CalAIM: Understanding Enhanced Care Management and Community Supports

CFPIC
Building capacity. Leading change.

CWDA 100 YEARS OF IMPACT
A Century of Advancing Human Services for the Welfare of All Californians

CDSS

Introductions

Baljit Hundal, M.S.W., has built a thirty-year career in the Health and Human Services arena. Baljit has held several significant leadership roles over her career, with her last role at the county as the Child Welfare Director and Local Mental Health Director for a small county in California. Baljit is now working as a consultant and trainer across the state.

Loc H. Nguyen, DrPH, MSW , Dr. Nguyen has been a child welfare policy consultant with the County Welfare Directors Association of California (CWDA) since the beginning of 2018 and is the CWDA representative to State Technical Assistance helping counties to address the needs of foster youth with the most complex needs. He has worked with vulnerable populations for more than 37 years including refugees, the elderly, those affected by disasters, and children. He has held various roles in the public child welfare field since 1999, including as an Adoptions social worker/supervisor, assistant regional administrator in the Los County Department of Children and Family Services, the director of the regional training academy for Los Angeles County (now known as the LADCFS + UCLA Academy of Workforce Excellence), and was the child welfare director in San Mateo County for more than 5 years.

Participant Introductions

Please introduce yourself in the chat by sharing:

1. Your Name
2. Your Organization
3. Your Role

Agenda

01	CalAIM Medi-Cal Transformation and Six Insights
02	Medi-Cal and Managed Care Plans
03	MCP Medi-Cal Care Management Continuum
04	Enhanced Care Management
05	Community Supports
06	Definitions and Context
07	Applying CalAIM for Foster Youth in Adoptive Placement
08	Applying CalAIM for Adopted or Guardianship Youth
09	Referral Pathways

Acronyms Reference

APL All Plan Letter

APS Adult Protective Services

BH Behavioral Health

BPHM Basic Population Health Mgmt

CalAIM CA Advancing & Innovating Medi-Cal

CBO Community-Based Organization

CCM Complex Care Management

CCS California Children's Services

CHW Community Health Worker

CPSP Comprehensive Perinatal Svcs Program

CS Community Supports

CWS Child Welfare Services

DHCS Dept. of Health Care Services

DMC Drug Medi-Cal

DMC-ODS Drug Medi-Cal Org. Delivery System

ECM Enhanced Care Management

ED Emergency Department

EPSDT Early & Periodic Screening, Dx & Tx

FFS Fee-for-Service

FFY Former Foster Youth

I/DD Intellectual/Developmental Disability

IHCP Indian Health Care Provider

IHSS In-Home Supportive Services

LTC Long-Term Care

MCP Managed Care Plan

MHP Mental Health Plan

PHM Population Health Management

PMPM Per-Member Per-Month

POF Population of Focus

SMHS Specialty Mental Health Services

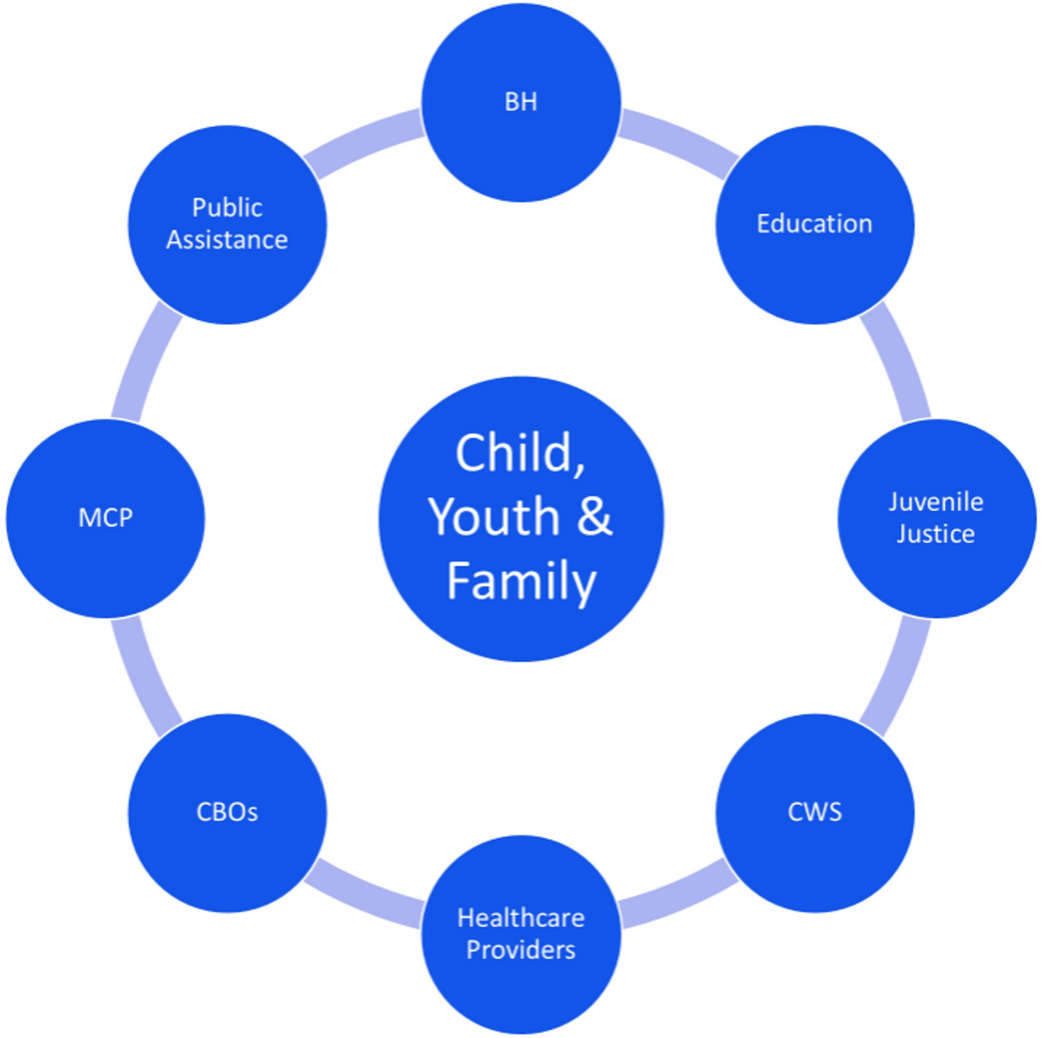
SNF Skilled Nursing Facility

SUD Substance Use Disorder

TBI Traumatic Brain Injury

TCS Transitional Care Services

WCM Whole Child Model


BH
Education
Juvenile Justice
CWS
Healthcare Providers
CBOs
MCP
Public Assistance
Child, Youth & Family

