Tri Counties CalAIM PATH Collaborative

May 21, 2025

BluePath HEALTH

DHCS | PATH
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Please introduce yourself in the chat!

BluePath HEALTH

Today's Agenda

Time	Agenda Topic
11:00-11:05	Welcome and Introductions
11:05-11:15	DHCS Policy Updates
11:15-12:15	TDU Social Determinants of Health Training: • *JB Del Rosario* • *JaDawn Wright-Morgan*
12:15-12:25	Managed Care Plan Announcements
12:25-12:30	Closing and Next Steps

2025 Collaborative Aim Statement

By December 2025, the Collaborative will strengthen local implementation of CalAIM by creating a sustainable network of providers. We will accomplish this through hosting quarterly peer learning sessions and at least 2 workforce development trainings.

- Strengthen the capacity of providers to sustainably deliver CalAIM services
- Build education and awareness of CalAIM among members, providers, and community partners to drive referrals
- Increase ECM & Community Supports referrals and care coordination among providers

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DHCS Policy Updates

Volume 1 Community Supports Revisions

- DHCS released updated Community Supports definitions for the following services in February 2025, with minimal changes released in April:
  - Assisted Living Facility (ALF) Transitions
  - Asthma Remediation
  - Community or Home Transition Services
  - Medically Tailored Meals/Medically Supportive Food
  - Personal Care and Homemaker Services (PCHS)
- These new definitions are effective **July 1, 2025**
- Added **HCPCS Codes** for all Community Supports definitions

Community Supports With No Significant Updates (Volume 1)

- The following services do not have major definition updates:
  - Environmental Accessibility Adaptations (Home Modifications)
  - Respite Services
  - Sobering Centers

Volume 2 Community Supports Revisions

- In April 2025, DHCS released updated Community Supports definitions for the following services:
  - Housing Transition Navigation Services (HTNS)
  - Housing Deposits
  - Housing Tenancy and Sustaining Services (HTSS)
  - Day Habilitation Programs
  - Recuperative Care (Medical Respite)
  - Short-Term Post-Hospitalization Housing
  - Transitional Rent **(NEW)**
- These new definitions are effective **July 1, 2025**

Key Themes for Updated Community Supports Guidance Volume 2

- **Global Cap on Room and Board Services**, 6-month limit per 12 rolling month period for room and board services:
  - Recuperative Care
  - Short-Term Post-Hospitalization Housing
  - Transitional Rent
- Coordination with County Behavioral Health
- **NEW** Community Support: Transitional Rent
- All Members who receive Housing Community Supports must also be offered ECM

Volume 2: Housing Community Supports and ECM Across a Member's Journey

- In this example, the Member's journey begins with an acute hospitalization for injury or illness. The Member also meets the criteria for access to Medi-Cal Specialty Mental Health Services (SMHS) and is experiencing homelessness.
- Following DHCS' requirements for Transitional Care Services,[22] the hospital discharge team coordinates with the Member's MCP prior to discharge and

Source: DHCS - Community Supports Policy Guide Volume 2

Updated Closed Loop Referral Guidance

- DHCS released an updated version of the CLR Implementation Guidance this month
- Changes are **primarily clarifications**
- July 1, 2025 go-live date remains unchanged
- Changes include: updated legal references and references related to HIPAA; clarification that CLR requirements will not apply to Sobering Centers but will apply to Transitional Rent

Social Determinants of Health: Promoting Health Equity

May 21, 2025

In the chat box share:
“What social determinant of health do you see the most in your work?

TRAINING DEVELOPMENT UNIT

Tips for Using Zoom

MICROPHONE

Mute or Unmute your Microphone

(Mute during presentations- unmute to speak and while in break-out sessions)

CAMERA

Please use your camera as much as possible- especially for small breakout group activities. We want to see your face and it helps us all to connect!

CHAT FUNCTION

Please use this function to communicate to the group and respond to questions posed during the course

YOUR NAME

Please make sure your name shows in the participant list so we know who is in the (virtual) room

https://support.zoom.us/hc/en-us/articles/206618765-Zoom-Video-Tutorials?_ga=2.127701645.105022513.1595466712-93141167.1550779225

THE
TRAINING & HEALTH EQUITY
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Project Coordinator

Who is TDU?

We are funded by managed care plans to support the CalAIM Initiative.

ALAMEDA Alliance FOR HEALTH

Anthem

TDU provides training opportunities for Enhanced Care Management and Community Supports providers across the state.

Learning Objectives

- Define social determinants of health and health equity.
- Describe the connection between health disparities and social determinants of health
- Describe at least one causal pathway particular social determinants create for accessing care
- Identify at least one strategy to address social determinants to promote healthcare access

Group Agreements

RESPECT

BALANCED PARTICIPATION

CONFIDENTIALITY

OPEN TO LEARNING

TAKE CARE OF YOURSELF

TAKE RISKS

Please keep cameras on and engage with other participants

You have a unique perspective that only you can provide

Your experiences as a provider may be helpful to others

You are the expert!

Share your expertise and knowledge with your colleagues

You can actively contribute to your own learning

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Anonymous
Poll #1

Short Answer

What is one main reason for the health inequities for your clients or community you serve?

Social Determinants of Health:

Promoting Health Equity

TRAINING DEVELOPMENT UNIT

Social Determinants and Health Equity

How would you define health?

How would define what being healthy means for you personally?

Health

“A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.”

Preamble to the Constitution of the World Health Organization 1946 http://www.who.int/about/mission/en/

Health Inequity

"refers to those inequalities in health that are deemed to be unfair or stemming from some form of injustices"

Kawachi,I., Subramanian, S., & Almeida-Filho (2002). A glossary for health inequalities. Journal of Epidemiology and Community Health: 56

Health Disparity

"..the term used in epidemiology to describe differences, variations and disproportions in the hea status of individuals or groups."

