CHCF

Exploring Emerging Medi-Cal Community Care Hubs

OCTOBER 2024

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About the Authors

Jill Donnelly, MPH; Brianna Nielson; and Blake Owens are consultants at Aurrera Health Group, a mission-driven national health policy and communications firm based in Sacramento.

Acknowledgments

The authors would like to thank all organizations that participated in the interview process for their time and candor. While there is much variation among the hub organizations, a mission-driven passion for serving local communities is a constant across the state. Many thanks as well to Jennifer Sayles, MD; Rishi Manchanda, MD; Sadena Thevarajah, JD; and Ralph Silber for lending their support and expertise on this project. Lastly, we greatly appreciate Aurrera Health Group consultants Lucy Pagel, MPH and Caitlin Crowley, MPH for supporting this project.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Aurrera Health Group, in collaboration with the California Health Care Foundation (CHCF), conducted a comprehensive study including literature reviews, stakeholder interviews, and a focus group to understand the current landscape of California administrative hubs or Medi-Cal community care hubs (MCCH). The study highlights various models and solutions deployed to address the needs of community providers, MCPs, and members, and aims to support stakeholders in identifying what next steps are needed to integrate these hubs into the Medi-Cal landscape.

Contents

Introduction

New Providers and Network Arrangements Under CalAIM

Many recent initiatives within Medi-Cal, California's Medicaid program, have provided an opportunity for non-traditional, community-based providers to enter into contracts with Medicaid managed care plans (MCPs) for the first time. In particular, the launch of California's Section 1115 demonstration and Section 1915(b) waiver, collectively referred to as CalAIM, have introduced several new initiatives that seek to provide whole-person care, integrating physical health, behavioral health, and health-related social needs (HRSNs), including Enhanced Care Management (ECM) and Community Supports. Though separate from CalAIM, the related Community Health Worker (CHW) benefit went live in July 2022, authorized through State Plan Amendment (SPA) 22-0001, and doula services became a covered benefit in January 2023 under SPA 22-0002.[1]

ECM, Community Supports, the CHW benefit, and doula services are intended to be delivered by local providers who have extensive experience and specialized knowledge about their communities and can provide services in a culturally appropriate and accessible way. Although many existing, community-based providers, often led by people of color and focused on serving racially and linguistically diverse communities, are well positioned to provide these new Medi-Cal services, they have struggled to participate due to contracting, capacity, and administrative barriers to entry. Existing hubs, which typically have well-established infrastructure, have emerged to centralize administrative functions, allow more providers to engage with managed care, and support the delivery of services in a way that advances health equity.

The following paper, developed by Aurrera Health Group (Aurrera) in close collaboration with CHCF, provides a snapshot of the current landscape of hubs throughout California, many of which are participating in Medi-Cal's ECM and Community Supports through CalAIM and/or providing Medi-Cal, CHW, or doula services. For the purposes of this paper, we will employ the term Medi-Cal community care hubs (MCCH) to refer to California hubs that meet the project's inclusion criteria. Since the term "hub" has multiple meanings throughout health care, MCCH will be used as a differentiator. This review was accomplished through a nine-month process, which included summarizing the findings of a literature review, 40 stakeholder interviews, and a targeted focus group. This paper captures the variety of models and solutions that have been deployed to meet the growing need of community providers, MCPs, and members. It also explores some important considerations that should be thoughtfully addressed as these entities take on a new role in the complex and ever-evolving Medi-Cal system. The goal of this work is to inform and support stakeholders as they consider policies or guidance, learning opportunities and technical assistance (TA), and other approaches to integrating these MCCHs into the Medi-Cal landscape.

Network Differences by Benefit

This landscape focuses on hubs that primarily support CalAIM's ECM and Community Supports initiatives, as well as related CHW and doula benefits, due to similarities in service provision and the contracting of providers historically outside of the Medi-Cal program. That said, each initiative differs in the types of providers needed, the intensity of services offered, and the associated administrative functions required.

Enhanced Care Management (ECM)

ECM is a new, Medi-Cal managed care benefit under the CalAIM initiative that supports members with complex clinical and non-clinical needs through

comprehensive care management. Enrolled members are assigned a lead care manager who coordinates their health and health-related care and services. ECM went live in January 2022 for certain populations of focus; the remaining eligible groups became eligible in phases rolled out through January 2024.

ECM is delivered by community-based entities that hold contracts with MCPs. In many counties, MCPs built upon the existing provider networks established under the Health Homes Program and Whole Person Care pilots. These networks often include county agencies, Federally Qualified Health Centers (FQHCs), and other community clinics. In most counties, networks are being expanded to include new services and new types of providers, including community-based organizations (CBOs).

Community Supports

Community Supports, another CalAIM initiative, launched in January 2022. Community Supports are optional, community-based services and supports that address health-related social needs. MCPs may offer these alternative services to their members to help avoid hospital care, skilled nursing facility care, visits to the emergency department, or other costly services.

There are currently 14 Community Supports pre-approved by DHCS. That number will increase to 15 if the Centers for Medicare and Medicaid Services (CMS) approves Transitional Rent Services as a new Community Support.[2] Existing Community Supports include short-term post-hospitalization housing and housing tenancy and sustaining services, environmental/home modifications, medically tailored meals, homemaker services, and others. Because MCPs are not required to provide these services, Community Supports offerings and member utilization differ widely by county.[3]

Providers of Community Supports are often non-clinical CBOs, such as supportive housing providers or organizations that prepare and deliver meals. Some may have participated in Whole Person Care pilots or other local collaborations, but many are engaging with MCPs for the first time.

Community Health Worker (CHW) Benefit

Under the new CHW Benefit, CHW services are defined as preventive health services to target disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services are delivered by individuals known by a variety of job titles, including *promotores*, community health representatives, and navigators, and other non-licensed public health workers including violence prevention professionals. CHW services include screening and assessment, physical or mental health education, and support connecting to and navigating health care services.

CHW services are often provided by linguistically and culturally diverse organizations or individuals that have not historically participated in Medi-Cal, including CBOs and local health jurisdictions (LHJs). Alternatively, some CHWs may operate within FQHCs, which cannot bill for the CHW benefit within the FQHC Prospective Payment System (PPS) without changing scope, or as individual contractors, who may be unable to contract directly with an MCP. At the outset of this initiative, it was anticipated that provider participation and enrollment would steadily increase over time. However, the statewide ramp-up has progressed more slowly than expected. This slower pace may be attributed, in part, to providers' limited familiarity with Medi-Cal and concerns about reimbursement rates, which some perceive as inadequate. According to a recent DHCS announcement, the 2024 Budget Act and Senate Bill (SB) 159 (Chapter 40, Statutes of 2024) authorized new targeted Medi-Cal provider rate increases from the MCO Tax effective

January 1, 2025, and January 1, 2026. Effective in 2025, CHWs will be among the providers targeted for rate increases. This combination of unfamiliarity and perceived insufficiency in reimbursement has contributed to the slower-than-anticipated provider engagement and Medi-Cal member service utilization across the state.

Doula Benefit

Doula services provide personal support to individuals and families throughout pregnancy and during the first year postpartum, which includes emotional and physical support provided during pregnancy, labor, birth, and the postpartum period, as well as support for and after miscarriage and abortion, to improve health outcomes for birthing parents and infants. As a preventive benefit, federal law requires that doula services have a written recommendation from a physician or other licensed practitioner of the healing arts. To increase access and reduce barriers to services, DHCS has issued a standing recommendation, which satisfies the federal requirement and makes the benefit more readily available to all pregnant and postpartum members. Similar to other initiatives aimed at integrating new providers into Medi-Cal, it was anticipated that provider participation would gradually increase over time. Doulas, who have not traditionally participated in Medi-Cal, are not familiar with the enrollment process and other administrative requirements. Furthermore, many doulas operate as independent contractors, which has presented challenges in contracting with MCPs and scaling the benefit. According to interviewees, there is concern that the benefit is not yet reaching all eligible members, but they are hopeful that with adequate financial and technical support this will improve over time.

Project Background

Objectives

In collaboration with CHCF, Aurrera Health Group explored the emerging landscape of MCCHs in California and their role in the delivery of new services available through Medi-Cal, including ECM, Community Supports, the CHW benefit, and the doula benefit.

The project sought to:

- Deepen stakeholder understanding of the emerging landscape of MCCHs and networks
- Support informed decision making about any future scaling and investment in MCCHs and networks
- Increase the connection of Medi-Cal to the communities it serves by increasing the capacity of CBOs to meaningfully and sustainably participate in Medi-Cal.

The project involved an extensive literature review of hub methodologies and frameworks, three phases of interviews with a variety of stakeholders, a focus group with existing or emerging MCCHs, and conversations with DHCS.

