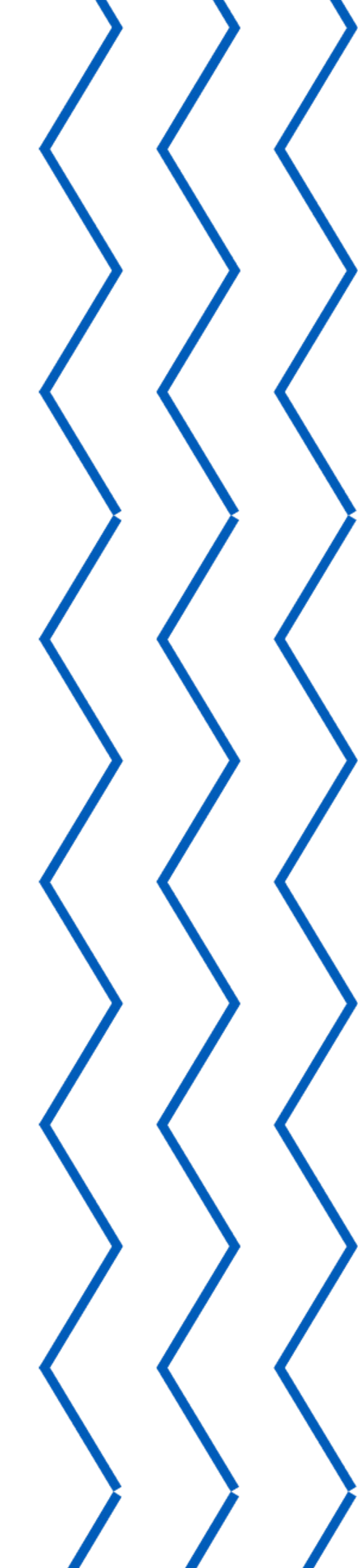




CalAIM for Self Sufficiency Programs - Part 2

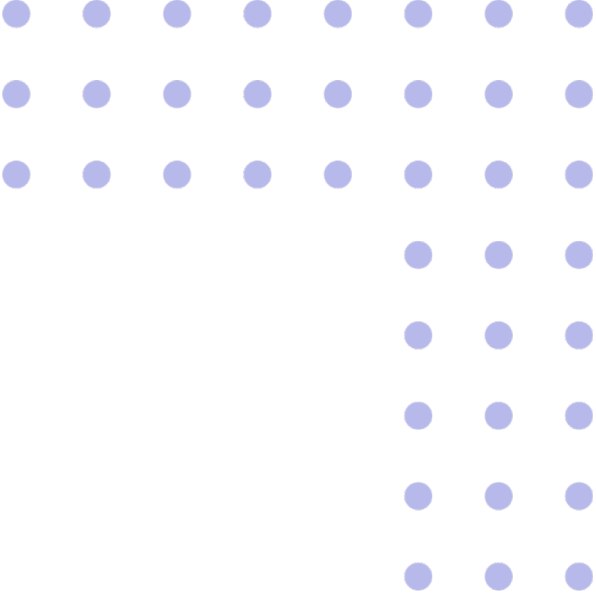
Presenter: Gretchen Schroeder

September 24, 2026



Objectives

- Consider ways to engage with Enhanced Care Management (ECM) and Community Supports
- Explore referral pathways for ECM and Community Supports
- Deepen understanding of ECM and Community Supports and overlap with existing services



