

UNDERSTANDING MEDI-CAL'S NEW PROVIDER CLASSES IN THE CONTEXT OF CHILD WELFARE



A Brief for Child Welfare Agencies and Their Community-Based Networks

Medi-Cal reforms—specifically those under the State's CalAIM initiatives—have expanded opportunities for non-traditional health care providers to receive payment for delivering Medi-Cal-covered services. Now, culturally aligned staff providing navigation and supportive services, and the community-based organizations that employ them, can become Medi-Cal providers as doulas, community health workers, and other navigation and social service provider organizations.

In this brief, we discuss Medi-Cal's new benefits and services and how organizations with experience serving the child welfare community can leverage the expanded Medi-Cal provider classes to become contracted health care providers. This guide is intended for child welfare program staff to assist their strategic planning as it relates to these new Medi-Cal opportunities.

Consider the example of Karla, below, to understand how these new provider classes support involved children and families, and child welfare systems as a whole.



Karla is a 15-year-old female who has a complex medical history. She was diagnosed with a life-threatening illness as a young girl, which resulted in her kidneys being removed. Karla began receiving dialysis until she was able to receive a kidney transplant, which she did around her 12th birthday. Now, Karla's illness is in remission and her kidney transplant is working, but she has to take medications and see her doctors regularly.

Karla and her family have been involved in the child welfare system for many years. Karla and her siblings have been removed from the home multiple times. She and her siblings are currently living at home with their father, who is their sole caregiver.

Karla's father struggles to maintain a job and stable housing, care for his children, and address his own health needs. Money is often short and he finds it especially challenging to get Karla to her required doctors appointments as instructed due to the distance, cost of gas, and his own work schedule.

Karla is tired of being treated like a young child. She is starting to experiment with high-risk behaviors and has been skipping school recently. Her kidney transplant team has talked with her about her increased risk of infection and potential risks associated with an unplanned pregnancy due to her transplant medications. Karla doesn't feel comfortable talking about these things with the doctors who have been seeing her since she was a young girl.

New Provider Classes

COMMUNITY HEALTH WORKER (CHW)

Medi-Cal's Community Health Worker (CHW) benefit is designed to be a preventive service that uses CHWs with lived experience as a means to help individuals address health needs. CHW services can support needs, including chronic diseases or behavioral health; pregnancy, prenatal, and perinatal care; oral health; aging and injury prevention; domestic violence and community violence prevention.

Value to the Client

Because it is intended to be a preventive health service, the CHW benefit has broad eligibility criteria and is available to a large portion of Medi-Cal beneficiaries. Community Health Workers must be aligned with the population they serve through lived experience, be it culturally and linguistically, or through other life experiences. Clients receiving CHW services will work with someone who has had experiences like them.

Importance to Child Welfare Agencies

CHWs and the CHW benefit align with existing roles in the child welfare system, such as navigators or parent partners because of their experiences in the system and/or cultural and linguistic overlap. The CHW benefit presents an opportunity for systems to incorporate a new funding stream to supplement existing funding, while also offering a career advancement pathway for parent partners and navigators via CHW certification.

CHW SERVICES ELIGIBILITY

CHW services are available to fee-for-service and Managed Care Medi-Cal beneficiaries. Eligibility criteria are broad and include:

- » One or more chronic health or behavioral health conditions
- » Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure or blood glucose levels)
- » Positive adverse childhood experiences (ACEs) screening
- » Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse
- » Screening results that show unmet health-related social needs, such as housing or food insecurity
- » 1+ visits to a hospital ED within the prior six months
- » At-risk of institutionalization
- » 1+ stays at a detox facility within the prior year
- » 2+ missed medical appointments within the prior six months
- » Enrollee who asks for support in health system navigation or resource coordination services
- » Need for recommended preventive services

CHW Service Pathways

Clients can access the CHW benefit via two pathways: a community-based pathway, and a medical pathway. The community-based pathway likely has the most overlap with child welfare providers.