Methods

The project began with a literature review focused on hub models in California and national frameworks sourced from desk research, subject matter experts, and members of the project's advisory group. Findings from this research informed and supplemented information the project team gathered in the next stage of the project, which consisted of 40 stakeholder interviews over three phases:

- Phase 1: November–December 2023 (18 interviews completed)
- Phase 2: January–February 2024 (15 interviews completed)

- Phase 3: March–April 2024 (7 interviews completed)

Interviewees included subject matter experts; existing and emerging MCCHs, MCPs, community-based providers; and other key stakeholders. The Interview Summary Chart (Appendix A) provides a list of individuals and organizations interviewed.

In Phase 1, Aurrera developed an interview guide to understand common characteristics of MCCHs, the value of MCCHs to various stakeholders, and considerations for standing up a successful and sustainable MCCH. In between Phase 1 and 2 interviews, the interview guide was updated to focus questions on each organization's structure, the functions of existing or emerging MCCHs, MCP perspectives and policies, and opportunities for state guidance or support. This updated interview guide was used in Phase 2 and 3 interviews. Organization information and MCCH functions were documented and reviewed by each interviewee following the interview to support development of an MCCH inventory (refer to Appendix B).

In order to establish a broad landscape of the California field, the team employed a working definition of "MCCH" that evolved throughout the process. The final definition used in this project is as follows:

MCCHs are entities that centralize administrative functions for Medi-Cal direct service provider organizations that address social drivers of health; this may also include centralized contracting, operational infrastructure, and training.

In April 2024, Aurrera completed a focus group with representatives from nine existing and emerging MCCHs, most of whom were previously interviewed, to explore interview themes and discuss potential state-level policy considerations. Their feedback further informed the project's findings.

Defining MCCH Models

As MCCHs in California continue to emerge and develop, the task of defining core functions for MCCHs takes on critical importance. There are several standardized hub models that have been more widely adopted across the country that can inform this conversation.

The Partnership to Align Social Care (Community Care Hub)

The Partnership to Align Social Care is a national learning and action network consisting of health plans, health systems, CBOs, Community Care Hubs (CCHs), national associations, and governments.[4] CCHs are community-focused entities that organize and support a network of CBOs providing services to address HRSNs. A CCH centralizes administrative functions and operational infrastructure, including, but not limited to, healthcare organization contracting, payment operations, referral management, service delivery fidelity and compliance, technology, information security, data collection, and reporting.

This organization has several stakeholders who are active in California health care, including Partners in Care Foundation, Elevance Health, Centene Corporation, and Kaiser Permanente.

Pathways Community HUB Institute Model (PCHI® Model)

The Pathways Community HUB Institute model is focused on building a community-based care coordination network supported by and designed for CHWs.[5] The model provides training and tools to help CHWs identify risk factors, infrastructure to support population health management (e.g., tracking risk factors, linking payment to outcomes), and a quality improvement framework. A key component of the PCHI® model is a Pathways Community HUB which is certified by PCHI® to operate as a neutral and accountable body responsible for training

CHWs, billing Medi-Cal and other partners, and ensuring community needs are addressed.

The PCHI model is currently utilized at several sites throughout California, including the Fresno Hope Pathways Community Hub of Fresno Community Health Improvement Partnership (FCHIP) and the San Joaquin Pathways Community Hub.

California Accountable Communities for Health Initiative (CACHI) Model

An Accountable Community for Health (ACH) is a community-driven collaborative that seeks to advance equity and build more cohesive communities by providing residents and cross-sector partners with infrastructure to address existing and emerging health challenges.[6] An essential component of this model is the presence of a "backbone entity" that works across organizations to elevate community voices, facilitate action, build sustainability for impact, steward systems change, and influence policy.

CACHI supports 37 ACHs located throughout the state, including FCHIP.[7]

Social Care Networks

New York State is currently in the process of establishing Social Care Network (SCN) lead entities. Selected organizations will be tasked with centralizing networks of CBOs and establishing contracts with Medicaid MCPs. SCNs must be 501(c)(3) nonprofit organizations, limited to CBOs, Independent Physician Associations (IPAs), Health Homes, Behavioral Health Collaboratives, FQHCs, and former/current Delivery System Reform Incentive Payment (DSRIP) Performing Provider Systems. There are also significant restrictions to the entities that comprise the SCNs. New York's SCNs are intended to offer regional networks to coordinate social services for Medicaid members.

California's MCCHs

The current network of MCCHs that have engaged in CalAIM's ECM and Community Supports, as well as related CHW and doula services, are part of a rapidly evolving landscape and do not easily fit into a standard description. While many MCCHs hold direct contracts with MCPs, others provide centralized services to organizations downstream from service delivery. These organizations typically have the ability to share data with MCPs.

Given the various models and definitions used within and outside of the health care delivery system, many organizations may identify as MCCHs. This includes those that serve as a medical home or MCCH for an individual patient by providing care coordination and other supports as well as organizations that provide MCCH-like services to individual practitioners. To differentiate MCCHs from other types of convening entities, organizations had to meet the following criteria to meet our definition of MCCHs and be included in our review:

- Have contracts or Business Associate Agreements (BAA) with an MCP and provider organizations to support the provision of ECM, Community Supports, the CHW benefit, or doula services **and/or** have an existing hub that is exploring participation in Medi-Cal; **and**
- Provide a set of substantial core administrative functions that may include payment operations, reporting to an MCP, provider organization onboarding/readiness, basic data exchange, basic referral management, performance and quality management, and participatory governance structure.

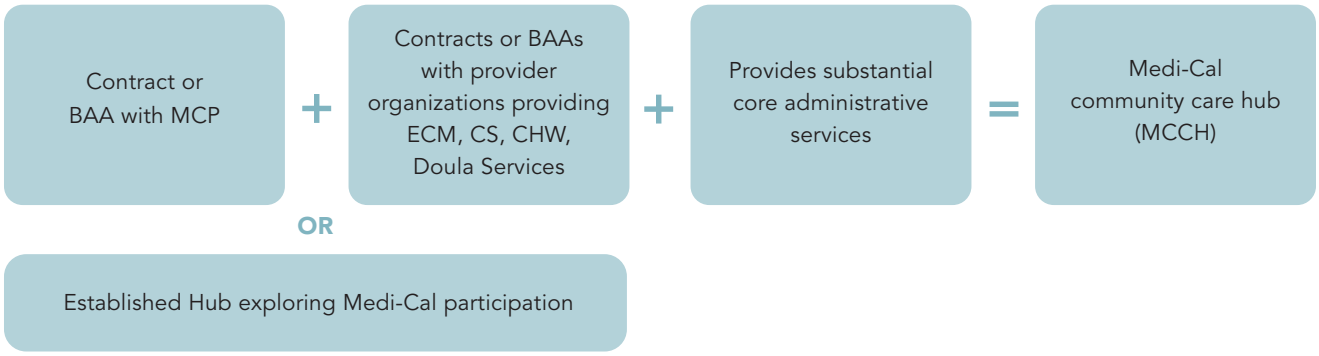
Some MCCHs offer direct services to members – from outreach and engagement to care management – while others act as true administrative intermediaries. That said, all MCCHs have certain core components, including payment operations, reporting, onboarding activities, data exchange,

referral management, performance and quality management, and some degree of participatory governance.

Beyond the core components, many MCCHs offer add-on services, such as legal support for MCP contracting, enhanced technical capabilities such as integrated electronic health records (EHRs), and ongoing training and opportunities for shared learning with other organizations within the MCCH's network.

Additional work is needed within the field to establish and define benchmarks for each domain and more robustly evaluate the various models within California.

Figure 1. Defining Medi-Cal Community Care Hubs



Notes: *BAA* is Business Associate Agreement; *MCP* is managed care plan; *ECM* is Enhanced Care Management; *CS* is Community Supports; *CHW* is Community Health Worker.
Source: Aurrera Health Group, 2024.

Figure 2. Services Provided by Medi-Cal Community Care Hubs

MUST HAVES	ADVANCED STANDARDIZATION	MEMBER ENGAGEMENT	TECHNICAL CAPABILITIES
▸ Payment operations ▸ Reporting to MCP ▸ Onboarding/ readiness ▸ Basic data exchange ▸ Basic referral management ▸ Performance and quality management ▸ Participatory governance structure	▸ Required MOC by Population of Focus ▸ Strong oversight and monitoring ▸ Operational standardization (P&Ps, workflows, etc.)	▸ Enhanced referral management ▸ Strategic member assignment ▸ Direct member outreach and engagement	▸ Shared, integrated EHR ▸ Shared care management platform ▸ Data visualization for orgs ▸ Tech support ▸ Data security support
	DIRECT SERVICE PROVISION	**TRAINING/TA**	**MISCELLANEOUS**

	▸ Participation in ECM, CS, CHW, and/or Doula program as direct provider	▸ Support with:
		  ▸ MCP certification
		  ▸ Practice transformation
		  ▸ Financial sustainability
		▸ Ongoing training/TA
		▸ Opportunities for shared learning
			▸ Legal support
			▸ Enhanced quality improvement program
			▸ Program design support
			▸ Advocacy
			▸ Short-term financial protection
			▸ Data integration with primary care
			▸ Strong community focus

Notes: *MCP* is managed care plan; *MOC* is model of care; *P&P* is policies and procedures; *ECM* is Enhanced Care Management; *CS* is Community Supports; *CHW* is community health worker; *TA* is technical assistance; *EHR* is electronic health record.
Source: Aurrera Health Group, 2024.

