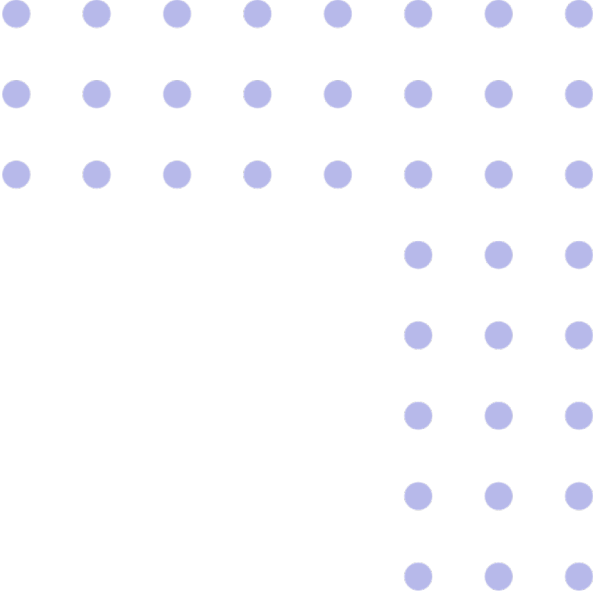




CalAIM for Self-Sufficiency Programs - Part 1

Presenter: Gretchen Schroeder

September 17, 2026

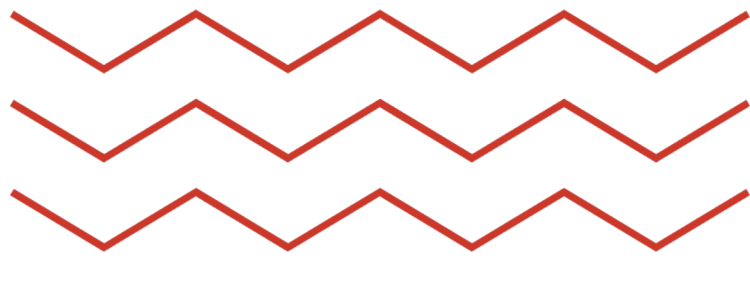


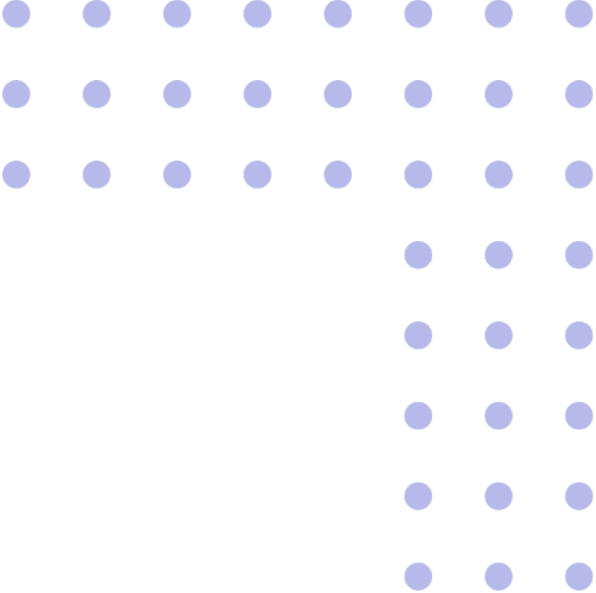
Objectives

1 Review the CalAIM services

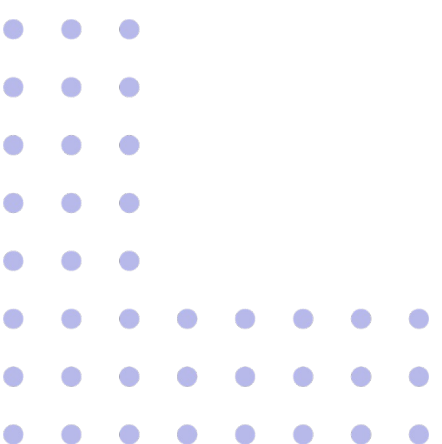
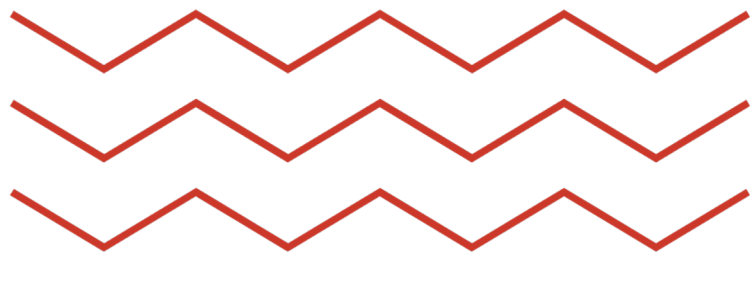
2 Deepen your understanding of Enhanced Care Management and Community Supports and how they connect to the recipients you already serve

3 Discuss how these services can expand Self-Sufficiency resources at this time





Agenda

- 1** CalAIM Overview
 - 2** Enhanced Care Management (ECM)
Benefit
 - 3** Community Supports Services
 - 4** CalAIM Resources
 - 5** Case Studies
- 
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What is CalAIM?

