CFPIC

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Lunch and Learn

Understanding CalAIM and Its Relation to Foster Youth

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Agenda Review

1. Welcome
2. Definitions and Concepts
3. Pre-CalAIM
4. CalAIM, BPHM, CCM, and ECM
5. CalAIM and Foster Youth

CWDA Context

- CWDA is the non-profit that represents the human services directors in the 58 CA counties.
- I am really proud to be a part of an organization that is celebrating 100 years of addressing the welfare of all Californians.

A Century of Advancing Human Services for the Welfare of All Californians

CWDA Context

- Part of my CWDA role in being a child welfare policy consultant to the counties and other partners is to provide technical assistance and expertise to navigate the very complex issues of youth who are in foster care, including addressing their physical, mental, and other health needs.
- What you are going to hear today will be some of that TA and expertise so that you can see how we might better assist these youth and their families.

Managed Care Plan/Organization

- A Managed Care Plan (MCP) or Managed Care Organization (MCO) is an entity that manages the health care of a beneficiary through paid premiums and contracts with providers to manage that health care for a beneficiary.
- The original premise was to protect a person's income from adverse health issues, so often, these plans were tied to a person's employment.
- MCPs have been around a long time: Anthem Blue Cross and Blue Shield date to the 1930s, and Kaiser Permanente dates to the 1940s.

https://www.ncbi.nlm.nih.gov/books/NBK235989/

Medicaid/Medi-Cal

- By the 1960s, it was recognized nationally that not all people, even some of those who were employed, had access to MCPs/MCOs.
- As such, in 1965, Title XIX of the Social Security Act created Medicaid which:
  - Focused on poor individuals who were eligible for certain other federal welfare benefits, in particular, Aid to Families with Dependent Children (AFDC or SNAP in CA);
  - Was administered by the States under Federal rules; and
  - Cost-shared/financed between the Federal government and the States.
- As states managed their own Medicaid plans (e.g., Medi-Cal in CA), a beneficiary would have to apply to another Medicaid program if they moved to another state.

https://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx

Straight Medi-Cal or Medi-Cal Fee-for-Service

- Beneficiaries are responsible for finding their own primary care doctor and specialists; there is no one to match them to a health care provider.
- The Department of Health Care Services establishes fee schedules, negotiates rates with providers, determines medically necessity criteria and pays provider claims for services provided.

https://www.lhpc.org/key-terms

Medi-Cal Managed Care Plan

- California was the first state back in the early 1970s to provide a Medicaid Managed Care model (aka Medi-Cal Managed Care Plan or MCP).
- In the 1990s, in response to rising fee-for-service costs and concerns about access to care, California expanded its effort to enroll a significant portion of the Medi-Cal population into managed care.
- While the MCPs differ by county, each of the participating MCP contracts with the Department of Health Care Services and assumes full financial risk for all covered services.

https://www.lhpc.org/key-terms

Straight Medi-Cal vs. MCP

Area	Straight/FFS	MCP
Geography	Statewide.	In 40 counties, a beneficiary must enroll in MCP. In 18 counties, there are multiple MCPs to choose from.
Provider Choice	Beneficiaries can go to any provider who accepts Medi-Cal, though there is no directory.	MCPs must have a directory of providers that have to be used by the beneficiary. There are exceptions if service is not available within the network.

Straight Medi-Cal vs. MCP

Area	Straight/FFS	MCP
Screening and Preventative Services	The state does not ensure that providers offer screening or preventative services.	Required to screen all children per American Academy of Pediatrics guidelines as well as offer preventative services.
Transportation Assistance	Non-emergency medical transportation is a covered benefit, but no assistance is provided to secure the benefit.	MCPs must provide non-emergency medical transportation and help coordinate the transportation.
Language Interpretation	Should be made available, but there is no state monitoring system.	MCPs must make language interpretation available in its network.

https://publicworksalliance.org/

Primary Residence

- The primary residence of the child in the context of a MCP is the county where the parent resides.
- Primary residence for the child does not change if they go on vacation, summer camp, or enroll in college in another county.
- If a beneficiary moves to another the county, they have 30 days to choose a Medi-Cal Managed Care Plan, unless there is only one MCP in the county.

https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

Primary Care Provider (PCP)

- A PCP is the main health care clinician, usually a physician, for the beneficiary.
- They are a part of a core health team and addresses a person's preventative health care needs, including annual physical exams and arranging for yearly vaccines, etc.
- A PCP is also the point person that will refer a beneficiary to specialists should they need more specific care.

https://mydoctor.kaiserpermanente.org/ncal/article/your-primary-care-team-2513003

Specialist

- A health clinician with additional training and expertise.
- Pediatrician: A physician who specializes in the health of children.
- Child psychiatrist: a physician with expertise in psychiatric issues among children.
- Licensed Clinical Social Worker: A person who has a Master's degree in Social Work and is a licensed mental health clinician.

https://mydoctor.kaiserpermanente.org/ncal/article/your-primary-care-team-2513003

Consultation, Referral, and Transfer

- A consultation is a request from one health care provider (e.g., primary care doctor) to another (e.g., child psychiatrist) for an advisory opinion.
- A referral is a request from one health care provider (e.g., primary care doctor) to another (e.g., child psychiatrist) to manage one or more conditions and that other provider is the responsible lead for all aspects of care for those conditions.
- A transfer of care occurs when one health care provider (e.g., primary care doctor) turns over responsibility for the comprehensive care of a patient to another health care provider temporarily (e.g., when a child is hospitalized) or permanently (e.g., when a beneficiary moves).

https://www.aafp.org/about/policies/all/consultations-referrals-transfers-of-care.html

Core Health Team

- A Core Health Team includes the primary care provider as the lead health clinician, as well as others such as a nurse practitioner, a nurse, a pharmacist, a social worker, a medical assistant, etc.
- Sometimes the PCP could refer a beneficiary to additional specialists (e.g., child psychiatrist) and have that specialist join the Core Health Team should the need arise.

https://mydoctor.kaiserpermanente.org/ncal/article/your-primary-care-team-2513003

In-Network vs. Out-of-Network

- In-Network provider means a doctor, health care provider, and/or facility that has contracted with a MCP to provide services at agreed upon rates.
- Out-of-Network provider means a doctor, health care provider, and/or facility that does not have a contract with a MCP and will set their own rates.

https://healthy.kaiserpermanente.org/learn/in-network-vs-out-of-network-care

Outpatient vs. Inpatient

- Outpatient services are usually those that a beneficiary receive outside of a hospital and do not require an overnight stay.
- These can include things like an annual visit with your primary care provider, vaccines, lab tests, and outpatient surgery.
- STRTPs and CTFs are residential facilities that provide outpatient specialty mental health services.
- It can also include an emergency room visit where a beneficiary might have to stay overnight, but a doctor has not admitted you into a hospital.

https://healthy.kaiserpermanente.org/health-wellness/health-encyclopedia/he.outpatient-services.ty7319
https://www.govinfo.gov/content/pkg/GOVPUB-HE22-PURL-gpo2047/pdf/GOVPUB-HE22-PURL-gpo2047.pdf

Outpatient vs. Inpatient

- Inpatient services are those related to when a beneficiary has been admitted into a hospital or other inpatient facilities.
- The inpatient services usually include health care staff (at minimum a nurse) that as a part of formal inpatient treatment plans are monitoring a beneficiary onsite 24/7 for days, weeks or months.

https://healthy.kaiserpermanente.org/health-wellness/health-encyclopedia/he.inpatient-and-outpatient-treatment-for-substance-use-disorder.ad1101

https://www.govinfo.gov/content/pkg/GOVPUB-HE22-PURL-gpo2047/pdf/GOVPUB-HE22-PURL-gpo2047.pdf

Prior- or Pre-Authorization (PA)

- Basic services, such as going for a annual physical or getting vaccinations do not require prior- or pre-authorization.
- However, certain services (e.g., specialized services) and/or medications require PA as it gives the ability for MCPs to determine if such services are medically-necessary.

https://www.kff.org/mental-health/examining-prior-authorization-in-health-insurance/

Timely Access Standards

- The maximum time-period in which a Medi-Cal or other beneficiary has to have access to contracted services once referred or appointment has been requested.
- Urgent Care: 48 hours.
- Primary Care Provider: 10 business days.
- Specialty Mental Health Services: 10 business days.
- Psychiatry Services: 15 business days.

