Managed Care Plan/Enhanced Case Management Services
Guide for CWS

Enhanced Care Management (ECM), started through the California Advancing and Innovating Medi-CAL (CalAIM) initiative, is a Medi-Cal benefit for children and youth enrolled in Medi-Cal managed care plans (MCPs). Youth can receive additional supportive services by ECM providers to address their needs in all areas of health and well-being including: primary care, specialty care, dental care, mental health, substance use disorder treatment, and long-term services and supports.

ECM can service child welfare-involved children, youth and families, whether they are in out-of-home foster care, remain with their families of origin, or have exited the foster care system. The **CalAIM Enhanced Care Management Policy Guide** prioritizes the child welfare population as a "Population of Focus" for ECM services, specifically children and youth involved in child welfare and youth who meet one or more of the following conditions:

- Are under age 21 and are currently receiving foster care in California;
- Are under age 21 and previously received foster care in California or another state within the last 12 months;
- Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state;
- Are under age 18 and are eligible for and/or in California's Adoption Assistance Program;
- Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months.

Note that for older foster youth who are transitioning from foster care, they are entitled to continued receipt of Medi-Cal services to age 26 but **must be** enrolled into a managed care upon exit from foster care. Former foster youth are also eligible for ECM services to age 26, and may be eligible for certain Community Supports such as housing navigation, housing tenancy/sustaining, and transitional rent services (for up to 6 months).

To implement ECM across child welfare services (CWS), MCPs are engaging in partnerships with counties to enroll youth into MCPs and have access to available ECM services. In multi-plan counties, the social worker, in partnership with the family, youth, and caregiver, select the appropriate MCP for the youth considering the complex needs of the youth, the location of the youth and providers, and the family of origin's medical plan.

In single plan counties, youth will be automatically enrolled in the county health plan, which also provides for all ECM services.

This guide is intended to assist counties in identifying how to select a managed care plan, how to enroll in that plan, then how to identify and begin engaging in ECM services appropriate for the youth and family. The processes outlined in this guide are general steps that counties should modify to meet their partnership and operational needs. The guide was developed to help counties identify the roles and responsibilities of the social worker (SW), eligibility worker (EW), Tribal or Indian Child Welfare Act (ICWA) representative, Managed Care Plan (MCP), Managed Care Plan CWS Liaison, public health nurse (PHN), ECM Provider, Resource Family (RF), youth and Non Minor Dependents (NMDs), and birth parents. Counties are encouraged to partner closely with their MCPs and ECM Providers to implement the steps and strategies outlined and for families with Indian tribe ancestry will include tribal or ICWA representation.

Table of Contents

Family Voice and Choice: Engagement, Consents, and Releases

In partnership between CDSS and DHCS, the California Integrated Core Practice Model (ICPM)[1] is a framework that outlines the shared values, core components, and standards of practice to be used when serving youth and families in the child welfare system. The ICPM provides guidance around actions for the social worker and behavioral health provider to engage in to support the delivery of timely, effective, and collaborative services. Additionally, the ICPM creates a culturally relevant and trauma-informed system of care that highlights the voice and choice of the child, youth, and family, including tribe representation for Indian children and families, regarding their strengths and needs in service planning and delivery.

In support of the ICPM, decisions regarding health care, behavioral health care, and other complex services should be made considering the voice and choice of the youth and family, as identified through individual engagement with the family and within the Child and Family Team. Information regarding available plans and services should be provided to all Child and Family Team (CFT) members in order to make an informed plan selection. Counties should work with their MCP CWS Liaisons and ECM Providers to create materials for the CFT members to utilize during CFT meetings.

Consent: Consent for the services identified by the social worker, youth, family, and CFT must be provided prior to any referrals social workers make to ECM services. Before a SW refers a family to their MCP for ECM services, or refers directly to an ECM service provider, the SW must have verbal consent from the youth or family to make the referral. All consent provided should be included in CWS documentation and include:

- A verbal explanation of the provider and service to the youth and/or family
- An explanation regarding what information will be shared with the provider
- The length of time information will be shared, and
- The youth and/or family's ability to withdraw consent

If a parent, caregiver, or NMD refers themselves to services, this consent is not required, but confidentiality releases may still be needed for the social worker to communicate with the ECM provider. Please see the Information Sharing section below for more details.