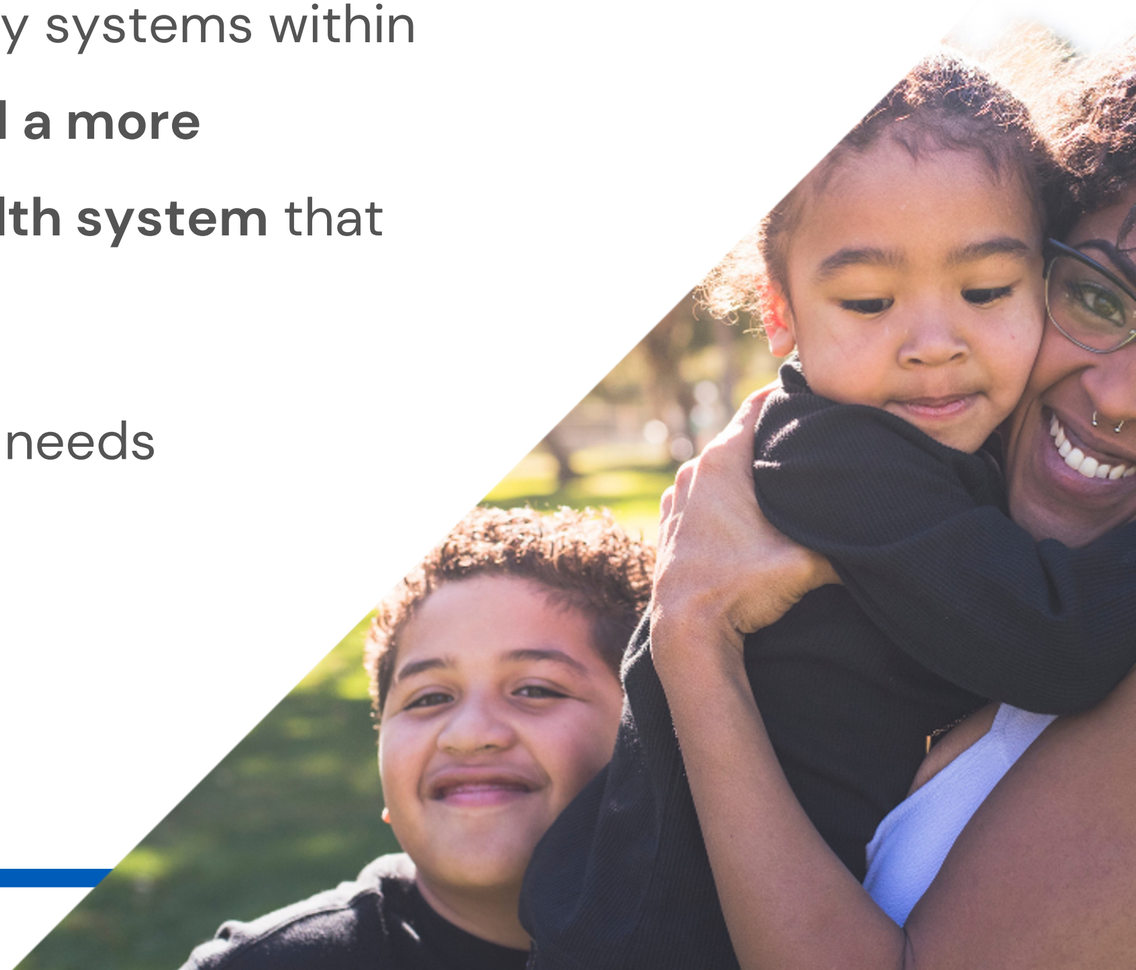
CALAIM: MEDI-CAL TRANSFORMATION

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



Medi-Cal Transformation

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

CalAIM and Six Insights

- 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.

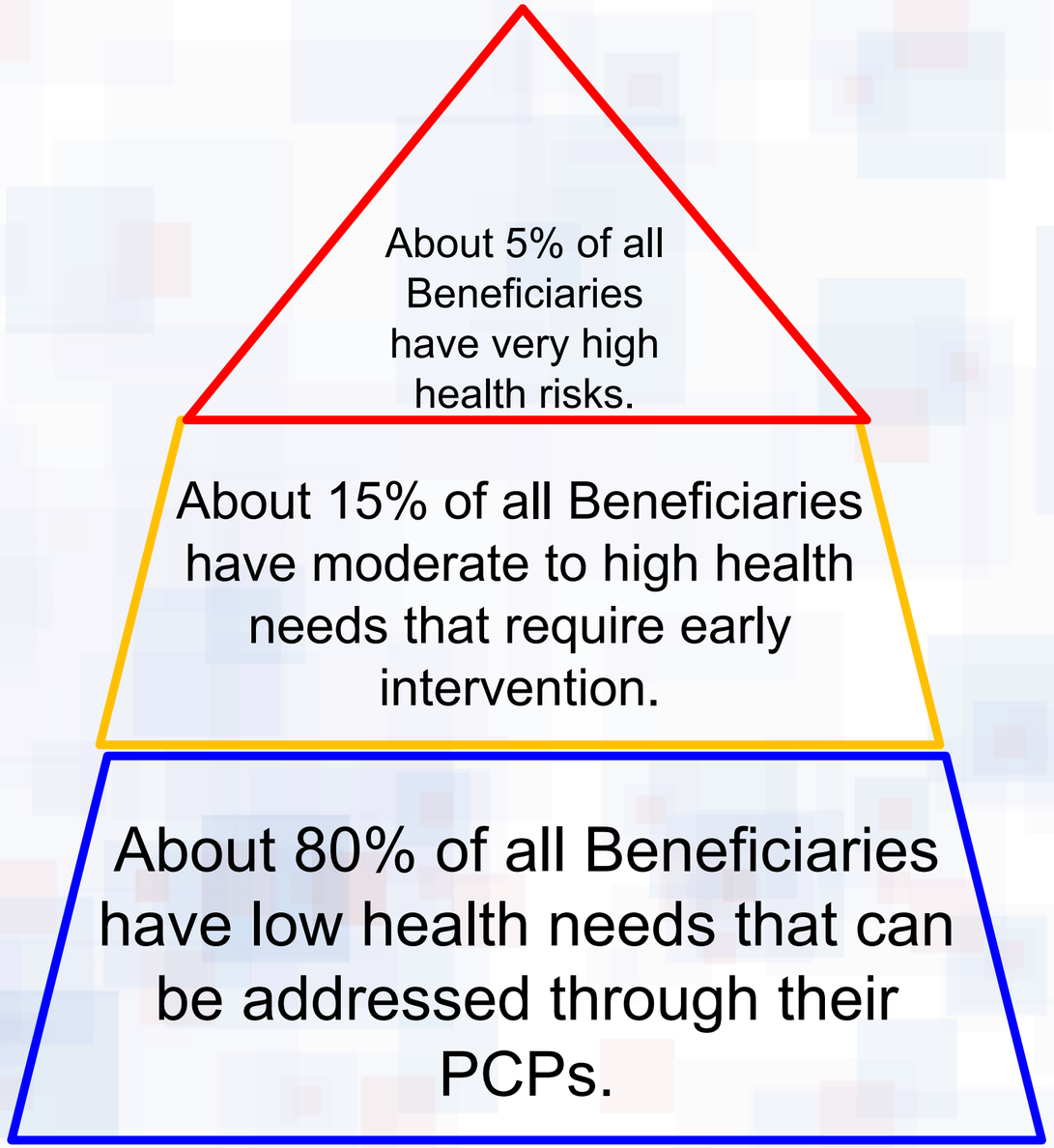
https://www.dhcs.ca.gov/calaim

First Insight: Different Populations have Different Health Needs

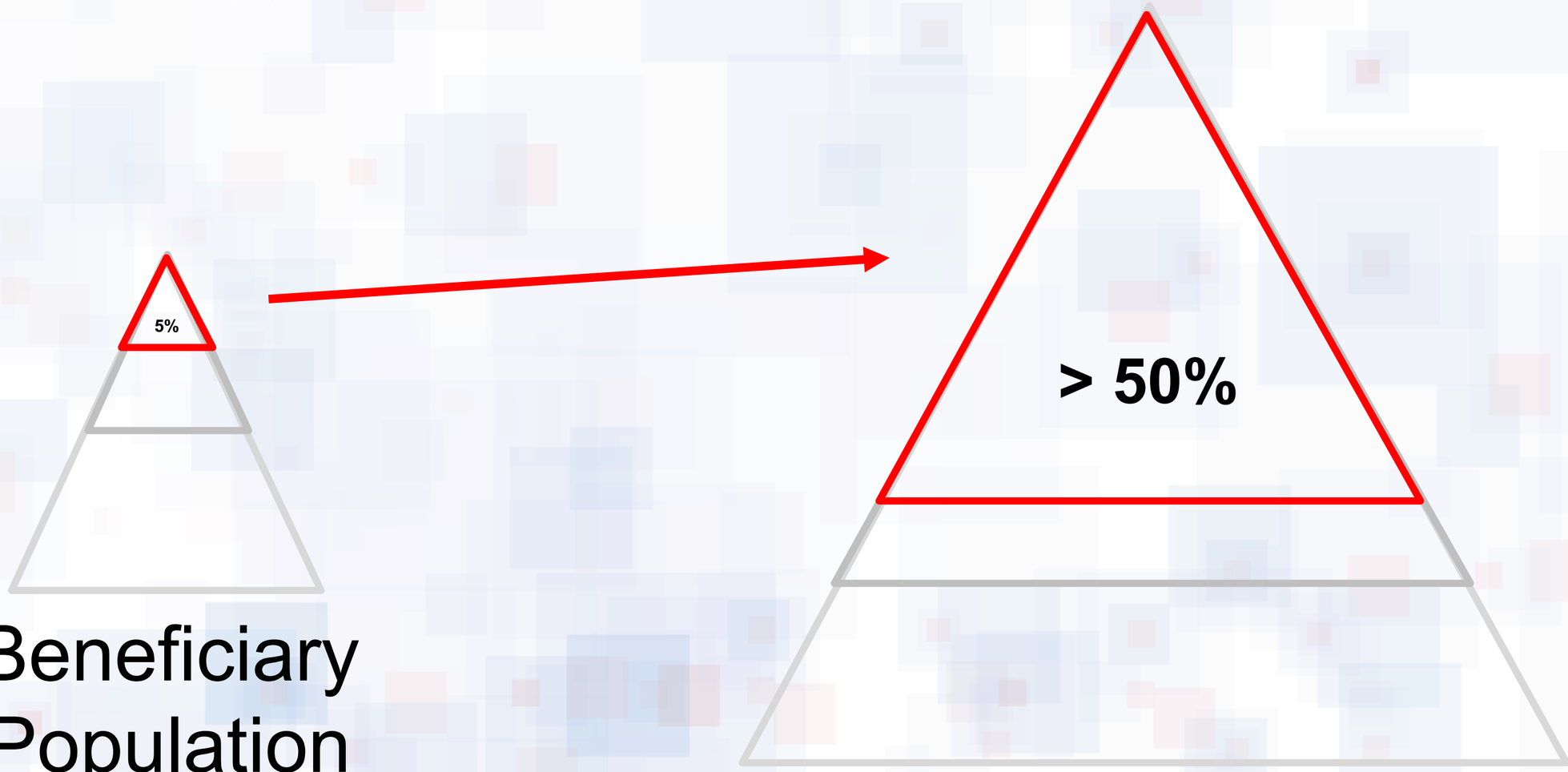
- People in the population have different health needs.
- Some have low health needs, others have higher needs, and you can “categorize” health needs by level.