Community-based pathway. DCHS issued in April 2025 a [standing recommendation](#) for clients to receive CHW services via the community-based pathway. This means that a Medi-Cal beneficiary who meets the eligibility requirements can begin receiving services right away without a clinician's order. Under the standing recommendation, clients can receive up to 6 hours of face-to-face support with the CHW, who can help with services including health education, navigation of the health care system, connection to specialists, and connection to community resources.¹ After the initial 6 hours of service, an authorization is required from the health plan every 6 months. A maximum of 2 hours per day is allowed.

The medical pathway creates access to CHW services for a client identified as having significant unmet social needs by a licensed Medi-Cal provider. The licensed Medi-Cal provider must then work with the CHW to develop a plan of care to address the client's unmet social needs. The client can receive up to 3 hours of CHW services per calendar month, for up to 12 months.

Becoming a CHW: Lived Experience & Training

CHW alignment with the population served is essential. CHWs must have lived experience and share a commonality with those they serve. This can be through language or culture, or lived experiences such as incarceration or military service, pregnancy and birth, homelessness, substance use history, domestic violence, and others.

To be reimbursed for services, CHWs must achieve certain levels of experience and training. They must either possess a CHW training certificate or be able to obtain a certificate within 18 months of hire as long as they have required related field experience.² Additional training and certificate requirements apply for CHWs working in violence prevention or asthma prevention services.

Community-based organizations that already employ parent partners, navigators, promotores, or CHWs, or work with organizations that have such staff are likely well positioned to implement the CHW benefit. Having a pre-existing community presence and reputation as a trusted partner and service provider will also be key in establishing an organization as a CHW provider.



¹ Note: A participant cannot be enrolled in ECM and CHW services at the same time. If a participant requires additional support beyond the 6 hours, a plan of care must be developed with a licensed clinician to outline the participant's needs, and additional authorization must be obtained from the Managed Care Plan (MCP).

² More information about CHW experience and certificate requirements is available in the [CHW Medi-Cal Provider Manual](#).

DOULA SERVICES

Doula services are available to Medi-Cal beneficiaries through Managed Care Medi-Cal or Fee-for-Service Medi-Cal. Doulas are birth workers who provide education and non-medical support to pregnant and postpartum women. Doulas can contribute to prenatal education, help develop a birth plan, provide support during childbirth, assist with postpartum recovery, offer lactation support, and provide connection to community resources.

Value to the Client

Doula services are designed to help improve birth outcomes and provide comprehensive support for pregnant individuals, especially for minority communities at the highest risk for poor maternal outcomes. Doula services are intended to be an extra support and assistance to pregnant and postpartum Medi-Cal beneficiaries through the provision of person-centered and culturally competent care.

Health education, advocacy, and physical, emotional and nonmedical support during pregnancy, birth, and postpartum period are within the Doula's scope of services. Doula services can begin during pregnancy, and extend up to 12 months postpartum. Doulas may also support individuals who experience pregnancy loss, including miscarriage, still birth, and abortion.

Importance to Child Welfare Agencies

The presence of a Doula to provide education and supportive intervention during pregnancy, birth, and postpartum care can be especially comforting for many, especially those who may historically have felt underrepresented or marginalized in the health care system. Young women in foster care are pregnant at much higher rates than their peers in their teens and early 20s. These young women need support during and after pregnancy that a doula from her community could be well suited to deliver.³ Further, becoming a Doula may be a career pathway of interest for former child welfare clients, parent partners, or others who are driven

to improve outcomes for their communities via birth support services.

DOULA SERVICES ELIGIBILITY

Doula services are available to pregnant and post-partum Medi-Cal beneficiaries enrolled in fee-for-service or Managed Care Medi-Cal. A request for Doula services must be written by a licensed practitioner. In total, a Medi-Cal beneficiary could receive up to 11 visits with a Doula over the course of a pregnancy and postpartum period, in addition to having the doula present during childbirth.