Information Sharing: All information sharing between child welfare and the MCP and ECM Providers must be in accordance with all federal, state, and local regulations including

[1] For more information about the ICPM, visit: https://www.cdss.ca.gov/inforesources/the-integrated-core-practice-model/about-icpm

confidentiality guidance. In general, Releases of Information (ROI) should be signed by all youth and NMD and family members to allow information sharing between child welfare and the providers in order to share necessary information to support the family's progress in services and/or address barriers to enrollment and engagement.

Glossary

Adoption cases – For kids who did not reunify with their family of origin and are achieving permanency through adoption.

Another Planned Permanent Living Arrangement (APPLA) – For foster youth over age 16 or Non-Minor Dependents (NMD) in an out-of-home care where they may remain until adulthood, when all other permanency options have been ruled out.

Authorized Representative (AR) – An authorized representative for Medi-Cal is an individual who is legally permitted to act on behalf of a Medi-Cal applicant or beneficiary. This person can help with the application process, submit documents, report changes, and communicate with Medi-Cal officials on the beneficiary's behalf. A social worker/probation officer, along with the caregiver, may act as an AR for routine medical care decisions. Non-Minor Dependents (NMDs) may act as their own AR.

BH–CONNECT – The BH-CONNECT initiative is designed to increase access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. For more information, visit **https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx**

Continuity of Care - Foster youth may be able to keep their Medi-Cal provider, including ECM providers, for up to 12 months after they are enrolled in a new managed care plan. This includes their primary care doctor, specialists, and most therapists. This may also apply to any physical, occupational, respiratory, and speech therapists, and behavioral health treatment providers.

Emergency Response – For kids likely to be detained per Structured Decision Making (SDM) safety assessment and other investigative findings by the SW.

Enhanced Care Management – A statewide Medi-Cal managed care plan (MCP) benefit that provides person-centered, community-based care management for high needs clients, including foster youth.

Enhanced Care Management Provider – Physical health, behavioral health, and social service providers, agencies, and community-based entities that deliver ECM services.

ECM Presumptive Authorization - Enables a subset of ECM Providers to directly authorize ECM for a timeframe of 30 calendar days, so they can more rapidly initiate ECM services and engage members in the care they need.

Family Maintenance (Court or Voluntary) – For kids who remain with, or who are returned back to, their parents while participating in an open case through court or voluntarily to address the original protective issue and achieve safety in the home.

Family Reunification (Court) – For kids who immediately come into care during the investigation.

Fee For Service (Otherwise called Straight Medi-Cal) – Medi-Cal enrollment outside of a managed care plan. Clients can visit any provider who accepts Medi-Cal, and the provider is reimbursed by the State Department of Health Care Services directly for the services rendered.

Full Circle Health Networks (FCHNs) - Created by/for community-based organizations (CBOs) providing efficient access to Medi-Cal managed care contracts and the full suite of administrative services needed for delivering high quality, culturally aligned care. FCHN is a Network Lead Entity (NLE) with Kaiser, otherwise known as a Administrative Service Organization (ASO) Model. FCHN has a network of providers across the state providing ECM services with experience and expertise in the child welfare population.

Intake/Case Management (CM) – The worker who will assist families in MCP and ECM enrollment in the Prevention Pathway. This is the worker identified by the County based on their Prevention Pathway structure.

Managed Care Plan – Medi-Cal plans administered by a provider who can deliver a wide array of services including primary care, specialty care, and prevention services.

MC 382 form - A State Department of Health Care Services form which allows an individual/organization to represent the member as an AR. The foster parent usually signs this form for foster youth giving them access to member services and selecting a primary care provider.

MCP CWS Liaisons – Employed by a MCP as a designated person to ensure the needs of children and youth involved with CWS are met. Please email **cwshealth@dss.ca.gov** to obtain the list of MCP Child Welfare Liaisons.

MEDS – Medi-Cal Eligibility Data System (MEDS) contains information about clients' Medi-Cal enrollment.

Older TAY Youth/Non-Minor Dependents – For youth over the age of 18 who remain in the foster care system who either live independently, or remain with a caregiver, while getting support to achieve independence outside of foster care.

