



CalAIM/Medi-Cal Transformation: Promoting Whole-Person Care through CalAIM Services

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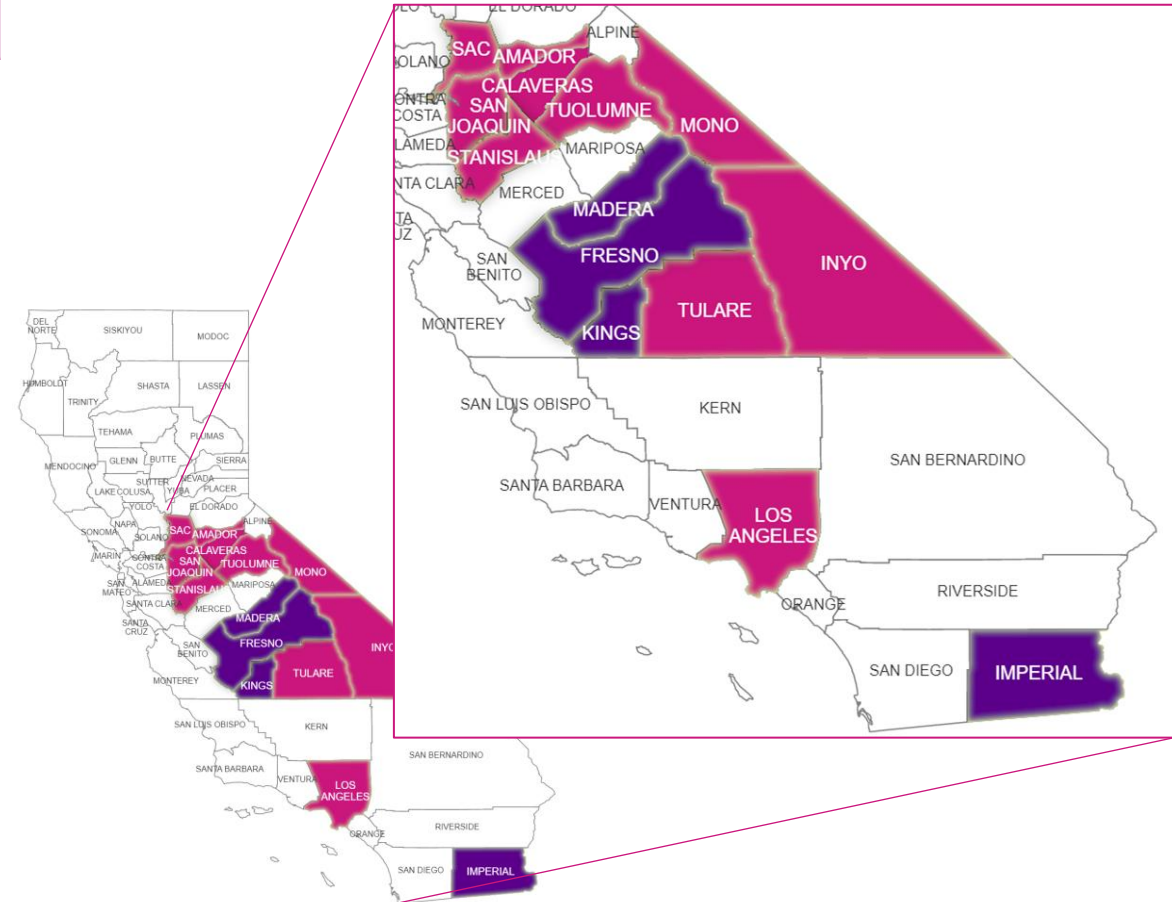
Agenda

- Welcome and Introductions
- Overview of:
 - Child Welfare Population of Focus for Enhanced Care Management (ECM);
 - Community Supports (CS) Services
 - Child Welfare Liaison Scope
 - MCP-Child Welfare MOU
- Q&A



Health Net Medi-Cal Footprint in 2024

Based on the latest DHCS announcement



3+ Million Members



90,000+ Providers



Multicultural Health Care Distinction

by the National Committee for Quality Assurance



5,700+ Health Net and Centene Employees



25+ Years Medi-Cal



Founded 1979



Health Net Community Solutions
Direct Contract with DHCS

Local County Partners
Subcontractor to local plan

CalAIM Overview

Medi-Cal has created new and expanded benefits focused on children and prevention