Becoming a Doula: Experience & Training

[Doulas](#) are not licensed providers or clinicians, and do not require supervision. Doulas providing services under Medi-Cal must either complete a minimum of 16 hours of training in specified birth-related topics and be present at 3 live births, or have experience serving as Doula for at least 5 years within the last 7 years, and attestations from 3 individuals or organizations (including at least one licensed provider, Doula, or Doula organization) speaking to their skills and qualifications. Doulas must be at least 18 years old, have certification in adult and infant CPR, and have completed basic HIPAA training. Doulas must also complete 3 hours of continuing education annually in maternal, perinatal and/or infant care every 3 years.

³ Dworsky, A. & DeCoursey, J. (2009). *Pregnant and Parenting Foster Youth: Their Needs, Their Experiences*. Chicago: Chapin Hall at the University of Chicago

Opportunities for Community Based Organizations (CBOs)

ENHANCED CARE MANAGEMENT (ECM)

ECM is a new pathway for CBOs that are experienced child welfare service providers to become Medi-Cal providers and draw down additional funding for complementary work. As an intensive care management benefit available to select individuals who are enrolled in Managed Care Medi-Cal, ECM is available for adults and children who meet eligibility criteria for at least one of its [Populations of Focus](#) (POFs). ECM is intended for Medi-Cal members with the most complex needs, including individuals who are unhoused or at risk of homelessness, have a diagnosis or symptoms of severe mental illness, having frequent and avoidable ER or hospital admissions, having a history of correctional involvement, or are part of the child welfare system.

Value to the Client

As part of the ECM benefit, clients are assigned to a Lead Care Manager (LCM) who is responsible for coordinating the individual's clinical and non-clinical needs. With the partnership of the LCM, clients complete a comprehensive assessment, develop goals focused on the individual's priorities, receive coordination across all systems of care, health education, and connection to community resources and supports to help address needs and meet identified goals. Family members and social supports can also receive services from the LCM to help support the client's self-management and fulfillment of identified goals. A client can receive ECM for up to a year or longer. ECM can continue for six months after a child or family's involvement in the child welfare system ends, offering important after-care support to prevent re-entry.

Importance to Child Welfare Agencies

Children with child welfare involvement are eligible for ECM services, which can assist with navigation of health care and social services systems. Some parents and caregivers of child welfare involved youth may also be ECM eligible under other POFs. ECM is a pathway for CBOs who currently partner with local county child welfare agencies to enter the Medi-Cal space, bill for services, and generate additional revenue. ECM LCMs do not have to achieve a specific certification or level of licensure, thereby also creating a pathway for individuals who may be interested in human services careers.

Becoming an ECM Provider: Community Footprint

Community-based organizations, clinics, homeless service agencies, correctional service partners, community-based mental health centers, and others are encouraged to become providers of the ECM benefit. The most successful [ECM provider organizations](#) are those that have a strong footprint, meaning they are known and trusted in their community, and who are already engaged in some form of service provision with the community. As noted earlier, there are no specific certificate or licensure requirements for ECM Lead Care Managers. DHCS and the Managed Care Plans will outline specific ECM-related training requirements for the CBO and staff.

COMMUNITY SUPPORTS (CS)

Community Supports are a group of services to help Managed Care Medi-Cal beneficiaries address health-related social needs. [Community Supports](#) are designed to be cost-effective alternative services that can potentially offset other, more costly, traditional health care services. CS services can be offered in conjunction with care management services—such as ECM or the CHW benefit—though a client does not have to be enrolled in a care management program to be eligible for CS.

There are [14 Community Supports](#) currently supported by DHCS. Because CS services are not Medi-Cal benefits, MCPs have the option to choose [which of those 14 services](#) they offer to their members. DHCS requires standardized eligibility criteria for each CS service, based on the service's intended population and outcomes. CS services also have a referral and authorization process that mirrors that which is used for ECM.

