PATH Collaborative Planning & Implementation (CPI)

Welcome! The Southwest Collaborative Planning Meeting will be starting shortly.

February 20, 2025

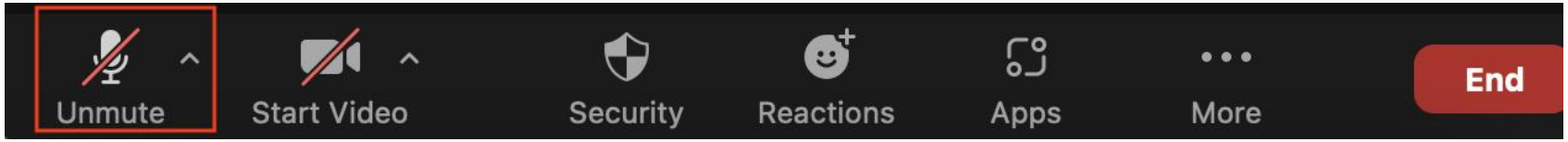
POPULATION HEALTH
INNOVATION LAB
A Program of the PUBLIC HEALTH INSTITUTE

REC

This event is being recorded.

Recordings will be available per request after the event.
Please email **PATH@pophealthinnovationlab.org**

Please mute your microphone during the presentation.



PATH – Collaborative Planning & Implementation (CPI)

Southwest Collaborative Planning Meeting

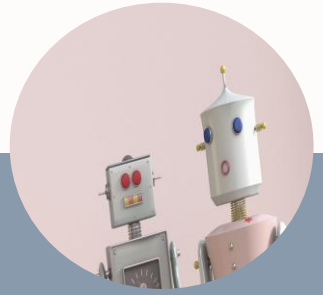
February 20, 2025

POPULATION HEALTH
INNOVATION LAB
A Program of the PUBLIC HEALTH INSTITUTE

Thank you to our sponsors

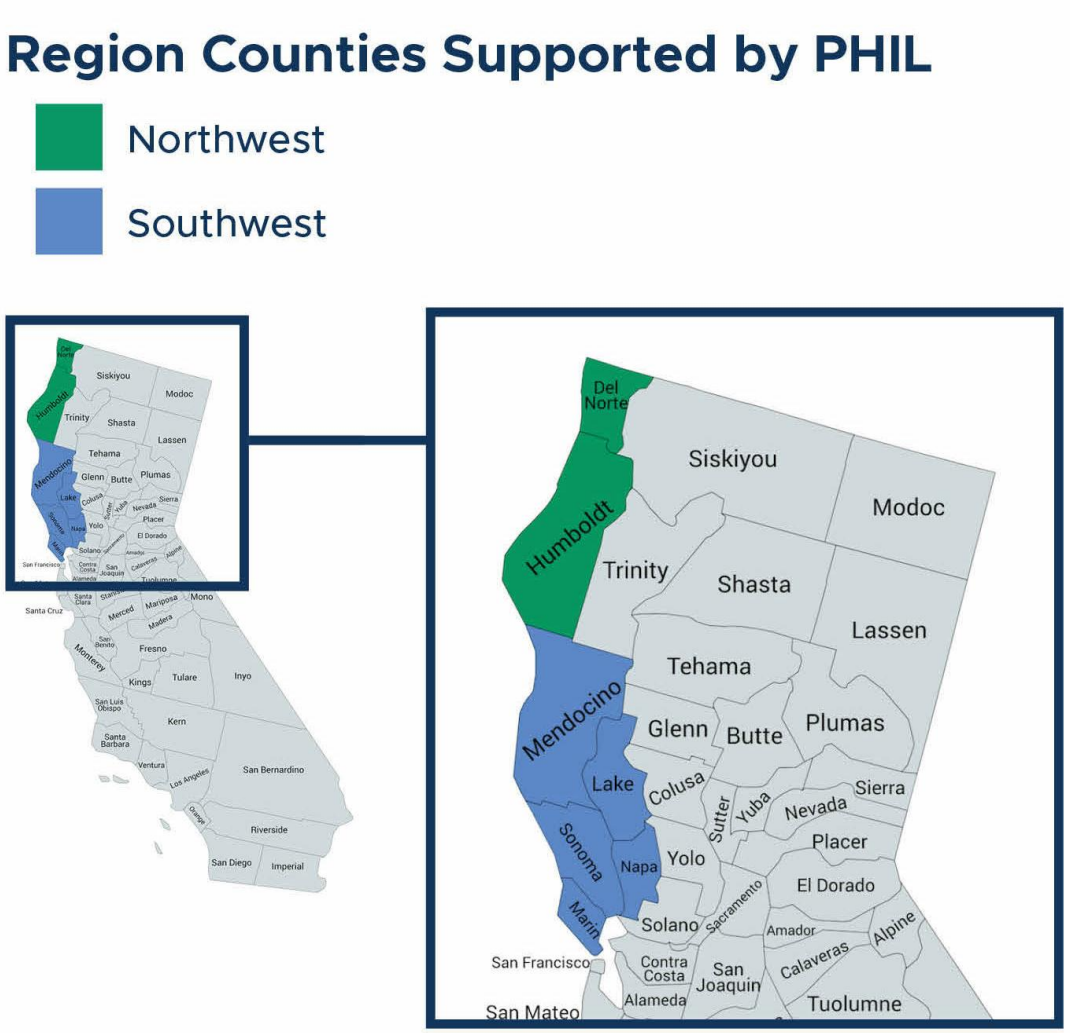
Welcome & Housekeeping

Roll Call
Please share your name, location, title, and organization in the chat.



Participation Eligibility
Vendors and salespeople should recuse themselves from soliciting during this collaborative convening.

Collaborative Planning & Implementation Overview



CPI collaboratives will work together to identify, discuss, and resolve CalAIM implementation issues.

- Learn more about the PATH CPI initiative here.
- Catch up with us! Find meeting minutes, Readiness Roadmap Resources, and registration links on the PHIL website.

Population Health Innovation Lab (PHIL)
PATH CPI Project Team

Tammy Chandler
PATH CPI Policy & Quality Improvement Manager
tchandler@phi.org

Jessica Sanchez
Program Associate
jsanchez2@phi.org

Kathryn Stewart
Director of Strategy & Operations
kastewart@phi.org

Sue Grinnell
Director of PHIL
sgrinnell@phi.org

Stephanie Bultema
Director of MERLIN
sbultema@phi.org

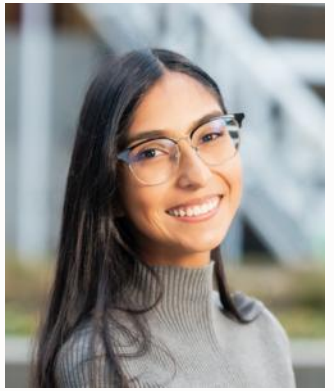
Seun Aluko
Associate Director of Applied Research & Implementation
saluko@phi.org