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

Different Populations – Different Needs



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.

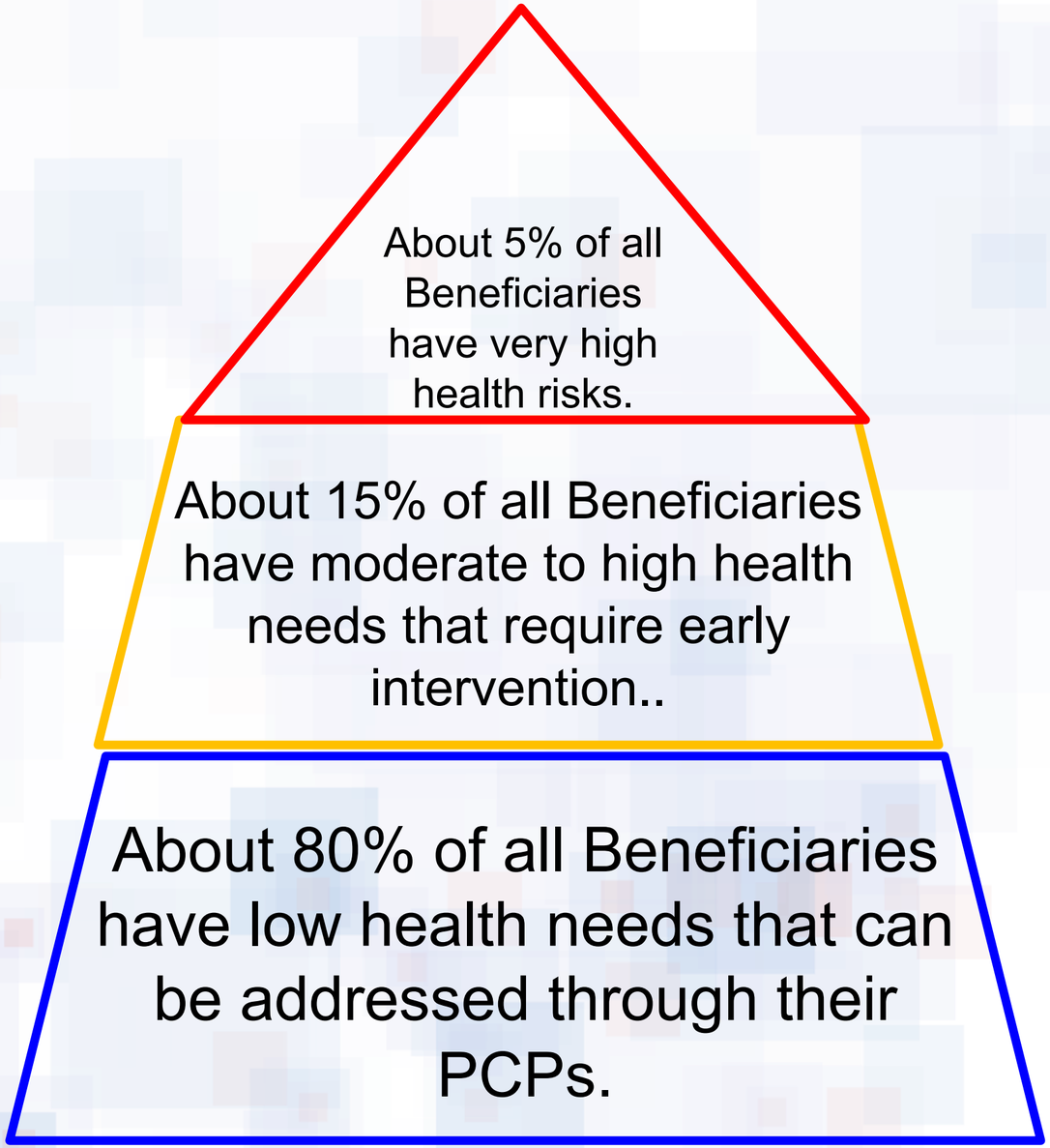
Fourth Insight: Community-Based

- 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

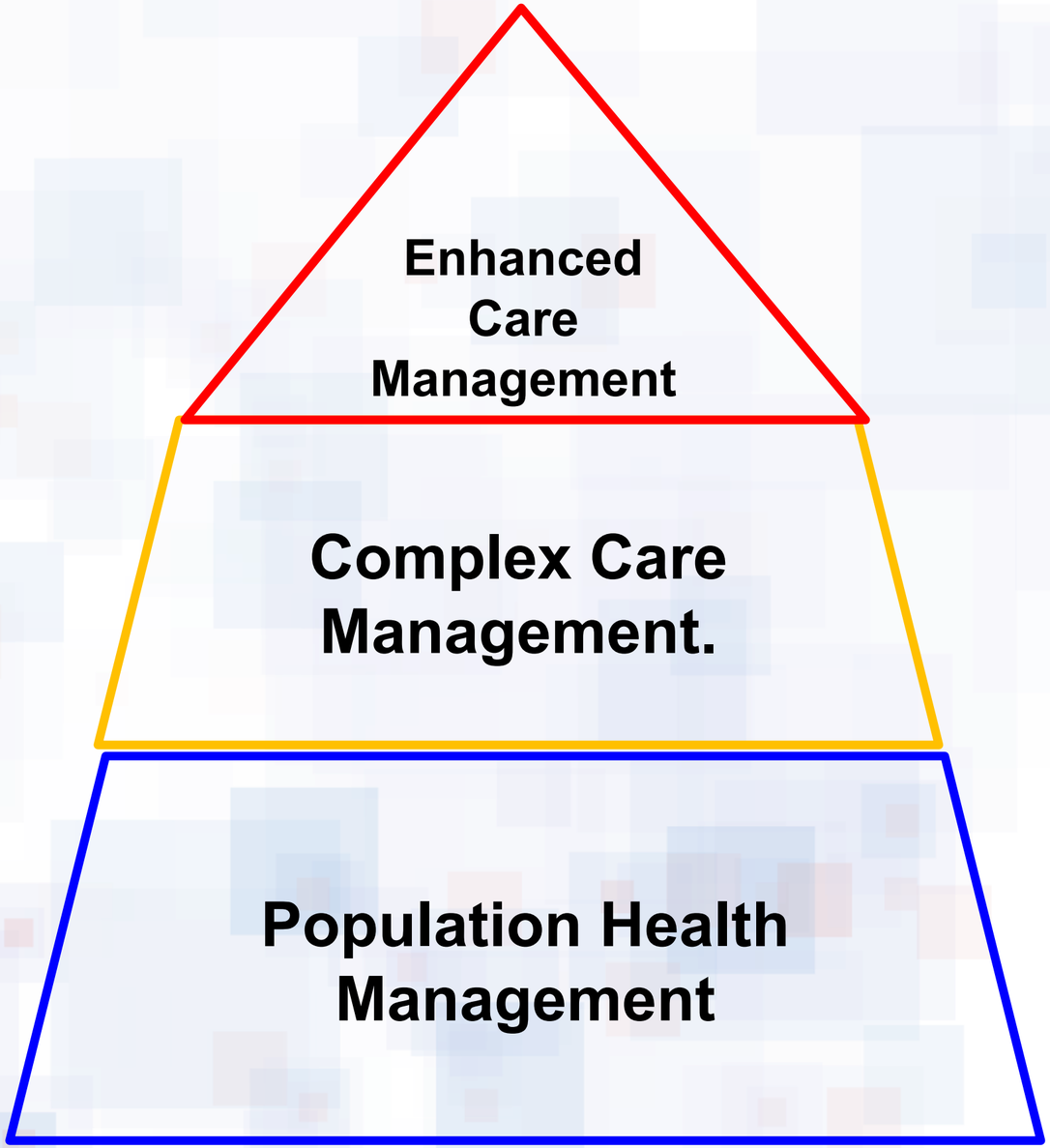


Enhanced Care Management by Community-Based Providers (usually non-health care)