The current offering of CS services includes:

- » **Housing Transition Navigation**
- » **Housing Deposits**
- » **Housing Tenancy Sustaining Services**
- » **Day Habilitation**
- » **Recuperative Care**
- » **Short-Term Post-Hospitalization Housing**
- » **Sobering Centers**
- » **Nursing Facility Transition/Diversion to Assisted Living Facilities**
- » **Community Transition Services / Nursing Facility Transition to a Home**
- » **Personal Care and Homemaker Services**
- » **Respite Services**
- » **Medically Tailored Meals and Supportive Food**
- » **Environmental Accessibility Adaptations (Home Modifications)**
- » **Asthma Remediation**

Value to the Client

Through Community Supports, certain services to address social-related health needs are available free of cost to Managed Care Medi-Cal beneficiaries. For example, with CS services, Medi-Cal recipients can now get assistance with housing navigation and move-in funds, temporary lodging following a hospital discharge, in-home caregiving, and much more. Clients can receive more than one CS service at the same time.

Becoming a CS Provider: Service Experience

There are a broad range of potential CS providers given the varied types of services covered under CS. Community-based organizations, homeless service agencies, correctional service partners, and others are encouraged to become CS providers. The most successful [CS providers](#) are those that have a strong community presence and who already offer or are experienced with that type of service provision with the community. Such organizations are likely already interacting with CS-eligible individuals on a daily basis.

Organizations interested in contracting as a provider of CS services should reach out to their local MCP(s) to begin the provider vetting process, during which the MCP will review the organization's ability to meet contractual requirements related to service provision and member care.

Importance to Child Welfare Agencies

Below is detailed information on CS services that are most relevant for parents and families involved in child welfare systems.

Housing Transition Navigation & Housing Deposits [2 CS services]

Housing Transition Navigation is designed for individuals experiencing homelessness or at imminent risk of homelessness. Through this CS service, a participant receives 1:1 assistance from a dedicated Housing Navigator, who can help the participant learn about housing options available to them, create a housing plan, complete housing applications and support overall housing readiness. Once housing is identified, participants can qualify for direct financial assistance in the form of Housing Deposits to help cover move-in expenses. These funds are not paid to the participant, and are instead used to pay for a rental deposit (first and last month's rent) or to help purchase necessary furnishings for the new residence.

Medically Tailored Meals & Supportive Food

Medically Tailored Meals & Supportive Food is designed for individuals who are being released from the hospital, have a chronic condition, or have complex health care needs. This CS service provides eligible participants 2 meals per day for 12 weeks, and can include sessions with a Registered Dietitian, to help the individual understand their health needs as it relates to food and nutrition.

Asthma Remediation

Asthma Remediation is a CS service that helps provide environmental enhancements to make a home safer for an individual with asthma that may be poorly controlled. This CS service can provide funding for air purifiers, mattress and pillow covers, pest management, ventilation improvements, and other enhancements that are medically necessary to enable the individual to function in the home without acute asthma episodes that could result in emergency services or hospitalization.

Caregiver Respite

This CS is available to clients who require significant caregiving support so that their primary caregiver can have brief episodes of time away to attend to their own needs and care. Respite services are intended to be short-term in nature and provide caregiving relief on an hourly, day, or overnight basis, and include attending to the client's basic self-help needs and other activities of daily living.

As with ECM, CS offers a pathway for experienced CBOs to enter the Medi-Cal space, bill for services, and generate revenue. While some CS services have specific staffing requirements and criteria, many services offer opportunities for individuals to gain experience in community-based social service careers while supporting their communities.

How CalAIM Services Can Work Together

The services available under CalAIM are new tools that can be used to better support California's Medi-Cal beneficiaries. They offer new financial streams and resources to make needed services and tangible goods more accessible in effort to address health-related social needs. Below are some client examples of how multiple CalAIM services could be used to support a Medi-Cal beneficiary.

CLIENT EXAMPLE: KARLA

Returning to Karla's story, we recall that Karla is a teenager with involvement in both complex medical care and child welfare systems for many years. She is working to establish her own independent identity, experimenting with high-risk behaviors, and experiencing truancy. Karla lives with her father and siblings.