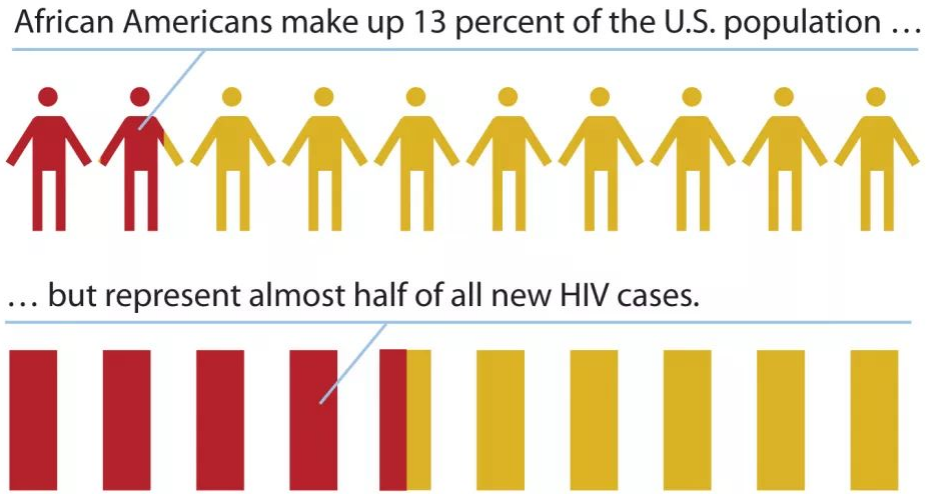
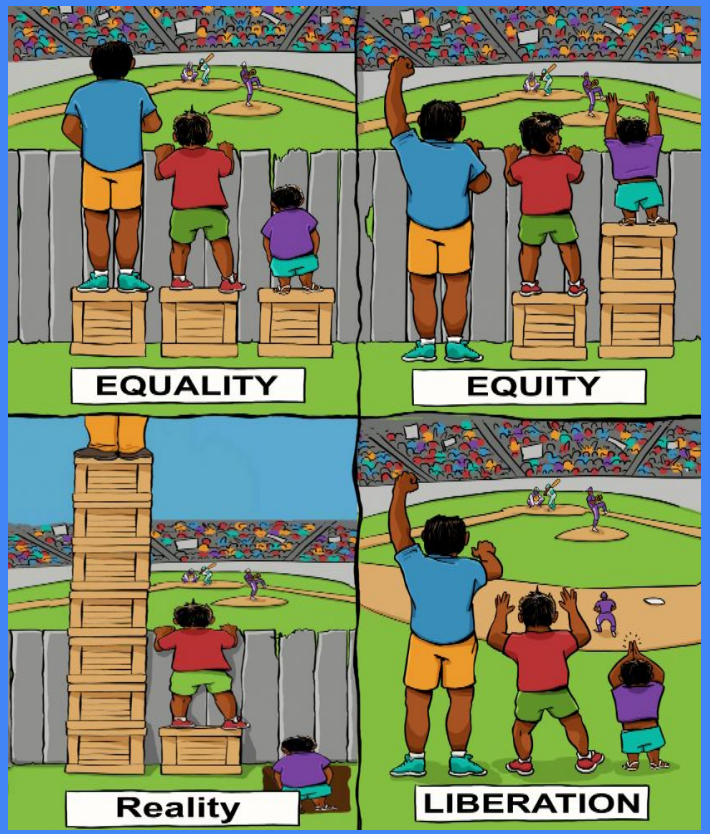


Image Source: CDC, 2017

Adapted from:

1) Kawachi,I., Subramanian, S., & Almeida-Filho (2002). A glossary for health inequalities. *Journal of Epidemiology and Community Health*: 56: 647 -652
2) Carter-Pokras, O., & Baquet, C. (2002). What is a health disparity? *Public Health Reports, 17: 426 - 434*



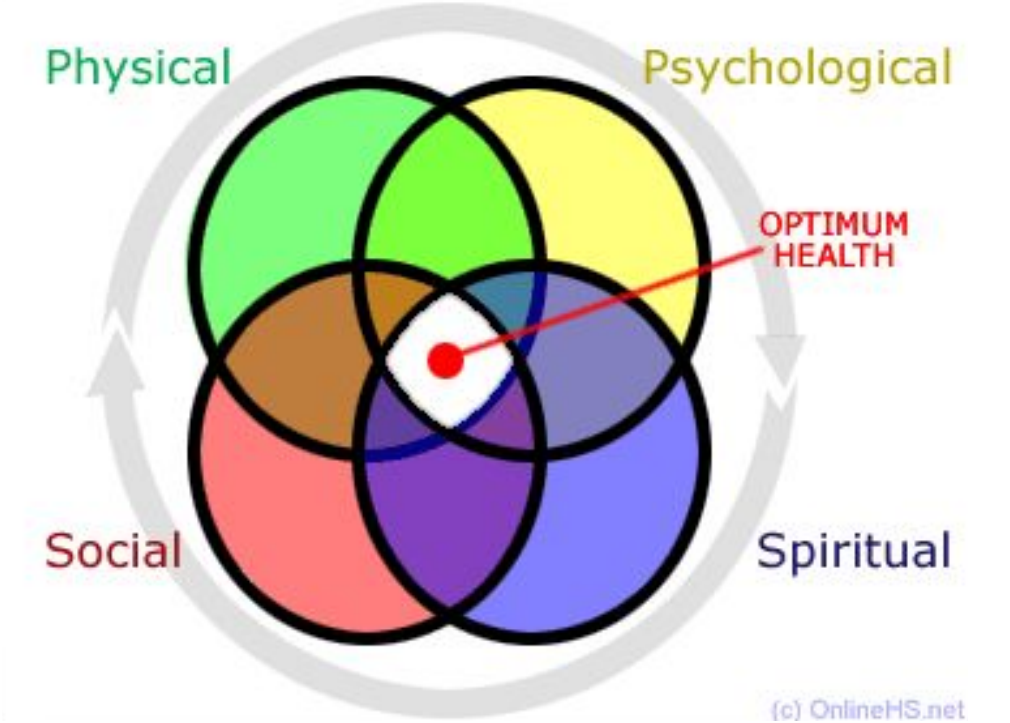
Health Equity

Health equity means that everyone has a fair and just opportunity to be healthier.