- CalAIM, or Medi-Cal Transformation, is California's initiative to move Medi-Cal beyond just medical care, into the social and practical needs that keep people healthy like housing and care coordination.
- CalAIM also brings new types of organizations into the Medi-Cal delivery system. Community-based organizations, housing providers, and other local partners now deliver services alongside traditional medical providers.
 - Many of these providers will be supporting individuals to keep their Medi-Cal.

Why CalAIM Matters for Self-Sufficiency Right Now

- Budgets are tighter and demand is rising as federal policy changes affect eligibility and caseloads.
- CalAIM is additional, complementary support for your recipients. It is funded through Medi-Cal managed care, not your program's budget.
- This is about giving staff another resource to lean on, not another thing to administer.

How CalAIM Reaches Clients

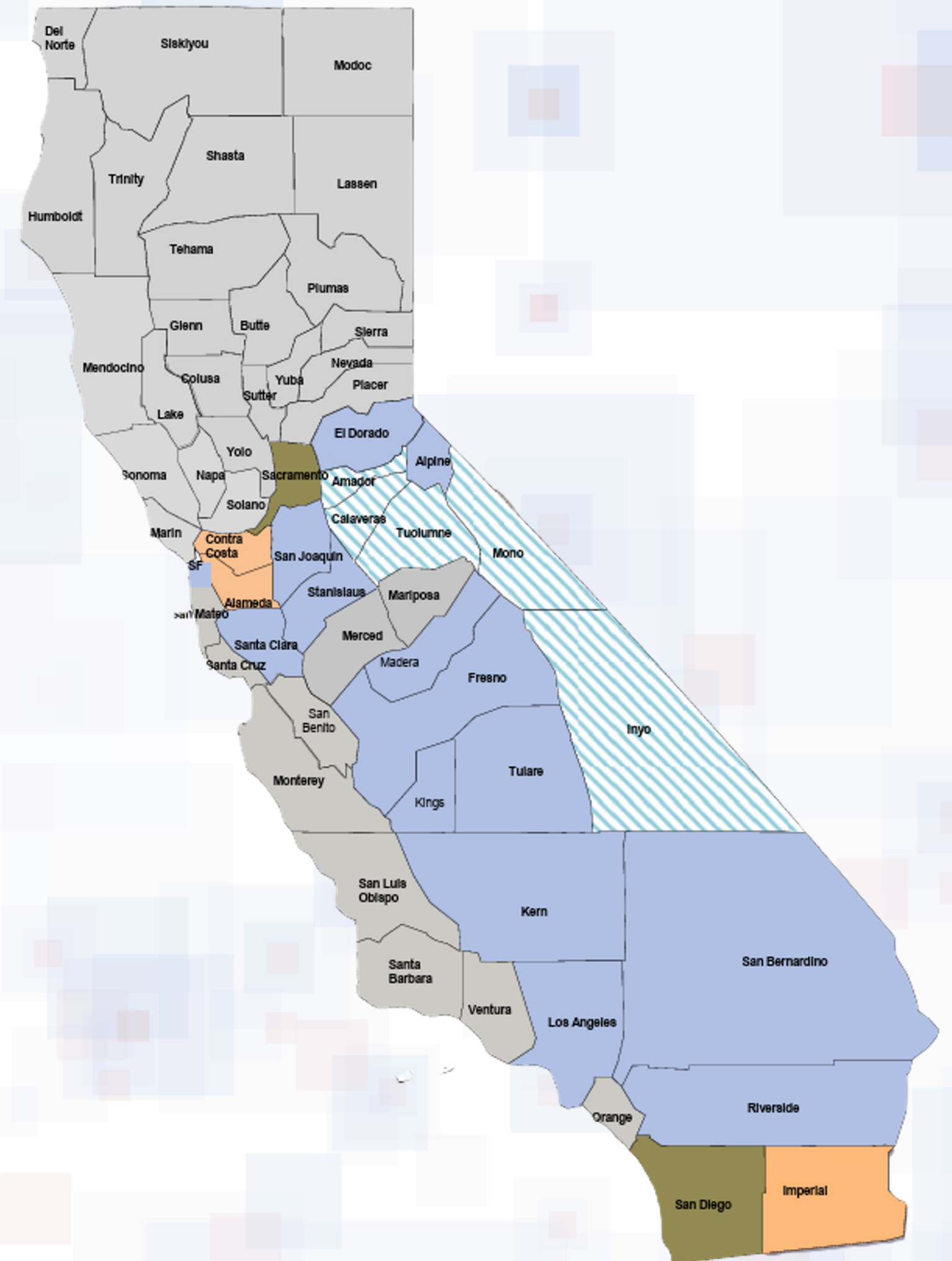
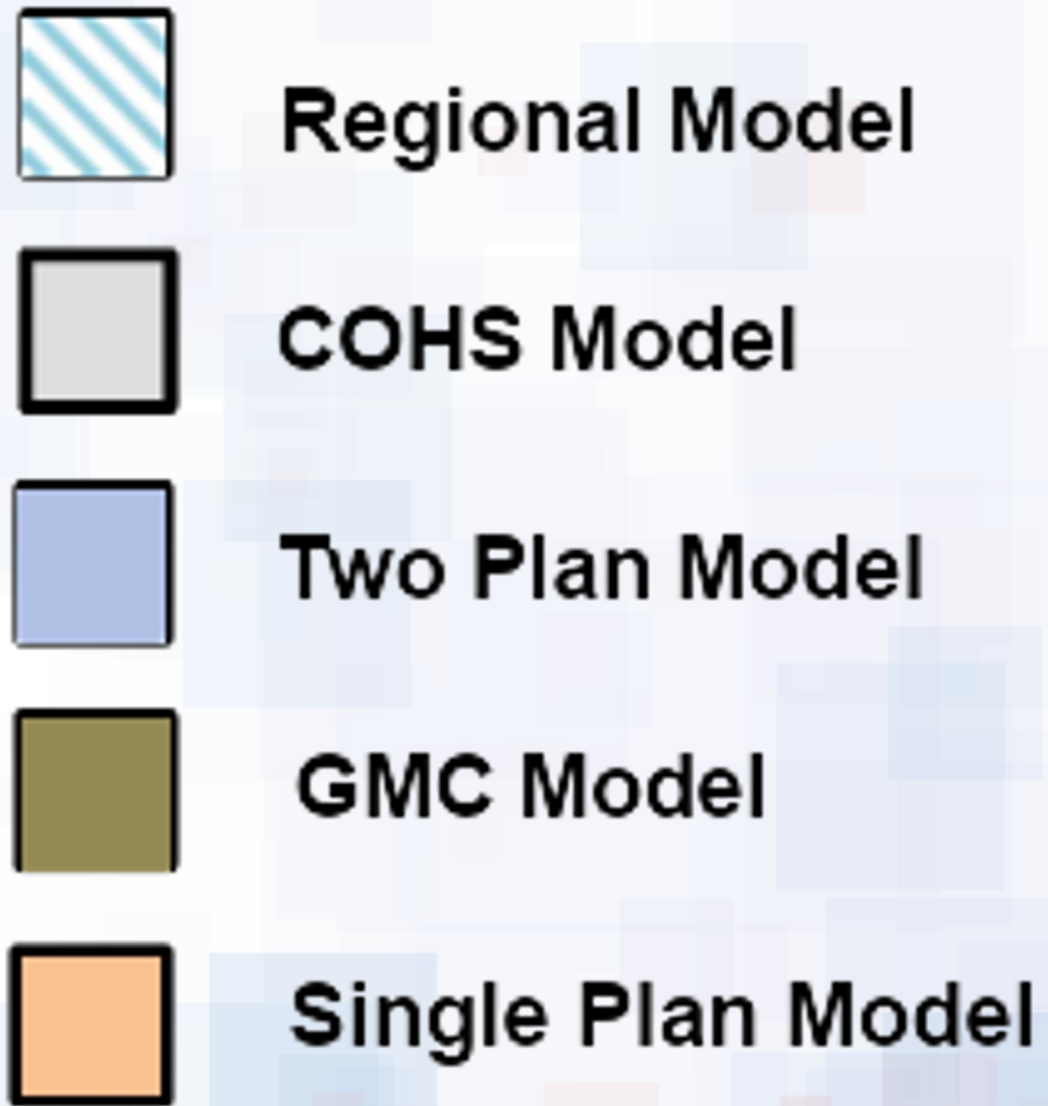
Most Medi-Cal members are enrolled in an MCP. ECM and Community Supports are only available through that plan, delivered by the providers and organizations it contracts with.



**Medi-Cal Managed Care
Plans (MCPs)**

CalAIM Provider: ex. CBO serving homeless populations

Managed Care Plan Models



Role of the Medi-Cal Managed Care Plans

- They must authorize these additional services for your recipients.
- Partners in serving your recipients - consider building relationships with the Managed Care Plans (MCPs) in your county.
- View the MCPs as another partner with resources. In addition to ECM and Community Supports the MCPs can assist with accessing other health services, even when a recipient moves to another county.