Karla's father has multiple health issues of his own and struggles to manage his own needs, his children's needs, and requirements for Karla's follow-up care. CalAIM services and new provider classes can help Karla and her father in several ways.

How CalAIM Services Can Help Karla

🟢 Enhanced Care Management

As a California Children's Services (CCS) recipient and a youth involved in the child welfare system, Karla is eligible for ECM. She can work with a care manager who can help identify her priorities and connect her to behavioral health services and adolescent medicine, where Karla can address some of her concerns and better understand how to take care of herself. The care manager can help coordinate with the school in an effort to address her truancy. Karla can also get help coordinating transportation and getting connected to other services in the community.

🟢 Community Health Worker Benefit

As an alternative to ECM, or as a step-down program following ECM, this benefit could provide Karla with a CHW with lived experience to help access reproductive health care and education, behavioral health services, and stay current on preventive care and health screenings.

🟢 Community Supports:

Medically Tailored Meals: As a kidney transplant recipient, Karla may qualify for medically tailored meals that fit her special nutritional needs. She could receive up to 2 meals per day for 12 weeks.

How CalAIM Services Can Help Karla's Father

🟢 Community Health Worker Benefit

As a Medi-Cal beneficiary who has multiple chronic conditions and unmet social needs, Karla's father can receive help from a Community Health Worker. This CHW can assist with navigation of the health care system, coordination of transportation, help scheduling appointments, and health education to support management of his chronic conditions.

🟢 Community Supports:

Housing Navigation or Housing Tenancy Sustaining Services: As someone who has had trouble maintaining stable housing, Karla's father could be eligible for assistance through CS housing services to help identify and maintain housing.

Medically Tailored Meals: As a Medi-Cal beneficiary with several chronic conditions, Karla's father could also receive meals tailored to his nutritional needs. He can receive up to 2 meals per day for 12 weeks.

CLIENT EXAMPLE: GLORIA

Gloria is a 19-year-old Black female who is 20 weeks pregnant. She and her partner live together in a small apartment, work part-time jobs, and barely earn enough for rent and food.

Gloria hadn't planned to get pregnant yet and is nervous about becoming a young mother. Gloria is a former foster youth, and has not been close with her family since moving in with her partner. Gloria also knows her family won't be able to help her care for the baby.

Gloria knows several of her family members experienced difficult pregnancies and deliveries and is scared that hers will be the same. Many people in Gloria's family have diabetes, and some of her aunts and cousins developed diabetes during their pregnancies. Gloria's doctor has told her that she also has gestational diabetes.

Gloria is getting prenatal care through her local community clinic, and was encouraged to consider other services that can give extra help with her pregnancy, delivery, and post-partum care.

How CalAIM Services Can Help Gloria

✔ Doula Services:

As a pregnant woman, Gloria can receive extra prenatal and postpartum support from a Doula. The doula will assist with health education, birth planning, lactation coaching, and postpartum care.

✔ Enhanced Care Management

As a former foster youth and a Black pregnant woman, Gloria is eligible for Enhanced Care Management. She can be assigned a care manager to help identify goals that are of the greatest importance to Gloria, help coordinate her care across providers, and make connections to needed community and social services.

✔ Community Health Worker Benefit

As an alternative to ECM, or as a step-down program following ECM, this benefit could provide Gloria with a CHW with lived experience to help navigate the health care system, receive postpartum and reproductive health care, and support connections for her newborn to preventive care.

✔ Community Supports:

Medically Tailored Meals: As a pregnant woman with gestational diabetes, Gloria could qualify for medically-tailored meals, which would provide her with specialized meals tailored to her nutritional needs. She can receive 2 meals per day for 12 weeks.