Population of Focus (POF) – Nine POFs were identified by DHCS from the Medi-Cal populations that are at the highest risk and most vulnerable, and require the highest level of care, which includes ECM. More definition and guidance on each population of focus can be found here: **CalAIM Enhanced Care Management Policy Guide**.

Prevention Pathway – Access to receive prevention services under the Family First Prevention Services (FFPS) Program without an open child welfare case. All case management and/or prevention services are generally offered through a community-based organization (CBO). A **Title IV-E Prevention Pathway** allows a family to receive the supports and services directly from the child welfare agency.

Single Plan County COHS – County organized health system that provides the same benefits as an MCP but is not run by one of the MCPs, it is overseen by the County.

Specialty Mental Health Services – A wide range of mental health services, which may be provided if a client is determined to meet medical necessity criteria. Some examples of SMHS are: individual and group therapy, medication support, case management, day programs, in-home support, crisis support, and other services including Intensive Care Coordination, Intensive Home-Based Services, Therapeutic Foster Care, and Therapeutic Behavioral Services. Services are largely delivered by the county mental health plans with certain specialty services also delivered by managed care plans. For additional information on SMHS, visit **https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf**

New Cases: Initial Removal to the first CFT Meeting

County Responsibilities: MCP Enrollment/Selection

Step	Task	Details	Responsible Party
1	Determine if the family/youth is already enrolled in Medi-Cal (MC).	Check the child's health plan in MEDS with the Eligibility Worker's (EW) assistance.	EW
2	If MC enrolled, obtain documentation.	Provide a copy of the MC card and current health plan enrollment to the resource family and Public Health Nurse (PHN).	EW
3	If not MC enrolled, facilitate application and enrollment.	The EW, with input from PHN, SW, Resource Family (RF), and birth parent/youth, will process the Medi-Cal application and determine health plan selection.	EW, PHN, SW, RF, Birth Parent
4	Check available MCPs.	Use the **MCP County Table** to verify plan options.	EW
5	Determine managed care plan (MCP) type based on county.	If in a **single-plan county (COHS)**, foster child/youth is auto-enrolled into MCP. If in a **multiple-plan county**, the child/youth must select an MCP or remain in Fee-for-Service (FFS).	EW
6	Check if birth parents are enrolled in an MCP.	This may help determine their eligibility for CalAIM services to aid reunification. Materials such as this **At A Glance** publication from Public Works Alliance can be used or created for county use.	SW
7	Discuss the pros/cons of MCP vs. FFS with the birth family and RF.	Provide a family-friendly informational packet explaining benefits.	PHN
8	Contact Health Care Options for non-urgent changes.	For enrollment into an MCP, call **1-800-430-4263** (8 am – 6 pm, M-F) or visit **www.healthcareoptions.dhcs.ca.gov**.	EW, SW, PHN
9	Contact the Medi-Cal	Call **888-452-8609** (8 am – 5 pm, M-F) or email	EW, PHN

	Ombudsman for urgent changes.	MMCDOmbudsmanOffice@dhcs.ca.gov.	
10	Notify parents and youth of the MC plan choice.	Send the appropriate **Notice of Action (NOA) at least 10 days prior** to benefit activation.	EW

ECM Provider Selection

Step	Task	Details	Responsible Party
1	Provide information on ECM and benefits.	SW/PHN should introduce ECM services, provide reading materials, or allow an ECM provider to conduct outreach to the family directly.	SW, PHN
2	Complete referral to MCP CWS Liaison or ECM Provider.	Obtain youth/family approval before referral for ECM outreach. Since ECM is part of managed care, verbal consent should suffice for referral to MCP for ECM services.	SW, PHN
3	Ensure independent ECM provider outreach.	ECM provider will independently engage the family to avoid the perception that ECM services are an extension of CWS, increasing acceptance likelihood.	ECM Provider
5	Include ECM provider in CFT meeting scheduling.	Ensure ECM providers are part of the child's care team discussions.	SW
6	If family agrees to ECM outreach and youth remains in MCP, proceed with engagement steps.	Follow structured outreach steps in the MCP CWS Liaison/ECM Provider Activities section for ECM implementation.	ECM Provider