Enhanced Care Management (ECM)



ECM Seven Core Services



Outreach and Engagement



Comprehensive Assessment
and Care Management Plan



Enhanced Care Coordination



Health Promotion



Comprehensive Transitional
Care



Member and Family
Supports



Coordination of and Referral
to Community and Social
Support Services

Who is eligible for ECM?



- Recipients must be enrolled in Medi-Cal managed care.
- Recipients with the highest need, highest complexity of issues (may be accessing resources from multiple systems).

ECM Populations of Focus

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

ECM Populations of Focus

Individuals and Families Experiencing Homelessness

- Experiencing or at risk of experiencing homelessness AND
- Have at least one complex physical, behavioral, or developmental need

Individuals at Risk for Avoidable Hospital or Emergency Department Utilization

- For adults: Five or more emergency department visits in a 6-month period OR three or more unplanned hospital and/or short-term skilled nursing facility stay in a 6-month period
- For children/youth: Three or more emergency department visits in a 12-month period OR two or more unplanned hospital and/or short-term skilled nursing facility stays in a 12-month period

ECM Populations of Focus (continued)

Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs:

- Adults: Meet eligibility criteria for specialty mental health services delivered by the county mental health plan or the Drug Medi-Cal Organization Delivery System or Drug Medi-Cal program, AND
- Are experiencing at least one complex social factor influencing their health, AND
- Are at high risk for institutionalization, overdose and/or suicide, use crisis services as primary source of care, or experienced two or more emergency department visits or two or more hospitalizations due to serious mental health or SUD in the past 12-months
- Children/Youth: Meet eligibility criteria for specialty mental health services delivered by the county mental health plan or the Drug Medi-Cal Organization Delivery System or Drug Medi-Cal program

ECM Populations of Focus (continued)

Individuals Transitioning from Incarceration

- Adults: Transitioning from a correctional facility or transitioned within the past 12 months, AND
 - Have at least one of the following conditions:
 - Mental illness
 - SUD
 - Chronic condition
 - Intellectual or Developmental Disability
 - Traumatic Brain Injury
 - HIV/AIDS
 - Pregnancy or Postpartum
- Children/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

ECM Populations of Focus (continued)

Adults Living in the Community At Risk for Long Term Care Institutionalization

- Living in the Community who meet Skilled Nursing Facility level of care criteria, AND
- Actively experiencing at least one complex social or environmental factor influencing their health, AND
- Are able to reside continuously in the community with wraparound supports

Adult Nursing Facility Residents Transitioning to the Community

- For those interested in moving out of the institution, AND
- Are likely candidates to do so successfully, AND
- Are able to reside continuously in the community

ECM Populations of Focus (continued)

Birth Equity

- Adults and Youth: Who are pregnant or are postpartum (through 12 months), AND
- Are subject to racial and ethnic disparities as defined by CA public health data on maternal morbidity and mortality

Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model with Additional Needs Beyond the CCS Condition

- Are enrolled in CCS or CCS Whole Child Model AND
- Are experiencing at least one complex social factor influencing their health



ECM Populations of Focus (continued)

Children and Youth Involved in Child Welfare

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

What does a Lead Care Manager (LCM) do?

- Help find doctors and make appointments
- Arrange transportation
- Connect to Community Supports
- Link individual to other social services
- Coordinate with a broader care team



How does ECM complement your work?

- ECM is supposed to be provided primarily in person
- LCMs can help recipients navigate complicated systems
- LCMs can provide more dedicated 1:1 support and coordination



Community Supports



Community Supports

- Community Supports are services that address MCP Members' social drivers of health and help them avoid higher, costlier levels of care.
- DHCS has pre-approved 15 medically appropriate and cost-effective Community Supports that MCPs are strongly encouraged but not required to offer as *substitutes for utilization of other services or settings*.

Pre-Approved DHCS Community Supports:

Non-Housing Services

- Assisted Living Transitions
- Asthma Remediation
- Community or Home Transition Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically-Tailored Meals or Medically-Supportive Foods
- Personal Care and Homemaker Services
- Respite Services
- Sobering Centers

Housing-Related Services

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Recuperative Care (Medical Respite)
- Day Habilitation Programs
- Transitional Rent
- *Short-Term Post-Hospitalization Housing*

Non-Housing Community Supports

- Assisted Living Facility Transitions
 - Facilitate nursing facility transition back into a home-like, community setting or to prevent nursing facility admissions for recipients living in the community
- Asthma Remediation
 - Supplies or physical modifications to a home
- Community or Home Transition Services
 - Help individuals live in the community and avoid further institutionalization in a nursing facility
- Environmental Accessibility Adaptations (Home Modifications)
 - Physical adaptations to a home to support recipients living at home with more independence