Findings

Current MCCH Approaches in California Medicaid

While the scope of functions and intensity of support varied across MCCHs, there were several themes in the types of organizations that are best situated to take on the MCCH role. The categories and examples below capture many existing and emerging California MCCHs operating in California (referred to as "MCCHs" in this section), but this is not an exhaustive list. Detailed information about the project's inclusion criteria, additional examples, and key information about each MCCH can be found in Appendix B.

Nonprofit MCCHs

Many nonprofit MCCHs in California were designed to support a specific population by contracting with providers for one Medi-Cal service or benefit such as ECM, Community Supports, or the CHW or doula benefits. In addition, many engage with only one organizational or provider type (e.g., CHWs or FQHCs). For some, this approach allows MCCHs to tailor their administrative services, infrastructure, rates and payment model, and provider networks to meet the specific requirements of a given Medi-Cal program or provider type. Others have an interest in expanding their participation to other benefits and/or provider types in the future.

Rising Communities and Fresno HOPE Pathways Community MCCH (PCH) are emerging MCCHs focused on CHW engagement in their respective communities and exploring how to contract for the CHW benefit with MCPs. While the two organizations have approached MCCH development in slightly different ways — Rising Communities' model is similar to that of a management services organization (MSO), and Fresno HOPE PCH has adopted the PCHI® Model — both have tapped into their networks of CBOs that support CHWs. Both organizations mentioned that CHW services are at the core of their work and a starting point for engaging in Medi-Cal service delivery and funding opportunities.

County MCCHs

Counties are often well positioned to take on the role of an MCCH. Their sizable infrastructure and experience operating as a Medi-Cal plan responsible for providing behavioral health and other services better enable them to meet the administrative demands of new Medi-Cal benefits. As key players in the local safety net, they also have existing funding streams, relationships with community providers, and Medi-Cal members receiving county services, all of which can be leveraged in the provision of new services. Several county MCCHs have evolved as a result of the central role that they played in the Whole Person Care (WPC) Pilot program, California's prior Section 1115 demonstration.

LA County has engaged its sizable infrastructure, which includes a care management system and referral management processes built under Los Angeles County Department of Health Services (LADHS) Community Programs, to provide ECM and multiple housing-related and personal care Community Supports to all eligible clients within the county system. The county's program was built through years of braiding and blending funds from initiatives such as Measure H and WPC and bolstered by new investments through the Incentive Payment Program (IPP) and PATH CITED Initiative.[8]

Sacramento County is focused on ECM delivery to individuals with serious mental health and/or substance use disorder needs who are already engaged in Specialty Mental Health Services (SMHS) and/or the Drug Medi-Cal Organized Delivery Systems (DMC-ODS). The organization draws upon their experience as a county-based provider and leverages their existing subcontracts with community-based providers, clinics, and organizations to deliver this service.

Alameda County has leveraged their Social Health Information Exchange (SHIE) infrastructure, established under WPC, to determine member eligibility, support care management services, and enable automated Medi-Cal claiming for a network of more than 20 CBO providers. To ensure all county residents have equitable access to homelessness services, they have also aligned housing-related ECM and Community Supports services with their Coordinated Entry System (CES) and broader countywide system of care for homelessness.

MSO-like/Non-Contractual MCCHs

One of the more unusual models that has emerged in California is for MCCHs to provide administrative support to provider organizations, but not contract with MCPs. Instead, they only hold contracts with individual provider organizations, much like some MSOs. In this model, the MCP contracts with the direct provider and the MCCH entity provides wrap-around support with provider training, claiming, reporting, and other administrative functions. BAAs are deployed to enable data exchange between the MCP, MCCH, and direct provider organization.

Ritter Center, a small FQHC providing ECM services in Marin County, contracts directly with their MCP to provide ECM services and receives administrative support from Aliados Health. Aliados, a regional association that has historically supported and advocated for community-based health centers across six counties in Northern California, developed a two-part Administrative Services Entity (ASE). As an ASE, Aliados delivers provider onboarding and training, supports claiming and reporting, offers quality oversight, and advocates to the MCP on behalf of the health center.

IPAs and CINs as MCCHs

Independent Physician Associations (IPAs) and Clinically Integrated Networks (CINs) have emerged as another type of MCCH model, drawing upon experience and expertise working directly with FQHCs and other existing Medi-Cal providers. As a result, IPA MCCHs tend to be more easily established than those comprised exclusively of CBOs.

Health Care LA, IPA (HCLA IPA) is a nonprofit network of FQHCs and Community Health Centers (CHCs) serving over 725,000 members in Los Angeles County. As an IPA, HCLA advocates for and negotiates with MCPs on behalf of the health centers. HCLA views health centers as well suited to provide ECM due to their established connections in the community. The organization provides value to its member organizations by managing MCP contracts of all types and coordinating the fulfillment of MCP and program requirements. This relationship allows the health centers to focus on care delivery. HCLA began piloting this model in 2023 and is hoping to scale in the coming years.

Integrated Health Partners of Southern California (IHP) is a clinically integrated network of FQHCs providing ECM in Riverside and San Diego counties. They operate as an MCCH for ECM services by centralizing contracting, referrals, claims, billing, and training for FQHCs in their network while offering coding and documentation audits and ongoing education services. As a risk-bearing organization, they are particularly focused on improving quality measures and member outcomes and utilize a population health informatics and analytics tool to support this.

For-Profit MCCHs

Setting up an MCCH is resource intensive and often requires a significant initial investment to support hiring administrative staff, procuring data exchange platforms, conducting outreach to provider organizations, and other functions required to set up a network. For-profit organizations often have greater access to flexible funds, which can facilitate their entry into the Medi-Cal market.

Pear Suite operates as a direct service provider, CHW MCCH, and technology vendor for both individual CBO providers and other MCCH organizations. They have a team of CHWs who provide culturally sensitive, community-based care throughout the state, and also support other organizations with administrative, operational, and clinical support for CHW services, ECM, and Community Supports. They found this model necessary as CBOs were unfamiliar with MCP contracting, data management, and workflow alignment, and some MCPs were unwilling to contract with small CBOs and individual CHW providers. For this work, Pear Suite relies on their care navigation and billing platform, which provides assessments, care planning, referral management, care coordination support, report generation, and claims submission for CBO providers offering the CHW benefit, ECM, Community Supports, and other services.

Independent Living Systems (ILS) is a company focused on managing home- and community-based programs for the health care industry. In California, ILS is one of three Network Lead Entities (NLE) with Kaiser Permanente to support Kaiser's delivery of ECM, Community Supports, and CHW benefits to eligible MCP members.

The Value Proposition of MCCHs

Community-based MCCHs provide opportunities to facilitate connections between Medi-Cal and new types of providers. Many exist to support the development of a Medi-Cal provider network that can expand the populations served and meet the needs of California's culturally, linguistically, and geographically diverse communities.

Despite this unique positioning, there is a fear that MCCHs will be extractive from the Medi-Cal system, adding complexity and cost without tangible improvement to members' quality of care and health outcomes. However, in practice, many MCPs and providers find MCCHs to be additive to the system, bringing centralization and efficiency to an otherwise fractured process, and allowing for a greater number of provider organizations to participate. Though there are additional costs to establish and operate their centralized administrative functions, MCCHs often offset them for providers and MCPs alike.

Stakeholder interviews highlighted many bright spots in California's evolving MCCH landscape and the value MCCHs can offer to multiple stakeholders, including community providers who do not have the capacity to contract with MCPs; MCPs who need to expand their local networks in order to comply with state policy but who do not have sufficient existing relationships or staffing capacity to manage this type of network expansion and management; and the state, whose goals include expanding access to specialized, community-based services.

Achieving Economies of Scale

Programs like ECM, Community Supports, and the CHW and doula benefits place many new requirements on organizations that have not previously participated in Medi-Cal, including the needs to enter into contracts with MCPs, verify Medi-Cal and program eligibility, submit claims or invoices for each service they provide (typically in 15-minute increments), and share and report data to the MCP on a frequent basis. For many non-traditional providers, the costs associated with meeting these administrative requirements can be insurmountable as they may need to hire new staff who can support program administration and perform costly upgrades to the organization's data systems. Additionally, the volume of Medi-Cal participants that any one contracted entity may engage with may not defray the costs associated with setting up a Medi- Cal administrative infrastructure. By centralizing administrative functions, MCCHs can achieve economies of scale and address gaps and capacity issues that organizations have flagged as significant barriers to

participation, enabling providers to access a sustainable source of funding through Medi-Cal.

