



# **Making CalAIM Work for Community Providers:**

Lessons and  
Strategies from  
California's  
First 5 Network

**FIRST 5** CENTER FOR  
CHILDREN'S POLICY

**BRIEF**

March 2026

# Executive Summary

## THE OPPORTUNITY: NEW MEDI-CAL BENEFITS FOR EARLY CHILDHOOD

California has created a historic opportunity to transform care for young children through two new Medi-Cal benefits that leverage trusted community organizations. The community health worker (CHW) services benefit (June 2022) provides Medi-Cal reimbursement for community health workers to deliver health education, navigation, advocacy support, and screening – preventative services addressing social determinants of health with broad eligibility criteria. The enhanced care management (ECM) benefit offers community-based, high-touch care coordination for populations with complex needs, including certain children (July 2023) and pregnant/postpartum individuals (January 2024).

Yet without addressing critical implementation barriers, California risks squandering this opportunity. Data from 2025 indicate only 1 percent of children under 21 have received CHW services. Meanwhile, children birth to five account for just 6 percent of ECM recipients even though they make up 26 percent of the under 21 Medi-Cal population.

If the state fails to remove barriers preventing trusted community providers from participating, hundreds of thousands of young children will miss out on preventative health support and care navigation. California will forgo millions in Medi-Cal revenue that could flow to community organizations and sustain critical early childhood services. And the state will undermine its own transformation goals of equitable, community-integrated care.

## FIRST 5 ENGAGEMENT AND PROGRESS

California has a unique asset to close this gap: First 5 county commissions, voter-mandated public agencies established by [Proposition 10](#) (1998) to support early childhood development. This network of 58 commissions has deep early childhood expertise, community connections, and established trust with families. The CHW and ECM benefits align directly with First 5 core investments, including home visiting, parenting education, and care coordination, and offer a pathway to braid Medi-Cal funds with First 5 Proposition 10 funds to expand reach and sustain services.

To date, eight First 5s have contracted with Medi-Cal managed care plans (MCPs) to deliver CHW and/or ECM services, with six more actively engaged in the contracting process. In this work, First 5s have identified four models for engagement:

- » **Direct Service Providers:** First 5 contracts with MCP and First 5 staff deliver services directly to families.
- » **Hubs:** First 5 contracts with MCP on behalf of community partners working directly with families.
- » **Administrative Partners:** First 5 supports partner organizations with administrative aspects of the partner's contract with the MCP.

- » **Champions:** First 5 provides strategic leadership to ensure early childhood providers participate in new benefits.

### CRITICAL BARRIERS REMAIN

Despite this progress, contracting with MCPs and beginning Medi-Cal billing has taken years for most First 5s. Several key barriers persist:

- » Policy guidance and requirements designed for clinical providers, not community organizations like First 5s.
- » Limited technical assistance available for capacity building, with existing resources via the Department of Health Care Services' (DHCS) [Providing Access and Transforming Health \(PATH\)](#) initiative sunseting after 2026.
- » Inconsistent MCP implementation approaches and readiness to support community partners with contracting.
- » Reimbursement rates inadequate to cover true cost of service delivery.
- » Substantial organizational change requirements to become a Medi-Cal provider including [HIPAA](#) compliance and new privacy/security infrastructure.
- » Federal policy uncertainty making organizations hesitant to invest without guaranteed sustainability.

### POLICY RECOMMENDATIONS

The experience of First 5s that have successfully become Medi-Cal providers reveals a clear path forward. Their multi-year journey, from initial conversations with MCPs to billing for services, demonstrates both the feasibility of community provider participation and the specific policy changes needed to enable it at scale. The following recommendations are grounded in First 5 implementation experience and address the barriers that prevent broader community provider engagement:

- 1. Standardize implementation across MCPs:** Create consistency in contracts, requirements, and expectations across MCPs statewide. Current flexibility has created confusion at the community level. Standardization will improve equitable access and reduce administrative burdens.
- 2. Sustain technical assistance:** Create ongoing TA infrastructure beyond PATH's 2026 sunset, including group-based learning cohorts modeled on the First 5 Medi-Cal Learning Community, accessible materials documenting field successes and challenges, and support that moves beyond time-limited 1:1 grants.

3. **Clarify hub roles:** DHCS recently published a Hub Toolkit to define hub roles, but it is written for healthcare and managed care audiences. Translate this guidance into accessible language for non-healthcare organizations that could serve as critical cross-sector hub partners.
4. **Increase CHW rates:** Raise base reimbursement to at least 87.5 percent of Medicare rates (\$53.35 per 30 minutes). Current rates are inadequate to cover true service costs, forcing organizations to blend and braid funding from other sources to sustain CHW services.
5. **Ensure dedicated community provider support staff:** Establish liaisons specific to community providers at DHCS and MCPs to triage questions and provide clear points of contact. Community providers face roadblocks navigating complex systems like enrolling as a Medi-Cal provider with the state.

First 5s and their community partners are not peripheral to Medi-Cal transformation – they are foundational to reaching California’s most vulnerable families. They bring cultural relevance, trust, community embeddedness, and the ability to bridge clinical systems to populations that have historically experienced barriers to healthcare access. Without their intentional involvement, there is a risk of rebuilding systems outside the trusted networks First 5s have cultivated for over two decades. DHCS must stay committed to supporting community organizations through this journey to fully realize Medi-Cal transformation goals for young children and families.



