CalAIM 301 Fiscal and Program Opportunities for Adult and Aging Programs

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CALAIM 301 TRAINING PURPOSE

- CalAIM has created numerous additional opportunities with which counties may begin to conceptualize how to **increase access, availability, and sustainability of services**.
- This training will be geared toward **exploration of new funding sources** and how they may be braided with other funds.
- These ideas are still in a conceptual phase, and the **goal is to have counties begin to strategize** on future use of these funds to address services gaps, and/or increase sustainability of needed programs.

CALAIM 301 LEARNING OBJECTIVES

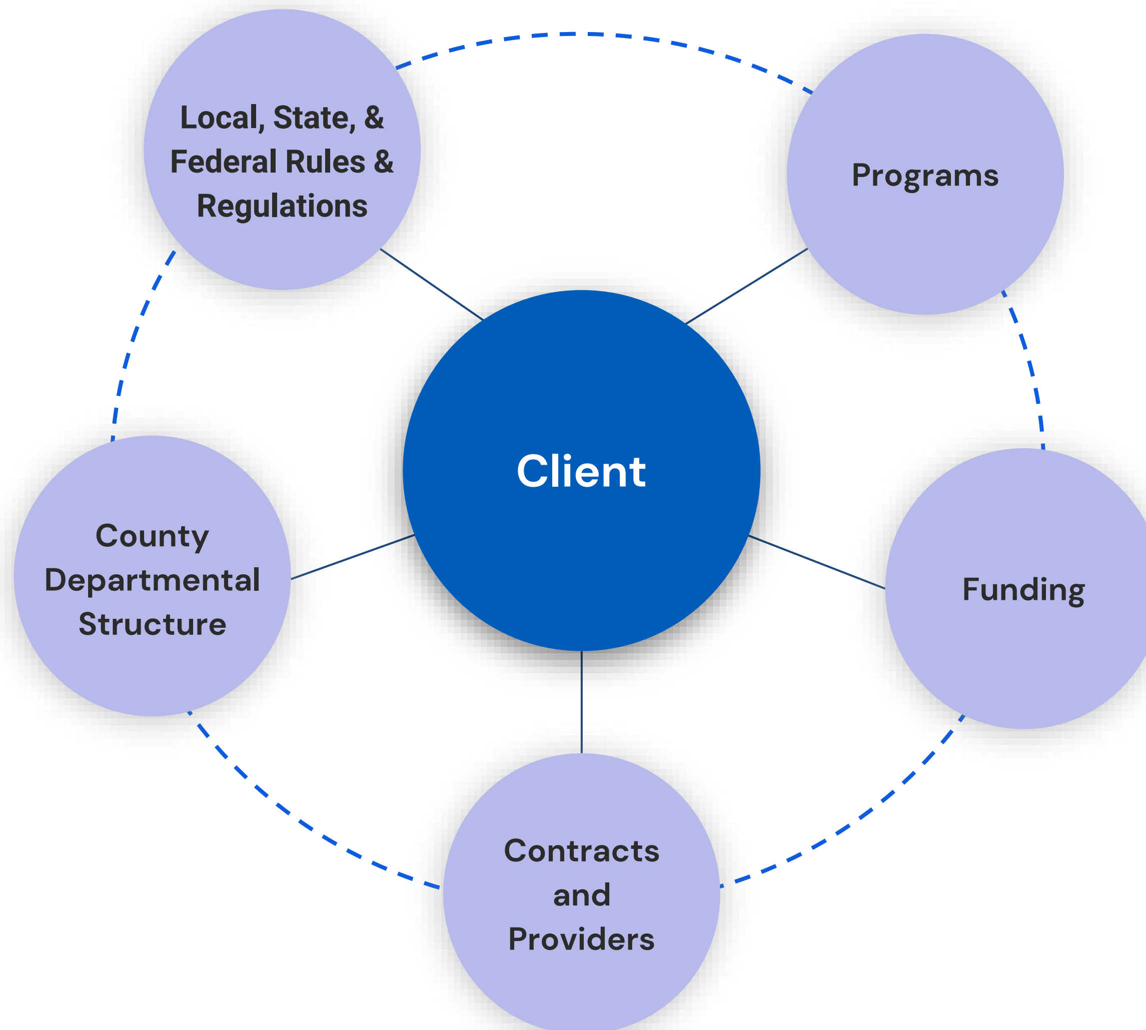
Our goals for the session today are to:

1. **Increase readiness** to engage in Enhanced Care Management (ECM) and Community Supports.

1. **Increase understanding of the fiscal components** of ECM and Community Supports and how to enhance current funding streams through these programs.

1. **To walk away with next steps** to further ECM and Community Supports engagement.

THE FOCUS IS THE CLIENT



OUR AGENDA

01. CalAIM Medi-Cal Transformation

02. Enhanced Care Management

03. Community Supports

04. Meet David

05. Operationalizing ECM and Community Supports

06. CalAIM Funding Opportunities

07. What Role Do Counties Play?

08. What's New in 2025?

CALAIM: MEDI-CAL TRANSFORMATION

WHAT IS MEDI-CAL?

Medi-Cal is **California's Medicaid program** which is public health insurance that provides needed health care services for qualifying individuals.

Financing

Medi-Cal is financed equally by the state and federal government. (Medi-Cal Overview)

Eligibility

Medi-Cal covers low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and low-income people with specific diseases such as tuberculosis, breast cancer, or HIV/AIDS.

Enrollment

Medi-Cal enrollment hovers around 15,000,000. Medi-Cal managed care enrollment is 90-95% of the total Medi-Cal enrollment.