Stefani Hartsfield
Consultant
stefani@hartsfieldhealth.com

Zachary Ray
Consultant
zray@nativespiritconsulting.com

Megan Kenney
Program Specialist
mkenney@phi.org

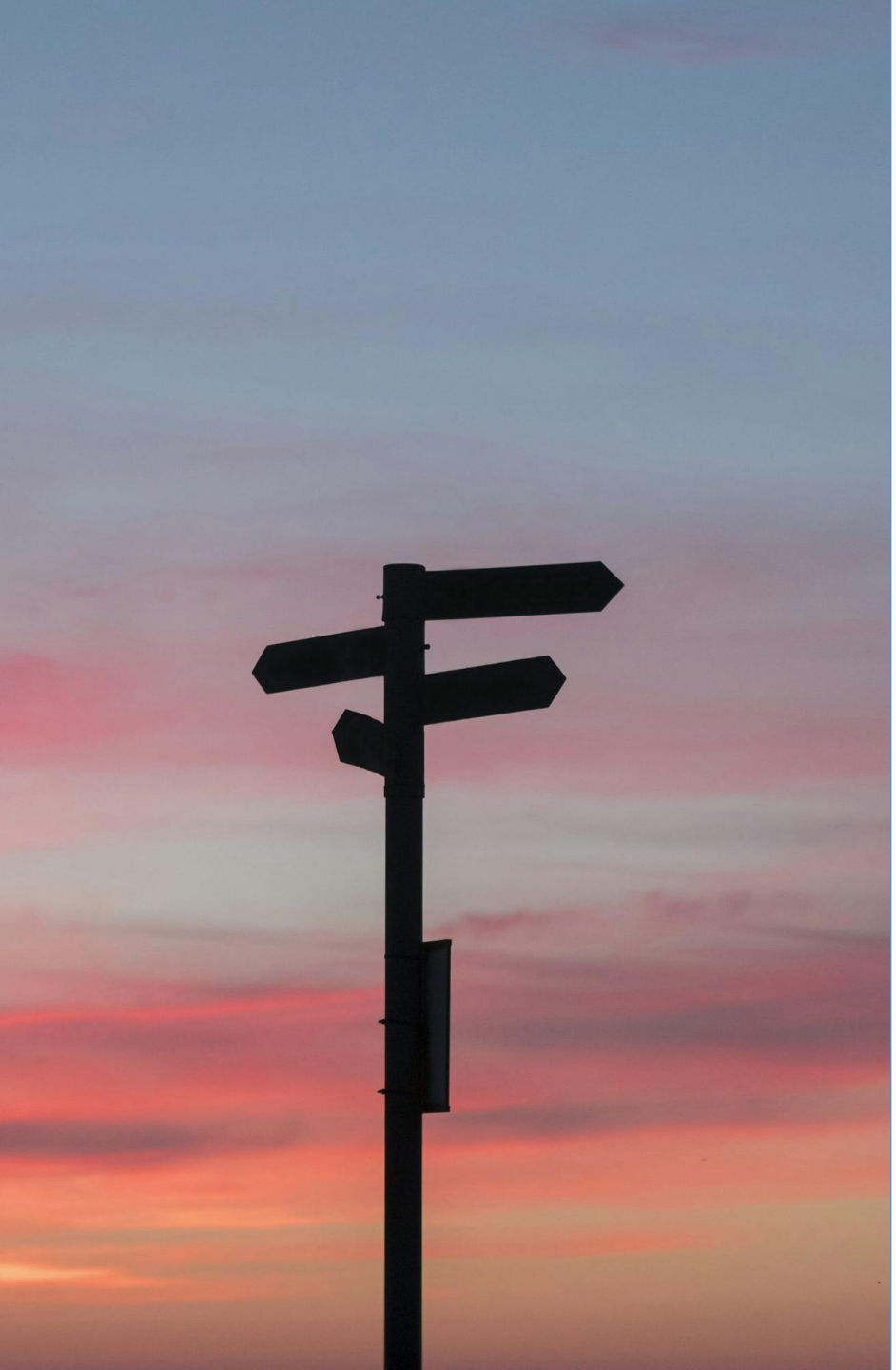
Katie Christian
Program Associate I
kchristian@phi.org



Esmeralda Salas
Research Associate III
esalas@phi.org

April Phan
Research Associate I
aphan@phi.org


The Big Welcome



Check-In

What is on your mind related to CalAIM implementation and sustainability?

Agenda for Today

- Check In: CalAIM Ecosystem of Care in 2025
- Highlights from Kaiser Permanente and Partnership HealthPlan of California (PHC)
- PATH Collaborative Planning & Implementation (CPI) in 2025
- Regional and County-specific data for ECM and Community Supports
- CalAIM Updates, Events and Announcements
- Evaluation and Closing

Objectives

- Establish a shared understanding of the **collaborative's primary goals and key drivers** for 2025.
- Review and discuss **CalAIM provider networks and member utilization data** for ECM and Community Supports.
- Encourage shared learning and provide a platform for **open dialogue** with CalAIM providers, local Managed Care Plans, and other local stakeholders to strengthen a culture of collaboration.
- Facilitate an open forum to **enhance transparency** surrounding challenges, successes, and innovations in CalAIM Enhanced Care Management (ECM) and Community Supports services.

Commitments to Community Inclusivity

Be Present, Brave, and Curious

- Encourage different opinions and respectful disagreement
- Embrace conflict which can deepen our understanding
- **Acknowledge the risk speakers take, and value the privilege to learn from one another**
- Make use of opportunities to connect person-to-person

Create An Inclusive Space

- Invite the unheard voices
- **Take responsibility for our own voices (make space)**
- Resist the temptation to only witness the dialogue (take space)

Invite Anti-Racist Dialogue

- Be aware we all have a bias that may impact action; biases are learned and can be unlearned
- **Address racially biased systems and norms**
- Recognize the vast and varied lived experiences participants have with racism
- Be intentional about power dynamics and how you exercise your privilege
- Avoid defensive responses when people speak from lived experiences with racism

Be Accountable

- Foster awareness of unrepresented community members not "in the room"
- Respect each other's time - participate fully and prepare for each activity
- Commit to actions that move items beyond discussion
- **Practice patience and persistence – we cannot solve everything in a single conversation and will revisit topics that require additional discussion**

Commitments Courtesy of: Community Health Worker & Promotor Workforce Development Resource Library — Health Leads. (2023, June 29). Health Leads. https://healthleadsusa.org/communications-center/resources/community-health-worker-promotor-workforce-development-resource-library/

Kaiser Permanente

February PATH CPI Meeting
Southwest, Marin, Napa & Sonoma Counties
February 20th, 2025

Additional NLE Provider Support | Provider Office Hours

Kaiser Permanente is working with Network Lead Entities (NLEs) to develop a network of community-based ECM, CS, and CHW providers.

NEW: Contracted Providers
Second/Fourth Thursdays
1:00 – 2:00 pm
Join Meeting Now

NEW: Prospective Providers
First Thursdays of the Month 1:00 - 2:00 pm
Begins Feb 6
Join Meeting Now

Questions?
ILSCAProviderRelations@ilshealth.com
Phone number: 844-269-3447

Contracted Providers
Tuesdays 3:00 - 4:00 pm
Register and Join Here

Prospective Providers
Second/Fourth Thursdays of the Month
12:00 - 1:00 pm
Register and Join Here

Questions?
network@fullcirclehn.org
Phone number: 888-749-8877

ECM Pilot Influencer Campaign is Live!

Kaiser Permanente partnered with Public Good Projects (PGP) on a social media influencer campaign to expand knowledge and drive enrollment into Enhanced Care Management (ECM) for Birth Equity and Foster Youth populations of focus.

Timing

- January 14 - February 28

Targeted Outreach

- Birth Equity Statewide
- Foster Youth in San Bernadino and Sacramento

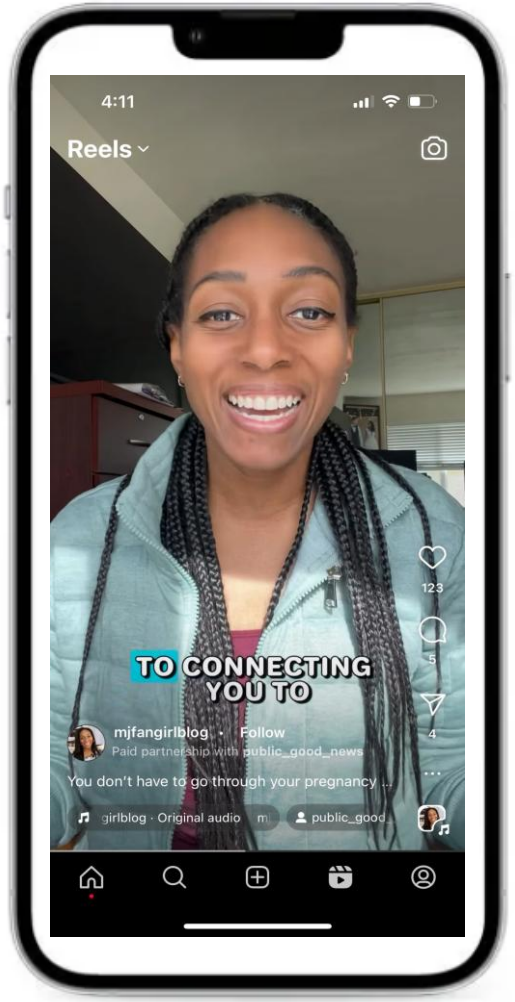
Influencers

- Individuals who can reach target populations
- Community organizations (some delayed due to LA fires)

Next Steps

- Test and learn from pilot approach
- PGP will provide an evaluation
- Based on the evaluation, KP will scale to other populations of focus (with other managed care plans, if interested) or sunsetting.

