FIRST 5 CENTER FOR CHILDREN'S POLICY

MEDI-CAL LEARNING COMMUNITY

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# Medi-Cal Contracting Journey: Considerations and Learnings from the First 5 Network

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# Overview

Becoming a Medi-Cal provider requires deep organizational transformation. California's First 5 county commissions (First 5s) have been early leaders in this work, contracting with managed care plans (MCPs) to deliver new benefits such as community health worker (CHW) and enhanced care management (ECM) services.

This brief draws on First 5 experience to guide organizations navigating their own Medi-Cal contracting journey. Every organization's path will look different depending on its MCP, the benefit(s) it is contracting for, and its organizational structure, services, and staffing. Our aim is to demystify the process and offer practical support for what lies ahead.

# Understanding the Opportunity to Engage in Medi-Cal Transformation

As highlighted in our previous brief, "Making CalAIM Work for Community Providers: Lessons and Strategies from California's First 5 Network," the state has created a historic opportunity to transform how families with young children receive care through Medi-Cal. For community organizations already serving Medi-Cal members, new Medi-Cal benefits focused on community providers offer an opportunity to sustain funding for crucial programs or scale service delivery for families with young children.

### CALAIM AND NEW MEDI-CAL BENEFITS

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 fall 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 benefits that leverage community-based providers, such as the community health worker services (CHW) benefit and the enhanced care management (ECM) benefit. This brief focuses on CHW and ECM, as those are the primary benefits leveraged by First 5s.

The CHW benefit was added to the Medi-Cal program in July 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 ECM benefit provides community-based, interdisciplinary, high-touch, and person-centered care coordination for members with complex health and social determinants of health needs. ECM went live for certain child populations in July 2023, and in January 2024 for Black, American Indian and Alaska Native, and Pacific Islander pregnant and postpartum individuals.

Fundamentally, Medi-Cal is a health care program governed by rules and compliance expectations that flow from the federal government to the state. These expectations shape what California's Department of Health Care Services (DHCS) can and cannot do. They also shape the requirements that MCPs, and subsequently, Medi-Cal providers must comply with. Medi-Cal transformation offers a unique opportunity for community providers who have been on the periphery of the Medi-Cal program to now have a seat at the table.

For community organizations accustomed to grant funding, blending and braiding Medi-Cal dollars into their work asks everyone in the system (providers, MCPs, and members) to expand their understanding of what health care looks like. This brief focuses on community providers, but it is worth noting that MCPs and members are navigating this shift too. The path involves roadblocks but also offers an unprecedented opportunity for organizations to take part in expanding access to care for children and families. Organizations looking to take the next step towards becoming a Medi-Cal provider will have the benefit of learning from organizations that have navigated this process before them, leveraging these best practices to propel them forward as they embark on their Medi-Cal journey.

In the following four sections, we explore the key areas organizations may need to navigate on the path to becoming a Medi-Cal provider from change management and organizational readiness, to contracting, infrastructure building, and implementation.

# Part 1: Change Management and Organizational Readiness

Before embarking on this work, leaders must understand the fundamental nature of what engaging in Medi-Cal benefits and contracts means for their organization. The administrative, compliance, and operational demands of a Medi-Cal contract are substantially greater than typical grants or government contract requirements that many community organizations are used to. Across the First 5 network, organizational change management and fiscal planning have been identified as foundational components to ensure a smooth transition to becoming a Medi-Cal provider. Below are key considerations and questions organizations should ask, based on learnings from First 5s in this work:

### KEY THINGS TO CONSIDER:

By delivering Medi-Cal benefits, organizations and unlicensed providers become health care providers. The services delivered through the CHW and ECM benefits are considered health care services even if they are not delivered by licensed practitioners. This has implications for compliance, contracting, and operations. For instance, organizations must comply with HIPAA (Health Insurance Portability and Accountability Act).

MCP contracts carry non-negotiable state and federal requirements. The contracts community organizations are asked to sign are based on the Medi-Cal contracts DHCS holds with MCPs. This means much of the language is not negotiable, as it reflects state and federal requirements that flow down the contracting chain. Community organizations will encounter laws, terms, and compliance frameworks that may be entirely new to them.