The **San Diego Wellness Collaborative** operates the Neighborhood Networks MCCH, which has served the San Diego Community since 2019. Neighborhood Networks was developed and incubated at the San Diego Accountable Community for Health (SD ACH), a part of the California Accountable Communities for Health Initiative (see Appendix B). Through the SD ACH partnerships and relationships with CBOs, they were able to co-design and develop a thoughtful, inclusive MCCH model that supports CBOs in leveraging their individual strengths in the community while providing administrative services at scale. The MCCH handles all claims and associated reconciliations, outreach and engagement, and training, and operates a single case management platform. The MCCH holds contracts with the majority of county MCPs, allowing the providers to focus on care delivery.

Enhancing Provider and MCP Capabilities

MCCHs can also enhance provider capabilities by building their technical sophistication and offering services and supports that improve the quality of care delivered to members. Most of the California administrative MCCHs interviewed have the technical capacity to submit compliant electronic claims, automating a process for providers who otherwise would have had to rely on paper invoices, which can be time and resource intensive. Many MCCHs also provide software or platforms to support referral management and streamline data exchange, which can support compliance with provider reporting requirements and improve timely connection to services for members. Common functions of California administrative MCCHs also include onboarding and readiness training, performance monitoring and improvement activities, peer learning opportunities, and other forms of clinical support designed to improve quality of care.

These enhancements may also offset costs and burdens for MCPs, streamlining payment operations, standardizing quality and reporting, and supporting oversight functions that are typically run at the MCP level.

Full Circle Health Network allows for the participation of providers specializing in child and family care, including school health and family resource centers. They developed a "program in a box" that provides organizations with a standard model of care, training program, salary scale, and more. This not only creates more standardization within their network of contracted organizations but also lowers the barrier to entry for local providers who are already serving their communities to begin participating in Medi-Cal initiatives.

Providing Flexibility to Maximize Value

A cornerstone of the success of MCCHs is their ability to adapt to local needs and regional contexts. California has five different models of managed care employed throughout the state.[9] This leads to significant variation in the number and types of MCPs that are operating in each county and results in differences in how new Medi-Cal managed care benefits and programs like ECM, Community Supports, and CHW and doula services are implemented. MCCHs help providers navigate this dynamic by structuring their models to accommodate the differences in requirements and preferences held by each MCP. Many MCPs, for example, prefer to enter into a single contract with the Medi-Cal MCCH, granting them access to the network of providers underneath the MCCH without needing to negotiate and manage several distinct contracts. MCCHs operating in counties with MCPs that prefer to contract in this way have set up their MCCH to fit this model. Other MCPs prefer to contract directly with each provider organization in their network, and MCCHs in these counties have crafted their operations to enable this type of contracting.

Mitigating Risk to Providers

A key goal of CalAIM is to create a more person-centered and equitable health system. Ensuring Medi-Cal members are met "where they are" and connected to culturally appropriate and community-based services is best done by providers already embedded where members live, work, and access services. However, these organizations, which are often focused on serving racially and linguistically diverse communities, are most likely to face not only administrative barriers, but also significant risk that prevents them from participation in Medi-Cal. This connection to the community creates buy-in and sustainability and ensures the entity meets the needs of the individuals who stand to benefit from services like ECM, Community Supports, and the CHW and doula benefits.

Many community providers are new to managed care business models, unequipped to manage the financial variability resulting from enrollment-based payment models, and may lack the scale and knowledge necessary to facilitate strong negotiations with MCPs. To minimize risk for new providers, many MCCHs have gone beyond core administrative functions by offering legal support, advocacy, and/or financial protection. The specific services provided to community-based entities vary by MCCH but could include training and support before and during rate negotiations with MCPs, guidance and modeling to improve financial sustainability for the program, payments to provide cash flow support while the provider organization is waiting for claims to be paid during the first few months of service delivery, and other functions designed to support the transition from primarily grant-based funding.

Centering the Community Voice

Many of the existing MCCHs interviewed were established prior to the launch of CalAIM and have operated in their local communities for years. By building upon existing relationships with community providers, MCCHs have created the opportunity for many Medi-Cal members to maintain continuity with their current providers and receive new and expanded services through organizations they already trust.

Considerations

Despite the clear value MCCHs may offer MCPs, providers, and members, there are also important considerations that should be thoughtfully addressed as these entities take on a new role in the complex and ever-evolving Medi-Cal system. Some are intrinsic to MCCHs, which add a new layer of administration to the health care safety net, while others pertain to the barriers within the environment, including non-standard policies and processes among MCPs and challenges securing sustainable funding. These considerations do not negate the value proposition of MCCHs, but they underline the importance of thoughtful planning on the part of MCCHs, MCPs, and providers as these entities develop, evolve, and enter into the Medi-Cal delivery system. Given the highly regional nature of Medi-Cal contracting and network development, the challenges MCCHs experience and approaches for addressing them will vary across the state.

Potential Inefficiencies within the MCCH Model

While MCCHs often create economies of scale within certain markets, there is also the risk for increased inefficiencies, from both the MCP and provider perspective. MCCHs can act as an additional layer of administrative activity, making it challenging for MCPs to correct operational issues at the provider level. In addition, MCCHs have the potential to add costs to the overall system without a guarantee that they will provide value to providers.

For example, several interviewees discussed scenarios in which providers are dually contracted directly with MCPs and through an MCCH in their

community, splitting their operational functions. For some providers, this appears to be a strategy to enroll more members. For others, it is not clear why they would opt in to such a complex contracting arrangement that seemingly creates a need for duplicate infrastructure. Additionally, challenges may arise if multiple MCCHs are operating in the same region. For example, Kaiser Permanente sought to standardize its network approach for ECM and Community supports by forgoing direct provider contracting and opting instead to contract with a limited number of MCCHs. While there have been many benefits to this model, it has also created contracting challenges when there are multiple existing MCCHs who are equipped to provide similar services operating in particular regions. This redundancy calls to question how MCCH infrastructure should be leveraged in a given region and could create access challenges for providers and members.

Challenges in Low-Volume Markets

MCCHs may not be a sufficient solution for all providers. Many providers have voiced concern that even with centralized administrative and operational functions, the funding is not sufficient for their participation. This challenge is particularly prevalent in rural regions and among small providers where there is a low volume of members eligible for services. This points to the importance of assessing the costs and benefits from financial, operational, and patient perspectives to determine whether to invest in, start up, or participate through an MCCH.

For example, one MCP was interested in contracting with an Area Agency on Aging (AAA) to provide medically tailored meals to their members in a rural county. For the option to have been financially viable for the organization, however, the AAA would have needed three times the service volume and reimbursement at a rate significantly higher than what the MCP could offer.

Administrative Challenges in Multi-Plan Counties

Administrative challenges can be both solved and amplified at the MCCH level, especially in multi-plan counties. Unlike a provider that can be selective about contracting with certain MCPs, most MCCHs require contracts with all plans possible to achieve scale. Given the volume of members who are managed at the MCCH level, differing processes and a lack of standardization can lead MCCHs to rely heavily on manual processes to be compliant with each contract.

However, multi-plan counties are also where MCCHs demonstrate the most value by removing barriers to entry for small community providers, providing increased access for members, and allowing providers to focus on service provision over complex administrative tasks. There has been progress, particularly in CalAIM, related to standardization as the result of additional guidance from DHCS, efforts on the part of MCPs, and advocacy on the part of CalAIM providers; however, additional efforts to standardize policies, processes, and systems would likely be beneficial to local provider networks.

LA County is contracted with all six MCPs to provide Community Supports and with two MCPs to provide ECM to various communities in their Housing for Health Division. As both the referring and receiving provider, the county takes on a huge amount of administrative work on behalf of more than 100 contracted organizations. Even two years into implementation, it struggles with a lack of standardization among MCPs, particularly with regards to the highly manual processes around authorizations and data sharing.

Implementation and Operational Challenges

MCCHs experience many of the same internal challenges as other safety-net providers, including workforce shortages, concerns around sustainable funding, and keeping up to date with

a rapidly changing policy environment. Several MCCHs described difficulties with adding new partner organizations given the amount of engagement required to establish trust. Additionally, for some provider organizations, the value proposition of working with an MCCH was insufficient given their existing grant funding and the complexity of providing Medi-Cal services.

San Joaquin Pathways Community Hub (SJPCH) is a developing MCCH with some funding secured. The team noted that the MCCH's development is not linear and has been hindered by the complexity of CalAIM, the lack of state-level funding to support MCCH work, and the existence of competing funding priorities with other government departments. SJPCH is using the PCHI® model as a framework with the organization's focus on Black Maternal Health as a guiding star to reduce the complexity associated with the MCCH's development.