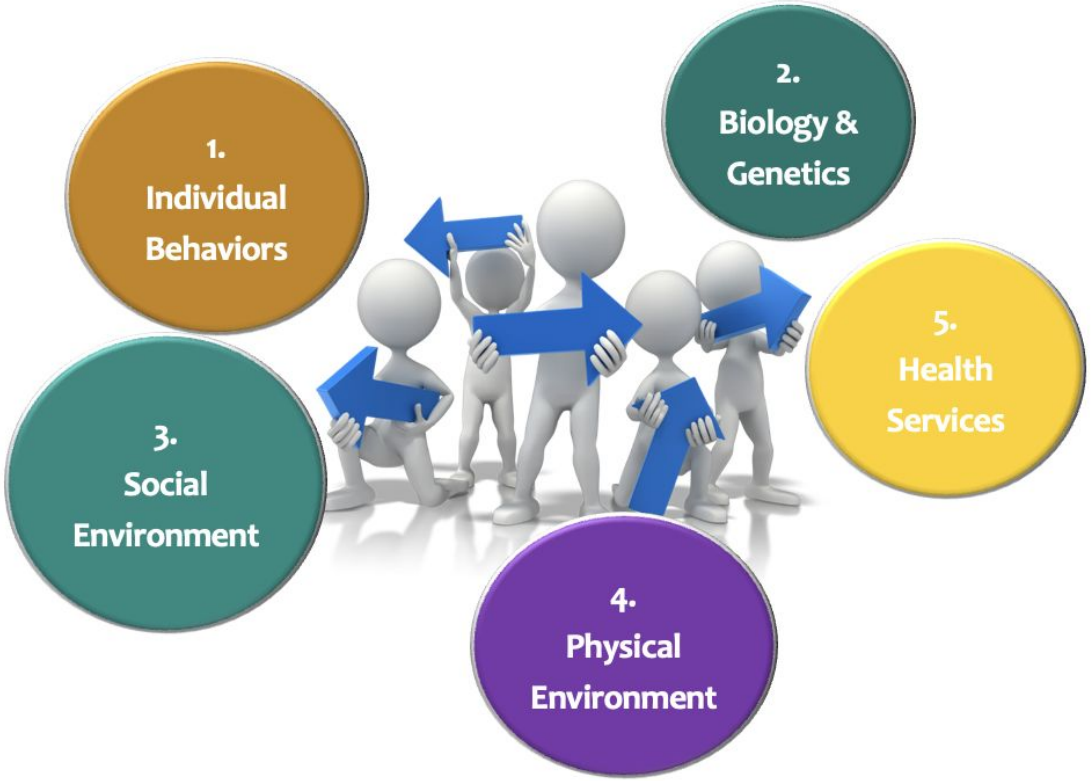
This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Robert Wood Johnson Foundation (RWJF)

Wellness: The Holistic Model



Determinants of Health



Social Determinants of Health

Conditions in which people are born, grow, live, work, pray and age

- Shaped by distribution of money, power and resources at global, national, local levels
- Influenced by policies and regulations

Adapted from World Health Organization (WHO)

WHO; 2018

Determinants of Equity

“Racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."

APHA Past-President Camara Phyllis Jones, MD, MPH, PhD

Examples of Social Determinants of Health

HANDOUT

1. Housing Stability
2. Residential Segregation
3. Food Security
4. Social Norms and Attitudes--(e.g. stigma)
5. **Racism**
6. Socioeconomic Conditions
7. Culture
8. Social Support
9. **Gender Identity**
10. Access to Health Care Services
11. Educational Attainment
12. **Sexual Orientation**
13. Transportation Options
14. Language/Literacy
15. Exposure to violence, crime, social disorder
16. Access to mass media, and emerging technologies

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.

Examining Social Determinants

BREAKOUT

- Which 2 social determinants do you believe have the biggest impact on health outcomes in the communities you serve?

- Choose one social determinant you would like to know more about regarding its impact on health outcomes with clients.

Responding to Social Determinants of Health

Why treat people and send them back to the conditions that made them sick in the first place?”

Sir Michael Marmot

What is CalAIM?

California Advancing and Innovating Medi-Cal (CalAIM) is a **five-year initiative** led by California's Department of Health Care Services (DHCS) to **transform** California's Medi-Cal program and to make it **integrate** more seamlessly with other **social services.**

The goal of CalAIM is to **improve the quality of life and health outcomes** for **Medi-Cal enrollees**, especially those with the most complex needs.