Summary

Medi-Cal offers a comprehensive set of services that now includes additional provider classes that both offer support and possible career pathways to individuals and families served by and transitioning out of the child welfare system. These provider classes and services offer unique ways to better support foster youth and families through the provision of culturally concordant, community-based care that assists in meeting social needs and with navigating the health care system. Maximizing these benefits is a mutual gain for both clients and child welfare systems.

Appendix: Additional Details on the Provider Classes & Service Options

COMMUNITY HEALTH WORKER (CHW)

Additional Provider Requirements

There are several important requirements for organizations interested in contracting as a provider of CHW benefit services. Provider organizations holding the MCP contract are known as Supervising Providers, and are responsible for meeting Medi-Cal contracting requirements. Many organizations can fulfill the role of Supervising Provider, including licensed providers, hospitals, outpatient clinics, CBOs or local health jurisdictions. It is important to note that Federally Qualified Health Centers (FQHCs) are not able to bill for the CHW benefit.

Additional provider requirements include being able to contract with Managed Care Medi-Cal Plans (MCPs), having a National Provider Identifier (NPI), providing direct and indirect oversight to the CHWs, completing required documentation and billing.

Financials

State CHW Medi-Cal reimbursement rates for the community based pathway are \$27.43 for each 30-minute face-to-face session with an individual. CHW services can also be provided in a group setting with 2–4 participants or 5–8 participants; these are billed with different CHW codes to indicate a group and are paid at adjusted rates. A CHW cannot bill for more than 2 hours of CHW services for the same participant on the same day. It is important to note that MCPs can choose to pay more than the identified state rate and some MCPs are choosing to do so.

The medical pathway uses a different billing code set for billing and offers a higher reimbursement rate of approximately \$79 per unit. This pathway also is more closely intertwined with clinical services, requires an initiating visit conducted by a licensed Medi-Cal provider, and that the licensed provider participates in the development of a CHW plan of care for the client at the time of service initiation.

Regardless of pathway, CHW reimbursement rates are often not sufficient to independently finance and sustain staffing and operations. An important consideration is how to braid additional sources of funding to complement and fully support the services. One option, for example, could be that existing staff currently funded to provide a CHW-like service become CHW certified and bill for Medi-Cal CHW services as applicable.

Additional Considerations

Staffing: As noted above, the CHW benefit requires CHWs to either have a training certificate or obtain one within 18 months of hire. A best practice would also be to have a licensed clinician available to support CHWs, and have that clinician contribute to development of a plan of care. Administrative staff needs include MCP relationship management, service oversight, billing and claims submission, and revenue cycle management.

Technology: CHW providers must have a system in which they can document services provided to the participant. The system should be able to capture the date of service, time and duration of service, and a brief progress note, at a minimum. Ideally, the system also supports data collection as well as claims or invoice generation for billing purposes.

Other infrastructure: Additional infrastructure to consider includes equipment (computers, telehealth platforms, phones, etc.) and also reimbursement or use of company vehicles for field-based CHW activities.

Training: Development and delivery of training courses—both at the time of initial implementation and as continuing education—is critical to ensuring ongoing professional development. CHWs must complete at least 6 hours annually of continuing education.

DOULA SERVICES

Additional Provider Requirements

Doulas must have a National Provider Identifier (NPI) and be able to bill for services using specialized code sets provided by Medi-Cal.

Financials

Doula visits across the pregnancy and postpartum period range in duration and complexity. In total, based on current Medi-Cal rates, a Doula could receive \$3,152.65 in payments when all authorized visits are billed for a client.

Claims are submitted for each service using the identified code set to the appropriate payor (State for fee-for-service beneficiaries or Managed Care Plan for managed care beneficiaries). Payment for Medi-Cal Fee-for-Service clients is made by the State, while payment for Managed Care Medi-Cal clients are made via the MCPs.

Additional Considerations

Technology: Doulas must have a system of record in which they can document about services provided to the client. The system should be able to capture the date of service, time and duration of service, and a brief progress note, at a minimum. Ideally, the system also supports data collection as well as claims or invoice generation for billing purposes.