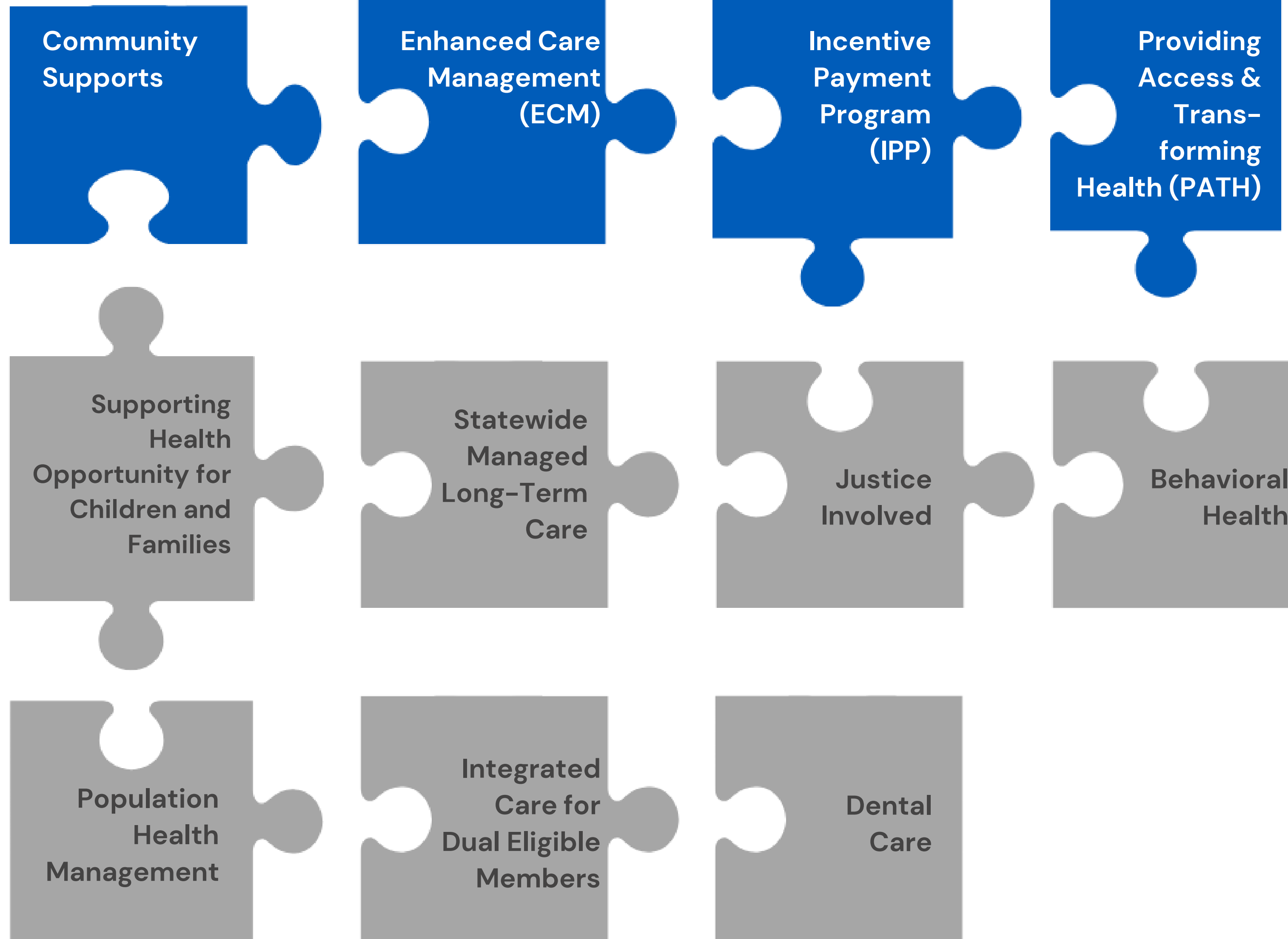
CALAIM: MEDI-CAL TRANSFORMATION

What is it?

A multi-year effort to change the health care delivery systems within CA's Medicaid program. Medi-Cal is working to **build a more coordinated, person-centered, and equitable health system** that works for everyone that will:

- Address California's physical and mental health needs
- Improve and integrate care for Californians
- Be a catalyst for equity and justice
- Work together to build a healthier state

CALAIM MEDI-CAL TRANSFORMATION INITIATIVES



WHY DOES CALAIM MATTER?

New revenue streams, which extend support and services

New benefits and services available to vulnerable populations

Opportunity to break down silos and create a more coordinated system of care

Other Initiatives/Programs That Align with CalAIM:

- → Home Safe
- → Master Plan for Aging
- → IHSS
- → APS
- → PGPC
- → AAA Programs
- → Senior Centers
- → Local Aging & Disability Friendly Action Plan (LADAP)

ENHANCED CARE MANAGEMENT (ECM)

ENHANCED CARE MANAGEMENT (ECM)

A new statewide Medi-Cal benefit intended to:

- Break down the traditional walls of health care, and extend **beyond hospitals and health care settings into communities**;
- Provide high-need members with **in-person care management** where they live;
- Introduce a better way to **coordinate care**;
- Provide access to a single **Lead Care Manager** who provides comprehensive care management and **coordinates their health and health-related care and services**; and,
- Makes connections to the **quality care** they need, no matter where members seek care – at the doctor, the dentist, with a social worker, or at a community center.

Source: ECM Policy Guide – August 2024

WHAT IS ECM?

ECM is a statewide Medi-Cal Managed Care Plan (MCP) benefit to support comprehensive care management for Members with complex needs.

Medi-Cal MCP Care Management Continuum

ECM

Complex Care Management
for MCP Members with higher- and medium-rising risk

Basic Population Health Management
For all MCP Members

Plus: Transitional Care Services
For all MCP Members transitioning between care settings

Source: CalAIM Enhanced Care Management Policy Guide

WHO IS ELIGIBLE FOR ECM?

