stable housing, connect with a primary care provider, and establish regular medication routines. Her health has stabilized, and she is now consistently attending appointments and managing her condition well. During their most recent check-in, Natasha confirms that Louise has completed all their care plan goals and no longer requires the intensive, wraparound services provided through ECM. However, she would still benefit from support with things like health education, community resources, and help navigating benefits, so Natasha referred Louise to her CHW colleague.



Conclusion

California's Medi-Cal 1115 waiver, CalAIM, has created new opportunities for providers to receive reimbursement for comprehensive, relationship-based support services that community-based organizations have long delivered without sustainable funding. While Medi-Cal reimbursement should not be viewed as a mechanism to fully cover the cost of care, it can serve as an important long-term strategy when organizations thoughtfully bundle and align allowable services with their existing programs and community expertise. Within this landscape, ECM and CHW services offer a particularly strong opportunity for alignment, as both center on care coordination, share many reimbursable activities, and can support the same Medi-Cal members at different points along their health journeys.

Intrepid Ascent is deeply committed to advancing equitable, community-centered health systems. Through the experience of working side by side with California Medi-Cal providers as one of the California Department of Health Care Services' Collaborative Planning and Implementation facilitators, Intrepid has reaffirmed our belief that community anchored providers are essential partners in Medi-Cal's future. If you or your organization have additional questions about this resource, or want to discuss how it can apply to your community, please feel free to email **path-cpi@intrepidascent.com**

Our sincerest gratitude for all the organizations that participated in the Contra Costa CalAIM CPI ECM – CHW Work Group: Contra Costa Health Services - Public Health, Independent Living Systems, J&M Homecare Services, Pacific Clinics, Seneca Center, Serene Health, Brighter Beginnings, Star Nursing, Koinonia Family Services, Hijas del Campo, Inspiring Communities, Pear Suite, Diablo Valley College, Aliados Health, Zocalo Health, Fred Finch Youth and Family Services, East Bay Asian Local Development Corporation, Tangelo, Bay Shelter Homes, Lao Family Community Development, Wayfinder Family Services, Aspiranet, Omatochi.

Appendix A ECM & CHW: A Side-by-Side Comparison[6]

ECM	VS	CHW
Eligibility		
• Adults, unaccompanied youth & children, & families experiencing homelessness • Adults, youth, & children who are at risk for avoidable hospital or emergency department care • Adults, youth, & children with serious mental health &/or substance use disorder needs • Adults living in the community & at risk for long-term care institutionalization • Adult nursing facility residents transitioning to the community • Children & youth enrolled in California Children's Services (CCS) or CSS Whole Child Model with additional needs • Children & youth involved in child welfare • Adults & youth who are transitioning from incarceration • Pregnant & postpartum individuals; birth equity population of focus		One or more of the following: • Diagnosis of one or more chronic health condition(s), or a suspected mental disorder or substance use disorder that has not yet been diagnosed • Presence of medical indicators of rising risk of chronic disease &/or known risk factors (e.g, domestic or intimate partner violence, tobacco use, excessive alcohol use, &/or drug misuse) • Positive Adverse Childhood Events screening indicating a need for follow-up services • Results of a social drivers of health screening indicating unmet health-related social needs • One or more visits to a hospital emergency department, inpatient stays, risk of institutionalization, or two or more missed medical appointments within the previous six months • Expressed need for support in health system navigation, resource coordination services • Need of recommended preventive services
Services		

• Outreach & Engagement
• Comprehensive Assessment & Care Management Planning
• Enhanced Coordination of Care
• Health Promotion
• Comprehensive Transitional Care
• Member & Family Supports
• Coordination of & Referral to Community & Social Support Services
		• Health navigation:
		  ◦ Support member in accessing & understanding the health care system
		  ◦ Connecting to community resources
		  ◦ Serve as cultural liaison
		  ◦ Outreach & resource coordination
		  ◦ Help member enroll or maintain enrollment in assistance programs
		• Screening & assessment to connect to appropriate services
		• Health education
		• Individual support or advocacy that assists members in preventing the onset or exacerbation of a health condition or preventing injury or violence.

Provider Eligibility		

• Organizations that have experience supporting ECM's populations of focus
• Ability to contract with the MCP
• Organizations that have an existing foothold in the community they serve
		• Must have lived experience that aligns with the community or population being served.
		• Demonstrate qualifications in one of the following pathways:
		  ◦ CHW Certificate
		  ◦ Violence Prevention Certificate
		  ◦ 2,000 hours working as a CHW in paid or volunteer positions within the previous three years

Rates		
Rates as Per Member, Per Month • Initial outreach & engagement: $124 - $250 • Care management plan activities: $469.10 - $503 *Note: ECM rates are negotiated by MCPs. Rates may fall within, below, or above this range.*		Rates as Fee-For-Service; billed in 30 minute increments. Maximum frequency is four units, per member, per day • Treating an individual: $26.66 • Treating a group of two - four individuals: $12.66 • Treatment a group of five to eight individuals: $9.49 *Note: DHCS issued guidance that all members who meet eligibility criteria are allowed up to six hours of CHW services annually. Rates are published on DHCS Medi-Cal rates webpage.*

[6] Comparing Three Medi-Cal Benefits: Community Health Workers, Doulas, and Peer Support Specialists
Community Health Workers in Enhanced Care Management and In Lieu of Services: *A Model of Care Resource*