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

Medi-cal and Managed Care Plans

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 jointly 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 approximately 97% of the total Medi-Cal enrollment.

Primary Delivery Models of Medi-Cal Services

Fee for Service (FFS) Medi-Cal

- State pays providers **directly** for each service
- No defined network of providers

Managed Care Plans (MCP)

- State contracts with Medi-Cal managed care plans (MCPs)
- State pays a Medi-Cal managed care plan a **capitated rate** or a **per-member per-month** (PMPM) payment for all the contracted services provided to a Medi-Cal enrollee. (Medi-Cal Explained: Medi-Cal Financing and Spending)
- MCPs **establish a network of providers** and pay them directly.

Medi-Cal Managed Care Plans (MCPs)

Commercial Health Plans

- Anthem
- Blue Shield of California
- Health Net
- Kaiser
- Molina

Local Plans

- 17 local plans across the state
- Local plans serve over 70% of Medical Managed Care enrollees statewide
- Provide care in 51 of 58 counties

Medi-Cal Managed Care Plans by County

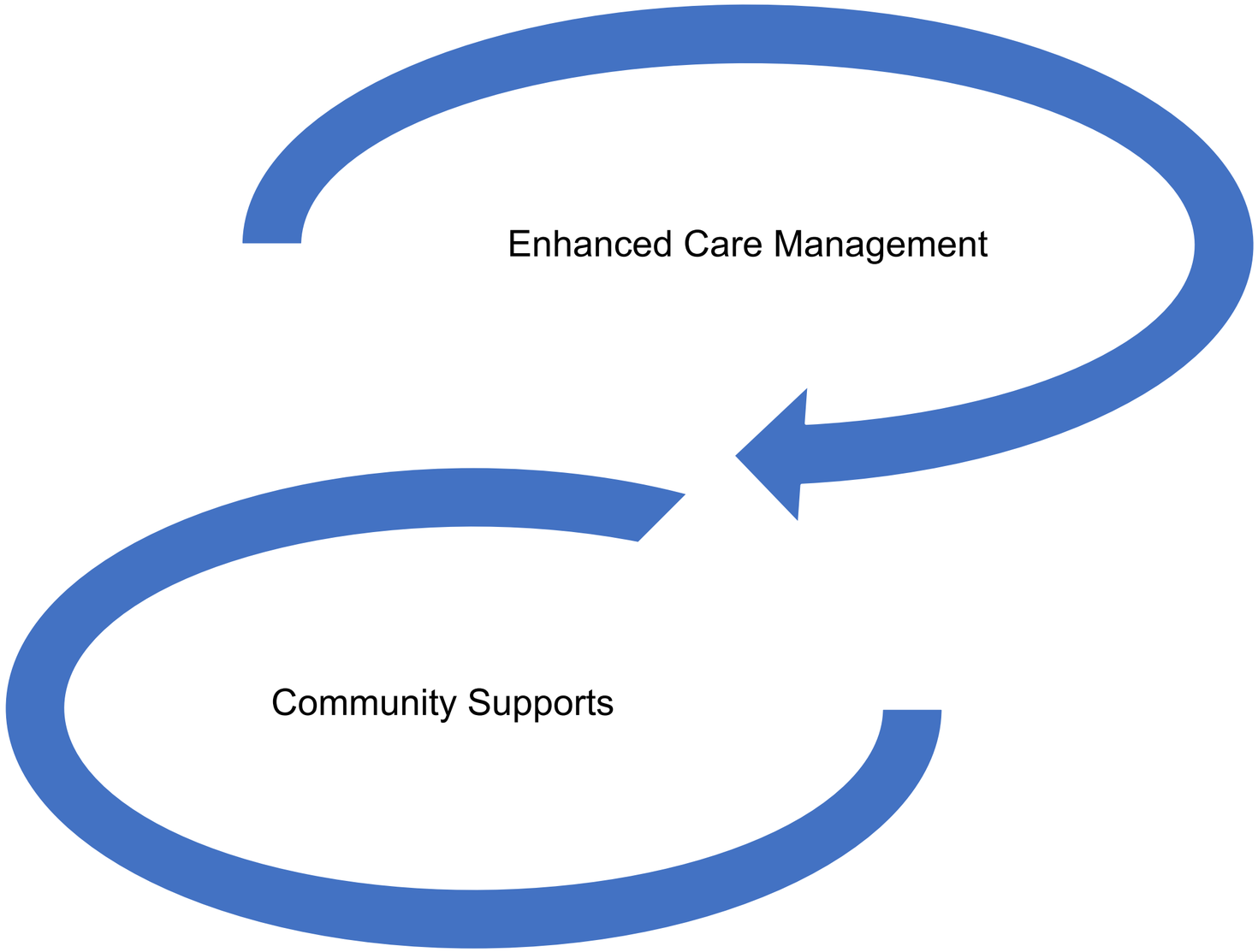
Medi-Cal Delivery Systems: FFS vs. Managed Care

How care coordination, access, and member supports differ across delivery systems

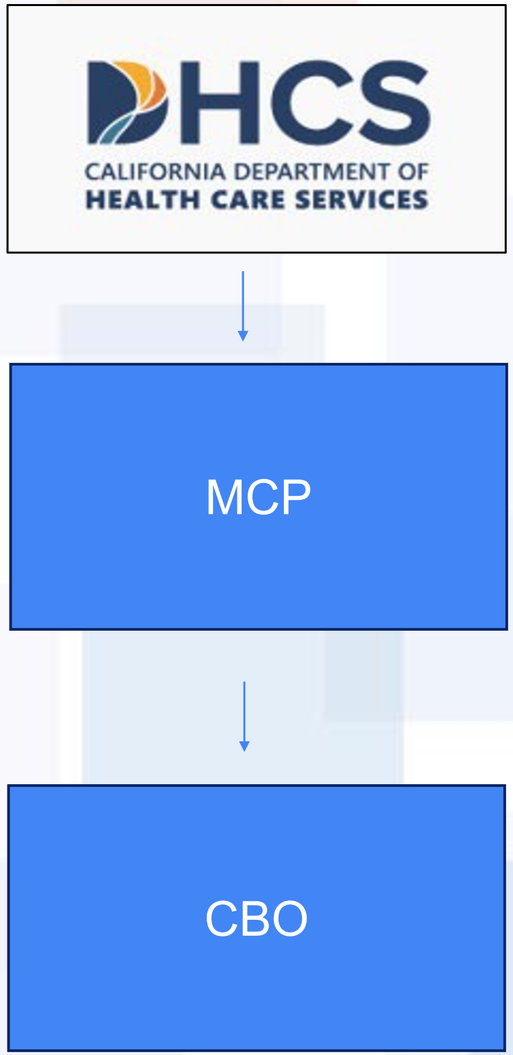
Topic	Fee-for-Service (FFS) Medi-Cal	Managed Care Plan (MCP) Medi-Cal
Care Management & Coordination	No care management benefit or program. HCPCFC public health nurses may help coordinate medical and dental needs for foster youth. No ECM or other CalAIM services.	In addition to HCPCFC PHN support, MCPs offer tiered care management and coordination for members with complex needs. Beginning 2024, MCPs must have a dedicated Child Welfare Liaison (PHM Policy Guide, Jan 2026; APL 24-013).
Provider Choice	Beneficiaries can go to any provider who accepts Medi-Cal; no provider directory is maintained.	MCPs must maintain a provider directory; members generally must use in-network providers, with exceptions when services are unavailable in-network.
Screening & Preventive Services	The State does not ensure that providers offer screening or preventive services.	MCPs must screen all children per American Academy of Pediatrics (AAP/Bright Futures) guidelines and offer preventive services.
Transportation Assistance	Non-emergency medical transportation (NEMT) is a covered benefit, but no assistance is provided to secure the benefit.	MCPs must provide and help coordinate NEMT. Transportation is also available to mental health and SUD appointments the MCP does not directly arrange (APL 22-008).
Language Interpretation	Should be made available, but the State lacks the infrastructure to monitor that all providers offer language translation and interpretation.	MCPs must provide access to language interpretation and ensure contracted providers make services available in the language a beneficiary requires (APL 21-004).
Continuity of Care	No specific continuity-of-care protections.	MCPs must follow continuity-of-care protocols that allow members changing plans — or switching from FFS to managed care — to continue seeing an out-of-network provider with a pre-existing relationship for up to 12 months or through completion of treatment for certain conditions (APL 23-022).
Network Adequacy	Availability of providers and specialists who accept FFS has diminished over time due to increased managed-care penetration and low FFS reimbursement rates.	MCPs must submit annual evidence of network adequacy demonstrating compliance with federal and State minimum network standards (APL 23-001).
Appointment Assistance	Aside from HCPCFC public health nurses, no assistance is provided. HCPCFC case ratios vary by county but shall not exceed 1:200.	MCPs must help members find and make appointments upon request. Beginning 2024, each MCP must designate a Child Welfare Liaison as single point of contact to help members navigate managed care (APL 24-013).