ECM and Community Supports

Effective July 2023

- Provides comprehensive case management for eligible beneficiaries, across systems of care
- Provides specific concrete supports to families as alternatives to traditional medical services or settings



Family Therapy

Effective 2021

- Available to support members under age 21 to receive sessions before a mental health diagnosis is required.
- Provided by **managed care plans** under Medi-Cal's Non-Specialty Mental Health Services

Dyadic Care

Effective March 2023

- Recognizes the critical role of the child's caregivers' health in promoting positive outcomes and healthy child development
- Allows eligible providers to address parent/child by billing services via the CHILD's Medi-Cal number

Community Health Worker

Effective July 2022

- CHW services are preventive health services delivered by a CHW to prevent disease, disability, and other health conditions and their progression
- Covered Services:
 - Health education
 - Health navigation
 - Screening and assessment
- Individual support and advocacy

Children & Youth Involved in Child Welfare



Children & Youth who meet one or more of the following conditions:

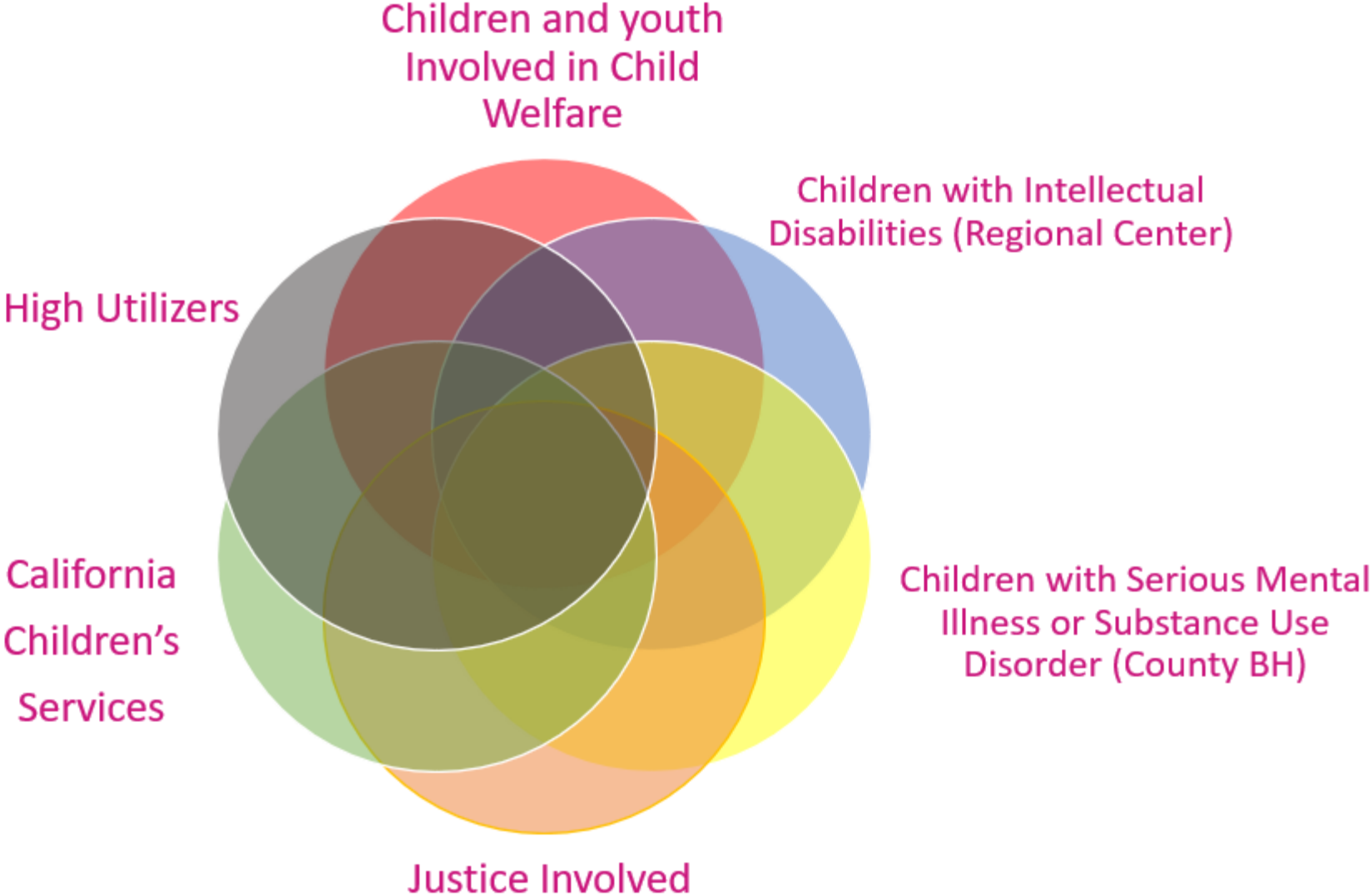
- (1) Are under age 21 and are currently receiving foster care in California;
- (2) Are under age 21 and previously received foster care in California or another state within the last 12 months;
- (3) Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later)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