Links to ECM Pilot Influencer Posts



[Lesha, Los Angeles Creator]

[Kim, Digital Creator]

[Kat, Mom Influencer]

KAISER PERMANENTE®

Submitting ECM & CS Referrals

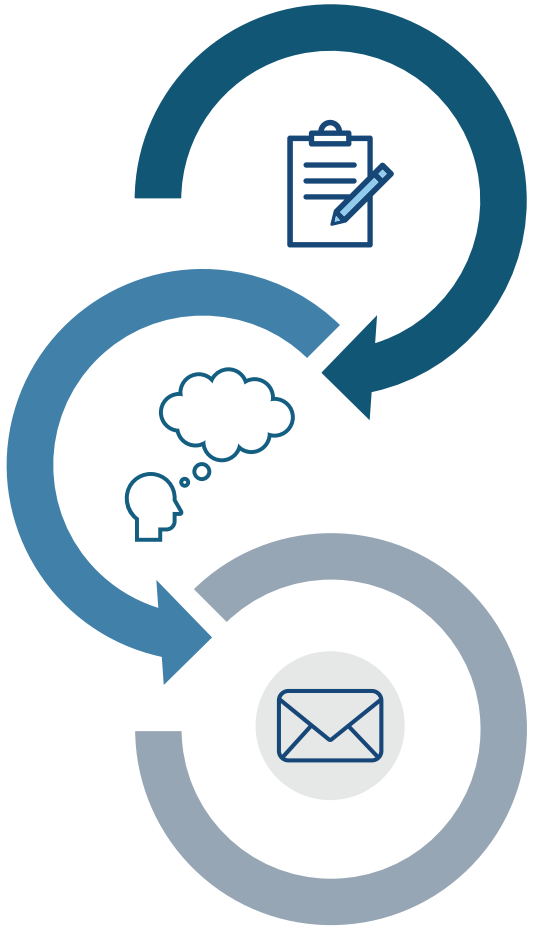
KP has a no-wrong-door approach for referrals

- Referrals are accepted from any source (members, providers, family, community organizations, etc.)
- Referrals may be placed via email or via phone or KP Health Connect
- **NEW: For providers/organizations submitting referrals to your own ECM/CS/CHW organization, please send the referral form directly to your contracted Network Lead Entity**

Area	All Northern California Counties	All Southern California Counties
Phone (Member)	1-833-721-6012 (TTY 711) Monday-Friday (closed major holidays) 8:30 a.m. to 5:00 p.m.	1-866-551-9619 (TTY 711) Monday-Friday (closed major holidays) 8:30 a.m. to 5:00 p.m.
Email (Counties/CBOs)	Send completed referral form to REGMCDURNs-KPNC@kp.org with the subject line “ECM Referral” or “CS Referral” or “CHW services request”	Send completed referral form to RegCareCoordCaseMgmt@kp.org with the subject line “ECM Referral” or “CS Referral” or “CHW services request”
Email (NEW: NLE Contracted providers submitting referrals to their own organization)	Send completed self referral form to contracted Network Lead Entity	Send completed self referral form to contracted Network Lead Entity

Process for Community Providers to Refer to Own Organization

If you are a **contracted** community provider and want to refer a KP member **directly** to your **ECM/CS/CHW** organization, please send the referral directly to your **contracted Network Lead Entity** rather than KP.



Email ECM/CS/CHW referral directly to contracted NLE:

- Full Circle Health Network: referral@fullcirclehn.org
- ILS: kpreferrals@ilshealth.com
- Partners in Care Foundation:
  - ECM: ECM@picf.org
  - Personal Care/Non-Medical Respite:privateduty@picf.org
  - Housing Trio: HousingCS@picf.org

Send any questions regarding self-referrals to your contracted NLE

For issue resolution, email Network Lead Entity and cc medi-cal-externalengagement@kp.org


PARTNERSHIP
HEALTHPLAN
of CALIFORNIA
A Public Agency
ACCREDITED
NCQA
HEALTH PLAN
Partnership Update
February 2025

Agenda

- DHCS Updates
- DHCS Monitoring and Oversight
- Partnership’s Updates

DHCS Updates

- DHCS continues to have monthly meetings with MCPs as they discuss how to operationalize Transitional Rent
- DHCS has indicated that a Policy Guide update may be out in late February with more updates to be released in late April
- Reminder that Closed Loop Referral was moved to start 7/1/25
- DHCS extended the PATH CITED grant deadline to May 2

DHCS Monitoring and Oversight

December 2024 - DHCS released annual monitoring priorities and measures for **2025/2026**

Overall monitoring goal:

- ✓ Provide ECM and CS to members who need the services, in a manner that is timely, in line with DHCS policy, and addresses their care management and health-related social needs

Steps and guardrails are required of MCPs to achieve these goals through data and internal measures by:

- ✓ Ensuring MCPs have a sufficient network of ECM and CS providers
- ✓ Increasing access to and uptake of ECM and CS
- ✓ Improving overall delivery of ECM and CS services

DHCS plans to:

- ✓ Meet regularly with each MCP to discuss the implementation and progress of each program
- ✓ Provide technical assistance through the monthly TA Meeting and other DHCS-MCP forums
- ✓ Continue to make data on MCP performance publicly available
- ✓ Take the necessary compliance actions (e.g., PIPs and CAPs) for primary measures

2025 ECM Measures

	2025	
	12-Month Growth in Percent of Members Receiving ECM	**ECM Provider Network Completion**
Description	Growth in the percentage of MCP members receiving ECM in each county, in the 12-month period after the ECM & Community Supports **Action Plan** was released.	Number of "active" ECM providers for each POF in each county, with "active" defined as a provider with at least one ECM encounter in that county that quarter.
Frequency	One-time, for the 12-month period from July 1, 2023, to June 30, 2024.	Quarterly
Minimum Performance Threshold	Growth > 0% in each county	**Starting 1/1/25:** At least 1 "active" provider per POF in each county
Compliance Actions	MCPs who do not meet the threshold will need to submit a **Performance Improvement Plan** (PIP).	• Q1 2025: MCPs who do not meet the threshold will need to submit a PIP. • Q2 and beyond: MCPs who do not meet the threshold will receive a **Corrective Action Plan** (CAP).

2026 ECM Measures

	2026	
	ECM Provider Type Diversity	**Percent of Members Receiving ECM**
Description	Number of "specialized" ECM providers for each POF in each county, with "specialized" defined as: 1. Eligible for ECM Prior Authorization per pages 110-112 of the **ECM Policy Guide**; 2. Identified as POF-specific specialized providers per pages 95-97 of the **ECM Policy Guide**; or 3. Shown to have proven expertise and experience in the specific POF, per MCP description.	Percentage of MCP members who received ECM in each county that quarter, stratified by adult and children & youth members.
Frequency	Semi-annual. (A semi-annual supplemental data submission will be needed for this measure.)	Quarterly
Minimum Performance Threshold	**Starting 1/1/26:** At least 1 "specialized" provider per POF in each county	**Starting 1/1/26:** At least 1% of MCP members receiving ECM in each county, stratified by adult and children & youth members
Compliance Actions	*To be defined in late 2025.*	*To be defined in late 2025.*

2025 Community Supports Measures

	2025	
	12-Month Referral Growth	**Active Provider Network**
Description	Growth in the number of Community Supports community-based referrals, in the 12-month period after the ECM & Community Supports Action Plan was released.	Number of "active" Community Supports providers for each elected service in each county, with "active" defined as a provider with at least one Community Supports encounter in that county that quarter.
Frequency	One-time, for the 12-month period from July 1, 2023, to June 30, 2024.	Quarterly
Threshold	Growth > 0% in each county	**Starting 1/1/25:** For each service, in every county, MCP has at least 1 "active" Community Supports Provider
Compliance Actions	MCPs who do not meet the threshold will need to submit a **Performance Improvement Plan** (PIP).	• Q1 2025: MCPs who do not meet the threshold will need to submit a PIP. • Q2 and beyond: MCPs who do not meet the threshold will receive a **Corrective Action Plan** (CAP).

A third measure that requires plans to have CalAIM information available on the MCP website for members and providers – checked twice annually.

Partnership Updates

- Partnership has started Q1 provider audit and oversight. Reminder that updates may be made to the oversight materials as we move thru the year. Partnership will share any updates with providers.
- Partnership will continue strategizing with local partners and providers on ways to increase awareness and utilization of services.
- IPP information will be shared with all providers in late February.
- CalAIM (Transforming Medi-Cal) webpage re-launch
  - https://www.partnershiphp.org/Community/Pages/CalAIM.aspx

Questions

Contacts:

- ECM@partnershiphp.org
- CommunitySupports@partnershiphp.org
- ClaimsECMhelpdesk@partnershiphp.org

2025 Collaborative Goals

The Southwest PATH Collaborative Planning and Implementation (CPI) initiative's aim for 2025 is to enhance the quality and equity of CalAIM Enhanced Care Management (ECM) and Community Supports by **facilitating CPI participant advancement along the Readiness Roadmap.**

This will focus on increasing **Medi-Cal member ECM utilization to at least 3% for adults** and **at least 2% for children** by December 31, 2025.

Additionally, efforts will aim to increase overall **Medi-Cal member utilization of Community Supports to at least 1%** during the same timeframe. The initiative will prioritize addressing service gaps, improving access, and ensuring quality care for target populations.

How is this Different from our 2024 Goals?