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Many thanks to the following organizations who contributed their time, expertise, and helpful insights:

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Over the last several years, California has taken major steps to transform the Medi-Cal program and strengthen its commitment to young children. Many of the state's efforts in this space are under the [California Advancing and Innovating Medi-Cal \(CalAIM\) initiative](#), a long-term plan to transform Medi-Cal into a more equitable, coordinated, and person-centered program. An important aspect of Medi-Cal transformation is a slate of recently added Medi-Cal benefits that leverage community-based providers, such as the [community health worker services \(CHW\) benefit](#) and the [enhanced care management \(ECM\) benefit](#).

[More than half](#) of California's children ages birth to five depend on Medi-Cal for their health coverage. Therefore, CalAIM, and the broader Medi-Cal transformation initiative, presents a powerful opportunity for organizations serving young children and their families.

The success of Medi-Cal transformation and implementation of new Medi-Cal benefits depends on the integration of trusted community partners as Medi-Cal providers. First 5s' expertise in early childhood development and child-serving county systems, their connections to families with young children, and their relationships and contracts with family-serving community organizations, make them a key implementation partner. The experiences of First 5s in this work provide critical information to state leaders and other community partners working towards this shared goal.

This brief highlights First 5s' journey to engage in new Medi-Cal benefits, outlines the critical barriers that remain for community providers in becoming Medi-Cal providers, and uplifts the advocacy needed to improve implementation.

#### **FIRST 5s: A VOTER-MANDATED, EARLY CHILDHOOD INFRASTRUCTURE IN CALIFORNIA**

In 1998, California voters passed Proposition 10, the "Children and Families Act of 1998" initiative. The act levies a tax on tobacco products to fund early childhood development programs. Eighty percent of these funds are allocated to the 58 First 5 county commissions, according to annual birth rates. As public agencies governed by county-appointed commissions, First 5s hold a distinctive position in California's early childhood landscape. This public infrastructure combines the accountability and cross-sector convening power of government with the flexibility and community-rootedness of local organizations, making First 5s uniquely positioned to bridge families, providers, and systems.

# First 5 Investments and the Alignment With New Medi-Cal Benefits



The CHW benefit was added to the Medi-Cal program in June 2022. The benefit offers Medi-Cal reimbursement for community health workers and other similar community providers to deliver health education, health navigation, screening and assessment, and individual support or advocacy services. The benefit focuses on preventative services to support addressing the social determinants of health needs of Medi-Cal members and has broad eligibility criteria.

The ECM benefit provides community-based, interdisciplinary, high-touch, and person-centered care coordination for members with complex health and social determinant of health needs. In July 2023, ECM went live for certain child populations of focus, and in January 2024 for the birth equity population of focus, aimed at supporting Black, American Indian and Alaska Native, and Pacific Islander pregnant and postpartum individuals.

## CHW and ECM Implementation Update

Despite the CHW benefit's broad eligibility criteria, as of May 2025, only one percent of children under the age of 21 who are eligible for Medi-Cal had received CHW services.<sup>1</sup> Similarly, in the first quarter of 2025, children ages birth to five accounted for only six percent of the total number of Medi-Cal members who had received ECM services, despite accounting for 26 percent of the under 21 Medi-Cal population. Although ECM's eligibility criteria are much narrower compared to the CHW benefit, stakeholders widely acknowledge the slow rollout of ECM for kids and that there is room for additional trusted community providers to become Medi-Cal providers.

<sup>1</sup> Data received from the Department of Health Care Services via email on 5/8/2025. Excludes FQHC and RHC providers.

There are three core services in particular that align closely with the CHW and ECM benefits: home visiting, parenting education programs, and care coordination.

**Figure 1. New Medi-Cal Benefit Details**

BENEFIT	ELIGIBILITY CRITERIA	PROVIDER DETAILS	SERVICES
<u>Community Health Worker Services</u>	Broad including members who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services	Community-based providers with shared lived experience and work experience and/or certification	Health education, health navigation, screening and assessment, individual support or advocacy
<u>Enhanced Care Management</u>	Medi-Cal members with complex health and social determinant of health needs as outlined in priority populations of focus	Community-based care managers	<ol style="list-style-type: none"> <li>1. Outreach and Engagement</li> <li>2. Comprehensive Assessment and Care Management Planning</li> <li>3. Enhanced Coordination of Care</li> <li>4. Health Promotion</li> <li>5. Comprehensive Transitional Care</li> <li>6. Member and Family Supports</li> <li>7. Coordination of and Referral to Community and Social Support Services</li> </ol>

While CHW and ECM do not fund specific programs like home visiting, much of First 5s' programming meets these benefits' requirements. Crucially, First 5s that bill Medi-Cal can braid these funds with Proposition 10 revenue to sustain investments during a period of declining tobacco tax revenue.

## First 5s as Essential Medi-Cal Implementation Partners

As public agencies, First 5s already partner, understand, and support early childhood providers in each county. All First 5s invest in or coordinate critical services, and some even provide them directly.