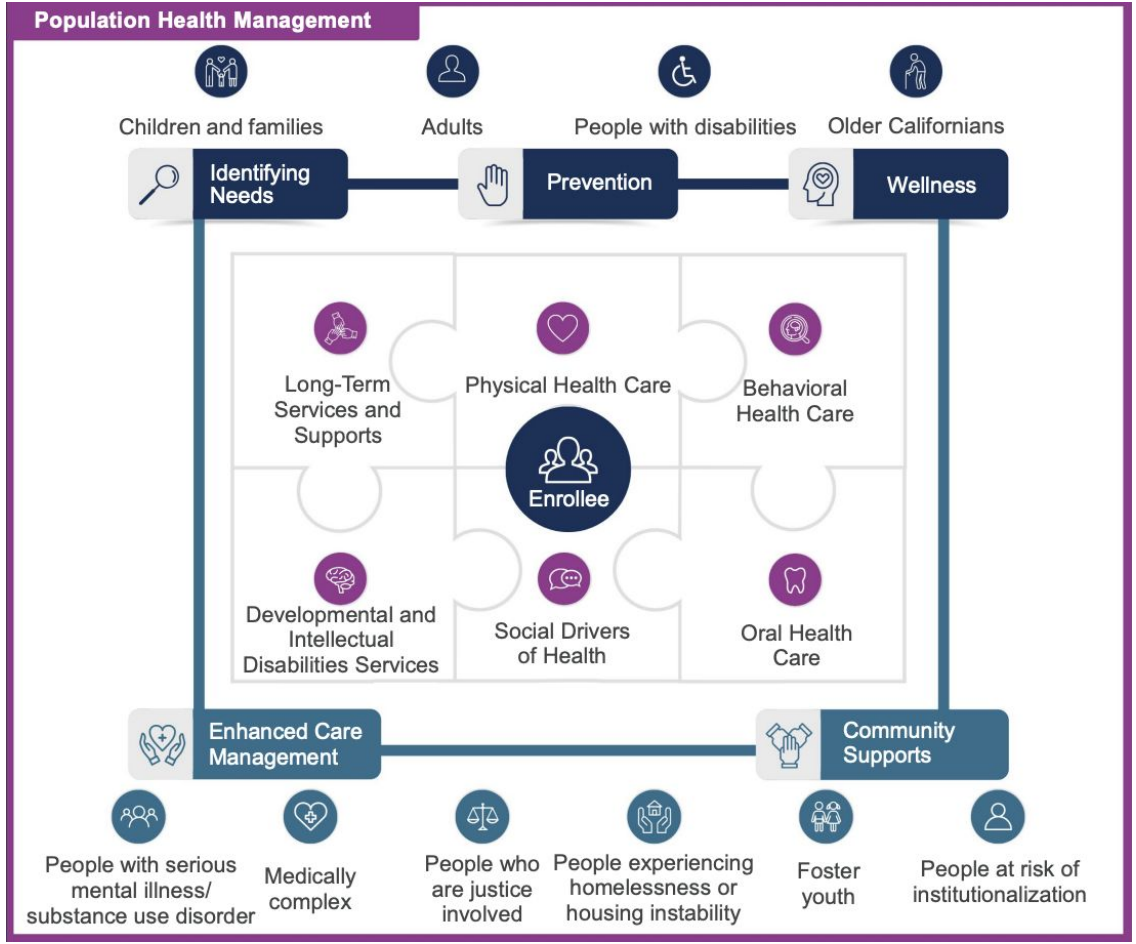
CalAIM Key Goals

Implement a whole-person care approach and address social drivers of health.

Improve quality outcomes, reduce health disparities, and drive delivery system transformation.

Create a consistent, efficient, and seamless Medi-Cal system.

Population Health Management



Perspective

Anonymous Poll #2

Select one: I believe the disparities I work with are most attributed to:

1 - individual behaviors

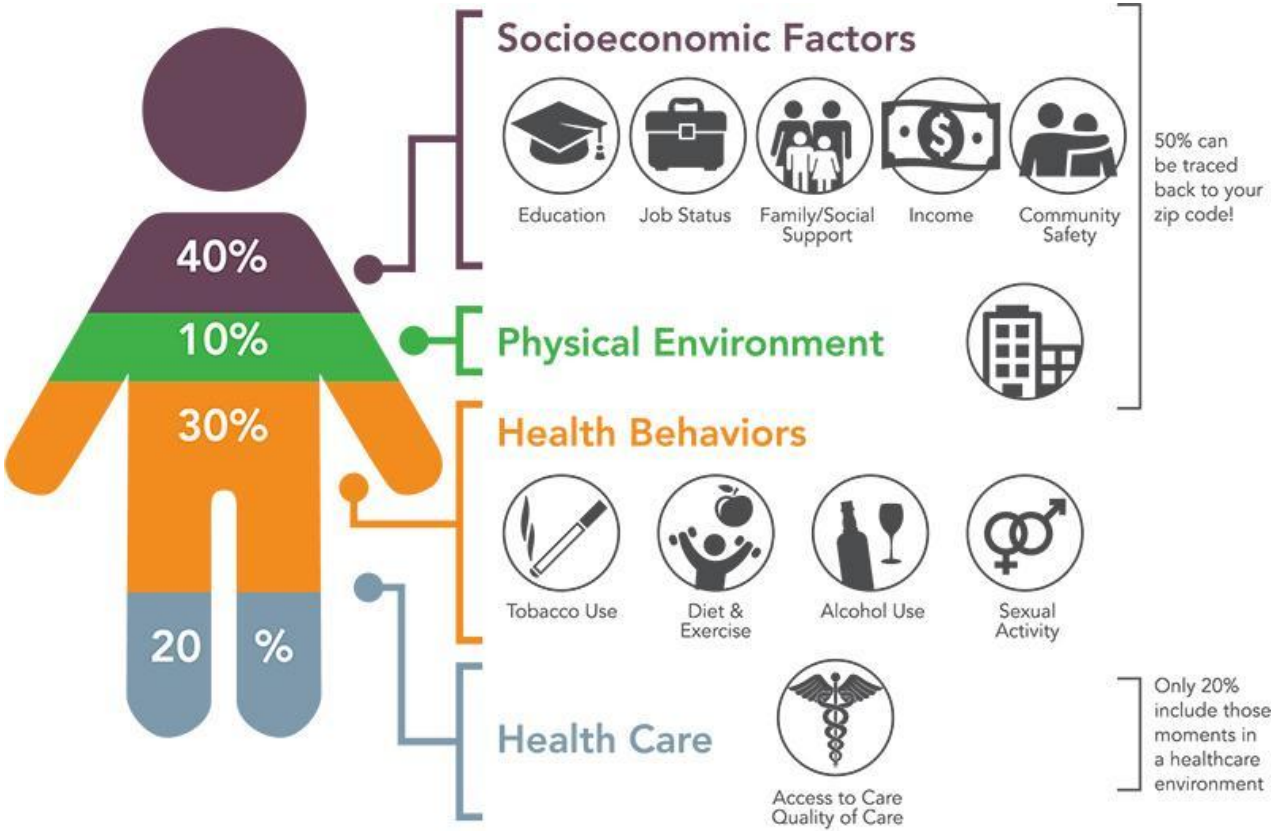
2 - biology/genetics

3 - social environment

4 - physical environment

5 - health systems

Social Determinants of Health In The Body



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Strategies to Address SDH

1. Create greater awareness of importance and consideration of social determinants of health
2. Improve assessment of SDH factors
3. Collaborate more effectively across sectors
4. Participate and support systems change

1. Communicating SDH

Communicating the Social Determinants of Health
GUIDELINES FOR COMMON MESSAGING
October 23, 2013

-Canadian Council on Social Determinants of Health

The following table summarizes the key guidelines for effectively communicating SDH:

WHAT TO DO	WHAT TO AVOID
✓ Use **clear, plain language**	× **Technical language or jargon**
✓ Make issues **tangible** with analogies and stories	× **Abstract concepts** or terms
✓ **Break down and round numbers**; place numbers in **context**	× **Complex numbers,** or large numbers without any context
✓ Challenge conventional wisdom with **one unexpected fact**	× **Exhaustive documentation**
✓ Use **inclusive** language (we, our, us)	× **Creating distance** between groups (them, they)
✓ Identify people by **shared experiences**	× **Labeling** people by group membership
✓ **Prime** your audience with a fact, image or story they are likely to believe, based on their values, interests and needs	× Facts, images or stories that audiences may find **too contentious or extreme to be believable** (even if they are true)
✓ Leave the audience with a memorable story or fact that can be easily repeated	× Being **forgettable**
✓ Use a **conversational and familiar** tone	× A **clinical or academic** tone
✓ Take the time to **understand your audience**—this includes **customizing your message** by selecting appropriate tools, approaches and information	× Assuming the **same message will work for all audiences**
✓ **Prepare** your message content and presentation	× Speaking **off the cuff**
✓ Focus on communicating **one thing** at a time	× Trying to **do too many things** at once

1. Communicating SDH (cont.)

Communicating the Social Determinants of Health
GUIDELINES FOR COMMON MESSAGING
October 23, 2013

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WHEN TALKING ABOUT ABSTRACT CONCEPTS OR GROUPS...	TRY USING SIMPLE, VALUES-DRIVEN AND EMOTIONALLY COMPELLING STATEMENTS.
Social determinants	• Our opportunities for better health begin where we live, learn, work and play. • Where we live, learn, work and play can have a greater impact on how long and well we live than medical care. • All people should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of their income, education, or ethnic background.
Health inequalities	• Giving everyone a fair chance to live a healthy life.
Vulnerable groups	• Too many people don't have the same opportunities to be as healthy as others. • People whose circumstances have made them vulnerable to poor health.
Poverty	• Families who can't afford the basics in life.
Low-income workers	• People who work for a living and still can't cover basic costs.

2. Tools for Assessing SDH

- PRAPARE
- EveryONE Project
- Health Related Social Needs Screening Tool

Put in chat:
What tools are you utilizing?

https://www.nachc.org/research-and-data/prapare/
https://www.nachc.org/wp-content/uploads/2020/07/Printer-Friendly-PRAPARE-COVID-FS.pdf
https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit.html
https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

3. Cross-Sector Coordination

Complexity of Social Problems Vs. Our Solutions

Traditional Approaches > Isolated Impact

→ Funders select individual grantees

→ Organizations work separately and compete

→ Evaluation attempts to isolate a particular organization's impact

→ Large scale change is assumed to depend on scaling organizations

→ Corporate and government sectors are often disconnected from foundations and nonprofits

Large-scale social change requires broad cross-sector coordination, not the isolated intervention of individual organizations.

Source: Collective Impact by John Kania & Mark Kramer, Stanford Social Innovation Review Winter 2011. www.ssir.org.

Benefits For Your Members

1. Outreach and engagement for members
2. Lead care manager that works for the ECM provider
3. Enhanced coordination of care
4. Education on health-related topics
5. Comprehensive transitional care
6. Extra services funded under the CalAIM initiative

4. Systems Change

A fundamental change in policies, processes, relationships, and power structures, as well as deeply held values and norms, as the pathway to achieve common goals and make positive social gains sustainable at scale, whether it's around increasing equity, improving health, or reducing poverty.

Source: Fostering System Change by Srik Gopal & John Kania, Stanford Social Innovation Review November 2015 www.ssir.org

Benefits For Your Organization

1. Expand your services and client community
2. Connect with new partners in your area
3. Get reimbursed for services provided
4. Participate in a transformative healthcare initiative
5. Positively impact the social determinants of health in your community

Anonymous Poll #3

Select one:
The strategy that is most important for addressing SDH is

1 - Communication

2 - Improving Assessment

3 - Cross Sector Collaboration

4 - Systems/Policy Changes

Today's Case Scenario

Leo is a 34-year-old male migrant farm worker from Jalisco, Mexico. He works seasonally as a farmworker, primarily harvesting strawberries and other crops across Ventura, San Luis Obispo, and Santa Barbara counties. José travels as part of an informal agricultural caravan that follows the harvest seasons from April through September.

During the working months, Leo sleeps in his car, which he parks near the fields or in rural areas with other workers. His diet primarily consists of inexpensive canned or fast food items due to limited cooking options and long work hours.
Leo was recently seen at a community health clinic after experiencing fatigue, swelling in his legs, and decreased urination.

He was diagnosed with an acute kidney injury (AKI), likely exacerbated by dehydration, high heat exposure in the fields, and chronic alcohol consumption. He drinks approximately five beers a day, which he reports helps him "wind down" after work and manage back pain.

He tells the front desk receptionist that he is saving up to get his wife and two kids an apartment near Atascadero so they can be closer to a school.

What is one thing you can do to respond to social determinants of health?

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Contact Information

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Training Development Unit

Thank You!

TDU@ucsf.edu

traininghealthequity.org

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Managed Care Plan Announcements

CenCal Health Training Opportunities

CenCal HEALTH
Local. Quality. Healthcare.

Training & Engagement Opportunities: Empowering CalAIM Providers for Success

CenCal Health remains dedicated to advancing the health and well-being of vulnerable populations through the **CalAIM Initiative (California Advancing and Innovating in Medi-Cal)**.

By working closely with both traditional and non-traditional healthcare partners, we strive to provide the tools and support necessary for individuals to achieve optimal health outcomes.

As part of this ongoing effort, we invite local **Community Supports (CS)** partners and **Enhanced Care Management (ECM)** providers to join us for one or more of our training and engagement opportunities!

Monthly CenCal Health CalAIM Spotlight Collaborative Meetings

These monthly collaborative meetings provide a vital space for discussion, knowledge sharing, and ongoing engagement with CenCal Health as we work together to enhance care coordination and improve service delivery for our members. Through these sessions, you'll have the opportunity to connect with peers, ask questions, and stay up-to-date on important updates and initiatives within the CalAIM framework.

When:

First Wednesday of every month at **12 p.m.**

How to Register:

Visit www.cencalhealth.org/providers/provider-training-resources/ to register for the meetings and explore a wide range of additional training resources available to providers.

