To CalAIM or Not to CalAIM?

The Question Every Community-Based Organization is Asking

AUGUST 2024

Leaders of community-based organizations (CBOs) that provide safety-net services to children, youth, and families are always looking for ways to diversify their funding sources, in particular looking for continuous funding not reliant grant timelines. Under a series of reforms, known collectively as CalAIM, Medi-Cal has broadened the managed care plan benefits to focus on community supports for social drivers of health and enhanced care management to help people navigate health care services and access available community supports. Additionally, Medi-Cal added community health workers and doulas as new provider types.

An underpinning of success for Medi-Cal's CalAIM reforms relies on bringing culturally competent, trusted community-based providers into Medi-Cal managed care plan (MCP) networks. Yet, available research shows most CalAIM-contracted providers are large organizations (>$11M revenue). As CBO leaders assess whether to pursue CalAIM services, they are working through a series of questions regarding program fit, administrative effort, total potential revenue and longevity.

This guide aims to help CBO leaders, such as executive directors and program directors, think through the various reform opportunities and help them decide if pursuing CalAIM services makes sense for their organization from a mission and financial perspective. We also summarize the role that network intermediaries can play in connecting CBOs to managed care plans and offer a framework for helping CBO leaders decide whether it makes sense to work with an intermediary or pursue direct contracting

This guide is broken into four sections. First, we summarize the new CalAIM service and provider types. Second, we dive deeper into Enhanced Care Management, as this service line seems most akin to care management services many organizations provide today. Third, we review MCP contracting strategies and discuss intermediaries, lastly, we present potential next steps

Part 1: New Opportunities

What Are the New Medi-Cal Opportunities?

CalAIM, Medi-Cal has expanded to cover new benefits and new provider types. The summary grids aim to help program leaders think about how these new services and provider types may fit within their existing array of services or staffing models.

NEW SERVICES

ENHANCED CARE MANAGEMENT

Enhanced Care Management (ECM) is a Medi-Cal managed care benefit for select clients with complex needs who can receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services.

ECM is a team-based care model. The lead care manager is the primary point of contact for the client and coordinates with all other service providers. This can be an unlicensed person. A licensed clinical consultant is required to inform the care plan development. This can be a licensed behavioral health professional or nurse. Some MCPs require a nurse in addition to behavioral health care licensed staff.

Clients are tiered based on acuity, which drives service intensity. Realistic caseloads range between 1:25 and 1:35, with the maximum caseload being 1:50.

Payment

- Reimbursement varies by MCP.
- MCPs reimburse separately for initial outreach and engagement and then ongoing service delivery. Usually, outreach is paid for both successful and unsuccessful attempts and almost always is capped, but that cap varies widely.
- Most MCPs pay a per client per month case rate for ongoing ECM that ranges from about $350–$500.
- Other MCPs pay on a fee-for-service basis that ranges from about $300 per encounter to $50 an hour for a non-licensed lead care manager.

Considerations

- Community organizations doing care management for other programs can also do ECM to improve coordination for things like medical or dental that they may not have time or staff to do today.
- Providers must have some type of care management system to document their activity. MCPs periodically may review files to ensure practice meets program expectations.
- Several MCPs require providers to document inside their portals as well as submit claims.

Learn More

- **ECM Fact Sheet**
- **ECM Child & Youth Spotlight**
- **ECM Policy Guide** (February 2024)

COMMUNITY SUPPORTS

Community Supports (CS) are services provided by Medi-Cal managed care plans (MCPs) to address Medi-Cal clients' health-related social needs, help them live healthier lives, and avoid higher, costlier levels of care. Clients may receive a Community Supports service if they meet the eligibility criteria, and if the MCP determines the Community Supports service is a medically appropriate and cost-effective alternative to services covered under the California Medicaid State Plan.

Community Supports most likely to benefit children and youth include asthma remediation, housing navigation, housing tenancy and sustaining services, housing deposits, and caregiver respite.

Payment

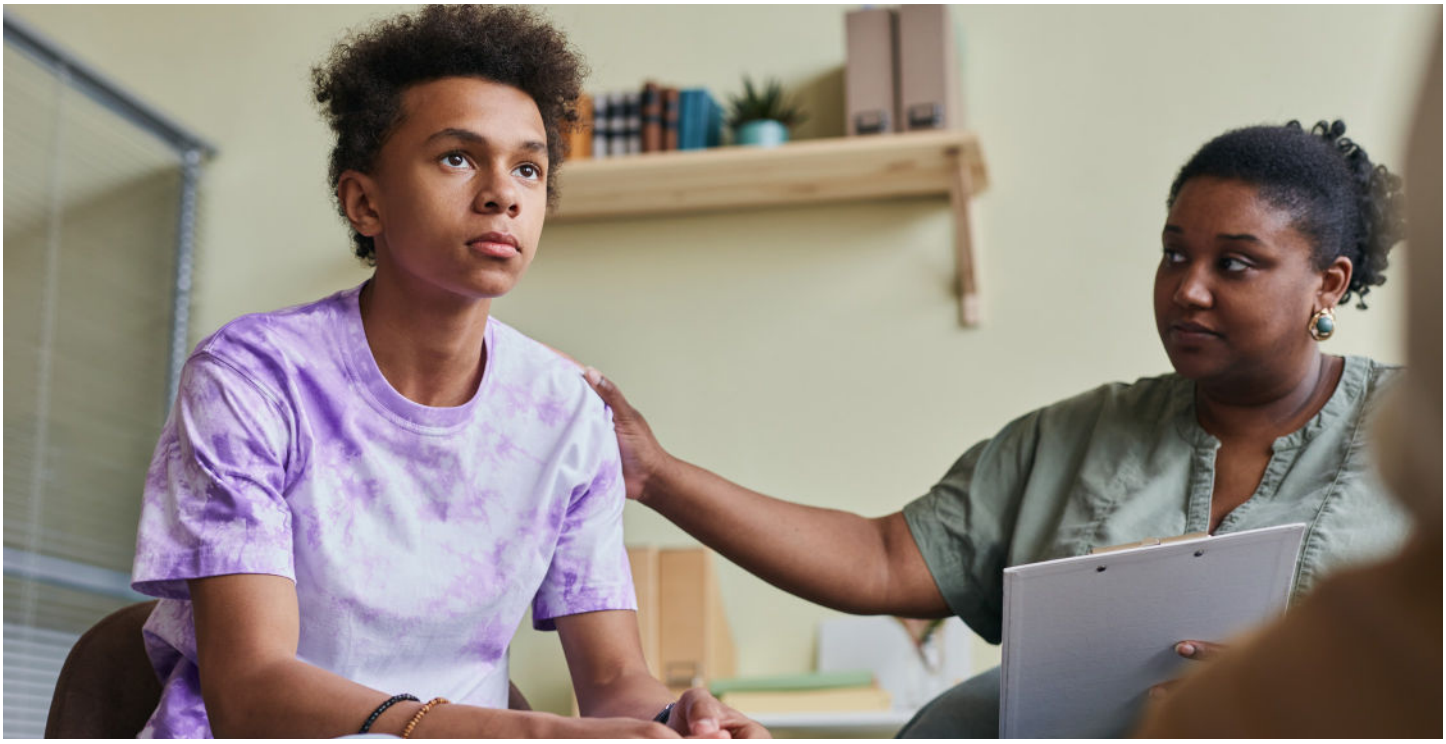
- Asthma Remediation (Lifetime maximum of $7,500)
- Housing Navigation ($324–$449 PMPM)
- Housing Tenancy and Sustaining Services ($413–$475 PMPM)
- Housing Deposits (lifetime max of $5k)
- Caregiver Respite ($29–$38 hourly)