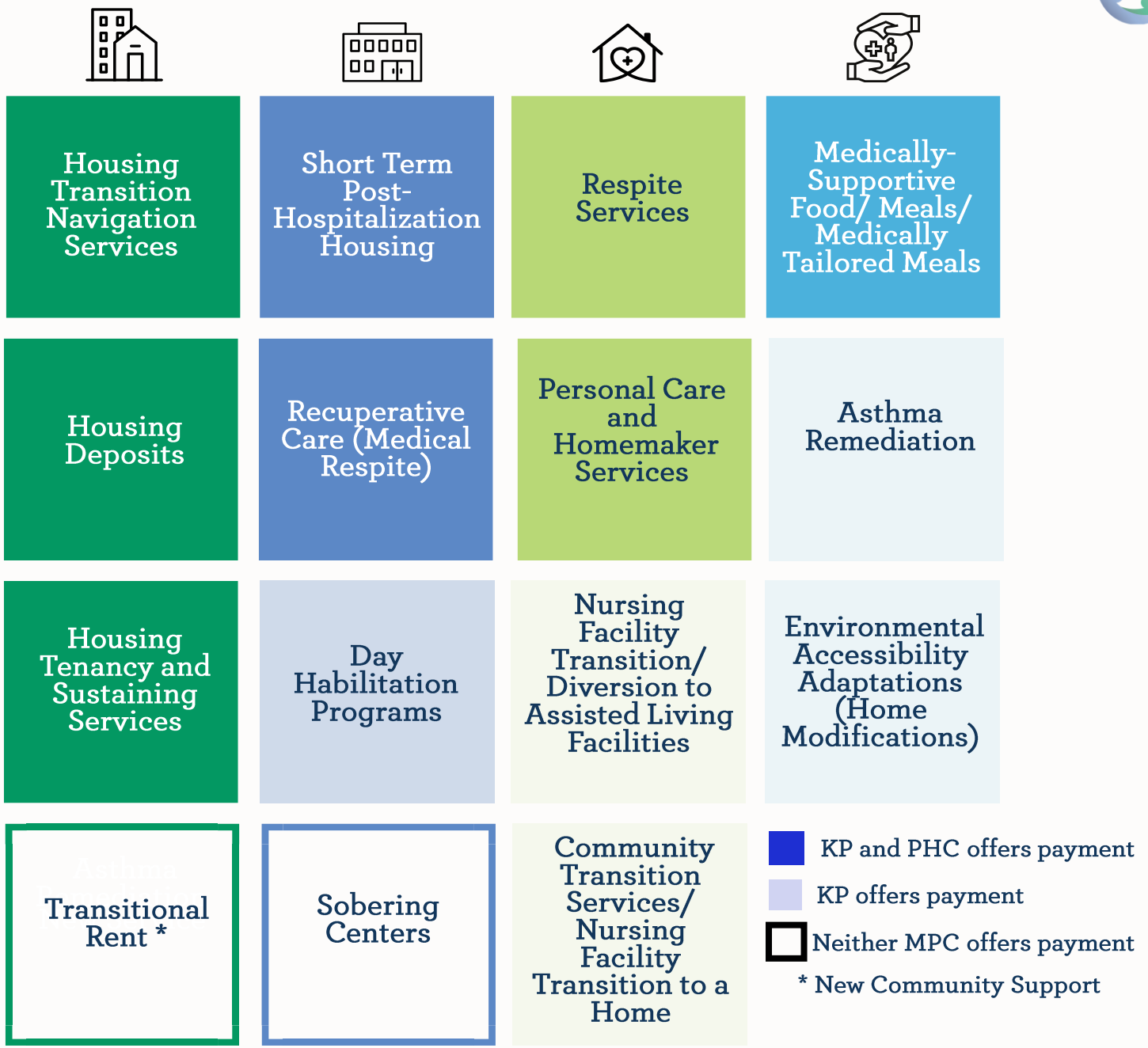
- Measuring ECM Utilization Data for Children separately from Adults
- Measuring Contracted Provider Networks for each ECM Population of Focus (7 Adult PoFs and 7 Children PoFs)
- Measuring Contracted Providers for each Community Support
- Data specific to each County instead of regionally
- Focus on equity and quality through the lens of “network adequacy”
- Participant opportunities to define quality as well as inform “robust provider networks” in each County

Enhanced Care Management (ECM) Populations of Focus (PoFs)

	ECM Populations of Focus	Adults	Children & Youth
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

Community Supports

- Supports are medically appropriate and cost effective.
- Supports are primarily related to the social drivers of health, which are newly funded in the Medi-Cal system under 1115 Waivers.



Readiness Roadmap

Where am I on the Readiness Roadmap?

1. What are ECM & Community Supports?

2. We're exploring the contracting process.

3. We have started to work on the contract!

4. We have a contract!

5. We are testing the service delivery and billing system.

6. We are making it work, but...

7. Coordinated delivery, billing, and referral system in place!

8. We are seeing more members utilizing services

9. We have a shared information infrastructure creating a unified support system.

10. Seamless coordination in the ecosystem of care!

(Updated 04/23/2024)

Regional and County-Specific Data for Enhanced Care Management

2024 versus 2025 Methodologies

2024 ECM Southwest Utilization Rate

Region	Average MCP Members in the Last 12 Months of the Reporting Period - Adults	Number of Unique Members Who Received ECM in the Last 12 Months of the Reporting Period- Adults	Percentage of MCP Members Who Were Enrolled in ECM in the Last 12 Months of the Reporting Period- Adults	Average MCP Members Under Age 21 in the Last 12 Months of the Reporting Period	Number of Members Under Age 21 Enrolled in ECM At Any Point in the Last 12 Months of the Reporting Period	Percentage of MCP Members Under Age 21 Who Were Enrolled in ECM in the Last 12 Months of the Reporting Period	Combined ECM Penetration Rate
Southwest	298551	4251	1.42%	112612	531	0.47%	**1.16%**

Data Source: DHCS ECM and Community Supports Quarterly Implementation Report

2025 Collaborative Goals for ECM

…This will focus on increasing **Medi-Cal member ECM utilization to at least 3% for adults and 1% for children** by December 31, 2025.

ECM Utilization Rates by County- Partnership

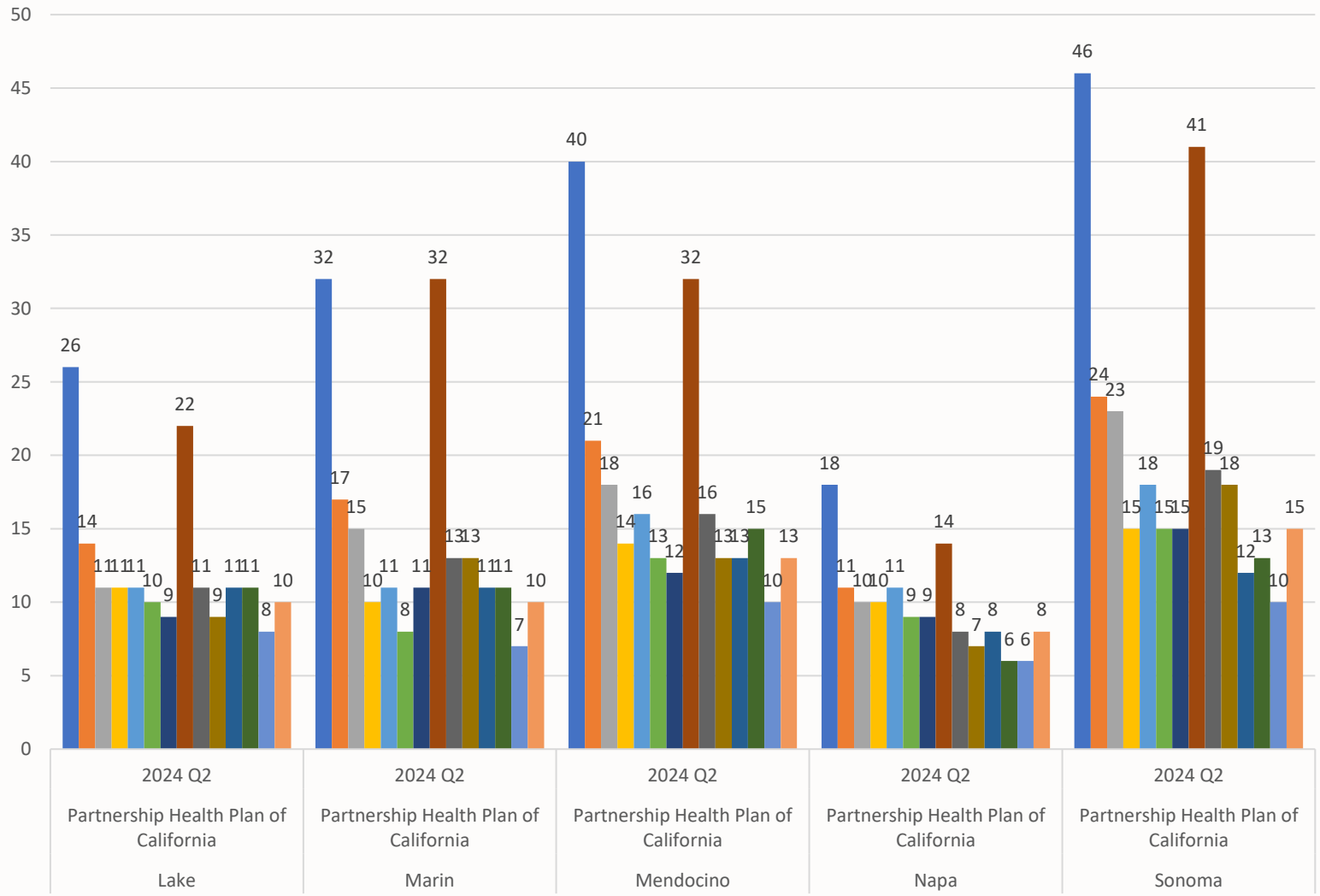
County	MCP	Last Date In the Reporting Period	Average MCP Members in the Last 12 Months of the Reporting Period - Adults	Number of Unique Members Who Received ECM in the Last 12 Months of the Reporting Period - Adults	ECM Utilization rate in the last 12 Months of the Reporting Period - Adults	Average MCP Members Under Age 21 in the Last 12 Months of the Reporting Period	Number of Members Under Age 21 Enrolled in ECM At Any Point in the Last 12 Months of the Reporting Period	ECM Utilization rate in the Last 12 Months of the Reporting Period -Under Age 21
Lake	Partnership Health Plan of California	6/30/24	35011	452	1.29%	12823	45	0.35%
Marin	Partnership Health Plan of California	6/30/24	49191	718	1.46%	17315	173	1.00%
Mendocino	Partnership Health Plan of California	6/30/24	41552	751	1.81%	15486	66	0.43%
Napa	Partnership Health Plan of California	6/30/24	31233	419	1.34%	12356	46	0.37%
Sonoma	Partnership Health Plan of California	6/30/24	121375	1764	1.45%	45628	168	0.37%