Agenda

1

Welcome & Introductions

2

CalAIM Overview

3

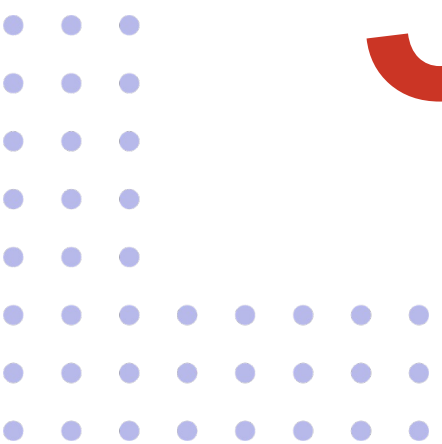
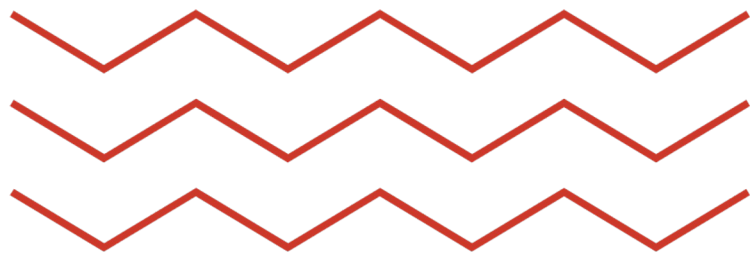
ECM and Community Supports
Engagement

4

Referral Pathways for ECM and
Community Supports

5

Case Study



What is CalAIM?

- CalAIM 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.
- CalAIM can support county efforts to keep individuals enrolled in 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 a Medi-Cal Managed Care Plan (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

Delivery Systems Overview

- Most Medi-Cal members are enrolled in an MCP. ECM and Community Supports are only available through a managed care plan, delivered by the providers and organizations it contracts with.
- Build relationships with MCPs in your county.
 - You do not need an MOU (Memorandum of Understanding) to engage with your MCPs on CalAIM services.
- MCPs can help support getting recipients the resources they need, even when recipients move or change plans.

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

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



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](#)

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
- Caregiver Services
- Transitional Rent
- *Short-Term Post-Hospitalization Housing*

ECM and Community Supports Engagement



Educate Staff on ECM and Community Supports

Staff Trainings

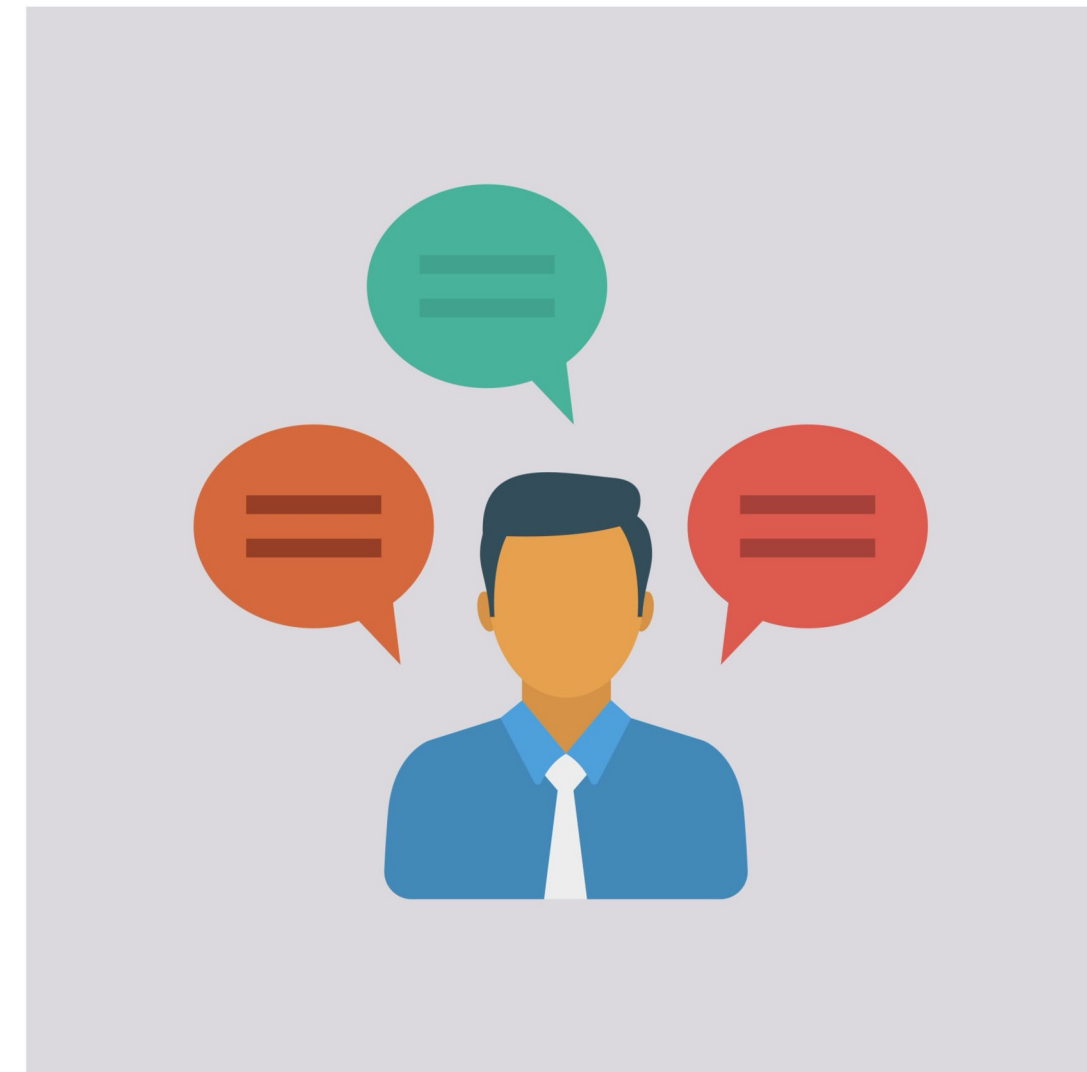
- What are ECM and Community Supports
- How can ECM and Community Supports help your recipients
- Where can staff and recipients access more information and connect with ECM and Community Supports services and providers