Given their long-standing leadership in early childhood systems and services, **First 5s represent a natural network to support Medi-Cal transformation.**

Their contributions include:

- » **Specialized early childhood expertise:** First 5s have dedicated infrastructure and staff who understand the unique developmental needs of young children and the importance of dyadic, evidence-based approaches that serve both the child and their caregivers.
- » **A whole-family perspective:** First 5s recognize that child health and well-being are inseparable from the health and stability of parents and caregivers.
- » **Cross-system leadership:** First 5s have deep relationships with local providers and leaders across health, early learning, family support, behavioral health, and other systems that serve young children and their families.
- » **Flexible operational models:** Some First 5s deliver services directly, while others work closely with subcontracted community partners. Both models provide pathways for supporting Medi-Cal transformation.
- » **The ability to strategically braid funding:** First 5s can leverage Proposition 10 dollars alongside Medi-Cal. For example, Proposition 10 funds can help fill gaps when Medi-Cal reimbursement rates do not fully cover the cost of delivering high-quality services.
- » **Public accountability and transparent governance:** As public agencies governed by county-appointed commissions, First 5s operate with built-in accountability mechanisms including public meetings, transparent budgeting, and rigorous financial oversight.

Together, these strengths position First 5s as critical partners in new benefit implementation and in ensuring that Medi-Cal transformation reaches young children and families effectively and equitably. Furthermore, without intentional First 5 involvement, CalAIM risks rebuilding systems outside the trusted networks these agencies have cultivated for over two decades.

#### A MEDI-CAL LEARNING COMMUNITY FOR FIRST 5S

To support First 5 network engagement in Medi-Cal transformation, the First 5 Center for Children's Policy (the Center) has provided technical assistance (TA) since 2021. In 2023, the Center formalized this body of work and launched the Medi-Cal Learning Community (MCLC). The MCLC was shaped to:

- » Build First 5 knowledge of Medi-Cal
- » Provide peer learning on Medi-Cal and partnering with Medi-Cal MCPs
- » Support local and regional partnerships with MCPs
- » Provide guidance on the organizational structures necessary to be a contracted partner with Medi-Cal MCPs for new Medi-Cal benefits

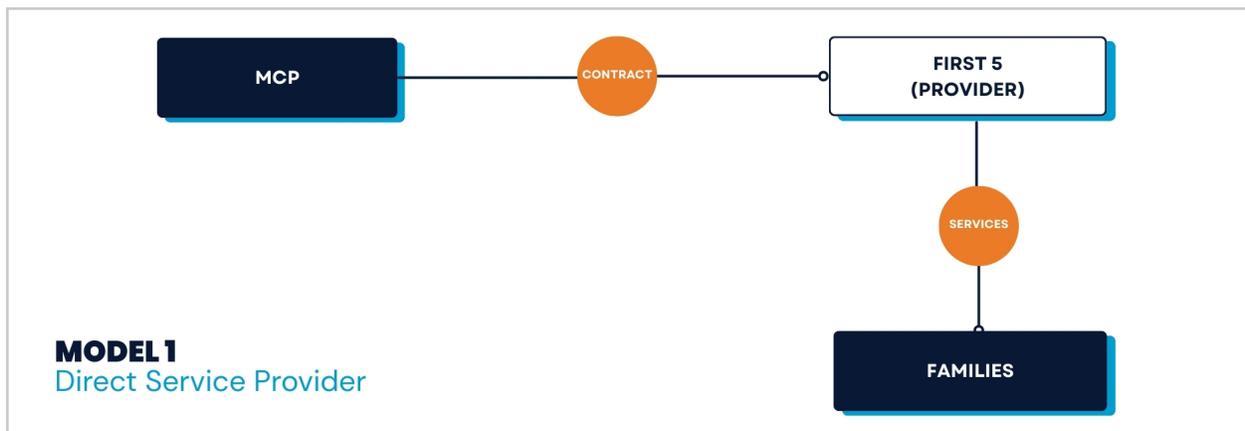
As part of this work, the Center has created feedback loops to key DHCS staff on questions the network has, resources communities need, or challenges First 5s are facing. The team supports counties in getting their implementation questions answered, while simultaneously promoting important policy changes based on First 5 experience.

# First 5s' Approach to Contracting with Medi-Cal MCPs

To date, eight First 5s are contracted with MCPs to deliver CHW and/or ECM services. Additionally, six more First 5s are actively in the process of contracting with their local MCPs and many more are exploring their role. There is not one way to engage in implementation work for CHW and ECM benefits. First 5s have assessed their capacity, leadership support, and local context to determine their best-fit role. Four main approaches have emerged:

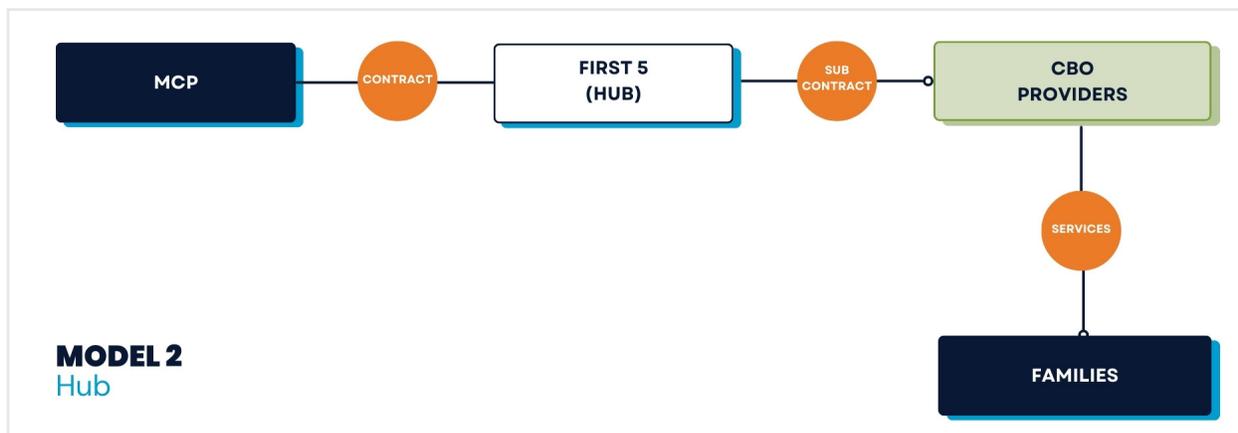
1. **Direct Service Providers** – First 5 employs staff that deliver services to children and/or families and contracts with local MCPs. This role is best suited for First 5s who are able to take on administrative, billing, and compliance responsibilities of becoming a Medi-Cal provider.

Figure 2. Model 1 – Direct Service Provider



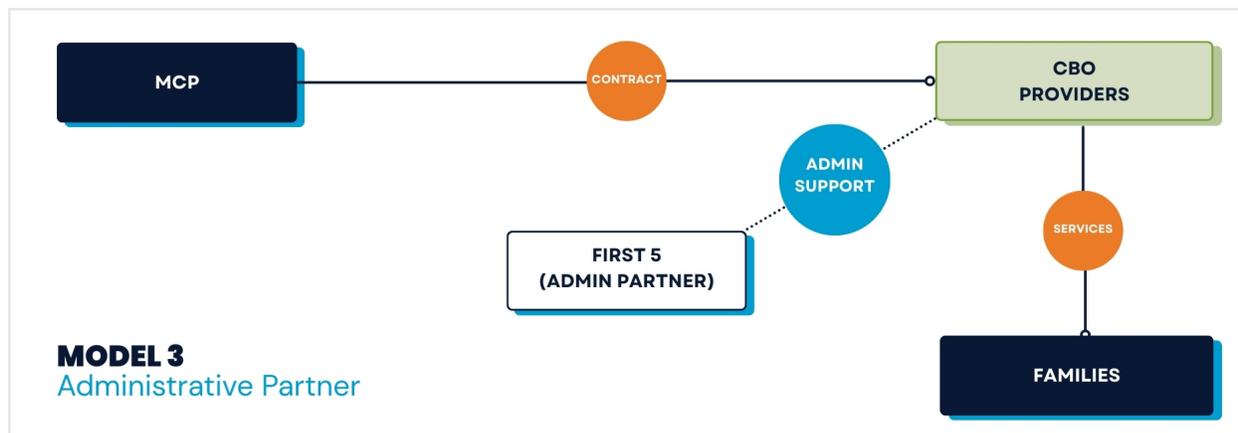
2. **Hubs** – First 5 contracts with their local MCPs on behalf of partners that deliver services directly to children and/or families. In this role, the First 5 directly holds the contract with the MCP and then subcontracts to their partners who are responsible for delivering services directly to children and their families. The First 5 operates as a hub and takes on administrative, billing, and compliance responsibilities on behalf of their direct service partners. As a hub, First 5s are able to facilitate connections between MCPs and their direct service partners who otherwise would be unable to take on the administrative burden of becoming contracted with the MCP themselves. Additionally, the hub model enables First 5s to braid funding for and oversee the administration of programs like home visiting that can leverage new benefits, but cannot be fully financed by them. This role makes sense when First 5s do not directly deliver services to families via First 5 staff.

Figure 3. Model 2 – Hub



- Administrative Partners** – First 5 operates as an administrative partner to direct service providers, assuming administrative responsibilities. In this role, the First 5 is not directly contracted with the MCP. Instead, the MCP is directly contracted with the organization providing services. Meanwhile, the First 5 holds a contract with the direct service provider, assuming administrative responsibilities such as provider training and licensing and claims support, much like a management services organization (MSO). This role makes sense for First 5s who cannot contract with the MCP directly, or in cases where an MCP is not working with hubs.

Figure 4. Model 3 – Administrative Partner



- Champions** – In this role, the First 5 does not hold a contract with either the MCP or direct service provider. First 5 provides strategic leadership, convenes partners, leverages contracts, and/or deploys funding to ensure trusted early childhood providers are included as Medi-Cal providers. This is either through the partners’ direct contracting with an MCP, or through the identification of a non-First 5 hub. This role makes sense for First 5s who cannot contract with the MCP directly/act as a hub, who notice a gap in early childhood CalAIM leadership, and who are interested in ensuring Medi-Cal is leveraged to scale and sustain aligned programs supported by First 5.