Or **scan this QR code with your smart phone** to register:

Join Our Bi-Weekly CalAIM Drop-In Meetings with Peers and CenCal Health

Looking to connect with CenCal Health and your professional peers? Our CalAIM Drop-In Meetings are an excellent opportunity to engage, share insights, and stay informed on the latest CalAIM updates. Held twice a month—on the first and third Thursday of each month—these informal meetings offer a relaxed environment for collaboration, discussion of best practices, and answering any questions you may have.

When:

First and third Thursday of every month from **12 to 1 p.m.**

How to Register:

Simply email amcneil@cencalhealth.org for the meeting link and further details.

These sessions are designed to foster a dynamic exchange of ideas, helping you stay connected with peers and ensure that your team is equipped with the knowledge to best serve our members.

We look forward to your active participation!

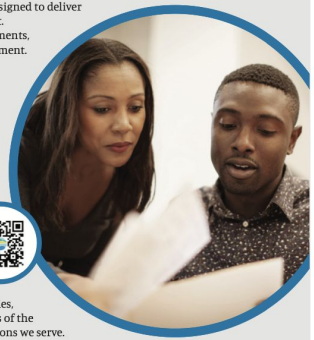
P-PR-JAN25PRTF-0125 E

CalAIM Provider Micro Training Resources

Micro training resources are quick, focused learning tools designed to deliver essential knowledge or skills in a digestible, bite-sized format. These resources break down complex topics into smaller segments, making them easy to absorb while minimizing time commitment.

Topics include:

- CalAIM CenCal Health Website Overview
- CenCal Health Member Eligibility Overview
- Community Supports Service Overview
- Enhanced Care Management Helpful Reminders & Tips
- Enhanced Care Management January 2025 Updates
- And more!



Resources are available online at **cencalhealth.org/providers/calaim/** or **scan this QR code with your smart phone**:

By taking part in these training and engagement opportunities, you'll be better equipped to contribute to the ongoing success of the CalAIM initiative and provide enhanced care for the populations we serve.

Let's work together to achieve optimal health outcomes for all!

What's Available

In addition to the monthly Spotlight Collaborative Meetings, you'll find other training programs designed to support provider staff and improve the quality of care and services provided to our members, which include:

- Back to Basics
- Bridging Care
- Member Eligibility
- In-person training sessions and more!

Register for the meetings and explore a wide range of additional training resources available to providers: http://www.cencalhealth.org/providers/provider-training-resources/

Or **scan this QR code with your smart phone** to register:

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Upcoming Events and Closing

See you in June!

San Luis Obispo + Santa Barbara CalAIM PATH Collaborative Meeting
June 18 | 11:00am - 12:30pm
On Zoom

Register for June 18 Collaborative:

Ventura CalAIM PATH Collaborative Meeting

June 25 | 11:00am - 12:30pm
On Zoom

Register for June 25 Collaborative:

Share your feedback!

Poll

BluePath HEALTH

Thanks for joining!

Questions? pathinfo@bluepathhealth.com

BluePath HEALTH

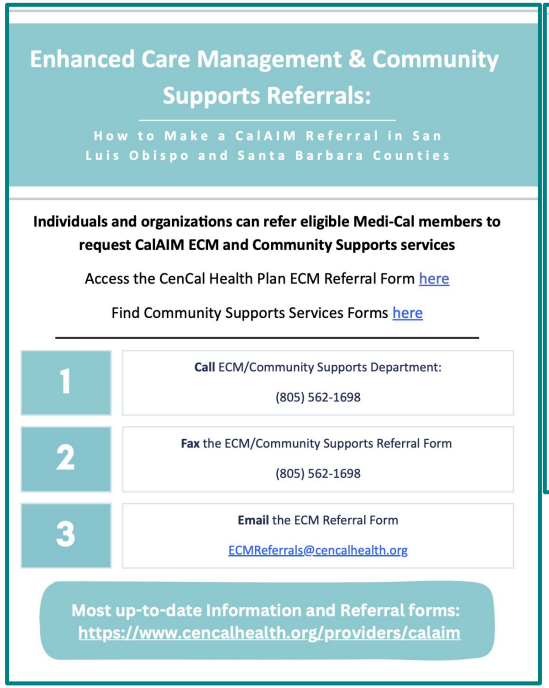
Office Hours

BluePath HEALTH

Appendix

New Resources on Referrals

SLO + Santa Barbara Referral 101 Flyer



Enhanced Care Management & Community Supports Referrals:

How to Make a CalAIM Referral in San Luis Obispo and Santa Barbara Counties

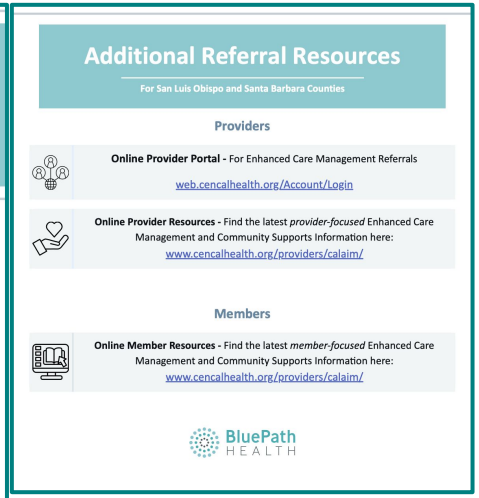
Individuals and organizations can refer eligible Medi-Cal members to request CalAIM ECM and Community Supports services

Access the CenCal Health Plan ECM Referral Form here

Find Community Supports Services Forms here

1	**Call** ECM/Community Supports Department: (805) 562-1698
2	**Fax** the ECM/Community Supports Referral Form (805) 562-1698
3	**Email** the ECM Referral Form ECMReferrals@cencalhealth.org

Most up-to-date Information and Referral forms: https://www.cencalhealth.org/providers/calaim



Additional Referral Resources

For San Luis Obispo and Santa Barbara Counties

Providers

Online Provider Portal - For Enhanced Care Management Referrals web.cencalhealth.org/Account/Login