Educate Staff on ECM and Community Supports

Scripts for staff

- How do staff talk about these services with recipients
- What are key pieces of information recipients need to know



Educate Staff on ECM and Community Supports

Descriptions of resources and providers

- Phone numbers for each MCP in your county so recipients can contact them directly for these services
- Listing of available services by MCP with brief descriptions
- Listing of trusted providers offering these services



Share ECM and Community Supports Information

- Share information with recipients
 - Flyers
 - MCP brochures
 - Website postings
- Incorporate some screening questions into your workflows to identify customers who may be eligible and could benefit from these services.
 - This may help with targeted information sharing and building out a more robust referral process
- Think about where and how you can share this information

Referral Pathways for ECM and Community Supports



Referral Pathways for ECM and Community Supports

There are a few pathways for ECM and Community Supports referrals:

- To the MCP directly
- To a trusted provider who is also a contracted ECM or Community Supports provider
- To your county's CalAIM Coordinator (if your county has one)
- Encourage your recipient to self-refer or work with their doctor or social services providers on a referral

Important Referral Information

- What do you need to know to make referrals directly to the MCP?
 - Which MCP a recipient is enrolled with
 - If referring for ECM, which Population of Focus (POF) the recipient may qualify for (can be more than one)
 - If referring to Community Supports, which service do they need and qualify for
 - Recipient's consent to make the referral

ECM and Community Supports Referrals Starting Points

- A robust referral workflow requires an investment in staff time and resources.
- Some counties have found it helpful to start small and then build out the referral workflow that works best for your recipients and staff.

- Develop points of contact with the ECM and Community Supports contracted providers in your county.

- Build relationships with the MCPs in your county.

- Incorporate screening questions into your workflows to identify customers who may be eligible for a targeted referral process.

- Do you want to track the outcomes of the referrals? How to create those communication channels.

Referrals Directly to the MCP

- Locate the appropriate MCP referral form:
 - MCPs house their ECM and Community Supports referral forms on their website.
 - CDSS: [Enhanced Care Management and Community Supports Referral Pathways](#)
- Complete an MCP referral form:
 - Use the specific MCP's referral form and completely fill it out - the more information provided the more likely a referral is to be approved.
 - Submit the MCP form as requested (upload, online, fax, etc.).



Referrals to Trusted Providers

- Develop a list of trusted providers, including:
 - The MCPs they are contracted with
 - For ECM, which POF they serve
 - For Community Supports, which services they provide
 - What information they need from you
 - Method for making the referral (fill out a form, call their front desk, etc.)