Data Source: DHCS ECM and Community Supports Quarterly Implementation Report

ECM Utilization Rates by County- Kaiser

County	MCP	Last Date In the Reporting Period	Average MCP Members in the Last 12 Months of the Reporting Period - Adults	Number of Unique Members Who Received ECM in the Last 12 Months of the Reporting Period - Adults	ECM Utilization rate in the last 12 Months of the Reporting Period - Adults	Average MCP Members Under Age 21 in the Last 12 Months of the Reporting Period	Number of Members Under Age 21 Enrolled in ECM At Any Point in the Last 12 Months of the Reporting Period	ECM Utilization rate in the Last 12 Months of the Reporting Period -Under Age 21
Marin	Kaiser Permanente	6/30/24	3597	52	1.45%	1278	11	0.86%
Napa	Kaiser Permanente	6/30/24	3855	16	0.42%	1877		0.00%
Sonoma	Kaiser Permanente	6/30/24	12737	79	0.62%	5849	22	0.38%

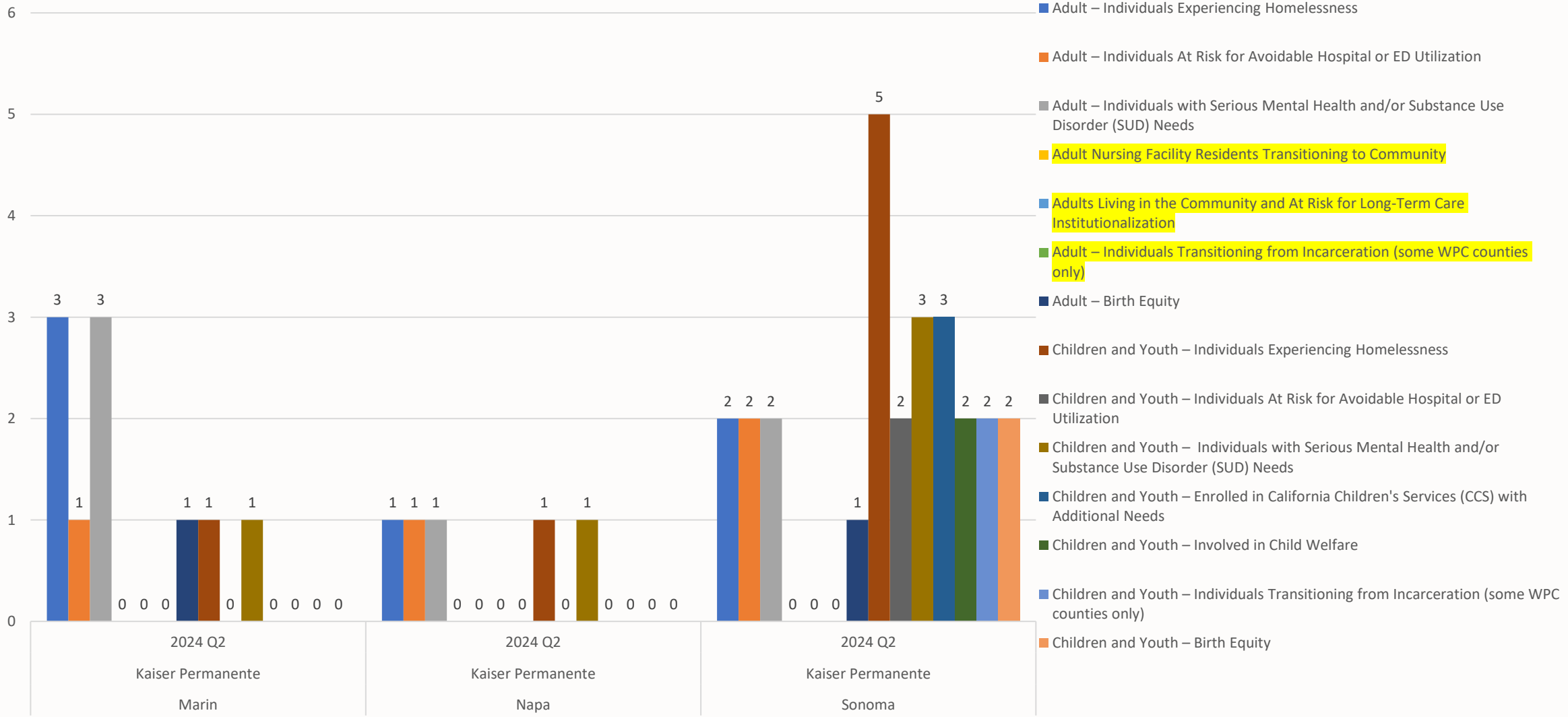
Southwest ECM Contracted Providers- Partnership Health Plan



- Adult – Individuals Experiencing Homelessness
- Adult – Individuals At Risk for Avoidable Hospital or ED Utilization
- Adult – Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Adult Nursing Facility Residents Transitioning to Community
- Adults Living in the Community and At Risk for Long-Term Care Institutionalization
- Adult – Individuals Transitioning from Incarceration (some WPC counties only)
- Adult – Birth Equity
- Children and Youth – Individuals Experiencing Homelessness
- Children and Youth – Individuals At Risk for Avoidable Hospital or ED Utilization
- Children and Youth – Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Children and Youth – Enrolled in California Children's Services (CCS) with Additional Needs
- Children and Youth – Involved in Child Welfare
- Children and Youth – Individuals Transitioning from Incarceration (some WPC counties only)
- Children and Youth – Birth Equity

Data Source: [DHCS ECM and Community Supports Quarterly Implementation Report]

Southwest ECM Contracted Providers - Kaiser Permanente



Population Health Innovation Lab (PHIL) PATH CPI Enhanced Care Management (ECM) and Community Supports Contracted Providers List

Northwest PATH CPI Collaborative: Del Norte, Humboldt, and

Southwest PATH CPI Collaborative: Lake, Marin, Mendocino, Napa, and Sonoma

Click here for a "live" link

Discussion Questions:

- How do you approach referrals for children and youth ECM services in your County?
- Are there gaps or barriers to quality or equitable access to care?
- What strategies or partnerships could help strengthen the provider network and improve ECM access for children and youth?

Regional and County-Specific Data for Community Supports

…Additionally, efforts will aim to **increase overall Medi-Cal member utilization of Community Supports to at least 1%** during the same timeframe.