ECM is available to MCP Members who meet criteria for ECM "Populations of Focus" (POFs), which are launching in phases from January 2022 to January 2024.

	ECM Population of Focus	Adults	Children & Youth
1	Individuals Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization	✓	✓
3	Individuals with Serious Mental Health and/or Substance Use Disorder Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

ECM has been available for adults with intellectual or developmental disabilities (I/DD) and pregnant and postpartum individuals from the launch of ECM if they meet the eligibility criteria for any existing Population of Focus. In July 2023, children and youth with I/DD or who are pregnant/postpartum will also be eligible for ECM if they meet the eligibility criteria for any existing Population of Focus.

Source: ECM Policy Guide – August 2024

WHAT ARE REQUIREMENTS TO BE AN ECM PROVIDER?

- Must be a **community-based** entity..
- **Have experience providing care to members of the specific POFs they serve.**
- Have an existing footprint in the communities they serve.
- Have expertise providing **culturally appropriate and timely** in-person care management activities.
- Use a care management documentation system or process.
- Must be able to either **submit claims to MCPs or use a DHCS invoicing template to bill MCPs** if unable to submit claims.

Medi-Cal
Managed Care Plans

Example: County
Department

Source: ECM Policy Guide – August 2024

COMMUNITY SUPPORTS

CALAIM AND COMMUNITY SUPPORTS

CalAIM Community Supports are **optional services** that health plans can opt to provide in lieu of higher-cost services traditionally covered by Medicaid.

MCPs selected Community Supports to offer when CalAIM went-live on January 1, 2022 and **have the option to add new Community Supports every six months.**

CalAIM currently includes **15** different Community Supports.

COMMUNITY SUPPORTS SUMMARY PART 1: HOUSING SERVICES

Community Supports Service	Eligible Populations	Example of Services
Housing Transition Navigation Services	Homeless, at-risk of homelessness	Housing assessment, plan & search for housing
Housing Deposits (reimbursement-based; once in a lifetime benefit)	Homeless, received housing transition navigation services	Security deposits, first month utilities, set-up fees
Housing Tenancy & Sustaining Services (once in a lifetime benefit)	Homeless, received housing transition navigation services	Advocacy & coaching to help maintain housing
Recuperative Care (Medical Respite) (stays of no more than 90 days)	Homeless, unstable living conditions	Interim housing for short-term residential care
Short-Term Post-Hospitalization Housing (up to 6 months; once in a lifetime benefit)	Exiting recuperative care or other facility, homeless, at-risk of homelessness	Interim housing for recuperation and recovery
Transitional Rent - *Optional for MCPs 7/1/25* - *Mandatory for MCPs 1/1/26*	Has its own POFs	Up to 6 months of rent

COMMUNITY SUPPORTS SUMMARY PART 2

Community Supports Service	Eligible Populations	Example of Services
Asthma Remediation (up to a total lifetime maximum of $7,500)	All populations	Air filters, pest eradication, mold removal
Sobering Centers	18 and above	Safe supportive environment to become sober
Medically Tailored Meals/ Medically- Supportive Food	All populations	Home-delivered meals and groceries

COMMUNITY SUPPORTS SUMMARY PART 3

Community Supports Service	Eligible Populations	Example of Services
Respite Services (336 hours/year)	Live in the community - *IHSS, APS*	Episodic, short-term caregiver
Day Habilitation Programs	Homeless, exited homelessness in past 24 months -	Peer mentoring to improve socialization and adaptive skills provided in a non-facility setting.
Nursing Facility Transition/Diversion to Assisted Living Facilities (some reimbursement-based services)	Able and willing to live in assisted living setting - *IHSS, APS*	Wrap around services to assist with ADLs/IADLs to keep living in home
Community Transition Services/ Nursing Facility Transition to a Home (up to a total lifetime maximum amount of $7,500)	Able and willing to live in community - *IHSS, APS,*	Security deposit, housing navigation, home modifications
Personal Care & Homemaker Services	*IHSS, APS*	Caregiver to assist with ADLs/IADLs
Environmental Accessibility Adaptations (home modifications, reimbursement-based services)	Individuals at risk for institutionalization in a nursing facility	Ramps, stair lifts, grab-bars

MEET DAVID

MEET DAVID

- David is a 62-year-old male who has been experiencing chronic homelessness for the past 3 years.
- He has Type 2 Diabetes and hypertension, which have worsened due to inconsistent access to medication and food.
- He has limited mobility from an untreated workplace injury and experiences chronic joint pain.
- He is frequently hospitalized due to complications from his medical conditions but is discharged back to the streets.
- He struggles with undiagnosed depression and occasional alcohol use to cope with stress.
- He currently sleeps in a tent behind a gas station and relies on food pantries for meals.

DAVID’S SERVICES

- David is connected to a Federally Qualified Health Center (FQHC) for primary care but has trouble attending appointments.
- A street outreach worker has been trying to link him to housing navigation services.
- He occasionally visits a food pantry but struggles with access to nutritious meals.
- He has no stable income, is eligible for General Assistance, but needs help applying.
- He has had multiple Adult Protective Services (APS) referrals.
- He started the IHSS recipient process but never finished enrolling.

CALAIM OPPORTUNITIES: SCENARIO 1

- ➔ Early Intervention – Preventing Further Decline
- ➔ No active case management yet, but his primary care provider refers him to ECM under the "Individuals Experiencing Homelessness" Population of Focus (POF).
- ➔ Or maybe a social worker notices David's deteriorating condition and refers him to ECM.

HOW CAN ECM HELP?