PWA_ataglance_10-8-24.pdf

CALAIM MEDI-CAL TRANSFORMATION INITIATIVES



ECM and Community Supports Administration and Delivery



MCP Medi-Cal
Care Management Continuum

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

Now includes pregnancy & postpartum TCS categories (effective July 1, 2026)

Source: PHM Policy Guide January 2026

Basic Population Health Management (BPHM)

BPHM is an approach to care that ensures needed programs and services are made available to each member, regardless of the member's risk tier, at the right time and in the right setting; all MCP members receive BPHM, regardless of their level of need.

BPHM includes access to primary care, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers under the new CHW benefit, wellness and prevention programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children under EPSDT.

BPHM ensures every Medi-Cal managed care member receives foundational health services, care coordination, and preventive care—not just those identified as high-risk—creating a baseline level of support for all members.

Source: PHM Policy Guide January 2026

Complex Care Management (CCM)

CCM is designed for Medi-Cal managed care members at higher- and medium-rising risk levels who require ongoing care coordination but do not meet criteria for Enhanced Care Management (ECM); CCM bridges the gap between ECM for the highest-need members and Basic Population Health Management (BPHM) for all members.

CCM includes ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions; these services support members with complex chronic conditions by coordinating physical health, behavioral health, and social services to address whole-person care needs.

MCPs are encouraged to contract with providers who can deliver a care management continuum of ECM and CCM programs, enabling seamless transitions as members step up or step down between levels based on changing needs and risk status—ensuring continuity of care under a single provider when possible.

Source: PHM Policy Guide January 2026

Transitional Care Services–CalAIM Population Health Management

Purpose: Transitional care services (TCS) support members transferring from one setting or level of care to another, including discharges from hospitals, institutions, acute care facilities, and skilled nursing facilities to home, community-based settings, Community Supports, post-acute care facilities, or long-term care settings, from discharge planning until successfully connected to all needed services.

MCPs must know when members are admitted, discharged or transferred; ensure timely prior authorizations; and for high-risk members, assign a care manager who coordinates with discharging facilities, reviews discharge instructions with members, ensures follow-up care including medication reconciliation, and connects members to needed services.

TCS Categories (Updated January 2026):

High-Risk TCS
Assigned care manager, coordination with discharging facility, post-discharge follow-up

Lower-Risk TCS
MCP telephonic team, lighter-touch model for lower-risk transitions

NEW High-Intensity Pregnancy & Postpartum TCS
Integrates PHM, CPSP requirements & clinical guidelines (eff. 7/1/2026)

NEW Moderate-Intensity Pregnancy & Postpartum TCS
Integrates PHM, CPSP requirements & clinical guidelines (eff. 7/1/2026)

Source: PHM Policy Guide January 2026

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.

PHM Policy Guide 2026 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.

PHM Policy Guide 2026 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).

PHM Policy Guide 2026 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.

PHM Policy Guide 2026 p. 51

Transitional Care Services and SMHS

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.

PHM Policy Guide 2026 pp 58-89

Transitional Care Services and SMHS

- 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.

PHM Policy Guide 2026 pp 58-89

MCP Child Welfare Liaison Position (MCP-CWL)

All Medi-Cal Managed Care Plans must designate Child Welfare Liaisons effective January 1, 2024 (APL 24-013)

Primary Purpose:

- Ensure healthcare needs of children/youth in foster care and child welfare are met
- Serve as point of contact to resolve escalated access and coordination issues
- Support care managers and child welfare staff

Core Responsibilities:

- Act as resource for ECM Lead Care Managers and child welfare staff
- Resolve barriers to accessing MCP services and referrals
- Facilitate enrollment/disenrollment when members move counties
- Coordinate with other MCP liaisons and attend quarterly county meetings
- Provide trauma-informed care training and Foster Youth Bill of Rights education

APL24-013

MCP Tribal Liaison Position

All Medi-Cal Managed Care Plans must designate Tribal Liaisons effective January 1, 2024 (APL 24-002)

Primary Purpose:

- Coordinate referrals and payment for services provided to American Indian MCP Members qualified to receive services from an IHCP
- Serve as dedicated point of contact for contracted and non-contracted Indian Health Care Providers (IHCPs)
- Enhance collaboration between MCPs, IHCPs, and American Indian MCP Members

Core Responsibilities:

- Coordinate and ensure access to care with in- and out-of-network IHCPs for American Indian MCP Members
- Assist IHCPs with Provider enrollment, MCP contracting, credentialing, and claims/payment resolution
- Provide benefits and services navigation (ECM, Community Supports, Behavioral Health, CCS, Foster Care, etc.)
- Assist with transportation access given logistical and geographical barriers unique to tribal communities
- Support grievance, appeal, and State Hearing processes for IHCPs and American Indian MCP Members
- Complete Cultural Humility training (Tribal Advisor) and Trauma-Informed Care/Historical Trauma training (IHS)

APL 24-002

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 – January 2026

7 Core Services of ECM

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

Source: ECM Policy Guide – January 2026

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.

ECM Policy Guide 2026

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. 48, 56

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. 56, 77

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. 77

ECM Populations of Focus (POFs)

ECM is available to MCP Members who meet criteria for ECM POFs, which launched in phases from January 2022 - January 2024

ECM Population of Focus		Adults	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 & Youth Enrolled in CA Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children & Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

Source: CalAIM Enhanced Care Management Policy Guide 2026

Individuals and Families Experiencing Homelessness ECM POF

Eligibility Criteria

Children/Youth and Families (members under 21 years of age):

- Experiencing homelessness = unhoused, in a shelter, losing housing in the next 30 days, exiting an institution to homelessness, or fleeing interpersonal violence). Or sharing housing.

Adults:

- Meet homelessness criteria plus have at least one complex physical, behavioral, or developmental health need for which the Member would benefit from care coordination.

Families:

- MCPs are strongly encouraged to work with ECM Providers to serve the family unit together through one ECM team.