Figure 5. Model 4 - Champion



Many First 5s have leveraged grants from MCPs and the DHCS to support their efforts in this space. This includes [MCP Incentive Payment Program grants \(IPP\)](#) and DHCS Providing Access and Transforming Health ([PATH](#)) [initiative resources](#). Both of these funding sources were set up to support community providers to ready their organizations for Medi-Cal billing. First 5s have used these funds to become compliant with the Health Insurance Portability and Accountability Act (HIPAA), build new data systems, and hire staff to take on the new responsibilities of being a Medi-Cal provider.



# Examples: First 5 Roles in Medi-Cal Contracting

## FIRST 5 ALAMEDA – CHW DIRECT SERVICE PROVIDER

First 5 Alameda's transition to billing the Medi-Cal CHW benefit in late 2024 to sustain its [Help Me Grow \(HMG\) program](#) was the culmination of a multi-year partnership with MCP Alameda Alliance for Health (the Alliance) grounded in trust, shared leadership, and demonstrated quality impact. Historically, First 5 Alameda delivered HMG services with support from a \$1.5 million grant from the Alliance to support pediatric preventative care, care management, and quality improvement. In spring 2024, after several years of operating under grant funding, the Alliance communicated that future support for these services would shift to a reimbursement model under the CHW benefit.

In response, First 5 Alameda negotiated a six-month service contract to allow for continued service delivery while preparing for full Medi-Cal provider certification and reimbursement readiness. One of the most significant challenges First 5 Alameda faced while transitioning its HMG program from grant funding to Medi-Cal billing was having to navigate the rapidly evolving CalAIM landscape, marked by ongoing policy and implementation updates. Additionally, entering into a CHW contract with the Alliance presented a steep learning curve, as both parties were interpreting and adapting to new guidance in real time.

To manage this uncertainty and maintain momentum, First 5 Alameda and the Alliance established weekly coordination meetings to share updates, resolve operational issues, and align on implementation milestones. First 5 Alameda also attended informational webinars, consulted with peers from other First 5s, and participated in the First 5 Medi-Cal Learning Community and the Alameda CalAIM PATH Collaborative to support their capacity building efforts.

In FY24/25 First 5 Alameda served over 9,000 families through its Pediatric Care Coordination division, which includes HMG. Over 90 percent of children served were enrolled in Medi-Cal. Building on this experience, First 5 Alameda is exploring becoming an ECM provider. In November 2025, First 5 Alameda was awarded a \$1.1 million PATH CITED grant to support this goal. This funding will provide critical startup and infrastructure support.

## FIRST 5 HUMBOLDT– CHW AND ECM DIRECT SERVICE PROVIDER

In 2024, First 5 Humboldt signed a contract with MCP Partnership Health Plan to become a direct service provider for the ECM benefit. First 5 Humboldt plans to serve the birth equity and children with a history of involvement in child welfare services/programs populations

of focus through its ECM program. In addition to being an ECM provider, First 5 Humboldt is also exploring becoming a CHW provider to help stand up [Help Me Grow](#). To support their journey to become contracted for the CHW benefit, First 5 Humboldt received an IPP grant from Partnership Health Plan. They used this grant funding to support the creation of a new data system, develop interoperability between their existing data system and the Community Information Exchange, and hire a full-time staff person to launch their HMG program.

First 5 Humboldt credits part of their success in contracting with Partnership Health Plan to their focus on strategic relationship building. By building a strong relationship with Partnership Health Plan, they have been able to have critical conversations about the core services First 5 Humboldt delivers and areas where they are aligned. Additionally, First 5 Humboldt has been invited to attend Partnership Health Plan's quarterly quality improvement meetings. Although these meetings are not always relevant to First 5 Humboldt's work, they have learned from the challenges of other organizations and even served as a thought partner to the MCP's contracted partners.

#### FIRST 5 MARIN – ECM AND CHW DIRECT SERVICE PROVIDER

First 5 Marin is leveraging the ECM and CHW benefits to provide direct services through [Help Me Grow Marin \(HMGM\)](#). HMGM provides a central access point for information, support and resources on early child development to Marin County families, early childhood education providers, physicians, and community-based organizations. When families reach out to HMGM, they are connected to case coordinators and child development specialists who can respond to developmental or behavioral concerns or questions, provide information regarding typical developmental milestones, make referrals to community-based supports, assist and empower families to overcome barriers to services, and follow up to ensure that linkages are successful.

First 5 Marin began their journey to becoming contracted in 2022. In 2023, they signed a contract with MCP Partnership Health Plan to deliver ECM services and, most recently, became a CHW provider in 2025. To support their Medi-Cal contracting journey, First 5 Marin utilized IPP grant funding from Partnership Health Plan and a PATH CITED intergovernmental transfer grant for organizational capacity building activities. This included leveraging funds to develop a CHW training cohort in Marin County focused on serving children from prenatal to age five and their families. The first CHW cohort is comprised of 15 bilingual Spanish-speaking providers. First 5 Marin plans to grow the cohort over time.

As part of becoming contracted with Partnership Health Plan, First 5 Marin also partnered with [Aliados Health](#) to support with Medi-Cal billing. Through HMGM, First 5 Marin has been able to receive reimbursement for supporting families to navigate the various behavioral and developmental resources needed to support their child.