Other infrastructure: Additional infrastructure to consider includes equipment (computers, telehealth platforms, phones, etc.) and also reimbursement or use of company vehicles for field-based Doula activities.

Training: Development and delivery of training courses - both at the time of initial implementation and as continuing education - is critical to ensuring ongoing professional development. Doulas must complete at least 3 hours annually of continuing education.

ENHANCED CARE MANAGEMENT (ECM)

Additional Provider Requirements

Additional provider requirements include being able to contract with Managed Care Medi-Cal Plans (MCPs), having a National Provider Identifier (NPI), access to a care management documentation system, and being able to fulfill billing and data exchange requirements.

Financials

Of all CalAIM services, ECM is the most intensive and requires the most complex reporting and data exchange. ECM generally also comes with the most robust reimbursement rates.

Additional Considerations

Staffing: ECM operates best in a team-based model, where LCMs are supervised and guided by a licensed clinician. There are no official certificate requirements for staff serving ECM LCMs.

LCMs are often trained paraprofessionals without clinical licensure but with sufficient field-based experience to provide intensive case management.

The licensed clinician does not have to be a physician, and could include an LCSW, LMFT, RN, NP, PA, etc.

Consider costs associated with LCMs (who bill for their time), a licensed supervisor (who may or may not also have a caseload and bill for some ECM services), and other administrative roles (biller, data or reporting analyst, administrative director).

Technology: ECM providers must have a case management system in which notes about services and care are documented. Ideally, the case management system also supports data collection and reporting for required data exchange with the MCP, as well as claims or invoice generation for billing purposes.

Other infrastructure: Additional infrastructure to consider includes equipment (computers, telehealth platforms, phones, etc.) and also reimbursement or use of company vehicles for field-based ECM activity.

Training: Development and delivery of training courses—both at the time of initial implementation and as continuing education—is critical to ensuring ongoing professional development of staff. MCPs will offer a set of required and optional training for ECM staff. It is important to clarify training expectations with the MCP at the time of contracting.

Potential revenue ranges:

Around \$400–\$500 per enrollee per month, with some caveats. MCPs are able to set their own rates and payment methodologies, including fee-for-service, per enrolled member per month, and utilization-based. Some MCPs offer incentive programs based on clinical indicators and outcomes.

COMMUNITY SUPPORTS (CS)

Additional Provider Requirements

Additional requirements include being able to contract with Managed Care Medi-Cal Plans (MCPs), having a National Provider Identifier (NPI), access to a care management documentation system, and being able to fulfill billing and data exchange requirements.

Financials

Because each Community Support service is distinct, each comes with its own expenses and revenue considerations. Some services—such as housing services—may require more staffing and team-based services. Other CS—such as asthma remediation—may require association with a contractor or other service providers to make changes to a home.

Additional Considerations

Staffing: In general, each CS service will require an administrative lead responsible for working with the MCP(s) and being the point of contact for communication and deliverables.

CS services also require the submission of claims, making billing and revenue cycle support necessary.

Additional specialized staffing will depend on the specific CS service, and could range from a Registered Dietitian to a Certified Health Education Specialist to a housing specialist to a contractor able to complete home modifications.

Technology: CS providers must have a system of record in which documentation about services and care are documented. Ideally, the system also supports data collection and reporting for required data exchange with the MCP, as well as claims or invoice generation for billing purposes. [Note that Sobering Center is the only CS service that does not require data exchange.]

Other infrastructure: Additional infrastructure to consider includes equipment (computers, telehealth platforms, phones, etc.) and also reimbursement or use of company vehicles for field-based activity. Specialty equipment could include beds, meal preparation equipment, and other items.

Training: Development and delivery of training courses—both at the time of initial implementation and as continuing education—is critical to ensuring ongoing professional development of staff.

Potential revenue ranges:

Depends greatly based on the CS service and payment methodology. DHCS provided recommended rates for each of the CS services, though each MCP can set its own rates and payment methodology.



The Public Works Alliance

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



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