- David is assigned an ECM Lead Care Manager who meets him in person at a local shelter.
- The ECM Lead Care Manager:
  - Secures an urgent doctor's appointment to manage his diabetes and hypertension.
  - Refers him to behavioral health services to address depression and alcohol use.
  - The ECM Lead Care Manager would also be able to link him to helpful **Community Supports** services he would qualify for.
  - Assists him in completing the IHSS application and process.

HOW CAN COMMUNITY SUPPORTS HELP DAVID?

- David would most likely be eligible for Community Supports services
- Given his housing instability and complex medical needs, he is likely eligible for:
  - Medically Tailored Meals to help manage his diabetes and hypertension.
  - Housing Transition Navigation Services to help find a room rental or supportive housing.

CALAIM OPPORTUNITIES: SCENARIO 2

- David's blood sugar spikes dangerously, leading to severe dehydration and a foot ulcer that lands him in the emergency room. He is admitted for four days due to complications.
- In addition to ECM and the Community Supports outlined in Scenario 1, David is now eligible for Short-Term Post-Hospitalization Housing through Community Supports.

CALAIM OPPORTUNITIES: SCENARIO 2

Under this new Community Support, David is placed in a temporary housing facility for up to six months where he can recover in a safe, stable environment.

During this time, his ECM Care Manager:

- Works with a housing specialist to find long-term rental assistance.
- Ensures follow-up medical care, including foot ulcer treatment and pain management for his mobility issues.
- Coordinates mental health and substance use support services.
- IHSS application is approved and ECM Lead Care Manager is helping to find a provider.

Additional Community Supports Provided:

- Housing Deposits: Once permanent housing is found, David is eligible for a security deposit and first month's rent assistance.
- Environmental Accessibility Adaptations: If housed, his unit could receive grab bars.

CALAIM OPPORTUNITIES: SCENARIO 3

- ➔ David has come out of the short-term post-hospitalization housing and has found a temporary housing unit.
- ➔ David is doing well in temporary housing, but his chronic conditions still put him at risk for long-term institutionalization in a skilled nursing facility if he doesn't secure stable housing and ongoing care.
- ➔ Through ECM and Community Supports Housing Transition Navigation Services, David finally secures permanent supportive housing in a small apartment.

CALAIM OPPORTUNITIES: SCENARIO 3

His ECM Lead Care Manager ensures that:

- He is connected to in-home care support services to assist with daily activities like meal prep and medication management.
- He continues attending behavioral health sessions to address his depression and substance use.
- He is enrolled in a chronic disease self-management program to prevent future hospitalizations.

Additional Community Supports Services:

- Nursing Facility Transition Services: If he had been institutionalized, this service would help move him back into the community.
- Personal Care & Homemaker Services: Helps him maintain independence in his home.
- Medically Tailored Meals

CALAIM OPPORTUNITIES:
David's Road to Stability Through ECM and Community Supports

- Prevented unnecessary ER visits and long-term institutionalization.
- Transitioned him from homelessness to stable housing with wraparound support.
- David is an IHSS recipient and has a provider that is meeting his needs.
- Improved his physical and mental health through coordinated care services.
- By integrating Enhanced Care Management (ECM) and Community Supports, David is no longer just surviving—he is thriving in a sustainable, supported housing environment with access to comprehensive healthcare.

OPERATIONALIZING ECM
AND COMMUNITY SUPPORTS

ROLE OF THE MANAGED CARE PLANS

- CalAIM is primarily being implemented through the **Medi-Cal Managed Care Plans**.
- Individuals enrolled in Medi-Cal managed care are eligible for services available under CalAIM initiatives.

ADMINISTRATION AND DELIVERY OF ECM AND COMMUNITY SUPPORTS

Medi-Cal Managed Care Plans

Example: County Department

ECM and Community Supports services are **administered by MCPs and delivered by community-based providers.** MCPs contract with community-based providers who are experienced and skilled in serving ECM Populations of Focus and providing Community Supports services.

COMMON PAYMENT MODELS FOR ECM AND COMMUNITY SUPPORTS

1

Per Member Per Month (PMPM) Bundled Payments

This often requires documentation of a certain number of "touches" or services or "attempted touches" each month

2

Fee for Service (FFS) Payment Model

Payments are made:

- Per Diem
- Per Service
- Per 15 minutes (or other specified time period)

3

Cost-Based Reimbursement

This payment model issues payment in which:

- There is typically a cap on the total amount reimbursed
- Typically only used for very specific purposes

MORE ON CALAIM AND MANAGED CARE PLANS

Payment Timeline

Make sure to set up an **efficient billing and claims system**

- Payments depend on submitting "clean" claims

Dedicated staff time to track invoices/claims and reconcile against payments is critical for consistent revenue generation

Audits

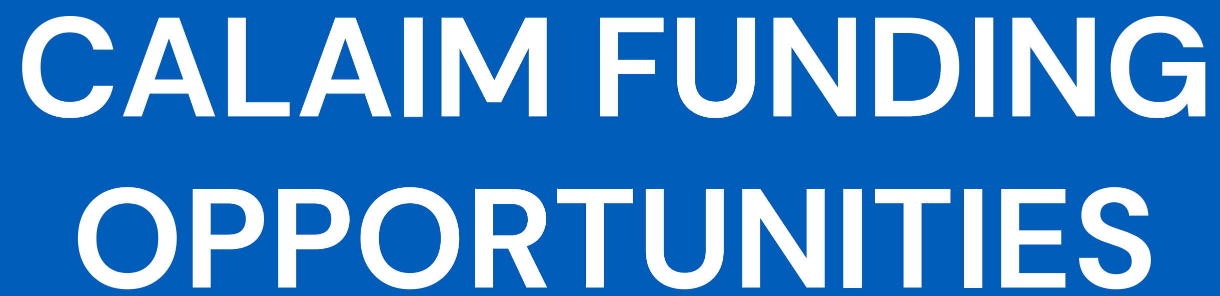
DHCS audits MCPs for ECM and Community Supports

MCPs will audit ECM and Community Supports Providers

- Some MCPs do rolling audits each month or quarter
- Some MCPs are beginning to do fiscal audits

Hub Models

Counties or another "third party administrator" could take on the contracting and billing for ECM and Community Supports and subcontract out the services to CBOs


CALAIM FUNDING
OPPORTUNITIES

FUNDING OPPORTUNITIES FOR CALAIM AND COMMUNITY SUPPORTS

IPP FUNDING

The Incentive Payment Program (IPP) supports the implementation and expansion of ECM, Community Supports, and other CalAIM initiatives by providing incentives to MCPs.