## FIRST 5 MERCED – CHAMPION

In January 2026, after identifying a need for local leadership to promote CalAIM implementation for young children and families, First 5 Merced launched an effort to identify a well-suited billing hub in the county for CHW and ECM benefits. The hub will provide capacity to smaller community organizations, including First 5 Merced funded partners, to engage with Medi-Cal and receive reimbursement for eligible services. First 5 Merced is part of the County of Merced health department and assessed that a third party with more flexible staffing and organization structures would be better suited to operate as a hub. As a trusted convener, First 5 Merced will catalyze progress for CalAIM in Merced and facilitate TA support for county and CBO partners.

## FIRST 5 MONTEREY – CHW AND ECM HUB

For two decades, First 5 Monterey has worked closely with its funded partners to develop a coordinated approach to delivering parent and child development services. Starting in 2022, First 5 Monterey began the journey to become a Medi-Cal provider to bill for ECM and CHW benefits. In this effort First 5 Monterey leveraged its coordinated approach, including its work as a centralized hub for the Monterey County [CalWORKs Home Visiting Program](#). This strategy allows them to leverage First 5 Proposition 10 funding for areas that Medi-Cal could not cover, provide oversight and support to CBOs who otherwise do not have in-house capacity to engage in Medi-Cal, and strategically lead efforts to focus services on families furthest from opportunities.

First 5 Monterey pursued all opportunities available to develop the infrastructure necessary to transition into a health care provider. In early 2023, they partnered with the County of Monterey to access PATH CITED Round 3 funds. These funds enabled them to hire key staff to begin the internal change process necessary to meet contract requirements as a health care provider. First 5 Monterey also engaged in four PATH TA projects and, in 2025, received IPP funds from the MCP Central California Alliance for Health (the Alliance). First 5 Monterey is now contracted with the Alliance to deliver ECM and CHW services. First 5 Monterey leads efforts and coordinates across three funded partners to manage the program, including credentialing, billing, referrals, training, and quality assurance and improvement.

First 5 Monterey is committed to working with partners at the speed of trust, which requires time, patience, listening, and authentic engagement. For that reason, they found that developing and implementing the hub model took longer than initially anticipated. This allowed for mindful engagement as First 5 Monterey and partners underwent significant changes to internal infrastructure and processes to meet Medi-Cal requirements. Another key insight First 5 Monterey gleaned from this process is that billing ECM and CHW services is only a supplemental source of funding. It will not fully fund the quality services being provided as not all parts of the work are reimbursable under those benefits. First 5 Monterey

is excited about the promise of partnership with the Alliance and is committed to serving families in the early childhood period.

### FIRST 5 ORANGE COUNTY – CHW AND ECM HUB

First 5 Orange County serves as both a direct service provider and supervising provider for the CHW benefit. In 2024, First 5 Orange County was accepted into MCP CalOptima’s CHW capacity building academy (an IPP grant opportunity). The academy supports organizations looking to deliver CHW services by training staff to partner with an MCP and preparing organizations to hold a Medi-Cal contract. By the summer of 2026, First 5 Orange County will have supported the training of 19 CHWs throughout their prenatal-to-three network. CHWs trained through the CHW academy have gone on to lead prenatal classes and developmental playgroups for families with new babies. Additionally, the academy has enabled the CHW trained resident leaders within [First 5 Orange County’s Engaged Neighborhood Initiative](#) to expand their service delivery to families, and in 2025, First 5 Orange County expanded its internal staffing to include a perinatal CHW staff member who triages and assists families with navigation and access to resources postnatally.

First 5 Orange County is also planning to leverage CHW and ECM benefits to support its home visiting program. [Strong Start Index](#) data show that many more families would benefit from home visiting than current funding supports. First 5 Orange County is using the expanded Medi-Cal benefits to reach these families. By blending and braiding existing funding with Medi-Cal revenue, First 5 Orange County can continue supporting families in receiving trusted, culturally responsive services, even as Proposition 10 revenue gradually declines. First 5 Orange County’s role as a hub and direct service provider has been critical to the success of this partnership by taking on oversight of contractual obligations, relieving administrative burden, and creating streamlined workflows. This partnership has led to improved care coordination for families.

In addition to delivering CHW services and operating as a CHW supervising provider, First 5 Orange County is in the contracting stage with Full Circle Health Network, one of three network lead entities (NLE – or “hubs”) for Kaiser Permanente, to bill for ECM, CHW, and Community Support (another new Medi-Cal benefit under CalAIM) services.

### FIRST 5 YOLO – CHW AND ECM HUB

In 2022, First 5 Yolo began exploring becoming contracted with Partnership Health Plan to leverage the CHW benefit to support its [Welcome Baby: Road to Resilience \(Welcome Baby\)](#) program. Welcome Baby is a maternal/child health equity home visiting program that offers all Medi-Cal or uninsured birthing families the opportunity to receive physical health assessments, lactation consultation, mental health screenings, parenting information, and connections to community resources from two providers. First, a Welcome Baby Nurse Home Visitor makes a home visit within one to two weeks postpartum. Then, for those

families who are eligible for more intensive services, a community health worker provides longer-term home visiting services. Welcome Baby is supported by nine different medical systems across the county, with birthing hospitals serving as the entry point for families, creating a seamless transition to home visiting services.