Members authorized for Transitional Rent automatically qualify — no additional criteria required

- **Youth who has been excluded from home due to their gender identity or sexual orientation and is now temporarily living with the family of a friend (e.g., couch surfing).**
- **Parent and child who are fleeing domestic violence.**

Source: CalAIM Enhanced Care Management Policy Guide 2026

Individuals At Risk for Avoidable Hospital or ED Utilization ECM POF

Adults who meet one or more of the following conditions:

- Five or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.
- Three or more unplanned hospital and/or short-term skilled nursing facility (SNF) stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

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

- Three or more ED visits in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment.
- Two or more unplanned hospital and/or short-term SNF stays in a 12 month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

Source: CalAIM Enhanced Care Management Policy Guide 2026

Individuals with Serious Mental Health and/or SUD Needs ECM POF

Adults who:

1. Meet the eligibility criteria for participation in, or obtaining services through: (i) SMHS delivered by MHPs; (ii) The Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program; **and**

1. Are experiencing at least one complex social factor influencing their health **and**

1. Meet one or more of the following criteria:
    a. Are at high risk for institutionalization, overdose, and/or suicide;
    b. Use crisis services, EDs, urgent care, or inpatient stays as the primary source of care;
    c. Experienced two or more ED visits or two or more hospitalizations due to serious mental health or SUD in the past 12 months.

Children & Youth who:

1. Meet the eligibility criteria for participation in, or obtaining services through one or more of:
    a. SMHS delivered by MHPs;
    b. The DMC-ODS OR the DMC program.

No further criteria are required to be met for children and youth to qualify for this ECM Population of Focus.

Source: CalAIM Enhanced Care Management Policy Guide 2026

Individuals Transitioning from Incarceration ECM POF

Adults who:

1. Are transitioning from a correctional facility (e.g., prison, jail, or youth correctional facility) or transitioned from correctional facility within the past 12 months; **and**

1. Have at least one of the following conditions:
    a. Mental illness;
    b. SUD;
    c. Chronic Condition/Significant Non-Chronic Clinical Condition;
    d. Intellectual or Developmental Disability (I/DD); (v) Traumatic Brain Injury (TBI);
    e. HIV/AIDS;
    f. Pregnant or Postpartum.

Children and Youth Transitioning from a Youth Correctional Facility

- Children and youth under 21 or former foster youth between 18 and 26 who are transitioning from a youth correctional facility or adult jail/prison or transitioned from being in a youth correctional facility or adult jail/prison within the past 12 months.

No further criteria are required to be met for Children and Youth to qualify for this ECM Population of Focus.

Source: CalAIM Enhanced Care Management Policy Guide 2026

Children & Youth: Two ECM Populations of Focus

California Children's Services (CCS) or CCS Whole Child Model (WCM):

1. Are enrolled in CCS OR CCS WCM; **and**
2. Are experiencing at least one complex social factor influencing their health. Examples include (but are not limited to) lack of access to food; lack of access to stable housing; difficulty accessing transportation; high measure (four or more) of ACEs screening; history of recent contacts with law enforcement; or crisis intervention services related to mental health and/or substance use symptoms.

Child Welfare

1. 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;

A. 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;

B. Are under age 18 and are eligible for and/or in California's Adoption Assistance Program;

C. Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months

Source: CalAIM Enhanced Care Management Policy Guide 2026

ECM Resources for the Child Welfare POF

- ECM and Community Supports brochures were intended to further support and provide education of these benefits to staff, youth, and families with child welfare involvement
  - ECM for Child Welfare and Foster Care Staff
  - ECM for Youth and Caregivers

- Enhanced Care Management Services for Children and Youth Involved in Child Welfare self-paced online course introduces learners to an overview of California's child welfare system with an emphasis on providing Enhanced Care Management for Children and Youth in Child Welfare.

- Enhanced Care Management and Community Supports Referral Pathways website was created to streamline the referral process to receive ECM and CS services for individuals enrolled into a Medi-Cal MCP

Birth Equity ECM POF

Adults and youth who:

1. Are pregnant or are postpartum (through 12 month period); **and**

1. Are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality (Black, American Indian and Alaska Native, and Pacific Islander pregnant and postpartum individuals).

Source: CalAIM Enhanced Care Management Policy Guide 2026

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 includes **15** Community Supports. The 15th Community Support was approved Dec 2024.

[CalAIM Community Supports – Managed Care Plan Elections]

[Community Supports Policy Guide: Volume 1]

[DHCS Community Supports Policy Guide: Volume 2]

DHCS' Menu of Community Supports Services

The updated Community Supports Policy Guide organizes the services into two volumes.

★ Volume 1 ★

1. Respite Services
2. Assisted Living Facility Transitions* $
3. Community or Home Transition Services*
4. Personal Care and Homemaker Services
5. Environmental Accessibility Adaptations (Home Modifications) $
6. Medically Tailored Meals/Medically Supportive Food
7. Sobering Centers
8. Asthma Remediation $

Volume 2

9. Housing Transition Navigation Services
10. Housing Deposits $
11. Housing Tenancy and Sustaining Services
12. Day Habilitation Programs
13. Recuperative Care (Medical Respite)
14. Short-Term Post-Hospitalization Housing
15. *New* Transitional Rent $

Source: Community-Supports-Policy-Guide-Volume-1-Webinar-Presentation

Pre-Approved DHCS Community Supports

Supports for Housing Insecurity	Supports to Keep People at Home	Supports to Keep People at Home	Support to Recover from Acute Intoxication
Primary Audience: Individuals experiencing homelessness	Primary Audience: Individuals at risk for institutionalization in a nursing home	Primary Audience: Individuals who have certain chronic conditions and require support	Primary Audience: Individuals found publicly intoxicated to divert from jail or the Emergency Department
1. Housing Transition Navigation Services **2. Housing Deposits** **3. Housing Tenancy & Sustaining Services** **4. Transitional Rent (starts Jan. 2026)** **5. Short-Term Post Hospitalization Housing** **6. Recuperative Care (Medical Respite)** **7. Day Habilitation**	**8. (Caregiver) Respite Services** **9. Nursing Facility Transition/ Diversion to Assisted Living Facilities** **10. Community Transition Services/ Nursing Facility Transition to a Home** **11. Personal Care & Homemaker Services** **12. Environmental Accessibility Adaptations (Home Modifications)**	**13. Meals/Medically Tailored Meals** **14. Asthma Remediation**	**15. Sobering Centers** *Note: majority of the referrals for this service are from law enforcement and stays must be less than 24 hours.*

Source: H2C Strategies

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

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

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

Definitions and Context

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 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 an 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

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

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.
- DHCS 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

Population Of Focus: Individuals At Risk for Avoidable Hospital or ED Utilization

- 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.

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Population Of Focus: Individuals with Serious Mental Health and/or SUD Needs:

- 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.

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Population Of Focus: Children and Youth Involved in Child Welfare

- 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.

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Applying CalAIM for Foster Youth In Adoptive Placement

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 in adoptive placement, even if they are placed outside of the county of jurisdiction.

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

After Adoptive Placement or Guardianship Granted, but Before Jurisdiction Termination

- It would be best practice for the child welfare social worker to confirm that the youth (if developmentally appropriate and the care provider are meeting 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, if applicable.

After Adoptive Placement or Guardianship Granted, but Before Jurisdiction Termination

- 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.

After Adoptive Placement or Guardianship Granted, but Before Jurisdiction Termination

- 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.

After Adoptive Placement or Guardianship Granted, but Before Jurisdiction Termination

- 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.

After Adoptive Placement or Guardianship Granted, but Before Jurisdiction Termination

- 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 arrangements for local services (e.g., does local provider know how and who to submit claims to at the MCP of record).

After Adoptive Placement or Guardianship Granted, but 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.).

After Adoptive Placement or Guardianship Granted, but 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.

After Adoptive Placement or Guardianship Granted, but Before Jurisdiction Termination – Move Out of County Discussion

- If the move is going to be 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.

After Adoptive Placement or Guardianship Granted, but Before Jurisdiction Termination – Move Out of State Discussion

- If the move is going to be 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/

Applying CalAIM for Adoptive and Guardianship Youth

Eligibility for ECM/Community Supports: Adoptive or Legal Guardian Youth.

- Remember, an adoptive youth or Legal Guardian youth could be automatically eligible for ECM/Community Supports under any of the different population of focuses, including avoidable hospitalizations/ER visits, those with serious mental health/SUD issues, and those involved in child welfare (including those are under age 18 and are eligible for and/or in California's Adoption Assistance Program).
- However, they first have to be in a Medi-Cal Managed Care Plan, and then enrolled in ECM/Community Supports.

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Adopted/Guardianship Youth on Medi-Cal

- The adoptive parents/legal guardians (LGs) should reaffirm who is the youth's primary care provider and reaffirm whether they are on a Medi-Cal Managed Care Plan (MCP).
- If the youth is on Straight Medi-Cal, the adoptive parents/LGs should consider if there would be benefits on keeping the youth on Straight Medi-Cal or to enroll them in Medi-Cal Managed Care.