Considerations

- Providers can combine ECM and CS and deliver both.

Learn More

- Community Supports Policy Guide (July 2023)
- Community Supports Fact Sheet
- Non-binding CS Pricing Guides
- Community Supports for Children & Youth



NEWLY COVERED PROVIDER TYPES

COMMUNITY HEALTH WORKERS

Community Health Worker (CHW) services are available in fee-for-service and through managed care plans (MCPs). These services are preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and well-being.

CHWs may include individuals known by a variety of job titles, including promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals.

A program cannot be paid to deliver CHW and ECM services to the same client at the same time.

Payment

- State Medi-Cal FFS rate is $27.43 for 30 minutes.

Considerations

- MCPs are allowed to pay more than the state rate, and some are choosing to do so.
- Pursuing CHW service reimbursement is a way to diversify funding for existing services and reduce reliance on grants, but current reimbursement rates are unlikely to cover the total cost.
- We estimate the break-even rate for a CHW is about 60% higher—closer to $40 for 30 minutes.

Learn More

- CHW Overview
- Medi-Cal Provider Manual for the community health worker
- Medi-Cal Provider Manual for asthma preventive services

CERTIFIED WELLNESS COACHES (school-based services only)

The certified wellness coach is a new provider type available in schools or school-linked settings (including public K-12, community colleges and UC and CSU campuses).

Coaches provide care to young people through prevention and early intervention services. These services support overall physical, emotional, and mental well-being. The goal is to increase availability of non-clinical behavioral health service providers within school-linked settings and building a pipeline of people to go into the behavioral health field.

Community colleges will be rolling out certification programs but right now providers who meet the criteria and have experience can start providing services.

Services rendered by wellness coaches need to be billed via claims submitted to state-contracted network and claims management organization (Carelon Behavioral Health).

Payment

- Reimbursement is about $20 per 15 minutes or about $80 an hour.

Considerations

- Community providers need to be nominated by their local school districts to be part of their "school linked network" and will then have to enroll with Carelon Behavioral Health.
- Certification programs are not yet up and running. To begin providers will need to meet requirements under the "experience pathway."

Learn More

- CAwellnesscoach.org

DOULAS

Doula services are available in fee-for-service and through managed care plans (MCPs). Services include personal support to individuals and families throughout pregnancy and one year postpartum. This includes emotional and physical support provided during pregnancy, labor, birth, and the postpartum period, as well as support for and after miscarriage and abortion.

Payment

Maximum per pregnancy with standing recommendation= $3,152.65

- One initial visit
- Eight visits that may be provided in any combination of prenatal and postpartum visits
- Support during vaginal labor and delivery
- Two extended postpartum visits
- With a second recommendation, a doula to receive an additional $1,458.99, on top of the maximum amount above if they provide all nine postpartum visits.
- For more information regarding the rate increase, visit: Medi-Cal Targeted Provider Rate Increase page.

Considerations

There are two qualifications pathways to become a Doula in Medi-Cal, as follows:

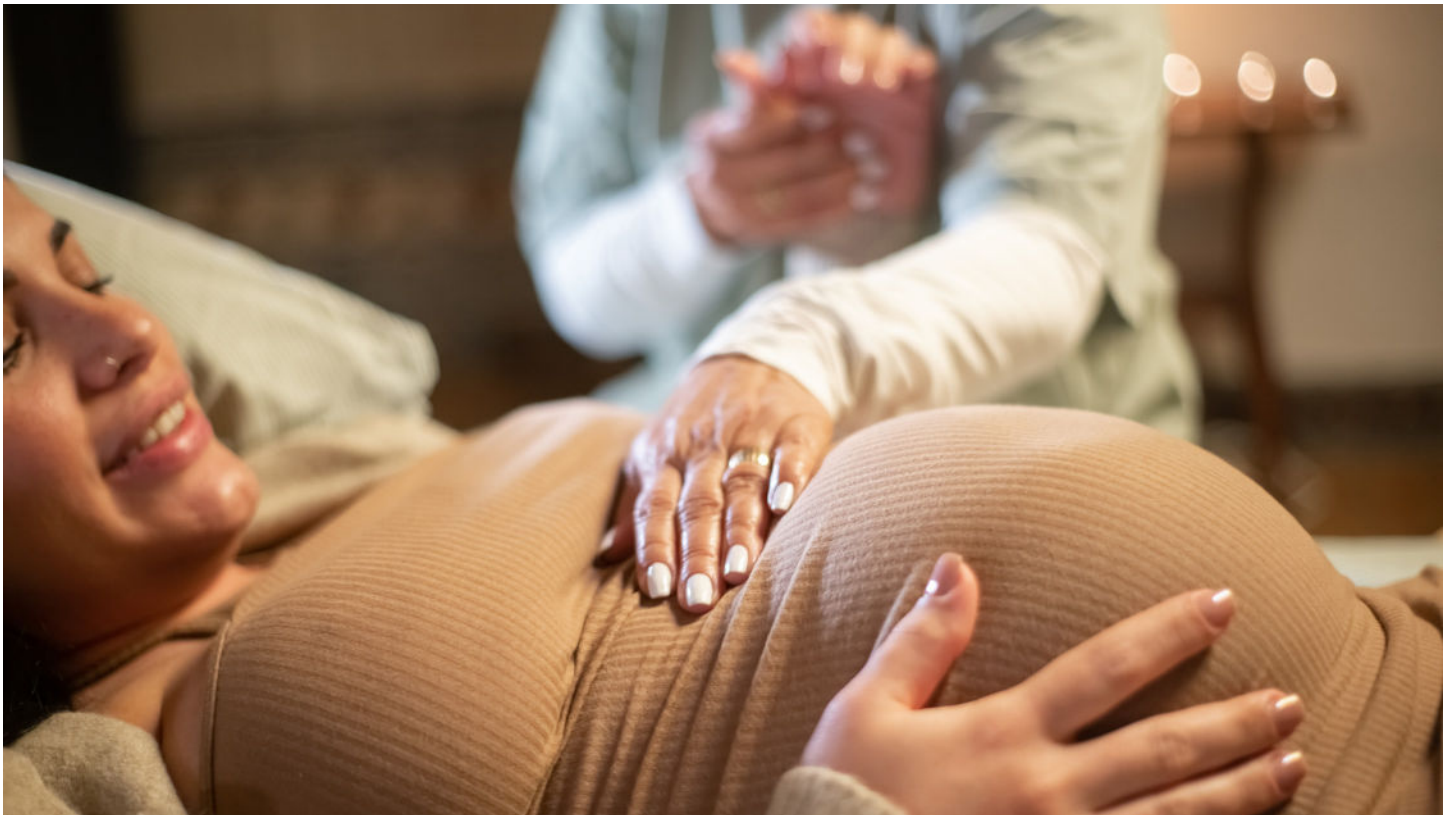
- Training Pathway: 16 hours of training, and attestation of supporting more than 3 births.
- Experience Pathway: 5 years of active doula experience within the previous 7 years, and 3 client testimonials or letters of recommendation and attestation.

Learn More

- DHCS Guidance
- Medi-Cal Provider Manual: Doula Services
- Billing Tips for Doula Providers

Medi-Cal Provider Manual for Doula Services

- MCP Contact List
- Doula Training regarding enrollment and billing
- DHCS Medi-Cal Doula Services Recommendation Form
- DHCS Standing Recommendation for Doula Services
- Frequently Asked Questions for Doulas



Part 2: Considerations: Strategic Fit and Capacity

How the CalAIM services "fit" among your organization's existing activities is an important strategic consideration when evaluating whether to pursue CalAIM services. Strategic fit has to do with how your activities interact and whether they mutually reinforce one another. This is important for sustainability. Whether your organization has capacity to add a new service line is another important consideration. This section walks through key considerations related to fit and capacity.

Deeper Dive into Enhanced Care Management

Enhanced Care Management (ECM) can be a service that complements existing programs offered by CBOs that serve children, youth and families. Examples of provider types that could be an excellent fit for bolting ECM onto an existing service array include specialty mental health service providers, foster family agencies, residential care programs working on youth discharges, organizations serving youth involved in probation, and family resource centers. Housing providers can offer ECM and housing Community Supports at the same time as a bundled package. With an ECM contract an organization can afford to expand its coordination to include medical and dental services, along with the broader array of supports important to achieving the care plan goals of the child or family.

PRINCIPLES OF ENHANCED CARE MANAGEMENT	SPECIFIC ACTIVITIES INCLUDED WITHIN ECM	RECOMMENDED SERVICE INTENSITY
» Community-based » In-person » Trauma-informed » Interdisciplinary » High-touch » Person/Family-centered » Aligned with other child and family team goals	1. Comprehensive Assessment and Care Planning using SMART goals 2. Helping clients access and coordinating care amongst various medical, behavioral health care and social services providers, ensuring effective communication to achieve the care plan goals 3. Health promotion through client education and teaching self-management strategies 4. Client and family engagement 5. Medication Reconciliation/Management ensuring medications are effective and don't have adverse interactions 6. Comprehensive transitional care for clients leaving hospitals or institutional settings 7. Referrals and supporting connection to community supports	**Tier 1:** Two to four contacts per month with at minimum one in person contact per month. **Tier 2:** One to two contacts per month with a minimum of one in-person contact per quarter. **Tier 3:** Two contacts during the first month, a minimum of one contact monthly with one in-person contact.

WHERE TO GET STARTED

Below is a simple decision tree with initial questions an organization should reflect on when deciding if they should try to become an ECM service provider.

1. Does your organization have the competency to carry out the ***specific activities (see table above)*** required as part of Enhanced Care Management?
    a. **YES →** move onto question 2
    b. **NO →** Do you have an internal experienced and capable champion who can build it?
        i. **YES →** move to question 2
        ii. **NO →** ECM may not be a good fit at this time
2. Does your organization have a plan to efficiently enroll a sufficient number of the eligible populations of focus to cover the associated program costs? Below are the key considerations for the most common pathways to convert eligible clients into ECM cases. We recommend caution if you are relying exclusively on paths 2 and 3. If none of these paths seem viable, then ECM may not be a good fit.
    a. **Path 1: Serve existing clients.** The most direct way, and arguably the approach that best serves individuals, is to add ECM as an additional service for clients you already serve in an existing program, such as wraparound, full service partnership, intensive care coordination, probation programs or other specialty mental health services.
        i. Does your organization serve enough clients who meet one of the eligible populations of focus?
        ii. Do you have a plan to add ECM enrollment into your existing workflows?
    b. **Path 2: Receive referrals from the managed care plan.** This strategy requires cold outreach to a list of eligible clients sent by the managed care plan. The managed care plans do reimburse for outreach (successful and unsuccessful) up to a certain level, but overall conversion rates seem to be less than 10 percent for children and youth populations. If your goal is enrolling 60 clients, you would have to outreach to 600. You need to be contracted or "in network" with enough MCPs or a large enough MCP to give you enough referrals.
    c. **Path 3: Generate referrals from partner organizations.** If you do not currently serve the existing populations of focus at sufficient volumes to build and sustain an ECM program, you can develop relationships with other community organizations, pediatricians or county departments to generate referrals. This will require the creation of marketing materials and dedicated staff time to create the relationships for the referrals. You should set a budget based on the cost of a converted referral and be mindful not to exceed about 5% ($200 per client).