- ➔ MCPs can give out their IPP dollars to providers to help with start-up costs or to incentivize investments in specific areas

PATH FUNDING

Providing Access and Transforming Health (PATH) provides funding to build up the capacity and infrastructure of on-the-ground partners for ECM, Community Supports and Justice-Involved services.

- Capacity and Infrastructure Transition Expansion and Development (CITED)
- Collaborative Planning and
- Implementation (CPI)
- Justice-Involved Capacity Building Program (JI)
- Technical Assistance Marketplace (TAM)

PATH CITED INITIATIVE

Capacity and Infrastructure Transition, Expansion and Development (CITED) Provides Funding to Build Capacity and Infrastructure

→ CITED provides **grant funding** to enable the transition, expansion, and development of capacity and infrastructure to provide ECM and Community Supports.

→ Funding can be used for a wide-range of items:

- Staff
- Rent
- Purchase of vehicles
- EHRs

→ Provider organizations contracted to provide ECM or Community Supports are encouraged to apply, as well as those with an attestation from an MCP showing the intent to contact.

PATH CITED Round 4 application window will be open January 6 – May 2

PATH CITED Round 4 Overview

Round 4 is the **final** round of CITED.

New for Round 4: **All milestones must be completed within one year.**

No limit on funding amount. Average award in previous rounds was $1.1 million for a 2 year funding cycle.

Round 4 Funding Priorities

- County-specific ECM/Community Supports gaps
- Statewide ECM/Community Supports gaps
  - Birth Equity, Justice-Involved, and Transitional Rent
- Tribal entities or other entities serving tribal members
- Rural counties
- Entities operating in counties with lower funding in prior CITED rounds
- Entities serving individuals whose primary language is not English
- Local CBOs
- Counties providing Transitional Rent

Source: CITED

Transitional Rent Populations of Focus

Transitional Rent (TR) Implementation Timeline

- **July 1, 2025**
  Optional go-live for MCPs for the BH POF and/or additional TR POFs
- **January 1, 2026**
  Mandatory launch for the TR Behavioral Health POF

POF 1 Behavioral Health POF

POF 2 Transitioning out of an institutional or congregate residential setting

POF 3 Transitioning out of a carceral setting

POF 4 Transitioning out of an interim setting

POF 5 Transitioning out of recuperative care or short-term post-hospitalization housing

POF 6 Transitioning out of foster care

POF 7 Experiencing unsheltered homelessness

POF 8 Eligible for Full-Service Partnership (FSP)

Source: CITED Round 4 Transitional Rent Webinar

PATH TA MARKETPLACE INITIATIVE

Technical Assistance Marketplace (TAM) provides support to ECM and Community Support providers.

- The TA Marketplace Initiative provides **free technical assistance** to providers, community-based organizations, county agencies, public hospitals, tribal partners, and others.
- TA is available across seven domains and includes resources for providers building data infrastructure and navigating contracting with MCPs.
- **Contracted and prospective ECM/Community Supports providers are encouraged to shop for Technical Assistance through the marketplace.**

WHAT ROLE DO COUNTIES PLAY?

WHAT DOES CALAIM MEAN TO YOUR COUNTY?

- Additional resources for families
- Funding for social determinants of health
- Sustainability
- Data sharing, collaboration and better coordination of care
- Bridging funds and assured revenue during transitions of care
- Opportunity
- New funding streams for local providers
- Reduced caseloads
- Potential additional workloads

NEW FUNDING OPPORTUNITIES

- ECM
- Community Supports
- PATH Funding
- Incentive Payment Program (IPP)
- Community Health Worker Medi-Cal Benefit

ONGOING FUNDING

- Realignment
- County General Fund
- County Tax Initiatives
- Title XIX

SUNSETTING FUNDS

- Home Safe
- APS ARPA

Let's look at how **Enhanced Care Management** and **Community Supports Services** intersect with your work and budgets.

Fiscal

- ➔ What are your budget pain points?
- ➔ When are general fund dollars being used?
- ➔ Are your county dollars being matched?
- ➔ What changes are coming?