Notes on the Definition:

- Foster care is defined in California by WIC 11400(f).
- California's Adoption Assistance Program is defined by WIC 16120.
- California's Family Maintenance program is defined by WIC 16506 and designed to support a child or youth remaining in a safe, secure, stable home.

Children and Youth are often engaged with multiple systems of care

ECM is intended to provide a **single point of accountability** to ensure care management across multiple systems/programs — the “air traffic control” role










CalAIM's Community Supports (CS)

- Medically appropriate and cost-effective alternatives to state plan services.
- These services provide considerable flexibility for plans to go beyond services defined in the Medicaid state plan to address social needs.










- 1) Housing Transition Navigation Services
- 2) Housing Deposits
- 3) Housing Tenancy & Sustaining Services
- 4) Short-Term Post-Hospitalization Housing
- 5) Recuperative Care (Medical Respite)
- 6) Respite Services
- 7) Day Habilitation Programs
- 8) Nursing Facility Transition (NFT)/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) & Adult Residential Facilities (ARF)
- 9) Community Transition Services/NFT to a Home
- 10) Personal Care & Homemaker Services
- 11) Environmental Accessibility Adaptations (Home Modifications)
- 12) Medically-Supported Food/Meals/Medically Tailored Meals
- 13) Sobering Centers
- 14) Asthma Remediation

Community Support Overview

Community Supports service	What you can get	Community Supports service	What you can get
Housing Transition Navigation Services 	<p>Help with getting housing. This may include help with:</p> <ul style="list-style-type: none"> Looking for a place to live or housing. How to apply for housing. Making a housing support plan. <p>You may be able to get services if you:</p> <ul style="list-style-type: none"> Are listed for housing help through the local homeless Coordinated Entry System, or similar system. Are experiencing homelessness. Are at-risk of becoming homeless. 	Recuperative Care (Medical Respite) 	<p>Short-term housing care for those who no longer need to be in a hospital but still need to heal from injury or illness.</p> <p>You may be able to get services if you:</p> <ul style="list-style-type: none"> Are at-risk of needing to be in the hospital, or are just out of the hospital. Live alone with no formal support. Face the prospect of having no housing. Or, you have housing that could harm your health without upgrades.
Housing Tenancy and Sustaining Services 	<p>Help with keeping your housing once you've moved in. This may include support with budgeting, timely rent payments, and understanding lease agreement rights and responsibilities.</p> <p>You may be able to get services if you:</p> <ul style="list-style-type: none"> Receive Housing Transition/Navigation services Are listed for housing help through the local homeless Coordinated Entry System, or a system like it. Are experiencing homelessness. Are at-risk of being homeless. 	Respite Services 	<p>Short-term relief given to caregivers of those who need care or support on a short-term basis.</p> <p>You may be able to get services if you:</p> <ul style="list-style-type: none"> Live in a place that limits your daily activity. Are needing a caregiver to provide most of your support. Need caregiver relief to avoid being placed in a nursing home or someplace like it.
Housing Deposits 	<p>Help with getting housing. This includes:</p> <ul style="list-style-type: none"> Security deposits to get a lease. First month's coverage of utilities. First and last month's rent if required before move-in. <p>You may be able to get services if you:</p> <ul style="list-style-type: none"> Receive Housing Transition/Navigation services. Are listed for housing help through the local homeless Coordinated Entry System, or a system like it. Are experiencing homelessness. 	Short-Term Post-Hospitalization Housing 	<p>A place where you can keep getting care for mental, or substance use disorder needs as soon as you leave a hospital.</p> <p>You may be able to get services if you:</p> <ul style="list-style-type: none"> Are leaving healing care. Are leaving an inpatient hospital. Meet the HUD meaning of homeless.
		Sobering Centers 	<p>A place where you can get help with alcohol or problems with drinking rather than being taken to an emergency department or jail instead.</p> <p>You may be able to get services if you are:</p> <ul style="list-style-type: none"> Aged 18 and older and are drunk. Taken to an emergency department or a jail. Sent to an emergency department and are a good fit for a Sobering Center.