MCP CWS Liaison/ECM Provider Activities

Step	Task	Details	Responsible Party
1	Coordinate with SW before outreach.	SW and ECM Provider may exchange relevant information before engaging the child/family.	SW, ECM Provider
2	Outreach to birth family and child/youth about ECM services.	ECM Provider directly engages with the family to discuss ECM and other MCP benefits. Families with Indian descent may choose to include their ICWA or tribal representative.	ECM Provider
3	Obtain signed consent and releases of information.	If the family agrees to ECM services and the child is in an MCP, necessary consents and releases must be signed.	ECM Provider, MCP CWS Liaison
4	Initiate ECM eligibility process.	Children/youth involved with CWS are automatically eligible for ECM services. ECM Presumptive Authorization applies, allowing providers to work with members for up to 30 days while authorization from the MCP is pending.	ECM Provider
5	Check prior ECM or Community Support services.	MCP CWS Liaison and/or ECM Provider should verify if the family has received similar services before, and if so, how that may impact this referral.	ECM Provider, MCP CWS Liaison
6	Inform PHN and SW of ECM enrollment.	Notification must be made within five working days for routine authorizations and 72 hours for expedited requests. MCP CWS Liaisons and counties should ensure that SW and PHN receive updates on ECM enrollment.	ECM Provider, MCP CWS Liaison
7	Initiate ECM assessment process.	ECM Provider should coordinate with SW and PHN to avoid unnecessary information duplication and conduct an assessment within 30 days.	ECM Provider, SW, PHN
8	Meet with child/youth and family for assessment.	Gather relevant information, obtain signed consents (if they have not been completed prior), and prepare for the CFT meeting.	ECM Provider

New Cases: CFT Meeting to Dispositional Hearing

County Responsibilities: Before and After the CFT Meeting

Note: Some activities may repeat here if they were not completed prior to the initial CFT meeting.

Step	Task	Details	Responsible Party
1	Follow up with child/youth (if age 12 or older), birth family, and RF before CFT meeting.	Ensure CANS assessment is initiated to inform MCP and ECM decisions. BH-CONNECT will soon require the county and a SMHS provider to conduct the assessment jointly.	SW, PHN
2	Obtain missing health info and complete JV-225.	PHN may conduct a joint visit or directly engage with families.	PHN, SW
3	Review FFS vs. MCP options.	If the child/youth is in FFS, SW and PHN determine if MCP enrollment is beneficial.	SW, PHN
4	Attend and participate in the CFT meeting.	PHN should attend if possible; SW and PHN ensure health needs are addressed. Tribal or ICWA representative participation is encouraged as family/child chooses.	SW, PHN
5	Educate the family on MCP and ECM benefits.	Discuss MCP services, provider options, and case plan goals.	SW, PHN
6	Initiate a team-based process for MCP and ECM selection.	Consider input from birth family, RF, and youth.	SW, PHN
7	Identify services available to birth parents through their MCP.	ECM, community supports, Mental health, substance use treatment, chronic disease management services, and transportation.	SW, PHN, MCP CWS Liaison
8	Obtain signed consent and releases of information.	If the family agrees to ECM services and the child is in and MCP, necessary consents and releases must be signed.	ECM Provider, MCP CWS Liaison

9	If family agrees to ECM services, proceed with enrollment steps.	Follow structured enrollment and selection steps in the **MCP CWS Liaison/ECM Provider Activities** section.	ECM Provider

MCP CWS Liaison and ECM Provider Responsibilities for the CFT Meeting

Step	Task	Details	Responsible Party
1	Resolve ECM enrollment/referral issues before CFT.	MCP CWS Liaison works with SW/PHN to ensure ECM referral or enrollment issues are resolved. Follow structured enrollment and selection steps in the **MCP CWS Liaison/ECM Provider Activities** section.	MCP CWS Liaison, SW, PHN
2	Engage with child/youth and family if ECM enrolled.	ECM Provider gathers information for needs assessment and ECM care plan before the CFT meeting.	ECM Provider
3	Facilitate CANS completion during CFT.	CFT facilitator ensures all parties discuss strengths, needs, and services, informing the case plan and court report.	CFT Facilitator, All Team Members
4	Develop action plan and coordinate care.	CFT team creates an action plan, ensuring ECM and other care providers align efforts.	CFT Team, ECM Provider
5	Coordinate between multiple MCPs if needed.	If the child is in a different MCP than the birth parent, coordinate benefits across MCPs.	SW, PHN, MCP CWS Liaison
6	Obtain final consents.	Ensure all necessary consents for services and information-sharing are secured.	SW, PHN, ECM Provider
7	Update ECM assessment and care plan post-CFT.	ECM Provider revises their care plan based on meeting outcomes.	ECM Provider
8	Follow up with SW/PHN for additional information.	ECM Provider checks with SW/PHN for missing details.	ECM Provider