Medi-Cal benefits pay for a set of services and will likely not cover the full cost of delivering programs. Unlike a grant, Medi-Cal contracting reimburses providers for specific, billable services delivered to eligible members. It is not flexible funding that can cover the full cost of running a program. This means expenses like staff supervision, provider transportation, and other operational costs may not be reimbursable, leaving organizations to identify separate funding sources to cover those gaps.

At the early stages of consideration, organizations should identify the appropriate members of their team who can develop an assessment of their organization's capacity and fit for becoming a Medi-Cal provider, as well as projections for return on investment before committing time and resources.

## KEY QUESTIONS ORGANIZATIONS SHOULD ASK INCLUDE:

- **What role can your organization play in Medi-Cal implementation?**[1] Depending on structure and staffing, an organization may take on different roles:
  - **Direct Service Provider:** Your organization is contracted directly with the MCP and employs its own staff to deliver direct services.
  - **Hub:** Your organization contracts directly with the MCP and subcontracts to partner organizations that deliver direct services. Critical caveat: not all MCPs support hub/delegation arrangements. This must be confirmed with the MCP before planning.

*Note: To learn more about Hub models, see Aurrera Health Group's report on Emerging Hub Models in Medi-Cal. Additionally, DHCS has published toolkits to support MCPs in integrating hubs into their provider networks.*

  - **Subcontractor:** Your organization, which delivers direct services, contracts with a hub organization that holds the contract directly with the MCP.
  - **Administrative Partner:** Your organization is not directly contracted with the MCP. Instead, the MCP is directly contracted with the organization providing services. Meanwhile, your organization has a contract or agreement with the direct service provider, under which it assumes administrative responsibilities such as provider training, billing, and other administrative functions.
  - **Champion:** Your organization provides strategic leadership, convenes partners, leverages contracts (such as the contracts First 5s have with grantees), and/or deploys other sources of funding to ensure trusted early childhood providers are included as Medi-Cal providers.
- **Is your local MCP enrolling new providers?**
  - MCPs are responsible for ensuring network adequacy to serve their members. MCPs have the authority to determine which providers they want to include in their network and whether they will accept new providers to serve a specific population of focus. Additionally, MCPs have the ability to decide how they will incorporate organizations looking to operate as a hub within their network. It will be important to establish a working relationship with your local MCP to discuss these topics and whether there is sufficient referral volume to make a contract viable. Increasingly, MCPs are creating community liaison positions to support engagement with local providers interested in delivering Medi-Cal services.
  - There is no one-size-fits-all method for connecting and building a relationship with an MCP, and depending on your local MCP, this process can vary significantly.



1. 1 For more detail see: Making CalAIM Work for Community Providers: Lessons and Strategies from California's First 5 Network

- **Is your organization's leadership supportive and aware of risks?**
    - Executive leadership and boards may need to commit organizational resources to a process that involves uncertainty, therefore, they should be engaged early given the complexity, financial risk, and compliance implications.
- **Does your organization have, or can it build, the needed staff capacity?**
    - Dedicated staff time at leadership levels will help move your organization through this process and develop infrastructure.
    - Most community organizations lack health policy experts and legal teams. This gap and the potential need for technical assistance and capacity building support require planning.
    - Organizations may need to hire staff to deliver direct services, handle billing and claims, and engage with a licensed provider to approve care plans where required. It is critical to assess current organizational capacity and staffing responsibilities to determine which staff can transition to new roles and where new staff might be needed.
- **Fiscal projection: What decision makes financial sense?**
    - Organizations can crosswalk the programs they offer with new Medi-Cal benefits to identify programs or services ripe for Medi-Cal engagement. Medi-Cal rates are set by the state and/or negotiated with MCPs. Often, the CHW and ECM benefits will not pay for the full cost of delivering a specific program. Fiscal mapping helps organizations compare the true cost of service delivery with potential reimbursement to determine whether Medi-Cal billing would be financially sustainable, result in a net loss, or be viable only at certain volumes.