Community Support Overview

Community Supports service	What you can get
Asthma Remediation 	<p>Changes to a home to get rid of harmful asthma triggers.</p> <p>You may be able to get services if you:</p> <ul style="list-style-type: none"> • Have had poorly controlled asthma in the past 12 months as defined by: <ul style="list-style-type: none"> - An emergency department visit. - Being admitted into a hospital. - Two sick or urgent care visits. • Have a score of 19 or lower on the asthma control test.
Day Habilitation Programs 	<p>Programs given to help you learn the skills needed to live in home-like settings. They can include training on use of public transportation or how to prepare meals.</p> <p>You may be able to get services if you:</p> <ul style="list-style-type: none"> • Are experiencing homelessness. • Are no longer homeless and have entered housing in the last 24 months. • Are at-risk of being homeless. Or, home-like setting could be improved.
Environmental Accessibility Adaptation (Home Modifications) 	<p>Changes to a home for your health and safety. Also, changes that allow you to function freely in the home. These may include ramps and grab bars.</p> <p>You may be able to get services if you:</p> <ul style="list-style-type: none"> • Are at-risk for being placed into a nursing home.
Meals/Medically Tailored Meals/ Medically Supportive Foods 	<p>Meals that are delivered to your home that are prepared and cooked based on your health and diet needs. This includes meals needed after you are released from the hospital.</p> <p>You may be able to get services if you:</p> <ul style="list-style-type: none"> • Have chronic conditions. • Are released from the hospital or skilled nursing home. • Are high risk of being admitted to a hospital or nursing home placement. • Have major care management needs. • Are assessed by a registered Dietitian or licensed Nutrition Professional.

Community Supports service	What you can get
Nursing Facility Transition/ Diversion to Assisted Living Facilities 	<p>Services given to help you move out of a nursing home to community settings, like an assisted living facility. This can also be services to keep you from being placed in a nursing home.</p> <p>You may be able to get services if you:</p> <ul style="list-style-type: none"> • Nursing Home Transition <ul style="list-style-type: none"> - Have lived 60+ days in a nursing home. - Are willing to live in an assisted living facility (a place to help you with your daily medical needs) as an option to a nursing home. - Can live safely in an assisted living facility with support. • Nursing Home Diversion <ul style="list-style-type: none"> - Want to stay in the community. - Are willing and able to live safely in an assisted living facility with support. - Are now getting nursing home services or meet the lowest standard to get nursing home services.
Community Transition Services/ Nursing Facility Transition to a Home 	<p>Services given to help you if you're moving from a nursing home to a home setting where you have to pay for living costs.</p> <p>You may be able to get services if you:</p> <ul style="list-style-type: none"> • Are now getting a medically needed nursing home level of care. • Have lived 60+ days in a nursing home and/or Medical Respite setting. • Want to move back to the community. • Can live safely in the community with support services.
Personal Care and Homemaker Services 	<p>Services provided to help you with your daily living needs, such as:</p> <ul style="list-style-type: none"> • Bathing • Dressing • Housecleaning • Grocery shopping <p>You may be able to get services if you are:</p> <ul style="list-style-type: none"> • At-risk for being admitted to a hospital or placed in a nursing home. • A person that needs day-to-day help and have no other support system. • Approved for In-Home Supportive Services.

Respite Services

Respite services are provided to caregivers of members who require intermittent temporary supervision. The services are provided on a short-term basis due to the absence or need for relief of the nonmedical caregiver. These services are distinct from medical respite/recuperative care and provide rest for the caregiver only.

Respite Services can include any of the following:

Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.

Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.

Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

Home Respite Services are provided to the Member in his or her own home or another location being used as the home.

Facility Respite Services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Members must meet the following criteria to qualify for Respite Services:

Members who live in the community and are compromised in their activities of daily living (ADL) and dependent on a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include: Children who previously were covered for respite services under the Pediatrics Palliative Care Waiver; Foster care program beneficiaries; Members enrolled in California Children's Services or Genetically Handicapped Persons Program (CHPP); and Members with complex care needs.