		ECM Provider and SW should communicate as needed for effective service integration.	

Joint Responsibilities - County and ECM Provider

Step	Task	Details	Responsible Party
1	Maintain ongoing communication.	ECM Provider and SW/PHN should regularly exchange information on youth/family progress.	ECM Provider, SW, PHN
2	Share ECM care plans.	ECM Provider may share the care plan with the SW as needed.	ECM Provider, SW
3	Ensure ECM participation in CFT meetings.	Counties should schedule ECM providers in all relevant CFT meetings.	County Officials, ECM Provider
4	ECM Provider provides updates at CFT meetings.	ECM Provider shares relevant information and supports the child/youth and family.	ECM Provider
5	SW updates court reports/case plan with ECM information.	SWs should document ECM services in case plans and court reports.	SW
6	Attach ECM care plan to the case plan or court report if applicable.	ECM care plans may be attached per local policies.	SW, ECM Provider

New Cases: Family Maintenance (Court/Voluntary)

MCP Selection/Enrollment

Step	Task	Details	Responsible Party
1	Determine if the family/youth is already enrolled in MC.	Check the child's health plan in MEDS with the Eligibility Worker's (EW) assistance.	EW
2	If MC enrolled, obtain documentation.	Provide a copy of the MC card and current health plan enrollment to the resource family and Public Health Nurse (PHN), per local policy if PHN works with FM cases.	EW
3	Check available MCPs.	Use the **MCP County Table** to verify plan options.	EW
4	If not MC enrolled, facilitate application and enrollment.	The EW, with input from SW, and birth parent/youth, will process the Medi-Cal application and determine health plan selection. Assess whether the family wants to continue with their current plan or select another option, if available.	EW, SW, RF, Birth Parent
5	Determine managed care plan (MCP) type based on county.	If in a **single-plan county (COHS)**, foster child/youth is auto-enrolled into MCP. If in a **multiple-plan county**, the child/youth must select an MCP or remain in Fee-for-Service (FFS).	EW
6	Discuss the pros and cons of MCP vs. FFS with the family.	Provide a family-friendly informational packet explaining benefits.	SW
7	Contact Health Care Options for non-urgent changes.	For enrollment into an MCP, call **1-800-430-4263** (8 am - 6 pm, M-F) or visit **www.healthcareoptions.dhcs.ca.gov**.	EW, SW
8	Contact the Medi-Cal Ombudsman for urgent changes.	Call **888-452-8609** (8 am - 5 pm, M-F) or email **MMCDOmbudsmanOffice@dhcs.ca.gov**.	EW, SW
9	Notify parents and youth of the MC plan choice.	Send the appropriate **Notice of Action (NOA) at least 10 days prior** to benefit activation.	EW

ECM Provider Selection

Step	Task	Details	Responsible Party
1	Provide information on ECM and benefits.	SW/PHN should introduce ECM services, provide reading materials, or allow an ECM provider to conduct outreach to the family directly.	SW, PHN
2	Complete referral to MCP CWS Liaison or ECM Provider.	Obtain youth/family approval before referral for ECM outreach. Since ECM is part of managed care, verbal consent should suffice for referral to MCP for ECM services.	SW, PHN
3	Ensure independent ECM provider outreach.	ECM provider will independently engage the family to avoid the perception that ECM services are an extension of CWS, increasing acceptance likelihood.	ECM Provider
4	Include ECM provider in CFT meeting scheduling.	Ensure ECM provider is part of the child's care team discussions. For FM cases, ECM Provider should be included with family consent.	SW
5	If family agrees to ECM outreach and youth remains in MCP, proceed with engagement steps.	Follow structured outreach steps in the **MCP CWS Liaison/ECM Provider Activities** section for ECM implementation.	ECM Provider