El Sol Neighborhood Educational Center (El Sol) has spent 30 years building organizational relationships in the Inland Empire community. It currently supports CHWs/*promotores* providing services in the Inland Empire and offers training and technical assistance across the state, but it is not an MCCH. Prior challenges contracting, reporting, and billing for the CHW benefit dissuaded the organization from becoming an MCCH or participating in one unless the goal is to develop the infrastructure of CBOs. It sees MCCHs as a short-term solution that does not provide the investment needed to enable CBOs to become self-sufficient Medi-Cal providers.

MCP Buy-In and Barriers to Contracting

While some MCCHs operate outside of Medi-Cal through grants and county funding streams, many are interested in integrating into Medi-Cal. MCCH access to Medi-Cal dollars is largely dependent on contracting with MCPs, which administer the ECM and Community Supports initiatives. The CHW and doula benefits are available in both the managed care and fee-for-service delivery systems, but over 90% of Medi-Cal members are enrolled in managed care.[10] Due to differences in network design and interpretation of DHCS guidance, MCPs have taken significantly different approaches to engaging with MCCHs.

Plans view the establishment and maintenance of provider networks as a core part of their role within the health care system, and many prefer to hold direct contracting relationships with their providers. There are various reasons for this decision, including concerns that MCCH arrangements may ultimately take away needed funding from the organizations providing direct services. Some MCPs also expressed concerns over higher rates when working with MCCH entities and discussed challenges with data capture and reporting with some MCCHs that are subcontracting to providers with insufficient technical infrastructure.

One large commercial MCP discussed the organization's mixed experiences contracting with MCCHs across California counties to deliver CalAIM benefits, which they said often places distance between the MCP and their members and makes it challenging for the plan to adequately oversee the benefit. Based on these experiences, they are interested in moving to an MSO-like model, where they contract directly with providers and leverage an MCCH as a third party to support administrative functions.

Another expressed significant concern about MCCHs that are not community based. They fear these organizations are pulling dollars out of the community and interfering with the development of a strong relationship between the plan and local providers. This MCP would prefer direct contracts

with CBOs to ensure cost containment and quality and to foster long-term relationships with providers.

Other plans have found value in the MCCH model. One commercial MCP appreciates the model because it allows them to employ their data infrastructure, use their experience with regulatory compliance, and provide service continuity and consistency across their network. Several local initiative health plans have also had success partnering with county MCCHs.[11]

The Road Ahead

Approach to Changes

Existing and emerging MCCHs in California's Medi-Cal market are operating across a range of California counties, serving diverse populations, and offering different sets of services to provider organizations. Even within common administrative functions such as MCP contracting, data and referral management, and payment operations, many MCCH entities have taken diverse approaches that are unique to the context of their organization's development and the needs of providers and plans operating within their community.

Feedback varied regarding what guidance is needed, and many MCCHs expressed concerns that policy changes could reverse the innovation that has already occurred in support of ECM, Community Supports, and the CHW benefit implementation or hinder future efforts. Participants in the focus group emphasized the need for structured stakeholder engagement and discussions with existing MCCHs before and throughout development of any new policies.

However, stakeholders across California have emphasized the importance of state and local support for MCCH models through the clarification of existing policy, funding, and infrastructure investments and development of technical assistance and tools to highlight promising practices from the field.

Stakeholder-Requested Interventions

During project interviews and in the focus group, stakeholders suggested potential strategies and considerations.

"Permission" to Contract

Interviews with MCPs and MCCHs highlighted the need some have for explicit permission and clarification on what constitutes delegation from DHCS prior to engaging with MCCHs. While DHCS has provided guidance on subcontracting agreements within its ECM policy guide and 2024 MCP Boilerplate Contract Template, the field remains split around what arrangements are truly allowable.[12]

MCP Oversight and Monitoring of MCCHs

MCPs appear to be taking a variety of approaches when it comes to MCCH oversight and monitoring of MCCH participation in various programs. Some MCPs maintain all regulatory functions, including referrals and authorizations, quality assurance, and compliance with state policies, while others partner with MCCHs for many of these activities. Several MCPs expressed interest in learning more about best practices regarding regulatory compliance, quality oversight, and grievances and appeals and requested support with quantifying the added value of working with a given MCCH organization.

Referral and Data Exchange Expectations

MCCHs reported a high level of administrative challenges when working with multiple plans, including highly manual data exchange processes and double documentation. MCCHs expressed a desire for more standardization around closed-loop referrals expectations and clinical information sharing. In addition, many expressed interest in a

statewide referral management platform that could be leveraged across organizations and delivery systems. In the absence of a state-generated Member Identification File (MIF), MCCHs are reliant on MCPs and their own self-referrals to ensure eligible members can access services.

Template Contract Language

One intervention that received mixed reactions was the development of template contract language. In discussions with MCPs, some hypothesized that if DHCS were to issue standardized MCP and MCCH contract templates, it would support greater uptake of the MCCH model. One large commercial MCP stated their legal department has been hesitant to deviate from the state's standard provider terms and conditions for ECM and Community Supports, which has created challenges when working with MCCH models. From their perspective, a standardized contract would ease those concerns and enable faster approval when adding MCCHs to their provider networks.

However, focus group participants who represented a variety of MCCHs already operating within California were very wary of this recommendation. The group emphasized that these contracts should be unique to each MCP-MCCH relationship, and the variation in MCCH models across the state makes it difficult to create standard language that would work for all entities.

Revisiting Payment Models and Rate Assumptions

Developing the infrastructure needed to operate as an MCCH takes considerable time and resources. Most MCCHs and emerging MCCHs interviewed often need to invest in data and billing infrastructure, and many have had to secure funding outside of Medi-Cal to cover their implementation and ongoing operational costs. Several interviewees representing both MCCHs and direct providers stressed the importance of revisiting payment models and rate assumptions to ensure that rates for ECM, Community Supports, and CHW and doula services provide an adequate level of funding to sustain MCCHs and their provider organizations.

These conversations are challenging; MCCHs offer a value proposition focused on efficiencies and cost savings, but typically require initial investments in infrastructure to realize that value. As previously mentioned, MCCHs are often offsetting costs at both the MCP and provider levels. For instance, if an MCP contracts with an MCCH that offers excellent claims processing services, the plan will not need to provide quite as much hands-on support for providers with payment processing issues. Similarly, if an MCCH offers quality oversight of their provider organizations, the MCP may not need to invest heavily in internal quality oversight staffing and processes. In this scenario, the MCP would still ultimately be responsible for quality oversight and ensuring access to services. With the MCCH providing the day-to-day functions, the MCP's tasks would shift to reporting, monitoring, and auditing to ensure compliance.

Similarly, providers who work with MCCHs do not often require the administrative staffing, systems infrastructure, or program staff that they would need if contracting directly with plans. That said, the value of these offsets does not return to the MCCH to cover additional administrative costs, making sustainability a long-term concern.

Conversely, many MCPs and providers have experienced successful direct contracting relationships and may not see the value in the increased costs and effort of working with an MCCH, regardless of offsets.

Finally, in regions without a sufficient participating network of community providers, MCCHs may be a path to organizational engagement and increased

access to services. Without an MCCH — even at a higher rates of reimbursement — providers may be unwilling to participate altogether.

Funding Opportunities

CHW and Doula Capacity and Infrastructure Building

Significant funding investment and technical support has been made available to ECM and Community Supports provider organizations through IPP, PATH CITED, and the TA Marketplace.[13] However, similar funding has not been robust enough to build capacity and infrastructure to implement the CHW and doula benefits.[1] Throughout interviews and during the focus group, MCCHs and CBOs emphasized the need for "parallel supports" for providers who are interested in participating in the CHW and doula benefits. While this does not only impact MCCH organizations — individuals and provider organizations would also be impacted — it is relevant to the MCCHs that participate in these initiatives.

Technical Assistance to Support Ongoing Learning

Interviews with both MCPs and existing and emerging MCCHs highlighted the desire across the state for additional technical assistance to support the implementation of MCCH models.

For CBOs and other direct service providers, organizations may benefit from a series of topics tailored to enhance their operations and integration within Medi-Cal frameworks. These include highlighting existing and emerging MCCHs and providing low-barrier templates and tools to support the creation of new MCCHs. Additionally, providers need support interpreting how various funding opportunities can be integrated with existing financial resources to optimize service delivery.

For MCPs, technical assistance is needed to bolster their implementation processes, especially if new guidance is issued. MCPs may need support defining and measuring quality outcomes, developing oversight, and monitoring expectations alongside best practices. Other critical areas include identifying network capacity issues, valuing centralized administrative functions, and understanding the financial benefits of MCCH functions that can offset internal MCP expenses such as training and practice transformation. Furthermore, establishing strong communication and coordination standards with MCCHs is emphasized, along with considerations for guardrails or requirements to ensure that sufficient funds are reaching providers and members.