Assessment, Care Planning and Collaborating Across Teams

The Goal: A Comprehensive Care Plan

ECM Providers should leverage Child Welfare's comprehensive assessment and care plan to inform the ECM care management plan development

Care management plans should incorporate the member's needs and strategies across the areas of:

- Physical Health Care
- Mental Health Care
- SUD Care
- Oral Health Care
- Social Supports
- SDOH Care

Reminders:

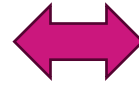
- **Services need to be coordinated and not duplicative of services provided through related child welfare programs.**
- **Children do not have to be enrolled in ECM to qualify for CS services**



Care Management for the Member also Enrolled in Child Welfare

ECM Services

- Outreach and Engagement
- Comprehensive Assessment and Care Management Planning
- Enhanced Coordination of Care
- Health Promotion
- Comprehensive Transitional Care
- Member and Family Supports
- Coordination of and Referral to Community Social Support Services



HCPCFC Case Management Service Components

- Medical and Health Care Case Planning
- Help Foster Caregivers to Obtain Timely Comprehensive Health Assessments and Dental Examinations
- Expedite Referrals for Medical, Dental, Mental Health, and Developmental Services
- Coordinate Health Services for Children in Out-of-County and Out-of-State Placements
- Provide Medical Education through the Interpretation of Medical Reports and Training for Foster Team Members on the Special Health Care Needs of Children and Youth in Foster Care
- Participate in the Creation and Updating of the Health and Education Passport for Every Child as Required by Law

CA Wraparound Case Management Service Components

- A Process for strengths-based planning using a team setting that:
 - Enhances strengths by creating a strength-based intervention plan with a child and family team
 - Promotes youth and parent involvement with family voice, choice, and preference
 - Uses community-based services
 - Creates independence and stability
 - Provides services that fit a child and family's identified needs, culture, and preferences
 - Creates one plan to coordinate responses in all life domains
 - Focuses on achieving positive goals

Tip: By identifying gaps in care, you can identify where ECM and/or CS can add additional services and address gaps in care..

Eligible populations of children and youth

ECM Populations of Focus (POFs)	Adults	Children
Individuals Experiencing Homelessness: <i>Adults without Dependent Children/Youth Living with Them Experiencing Homelessness</i>	●	
Individuals Experiencing Homelessness: <i>Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness</i>	●	●
Individuals At Risk for Avoidable Hospital or ED Utilization (<i>Formerly "High Utilizers"</i>)	●	●
Individuals with Serious Mental Health and/or SUD Needs	●	●
Individuals Transitioning from Incarceration	●	●
Adults Living in the Community and At Risk for LTC Institutionalization	●	
Adult Nursing Facility Residents Transitioning to the Community	●	
Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		●
Children and Youth Involved in Child Welfare		●
Birth Equity Population of Focus	●	●

Coordinating care across existing systems and services for children and youth

Existing programs with a care coordination/care management component serve many of the same children and youth who could be served in ECM

- Intensive Care Coordination (ICC) through County Mental Health's Specialty Mental Health Services
- California Children's Services (CCS) through DPH
- Child Welfare Public Health Nurses through DPH
- Family Maintenance Program through County Child Welfare
- Child and Family Teams through County Child Welfare
- Independent Living Program through County Child Welfare
- Adoption Assistance Program through County Child Welfare

ECM adds an intentional focus on health services and can fill care coordination gaps across systems of care for populations that may not be eligible for these programs.



Note: Managed Care Plans are responsible to ensure nonduplication of services

ECM can support the entire continuum of children/families involved in the child welfare system

Eligible families	Examples of How ECM/CS Can Fill Service Gaps
Currently or previously in Foster Care	<ul style="list-style-type: none"> • Provide coordination with primary care provider and health plan • Ensure health-related services are received and monitored • Coordinate supportive care/extracurricular activities to build the relationship between caregiver and child
Family Maintenance	<ul style="list-style-type: none"> • Case management and supporting connections to economic and other community services • Enrollment in family-based mental health services (Family Therapy) • Enrollment in community supports, such as medically tailored meals, and asthma remediation • Provide continuity of care after the Family Maintenance case is closed • Enrollment of caregiver(s) in ECM (if applicable)
Adoption Assistance Participants	<ul style="list-style-type: none"> • Aftercare and care coordination services to support adoptive families who may not be receiving other types of case management services • Ensure health-related services are received and monitored • Enrollment in community supports, such as medically tailored meals, and asthma remediation



Current opportunity

The new guidance from CDSS anticipates child welfare agencies begin implementing child and family teams (CFTs) for all families in voluntary and court-ordered Family Maintenance programs on Jan 1, 2025.