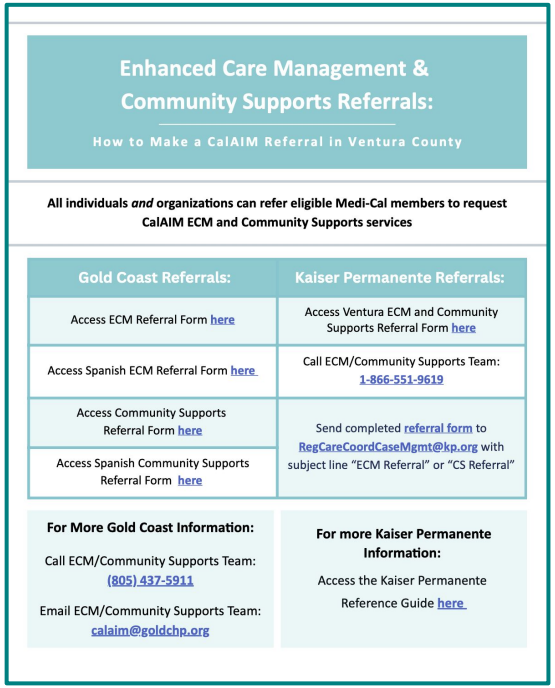
Online Provider Resources - Find the latest *provider-focused* Enhanced Care Management and Community Supports Information here: www.cencalhealth.org/providers/calaim/

Members

Online Member Resources - Find the latest *member-focused* Enhanced Care Management and Community Supports Information here: www.cencalhealth.org/providers/calaim/

BluePath HEALTH

Ventura Referral 101 Flyer



Enhanced Care Management & Community Supports Referrals:

How to Make a CalAIM Referral in Ventura County

All individuals *and* organizations can refer eligible Medi-Cal members to request CalAIM ECM and Community Supports services

Gold Coast Referrals:	Kaiser Permanente Referrals:
Access ECM Referral Form here	Access Ventura ECM and Community Supports Referral Form here
Access Spanish ECM Referral Form here	Call ECM/Community Supports Team: 1-866-551-9619
Access Community Supports Referral Form here	Send completed referral form to RegCareCoordCaseMgmt@kp.org with subject line "ECM Referral" or "CS Referral"
Access Spanish Community Supports Referral Form here	

For More Gold Coast Information:

Call ECM/Community Supports Team: (805) 437-5911

Email ECM/Community Supports Team: calaim@goldchp.org

For more Kaiser Permanente Information:

Access the Kaiser Permanente Reference Guide here

Updated Community Supports Revisions

- DHCS released updated Community Supports definitions for the following services:
  - Asthma Remediation
  - Medically Tailored Meals/Medically Supportive Food
  - Nursing Facility Transition/Diversion to Assisted Living Facilities
  - Community Transition Services/Nursing Facility Transition to a Home
- These new definitions are effective **July 1, 2025**

Community Supports Revisions: Medically Tailored Meals Definitions

Medically Tailored Meals (MTM): Meals that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

Medically Tailored Groceries (MTG): Preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

Community Supports Revisions: Medically Supportive Food

Medically Supportive Groceries: Preselected foods that follow the DGA* and meet recommendations for the recipients' nutrition-sensitive health conditions.

Produce Prescriptions: Fruits and vegetables, typically procured in retail settings, such as grocery stores or farmers' markets, obtained via a financial mechanism such as a physical or electronic voucher or card.

Healthy Food Vouchers: Vouchers used to procure pre-selected foods that follow the DGA* and meet recommendations for the recipients' nutrition-sensitive health conditions, via retail settings such as grocery stores or farmers' markets.

Food Pharmacy: Often housed in a health care setting, providing patients with coordinated clinical, food, and nutrition education services targeted at specific nutrition-sensitive health conditions. The healthy food "prescription" includes access to a selection of specific whole foods appropriate for the specific health condition(s) that follow the DGA* and meet recommendations for the targeted health condition(s).

*DGA = Dietary Guidelines for Americans

Community Supports Revisions: Eligibility Criteria

Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to):

Cancer(s) Cardiovascular disorders Chronic kidney disease Chronic lung disorders or other pulmonary conditions such as asthma/COPD Heart failure Diabetes or other metabolic conditions Elevated lead levels End-stage renal disease, High cholesterol Human immunodeficiency virus Hypertension	Liver disease Dyslipidemia Fatty liver Malnutrition Obesity Stroke Gastrointestinal disorders Gestational diabetes High risk perinatal conditions chronic or disabling mental/behavioral health disorders

Community Supports Revisions: Asthma Remediation

- Asthma Self-Management Education and In-Home Environmental Trigger Assessments are now covered under the Asthma Preventive Services (APS) Benefit (transition effective January 2026)
- Streamlines eligibility and documentation requirements
- Clarifies eligible supplies
- Confirms that supplies do not need to be delivered at a single point as long as service complies with $7500 lifetime maximum

Community Supports Revisions: Nursing Facility Transition

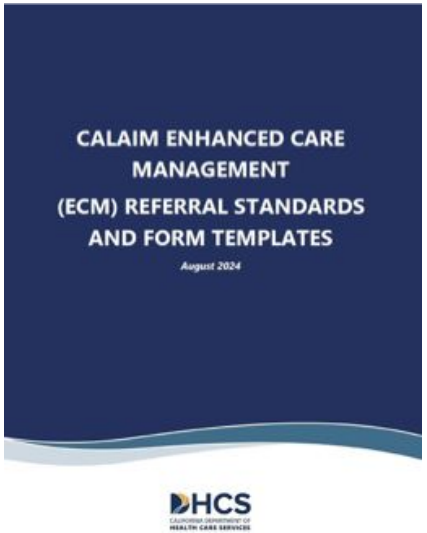
- Clarifies that members residing in private residences or public subsidized housing can be eligible for this support
- Clarifies that there are two distinct components of this Community Support:
  - Time-limited transition services and expenses
  - Ongoing assisted living services (not room and board, but support with Activities of Daily Living, meal prep, transportation, companion services, etc)

Community Supports Revisions: Community Transition Services

- Clarifies that members may receive Housing Transition Navigation, Housing Deposits, and/or Home Modifications at the same time as Community Transition Services
- Clarifies that there are two distinct components of this Community Support:
  - Transitional coordination services (securing housing, landlord communication, etc.)
  - One-time set-up expenses (security deposits, utility set-up fees, air conditioner or heater, etc.)