MCP CWS Liaison/ECM Provider Activities

Step	Task	Details	Responsible Party
1	Coordinate with SW before outreach.	SW and ECM Provider may exchange relevant information before engaging the child/family.	SW, ECM Provider
2	Outreach to birth family and child/youth about ECM services.	ECM Provider directly engages with the family to discuss ECM and other MCP benefits.	ECM Provider
3	Obtain signed consent and releases of information.	If the family agrees to ECM services and the child is in MCP, necessary consents and releases must be signed.	ECM Provider, MCP CWS Liaison
4	Initiate ECM eligibility process.	Children/youth involved with CWS are automatically eligible for ECM services. ECM Presumptive Authorization applies, allowing providers to work with members for up to 30 days while authorization from the MCP is pending.	ECM Provider
5	Check prior ECM or Community Support services.	MCP CWS Liaison and ECM Provider should verify if the family has received similar services before, and if so, how that may impact this referral.	ECM Provider, MCP CWS Liaison
6	Inform SW of ECM enrollment.	Notification must be made within five working days for routine authorizations and 72 hours for expedited requests. MCP CWS Liaisons and counties should ensure that SWs receive updates on ECM enrollment.	ECM Provider, MCP CWS Liaison
7	Initiate ECM assessment process.	ECM Provider will coordinate with SW and PHN to avoid unnecessary information duplication and conduct an assessment within 30 days.	ECM Provider, SW
8	Meet with child/youth and family for assessment.	Gather relevant information, obtain signed consents (if they have not been completed prior), and prepare for the CFT meeting.	ECM Provider

After CFT Meeting

Step	Task	Details	Responsible Party
1	Confirm ECM service consent and MCP enrollment.	If the family consents to ECM services and is enrolled in an MCP, follow standard referral, outreach, and engagement steps.	SW, ECM Provider
2	Coordinate service access with SW.	ECM Provider works with SW to ensure the family receives necessary services and support.	ECM Provider, SW
3	Share assessments and care plans.	ECM Provider provides SW with copies of assessments, care plans, and progress updates.	ECM Provider, CSW
4	Ensure ongoing care coordination.	ECM Provider and SW maintain regular communication and share relevant updates.	ECM Provider, SW
5	Resolve ECM enrollment/referral issues.	MCP CWS Liaison works with the SW to address any challenges in ECM enrollment or referrals.	MCP CWS Liaison, SW

Existing Cases

County Responsibilities

(for cases that opened prior to CalAIM/ECM launch)

Step	Task	Details	Responsible Party
1	Review caseloads for MCP and ECM benefits.	Counties should assess if youth, NMD, or families would benefit from MCP enrollment and ECM services.	SW
2	Determine Medi-Cal enrollment status.	Check the child/youth/NMD's health plan in MEDS with the Eligibility Worker's (EW) assistance.	EW
3	Obtain documentation if MC enrolled.	Provide a copy of the MC card and current health plan details to the resource family and Public Health Nurse (PHN).	EW
4	Check available MCPs.	Use the **MCP County Table** to verify plan options.	EW
5	Determine managed care plan (MCP) type based on county.	If in a **single-plan county (COHS)**, foster child/youth is auto-enrolled into MCP. If in a **multiple-plan county**, the child/youth must select an MCP or remain in Fee-for-Service (FFS).	EW
6	Assess child/youth's healthcare needs.	SW and PHN review known health care needs, service access, and enrollment status. Determine if they are utilizing mental health or other needed services through their MCP.	SW, PHN
7	Check if birth parents are enrolled in an MCP.	This may help determine their eligibility for CalAIM services to aid reunification. Birth parents can be provided materials to enroll in a managed care plan and ECM services if they are not already enrolled. Materials such as this At A Glance publication from Public Works Alliance can be used or created for county use.	SW
8	Discuss the pros and cons	Provide a family-friendly informational packet explaining benefits. Engage	PHN