Non-Housing Community Supports (continued)

- Medically Tailored Meals/Medically Supportive Food
 - Meals or groceries to address recipient's chronic or other serious conditions that are nutrition-sensitive. This is not to address food insecurity.
- Personal Care and Homemaker Services
 - To assist with Activities of Daily Living and Instrumental Activities of Daily Living
- Respite Services
 - Provided to caregivers of recipient
- Sobering Centers
 - Safe environment to become sober as an alternative to the ER or jail

Housing Community Supports - Housing Trio

- Housing Transition Navigation Services
 - Help find and secure housing
- Housing Deposits
 - Funding for one time services and modifications to establish a basic household; housing application fees; security deposits, etc.
- Housing Tenancy and Sustaining Services
 - Help maintain tenancy after a recipient is housed



Housing Community Supports (continued)

- Recuperative Care (Medical Respite)
 - For recipients who are experiencing or are at risk of homelessness and need a short-term residential setting in which to recover from an injury or illness
- Day Habilitation Programs
 - Assist recipients in acquiring, retaining, and improving skills for housing
- Transitional Rent for recipients with significant behavioral health needs
 - Up to 6 months of rental assistance
- *Short-Term Post-Hospitalization Housing - sunseting at the end of December 2026*



Who is eligible for Community Supports?



- Recipients must be enrolled in Medi-Cal managed care
- Each Community Supports Services has different eligibility criteria
- Find out which Community Supports the MCPs in your county offer - [Community Supports Elections \(by MCP and County\) July 1, 2026](#)

Self-Sufficiency and CalAIM



Self Sufficiency and CalAIM Overlap

- Self-Sufficiency has the largest reach into Medi-Cal members of any program area, but the least connection to managed care plans.
- The recipients most affected by housing instability and mental health needs are the same recipients CalAIM was built to serve.
- Self-Sufficiency is an important entry point for CalAIM referrals.

What You Can Do with CalAIM

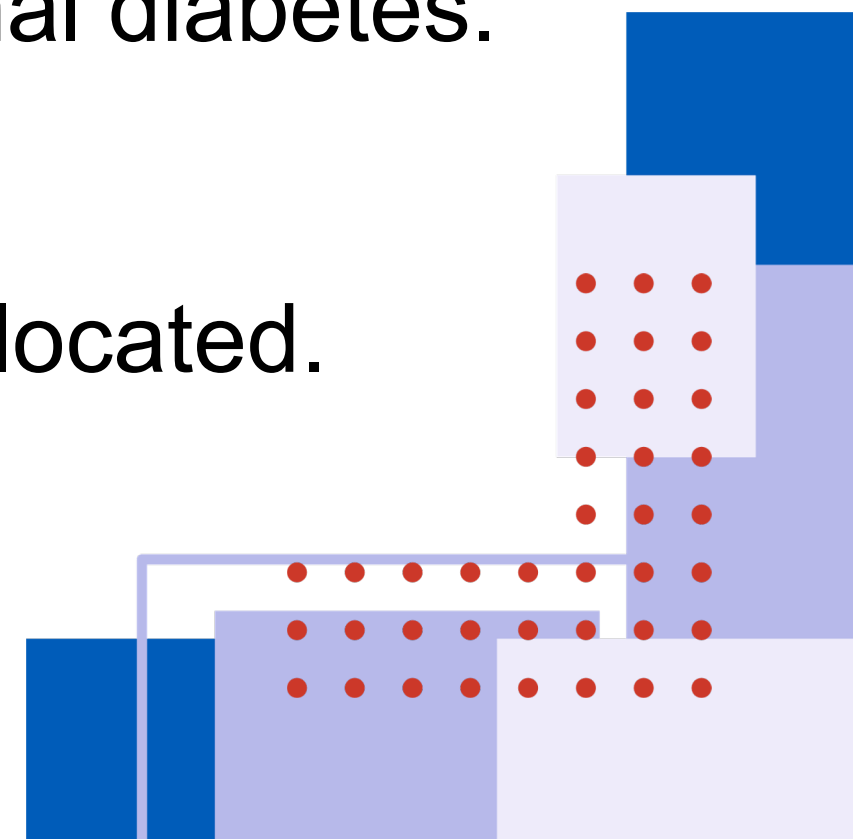
- Raise awareness – provide flyers to the recipients you work with
 - MCP flyers
 - County-generated flyers
- Build partnerships with your MCPs
- Identify likely eligible individuals for CalAIM and do targeted outreach
 - Screening questions
 - Engage recipients with specific needs
- Make referrals for ECM or Community Supports
 - To the MCP directly
 - To an ECM or Community Supports provider