Program

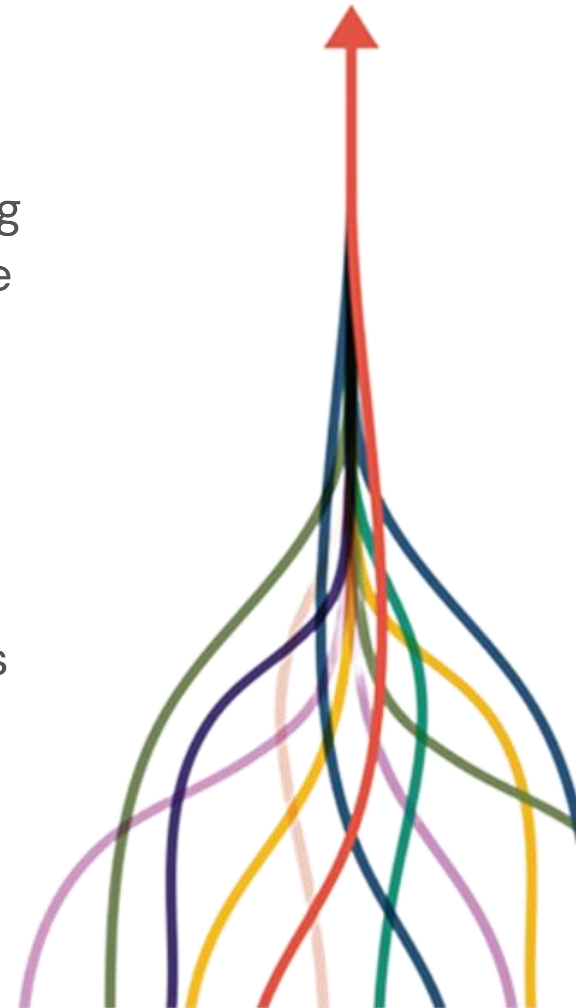
- ➔ What staff perform care management/case management for health or social services?
- ➔ What staff perform housing navigation?
- ➔ What contracts do you have that include care management, housing navigation, etc.?
- ➔ Are there enough ECM and Community Supports providers in the county?
- ➔ Are there projects you have wanted to launch but don't have budget, staff, etc.?

BLENDING AND BRAIDING FUNDING

- **ECM and Community Supports can supplement but cannot supplant existing services** funded through other State, local, or federally-funded programs
- ECM and Community Supports offer opportunities for “non-traditional” social service providers to access Medi-Cal funding.
- They offer counties a chance to think about how Medi-Cal can support the populations they work with and the services they provide, either directly or indirectly.
- **For many providers, ECM or Community Supports revenue is not in and of itself sustaining, but when blended or braided with other funding, can be an important component of financial sustainability.**

WHAT IS BRAIDED FUNDING?

- When an organization **brings funds together from various sources** to support a unified goal or program with careful accounting of how each funding source is used and spent.
- **Funding sources are independently tracked** from planning to service delivery, reimbursement, and reporting, to ensure that each funding source is only supporting allowable activities.
- Used to fill service gaps, expand service offerings, and/or increase program and staff capacity.
- Braiding **can be complex and challenging** for organizations to do effectively.



Source: Center for Health Care Strategies – August 21 webinar, "Braiding Funding Streams to Deliver Integrated Care for Medi-Cal Members Under CalAIM"

Image Source: https://www.dol.gov/agencies/odep/program-areas/bbs

CONSIDERATIONS WHEN BRAIDING FUNDS

- **Impacts On Other Allocations**
  - i.e., replacing a Social Service Expenditure position with other revenue, which threatens allocations
  - Time Studies
- **Cashflow**
  - Delayed Payments
  - Denials
- **Audit Risk**
  - Disallowances
  - Audits delayed
    - Carrying risk longer-term
- **Potential Duplication Of Services**
  - ECM and PACE or Targeted Case Management longer-term
- **Additional Administrative Costs**
  - Setting up a billing system and staffing to submit claims
    - IT, staff time, equipment/infrastructure
  - Contracting and oversight
  - Participating in additional audits/reviews
  - Quality Improvement/Assurance, Chart Review
  - Managing Client Records

Image Source: https://www.dol.gov/agencies/odep/program-areas/bbs

BEST PRACTICES WHEN BRAIDING FUNDS

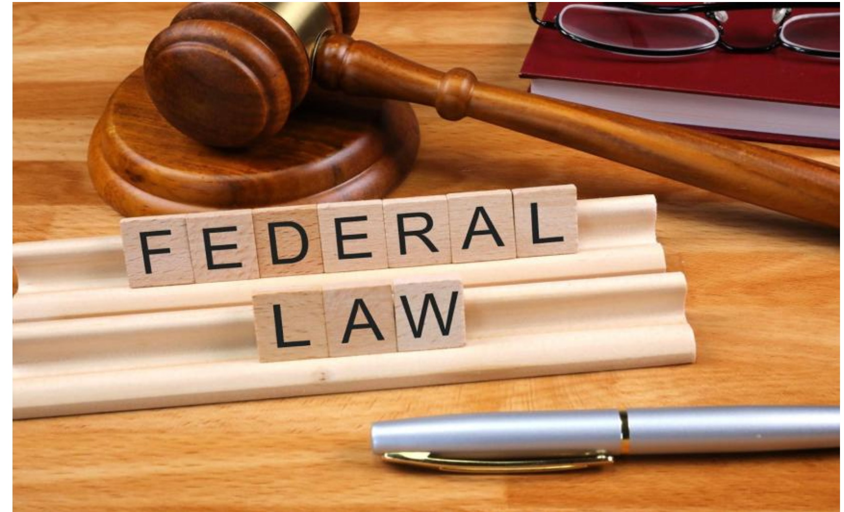
- ➔ **Conduct a Thorough Analysis**
  - ◆ Funding sources, gaps in services, and unmet client needs
  - ◆ Expand, address service gaps, and sustain, not replace
- ➔ **Evaluate Rates and Reimbursement Structure**
  - ◆ Compare with Costs
    - Staff costs, equipment/infrastructure infrastructure, administrative etc.
  - ◆ Know the requirements and limitations of each funding source
- ➔ **Collaborate with Other County Departments/ Systems to Share Resources**
  - ◆ Duplication solution
- ➔ **Where Possible, Implement Changes in Small Pilots Before Enacting System Wide**