Southwest Community Support Utilization by County-Partnership

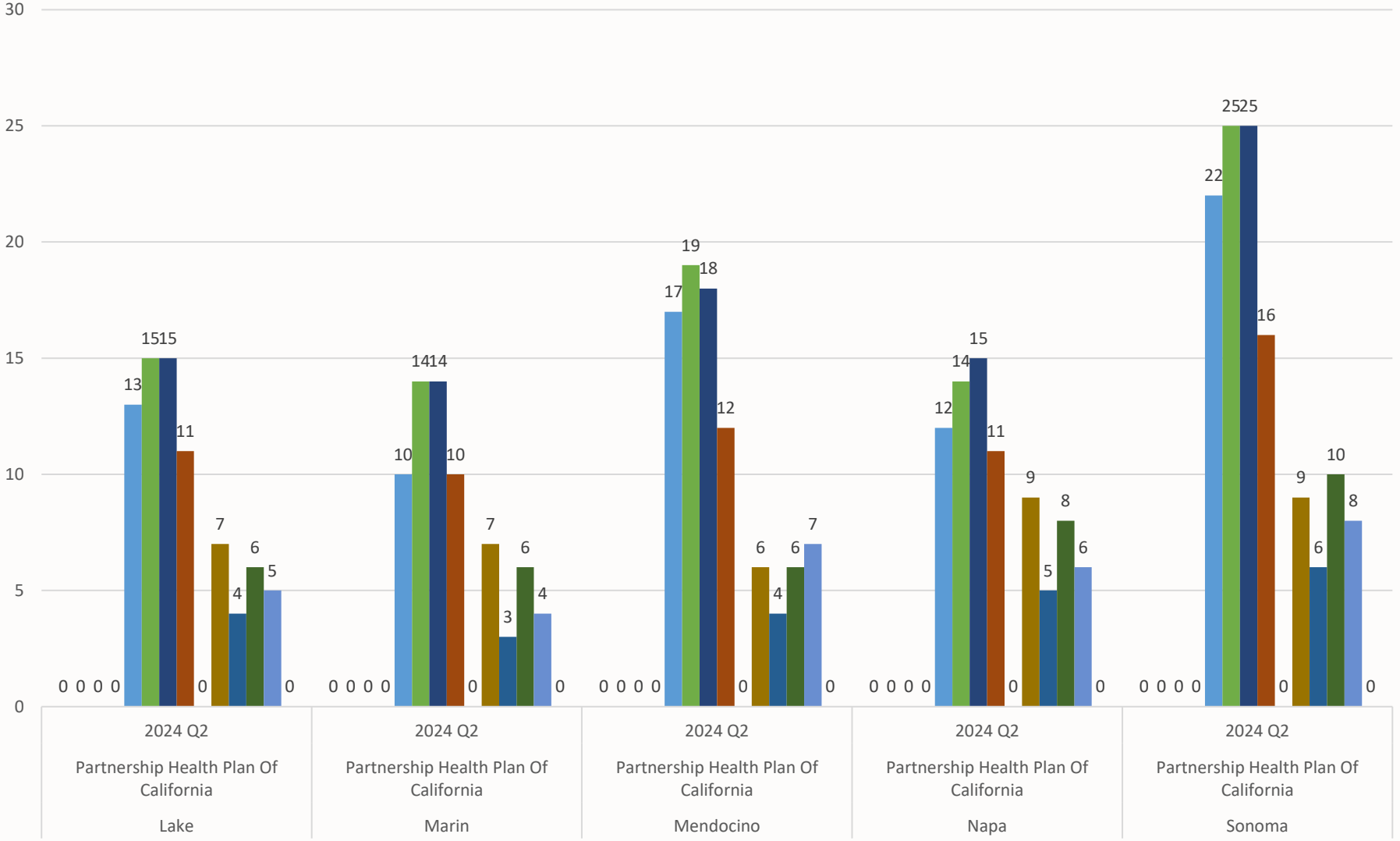
County	MCP	Last Date In the Reporting Period	Number of Community Support Services Offered	Average MCP Members in the Last 12 Months of the Reporting Period	Number of Members Who Utilized Community Supports in the Last 12 Months of the Reporting Period	Utilization Rate
Lake	Partnership Health Plan of California	6/30/24	8	35011	587	1.68%
Marin	Partnership Health Plan of California	6/30/24	8	49191	412	0.84%
Mendocino	Partnership Health Plan of California	6/30/24	8	41552	177	0.43%
Napa	Partnership Health Plan of California	6/30/24	8	31233	268	0.86%
Sonoma	Partnership Health Plan of California	6/30/24	8	121375	1108	0.91%

Data Source: DHCS ECM and Community Supports Quarterly Implementation Report

Southwest Community Support Utilization by-Kaiser

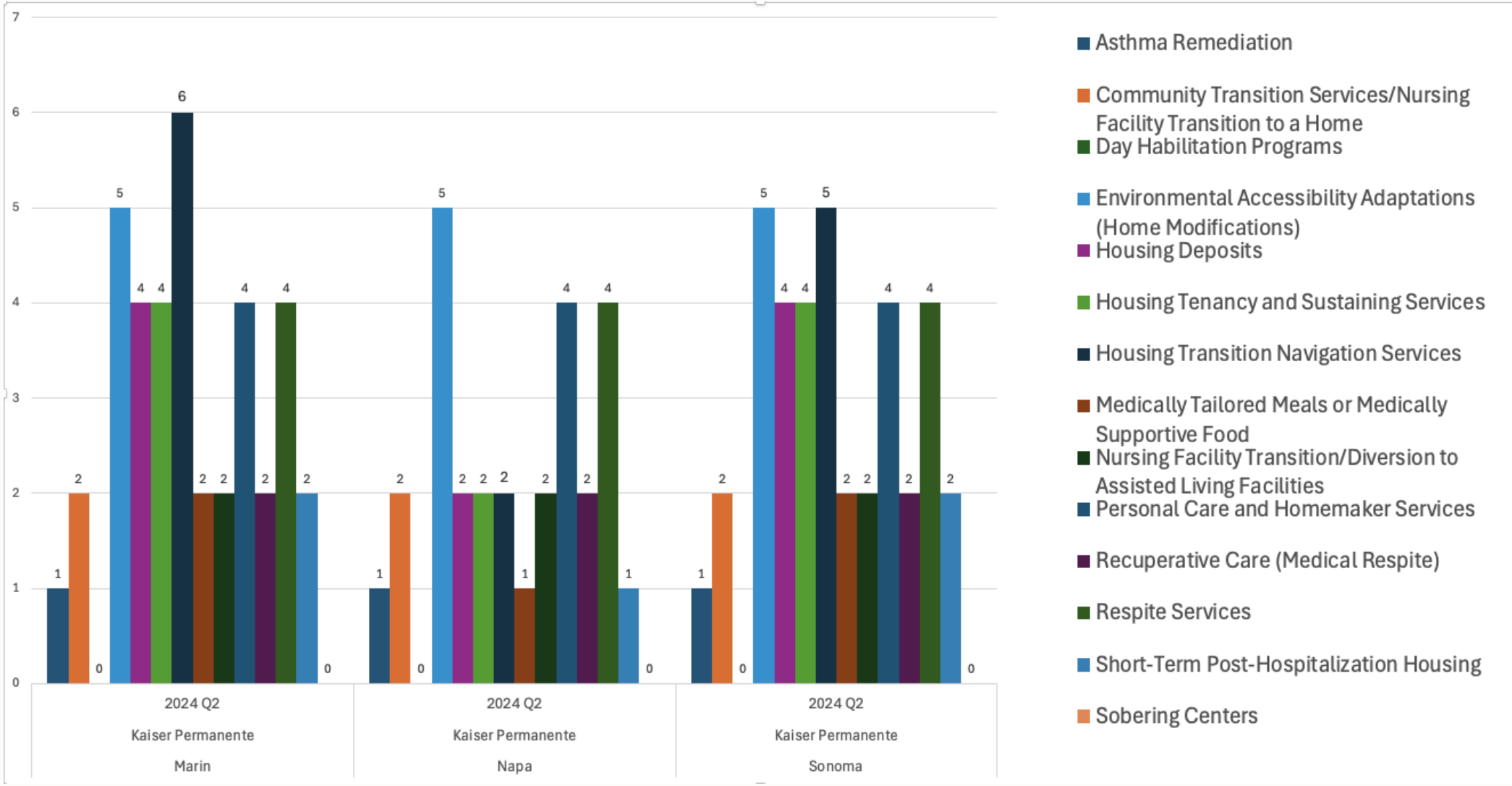
County	MCP	Last Date In the Reporting Period	Number of Community Support Services Offered	Average MCP Members in the Last 12 Months of the Reporting Period	Number of Members Who Utilized Community Supports in the Last 12 Months of the Reporting Period	Utilization Rate
Marin	Kaiser Permanente	6/30/24	11	3597	25	0.70%
Napa	Kaiser Permanente	6/30/24	11	3855	0	0.00%
Sonoma	Kaiser Permanente	6/30/24	11	12737	34	0.27%

Southwest Community Supports Contracted Providers-Partnership



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

Southwest Community Supports Contracted Providers-Kaiser



Discussion Questions:

- How would you assess the adequacy of the Community Supports provider network to meet community needs?
- How might we measure quality within Community Support networks?
- How can we help measure and assure robust and equitable networks of care?