Current FY23-24 funding available for county readiness and workforce training activities to support anticipated implementation of Family Maintenance Child and Family Teams

- “Intentional engagement of local community partners who can support programs that build youths’ strengths, wellbeing, and permanency within the CFT framework in FM cases.”
- “Training and technical assistance to prepare FM CFT facilitators to collaborate with ECM providers”

[ACL 24-24, Funding for County Readiness and Workforce Training Activities to Support the Implementation of Family Maintenance Child and Family Teams \(ca.gov\)](#)

[CLAIMING INSTRUCTIONS FOR WORKFORCE TRAINING AND COUNTY READINESS ACTIVITIES TO SUPPORT CHILD AND FAMILY TEAMS \(CFT\) FOR FAMILY MAINTENANCE \(FM\) CASES](#)



You can support families in accessing eligible benefits

How to refer



Complete the ECM Referral Form and send to managed care plan or Connect directly with a local ECM provider.



Share Contact List of county child welfare social worker with ECM provider or Create workflow for county child welfare social worker to receive ECM provider inquiry about a dependent.



Members can self-refer; Once enrolled in ECM, ECM provider can reach out to county child welfare social workers for care plan coordination. MOU is an opportunity to include all needed details.

Call to action

- **Help us identify eligible children and families!**
 - Children and youth involved in child welfare are eligible
 - Family members/caregivers may be eligible
- **Work with your local child welfare county regional office to:**
 - Present at an upcoming monthly meeting
 - Map the current practice and process for Fee for Service vs. Managed Care plan enrollment
 - Explore referral pathways to ECM providers in your service area
 - Connect you with your local ECM provider(s)



Health Net Child Welfare Liaison

Health Net Child Welfare Liaison

Health Net will have a team of individuals designated to serve as the Child Welfare liaisons for all service areas. Additional liaisons will be added/designated as needed to ensure the needs of children and youth, and families, involved with child welfare are met.

- Health Net's Child Welfare liaison(s) will follow DHCS-issued standards and expectations as set forth in DHCS APLs or other similar guidance. Health Net's Child Welfare liaison(s) will:
 - ✓ Have experience working with Child welfare services, and County Behavioral Health services.
 - ✓ Ensure appropriate ECM staff, including the ECM Lead Care Manager whenever possible, attend Child and Family Team meetings, as requested by local County Child Welfare, in accordance with relevant W&I Code(s) & section(s), and ensure that Covered Services are closely coordinated with other services, including social services and Specialty Mental Health Care Services.
 - ✓ Ensure streamlined coordination of ECM and other Covered services to child welfare-involved children and youth, by providing technical assistance as needed, and serving as the MCP point of contact for escalations to support the resolution of any operational obstacles.
 - ✓ Be sufficiently trained on County Care Coordination and assessment processes.
 - ✓ Coordinate with foster care liaisons at other Medi-Cal managed care plans to notify them when Members cross county lines and/or change managed care plans.
 - ✓ Also serve as a family advocate, as needed, on a case-by-case basis.

Health Net Child Welfare Liaison: Member Story

- 11-year-old boy with ADHD, seasonal allergies, extremely swollen tonsils and adenoids, and severe sleep apnea, in a foster home placement in County "X." Minor is exhibiting behavioral issue within the placement home, as well as frequent non-compliant behaviors at school.
- Minor is receiving BH services through County "X" Behavioral Health Department. He is participating in therapy, and he is prescribed ADHD medication. Minor has an Individual Education Plan (IEP), and is scheduled to have a sleep study, as well as a surgery to have his tonsils and adenoids removed within the coming weeks.
- The current Resource Parent is no longer able to effectively deal with his home and school behaviors and reports not having the energy to provide him with the level of care and intervention that he needs.
- The County Social Worker was notified of a new placement need.

Plan Liaison Support

County Social Worker contacts the Plan Liaison requesting support.

The Plan Liaison fields the request and locates the appropriate HN resources to meet the child's the needs.

The Plan Liaison stays in close contact with the County Social Worker, and provides the information or Plan representative to support the request.

As needed the Plan Liaison will advocate and escalate internally within HN for the County Social Worker and/or the Member's need.