Referrals to Your County's CalAIM Coordinator

- Determine who in the county is the CalAIM Coordinator
- What information do they need from you
- Method for making the referral (fill out a form, email, etc.)
- What do you need to know to make referrals to your county's CalAIM Coordinator?
 - Recipient's consent to make the referral

Recipient Self-Referrals

- Give recipients information on the programs and encourage them to contact their MCP directly.
 - Provide the MCP's number to call and/or website with the referral forms.
- Encourage the recipient to talk to their doctor or other social services providers they work with about these services.
 - Not all doctors are familiar with ECM or Community Supports.



Additional Referral Options

- For Community Supports referrals:
 - If a recipient is already receiving ECM, contact their ECM provider and request a referral for Community Supports.
 - If a recipient qualifies for ECM, you can make a referral to ECM, and then, if the recipient is approved for ECM, that provider can screen for and facilitate Community Supports referrals.
 - This can take several months from your referral to ECM to the provision of Community Supports services.
- For ECM referrals, if a recipient is already receiving a Community Supports service, request that the provider make a referral for ECM.

Referral Challenges

- Learning the outcome of referrals (closed loop referral)
 - Tracking options
- Don't know how to find contracted providers
- Concerns about duplication of services
- Time investment in referrals vs. outcomes for recipients

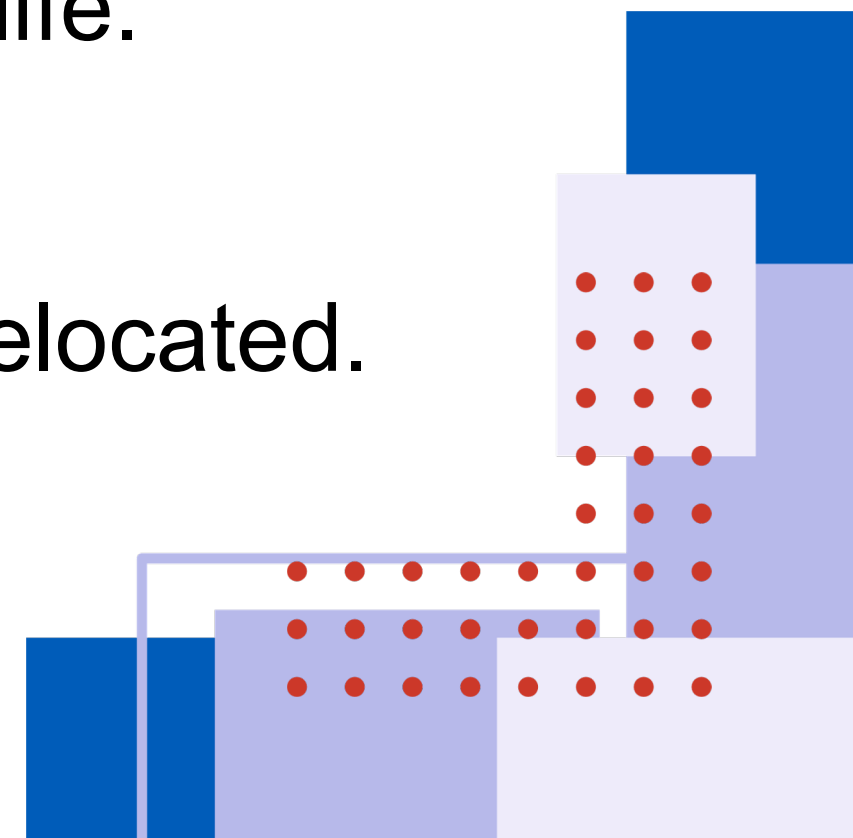


Case Study



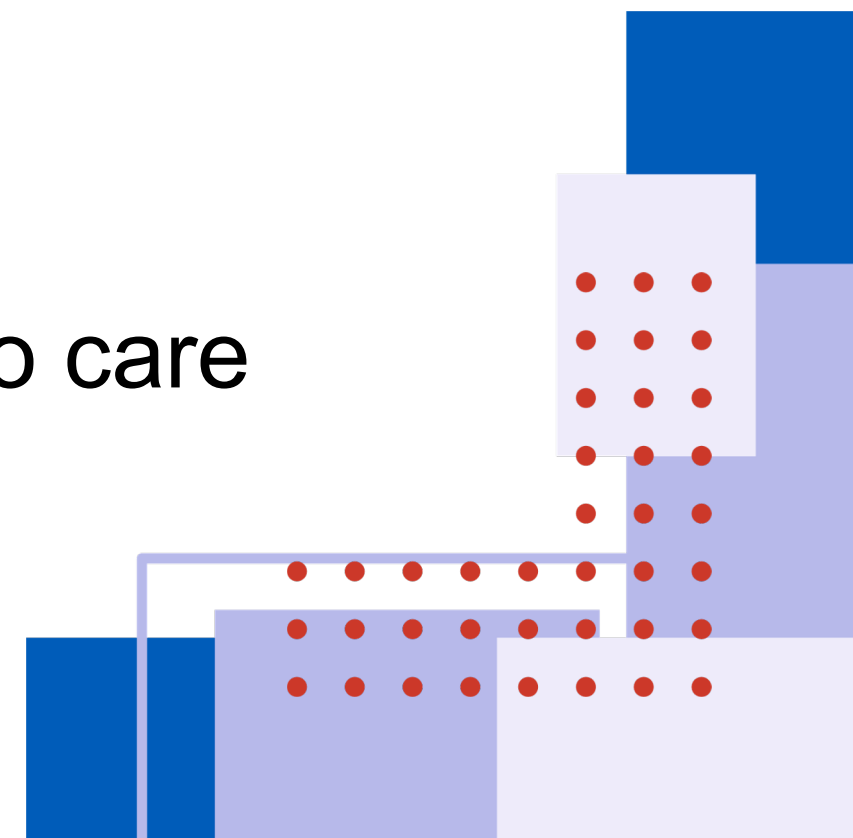
Meet Cassie

- Cassie is a 34-year-old mother of a 10-year-old daughter, applying for CalWORKs for the first time.
- She left an abusive relationship recently and in the six months leading up to her leaving, she went to the emergency room eight times.
- She has struggled with anxiety and depression for most of her life.
- She worked part time until she left, and lost the job when she relocated. She wants to return to work when she is settled.