Existing and emerging MCCHs may benefit from a range of strategic topics to enhance their operational effectiveness. These include blending and braiding funding — particularly for Community Supports and CHW services — and strategies for capacity building, growing, and sustaining a provider network. Many MCCHs are still learning how to effectively work within MCPs and the managed care system; learning the ins and outs of data exchange and care management platform solutions; troubleshooting administrative challenges, including technical support for claims and billing; and creating and enhancing quality frameworks.

Shared Learning Opportunities

Throughout the project, stakeholders emphasized their interest in shared learning opportunities. MCCH organizations expressed a need for peer learning to understand different models, share best practices, and troubleshoot common challenges. MCPs wanted to hear how other plans have approached and enrolled MCCHs to bolster their ECM, Community Supports, CHW services, and doula services while containing costs and improving quality. Providers contracted with MCCHs wanted to share their experience with other small providers

1. Notably, the CalAIM IPP Progress Report – Submission 5 included a measure designed to increase CHW utilization. It is not yet clear how much MCPs have leveraged this opportunity to invest in CHW infrastructure.

to encourage them to consider similar relationships if they are struggling to meet the administrative demands of Medi-Cal.

During the focus group, participants mentioned that this was the first convening of California administrative hubs, and they were excited to interact with one another and learn about the other hubs operating in the state and/or their region. Creating more opportunities for such convenings could further promote the development of MCCHs across the state.

Some project interviewees also expressed that they wished they had step-by-step guidance on MCCH development. One interviewee mentioned that although they eventually developed into a successful MCCH by adopting the PCHI® framework, there were many bumps along road. Another interviewee emphasized that if an organization is considering becoming an MCCH, they should talk with an MCCH that is operating to learn more about their process. These personal experiences in MCCH development in California, along with local and national resources on MCCH development, could be compiled to support the maturation of emerging MCCHs and further encourage the development of CHW and doula MCCHs, many of which have yet to contract with MCPs.

Conclusion

The ECM and Community Supports programs have been flagships of the CalAIM initiative, garnering national attention as they strive to integrate historically siloed delivery systems and bring more community-based providers into the Medi-Cal system. While member enrollment and the number of provider contracts have increased since the programs' rollout, recent data still depict low member enrollment and provider contracts in both programs, particularly in certain central and rural northern California counties. Similar challenges in member enrollment and provider network development exist for the CHW and doula benefits. While there are many factors contributing to enrollment and provider contracting, MCCHs may present an opportunity for MCPs and community providers to address barriers related to administrative burden. While MCCHs may experience their own scaling challenges in low-volume markets, across a wide region, there may be opportunity to provide significant value to MCPs, providers, and members.

The themes and considerations outlined in this report demonstrate California's emerging MCCH landscape and its effort to support community-based providers that are newer to contracting with health plans. California MCCHs have developed unique ways to support the needs of communities, helping non-traditional providers access Medi-Cal funding, improving member access and participation in Medi-Cal programs, and tailoring services to local needs and regional contexts. This developmental and operational variation is vital to support the diverse communities that exist across California.

MCCHs already provide a great deal of value to Medi-Cal members, and there is potential to scale these models to provide greater access to community-based care. This is an opportunity to provide policy clarification, technical assistance, and offer additional supports to ensure a member-centered and sustainable network of organizations.

Appendices

Appendix A. Interviewee Summary Chart

#	ORGANIZATION NAME
1	Administration for Community Living
2	Alameda County Health
3	Aliados Health
4	Anthem Blue Cross
5	California Area Agency on Aging
6	California Accountable Community for Health Initiative
7	Collaborative Consulting
8	CommonSpirit Health/Partnership to Align Social Care
9	Community Health Center Network
10	El Sol Neighborhood Educational Center
11	First 5 Association of California
12	Fresno County Department of Public Health regarding Fresno County Health Improvement Partnership and Fresno HOPE Pathways Community Hub
13	Full Circle Health Network
14	Health Care LA, IPA (HCLA)
15	Health Net
16	Housing for Health Orange County
17	Illumination Foundation
18	Independent Living System
19	Inland Empire Health Plan
20	Integrated Health Partners
21	Interface Children and Family Services
22	Kaiser Permanente

23	Kerry Landry Health Care Consulting, LLC
24	LA Care Health Plan
25	La Maestra Family Clinic
26	Lones Consulting
27	Los Angeles County Department of Health Services
28	Los Angeles County Department of Public Health
29	Nevada County Department of Behavioral Health
30	Partners in Care Foundation
31	Partnership HealthPlan of California
32	Pathways Community HUB Institute (PCHI®)
33	Pear Suite
34	Rising Communities
35	Ritter Center
36	Sacramento County Behavioral Health Services
37	San Diego Wellness Collaborative
38	San Francisco Bay Area Planning and Urban Research Association
39	San Joaquin Pathways Community Hub
40	The SCAN Foundation

Appendix B. MCCH Inventory

Overall Note: The following table is not an exhaustive list of Medi-Cal community care hubs (MCCHs) in California. The following list only includes MCCHs interviewed through the CHCF Hubs project and includes their organizational characteristics. The organizational characteristics were confirmed with each interviewee and updated between June and July 2024. Permission was received from each interviewee to share this information.

For each hub, the following information is provided:

- **MCCH Name** provides the organization's name.
- **MCCH Composition** includes the type of provider organizations that are partnered/contracted with the MCCH and the populations served.
- **Medi-Cal Participation** outlines which Medi-Cal benefit(s) and/or optional service(s) the MCCH provides and whether they are currently contracted with a managed care plan (MCP).
- **MCCH Financing and Payment Models** indicates the source of start-up funding and how the hub has structured payment between the MCP and with their provider organizations.
- **MCCH Services** lists the administrative services provided by the MCCH for their provider organizations.
- **Direct Services** lists the direct services provided by the MCCH (as applicable).
- **Technology** provides information on whether the MCCH and provider organizations share a care management system or EHR.

Considerations:

- For the purposes of this project, Aurrera defines MCCH as "entities that centralize administrative functions for Medi-Cal direct service provider organizations that address social drivers of health; this may also include centralized contracting, operational infrastructure, and training." MCCHs listed in this table meet each of the following criteria:
  - Have contracts or Business Associate Agreements (BAAs) with an MCP and provider organizations to support the provision of ECM, Community Supports, the CHW benefit, or doula services and/or an existing MCCH that is exploring participation in Medi-Cal; and
  - Provide a set of substantial core administrative functions that may include payment operations, reporting to MCP, provider organization onboarding/readiness, basic data exchange, basic referral management, performance and quality management, and a participatory governance structure.
- MCCHs that do not meet these criteria, but may identify as MCCHs include:
  - Organizations that provide care coordination hub functions for individual clients/members
  - Organizations that aspire to be MCCHs in the future
  - Organizations that provide MCCH-like services to individual providers

- ECM Populations of Focus and Community Supports services are abbreviated below.
- Some organizations were not willing to share certain specifications about their business models. In those instances, "Did not disclose" was included.

ECM Coding for Population of Focus (PoF) under Medi-Cal Program Participation:

- PoF 1: Individuals experiencing homelessness
- PoF 2: Individuals at risk for avoidable hospital or emergency department (ED) utilization (formerly "high utilizers")
- PoF 3: Individuals with serious mental illness and/or substance use disorder (SUD) needs
- PoF 4: Individuals transitioning from incarceration
- PoF 5: Adults living in the community and at risk for long-term care (LTC) institutionalization
- PoF 6: Adult nursing facility residents transitioning to the community
- PoF 7: Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition
- PoF 8: Children and youth involved in child welfare
- PoF 9: Birth equity population of focus

Community Supports Coding under Medi-Cal Program Participation:

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications)
12. Medically Tailored Meals/Medically Supportive Food
13. Sobering Centers
14. Asthma Remediation