SIMPLIFIED ECM FINANCIAL SCENARIO

This is a simplified model for potential revenue and costs if a provider were to deliver ECM to 60 clients per month. This demonstrates that doing ECM on a small case volume works only if ECM is an additional revenue stream bolted onto an existing service array. That way you can use partial FTEs for the licensed consultant and supervisor and program overhead is minimal. Building a stand-alone ECM program requires volumes of at least 150 enrolled cases per month.

REVENUE			
ECM CASES	MONTHLY REIMBURSEMENT PER CASE	AVG LENGTH ENROLLED (MONTHS)	ANNUAL TOTAL
60	$400	10	$240,000

COSTS	
Costs for 2 lead care managers	$140,000
Partial FTE of Licensed Provider for consultation, care plan review	$40,000
Partial FTE of Program Director, staff supervision, program development, etc.	$30,000
Costs for billing, administration, etc.	$30,000
TOTAL	**$240,000**

**All numbers are hypothetical and not actuals.*

Compliance: No Double Dipping

ECM can be delivered alongside numerous Medi-Cal-funded programs and services that may seem like they overlap (See figure 1). This includes a variety of specialty mental health services and other care coordination programs, such as wraparound. Clients enrolled in Medi-Cal fee for service and certain waiver programs cannot get ECM. Also, clients cannot receive ECM and community health worker services at the same time. Providers should ask themselves if they have administrative capacity to manage the tracking of another funding stream.

Some strategies to help providers ensure they can demonstrate they are not "double dipping" or receiving funding for the same service include:

- **Assign specific staff to do ECM activities not otherwise covered by someone on the client's care team.** For example, the ECM lead care manager can ensure coordination with the primary care office, help ensure that a client has all recent immunizations, well child visits, etc and monitor data notifications for ED visits or hospital admissions and support transitions of care. The ECM staff can become your agency's expert at coordinating Community Supports, non-emergency medical transportation, language interpretation and other services available from the managed care plan.
- **Create a documentation strategy.** ECM requires its own assessment and care plan, but that doesn't mean you have to start from scratch. The lead care manager should pull information from existing assessments but you will also need to capture information on social determinants of health and medical, which may be more than you typically do. The care plan must address the multi-dimensional aspects of care delivery, have measurable goals and progress notes. While providers can keep documentation in one system for all their programs, they will need a method to isolate and quantify ECM activities and create claims with the specific codes for clinical and non-clinical staff for those activities. If audited, providers will need to demonstrate that this same time/note was not billed to a different Medi-Cal program.

FUNDER CONSIDERATIONS

CBOs often receive grant funding from local governments or philanthropic sources. Proactive communication to funders that you are pursuing CalAIM funding sources can position your organization as entrepreneurial and demonstrate how you are leveraging their initial investment to seek sustainable funding moving forward.

CASH FLOW: HOW LONG DOES IT TAKE TO GET PAID?

Agencies should plan for an initial 90–120 cash flow cycle when they go live with a new payer. As time goes on, this likely will improve to closer to 30 to 45 days. Ask if implementation support funds are available during the go-live stage with new funders. If not, plan to start slow and ensure you can afford to pay staff salaries and operating costs while you wait for claims reimbursement.

Recommendation: Be prepared for a worst case scenario of funding six months of staff salaries until reimbursement is flowing smoothly.

FIGURE 1: GUIDE TO ECM AND OTHER MEDI-CAL PROGRAMS

1 **Individual can be in ECM AND one of these programs** *Medi-Cal enrollees can be enrolled in both ECM and the other program with ECM enhancing and or coordinated wiht the other program, but specific services should not be duplicative.*	2 **Individual is enrolled in ECM OR the other program** *Medi-Cal enrollees can be enrolled in ECM or other programs but not both at the same time*	3 **Individual is NOT eligible eligble to enroll in ECM** *Medi-Cal enrollees enrolled in the other programs are exclused from ECM*
» Black Infant Health Program » California Children's Services » California Wraparound » CCS Whole Child Model » CDPH California Home Visiting Program » CDSS CalWORKS Home Visiting » Regional Center Services » Health Care Program for Children in Foster Care (HCPCFC) » Specialty Mental Health Services Intensive Care Coordination (ICC) » Specialty Mental Health Targeted Case Management » Specialty Mental Health Full Service Partnerships » California Perinatal Equity Initiative » Comprehensive Perinatal Services Program (CPSP) » Community-Based Adult Services » County-Based Targeted Case Management » Drug Medi-Cal Care Coordination and Care Management » American Indian Maternal Support Services (AIMSS) » Genetically Handicapped Person's Program » In-Home Supportive Services (IHSS)	» Assistend living waiver » California Community Transitions (CCT) Money follows the Person (MFTP) » Complex Care Management (CCM) » HCBS Waiver for I/DD » HIV/AIDS Waiver » Home and Community-Based Alternatives (HCBA) Waiver » Multi-purpose Senior Services Program (MSSP) » Self-determination Program for Individuals wiht I/DD	» Medi-Cal Fee For Service Enrollees » Medi-Medi Plan Special Needs programs » Hospice » PACE Programs » Palliative Care

Administrative Infrastructure Needs

Providers that already submit Medi-Cal claims for other services, such as for specialty mental health, may have necessary administrative infrastructure. Providers that have never been considered a HIPAA covered entity or enrolled in Medi-Cal will have more infrastructure to build to demonstrate compliance.