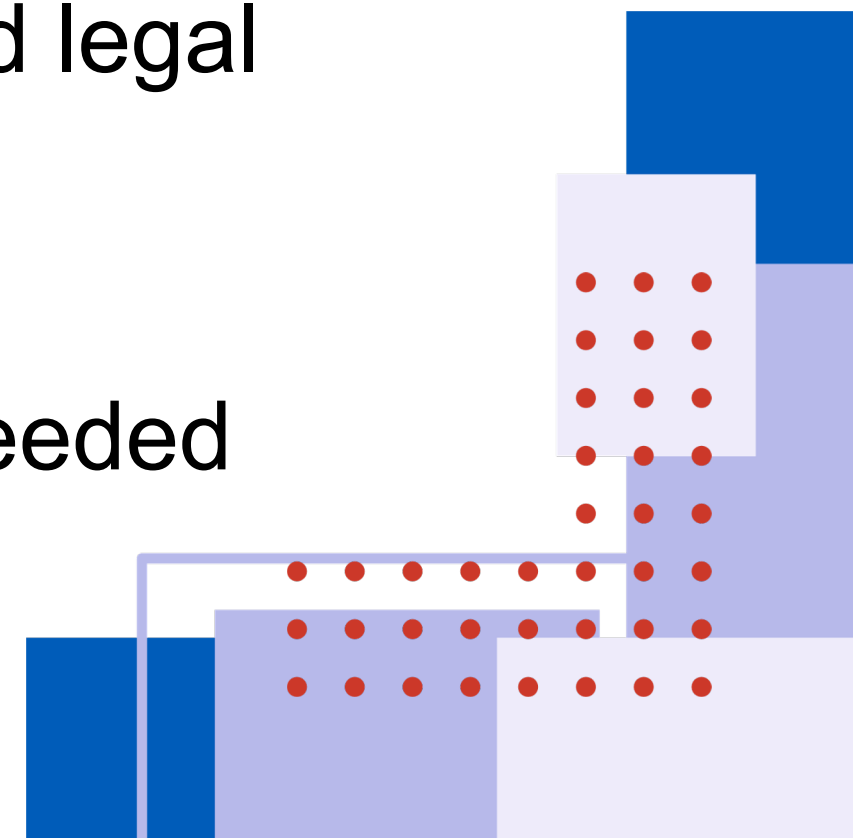
Cassie and CalAIM

- During her appointment at the county office, Cassie applied for CalWORKs, CalFresh, and Medi-Cal.
- Are Cassie and her daughter eligible for ECM and/or Community Supports?
 - Are they enrolled in Medi-Cal managed care plan?
 - Is Cassie navigating complex issues and multiple systems to care for herself and her daughter?



Cassie and ECM

- Cassie may be eligible for ECM under the *Individuals at Risk for Avoidable Hospital or ED Utilization* Population of Focus because she had more than five emergency room visits in a six-month period.
- How can ECM support Cassie?
 - A single Lead Care Manager coordinates Cassie's services.
 - Refers and connects her to domestic violence advocacy and legal services.
 - Refers Cassie for behavioral health services.
 - Refers for Community Supports services as well as other needed services.

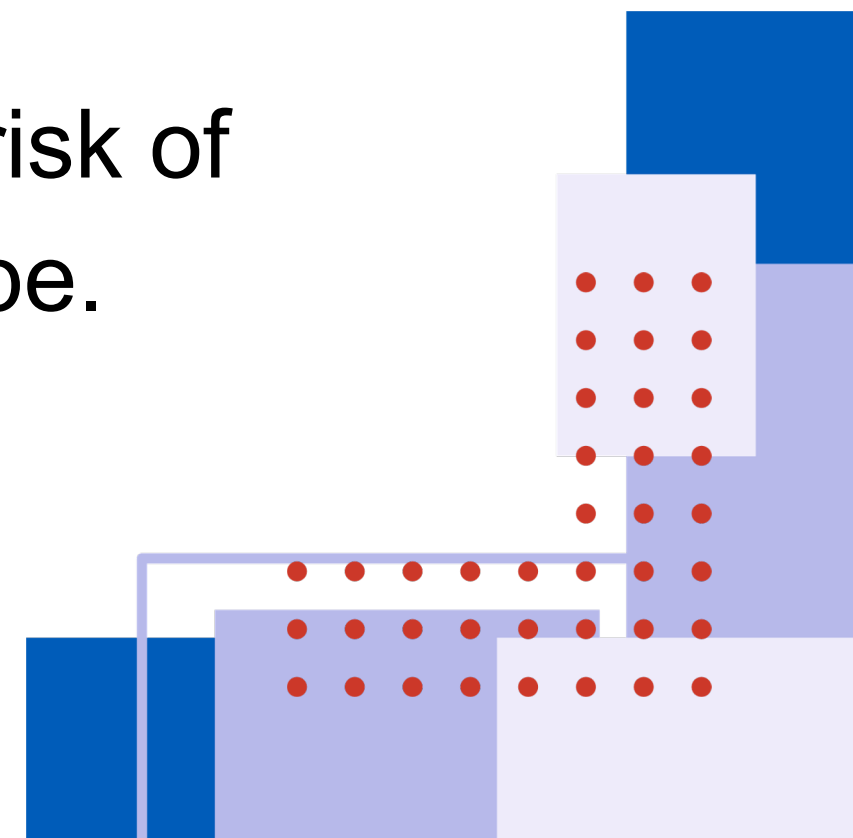


Child Welfare Involvement

- Cassie's daughter disclosed at school that she witnessed the violence. A mandated report was made and an Emergency Response investigation opened.

If the referral is evaluated out or the ER investigation closes without a case:

- CalAIM eligibility and services are unchanged.
- Linkages secondary prevention still applies as the family is at risk of future child welfare involvement, which is within Linkages' scope.