Next Steps

- **Partner Engagement:** Share insights with CPI participants to drive collaborative problem-solving and readiness advancement.
- **Integrate Data into Workplan:** ECM and Community Supports utilization goals have informed change ideas and implementation activities.
- **Targeted Strategies:** Use county-level data to identify gaps and strategies.
- **Performance Monitoring:** Assess progress toward the utilization goals.
- **Reporting to PCG and DHCS:** Use data to demonstrate impact and inform continuous improvement strategies.

Aim Statement

The Southwest PATH Collaborative Planning and Implementation (CPI) initiative's aim for 2025 is to enhance the quality and equity of CalAIM Enhanced Care Management (ECM) and Community Supports by facilitating CPI participant advancement along the Readiness Roadmap.
This will focus on increasing **Medi-Cal member ECM utilization to at least 1% for children and at least 2% for adults** by December 31, 2025. Additionally, efforts will aim to increase overall **Medi-Cal member utilization of Community Supports to at least 1%** during the same timeframe. *The initiative will prioritize addressing service gaps, improving access, and ensuring quality care for target populations.*

Primary Drivers

- Increase knowledge about CalAIM eligibility requirements to improve enrollment and understanding.
- Overcome barriers to community-based referrals.
- Ensure equitable/robust provider networks for each ECM PoF and Community Support.
- Increase awareness of ECM and Community Supports among Medi-Cal members to enhance utilization.
- Strengthen data sharing among CalAIM providers to improve care coordination.

Examples of Change Ideas

- Showcase successful enrollment of children and youth into ECM services.
- Facilitate workgroups on best practices and challenges in referral processes.
- Conduct outreach and technical assistance for Tribal entities.
- Host regional forums to share lessons learned and enhance market awareness.
- Share success stories on data exchange best practices.

Southwest PATH CPI March Convening

The Population Health Innovation Lab invites you to join us in-person for the Southwest PATH CPI Collaborative convening. This event brings together Enhanced Care Management (ECM) and Community Supports providers from **Lake, Marin, Mendocino, Napa, and Sonoma Counties** to discuss all things CalAIM.

Thursday, March 20, 2025
11:00 am - 2:00 pm PDT
Sebastopol Center For the Arts
282 S High St, Sebastopol, CA 95472

Scan to Register

Lunch and light refreshments will be served.

PATH CPI helps local organizations—CBOs, hospitals, county agencies, and tribes—build capacity and infrastructure to deliver ECM and Community Supports. For more information, visit the CPI page or contact the PHIL team at path@pophealthinnovationlab.org.

POPULATION HEALTH INNOVATION LAB
A Program of the PUBLIC HEALTH INSTITUTE

CalAIM Updates and Announcements

Federal Approvals to Transform Behavioral Health Care in Medi-Cal

The Department of Health Care Services (DHCS) received approval from the Centers for Medicare & Medicaid Services (CMS) for the BH-CONNECT initiative.

As part of the BH-CONNECT Section 1115 approval, **CMS also approved Transitional Rent** services to ensure members going through vulnerable periods are stabilized, reducing their risk of returning to institutional care or experiencing homelessness.

Transitional Rent Implementation Timeline

Key Dates	Original Timeline	Revised Timeline
January 1, 2025	MCP optional go-live 1	

July 1, 2025	MCP optional go-live 2	**Optional go-live for MCPs on 7/1/2025**
		• MCPs going live 7/1/2025 can choose to go live for:
		  • The BH population of focus that must go live 1/1/26, **and/or**
		  • Additional populations within Transitional Rent-eligible population
		- If choosing this option, must continue offering to this population

January 1, 2026	**Mandatory launch for all MCPs**	**Phase1: Mandatory launch for all MCPs to cover Transitional Rent *for BH Populations of Focus*** • **MCPs may also choose to** cover additional populations within the overall Transitional Rent-eligible populations
July 1, 2026 (Behavioral Health Services Act go-live)		
January 1, 2027		**Future phase-in of additional populations TBD**

Bridge from Transitional Rent to BHSA Housing Interventions

Transitional Rent can serve as a bridge to long-term housing for members living with significant BH needs, such as through connections to BHSA Housing Interventions.

Bridging Transitional Rent and BHSA Housing Interventions

- **DHCS recognizes that county BH is a critical access point for Transitional Rent for members living with significant BH needs** (i.e., many members within the Transitional Rent BH population of focus).
- **DHCS expects MCPs and county BH will collaborate** to ensure that members living with significant BH needs are smoothly transitioned from Transitional Rent to BHSA-funded services.
- **DHCS will release streamlined authorization procedures and referral processes** to support MCP coordination with county BH.

Overview of BHSA Housing Interventions

- Delivered via county BH effective 7/1/26
- Interventions available to both BHSA-eligible Medi-Cal members (as long as not supplanting a Medi-Cal service) and non-Medi-Cal individuals
- Counties will receive funding for *Housing Interventions* which aim to place and sustain individuals living with significant BH needs in permanent housing settings
- Housing Interventions include, but are not limited to, rental subsidies, operating subsidies, landlord outreach and mitigation funds, participant assistance funds, and capital development funding

Timeline for Stakeholder Engagement and Final Guidance for Transitional Rent prior to July 1, 2025

DHCS will conduct continuous stakeholder engagement to inform final policy design, which will be released in April.

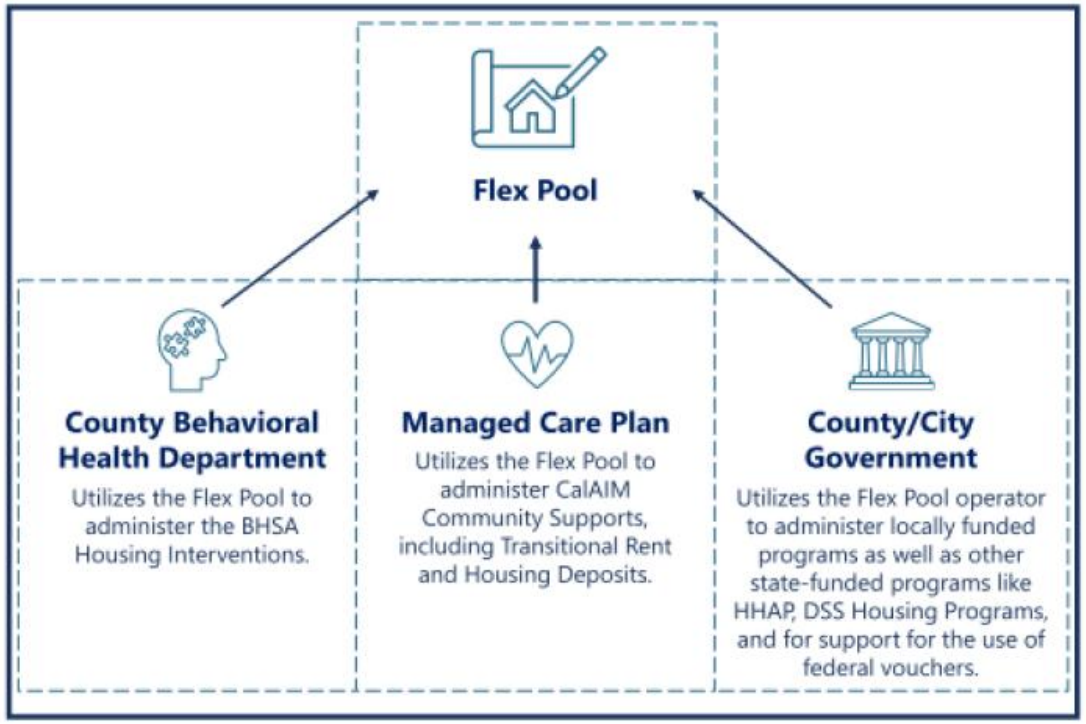
- **Model of Care (MOC):** DHCS will release the MOC template in February for MCPs that are deciding to opt-in to provide Transitional Rent in July 2025.
- **Final Transitional Rent Guidance:** DHCS will release the final Transitional Rent guidance in April.
- **Stakeholder Engagement:** DHCS will continue to routinely engage with MCPs, counties, housing providers, and associations to discuss and solicit feedback on Transitional Rent service design.