Image Source: https://www.dol.gov/agencies/odep/program-areas/bbs

SUPPLANTING SUPPLEMENTING & PAYOR OF LAST RESORT

Supplanting ❎ vs. Supplementing ✅

Example: Community Supports replaces a locally funded housing program. May add to these available funds "supplementing"



Payor of Last Resort

Example: A client has both Medicare and Medi-Cal insurance. Medicare must be billed first and Medi-Cal can only pay for any additional costs not covered by the Medicare portion

ROLES FOR COUNTY DEPARTMENTS IN ECM & COMMUNITY SUPPORTS

Grow Local Capacity

Leverage these programs to better serve your clients

- Shift county costs to ECM or Community Supports funding

Build capacity and infrastructure Supporting partner organizations

- Data sharing
- Care coordination
- Training

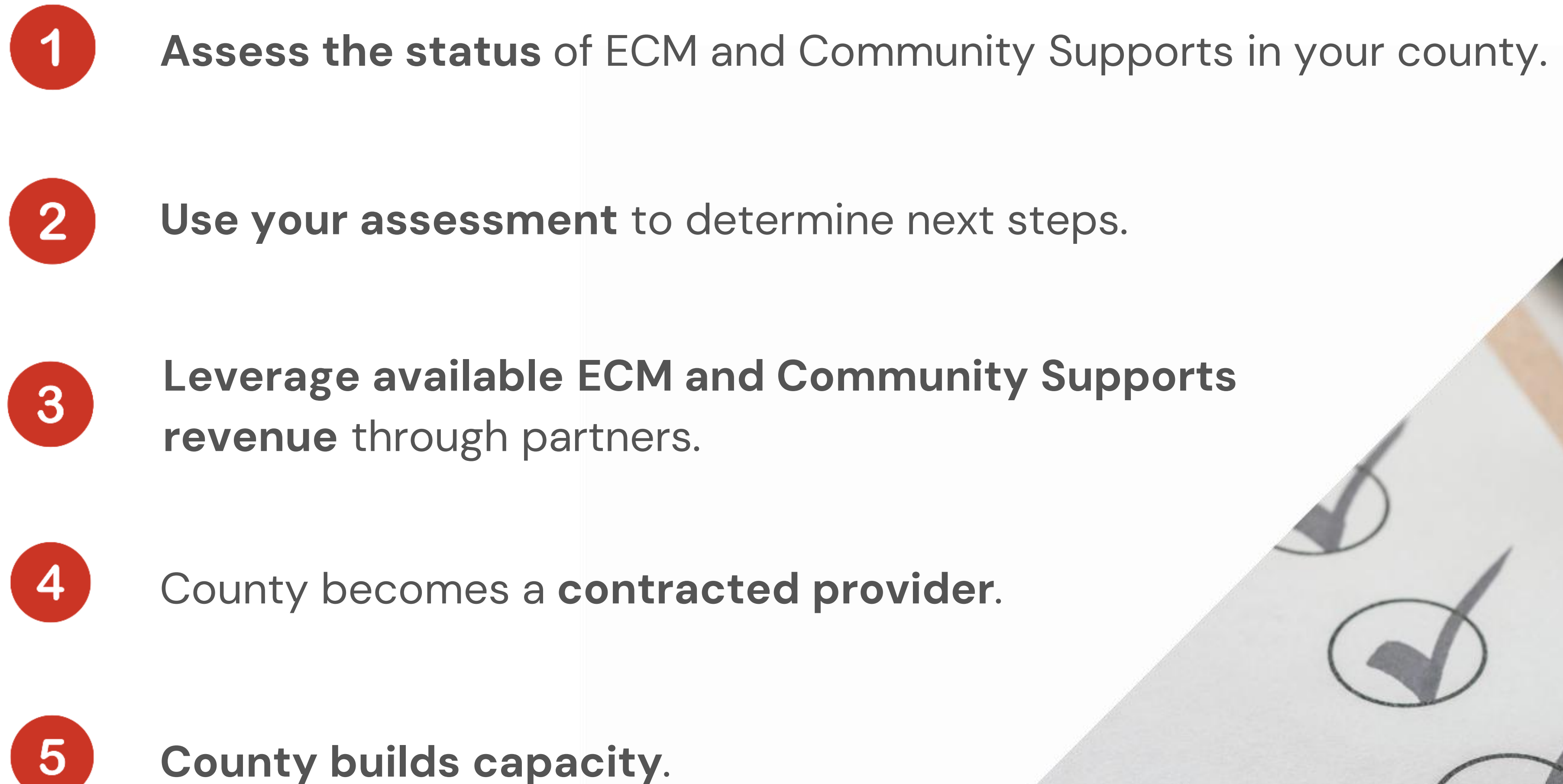
Become a Referral Partner

- Spread awareness of ECM and Community Supports services and providers
- Make referrals into ECM and Community Supports for individuals you work with

Become a Provider

- Contract as an ECM provider for specific Populations of Focus (PoF) that you are already serving and providing case/care management for
- Contract for Community Supports services that are services you already provide

WHAT CAN YOU DO?



1. **Assess the status** of ECM and Community Supports in your county.
2. **Use your assessment** to determine next steps.
3. **Leverage available ECM and Community Supports revenue** through partners.
4. County becomes a **contracted provider**.
5. **County builds capacity**.

STEP ONE: ASSESSMENT

How do you know what is operational and what is still needed within your county?

ECM and Community Supports Providers in Your County

- ❑ Every MCP is required to list all contracted ECM and Community Supports providers in each county on their website (not all lists are up to date)
- ❑ Assess which providers are involved and who may be missing
- ❑ Attend your county's PATH Collaborative Planning (CPI) Meetings

Capacity or Saturation

- ❑ Do you have providers serving all ECM populations of focus and providing all Community Supports?
    - If the provider market is saturated, is that because they need to enroll more individuals?