	of MCP vs. FFS with the birth family and RF.	child/youth (if over 12), birth parents (if FR), and RF to assess healthcare needs and continuity of care preferences. NMDs should be empowered to make their plan decisions.	
9	Contact Health Care Options for non-urgent changes.	For enrollment into an MCP, call **1-800-430-4263** (8 am - 6 pm, M-F) or visit **www.healthcareoptions.dhcs.ca.gov**.	EW, SW
10	Contact the Medi-Cal Ombudsman for urgent changes.	Call **888-452-8609** (8 am - 5 pm, M-F) or email **MMCDOmbudsmanOffice@dhcs.ca.gov**.	EW, PHN
11	Notify parents and youth of the MC plan choice.	Send the appropriate **Notice of Action (NOA)** **at least 10 days prior** to benefit activation.	EW

SW and PHN Ongoing Responsibilities with the ECM Provider

Step	Task	Details	Responsible Party
1	Complete outstanding healthcare steps.	Ensure necessary referrals, releases, and ECM provider assessments are finalized.	CSW, PHN, ECM Provider
2	Document ECM services in case plan and court reports.	If the child/youth is enrolled in ECM, include it in case documentation and coordinate with providers.	CSW, ECM Provider
3	Update ECM care plan.	ECM care plan should be reviewed and updated every 6 months.	ECM Provider
4	Plan for transition to case closure.	Ensure ongoing ECM services for the family, TAY, or NMD as CWS services end.	CSW, PHN, ECM Provider

Health Care Coordination

Note: Health care coordination services are provided to youth who are in out of home care.

Intake Health Care Coordination Steps

Step	Task	Details	Responsible Party
1	Provide the birth family with a copy of the **JV 225** form.	This should be done as early as possible to begin gathering health information. Share the information with the PHN and RF.	SW, PHN
2	Engage with the child/youth, NMD, and birth family regarding current healthcare providers.	Discuss any current providers, quality of care, and continuity of care options.	SW, PHN
3	Engage with RF regarding their ability to meet the youth's needs.	Ensure RF can meet the child/youth's health, mental health, and developmental needs.	SW, PHN
4	Ensure immediate healthcare needs are met within the first 30 days.	Prioritize keeping the child/youth with current providers when possible.	PHN, SW

Ongoing Health Care Coordination

Step	Task	Details	Responsible Party
1	PHN collects additional healthcare information.	Gather and document details about medical history, appointments, and provider preferences.	PHN
2	Schedule any necessary medical appointments.	Ensure timely care for developmental, mental health, and general health needs.	PHN
3	Contact the Ombudsman at Health Care Options for enrollment/ disenrollment issues.	Resolve any discrepancies or urgent issues related to the child/youth's MCP enrollment.	PHN
4	Contact MCP CWS Liaison for benefit navigation.	Work with the liaison to resolve service issues or access additional supports.	PHN

Out-of-County Placement

Note: Youth moving counties are entitled to Continuity of Care. If the child/youth is in one of 37 counties that is known as "single plan" or "county organized health system" (COHS) and moves to a different county, the county has 24 hours to determine the child/youth's plan of enrollment (**18-02E**). If a youth is moving out of a COHS, the DHCS Ombudsman can disenroll them within 24 hours by emailing **MMCDOmbudsmanOffice@dhcs.ca.gov**. Youth moving into COHS counties will be automatically enrolled in the MCP; youth moving to a multi-plan county, may be switched back to FFS until one of the county's MCPs is selected. However, enrollment into a new managed care plan cannot occur until new address is updated.

County Responsibilities

(if a child/youth is enrolled in MCP and ECM)

Step	Task	Details	Responsible Party
1	Assess existing health care needs.	SW and PHN discuss child's current MCP coverage and its availability in the new county. Check if a plan operates in both placement and origin counties.	SW, PHN
2	Evaluate impact of switching MCPs.	Consider changes to healthcare and ECM benefits that would occur if the youth switched plans.	SW, PHN
3	Assess provider continuity preferences.	Discuss healthcare preferences for the new placement. Determine if the child, RF, or birth family prefers to remain with the current provider.	SW, PHN
4	Check eligibility for Continuity of Care.	Identify if the child has health conditions qualifying them under **APL 22-032**.	SW, PHN
5	Decide on MCP enrollment or Fee-for-Service (FFS).	Update MCP choice in case plan and update Health and Education Passport (HEP).	SW, PHN
6	Update MEDS address.	Address must be updated immediately upon placement.	EW
7	Send Notice of Action (NOA).	EW issues a **10-day NOA** if applicable.	EW