MEDI-CAL ENROLLMENT

Medi-Cal enrollment is a federally required process for providers receiving Medicaid funds. The most common method for enrollment is via the online system, PAVE (pave.dhcs.ca.gov). Only nonprofit CBOs that intend to deliver ECM to clients inside jails or juvenile facilities or provide CHW/Doula services to fee-for-service enrollees must enroll via PAVE *as an organization.* However, all programs require supervision from licensed clinicians (RN, LVN, LCSW, LMFT, LPCC) and those individuals must enroll in PAVE.

NOTE: If you intend to enroll your organization in Medi-Cal via PAVE, this requires submitting personal information about all executive staff and key board members (e.g.g date of birth, social security numbers, addresses) as part of the application.

PRIVACY MANAGEMENT

Organizations contracted with a managed care plan will be required to execute a Business Associates Agreement that lays out requirements for client privacy under federal HIPAA law. You should have training and compliance plans in place to make sure staff understand how to keep client information secure.

SOFTWARE

ECM requires a secure electronic method for storing client information and logging care management activity. If you plan to generate referrals from community partners or do outreach from a client assignment list, having an activity log or customer relationship management platform can also be helpful. Ideally, the same care management system would be able to generate the required ECM reports and claims in an automated manner.

Providers will need some method to submit to the MCP claims or an agreed-upon report that the MCP will accept in lieu of claims. Here is an example of a sample claims **workflow**. Providers will then need to be able to monitor the end-to-end revenue cycle, reconciling funds received, tracking denials and contesting/resubmitting corrected claims.

MANAGED CARE PLAN PORTALS FOR ECM

ECM is unique from other Medi-Cal programs, even from Community Health Worker and Community Support services, in that it requires custom data exchanges—the Client Information File, Outreach Transmission File and Return Transmission File. These are not standard file exchanges and need to be custom built for this program. The purpose of the files is for the MCP to notify the provider of who their "assigned clients" and for the provider to notify the MCP of their outreach and program activity. This is required in addition to claims submissions.

Some MCPs envisioned providers would document all services inside the MCP's portal and spent a significant time, effort and expense building out their portals. For providers that operate in only one county with only one MCP this may work. For others, it is burdensome on staff to have multiple, different systems for documentation. While DHCS has directed the Medi-Cal MCPs that they cannot require providers to document inside a proprietary portal, as of June 2024, not all MCPs had built out automated methods for secure file exchanges. Moreover, some MCPs require portal documentation of activity AND require claims to be submitted separately. This necessitates double documentation because a provider cannot submit claims without having access to all the program activity.

ASSESSING STRATEGIC FIT

	KEY QUESTIONS TO ASK		
KEY DOMAIN	**ENHANCED CARE MANAGEMENT**	**CHW SERVICES**	**COMMUNITY SUPPORTS**
Strategic Fit	Do you have adjacent programs that this service could complement and be an additional revenue stream for a core program?	Do you already employ CHWs or staff that do work similar to CHWs and could become CHWs via the "experience pathway"? Do you have a pipeline for CHW training in place?	Do you have experience doing the housing community supports? Do you want to bundle these services with ECM?
Staffing	Are you able to add staff onto an existing team and leverage partial FTEs for licensed staff and leadership roles to reduce your costs and lower start-up risks? Are staffing challenges leading you under billing other contracts that pay more (specialty MH) making ECM, CHW or CS a costly distraction? Do you have an internal person who can champion the program launch?		
Case Management and Outreach	Does your staff have experience braiding funding streams? Can you implement workflows that allow you to meet all requirements in a compliant manner?		
Referrals and Partnerships	How many of your current program clients meet ECM eligibility criteria and do you think you can successfully enroll into ECM? If you want to generate referrals from outside your program, do you have client acquisition channels identified among community partners?	What is your current program volume of clients who meet eligibility criteria?	What is your current program volume of clients who meet eligibility criteria? If you want to generate referrals from outside your program, do you have client acquisition channels identified among community partners?
Program Documentation	Do you have an electronic care management system or health record for documentation that would not require significant time and cost to configure for the new services? If not, do you have an alternate documentation and billing strategy?		
Data Sharing	Do you have capacity for electronic data exchanges via secure file transfer protocols (SFTP) to receive and send key files, such as the client information file (assignments and authorizations), and activity data on outreach and program services?		
Analytics and Reporting	Ask if the MCP requires documentation inside its own portal and if this will be a burden on your staff. Make sure your staff understands the various reporting required for the service you are contracting.		
Eligibility and Authorizations	You will need to implement processes for checking client eligibility at least monthly and for discontinuing services if the client is no longer enrolled in the MCP. Do you have someone who can lead the creation of this process? You will need to develop a process to request authorizations and track when they are going to expire. Do you have someone who can implement this?		
Claims, Billing & Revenue Cycle Management	Do you have infrastructure and processes (perhaps already working with a third-party biller) to successfully complete end-to-end revenue cycle management? Is a 60-day cash flow cycle OK?		
Working with a network intermediary	Do you want to hold the direct contract with the managed care plan or are you OK going under an intermediary's umbrella contract?		

Part 3: Contracting Strategy

What Is Managed Care and Why Does It Matter?

About four in five Medi-Cal beneficiaries access their Medi-Cal benefits through a managed care plan (MCP). Managed care plans are contracted with the California Department of Health Care Services (DHCS) to organize and reimburse a network of providers to deliver timely, medically necessary services.

California has more than 20 managed care plans that operate statewide. Some MCPs operate in multiple counties (Partnership HealthPlan is in 22, Kaiser Permanente Health Plan is in 32, Anthem Blue Cross of California is in 16 and Health Net of California is in 14) and other MCPs operate in only one county (San Francisco Health Plan, Contra Costa Health Plan, Alameda Health Alliance and Santa Clara Family Health Plan).