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202025/APL25-006.pdf
https://www.dhcs.ca.gov/Documents/2024-DHCS-BH-SMHS-Methodology-Description.pdf

Network Adequacy Standards

- The maximum distance or travel-time availability of a service in relation to a beneficiary's primary address.
- Primary Care, Hospital Services or Pharmacy: Within 10 miles or 30 minutes of primary residence.
- Psychiatry or SMHS Services: Varies by county, and could be 15 to 30 minutes within primary residence or 60 to 90 minutes within a residence for some rural areas.

https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx
https://www.ocelderlaw.com/list-of-medi-cal-managed-care-plans

Continuity of Care

- One definition is the ability to stay with a provider or get the same services at no additional cost or pre-authorization for a specified amount of time regardless of where you move and have to change MCPs.
- A beneficiary must request continuity of care and may get such services for up to 12 months if they move, including if they move to a county where there is a single MCP.

https://www.dhcs.ca.gov/services/Pages/ContinuityOfCare.aspx
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-022.pdf

Continuity of Care

- The other definition is a continuum of levels of health care for a beneficiary.
- This will involve either outpatient or inpatient services, and would start with an initial visit with a beneficiary's primary care provider (e.g., primary care doctor, dentist, etc.).

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/

Continuity of Care

Hospital - Inpatient	
Residential - Inpatient	Residential - Inpatient
Residential - Outpatient	Residential - Outpatient
Partial Hospital Program	Partial Hospital Program
Intensive Outpatient	Intensive Outpatient
Outpatient	Outpatient

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/

Continuity of Care – Mental Health

Hospital - Inpatient	Acute Psychiatric Hospitals
Residential - Inpatient	Psychiatric Residential Treatment Facilities
Residential - Outpatient	STRTPs or CTFs
Partial Hospital Program	PHP – Mental Health
Intensive Outpatient	Wraparound
Outpatient	Regular Office Visits with MH Clinician

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/

Continuity of Care – MH In Community

Acute Psychiatric Hospital – Psychiatric Emergency	
PRTFs	PRTFs
STRTPs or CTFs	STRTPs or CTFs
PHP – Mental Health	PHP – Mental Health
Wraparound	Wraparound
Regular Visits with MH Clinician	Regular Visits with MH Clinician

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/

Continuity of Care – MH in Foster Care

Acute Psychiatric Hospital – Psychiatric Emergency	
PRTFs	PRTFs
STRTPs or CTFs	STRTPs or CTFs
PHP – Mental Health	PHP – Mental Health
Wraparound	Wraparound
Regular Visits with MH Clinician	Regular Visits with MH Clinician

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/

Transitional Care Services (TCS)

- Services that relate to when a beneficiary is admitted into a healthcare facility (e.g., hospital), transferred from such a facility, or is discharged from such a facility.
- TCS is available to all beneficiaries in MCPs.
- While TCS existed before CalAIM, it was not as robust as today.

https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf

Example

- Parents with a 6th grader and all are on Kaiser MCP move from San Diego to Shasta (only one MCP: Partnership Health Plan of CA).
- In San Diego, the youth had asthma and a Kaiser pulmonologist (a physician who specializes in respiratory issues) who had prescribed some asthma medication.
- The parents ask their child's PCP to coordinate continuity of care including transfer of medical records as well as to continue with the Kaiser pulmonologist via telehealth and continued asthma medication without needing prior authorization.

Example

- Parents identify a PCP for their youth in Shasta and ask the PCP for a referral to a local pulmonologist in the area.
- When the child was in the 9th grade, the family was in a bad car accident, and child was transferred to UC Davis Health (it has the only Level 1 Trauma Hospital in No. Cal. for children and for adults) for multiple broken bones in their legs.

Example

- Parents contacted the MCP to get assistance with Transitional Care Services (TCS) as the child has to be admitted for several weeks at UC Davis and care is formally and temporarily transferred to the UC Davis orthopedic surgeon and their team.
- After several weeks, the MCP assists with TCS to help with discharge for the youth back home, and one of the first recommendations of the discharge plan is for the youth to meet with their primary care doctor.

Example

- Additional recommendations include a referral (with prior-authorization) to physical therapy for the youth, as well as to see the UC Davis orthopedic surgeon a couple of more times for follow up.
- The Youth has fully recovered by the beginning of the 10th grade.

Example

- Youth goes to UC San Diego for their Freshman year.
- As their parents still has primary residency in Shasta, the parents keep the youth with Partnership and youth also has minimal “double” health coverage at the UC San Diego Health Center as part of their registration fees.
- Right after Freshman finals, youth goes out with friends and are in a bad car accident, but no one is physically hurt.

Example

- Youth, however, has traumatic psychiatric responses which leads to a 5150 admission into Rady's Children's Hospital in San Diego.
- Parents notify the MCP for TCS assistance and the MCP coordinates with Rady's on the discharge plan, and youth is released; part of discharge plan is to consult with youth's core health team as soon as possible and recommend a referral to a child psychiatrist.
- Youth is discharged and goes home for the summer.

Example

- Parents asks the PCP for referral to a Child and Adolescent Psychiatrist (CAP) who in turn recommends referral/transfer to a Short-Term Residential Treatment Facility in the Shasta area.
- The STRTP is overseen by Shasta County's Behavioral Health, and their SMHS is overseen by the STRTP CAP; the youth's primary care is still handled by the youth's PCP.
- Once discharged before summer ends, the youth's "regular" CAP works with youth on non-SMHS.

CalAIM

- So if these systems already exist what is CalAIM, and why did DHCS in 2018/2019 pull in experts and stakeholders from all over CA to reimagine Medi-Cal?
- What was the fuss about?
- After 50 years in working with Medi-Cal Managed Care, the State and others recognized 6 issues.