Adopted/Guardianship Youth on Medi-Cal

- If they do not yet have Enhanced Care Management, the caregiver should 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

Adopted/Guardianship Youth on Medi-Cal

- The adoptive parents/LGs should make sure the ECM lead care manager is a part of the youth's core health team, and that their child's PCP is aware of the ECM lead care manager.

Adopted/Guardianship Youth on Medi-Cal

- The adoptive parents/LGs should identify who is on their 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.

Adopted/Guardianship Youth on Medi-Cal

- If the youth is hospitalized on a psychiatric or other medical emergency, the adoptive parents/LGs should 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.
- The adoptive parents/LGs should work with the TCS care manager to get a copy of both the discharge plan and discharge plan evaluation.

Adopted/Guardianship Youth on Medi-Cal

- If STRTP is in another county, remember continuity of care and their 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 arrangements for local services (e.g., does local provider know how and who to submit claims to at the MCP of record).

Medi-Cal Payer of Last Resort

You may have heard of variants of the following:

- Medi-Cal is the payer of last resort, so any youth receiving AAP will not qualify.
- Medi-Cal Managed Care Plans will not cover any services for a youth on AAP.
- Medi-Cal will not cover an adopted youth who is in a STRTP that is being covered by AAP.

Medicaid for Children's Mental Health Residential Treatment

Federal guidance emphasizes "inpatient and residential levels of care must not be the default treatment setting, either explicitly or because of a lack of capacity of services offered in integrated settings, including for children and youth with severe needs, and should be reserved for children and youth with acute needs on a short-term basis."

* https://shvs.org/wp-content/uploads/2025/03/EPSDT-Guidance_State-Implications-and-Approaches-to-Behavioral-Health-for-Children-and-Youth.pdf#:~:text=and%20Youth.%20The%20guidance%20reiterates%20states'%20statutory,if%20it%20is%20not%20covered%20for%20adults.

** https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf

Medicaid for Children's Mental Health Residential Treatment

- Medi-Cal (Medicaid in CA) for Kids & Teens (the EPSDT benefit) allows enrolled members (under age 21) to receive any medically necessary treatment or procedure, regardless of whether or not Medi-Cal covers it.
- As such, if it is medically necessary, Medi-Cal will pay for it, including residential treatment for mental health services for children.

* https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Provider-Information.aspx

** https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf

Medi-Cal Payer of Last Resort

- States are required to take "all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan." 42 U.S. Code § 1396(a)(25)(A).
- An applicant or beneficiary shall utilize other available health care coverage prior to utilizing Medi-Cal coverage. Cal. Code Regs. Tit. 22, § 50763 (a)(3).

AAP Placements in STRTPs

- For any placements in a STRTP in California, it still should be for medically-necessary reasons and AAP payments are currently limited to 18 months and no more than the established rate for the fiscal year, which currently is $17,616 per month.*
- Any costs after 18 months or above $17,616, Medi-Cal would have to be utilized, but **only if** it can be established that it is medically-necessary.
- Further, any services not related to the mental health services for the youth, would have to be covered by Medi-Cal, including, but not limited to preventative health, primary health care, physical health, dental health, applied behavioral analysis, etc.).
- The proposal in California is to limit any AAP payments for STRTPs to a cumulative total of 12 months.
- The Tier Rate Structure which will take effect on July 1, 2027 will set the STRTP rate at $13,509.**

* https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACLs/2025/25-45.pdf?ver=IU60_1BDsIV44d_-W8zG_Q%3d%3d

** https://www.cdss.ca.gov/inforesources/cdss-programs/foster-care/foster-care-audits-and-rates/foster-care-rate-reform-proposal

AAP Placements in QRTPs

- Per WIC§ 16121.5, any placements in an out-of-state residential facility must meet the requirements of a qualified residential treatment program (QRTP).
- For those adoptive placements that occurred prior to June 30, 2025, the AAP payments could continue for 18 months with a 60-day extension* and no more than the established rate for the fiscal year, which currently is $17,616 per month.**
- For those adoptive placements that occurred after June 30, 2025, the time period is a maximum of 12 months with a 60-day extension* and currently limited $17,616 per month.**
- Further, any services not related to the mental health services for the youth, would have to be covered by Medi-Cal, including, but not limited to preventative health, primary health care, physical health, dental health, applied behavioral analysis, etc.).

* https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACLs/2026/26-07.pdf?ver=UQPyMOD-tKUsuVUGzw45_Q%3d%3d
** https://www.cdss.ca.gov/inforesources/cdss-programs/foster-care/foster-care-audits-and-rates/foster-care-rate-reform-proposal

Notes on FFS Medi-Cal Provider

- If the adopted/legal guardian youth has a Fee-for-Service (aka Straight Medi-Cal) provider and wants to keep that provider, they can do so.
- The FFS provider has to agree to an “out-of-network” contract from the Medi-Cal Managed Care Plan.

https://www.dhcs.ca.gov/services/Pages/ContinuityofCareFAQ.aspx#:~:text=2.,Care%20(adult%20and%20pediatric).

Notes on FFS Medi-Cal Provider

- The adoptive/LG child may continue to see their FFS provider for 12 months if all the following provisions are met:
- If the Member has a current relationship with the FFS provider;
- If the Plan does not have quality-of-care issues with that provider;
- If the provider will accept the Plan's contracted rates or FFS rates; **and**
- The provider is a California State Plan approved provider.

https://www.dhcs.ca.gov/services/Pages/ContinuityofCareFAQ.aspx#:~:text=2.,Care%20(adult%20and%20pediatric).

Notes on FFS Medi-Cal Provider

- If these requirements are met, the Plan must allow the Member to continue to see providers who are physicians; surgeons; specialists; physical therapists; occupational therapists; respiratory therapists; behavioral health treatment providers; speech therapists; durable medical equipment providers; Long-Term Care (LTC) providers which include Skilled Nursing Facilities (SNF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), ICF/DD-Nursing (ICF/DD-N), and Subacute Care (adult and pediatric).
- The Plan is not required to allow the Member to continue to receive services from providers of radiology; laboratory; dialysis centers; transportation, other ancillary services, carved-out Medi-Cal services (Medi-Cal services that are not provided by the Plan); or services not covered by Medi-Cal.

https://www.dhcs.ca.gov/services/Pages/ContinuityofCareFAQ.aspx#:~:text=2.,Care%20(adult%20and%20pediatric).

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.

Adopted/Guardianship Youth on Private Health Insurance

- If their child has private health insurance, they can still qualify for Medi-Cal. Medi-Cal coverage can be added to an existing insurance plan. The Medi-Cal provider will first bill your private insurance. Then, Medi-Cal will pay for any additional services.*
- It triggers a formal concept called Coordination of Benefits where both services and funding are coordinated between the two or more insurances for Medicaid beneficiaries. It is recognized at the federal level.**

* https://www.healthforcalifornia.com/covered-california/health-insurance-companies/medi-cal/apply

** https://www.medicaid.gov/medicaid/eligibility-policy/coordination-of-benefits-third-party-liability#:~:text=Coordination%20of%20Benefits%20(COB)%20is%20the%20process,party%20payments%20to%20the%20State%20Medicaid%20Agency.

Private Health Insurance and Medi-Cal

1. Request enrollment in Medi-Cal Managed Care Plan.
2. Once enrolled, request enrollment in ECM (which the youth should be eligible as an AAP youth; they could also qualify under the other special populations including SMHS and frequent hospitalizations).
3. As the MCP has to send information to an ECM Provider within 10 business days, ask for contact information for the ECM care manager, and ask to meet with that ECM care manager.

Private Health Insurance and Medi-Cal

4. Request ECM and/or Community Supports, and ask the ECM care manager/primary care provider (PCP) for assistance to confirm that private health insurance does not cover ECM/Community Supports.
    - For example, a ECM Care Manager and/or the PCP might have to notify the MCP Claims Department that private health insurance does not cover ECM/Community Supports by getting a letter from the private health insurer affirming this component.

Private Health Insurance and Medi-Cal

- More importantly, the PCP who accepts the child's Private Health Insurance may have no idea that the youth as Medi-Cal MCP as a secondary insurance or that the child has an ECM lead care manager, or know what the ECM lead care manager does.
- As such, it is very important that the adoptive parent/LG work closely with the ECM lead care manager who should help with that coordination.