Flexible Housing Subsidy Pools

DHCS released a **TA Resource Paper and Toolkit** linked here. This purpose of this resource is start creating opportunities for the creation of local "Flex Pools" in CA by:

- Defining what a Flexible Housing Subsidy Pool is;
- Describing the key functions;
- Describing the benefits and components;
- Providing information about the roles and responsibilities for different partnering organizations.

Transitional Rent and BHSA Housing Interventions are part of a successful Flex Pool.



More information is available at the [DHCS Housing for Health website]

Questions can be submitted to [flexpools@DHCS.ca.gov]

Flexible Housing Subsidy Pools

Receive TA via the Flex Pool Academy

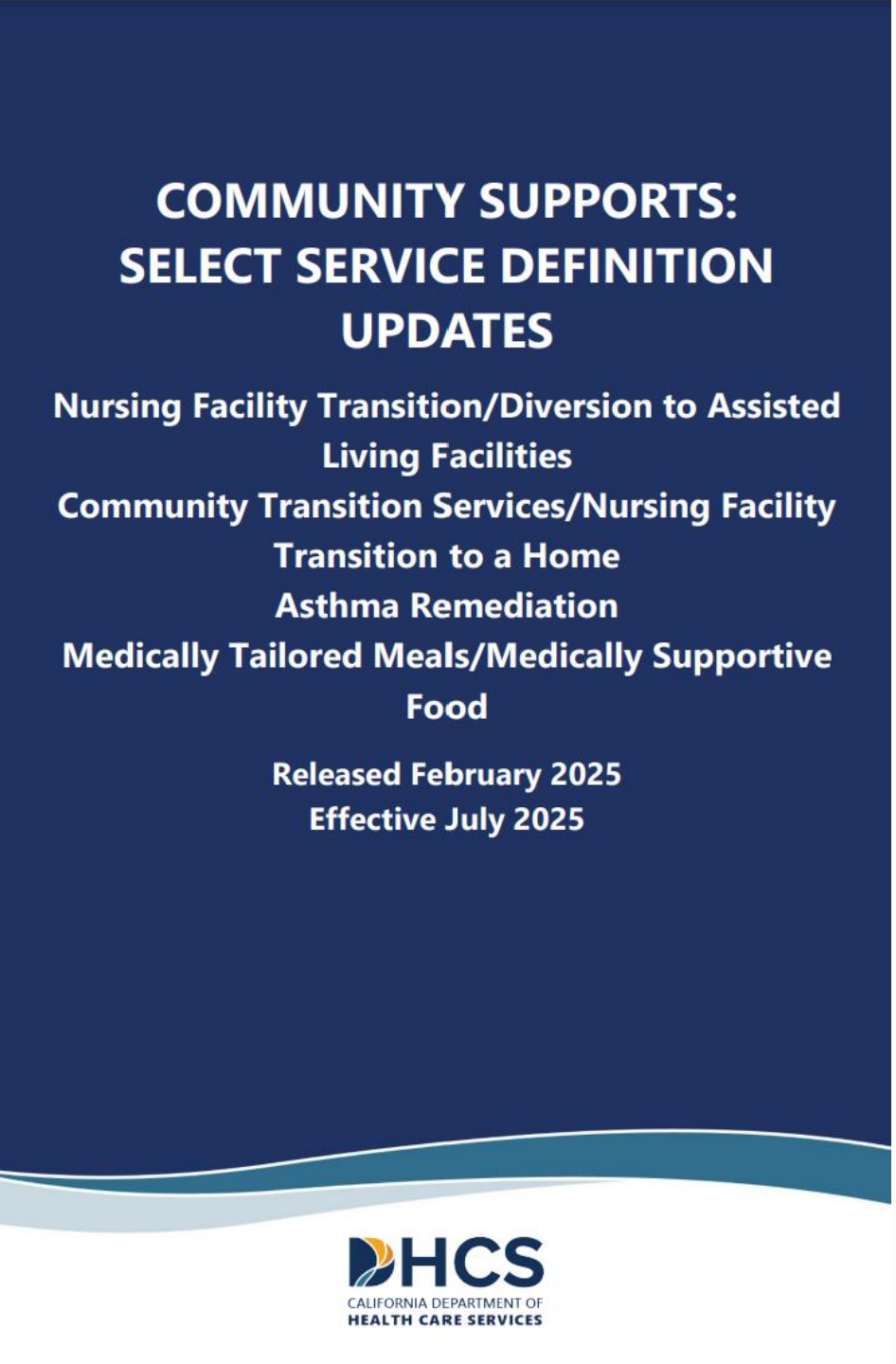
Interested organizations can apply to receive tailored coaching through the Flex Pool Academy.

Who should apply?

- Any organization interested in **serving as the Flex Pool Lead Entity** in their community, such as:
  - County departments
  - MCPs
  - CoC lead agencies
- Interested organizations should have **identified potential partners** to support the Flex Pool model (e.g., Lead Entity, funders)

What support will be provided?

- Each organization, and their partners, selected for TA via the Flex Pool Academy will receive tailored TA, which may include:
  - Support to host a **local community kickoff** for visioning and relationship building
  - Ongoing support through **personal coaching sessions with the Flex Pool faculty** to facilitate local progress
  - **DHCS-hosted community convenings** to build relationships and learnings within and across communities



Community Supports Service Definition

The newly released memo is linked here and provides the background, overview, and rationale of the refinements with accompanying, updated service definitions for the following Community Supports:

- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Asthma Remediation
- Medically Tailored Meals/Medically Supportive Food

Questions can be submitted to CalAIMECMILOS@dhcs.ca.gov using the email subject line "Community Supports Service Definitions."

CITED Round 4 Application Deadline Now Open Through May 2, 2025

DHCS has decided to extend the Round 4 application deadline to 11:59 p.m. PST on May 2, 2025.

CITED Resources:

- CITED Round 4 Information Session Slides
- How to Make Your Grant Application Stronger Part 1 Slides
- How to Make Your Grant Application Stronger Part 2 Slides

Office Hours

Regional PATH CPI Office Hours hosted by PHIL:

Don't miss our upcoming Office Hours:

Getting Ready for 2025: PATH CITED Round 4

February 24 from 1:00 – 2:00 pm (Register here)

Statewide PATH CITED Office Hours hosted by PCG:

February 20 from 10:00 – 11:00 am (Register here)

February 27 from 10:00 – 11:00 am (Register here)

March 13 from 10:00 – 11:00 am (Register here)

PATH CPI Events

Our next CPI regional meeting is in-person!

Thursday, March 20th

11:00 – 2:00 PM

Sebastopol Center for the Arts

Sebastopol, Sonoma County

RSVP NOW!

Academy for Hospitals and Health Systems

- Hospital executives, leaders, and staff are invited to join HC² Strategies and Communities Lifting Communities for the **CalAIM Academy for Hospitals and Health Systems six-part webinar series, starting in February 2025.**
  - Background: This series will dive deeply into hospitals' opportunities and strategies with CalAIM, with a focus on practical tips, bright spots from the field, and connection with others.
  - See this flyer for more information and register now.

PHIL Events

- **Northern Aces Collaborative (NAC) February 2025 Champion Convening**
  - Virtual discussion on California's Youth Behavioral Health Ecosystem featuring:
    - Tehama County Department of Education
    - Butte County Office of Education
  - Tuesday, February 24 from 12:30 – 2:00 pm (Register here)
- **The PHIL Collective update**
  - Learn more about what PHIL is doing to support individuals and communities dedicated to improving health, well-being, and equity.
  - PHIL Up Your Cup Series starts March 5

Resources You Can Rely On

California Department of Public Health (CDPH) works to protect the public's health in the Golden State and helps shape positive health outcomes for individuals, families and communities.

Protect Yourself from Flu

Post-Event Evaluation

To continue improving our work as your CPI Facilitator, PHIL kindly asks that you complete the brief survey that pops up in a new tab at the close of the meeting. Your feedback ensures quality improvement and will inform planning and activities through the evolution of the collaborative.

https://bit.ly/4gOpivw

Thank You!

Feel free to contact our PATH CPI team

Kathryn Stewart
Director of Learning and Action
kastewart@phi.org

Tammy Chandler
PATH CPI Policy & Quality Improvement Manager
tchandler@phi.org

Zachary Ray
Consultant
zray@nativespiritconsulting.com

Jessica Sanchez
Program Associate II
jsanchez2@phi.org

Megan Kenney
Program Specialist
mkenney@phi.org

Stefani Hartsfield
Consultant
stefani@hartsfieldhealth.com

For general inquiries, please feel free to email path@pophealthinnovationlab.org


Thank you!