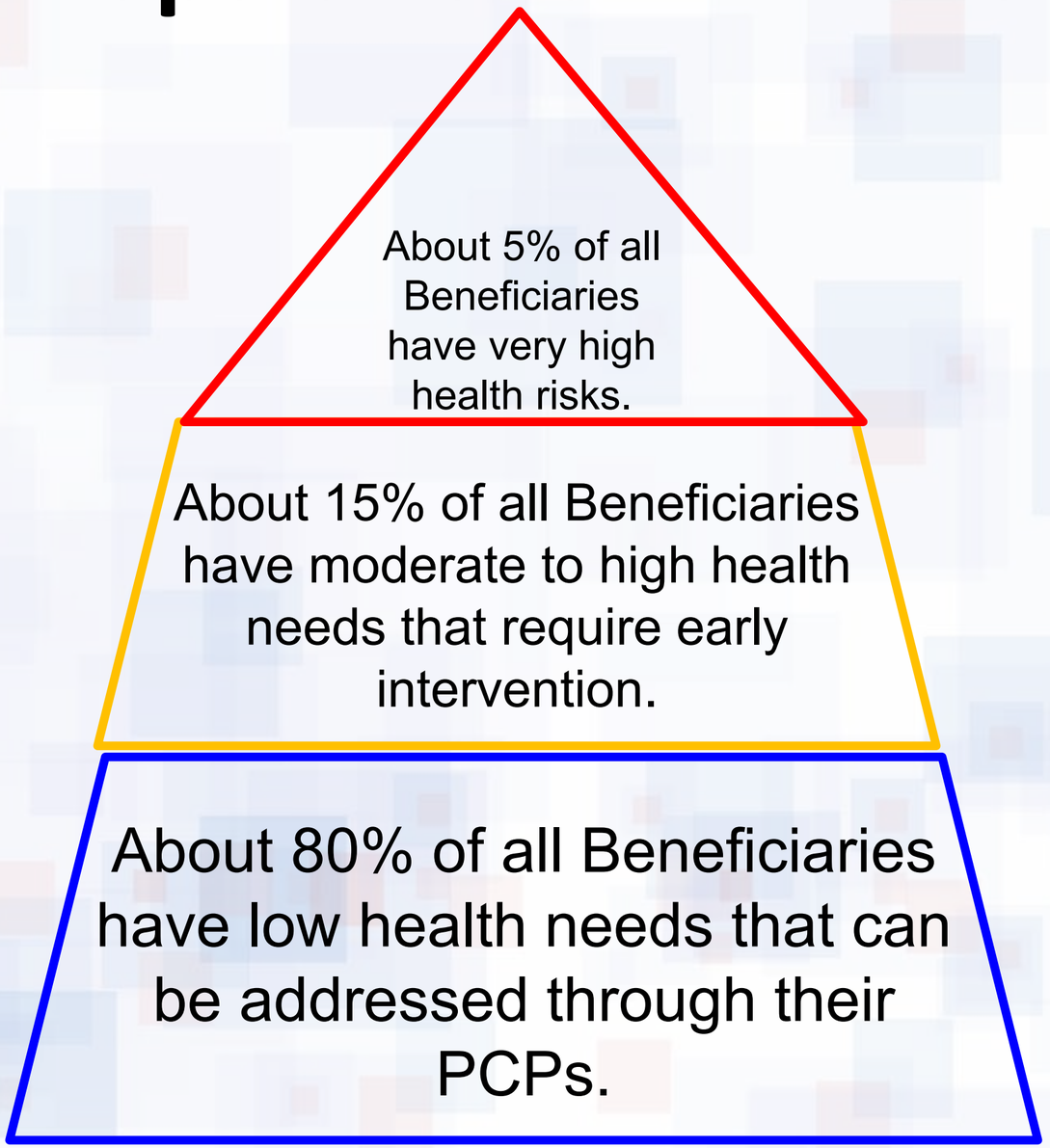
https://www.dhcs.ca.gov/calaim

First Insight: Different Populations have Different Health Needs

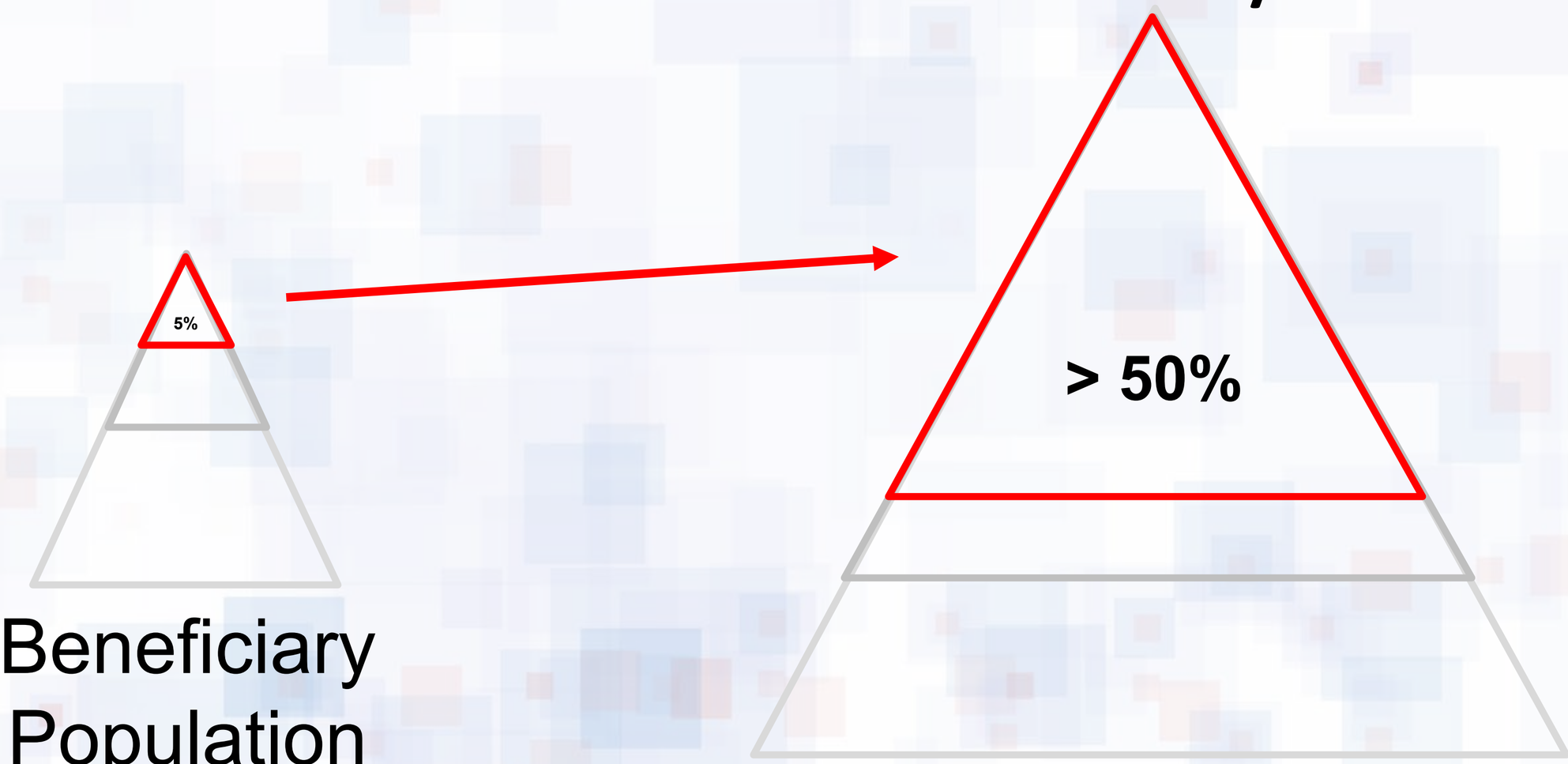
- People in the population have different health needs.
- Some have low health needs, others have higher needs, and you can “categorize” health needs by level.

https://www.cde.ca.gov/ci/cr/ri/

Different Populations – Different Needs



Second Insight: 5% of Highest Risk Population Accounted for More than 50% of the Health Care Costs/Resources