Missing services

- ❑ Are there populations of focus that are not being fully served or are being served by providers unknown to you?
- ❑ Engage with your MCP(s) to learn how you can support growth
- ❑ What Community Supports services are being offered in your county?

STEP TWO: USE RESULTS

Based on your assessment, is there a need for the county to:

- ❑ Become a contracted ECM or Community Supports provider?
- ❑ Make referrals to ECM and Community Supports services?
- ❑ Support trusted partners in becoming contracted providers?
  - ➔ Program implication consideration– does this help with county staff workload and capacity?
  - ➔ Fiscal implication consideration - if partners are ECM or Community Supports providers, can that offset county spending on services?

STEP THREE: LEVERAGE REVENUE

Develop an understanding of how to leverage revenue available through Enhanced Care Management (ECM) and Community Supports services.

Support partners in billing for ECM and Community Supports

- ➔ County funded administrative positions

Review current county contracts to determine if any of the funded services could be funded through ECM or Community Supports

- ➔ Common contracts to consider:
  - ❑ Housing & Homeless Services
  - ❑ Jail & Reentry Services
  - ❑ ADRC Contracts

STEP FOUR: BECOMING A CONTRACTED PROVIDER

Key considerations while assessing becoming a contracted provider of Enhanced Care Management (ECM) and/or Community Support services.

Organizational Structure for ECM/CS

Create a stand-alone department/unit, or build into existing organizational chart

Focus for ECM/CS

- ➔ Adjunct service so individuals can participate in current services
- ➔ Preventative service, so individuals don't need more intense services (i.e., specialty mental health services)

Capacity for data collection and invoices

Referrals and Enrollment

- ➔ Effective outreach from the Member Information File (MIF), which can include hundreds of names
- ➔ Ways to encourage community partners to refer to the county for ECM/CS

Financial Sustainability

- ➔ Braid funding
- ➔ Staff that can do both care management and ECM/CS

STEP FIVE: BUILD CAPACITY AND INFRASTRUCTURE

Ideas of ways to build capacity and infrastructure to support successful implementations of Enhanced Care Management (ECM) and Community Supports service programs.

- Offer Meeting Space
- Support Data Sharing
- Conduct or Host Trainings
- Care Coordination Opportunities
- Raise Awareness of ECM and Community Supports

NEXT STEPS

- Understand what services are missing and what services could be expanded
- **Review county contracts** to determine:
  - What guidance should be provided and which universal contracts should be prioritized
  - What programs/activities could start to be billed under new funding streams
- **Develop a one-pager** for county partners to understand opportunities for new funding streams
- **Develop conversation guides** for your county to use about how to talk to your MCP and your partners about new funding streams
- **Convene partners** to talk about how best to leverage new funding streams, manage start-up costs, benefits to doing so, etc.
  - If county frees up these dollars, how could they be used?

WHAT'S NEW IN 2025?

ECM Updates

- Universal ECM referral standards (for all MCPs) with a referral form specifically for adults
  - Intended to support community-based referrals
  - Includes provisions to enroll individuals with ECM providers they have an established relationship with

Presumptive authorizations for ECM (more on next slide)

- Applies to all eligible contracted providers
- Provides 30 days of presumptive authorization
  - Allows ECM services to be provided more rapidly
  - ECM providers must still submit a formal referral to render services beyond the 30 days

PRESUMPTIVE AUTHORIZATION PROVIDERS

ECM Population of Focus (Adults Only)	ECM Providers Covered by Presumptive Authorization Requirements
Adults & Children Experiencing Homelessness	● Street Medicine Providers ● Community Supports Providers of the Housing Trio Services: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services ● County-contracted and County-operated Specialty BH Provider
Adults & Children At Risk of Avoidable Hospital or ED Utilization	● Primary Care Provider practices (including FQHCs, County-operated primary care, and other primary care)
Adults & Children with Serious Mental Health and/or SUD Needs	● County-contracted and County-operated Specialty BH Providers
Adults & Children Transitioning from Incarceration	● Existing DHCS guidance governs authorizations and warm handoffs to support Members receiving pre-release services in the JI POF.
Adults Living in the Community At Risk for LTC Institutionalization	● California Community Transitions (CCT) Lead Organizations ● Community Supports providers of the Nursing Facility Transition/Diversion to Assisted Living Facilities and Community Transition Services
Adult SNF Residents Transitioning to the Community	● California Community Transitions (CCT) Lead Organizations ● Community Supports providers of the Nursing Facility Transition/Diversion to Assisted Living Facilities and Community Transition Services

WHAT ELSE YOU SHOULD KNOW

→ Closed Loop Referral Guidance (draft)

- Required for MCPs to operationalize in July 2025 for ECM and Community Supports
- Will include referral tracking, supporting, and monitoring
- *Nothing needs to be added to the IHSS and CWS MOUs for Closed Loop Referrals at this time*

→ Community Reinvestment Requirements (draft)

- DHCS is providing MCPs with guidance regarding the 2024 MCP contract requirement for MCPs to reinvest a minimum level of their net income into their local communities.
- Reinvestments must focus on:
  - Pursuing health equity
  - Address Social Drivers of Health (SDOH)
  - Advance quality outcomes for MCP Members
  - Engage with the community - consult with Community Advisory Committees and must be informed by the Community Health Assessment

- → ECM and Community Supports Policy Cheat Sheet
- → ECM Policy Guide
- → Community Supports Policy Guide
- → DHCS ECM & Community Supports Main Page
- → PATH Home Page

GET IN TOUCH

CFPIC

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CFPIC Adults Expansion

DHCS

DHCS ECM and Community Supports Teams

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Thank you for completing the survey!

CFPIC.

Celebrating 20 Years

THANK YOU!