Case Study



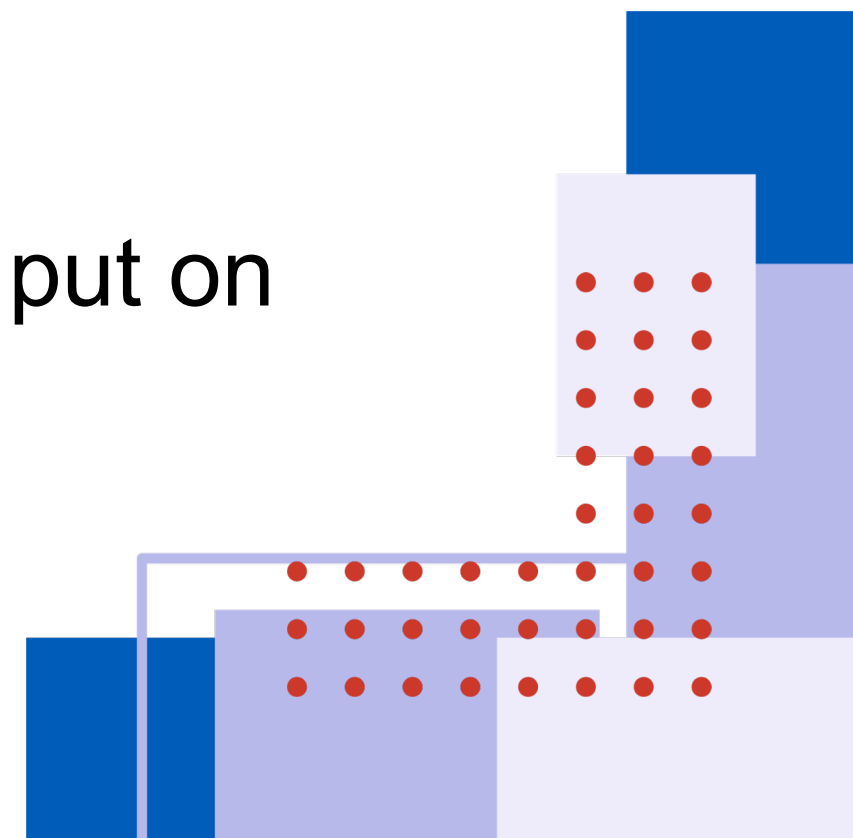
Meet Marisol

- Marisol is a 29-year-old Pacific Islander mother of two, ages 4 and 7, applying for CalWORKs for the first time.
- She left a domestic violence situation recently and has been staying in a domestic violence shelter with her children.
- She is 25 weeks pregnant and just found out she has gestational diabetes.
- She worked full time until she left, and lost the job when she relocated. She intends to return to work.



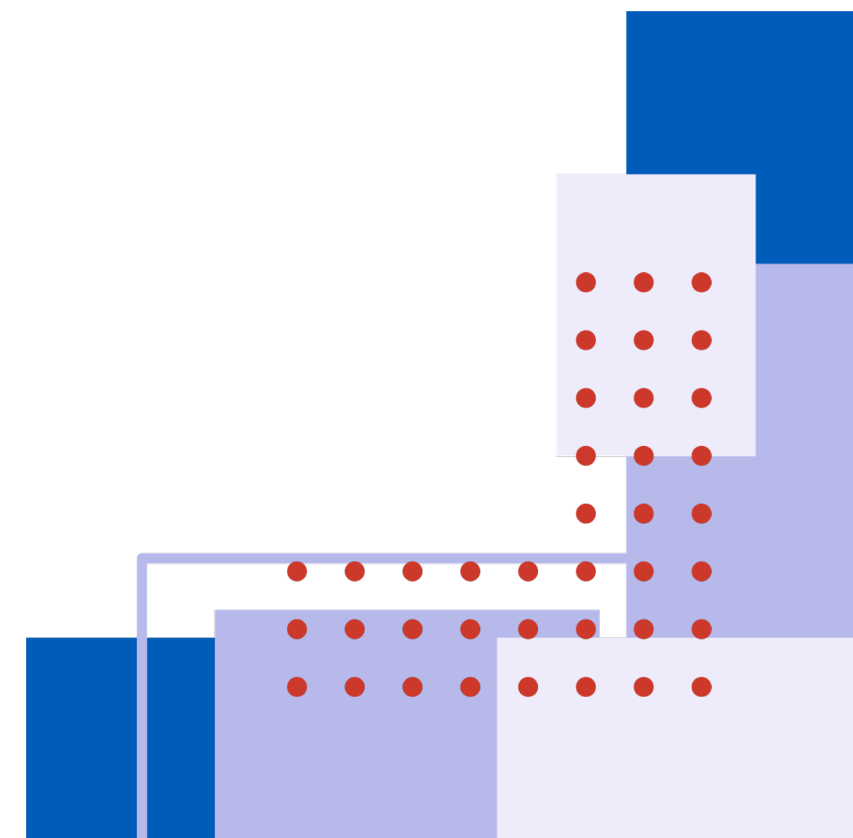
Marisol's Services

- Shelter placement through a local provider, with a time limit.
- Prenatal care established with a community clinic.
- No open child welfare case. No behavioral health services and no substance use treatment history.
- She applied for CalWORKs, CalFresh, Medi-Cal, and Temporary Homeless Assistance at the same appointment.
- She was referred to the Housing Support Program (HSP) and put on the waitlist.