Second Insight Example

- Youth in Foster Care represent less than 4% of entire child population on Medicaid and yet, they account for:
- 53% of all psychology visits;
- 47% of all psychiatry visits;
- 43% of all inpatient public hospital visits; and
- 27% of all psychiatric inpatient hospitalizations.

https://www.cwla.org/the-intersection-between-medicaid-and-child-welfare/

Third Insight: Social Determinants of Health

- The determinants of health, especially those with very high health risks, are not *biological*; they are not due to bacteria, viruses, etc.
- The determinants of health are **Social Determinants of Health** (**SDOH**).
- In essence, SDOHs are the conditions in which people are born, grow, live, work, and age which can then affect their health.*

* https://iris.who.int/server/api/core/bitstreams/cb08095c-55c8-484e-bff6-0e9c78fd38dd/content

Third Insight: Social Determinants of Health

- Job loss, food insecurity,* housing instability and homelessness** leads to increased adverse physical and mental health issues, especially in children.
- Being uninsured leads to poorer health and increases the chance of premature death by 25%.***
- This was partly due to the fact that people waited for as long as possible to get health care, and for some, they waited so long that their severe health issues could no longer be addressed.

*_https://www.journals.uchicago.edu/doi/abs/10.1086/694111
** https://www.journalslibrary.nihr.ac.uk/phr/TWWL4501
*** https://www.nilc.org/wp-content/uploads/2015/11/consequences-of-being-uninsured-2014-08.pdf

Third Insight: Social Determinants of Health

- Of the ACES questions, 6 of the 10 (physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, exposure to DV) relate to abuse or neglect as children.
- Research has shown severe adverse health effects at a score of equal to or greater than 4 ACEs.

Nguyen LH. (2025). STRTPs as part of an integrated trauma informed system: Training to Counties. CWDA: Sacramento, CA.

Third Insight: Social Determinants of Health

- 2.4 times as likely to get cancer than those with no ACES.
- 3.0 times as likely to get diabetes than those with no ACES.
- 3.1 times as likely to get heart disease than those with no ACES.
- 3.5 times as likely to get respiratory diseases than those with no ACES.
- 5.8 times as likely to get a stroke than those with no ACES.

Nguyen LH. (2025). STRTPs as part of an integrated trauma informed system: Training to Counties. CWDA: Sacramento, CA.

Third Insight: Social Determinants of Health

- Those with at least 4 ACES die an average of 15 years younger than those with no ACES.
- Those with at least 6 ACES die an average of 20 years younger than those with no ACES.
- Those who do not have ACES, but who have family members who do have ACES, are twice as likely to die prematurely.

Nguyen LH. (2025). STRTPs as part of an integrated trauma informed system: Training to Counties. CWDA: Sacramento, CA.

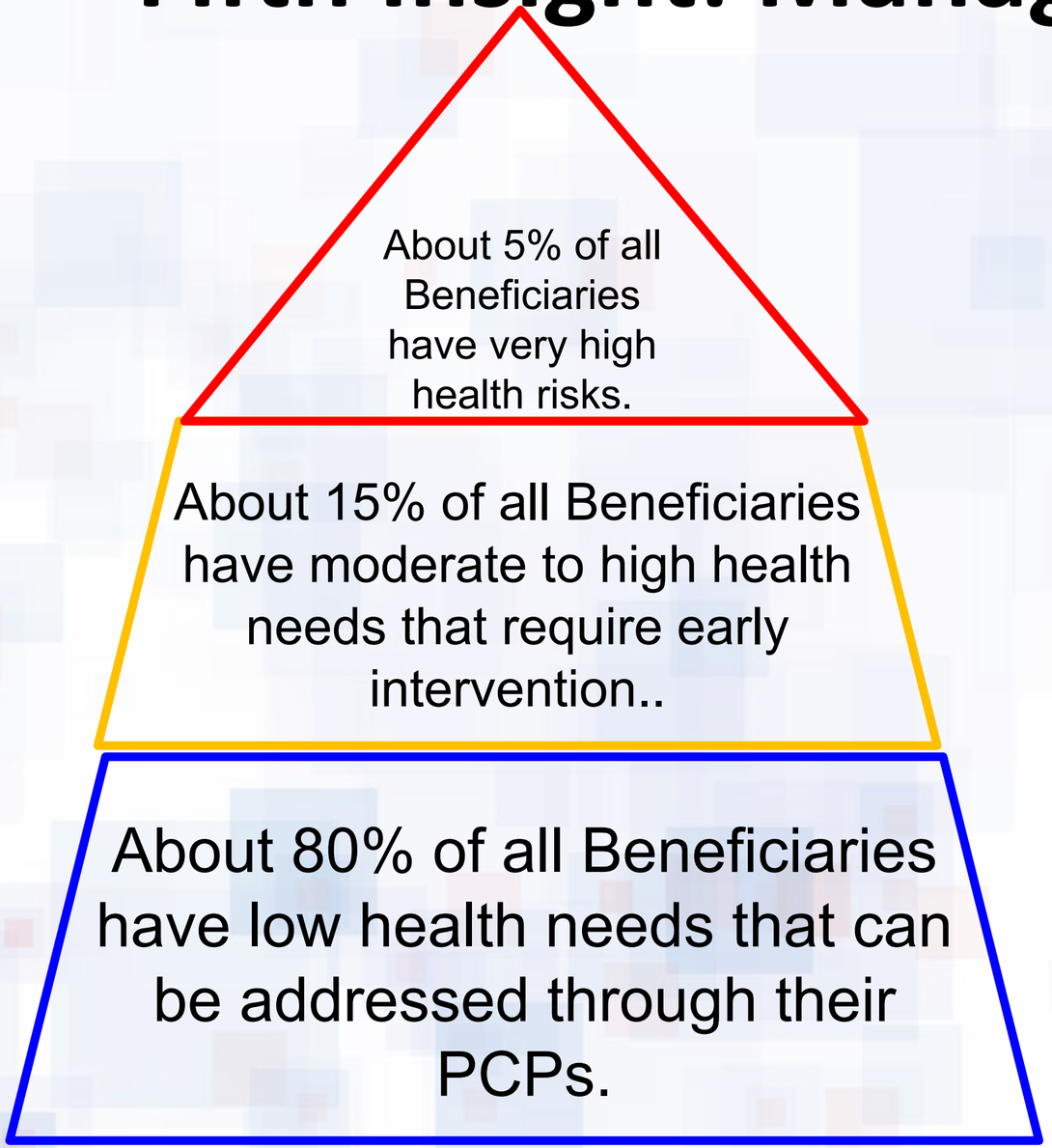
Fourth Insight: Community-Based

- While doctors, nurses and other healthcare professionals are an important part of addressing SDOH, most of the resources will have to come from the community where a person lives.
- This includes not only human services agencies, but also community-based non-profit organizations and other non-health care providers.

Fourth Insight: Community-Based

- A benefit's analyst in a Human Services Agency will reduce the likelihood of an early death for one out of every four people they sign up for health insurance.
- Child welfare and probation staff lessen the likelihood of ACE scores increasing when they are working with youth and their families.
- Non-profit agencies and other community partners reduce adverse SDOH outcomes by helping people secure food, jobs, and housing.