Inventory continues onto next page

Table 1. Medi-Cal Community Care Hub (MCCH) Inventory

MCCH NAME	MCCH COMPOSITION	MEDI-CAL PARTICIPATION	MCCH FINANCING & PAYMENT MODELS	MCCH SERVICES	DIRECT SERVICES	TECHNOLOGY
Alameda County Health	**Provider organizations:** CBOs, Clinics, Mental Health Providers (Subcontracted) **Populations served:** People experiencing homelessness and adults with SMI	**Program participation:** ECM (PoF 3, 7); Community Supports (1, 2, 3, 12, 14) **MCP contract status:** Contracted	**Start-up funding:** PATH CITED, County, IPP, HHIP funds **Medi-Cal payment model** MCP: PEMPM and per service Provider orgs: PEMPM	▸ Contracting/negotiation support with MCPs ▸ Legal support ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Outreach & engagement ▸ Direct ECM/ Community Supports/ CHW services ▸ Standardized MOC ▸ Social services navigation	Hub and provider organizations share systems. They use the Social Health Information Exchange and Salesforce.
Aliados Health	**Provider organizations:** FQHCs, Community Health Centers, CBOs (MOU BAA) **Populations served:** Children/youth; People experiencing homelessness; adults with multiple chronic conditions, SMI and/or disabilities; and aging adults	**Program participation:** ECM (PoF 1, 2, 3, 4, 5, 6, 7, 8, 9); Community Supports (1, 2, 3); exploring CHW **MCP contract status:** MOU, DSA	**Start-up funding:** Self-funded **Medi-Cal payment model** MCP: PEMPM Provider orgs: % of claims	▸ Contracting/negotiation support with MCPs ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Outreach & engagement ▸ Direct ECM/ Community Supports/ CHW services ▸ Standardized MOC ▸ Social services navigation	Hub and provider organizations do not share systems.

continued

MCCH NAME	MCCH COMPOSITION	MEDI-CAL PARTICIPATION	MCCH FINANCING & PAYMENT MODELS	MCCH SERVICES	DIRECT SERVICES	TECHNOLOGY
Community Health Center Network	**Provider organizations:** FQHCs/Community Health Centers (MOUs) **Populations served:** Variety of population types	**Program participation:** ECM (PoF 1, 2, 3, 4, 5, 6, 9) **MCP contract status:** Contracted	**Start-up funding:** PATH CITED, IPP, Self-funded **Medi-Cal payment model** MCP: PEMPM (ECM), MSO fee Provider orgs: Did not disclose	▸ Contracting/negotiation support with MCPs ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Outreach & engagement ▸ Social services navigation	Hub and provider organizations share EHR.
Fresno HOPE Pathways Community Hub supported by FCHIP	**Provider organizations:** CBOs (contracted) **Populations served:** People experiencing homelessness; aging adults; and adults with multiple chronic conditions, SMI, and/or disabilities	**Program participation:** Community Supports (1, 2, and 3); CHW **MCP contract status:** Contracted	**Start-up funding**: Federal COVID-19 grant and county funding **Medi-Cal payment model** MCP: FFS Provider orgs: FFS	▸ Contracting/negotiation support with MCPs ▸ Legal support ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Outreach & engagement ▸ Standardized MOC ▸ Social services navigation	Hub and provider organizations share system.
Full Circle Health Network	**Provider organizations:** CBOs, Mental Health Providers (Contracted) **Populations served:** Children/Youth and supporting family members	**Program participation:** ECM (PoF 1, 3, 4, 7, 8, and 9); Community Supports (1, 2, 3, 6, 14); CHW **MCP contract status:** Contracted	**Start-up funding:** PATH CITED, Self-funded **Medi-Cal payment model** MCP: PEMPM, FFS Provider orgs: % of claims	▸ Contracting/negotiation support with MCPs ▸ Legal support ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Outreach & engagement ▸ Standardized MOC ▸ Social services navigation	Hybrid - Hub and most providers share system.

continued

MCCH NAME	MCCH COMPOSITION	MEDI-CAL PARTICIPATION	MCCH FINANCING & PAYMENT MODELS	MCCH SERVICES	DIRECT SERVICES	TECHNOLOGY
Health Care LA IPA	**Provider organizations:** Clinics (MOU) **Populations served:** Children and youth; People experiencing homelessness; adults with multiple chronic conditions, SMI, and/or disabilities; aging adults; and incarcerated and transitioning populations	**Program participation:** ECM (all PoF) **MCP contract status:** Contracted	**Start-up funding:** PATH CITED **Medi-Cal payment model** MCP: PEMPM Provider orgs: Other (IPA structure)	▸ Contracting/negotiation support with MCPs ▸ Legal support ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Outreach & engagement ▸ Standardized MOC ▸ Social services navigation	Other
Housing for Health Orange County	Provider organizations: CBOs **Populations served:** People experiencing homelessness	**Program participation:** ECM (PoF 1); Community Supports (1, 2, 3, 4, 7) **MCP contract status**: Contracted	**Start-up funding:** PATH CITED, WPC pilot **Medi-Cal payment model** MCP: FFS Provider orgs: % of claims	▸ Contracting/negotiation support with MCPs ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Outreach & engagement ▸ Standardized MOC ▸ Social services navigation	Hub and provider organizations share systems.

continued

MCCH NAME	MCCH COMPOSITION	MEDI-CAL PARTICIPATION	MCCH FINANCING & PAYMENT MODELS	MCCH SERVICES	DIRECT SERVICES	TECHNOLOGY
Integrated Health Partners	**Provider organizations:** FQHCs, Community Health Centers **Populations served:** Children/youth; People experiencing homelessness; adults with multiple chronic conditions, SMI, and/or disabilities; and aging adults	**Program participation:** ECM (PoF 1, 2, 4, 5, 6, 7, 8, 9) **MCP contract status:** Contracted (Medi-Cal network contracts for 9 health centers [400,000 lives])	**Start-up funding:** PATH CITED, Self-funded **Medi-Cal payment model** MCP: Transition from FFS to PEMPM through larger network contract; Non-ECM contracts are PCP capitation or full professional risk with a DOFR Provider orgs: Value-Based (PCP capitation + pay-for-performance incentives based on quality outcomes)	▸ Contracting/negotiation support with MCPs ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Outreach & engagement ▸ Social services navigation	Hub and providers have different systems, but hub uses population health management tool.
Los Angeles County Department of Health Services	**Provider organizations:** CBOs, Clinics, Mental Health Providers (Contracted) **Populations served:** Children/youth; People experiencing homelessness; adults with multiple chronic conditions, SMI, and/or disabilities; and aging adults	**Program participation:** ECM (PoF 4); Community Supports (1, 2, 3, 5, 10) **MCP contract status:** Contracted	**Start-up funding:** PATH CITED, County general funds, IPP, WPC pilot **Medi-Cal payment model** MCP: PEMPM Provider orgs: FFS	▸ Contracting/negotiation support with MCPs ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Outreach & engagement ▸ Direct ECM/ Community Supports/ CHW services ▸ Standardized MOC ▸ Social services navigation	Hub and provider organizations share system.

continued

MCCH NAME	MCCH COMPOSITION	MEDI-CAL PARTICIPATION	MCCH FINANCING & PAYMENT MODELS	MCCH SERVICES	DIRECT SERVICES	TECHNOLOGY
Partners in Care	Provider organizations: CBOs (contracted) Populations served: People experiencing homelessness; adults with multiple chronic conditions, SMI, and/or disabilities; and/or aging adults	**Program participation:** ECM (PoF 1, 2, 3, 5, 6, 9); Community Supports (6, 10, 12) **MCP contract status:** Contracted	**Start-up funding:** PATH CITED, Foundation, Self-funded **Medi-Cal payment model** MCP: PEMPM, FFS Provider orgs: PEMPM, FFS	▸ Contracting/negotiation support with MCPs ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Outreach & engagement ▸ Social services navigation	Hub and provider organizations share systems.
Pear Suite	**Provider organizations:** CBOs (Contracted) **Populations served:** Children/youth; People experiencing homelessness; adults with multiple chronic conditions, SMI, and/or disabilities; and aging adults	**Program participation:** ECM; Community Supports (1, 2, 3, 14); CHW **MCP contract status:** Contracted	**Start-up funding:** CHCF Grant **Medi-Cal payment model** MCP: Varies by contract Provider orgs: % of claims, fixed monthly amount	▸ Contracting/negotiation support with MCPs ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Standardized MOC ▸ Social services navigation	Hub and provider organizations share system.

continued

MCCH NAME	MCCH COMPOSITION	MEDI-CAL PARTICIPATION	MCCH FINANCING & PAYMENT MODELS	MCCH SERVICES	DIRECT SERVICES	TECHNOLOGY
Rising Communities	**Provider organizations:** CBOs **Populations served:** Children/youth; People experiencing homelessness; adults with multiple chronic conditions, SMI, and/or disabilities; and aging adults	**Program participation:** CHW **MCP contract status:** Not contracted	**Start-up funding:** Foundation **Medi-Cal payment model** MCP: To be determined Provider orgs: % fee	▸ Contracting/negotiation support with MCPs ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Outreach & engagement ▸ Direct ECM/ Community Supports/ CHW services ▸ Standardized MOC ▸ Social services navigation	Hubs and provider organizations will share systems.
Sacramento County Behavioral Health Services	**Provider organizations:** Mental Health and SUD providers, CBOs **Populations served:** Adults with SMI/SUD	**Program participation:** ECM (PoF 3) **MCP contract status:** Contracted	**Start-up funding:** PATH CITED, BHQIP, IPP funds **Medi-Cal payment model** MCP: PMPM, FFS Provider orgs: PMPM	▸ Contracting/negotiation support with MCPs ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/ **ongoing**)	▸ Standardized MOC ▸ Social services navigation	Other - Recently transitioned to SmartCare. Providers vary in their usage; some use for just billing/claims; others fully transitioned for full EHR capabilities.