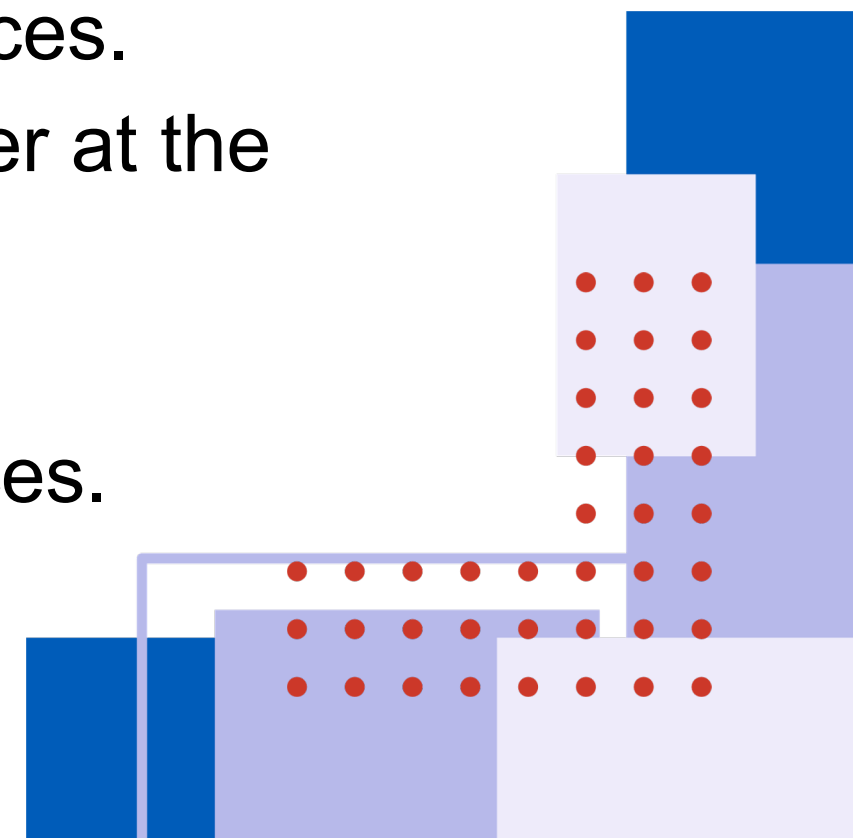
CalAIM Opportunities for Marisol

- Is Marisol eligible for ECM and/or Community Supports?
 - Is she enrolled in Medi-Cal managed care plan?
 - Is she navigating complex issues and multiple systems to care for herself and her family?