Fifth Insight: Managing Health Risks

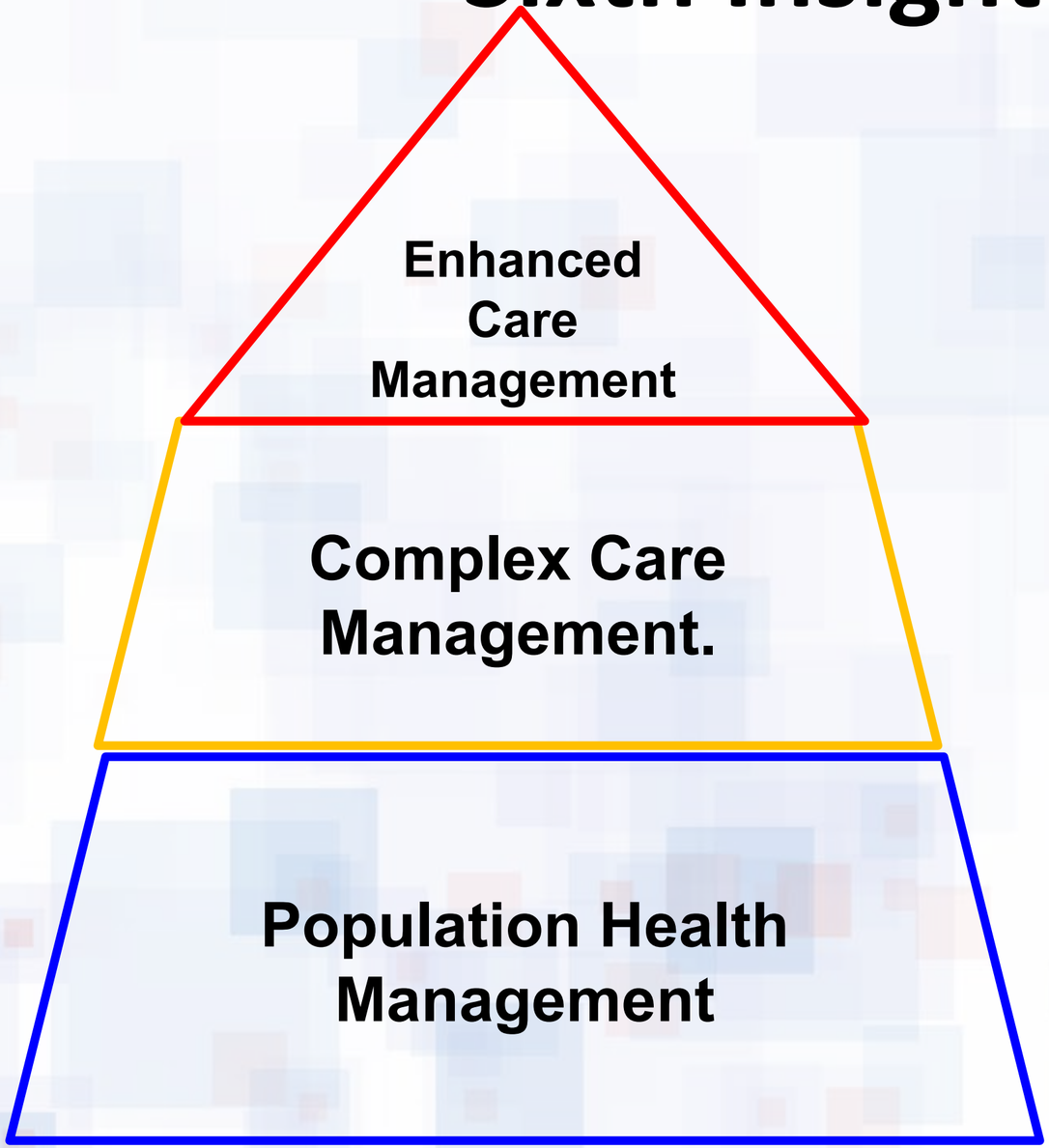


Enhanced Care Management by Community-Based Providers (usually non-health care)

Complex Care Management by Health Care Providers

Population Health Management by Health Care Providers

Sixth Insight: Capacity



ECM Infrastructure has not been built, we need to build capacity.

Infrastructure for CCM already built, we just need to enhance.

Infrastructure for PHM already built, we just need to enhance.

Sixth Insight: Capacity

- California invested $1.5 billion over 2.5 years to build out both Enhanced Care Management and Community Supports.
- DHCS has created policy manuals for both ECM** and Community Supports.***

* https://lao.ca.gov/Publications/Report/5003
** https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf
*** https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

CWDA
County Welfare Directors Association of California

Beneficiary/Patient-Centered Care

- Beneficiary/Patient Centered Care was always a part of Medi-Cal Managed Care Plans, but with CalAIM, the meaning was re-emphasized to a whole new level of focus.
- Planning, delivering, and evaluating health care was based upon partnerships between the beneficiary, their family, and their health care provider.

https://pmc.ncbi.nlm.nih.gov/articles/PMC11554389/

Beneficiary/Patient-Centered Care (Important Slide)

- It is not about the typical and old model question of "What **is the matter** with the beneficiary/patient?"
- It is now about "What **matters** to the beneficiary/patient?"
- How can we help a youth and their family with the youth's own health care journey?

https://pmc.ncbi.nlm.nih.gov/articles/PMC11554389/

Beneficiary/Patient-Centered Care Parallels

- There are parallels in other systems including child welfare.
- A shout out to the CDSS Technical Assistance Call Teams as one of their main questions is to re-ask questions that child welfare supervisors ask their social workers as part of the Integrated Core Practice Model:
- **What does the youth want? What is important to them? What matters to them?**

https://pmc.ncbi.nlm.nih.gov/articles/PMC11554389/

Risk Stratification, Segmentation, and Tiering (RSST)

- RSST is differentiating members into different subgroups.
- RSST has to occur:
  - Upon each member's enrollment.
  - Annually after each member's enrollment.
  - Upon a significant change in the health status or level of care of the member (e.g., inpatient medical admission or emergency room visit, pregnancy, or diagnosis of depression).

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/ pp. 28-32

Assessments and Reassessments Examples

- Those beneficiaries entering Complex Care Management or Enhanced Care Management.
- Child and Youth with Special Health Care Needs (i.e., those child with at least one chronic physical or health issue).

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/ p. 33-34

Assessments and Reassessments Examples

- Currently residing in an acute hospital setting.
- Hospitalized in last 90 days or 3 or more hospitalizations in last 12 months.
- 3 or more emergency room visits in last 12 months.
- Within the last 90 days, prescribed an antipsychotic or 15 or more (any) medications .

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/ p. 33-34

Basic Population Health Management (BPHM)

- Every beneficiary, no matter health risk level, receives BPHM.
- This means that they will have a Primary Care Doctor, as well as basic primary care, and referrals to others as warranted.

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/

BPHM Continuity of Care Coordination (Important Slide)

- Even though some Medi-Cal services are typically carved-out of the MCP benefit package (e.g., specialty mental health services), MCPs must ensure that members have access to needed services that address all their health and health-related needs, including developmental, physical, mental health, SUD, dementia, LTSS, palliative care, oral health, vision, and pharmacy needs. (pp. 38-39)

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/

BPHM Continuity of Care Coordination (Important Slide)

- Each beneficiary's assigned Primary Care Provider plays a key role in coordination of care, ensuring each member has sufficient care coordination and continuity of care with out-of-network providers, and communicating with all relevant parties on the care coordination provided.
- **In essence, continuity of care starts with a beneficiary's primary care doctor regardless of what health insurance that a beneficiary has.**

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/ p. 39

BPHM Continuity of Care for Children (Important Slide)

- MCPs **must** coordinate health and social services for children between settings of care and across other delivery systems.
- Specifically, MCPs **must** support children and their families in accessing medically necessary physical, behavioral (including specialty mental health services), developmental, and dental health services, etc., as well as social and educational services.