Memorandums of Understanding (MOUs): MCP-Child Welfare

MCP-Child Welfare MOUs

- Medi-Cal Managed Care Plans (MCPs) Contract with the California Department of Health Care Services (DHCS) to provide high-quality, accessible, and cost-effective health care through managed care delivery systems.
- The MCP Contract with DHCS requires MCPs to build partnerships with designated County Departments/Programs and Other Third-Party Entities to ensure Member care is coordinated and Members have access to community-based resources to support whole-person care.
- MOUs are intended to be effective tools to clarify roles and responsibilities between MCPs and County Departments/Programs or Third-Party Entities, support local engagement and the exchange of information necessary to enable care coordination, as well as and improve referral processes and streamline access to services.

Successes:

- ✓ Health Net is successfully collaborating with Plan partners and Child Welfare Departments/teams in all counties/service areas to engage in MOU discussions and execution efforts.
- ✓ Execution efforts are underway, and Health Net has successfully submitted three “good-faith-efforts” MOU Quarterly Reports to DHCS.

Challenges:

- ✓ In many counties/service areas, substantial language changes (additional language) have been proposed to the DHCS template language – will likely impact execution timeline.
- ✓ In many counties/service areas, a growing area of concern (post-execution) is around the requirements for information exchange/data sharing between MCPs and Child Welfare Departments.



Frequently Asked Questions (FAQs)

FAQs

1. How can social workers/foster families check PCP assignment? If they call customer service on behalf of the youth, will the agent talk to a social worker?

- To speak with social workers or foster families/resource parents about member care, Health Net will first need proof of dependency, placement, and ROI naming those with whom we are authorized to speak.
- It would be great if County Child Welfare/Social Worker(s) could email the required documents 24 to 48 hours in advance of the outreach to the health plan (if possible).
- County Child Welfare/Social Worker will send correspondence to Health Net Child Welfare Liaison/Public Programs Team's designated inbox. Correspondence should be sent via secure (encrypted) email.
 - **Subject Line** should contain first letter of member first name, and member last name, followed by Release of Information (*example: J. Smith Release of Information*).
 - **Body of email** should contain member full name, date of birth, and Benefit Information Number (BIN).

❖ *County Child Welfare/Social Workers*

- County Child Welfare/Social Worker(s) should reach out directly to the HN Child-Welfare Liaison/Public Programs Team. HN Child-Welfare Liaison/Public Programs Team can provide relevant information (PCP assignment, etc.) and support with any issues impacting care/service delivery.
- County Child Welfare/Social Worker(s) may contact the HN Child-Welfare Liaison/Public Programs Team via one of the following:
 - HN Child-Welfare Liaison/Public Programs Team designated inbox (will be provided soon)
 - HN Child-Welfare Liaison/Public Programs Team designated dial-in number (will be provided soon)

❖ *Foster Families/Resource Parents*

- Foster families/resource parents should contact Health Net Member Services.
- Member Services representative can provide relevant information and support (PCP assignment, support with changing PCP assignment, etc.).
- Foster families/resource parents may contact Member Services via the following:
 - Health Net Member Services **1-800-675-6110**



FAQs

2. How does a social worker/family update the child/youth's PCP assignment?

- County Child Welfare/Social Worker(s) may contact HN Child-Welfare Liaison/Public Programs Team (see above).
- Foster Families/Resource Parents may contact Member Services (see above).

3. How can they find out which PCPs have availability?

- **All** parties should reach out to Health Net Member Services these requests, as Member Services reps are able to perform PCP availability checks.

4. Can the MCPs create an expedited PCP assignment pathway for child welfare-involved youth?

- **Not sure this will be possible, but it is currently under review.**

5. Does the MCP have a point of contact to help identify PCPs available to inform placement? How do we find out who this is? Do you have a centralized inbox that could be used for information? What is the turnaround time for answering inquiries into that inbox?

- Yes, the point of contact will be someone from the HN Child-Welfare Liaison/Public Programs Team
- HN Child-Welfare Liaison name(s), designated inbox and dial-in info will be provided soon.
- Turnaround time for answering inquired is as follows:
 - Response within 24 hours (1 business day).
 - **Note:** Resolution may take longer depending on the circumstances/case-specifics

6. What happens when a child moves placements, and they are awaiting primary care provider change to take effect on the first of the next month, but they need to see a Doctor ASAP?

- If the need is urgent, but not an emergency, the member can be seen at a local Urgent Care.
- If emergency, member should be taken to the E.R.