First 5 Yolo began billing for the CHW benefit as a supervising provider for the Welcome Baby program in 2024. More recently, First 5 Yolo also received a contract with MCP Partnership Health Plan to serve as an ECM hub and continue supporting its Welcome Baby program for Medi-Cal members with more complex care needs. With PATH TA assistance, First 5 Yolo secured an IPP grant from Partnership Health Plan, which enabled them to hire fiscal support and project management staff to help develop internal processes and procedures for implementing their new contract with Partnership Health Plan for the CHW benefit.

As a supervising provider and hub, First 5 Yolo works closely with funded partners to take on the administrative, coordination, and billing responsibilities for its contracted community organization partners that deliver the Welcome Baby program. While the CHW and ECM benefits do not pay for the full cost of the Welcome Baby program, First 5 Yolo is actively billing the Medi-Cal CHW and ECM benefits as a way to braid funding to support their Welcome Baby program.



# Key Challenges Faced by First 5s and Other Community Partners

Despite measurable success, contracting with MCPs for new benefits has taken years for many First 5s, from initial conversations, to submitting the first claim for reimbursement. The journey requires organizational change management, leadership and board buy-in, readying internal systems, and contract negotiation.<sup>2</sup> Some of the key challenges First 5s encountered are:



**AMBIGUOUS POLICY GUIDANCE** – First 5s and community partners need clear guidance from the State and MCPs to implement new benefits, contract with managed care plans, and prepare their organizations for Medi-Cal participation. However, policy documents, such as contracts, are often written with clinical providers in mind and lack clarity for organizations like First 5s navigating these requirements for the first time. The high stakes of Medi-Cal compliance make First 5s understandably cautious. Without clear guidance, organizations cannot move forward confidently. For example, there is ongoing confusion about whether CHW and ECM services are considered “health services” for regulatory and operational purposes even though they are delivered by non-licensed providers. This ambiguity affects everything from how organizations structure their programs to which compliance frameworks apply, creating additional hesitation and complexity for community providers.



**REQUIREMENTS THAT DO NOT ALIGN WITH HOW COMMUNITY PROVIDERS OPERATE** – Many Medi-Cal credentialing and compliance requirements assume a traditional clinical setting and organizational structure. For example, requiring Social Security numbers from board members and management teams as part of the process to become a Medi-Cal provider creates significant barriers for community organizations. While these requirements are in place to combat Medicaid fraud, these requirements often do not account for the governance models and operational realities of community organizations.



**LIMITED ACCESS TO TECHNICAL ASSISTANCE** – First 5 experience demonstrates that organizations need sustained support to navigate the complex process of becoming a Medi-Cal provider. While the PATH CITED initiative and IPP grants have provided valuable assistance to First 5s, they are time-limited and ending. Without ongoing, accessible technical assistance infrastructure, community providers who are just starting to think about leveraging Medi-Cal will lack the support needed to successfully implement and sustain these new benefits.



**VARIABLE MCP READINESS TO SUPPORT COMMUNITY PARTNERS** – MCPs offer different levels of support to community organizations attempting to contract with them. Often no single MCP representative can answer all the questions that a community provider has as it moves along the internal readiness and contracting process. This can create an environment of unclear answers and implementation delays.



**INCONSISTENT APPROACHES ACROSS MCPS CREATING CONFUSION** – MCPs have adopted dramatically different strategies for working with community providers, creating confusion in the field. For example, Kaiser Permanente exclusively works through hub organizations, “lead care entities,” for ECM and CHW implementation, while Partnership Health Plan prefers direct contracts with frontline service providers. This lack of standardization forces organizations to develop entirely different approaches depending on which plan serves their community.



**LOW REIMBURSEMENT RATES RELATIVE TO ADMINISTRATIVE BURDEN** – CHW reimbursement rates in particular do not adequately cover the true cost of service delivery when accounting for the administrative requirements of Medi-Cal billing. With significant barriers to successful claims submission and payment, some providers are questioning whether the financial sustainability of these benefits justifies the effort required to participate.



**ISSUES WITH REFERRALS AND BILLING AFTER BECOMING CONTRACTED** – Community providers can face various issues after contracting. This includes billing issues (i.e.: learning how to correctly submit claims and having claims denied). First 5s also report challenges in getting well-suited referrals for their programs. For example, a teenager referred to an early childhood program.

**Beyond external barriers, First 5s looking to become Medi-Cal providers also had to navigate significant internal organizational changes.** These change management challenges require substantial investment in new infrastructure, expertise, and organizational culture shifts that many organizations are not equipped to undertake without support or a long-time horizon.



**SUCCESS DEPENDS ON ORGANIZATIONAL LEADERSHIP AND RISK TOLERANCE** – Becoming a medical provider requires some level of tolerance with “building the plane while flying it.” Executive directors and boards must see the opportunity through uncertainty, secure stakeholder buy-in and commit organizational resources to pilot Medi-Cal billing without exactly knowing how it is going to work for their programs or organization.



**UNCERTAINTY ABOUT THE FUTURE OF MEDI-CAL BENEFITS** – Community providers are hesitant to make significant investments in infrastructure, staffing, and systems changes when federal policy changes could alter or eliminate these benefits. Although DHCS has expressed commitment to the benefits, uncertainty makes it difficult for organizations when startup costs and administrative burdens of the work are substantial.