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/ pp. 43

BPHM Continuity of Care for Children (Important Slide)

- This does not mean that MCPs will supplant what ever services are already in place.
- It is the recognition that beneficiaries, especially children, will move between systems, will step down from higher level of care back to their homes in the community, etc.
- DCHS has said that the best entity to ***coordinate*** this continuity of care is the MCP with the PCP as the lead.

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/ pp. 43

Complex Care Management (CCM)

- Every beneficiary who is signed up for CCM will be assigned a CCM Care Manager (p. 41) who will work with the beneficiary to develop a Case Management Plan (p. 40) which is analogous to a CWS case plan.
- For children under 21, CCM must include EPSDT.
- If the beneficiary needs Transition Care Services, the CCM Care Manager will take the role of the TCS care manager.

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/

Complex Care Management (CCM)

- Services could include (p.40):
- Care coordination focused on longer-term chronic conditions.
- Interventions for episodic, temporary member needs.
- Disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education.
- Community Supports, if available and medically appropriate, and cost-effective.

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/

Enhanced Care Management

- Going live in Jan 2022, ECM is community-based, interdisciplinary, high touch, person-centered, and provided primarily through in-person interactions (p. 42).*
- Initial authorization for any beneficiary with ECM will be for the first 12 months and reauthorization every 6 months thereafter (p. 108).**

* https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/
** https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

Enhanced Care Management

- MCPs are required to contract with community providers such as FQHCs, Counties, County behavioral health providers, Local Health Jurisdictions, CBOs, and others, to become ECM providers, and those providers will assign a Lead Care Manager to each member.
- The Lead Care Manager meets members wherever they are – at home, on the street, in a shelter, in their doctor's office, etc.

https://www.dhcs.ca.gov/pa/CalAIM/Documents/PHM-Policy-Guide.pdf/

Enhanced Care Management

	ECM Populations of Focus	Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✓	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or SUD 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 CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

Sub-Population: SMHS

- Children and Youth eligible for or receiving specialty mental health services through a County Mental Health Plan.
- Children and Youth receiving Drug Medi-Cal (DMC) services.

https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

Sub-Population: Hospitalized/ERs

- A beneficiary with 2 or more hospital admissions in the last 12 months.
- A beneficiary with 3 or more emergency room visits in the last 12 months.

https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

Sub-Population: Foster Care

- 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.

https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

ECM Goals

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Addressing SDOH;
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf p. 6

ECM Core Components

1) Outreach and Engagement;
2) Comprehensive Assessment and Care Management Plan;
3) Enhanced Coordination of Care;
4) Health Promotion;
5) Comprehensive Transitional Care;
6) Member and Family Supports; and
7) Coordination of and Referral to Community and Social Support Services. Notably, the nuances of supports and services provided through ECM will vary based on the needs of the Member.

https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf p. 60

ECM Lead Care Manager

- Per Timely Access Standards, once a beneficiary is deemed eligible for ECM, the MCP has to refer the beneficiary to an ECM provider within 10 business days.
- Unless that ECM Provider does not have capacity, that ECM Provider will immediately accept the beneficiary and assign them an ECM Lead Care Manager.
- This ECM Lead Care Manager is then responsible for the coordination of a beneficiary's ECM as well as community supports through a development of a beneficiary's ECM care management plan.

https://www.dhcs.ca.gov/services/Documents/MCQMD/ECM-and-Community-Supports-Standard-Provider-Terms-and-Conditions.pdf

ECM Lead Care Manager

- There is redundancy in the system in that if the beneficiary does not yet have a primary care provider, the ECM Lead Care Manager assures that the beneficiary is assigned a PCP.
- Further, if the beneficiary needs Transitional Care Services, the ECM Lead Care Manager will become the beneficiary's TCS Care Manager.
- There are no network adequacy issues, as the ECM Lead Care Manager will meet with the beneficiary (and, if the beneficiary is under 18 years of age, their parents) in person where the beneficiary lives, seeks care or is accessible, to develop a Case Management Plan.

https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

ECM Care Management Plan (Important Slide)

- The ECM Care Management Plan is a comprehensive, individualized, person-centered care plan developed **for** the beneficiary ***by*** the beneficiary and their parent (or whoever has care/custody/control) with appropriate clinical input including their core health team.
- The care plan incorporates desires of the beneficiary and addresses their needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports and SDOH.

https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf p. 62

ECM Care Management Plan (Important Slide)

- The ECM Care Management Plan must include goals, as well as what is to be monitored, identify services and service providers (those that are in place and those are needed), and timeframes of when to follow-up with the beneficiary.
- A copy of this Care Management Plan has to be given to the beneficiary, and, if applicable, their parent (or whoever has care/custody/control).

https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf pp. 40, 62

CCM vs. ECM

- A beneficiary cannot be enrolled in CCM and ECM at the same time.
- Rather CCM is considered on the ECM continuum of case management continuum.
- DHCS encourages MCPs to work with providers to contract for a care management continuum of ECM and CCM programs, including if one provider can cover both ECM and CCM programs.

https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf p. 42

Transitional Care Services (TCS)

- MCPs are expected to use a consistent assessment process and/or assessment tools to identify members who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with hospitals' current processes.
- For those who have had hospital discharge training with me or have heard me on TA calls, this is analogous Health and Safety Code § 1262.5 which requires a ***hospital discharge plan evaluation***, in addition to the *hospital discharge plan* to determine potential adverse health consequences.

https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf p. 48

Transitional Care Services (TCS)

- MCPs have to know, in a timely manner, each Member's admission, discharge, or transfer to or from an ED, hospital inpatient facility, SNF, **residential or treatment facility**, **incarceration facility**, or other treatment center and communicating with the appropriate care team members.
- **Residential or treatment facility**: Short-Term Residential Treatment Programs or Community Treatment Facilities.
- **Incarceration facility**: Juvenile Hall.

https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf p. 65

Transitional Care Services Care Manager

- MCPs must ensure that beneficiaries are offered the direct services of a care manager.
- For members who do not already have a care manager through ECM or CCM, the MCP may choose either to use its own staff to accomplish this, or to contract with the hospital, the PCP or another appropriate delegate such as an accountable care organization (ACO).

https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf p. 50

Transitional Care Services Care Manager

- MCPs must notify the identified responsible care manager of the assignment and of the member's admission status, including the location of admission, and ensure that the discharging facility has the name and contact information, including phone number of the identified care manager.
- MCPs must also ensure the member has the care manager's contact information.

https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf p. 51

Transitional Care Services and SHMS

- For members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, where the county MHP is the primary payor, and for members who are admitted for residential SUD treatment, including residential withdrawal management, where DMC-ODS is the primary payor, MHPs or DMC-ODS are primarily responsible for coordination of care with the member upon discharge.

https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf pp 58-89

Transitional Care Services and SHMS

- However, MHPs and DMC-ODS have limited access/ability to coordinate across the MCP or physical health care needs.
- As such, MCPs will also be required to assign or contract with a TCS care manager to coordinate with behavioral health or county care coordinators, ensure physical health follow-up needs are met, and assess for additional care management needs or services such as ECM (Enhanced Care Management), CCM (Complex Care Management), and/or Community Supports.

https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf pp 58-89

Community Supports

- Community Supports are an evolution of what was called In Lieu of Services (ILOS).