continued

MCCH NAME	MCCH COMPOSITION	MEDI-CAL PARTICIPATION	MCCH FINANCING & PAYMENT MODELS	MCCH SERVICES	DIRECT SERVICES	TECHNOLOGY
San Diego Wellness Collaborative	**Provider organizations:** CBOs (contracted) **Populations served:** Children and youth, People experiencing homelessness, and adults with multiple chronic conditions and/or SMI	**Program participation:** ECM (PoF 1, 2, 3, 4, 7, 8, 9); Community Supports (1, 2, 3); CHW **MCP contract status:** Contracted	**Start-up funding:** Foundation grants, funding through CACHI **Medi-Cal payment model** MCP: PEMPM Provider orgs: % of claims, fixed monthly amount	▸ Contracting/negotiation support with MCPs ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/**ongoing**)	▸ Outreach & engagement ▸ Standardized MOC ▸ Social services navigation	Hub and provider organizations share system.
San Joaquin Pathways Community Hub	**Provider organizations:** CBOs (contracted) **Populations served:** Birth equity PoF, unaccompanied children/youth experiencing homelessness	**Program participation:** ECM (PoF 1, 9); Community Supports (1, 2, 3, 7); CHW; Doula **MCP contract status:** Not contracted	**Start-up funding:** Foundation, health system and county funding **Medi-Cal payment model** MCP: To be determined Provider orgs: To be determined	▸ Contracting/negotiation support with MCPs ▸ Claims/billing ▸ Referral management ▸ Compliance and reporting ▸ Ongoing practice transformation support ▸ Training (one-time/**ongoing**)	▸ Outreach & engagement ▸ Standardized MOC ▸ Social services navigation	Hub and provider organizations to share systems.

Notes: *BAA* is Business Associate Agreement; *BHQIP* is Behavioral Health Quality Improvement Program; *CBO* is community-based organization; *CHW* is community health worker; *DOFR* is division of financial responsibility; *ECM* is Enhanced Care Management; *FCHIP* is Fresno Community Health Improvement Partnership; *FFS* is fee-for-service; *FQHC* is federally qualified health center; *HHIP* is Housing and Homelessness Incentive Program; *IPA* is Independent Physician Association; *IPP* is Incentive Payment Program; *MCP* is managed care plan; *MOC* is model of care; *MOU* is memorandum of understanding; *MSO* is management services organization; *PATH CITED* is Providing Access and Transforming Health Capacity and Infrastructure; Transition Expansion and Development; *PEMPM* is per-engagement member per-month; *PMPM* is per-member per-month; *PoF* is Population of Focus; *SMI* is serious mental illness; *SUD* is substance use disorder; *WPC* is Whole Person Care.

Source: Aurrera Health Group, 2024.

Appendix C. Glossary

- **Administrative Services Entity (ASE).**[14] Also termed Administrative Services Organization (ASO). An organization that performs administrative functions for another organization but does not operate under a co-employment model.
- **Area Agency on Aging (AAA).**[15] State and local programs that help older people plan and care for their life-long needs. These needs include adult day care, skilled nursing care/therapy, transportation, personal care, respite care, and meals.
- **Asthma Remediation Services.**[16] Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization
- **Business Associate Agreement (BAA).**[17] An agreement between a covered entity and a person or entity, other than a member of the workforce of a covered entity, who performs functions or activities on behalf of, or provides certain services to, a covered entity that involve access by the business associate to protected health information. The agreement serves to clarify and limit, as appropriate, the permissible uses and disclosures of protected health information by the business associate, based on the relationship between the parties and the activities or services being performed by the business associate.
- **Clinically Integrated Network (CIN).**[18] A group of health care providers that join together to improve patient care, reduce costs, and demonstrate market value. The provider organizations in CINs do not formally merge; rather, they contract to jointly provide care and share profits. Health systems offer CINs to health plans and other payers under managed care contracts.
- **Community Care Hubs (CCH).**[19] A community-centered entity that organizes and supports a network of community-based organizations providing services to address health-related social needs. A CCH centralizes administrative functions and operational infrastructure, including, but not limited to, contracting with health care organizations, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting.
- **Community Based Organization (CBO).**[20] A public or private not-for-profit organization that provides specific services to the community or targeted population within the community. CBOs include, but are not limited to, aging and disability networks, community health centers, childcare providers, home visiting programs, state domestic violence coalitions and local domestic violence shelters and programs, adult protective services programs, homeless services providers, and food banks that work to address the health and social needs of populations.
- **Community Health Record.**[21] Defined as both the proposed framework and a tool or system for integrating and transforming multisector data into actionable information. A community health record is informed by the electronic health record, personal health record, and County Health Ranking systems but differs in its social complexity, communal ownership, and provision of information to multisector partners at scales ranging from address to zip code.

- **Coordinated Entry System.**[22] Coordinated entry is a centralized and streamlined system for accessing housing and support services to end homelessness in a community, and it is required by the U.S. Department of Housing and Urban Development for all Continuums of Care (CoC) as stated in 24 CFR 578.7 (a)(8) of the CoC Program interim rule.
- **Drug Medi-Cal Organized Delivery System (DMC-ODS).**[23] Provides a continuum of care, modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder (SUD) treatment services, in California counties that opt in to the program. The system enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in SUD treatment, and coordinates with other systems of care.
- **Federally Qualified Health Center (FQHC).**[24] Health centers that have been approved by the government for a program to give low-cost health care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for people experiencing homelessness.
- **Health Homes Programs (HHP).**[25] Program designed to serve eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by eligible beneficiaries.
- **Incentive Payment Program (IPP).**[26] The CalAIM Incentive Payment Program (IPP) supports the implementation and expansion of Enhanced Care Management (ECM), Community Supports, and other CalAIM initiatives by providing incentives to Medi-Cal managed care plans (MCPs).
- **Independent Physician Association (IPA).**[27] Also termed Independent Provider Association or Independent Practice Association. A business entity organized and owned by a network of independent physician practices for the purpose of reducing overhead or pursuing business ventures such as contracts with employers, accountable care organizations (ACO) and/or managed care plans (MCPs).
- **Local Initiative Medi-Cal Managed Care Plans.**[28] In 14 of California's 58 counties, Medi-Cal members have a choice between a local health plan (known as a Local Initiative) and a commercial plan. Each Local Initiative has been created by its respective county board of supervisors and is overseen by a local commission.
- **Managed Care Plans (MCPs).**[29] Managed Care Plans are entities that serve Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers.
- **Management Services Organization (MSO).**[30] A business organization that provide the necessary administrative infrastructure, scale, and technology for risk-bearing organizations to function successfully in their relationships with contracted payers and regulators.
- **Providing Access and Transforming Health Capacity and Infrastructure Transition, Expansion, and Development (PATH CITED).**[31] The CalAIM PATH CITED initiative provides direct funding to provider entities, such as CBOs, county agencies, hospitals, and others that are contracted or plan to contract with an MCP. These entities can apply to receive funding for specific capacity needs to support the delivery of ECM and Community Supports services.

- **Risk-Bearing Organization (RBO).**[32] Either a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services. An RBO does not include an individual or a health care service plan.
- **Section 1115 Demonstration.**[33] Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serve Medicaid populations.
- **Section 1915(b) Waiver.**[34] Section 1915(b) waivers allow states to implement and modify a managed care delivery system by waiving certain federal requirements, including statewideness, comparability, and freedom of choice. With Section 1915(b) waivers, states must demonstrate that the managed care delivery system is cost- effective, efficient, and consistent with the principles of the Medicaid program.
- **Specialty Mental Health Services (SMHS).**[35] The Medi-Cal Specialty Mental Health Services (SMHS) program is "carved-out" of the broader Medi-Cal program and operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services under Section 1915(b) of the Social Security Act. DHCS is responsible for administering and overseeing the Medi-Cal SMHS Waiver Program, which provides SMHS to Medi-Cal beneficiaries through county mental health plans (MHPs). MHPs are required to provide or arrange for the provision of outpatient and inpatient SMHS to beneficiaries in their counties who meet SMHS medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals, as documented in their client plans.
- **Whole Person Care (WPC) Program.**[36] The Whole Person Care (WPC) program was implemented under the "Medi-Cal 2020," a Section 1115 Demonstration Waiver from January 1, 2016, to December 31, 2021, and it was focused on high risk, high-utilizing enrollees with multiple service needs. A total of 25 Pilots, representing the majority of counties in California, implemented WPC and started enrollment in January 2017. The overarching goal of WPC was to improve health and wellbeing by coordinating care across physical health, behavioral health, and social services sectors.

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