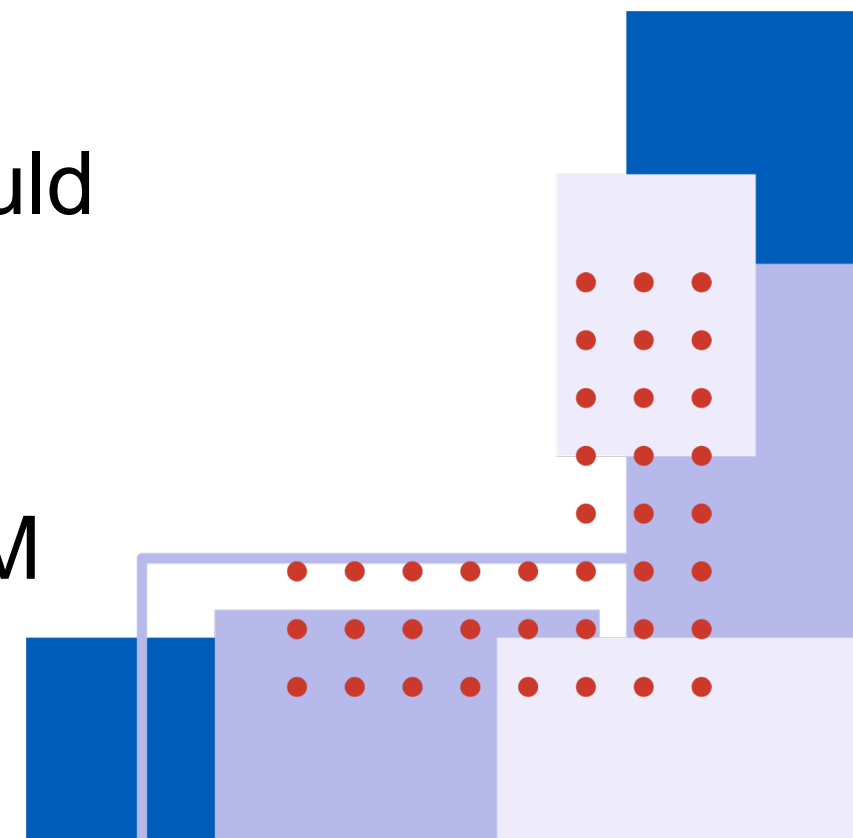
Child Welfare Involvement

If CWS opens a Family Maintenance case with the daughter remaining in the home:

- Cassie's daughter could be eligible for ECM under the Children and Youth Involved in Child Welfare POF.
- **Linkages is activated:** CalWORKs and CWS coordinate into a single case plan rather than two.

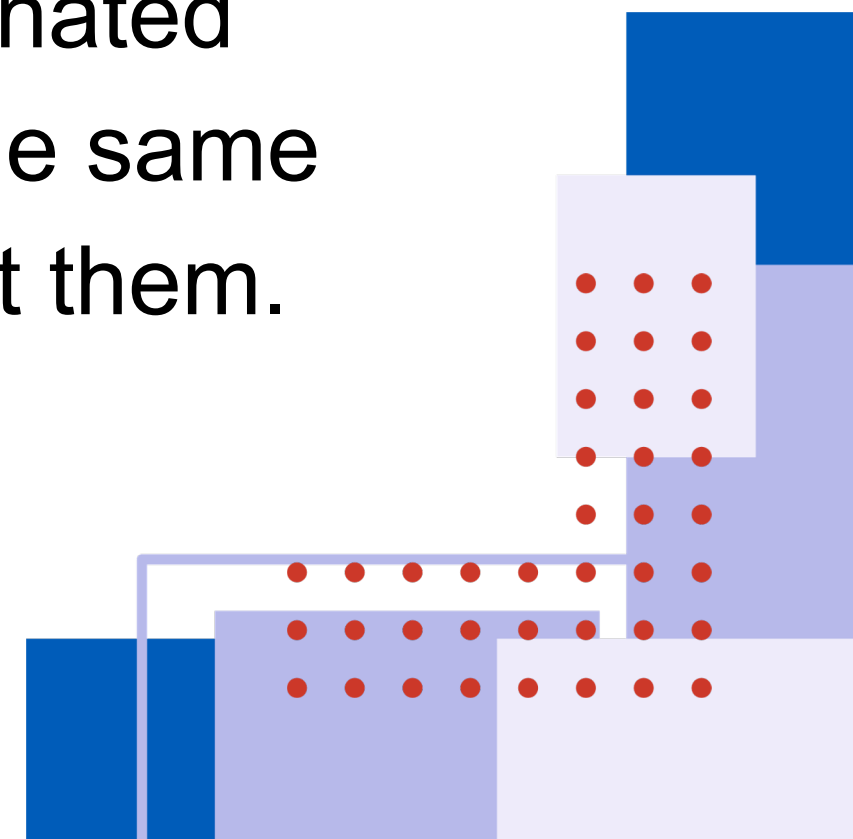
What This Changes for ECM:

- Cassie would still have her own ECM services, but her daughter would now be eligible to work with her own Lead Care Manager, if needed.
- **Try to keep the family with one ECM provider.** DHCS prefers a trusted provider already serving the individual to extend into the ECM role for the children.



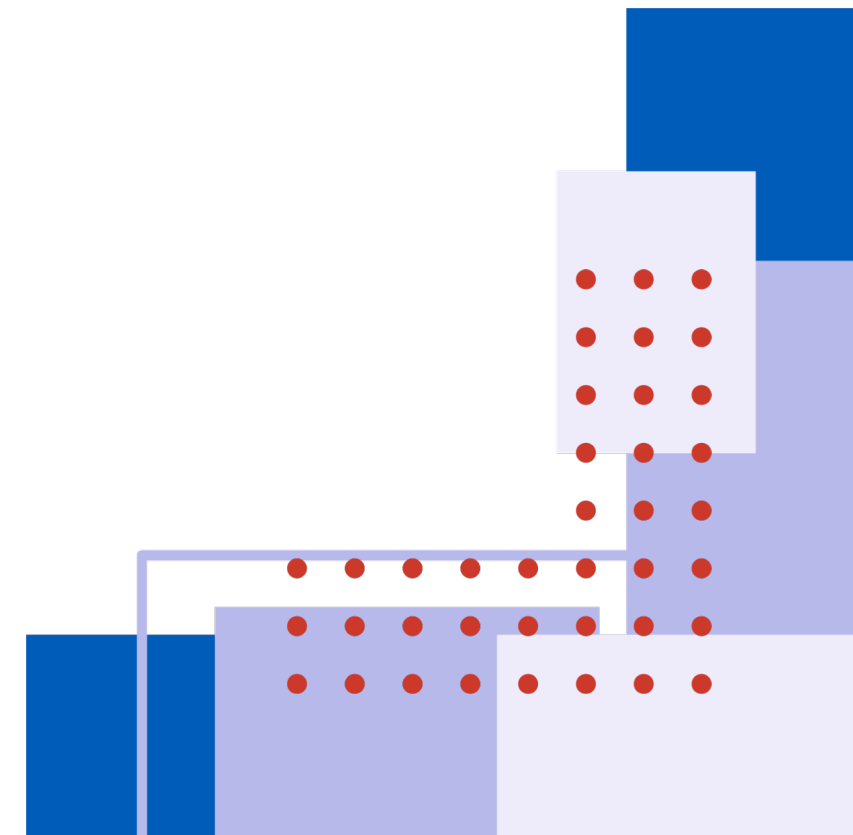
Linkages and CalAIM

- Linkages coordinates the **county side**: CalWORKs and CWS case plans, WTW requirements, timeframes, and services.
- ECM coordinates **other services**: behavioral health, any Community Supports services, and other community services.
- **Neither automatically talks to the other.** A Linkages coordinated case plan and an ECM care management plan can exist at the same time without referencing each other. Someone has to connect them.



Linkages and CalAIM

- The Linkages coordinated case plan is the natural place to name the ECM provider. Bring the Lead Care Manager into the CFT.
- CWS case plan activities and CalWORKs Employment Services requirements are already being reconciled through Linkages. ECM adds a third set of appointments. If nobody sequences them, Cassie has three plans and three sets of expectations.



Q & A



Next Steps

Toolkit for Self-Sufficiency Is Coming!

- Additional resources, including training modules and job aids are coming, framed around what they solve for staff and recipients