- Housing Transition Navigation Services
- Housing Tenancy and Sustaining Services
- Housing Deposit
- Transitional Rent
- Recuperative Care (Medical Respite)
- Short-Term Post-Hospitalization Housing
- Caregiver Respite Services
- Sobering Centers
- Asthma Remediation
- Day Habilitation
- Environmental Accessibility Adaptation (Home Modifications)
- Medically Tailored Meals/Medically Supportive Food
- Assisted Living Facility (ALF)
- Personal Care and Homemaker Services:

https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf

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https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf

Community Supports
Caregiver Respite Services

- Caregiver respite Services are provided to caregivers of Members who require intermittent temporary supervision.
- The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature.
- This service is distinct from medical respite/recuperative care and is rest for the caregiver only.
- Example: A relative resource parent (in Family Reunification) requests short-term respite.

https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf p. 10

Community Supports

Medically Tailored Meals/Medically Supported Foods

- Designed to address individuals' chronic or other serious conditions that are nutrition- sensitive, leading to improved health outcomes and reduced unnecessary costs.
- *Medically Tailored Meals*: Meals that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.
- *Medically Tailored Groceries*: Pre-selected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf p. 35

Community Supports
Personal Care and Homemaker Services

- Includes services as similarly provided by the In-Home Supportive Services (IHSS) program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and **protective supervision for the mentally impaired**.
- Protective supervision for the mentally impaired example: An aide to assist a relative resource family to help with supervision of a foster youth with mental health issues who has trauma triggers that lead them to leave their home.

https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf p. 25

Community Health Worker (CHW) Services

- CHW services is a Medi-Cal benefit that started July 1, 2022 and is available to both Straight Medi-Cal beneficiaries as well as beneficiaries who are a part of a Medi-Cal MCP.
- As a part of a Medi-Cal MCP, CHW services are an integral part of ECM and Community Supports.

https://www.dhcs.ca.gov/community-health-workers

Community Health Worker (CHW) Services

- CHWs are known by many roles including promotores, community health representatives, navigators, and front-line non-licensed public health professionals.
- They provide services that include preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and well-being.

https://www.dhcs.ca.gov/community-health-workers
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/03BBA223-8762-4A94-A268-209510E15E37/chwprev.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

CHW Service Areas

- **Health education** to promote the Medi-Cal member's health or address barriers to health care, including providing information or instruction on health topics.
- **Health navigation** to provide information, training, referrals, or support to assist Medi-Cal members to access health care, understand the health care system, and engage in their own care and to connect members to community resources necessary to promote their health.
- **Screening and assessment** that assist Medi-Cal members to connect to appropriate services to improve their health.
- **Individual support or advocacy** that assists Medi-Cal members in preventing the onset or exacerbation of a health condition or preventing injury or violence.

https://www.dhcs.ca.gov/provgovpart/Pages/CHW-General-Information-FAQ.aspx

Community Health Worker
How to be Referred to a CHW

- A licensed provider first determines that a Medi-Cal member would benefit from CHW services and recommends CHW services.
- The licensed provider could be a physician, dentist, behavioral health provider, nurse, midwife, or another licensed provider.

https://www.dhcs.ca.gov/provgovpart/Pages/CHW-General-Information-FAQ.aspx

MCP Continuity of Care Responsibilities for American Indian Beneficiaries

- All Plan Letter 24-002 states that there are additional continuity of care protections for beneficiaries who are American Indian including those who are members of a Federally-recognized Tribe.
- This includes the ability for an American Indian beneficiary to receive out-of-network services from an Indian Health Care provider without needed prior authorization or contract even if services are available from an in-network Indian Health Care Provider.

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-002.pdf

Medi-Cal Managed Care Plan Enrollment

- In CA, most Medi-Cal beneficiaries are enrolled in MCPs.
- At the beginning of 2019, 81.7% of Medi-Cal beneficiaries are enrolled in MCMCPs.
- As of Dec 2025, 97.4% of 14.3 million Medi-Cal beneficiaries are enrolled in a MCP.

https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-with-demographics-by-month/resource/2c28bf78-a385-4d0c-88d5-7d1eef09a5ab

Putting CalAIM for Foster Youth in Context

https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

Carve-Out

- Dental and Optometry are considered “carve-out” services in which an employer purchases a portion of health services from a specialized vendor.*
- Specialty Mental Health Services is a different type of carve out.**
- Normally, funding is capitated (a funding ceiling) to Medi-Cal Managed care plans to manage the care of their Medi-Cal beneficiaries.
- However, certain conditions, like mental health, can be very expensive to manage, so such services might be “carved-out” to “given” to other systems to address.

* https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf
** https://pmc.ncbi.nlm.nih.gov/articles/PMC1361127/

Primary Residency: Foster Youth

- Primary residency for a foster youth before termination of parental rights is where their parent(s) reside (WIC § 17102); in essence, the county of jurisdiction.
- Primary residency for a foster youth after termination of parental is the county where the court terminated jurisdiction (WIC § 17.1(e)); in essence, the county of jurisdiction.
- For the most part, primary residence will not change for a foster youth even if they are placed outside of the county of jurisdiction.

https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

Care/Custody/Control

- If the court orders removal pursuant to Section 361, the court shall order the care, custody, control, and conduct of the child to be under the supervision of the social worker…(WIC § 361.2(e)).
- Similar language for probation is under WIC § 727(a)(1).

Health Care Decisions/Authorization

- If a dependent child of the juvenile court is placed by order of the court within the care and custody or under the supervision of a social worker of the county where the dependent child resides…the court may…order that the social worker may authorize the medical, surgical, dental, or other remedial care for the dependent child, by licensed practitioners, as necessary. (WIC § 369 (c))
- This includes decisions on Medi-Cal Managed Care Plan enrollment.
- Similar language for probation is under WIC § 739(c).

Foster Youth on MCP

- No child in foster care shall be required to enroll in a Medi-Cal managed care plan. A foster child may be voluntarily enrolled in a Medi-Cal managed care plan only when the county child welfare agency with responsibility for the care and placement of the child, in consultation with the child and family team, determines that it is in the best interest of the child to do so and the department determines that enrollment is available to the child. WIC § 14093.09(a).
- If the foster youth is placed outside the County, the County in consultation with the CFT, determines whether to keep the youth on the current MCMCP or to change plans. WIC § 14093.09(b).

Foster Youth on MCP

- If the foster youth stays on the same plan, the MCP shall process and pay appropriately documented claims submitted by out-of-plan providers for services provided to foster children in out-of-county placements WIC § 14093.09(d).
- The County must provide every Medi-Cal applicant and beneficiary, including children in foster care, with a written notice of action at least 10 days before it takes any action affecting Medi-Cal benefits. 22 CCR §50179(d)(1).

Continuity of Care Beneficiaries Who are Foster Youth or Former FY in Single Plan Counties

- All Plan Letter 24-014 states that youth can continue to receive services from a previous provider for up to a year.
- Further, continuity of care requests can be made 60 days prior to the transition, processed within 5 calendar days upon receipt, and processed within the following timelines:
- 30 calendar days for non-urgent requests;
- 15 calendar days for those that need more immediate attention; and
- As soon as possible, but no more than 3 calendar days for urgent requests (potential immediate harm to the beneficiary).