MCP CWS Liaison and ECM Provider Responsibilities

Step	Task	Details	Responsible Party
1	Ensure continuity of care when MCP changes.	MCP CWS Liaisons from both previous and new plans may connect to maintain services and apply continuity of care with providers. *This would be best practice but can vary based on each individual MCP	MCP CWS Liaison
2	Assess need for a new ECM provider if child/youth moves far from existing provider.	Consider distance, service needs, and whether virtual or in-person services are required.	ECM Provider, MCP CWS Liaison, SW
3	Maintain ECM services if provider is contracted.	MCP CWS Liaison should assess if existing ECM provider can continue supporting the youth. If the current ECM provider is the best fit, maintain services even if there is an MCP change.	ECM Provider, MCP CWS Liaison, SW
4	Identify new ECM provider if needed.	ECM provider may help locate a new provider if they cannot continue working with the youth.	ECM Provider, SW
5	Transfer information to the new ECM provider.	If a new provider is needed and transition is non-disruptive, ensure information transfer with proper consents. This may include assessment and care plan details.	ECM Provider, MCP CWS Liaison, SW
6	Conduct a warm hand-off between ECM providers.	Best practice is for the outgoing and incoming ECM providers to coordinate with the SW, ideally at a CFT meeting.	ECM Provider, SW

Case Closure: Reunification, AAPLA, Guardianship, NMD

Step	Task	Details	Responsible Party
1	Inform the ECM provider.	Once the case is ready to close, inform the ECM provider if the family is going to continue services or not. Can be outlined in the child/youth's after care plan/CFT Meeting Action Plan.	SW
2	Continuation of services.	ECM services can continue without an open case for children, youth, NMD and families who no longer have a CWS open case which includes cases that have finalized adoption or guardianships. Youth may participate until age 26.	ECM Provider

Prevention Pathway

Note: Within the Prevention Pathway, County Comprehensive Prevention Planning (CPP) leads should meet with their CPP providers to orient them to ECM and the MOU established with local Managed Care Plans. This includes sharing the following steps that case management providers can engage in to refer to ECM services, when eligible. The following information should be shared with community providers delivering prevention services and/or providing prevention case management and embedded within contracts with community-based providers for CPP efforts, as appropriate.

Community Pathway Provider Activities

Step	*Task*	*Details*	*Responsible Party*
1	Collect Medi-Cal status	Determine if the family is enrolled in Medi-Cal and if they are assigned to a Managed Care Plan (MCP).	Intake/Case Manager (CM), EW
2	Discuss MCP options and benefits	If the family is on Medi-Cal but is not enrolled in an MCP, review available options and explain the benefits of enrollment. For enrollment into an MCP, call **1-800-430-4263** or visit www.healthcareoptions.dhcs.ca.gov	CM, , EW
4	Introduce ECM services.	Provide information on ECM benefits and how it supports care coordination for the family.	CM
5	Refer family for ECM services	If the family verbally agrees to ECM, submit a referral to the MCP using the state universal ECM form or directly to a known ECM provider in the family's community.	CM, EW
6	Coordinate services with ECM provider	Once enrolled in ECM, collaborate with the ECM provider to ensure the family's needs are being met.	CM, ECM Provider

ECM Provider Activities

Step	Task	Details	Responsible Party
1	Engage family after ECM approval.	Once enrolled in ECM, the ECM provider contacts the family to begin engagement.	ECM Provider
2	Conduct ECM needs assessment.	ECM provider collects relevant information to develop an ECM care plan tailored to the family's needs.	ECM Provider
3	Inform ECM care plan.	Use assessment findings to create a care plan that addresses the family's health and social service needs.	ECM Provider
4	Coordinate with referring party.	Communicate with the referring SW, CM, or MCP Liaison to ensure service alignment.	ECM Provider, CM, MCP Liaison
5	Collaborate with other service providers.	Work with other organizations and professionals supporting the family to ensure cohesive care.	ECM Provider