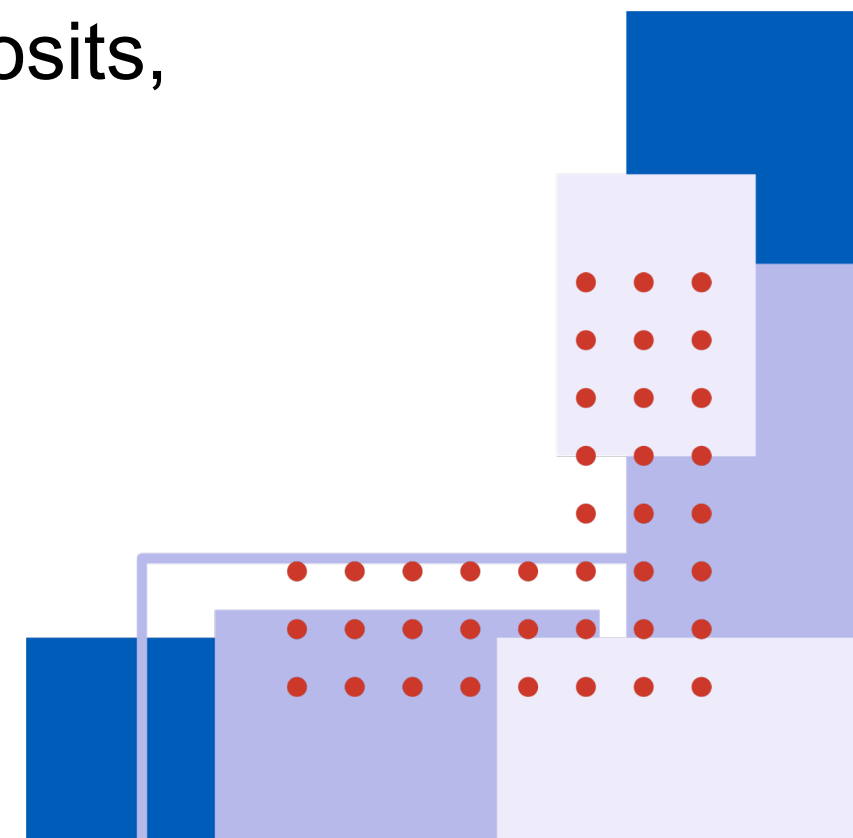
Marisol and ECM

- Two Populations of Focus (POFs) Marisol may be eligible for:
 - Individuals Experiencing Homelessness.
 - Birth Equity Population of Focus: She is pregnant and Pacific Islander.
- How can ECM support Marisol?
 - A single Lead Care Manager coordinates prenatal care, the children's care, and the housing work, rather than Marisol managing five systems from a shelter while managing safety.
 - Refers and connects her to domestic violence advocacy and legal services.
 - Coordinates with the domestic violence provider already working with her at the shelter.
 - Refers to behavioral health services for the family.
 - Refers for Community Supports services as well as other needed services.



Marisol and Community Supports Housing Trio Services

- Housing Transition Navigation Services:
 - Timeframe: She can access now
 - Develop a housing assessment and build a housing support plan
 - Provide assistance securing required documentation
 - Assist with searching for housing, landlord communication, and advocacy
- Housing Deposits:
 - Timeframe: When a housing unit is identified
 - Can cover: Lease application fee, security deposit, utility set-up and deposits, essential household furnishings, and more
- Housing Tenancy and Sustaining Services:
 - Timeframe: Once she has moved in to a housing unit, it will help her to maintain a safe and stable tenancy

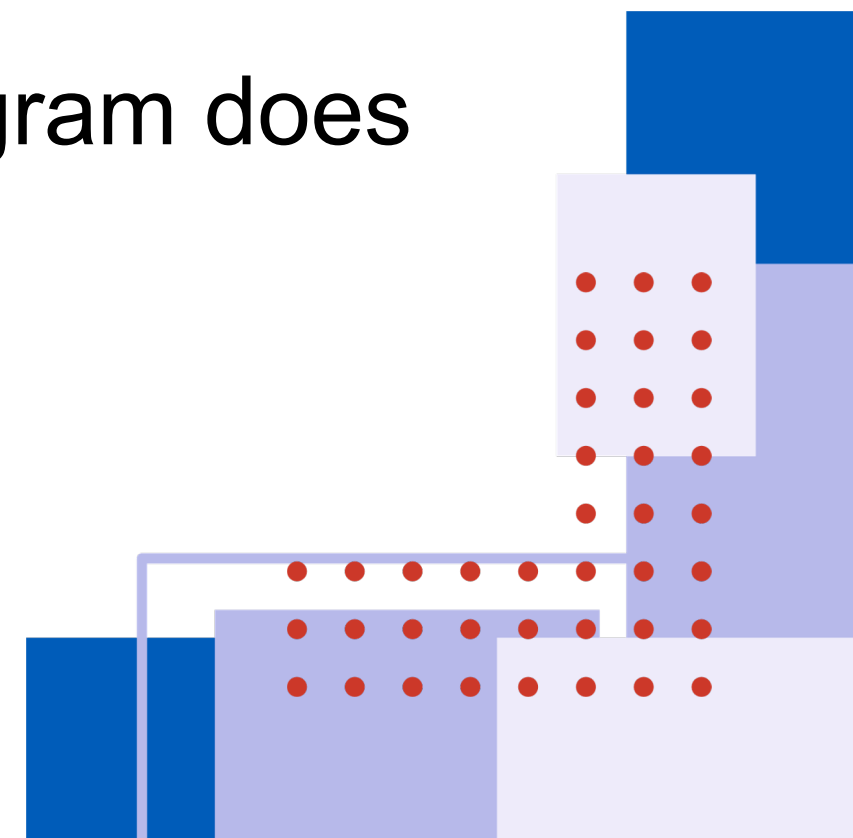


Community Supports Housing Trio and HSP

For a CalWORKS family with an HSP slot, when does Community Supports housing services make sense?

The Community Supports Housing Trio brings value when:

1. HSP is full;
2. The client leaves CalWORKS;
3. Tenancy support needs to run longer than the county's program does



Q & A



What's Next?

- CalAIM Training Series for Self-Sufficiency
 - CalAIM Training Part 2- September 24th
 - Session 1: 10-12pm
 - Session 2: 1-3pm
- Toolkit for Self-Sufficiency