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-014.pdf

When a Youth Comes Into Foster Care

- As soon as a youth comes into foster care, determine who is their primary care provider and determine whether they are on a Medi-Cal Managed Care Plan (MCP).
- If the youth is on Straight Medi-Cal, consult with the CFT to determine if there would be benefits on keeping them on Straight Medi-Cal or to enroll them in Medi-Cal Managed Care per WIC § 14093.09(a).

When a Youth Comes Into Foster Care

- If they are on a MCP, as a rule of thumb, per continuity of care, keep them on that MCP.
- If they were inadvertently switched off that MCP, arrange to get them back onto the MCP to maximize continuity of care and minimize health services disruptions to the youth.
- Remember that even if they are switch to straight Medi-Cal, by law, they have a right to continuity of care with their previous provider and/or equivalent level of services.

Youth in Foster Care

- If they do not yet have Enhanced Care Management, enroll them in ECM.
  - https://www.cdss.ca.gov/inforesources/cdss-programs/enhanced-care-management-and-community-supports-referral-pathways
- Per Timely Access Standards, the MCP has to communicate to the ECM provider within 10 business days of a beneficiary's ECM eligibility for assignment of an ECM Lead Care Manager and the ECM provider has to then immediately assign an ECM Lead Care Manager.
- Find out the contact information for their ECM lead care manager.

https://www.dhcs.ca.gov/services/Documents/MCQMD/ECM-and-Community-Supports-Standard-Provider-Terms-and-Conditions.pdf

Youth in Foster Care

- Explain to the foster youth and their caregiver that youth will be meeting with an ECM Lead Care Manager and explain in general terms what a Care Management Plan is (note: there is no network adequacy issue as the ECM Lead care Manager is supposed to meet with the beneficiary wherever they are).

Youth in Foster Care

- It would be best practice to for the child welfare social worker to also be there when the youth and the care provider meet with the ECM Lead Care Manager to develop the ECM Care Management Plan and get a copy.
- Make sure the ECM lead care manager is a part of the youth’s core health team, and invite them and/or a core health team representative to the next and future CFT meetings.

Youth in Foster Care

- Identify who is on the child's core health team.
- If the child has any special health care needs (e.g., a mental health disorder, autism, etc.), consider asking the primary care provider to submit a referral to a specialist (e.g., child psychiatrist, developmental pediatrician, etc.) to join the core health team.

Youth in Foster Care

- If the youth is hospitalized on a psychiatric or other medical emergency, reach out to the ECM lead care manager to see when they or someone else will take on the role of the transitional care services (TCS) care manager.
- Work with the TCS care manager to get a copy of both the discharge plan and discharge plan evaluation.

Youth in Foster Care

- If the CFT (which should now include the ECM lead care manager) determines that youth needs a STRTP or CTF, determine if the ECM lead care manager or someone else will take on the role of the transitional care services (TCS) care manager to help the youth transition to the STRTP or CTF.

Youth in Foster Care

- If STRTP is in another county, remember continuity of care and a foster youth's primary residence, and do not change Medi-Cal MCPs.
- However, do coordinate to make sure that all parties, including providers in the other county, are aware of the youth's Medi-Cal MCP of record and make any logistical arraignments for local services (e.g., does local provider know how and who to submit claims to at the MCP of record).

Before Jurisdiction Termination

- About six months before jurisdiction terminates, work with the ECM Lead Care Manager to schedule a Jurisdiction Termination Continuity of Care Coordination meeting, and include not only child welfare representatives and core health team representatives, but also the youth and their family (whether it is the biological parents for family reunification, legal guardians, or adoptive parents).
- Make sure that the youth and their family understand who will be the primary care provider and health insurer (Medi-Cal Managed Care Plan, private commercial insurance, etc.).

Before Jurisdiction Termination

- Explain to them that the current Primary Care Provider (PCP) for the youth has been and will continue to lead the continuity of care coordination efforts with the ECM Lead Care Manager as their primary point of contact after JT.
- If they decide to move to another county that has a different MCP, or even to another state, explain to them that the youth's core health team will assist, including making sure that continuity of care forms are completed, medical records are sent, etc.

Jurisdiction Termination – Move Out of County

- If the move is to another part of California, continuity of care could include access to the youth's current providers and/or at least the same level of services.
- The current core health team can assist with making sure medical records, Case Management Plans, Continuity of Care forms are forwarded to the child's new core health team in another county.

Jurisdiction Termination – Move Out of State

- If the move is to another state, work with the youth's core health team to encourage that the family signs the youth up for health insurance in the other state as soon as possible.
- The current core health team can assist with making sure medical records, Case Management Plans, Continuity of Care forms are forwarded to the child's new core health team in the other state.
- The point is to encourage the caregivers to ask questions and get more information, and prepare for the transition.

https://www.dhcs.ca.gov/services/Documents/Pub68_myMedi-Calcomparison.pdf/

Post-Adoption Services and Core Health Team

- For adopted children, do not replace existing systems and resources, including making sure that the family is actively working with the Post-Adoptions Services staff.
- In relation to health issues, including mental health issues, in addition to a call to Post-Adoption Services, one of the other first calls should be to the youth's primary care doctor and core health team.

Summary

- Dr. David Satcher, U.S. Surgeon General (1998-2002) had a very elegant saying:
- Risk factors…
- …are not predictive factors…
- …because of protective factors.
- All those here in this presentation, your colleagues who are not here, the foster youth and their families, all are a part of the potential protective factors.

Summary

- This includes maximizing CalAIM for foster youth.
- If a youth is healthy, keep them healthy.
- If a youth becomes sick, prevent them from getting worse and heal them as soon as possible.
- If the youth has serious/complex and/or very high-risk health issues, do everything possible to stabilize and maximize their health care, and do it in such a way that they can be in their own homes.

Focus on Youth in Foster Care

If this were your own child, how would you approach this?

What **matters** to the foster youth and how can we help that youth, their family and caregivers navigate the youth's own health care journey?

Resources

- DHCS Population Management Health (PMH) Policy Guide May January 2026 https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf
- DHCS Enhanced Care Management (ECM) Policy Guide Aug 2024 https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf

Resources

- DHCS Community Supports Policy Guide Volume 1 Apr 2025 https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf
- DHCS Community Supports Policy Guide Volume 2 Apr 205 DHCS-Community-Supports-Policy-Guide-Volume-2_April_2025
- CDSS information on enrolling into ECM or Community Supports for each MCP: https://www.cdss.ca.gov/inforesources/cdss-programs/enhanced-care-management-and-community-supports-referral-pathways

Resources

- Presentation on Community Health Workers: https://docs.cfpic.org/cbsi/CalAIM%20Lunch%20&%20Learns/Community%20Health%20Worker%20Opportunities%20for%20Child%20Welfare%20Program%20Lunch%20and%20Learn%20Presentation.pdf
- Recording of Presentation on Community Health Workers: https://docs.cfpic.org/cbsi/CalAIM%20Lunch%20&%20Learns/Community%20Health%20Worker%20Opportunities%20for%20Child%20Welfare%20Program%20Lunch%20and%20Learn%20(9.25.25).mp4

Resources

- All Plan Letter 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-002.pdf

Resources

- All Plan Letter 24-014: Continuity of Care for Medi-Cal Members Who are Foster Youth or Former Foster Youth in Single Plan Counties

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-014.pdf

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