Almost all counties have two Medi-Cal managed care options and some have many more: Los Angeles has six, Sacramento and San Diego each have four, and multiple have three Medi-Cal MCPs, including Kaiser. **See the Appendix for the full list of managed care plans by county.**

If a CBO chooses to offer a new CalAIM service, most likely they will want to offer the service uniformly to all qualifying clients regardless of which MCP the client is enrolled in. This improves fairness and creates operational consistency. However, it requires CBOs to secure a contract and "join the network" of all MCPs operating in their county. This means undergoing the certification, credentialing and contracting processes multiple times. Once a provider is contracted, the administrative activities, such as reporting, data exchanges and claims submissions, will need to be done separately for each MCP and often are different.

MCP MARKET SCAN

- Find out what MCPs operate in your county.
- Rank the MCPs in terms of market share (total enrollment). You can find this out by looking up your county's enrollment .
- Reputation diligence. Ask colleagues for feedback on ease of working with the MCPs in your service area.
- Go to the MCP website and find their CalAIM pages. Most have a central email inbox for provider inquiries. Email them to confirm if they are adding new providers. If they are, ask them how long the process usually takes.

HOW LONG DOES IT TAKE TO GET CONTRACTED?

The managed care contracting process involves multiple steps. Realistically, the end-to-end process could take six months. Steps include program certification, credentialing, contract execution and then training and onboarding. The timeline with an intermediary may take just as long but if an intermediary is under contract already with multiple MCPs in a county, a provider should only have to do those steps once.

Working With a Community Hub or Network Intermediary

Community Hubs or Network Lead Entities can **create efficiencies** for both CBOs and MCPs. Hubs distribute the start-up costs, support understanding of local, community needs, and shoulder admin burden for CBOs so they can focus on serving people.

KEY CONSIDERATIONS REGARDING INTERMEDIARIES

Below are essential functions of an intermediary. Use these as guideposts when deciding if working with an intermediary is the right path for your organization.

	DESCRIPTION	KEY QUESTION
Speed to market/ access to MCP contracts	Key to implementation speed is whether the intermediary has contractual standing with the managed care plan in your county.	Which MCPs does the intermediary have contracts with? Which is it pursuing and what is the timeline? If you have multiple MCPs in your county, does the intermediary have contracts with all of the MCPs or at least the larger ones? Does the intermediary have strategies to help providers deliver the same service regardless of MCP enrollment?
Access to start-up funding	Some MCPs offer start-up funding to CBOs via various grant mechanisms. This may or not flow through the intermediary.	Has the intermediary applied for Incentive Payment Program (IPP) start-up funding on behalf of providers? Is this available for new/future providers? How much?
Cost	Most intermediaries charge providers a percentage of revenue collected to cover their administrative costs.	What percentage of revenue does the intermediary keep? What services does this include? Would the cost of doing these services directly be more or less expensive than what the intermediary is charging?
Services available	Providers should make sure they are getting services from an intermediary that would be difficult or cost-prohibitive to stand-up on their own, as well as expertise and experience in each service area. These are the key areas.	1. Credentialing and onboarding. Does the intermediary have efficient processes for supporting credentialing and onboarding with MCPs? 2. Training and capacity building. Does the intermediary have knowledgeable staff who can help your organization think through workflow implementation and provide useful tools for staff to implement the new services in an efficient, effective and compliant manner? 3. Authorization tracking. Does the intermediary have processes established to efficiently submit and track authorizations? 4. Clinical documentation, data collection and reporting. Does the intermediary offer a pre-configured care management/electronic health record system or help providers configure their systems? Does it support compliant clinical documentation and reporting requirements? 5. Payment processing. Are there systems and processes to submit and reconcile payments between the MCP and service providers? What are expected turnaround times? 6. Quality improvement. Does the intermediary have collaborative processes with easy-to-use data that helps providers understand their performance and implement improvement strategies?
Advocacy	By combining voices of multiple providers, intermediaries may be able to influence MCPs and DHCS by lifting up challenges and promoting solutions that work for providers and clients.	Does the intermediary elevate the voice of providers with MCPs and DHCS to help improve collaboration and service delivery?

Part 4: What Comes Next?

Launching a CalAIM service may seem daunting, but below are concrete next steps CBOs can take to move forward and make a decision.

1. Use the prompts on page 10 to evaluate whether the CalAIM services are a good strategic fit for your organization. If you feel like programmatically there is a strategic fit but the administrative lift is too significant, consider working with an intermediary.
2. Identify your internal CalAIM program champion who will be responsible for developing and launching the new service lines. This may be two individuals—one focused on care management/staff development program development and another focused on operations/technology.
3. Join your county's PATH Collaborative Group (**directory**) to get information on CalAIM implementation in your county. This is a good forum to make connections with the MCPs, hear how others are proceeding with implementation, and to troubleshoot challenges.
4. Find out which MCPs are in your county and prioritize your approach to contracting. Likely, start with the MCP that has the greatest market share (**report**).
5. Decide on whether to go it alone or with an intermediary. Interview an intermediary using the question on page 13 to see what they have to offer, how easy it is to start, do they include your priority health plans and how much it costs.
6. If going it alone, investigate the level of effort and costs for 1) configuring a compliant care management system; 2) capability for HIPAA compliant data exchanges; 3) ability to import and export data reporting.
7. Contact the MCP and get a letter of support (if needed to apply for infrastructure funding) and explore getting free technical assistance from the PATH marketplace (see the overview on page 16).
8. Contract the MCP and start the contracting process.

The majority of smaller CBOs need to assess whether they have the infrastructure, capacity, and experience to enter into contractual relationships with managed care plans for ECM, CHW, or Community Support services. Launching new service lines may compete with other priorities from a small administrative staff, require program staff to build new skills, and create financial risk. However, as one CBO leader said, "I know it's going to be hard, but this is the wave of the future."

"CalAIM not only has enormous potential to transform Medi-Cal to be more equitable, prevention-oriented, and focused on the whole-person, but it also opens essential new revenue opportunities for community-based organizations, allowing them to enhance and expand core, nonclinical programs, including job training, housing and tenancy support, behavioral health services, violence prevention, and food and nutrition services. CBOs that engage in CalAIM reforms are able to bill for outreach and referral efforts to improve access to much-needed services and create a new revenue stream. This provides critical support for participants living in vulnerable circumstances and allows CBOs to further increase the health and well-being of the community."