ECM Referral Standards and Form

DHCS developed new ECM Referral Standards and Form Template to streamline and standardize ECM Referrals made to Managed Care Plans (MCPs) from providers, community-based organizations, and other entities.



The new ECM Referral Standards define the information that MCPs are expected to collect for Medi-Cal members being referred to an MCP for ECM.

The new **ECM Referral Form Templates** are forms for use by MCPs and referring organizations that prefer a PDF or hard copy form to make a referral.

ECM Referral Standards and Form

The ECM Referral Standards and Form Templates define the following:

- Medi-Cal Member Information
- Referral Source Information
- Eligibility Criteria for Adults and Children/Youth
- Enrollment In Other Programs
- Referral Transmission Methods – including guidance encouraging batch referrals

***Note: The ECM Referral Standards will not change the existing processes for the MIF and RTF.**

ECM Referral Standards and Form

BluePath HEALTH

- **Effective January 1, 2025:**
  - All ECM Referrals **must** follow the guidelines established in the ECM Referral Standards *regardless* of referral modality (electronic, EMR, hard copy, etc.).
  - MCPs choose **which** referral modalities (electronic, EMR, hard copy, etc.) they want to deploy in the community. Electronic referrals are encouraged.
  - MCPs **may not** require additional documentation (e.g., ICD-10 codes, supplemental checklists, Treatment Authorization Request (TAR) forms) from referring partners or ECM Providers beyond the information in the ECM referral.
  - DHCS expects that many MCPs will embed the referral standards into their existing provider portals but may also offer other electronic referral pathways.

Presumptive Authorization: POFs and Providers

Column 1: ECM Population of Focus	Column 2: ECM Providers That Can Serve Members Through Presumptive Authorization
1) Adults & Children Experiencing Homelessness	• Street Medicine Providers • Community Supports Providers of the Housing Trio Services: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services • County-contracted and County-operated Specialty Behavioral Health Providers
2) Adults & Children At Risk for Avoidable Hospital or ED Utilization	• Primary Care Provider practices (including Federally Qualified Health Centers (FQHCs), County-operated primary care, and other primary care)
3) Adults & Children with SMI/SUD Needs	• County-contracted and County-operated Specialty Behavioral Health Providers
4) Adults & Children Transitioning from Incarceration	• Existing DHCS guidance governs authorizations and warm handoffs to support Members receiving pre-release services in the JI POF. See Section 13.3.d of the Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative for details.
5) Adults Living in the Community and At Risk for LTC Institutionalization	• California Community Transitions (CCT) Lead Organizations • Community Supports Providers of the Nursing Facility Transition/Diversion to Assisted Living Facilities and Community Transition Services
6) Adult SNF Residents Transitioning to the Community	• California Community Transitions (CCT) Lead Organizations • Community Supports Providers of Nursing Facility Transition/Diversion to Assisted Living Facilities and Community Transition Services
7) Children & Youth Enrolled in CCS/CCS WCM	• CCS Paneled Providers and Local Health Department CCS Programs
8) Children & Youth Involved in Child Welfare	• County-contracted and County-operated Specialty Behavioral Health Providers • High Fidelity Wraparound Providers • Health Care Program for Children in Foster Care Providers • Department of Social Services (DSS) Offices • Foster Family Agencies • Transitional Housing Programs Current and Former Foster Youth • Children's Crisis Residential Programs
9) Birth Equity Population of Focus	• OB/GYN Practices • Midwifery Practices • Entities that deliver the following services: Entities that deliver the following services: Black Infant Health (BIH) Program, Perinatal Equity Initiative (PEI), Indian Health Program, American Indian Maternal Support Services (AIMSS)

ECM Presumptive Authorization

Starting on Jan. 1st 2025, select ECM Providers will be able to quickly initiate ECM services *prior to submitting an ECM referral to an MCP* and be reimbursed for services during a 30-day timeframe.

» **What ECM Presumptive Authorization IS:**

- **Select ECM Providers will be able to directly authorize ECM for Medi-Cal Members in select POFs they serve and be paid for ECM services for a 30-day timeframe** until the MCP communicates the authorization or denial of ECM based on a complete assessment of Member eligibility for ECM.
- ECM Providers under presumptive authorization will still check for Member eligibility and submit an ECM referral to the MCP within the 30-day timeframe to receive the full, 12-month ECM authorization.

» **What presumptive authorization is NOT:**

- ECM presumptive authorization is different from *"presumptive eligibility"* policies for Medi-Cal coverage that allow special populations to more rapidly access Medi-Cal insurance (children, pregnant individuals, individuals experiencing homelessness).
- ECM presumptive authorization is different from *"retrospective authorization"* in which MCPs pay for ECM services provided in the past, but only if a Member is ultimately authorized for ECM.

The ECM Presumptive Authorization Policy is included beginning on page 107 in the August 2024 version of the ECM Policy Guide.

ECM Presumptive Authorization

ECM Presumptive Authorization Reimbursement

Start of Payment: MCPs must allow network ECM Providers under presumptive authorization to start billing and be reimbursed for ECM services from the date the Member first receives ECM services.

Timeframe for MCP Payment: 30 days or up to the date the MCP communicates the authorization decision to the ECM Provider, whichever is sooner.

Does payment occur if a MCP does not authorize ECM for a Member after the presumptive authorization timeframe because the Member is enrolled in an overlapping program or plan (1915c waiver, D-SNP, etc.)?

Answer: The MCP must still reimburse for services delivered during the presumptive authorization timeframe for Members who are later denied for the full, 12-month ECM authorization due to enrollment in programs that may overlap with ECM.

ECM Presumptive Authorization

Exceptions to MCP Payment
In the Presumptive Authorization Timeframe

- If the Member has an **existing, open ECM authorization** with another ECM Provider, the MCP is not required to reimburse for services delivered in the presumptive authorization period. DHCS allows for this exception in MCP payment to limit instances of payment for duplicative services.
- If the individual is **not an active Member** of the MCP during the dates of ECM service delivery.

MCP Provider Portal Active ECM Authorizations
Required by January 1, 2025:

To reduce the risk that ECM Providers are not reimbursed for services due to an existing ECM authorization, MCPs must make Members' ECM authorization statuses accessible to ECM Providers via their Plan Portal or similar online system by January 1, 2025.