For Any Adopted/Guardianship Youth: Enrollment in a Medi-Cal Managed Care Plan

- Have the adoptive parent, LG go onto the following website to enroll in a Medi-Cal Managed Care Plan:

https://www.healthcareoptions.dhcs.ca.gov/en/enroll

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, adoptive youth, and those in guardianship.
- 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 Foster Youth, Adoptive Youth, and Guardianship Youth

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

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

Referral Pathways

How to Refer Your Clients

- **Call the client's Medi-Cal health plan directly** - this is the simplest method
- **Use the plan's online portal** if you have access
- **Fill out the ECM/CS referral form** (available on plan websites)

County	Health Plan	Link to Enhanced Care Management Referral Process	Link to Enhanced Care Management Member Resource Page	Community Supports
Alameda	Alameda Alliance for Health	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Alpine	Anthem Blue Cross Partnership Plan	Link	Link	Link
	Mountain Valley Health Plan	Link	Link	Link
Amador	Anthem Blue Cross Partnership Plan	Link	Link	Link
	Health Net Community Solutions, Inc.	Link	Link	Forms and Tools
	Kaiser Permanente	Link	Link	Link
Butte	Partnership Health Plan of California	Link	Link	Link
Calaveras	Anthem Blue Cross Partnership Plan	Link	Link	Link
	Health Net Community Solutions Inc.	Link	Link	Forms and Tools
Colusa	Partnership Health Plan of California	Link	Link	Link

Source

County	Health Plan	Link to Enhanced Care Management Referral Process	Link to Enhanced Care Management Member Resource Page	Community Supports
Contra Costa	Contra Costa Health Plan	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Del Norte	Partnership HealthPlan of California	Link	Link	Link
El Dorado	Anthem Blue Cross Partnership Plan	Link	Link	Link
	Mountain Valley Health Plan	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Fresno	Anthem Blue Cross Partnership Plan	Link	Link	Link
	CalViva Health	Link	Link	Forms and Tools
	Kaiser Permanente	Link	Link	Link
Glenn	Partnership Health Plan of California	Link	Link	Link
Humboldt	Partnership Health Plan of California	Link	Link	Link

Source

County	Health Plan	Link to Enhanced Care Management Referral Process	Link to Enhanced Care Management Member Resource Page	Community Supports
Imperial	Community Health Plan of Imperial Valley	Link	Link	Forms and Tools
	Kaiser Permanente	Link	Link	Link
Inyo	Anthem Blue Cross Partnership Plan	Link	Link	Link
	Health Net Community Solutions Inc.	Link	Link	Forms and Tools
Kern	Anthem Blue Cross Partnership Plan	Link	Link	Link
	Kern Family Health Care	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Kings	Anthem Blue Cross Partnership Plan	Link	Link	Link
	CalViva Health	Link	Link	Forms and Tools
	Kaiser Permanente	Link	Link	Link
Lake	Partnership Health Plan of California	Link	Link	Link

Source

County	Health Plan	Link to Enhanced Care Management Referral Process	Link to Enhanced Care Management Member Resource Page	Community Supports
Lassen	Partnership Health Plan of California	Link	Link	Link
Los Angeles	Health Net Community Solutions Inc.	Link	Link	Forms and Tools
	L.A. Care Health Plan	Link	Link	Link
	• Plan Partner: Blue Shield of California Promise Health Plan • Plan Partner: Anthem Blue Cross Partnership Plan	Link Link	Link Link	Link Link
	+Molina Healthcare of California (Subcontracting 50% of Health Net's members)	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Madera	Anthem Blue Cross Partnership Plan	Link	Link	Link
	CalViva Health	Link	Link	Forms and Tools
	Kaiser Permanente	Link	Link	Link

Source

County	Health Plan	Link to Enhanced Care Management Referral Process	Link to Enhanced Care Management Member Resource Page	Community Supports
Marin	Partnership Health Plan of California	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Mariposa	Central California Alliance for Health	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Mendocino	Partnership Health Plan of California	Link	Link	Link
Merced	Central California Alliance for Health	Link	Link	Link
Modoc	Partnership Health Plan of California	Link	Link	Link
Mono	Anthem Blue Cross Partnership Plan	Link	Link	Link
	Health Net Community Solutions, Inc.	Link	Link	Forms and Tools
Monterey	Central California Alliance for Health	Link	Link	Link

Source

County	Health Plan	Link to Enhanced Care Management Referral Process	Link to Enhanced Care Management Member Resource Page	Community Supports
Napa	Partnership Health Plan of California	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Nevada	Partnership Health Plan of California	Link	Link	Link
Orange	Cal Optima Health	Link	Link	Link and Link
	Kaiser Permanente	Link	Link	Link
Placer	Partnership Health Plan of California	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Plumas	Partnership Health Plan of California	Link	Link	Link
Riverside	Inland Empire Health Plan	Link	Link	Link
	Molina Healthcare of California	Link	Link	Link
	Kaiser Permanente	Link	Link	Link

Source

County	Health Plan	Link to Enhanced Care Management Referral Process	Link to Enhanced Care Management Member Resource Page	Community Supports
Sacramento	Anthem Blue Cross Partnership Plan	Link	Link	Link
	Health Net Community Solutions, Inc.	Link	Link	Forms and Tools
	Molina Healthcare of California	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
San Benito	Central California Alliance for Health	Link	Link	Link
San Bernardino	Inland Empire Health Plan	Link	Link	Link
	Molina Healthcare of California	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
San Diego	Blue Shield of California Promise Health Plan	Link and San Diego County-Wide Link	Link	Link
	Community Health Group Partnership Plan	Link and San Diego County-Wide Link	Link	Link
	Kaiser Permanente	Link and San Diego County-Wide Link	Link	Link
	Molina Healthcare of California	Link and San Diego County-Wide Link	Link	Link

Source

County	Health Plan	Link to Enhanced Care Management Referral Process	Link to Enhanced Care Managment Member Resource Page	Community Supports
San Francisco	Anthem Blue Cross Partnership Plan	Link	Link	Link
	San Francisco Health Plan	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
San Joaquin	Health Net Community Solutions Inc.	Link	Link	Forms and Tools
	Health Plan San Joaquin	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
San Luis Obispo	CenCal Health	Link	Link	Link and Link
San Mateo	Health Plan of San Mateo	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Santa Barbara	CenCal Health		Link	Link and Link
Santa Clara	Anthem Blue Cross Partnership Plan	Link	Link	Link
	Santa Clara Family Health Plan	Link	Link	Link
	Kaiser Permanente	Link	Link	Link

Source

County	Health Plan	Link to Enhanced Care Management Referral Process	Link to Enhanced Care Management Member Resource Page	Community Supports
Santa Cruz	Central California Alliance for Health	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Shasta	Partnership Health Plan of California	Link	Link	Link
Sierra	Partnership Health Plan of California	Link	Link	Link
Siskiyou	Partnership Health Plan of California	Link	Link	Link
Solano	Partnership Health Plan of California	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Sonoma	Partnership Health Plan of California	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Stanislaus	Health Net Community Solutions, Inc.	Link	Link	Forms and Tools
	Health Plan of San Joaquin	Link	Link	Link
	Kaiser Permanente	Link	Link	Link

Source

County	Health Plan	Link to Enhanced Care Management Referral Process	Link to Enhanced Care Management Member Resource Page	Community Supports
Sutter	Partnership Health Plan of California	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Tehama	Partnership Health Plan of California	Link	Link	Link
Trinity	Partnership Health Plan of California	Link	Link	Link
Tulare	Anthem Blue Cross Partnership Plan	Link	Link	Link
	Health Net Community Solutions, Inc.	Link	Link	Forms and Tools
	Kaiser Permanente	Link	Link	Link
Tuolumne	Anthem Blue Cross Partnership Plan	Link	Link	Link
	Health Net Community Solutions, Inc.	Link	Link	Forms and Tools

Source

County	Health Plan	Link to Enhanced Care Management Referral Process	Link to Enhanced Care Management Member Resource Page	Community Supports
Ventura	Gold Coast Health Plan	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Yolo	Partnership Health Plan of California	Link	Link	Link
	Kaiser Permanente	Link	Link	Link
Yuba	Partnership Health Plan of California	Link	Link	Link
	Kaiser Permanente	Link	Link	Link

Source

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