—Jenny Pearlman, Chief Policy Officer, Safe & Sound, lead organization of the San Francisco Family Services Alliance

---

Highlighting Community Hubs/Network Intermediaries

FULL CIRCLE HEALTH NETWORK

Full Circle Health Network is an integrated network of providers delivering coordinated, community-based services to vulnerable children, individuals and families across California since 2023. Started by the California Alliance of Child and Family Services, Full Circle enables CBOs to participate in CalAIM so that more Californians can access equitable, culturally congruent, and trauma-informed care that addresses their whole-person and whole-family needs. Full Circle's provider success team offers extra support through the certification, contracting and implementation process. Full Circle developed a provider self-assessment tool to inform how much support a provider needs to launch.

SERVICES FOR CBOs

- Contractual support with Medi-Cal managed care plans
- Case management system
- Billing and claims
- Program and staff development support
- Training and continuing education
- Quality monitoring and imrpovement support
- Model of care development and support
- Financial modeling
- Supporting providers in expanding to other counties and health plans
- Data management and reporting
- Community Pathway referral development

To learn more, email: info@fullcirclehn.org

NEIGHBORHOOD NETWORKS

Neighborhood Networks is a hub in San Diego launched by the Accountable Community for Health in 2019 to support CBOs in launching and maintaining Medi-Cal contracts for social drivers of health. By partnering with Neighborhood Networks, CBOs can focus on serving their communities and avoid the hassles of Medi-Cal contracts and billing.

Neighborhood Networks' supports CBOs in utilizing their current programs and strengths to expand into CalAIM services. Neighborhood Networks is open and interested in working with new CBOs to grow the model in other regions of the state.

SERVICES FOR CBOs

- Contractual support with Medi-Cal managed care plans
- Case management system
- Billing and claims
- CalAIM workforce onboarding and training
- Clinical consultant
- Continuing education
- Reflective practice

To learn more, email: liz@sdwellnesscollaborative.org

Technical Assistance Marketplace

The Department of Healthcare Services (DHCS) provides free technical assistance (TA) to support implementation of Enhanced Care Management and Community Supports. All of their offerings are available on their website and they include:

- **On Demand Resource Library**: The library includes webinars, slides and documents with information ranging from deep dives on populations of focus to information about TA vendors. The library is relatively new and content is added on a regular basis.
- **Capacity and Infrastructure Transition Expansion and Development (CITED) Grants:** These are grants provided by DHCS for the implementation of and capacity building for ECM and CS. The grant period opens and closes periodically. Check the website for current opportunities.
- **Collaborative Planning and Implementation (CPI) Groups:** These are county level groups run by consultants that meet monthly. The purpose is to learn, collaborate and troubleshoot Cal-AIM implementation on a regional level. We recommend that you join your county group in order to build relationships with managed care plans and learn about the efforts in your county.
- Technical Assistance Marketplace: DHCS contracts with a variety of TA providers to provide a wide range of assistance to organizations hoping to become Medi-cal providers. They provide off the shelf TA such as training and data tools. They also offer customizable TA where the CBO works with the TA provider to develop a scope of work.
- **The difference between the TA Marketplace and CITED grants:** CITED grants are paid directly to a CBO whereas TA Marketplace assistance is paid directly to a consultant who works with the CBO.

HOW TO ACCESS THE TA MARKETPLACE

1. **Apply for access to the TA Marketplace:** In order to apply for access you need one of three things: a contract with a MCP, an attestation letter from a MCP stating your intent to work together, or permission directly from DHCS. For CBOs just starting out, the best route is to get an attestation letter from a MCP. In order to do this, reach out to the MCP you are interested in contracting with. Most MCPs have an email address available for those interested in CalAIM. You could also join your regional collaborative planning group (described above) and make the connection that way. When speaking with the MCP, let them know that you are interested in becoming a Cal-AIM provider. Give a brief description of the services you think you could provide (either ECM, CS, or both). Say something about the population you serve and how it fits within CalAIM POFs. Tell them you need to access the TA marketplace in order to take the next step in becoming a provider. Ask for a meeting to discuss the potential of contracting and send them the attestation form which is available on the DHCS website.
2. **Choose a service and vendor:** Once you are approved to access the TA Marketplace, you must choose a service and a vendor. Keep in mind that you may start with a small project and build out the scope of work with your TA provider once you begin working together and continue to understand your needs. Do your due diligence in comparing TA Marketplace vendors. Consider speaking with past clients.
3. **Apply for the TA Project:** Complete the full application for your TA project. Keep in mind that you may always apply for and add other projects in the future.

USEFUL LINKS

- CalAIM in Focus: Resources for New Providers
- CalAIM budget estimator tool—Camden Coalition (camdenhealth.org)
- TA Marketplace