**LACK OF SPECIALIZED HEALTH CARE EXPERTISE ON STAFF** – Most community organizations do not have health policy experts or lawyers on staff who can review complex Medi-Cal provider agreements, interpret regulatory requirements, or navigate health care contracting. These specialized skills are essential for understanding contracts with MCPs, ensuring compliance with state and federal regulations, and advocating effectively when contract terms do not fit community provider models. Without this expertise, organizations must either hire expensive consultants or proceed with an incomplete understanding of their obligations and risks.



**INSUFFICIENT PRIVACY AND SECURITY INFRASTRUCTURE** – Becoming a Medi-Cal provider requires HIPAA compliance, which demands dedicated security and privacy infrastructure that most community organizations lack. Community organizations must implement technical safeguards (encrypted systems, secure data storage, access controls), administrative safeguards (policies, training, risk assessments), and physical safeguards (secure facilities, locked file storage) that represent significant operational and financial investments. Many organizations do not have IT staff, let alone staff with expertise in health information security, yet HIPAA violations can result in substantial penalties. Again, without this expertise, organizations must hire expensive consultants to support their internal readiness.



**ABSENCE OF HEALTH CARE-COMPLIANT ELECTRONIC HEALTH RECORDS** – Community organizations typically track their work using systems designed for social services, not health care. Becoming a Medi-Cal provider requires **electronic health record (EHR)** systems that meet health care standards, support claims billing, enable data exchange with MCPs, ensure HIPAA compliance, and document services according to Medi-Cal requirements. Transitioning to or implementing new EHR systems requires substantial financial investment, staff training, workflow redesign, and often painful transitions away from familiar systems. For smaller organizations, annual EHR costs can represent a significant percentage of their operating budget.

# Policy Opportunities

From the First 5 experience, there are clear opportunities to improve the process for other community providers and additional First 5s.

## 1. Standardize implementation of CalAIM Across MCPs

DHCS has provided MCPs with significant flexibility in how they implement various services and benefits. This has led to confusion at the community level. Streamlining implementation by creating greater standardization (contracts, expectations, requirements) across MCPs will improve equitable access, reduce administrative burdens, and ultimately save money for MCPs and the state.

## 2. Continued TA with a focus on community provider needs

With PATH sunsetting at the end of 2026, the state must rethink how it provides TA for community providers. If DHCS wants trusted, local community providers to join and stay as Medi-Cal providers, it must support their capacity to do so. Moving beyond 1:1 TA grants, DHCS should consider group-based learning opportunities focused on cohorts of new Medi-Cal providers – similar to the First 5 Medi-Cal Learning Community. Supplementing TA, DHCS should also develop accessible materials documenting successes, challenges, and questions from the field on implementation.

## 3. Continue to clarify the role of hubs

Local hubs are a critical catalyst to the success of new benefits, providing capacity to contract with MCPs and holding the administrative burdens of being a Medi-Cal provider for smaller community-based organizations whose services are Medi-Cal billable. DHCS recently published a [Hub Toolkit](#) to further define and clarify the role of hubs. However, the guidance is written for a health care and managed care audience in mind, full of complex and undefined technical terms (e.g., claims adjudication, Medical Loss Ratio (MLR), etc.) that are confusing for community providers new to Medi-Cal who lack staff with the necessary technical expertise to make sense of the guidance. For non-healthcare organizations that could serve as critical cross-sector hub partners, this healthcare-centric guidance may create more confusion than clarity and inadvertently discourage participation.

#### 4. Increase provider rates

The current reimbursement rate for CHW services is inadequate to sustain the true cost of providing services. While some organizations have successfully negotiated higher rates, many MCPs have been unwilling to pay more. This requires organizations to blend and braid funding from other sources to sustain their CHW services. Increasing the base reimbursement rate for CHW services to at least 87.5 percent of the Medicare rate, or \$53.35 per 30 minutes, would increase the financial viability of the benefit.

#### 5. Dedicated community provider support staff

Across both the local MCPs and DHCS, First 5s and other community providers face challenges navigating complex systems to bill Medi-Cal. Whether attempting to navigate the [Provider Application and Validation for Enrollment \(PAVE\) portal](#) or reviewing contracts, many community providers encounter roadblocks along the way with no clear resource or point of contact to support them. Having liaisons specific to community providers at both the local MCPs and DHCS to triage questions would work to foster an inclusive environment, lowering the barrier to entry for trusted community providers to leverage these new Medi-Cal benefits.

# Call to Action

First 5s and community providers occupy a critical position in our Medi-Cal service delivery infrastructure, especially in the implementation of the CHW and ECM benefits. They are essential bridges between clinical health systems and the communities they serve. They can also quickly pivot to address the unique needs and challenges their communities face in the current moment. They bring deep community embeddedness, cultural relevancy, and established relationships with populations that have historically experienced barriers to healthcare access.

The successful implementation of CalAIM's vision, and the broader Medi-Cal transformation, is **dependent on the ability of community providers to build capacity** and move through organizational change to begin billing for new Medi-Cal benefits.

This process takes time and the field is just starting to see success and collect lessons learned that can improve the process for MCPs, providers, and hubs, and improve care for children and their families. It is important that DHCS stay committed to community organizations on this journey to fully realize its goals.