7. If they are in ECM and change placements/move to a new county, can they keep the same ECM provider?

- This would only be possible if the ECM provider is a regional or state-wide provider.
- Since ECM best-practice is to provide hands-on, in-person support, the member will likely be transitioned to an ECM provider in the new county. That said, the current ECM provider can support with the transition and linkage to the new ECM provider.



Health Plan Tools for Child Welfare and ECM Providers

Swim Lane – Delineation of Roles for Members Involved in Child Welfare

Steps	Health Plan	CW Providers (CA Wraparound Care Coordinators, HCPCFC Public Health Nurses, County Child Welfare Program Staff, etc.)	ECM Provider*	Other Providers (e.g., PCP, specialists, school, CBOs, public health and social services programs)	Family (Biological family, foster family, relative caregiver, adopted family)
IDENTIFICATION	Use available data for timely identification	May refer to the MCP if they suspect eligibility criteria are met		May refer to the MCP if they suspect eligibility criteria are met	May self-refer
OUTREACH AND ENGAGEMENT			ECM Services offered to the member** and consult with other providers as appropriate		
COMPREHENSIVE ASSESSMENT AND CARE MANAGEMENT PLANNING		Develops and Maintains the following, as applicable: Wraparound Plans (CA Wraparound), Care Plans and Health Education Passports (HCPCFC)	Complete assessment and develop care plan, leveraging existing assessments where appropriate		
COORDINATING CARE	Facilitates assignment to the ECM Provider (preferably the existing CW Provider, if ok with the family) Foster Care Liaison facilitates connections to health plans and foster care agency partners		Whole-child care coordination, acting as “air-traffic control”, facilitating access to services, helping with transition planning, and ensuring foster families have the knowledge and resources needed. This includes consultation was the Member’s CFT, as applicable		
SERVICES	Ensures there is no duplication of care/case management services	Provides services, in accordance with their program and professional scope		Provides services, in accordance with their practice and professional scope	

*If the ECM provider is also the CW provider, or other provider such as the PCP or a local CBO, they would incorporate these roles into their existing workflows

**If the member’s CW Provider is also their ECM Provider, ECM services could be provided where the member receives their California Wraparound or HCPCFC services.

Coordinating Transportation

TRANSPORTATION SERVICES

- Medi-Cal offers transportation to and from appointments for services covered by Medi-Cal.
- This includes transportation to medical, dental, mental health, or substance use disorder appointments, and to pick up prescriptions and medical supplies.
- There are two types of transportation for appointments
 - Non-emergency medical transportation (**NEMT**) is transportation by ambulance, wheelchair van, or litter van for those who cannot use public or private transportation. (All NEMT services require a Physician Certification Statement (PCS) form which validates the level of service).
 - Non-medical transportation (**NMT**) is transportation by private or public vehicle which includes car, van, taxi, rideshare and mass transit.

HOW TO ARRANGE A RESERVATION

- Contact the Plan's Customer Service and choose the transportation option to be connected to ModivCare.
 - ModivCare is our contracted transportation vendor for NEMT and NMT.
 - Advance notice is required when arranging the different levels of transportation:
 - NEMT: 48 hours
 - NMT: 24 hours
- *Advanced notice is not required for members who need to seek medical attention for the following urgent appointments and treatment types: dialysis, chemotherapy, radiation therapy, urgent care, wound care & discharges
- Urgent trips may take up to 4 hours to complete
- Please have the following information available when reserving a ride:
 - Member ID
 - Name and address of doctor/specialist
 - Appointment date/time
 - Pick-up time and address

**Medi-Cal members may be assigned to Medical Groups responsible for arranging Non-Emergency Medical Transportation (NEMT). When contacting ModivCare, they will verify if the member is assigned to a Medical Group responsible for arranging NEMT and refer the caller to the number on the back of the member's card for the assigned Medical Group.*

Thank You!

Harout Torosian

Vice President, Medi-Cal Regional Lead

Harout.N.Torosian@healthnet.com

Counties Covered: Fresno, Kings, and Madera counties (CalViva Health)

Kathleen Lang

Vice President, Medi-Cal Regional Lead

KLang@healthnet.com

Counties Covered: Imperial County
(Community Health Plan of Imperial Valley)

Vernell Shaw III

Director, Medi-Cal Regional Lead

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Counties Covered: Amador, Calaveras, Inyo, Mono, Sacramento, San Joaquin, Stanislaus, Tulare, Tuolumne

Edward Mariscal

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