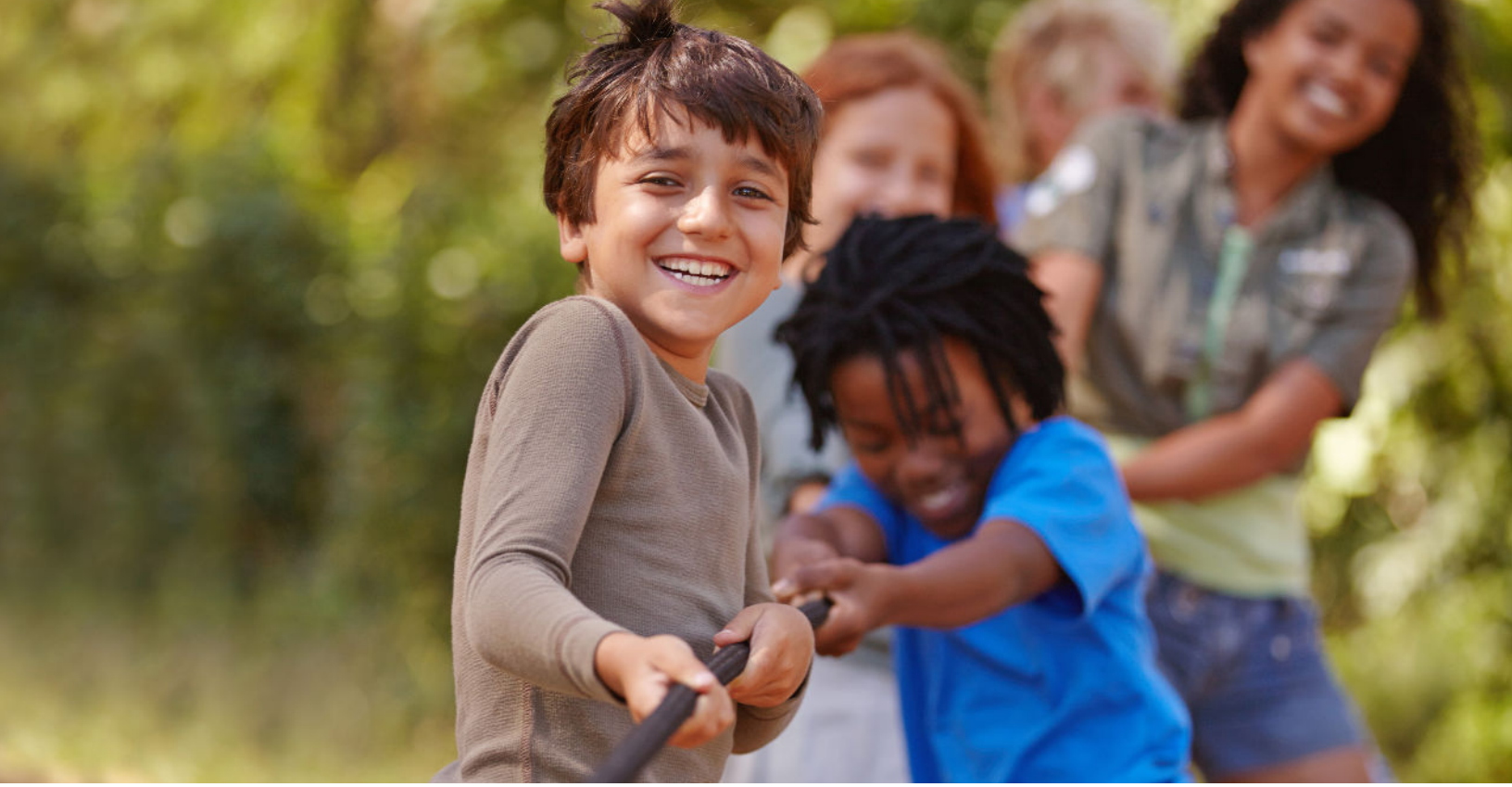
MANAGED CARE PLANS BY COUNTY

	Kaiser	Anthem Blue Cross	Health Net	Molina	San Joaquin/Mountain Valley Plan	Blue Shield Promise	Inland Empire Health Plan	L.A. Care	Santa Clara Family Plan	San Francisco Health Plan	Community Health Group	Kern Family Health Plan	Partnership Health Plan	Central California Alliance	CenCal	Gold Coast Plan	Alameda Alliance	Health Plan San Mateo	Contra Costa Plan	CalOptima
Alpine		X			X															
Tuolumne		X	X																	
Inyo		X	X																	
Mono		X	X																	
Calaveras		X	X																	
San Diego	X			X		X					X									
L.A.	X	X	X	X		X		X												
Riverside	X			X			X													
San Bernardino	X			X			X													
Sacramento	X	X	X	X																
Fresno*	X	X	X (ASO)																	
Kings*	X	X	X (ASO)																	
Madera*	X	X	X (ASO)																	
Amador	X	X	X																	
Tulare	X	X	X																	
San Joaquin	X		X		X															
Stanislaus	X		X		X															
El Dorado	X	X			X															
San Francisco	X	X								X										
Santa Clara	X	X							X											
Kern	X	X										X								
Imperial*	X		X (ASO)																	
Alameda	X																X			
San Mateo	X																	X		
Santa Cruz	X													X						
Mariposa	X													X						
Orange	X																			X
Contra Costa	X																		X	
Ventura	X															X				
Marin	X												X							

	Kaiser	Anthem Blue Cross	Health Net	Molina	San Joaquin/Mountain Valley Plan	Blue Shield Promise	Inland Empire Health Plan	L.A. Care	Santa Clara Family Plan	San Francisco Health Plan	Community Health Group	Kern Family Health Plan	Partnership Health Plan	Central California Alliance	CenCal	Gold Coast Plan	Alameda Alliance	Health Plan San Mateo	Contra Costa Plan	CalOptima
Napa	X												X							
Placer	X												X							
Solano	X												X							
Sonoma	X												X							
Sutter	X												X							
Yolo	X												X							
Yuba	X												X							
Humboldt													X							
Del Norte													X							
Colusa													X							
Lake													X							
Plumas													X							
Nevada													X							
Modoc													X							
Siskiyou													X							
Tehema													X							
Sierra													X							
Trinity													X							
Glenn													X							
Shasta													X							
Butte													X							
Lassen													X							
Mendocino													X							
Santa Barbara															X					
San Luis Obispo															X					
Monterey														X						
Merced														X						
San Benito														X						

*In Fresno, Kings and Madera counties, the Local Initiative Health Plan is CalViva. However, CalViva subcontracts network and clinical management to HealthNet so we have have listed them here. Same for Imperial County. The Local Plan is Community Health Plan of Imperial Valley but HealthNet is the network and clinical administrator.

**Mandatory enrollment in some counties goes into effect in 2025.



The Public Works Alliance

The Public Works Alliance (PWA) changes the economic future of marginalized communities by building equitable public systems that take action with people and for people. PWA opens new career pathways for youth, increases healthcare access for families, and leverages the power of Medicaid to sustain positive community impact.

The Justice Serving Network (JSN) is a 3-year initiative of the Public Works Alliance to reimagine the future for youth impacted by criminal legal systems and reconnecting with their communities.

California Children's Trust

We are a coalition-supported initiative to reimagine how California finances, defines, administers and delivers children's mental health supports and services. Equity + justice are at the center of our beliefs, our actions, and our strategy for change.

We acknowledge the San Francisco Family Services Alliance for their contributions to the development of this paper, with special recognition to Safe & Sound as the lead organization of the Alliance. https://safeandsound.org