## FISCAL MAPPING AND PLANNING

First 5s' experience demonstrates that CHW and ECM benefit reimbursements may not cover the full cost of program operation. Fiscal mapping has helped First 5s identify areas where they can braid funding. When thinking about fiscal planning, consider:

- Conducting a revenue projection using existing service data before entering contracting conversations.
- Modeling what braiding Medi-Cal reimbursements with other funding sources could look like at different billing volumes.
- Factoring in startup costs: staff time, consultants, new systems, insurance, and training. Costs are front-loaded, and revenues take time to materialize.
- Planning for the reality that billing cycles have a lag. Organizations need bridge funding or reserves to sustain operations while waiting for reimbursement.

Tools exist for projecting revenues based on existing service volumes. A basic revenue projection will help inform infrastructure planning decisions before contracting begins. The following resources may support your organization with fiscal mapping and planning:

- **CalAIM Budget Estimator Tool – Camden Coalition**
- **Braiding and Blending Funds to Support Community Health Improvement: A compendium of Resources and Examples – Trust for America's Health**

### TIPS

- Dedicate staff capacity specifically to infrastructure development.
- Engage leadership, governance bodies, and IT teams early.
- If planning to operate as a hub, involve funded partners in early dialogue. Identify their questions, concerns, and capacity before you commit on their behalf.
- For organizations early in their decision-making process, the Public Works Alliance and the California Children's Trust published a practical guide, **To CalAIM or Not to CalAIM?**, that walks through strategic fit, financial modeling, and contracting considerations.

# Part 2: Contracting

The contracting process can unfold in different ways depending on various factors, including the MCP, the Medi-Cal benefit, and the specific circumstances of the organization seeking a contract. However, there are a few key components of this process that all First 5s have had to navigate.

## PROVIDER ENROLLMENT AND CREDENTIALING

- **National Provider Identifier (NPI):** Every contracting organization must register with the federal government for an organizational NPI number. An NPI is a unique federal health care identifier used by MCPs to confirm the organization's standing. As part of the application, there are questions about the types of services the organization will provide. Personal information, including a Social Security number, may be required from the executive submitting the application.
- **MCP enrollment:** MCPs typically require enrollment to vet organizations for their provider network. Information requested includes existing insurance types and amounts (general liability, etc.), employer identification number (EIN), legal entity name, and other organizational identifiers.
- **Provider Application and Validation for Enrollment (PAVE):** State-level provider enrollment through DHCS's PAVE portal is required for providers who have a state-level enrollment pathway (or are required to enroll by their MCP). PAVE requires sensitive personal information from executives and all board members, which DHCS uses to screen for fraud, waste, and abuse.
- **Credentialing:** Although who is ultimately responsible for credentialing will depend on the specific contract details, credentialing is needed to vet the qualifications of frontline staff against DHCS requirements.

*Note: Contracting is a non-linear process. Organizations must obtain an NPI before submitting a PAVE application, but they can begin the overall contracting process by completing initial enrollment documentation with their MCP in parallel.*

## REVIEWING, NEGOTIATING, AND EXECUTING A CONTRACT

- MCP provider contracts include extensive references to health care laws that community organizations are unlikely to have encountered before and these laws have real compliance implications.
- The contract may refer to licensed provider requirements that may not apply to you. It may be possible to negotiate or strike these sections.

- Seek legal counsel for unfamiliar language or references to laws the organization does not know.
- Understand that MCPs often cannot change the language that flows down from their contracts with DHCS. Some terms are non-negotiable.
- Each MCP has its own policies and procedures for contracting with new providers. Some MCPs will only contract with new providers through hub organizations, while others prefer to only contract with direct service providers. It is important to be aware of these nuances, as they will directly impact how you move forward.

## CREATING POLICIES AND PROCEDURES

Organizations must have policies and procedures that outline how they will comply with MCP contract requirements. Some MCPs may require proof of policies and procedures. Policies and procedures may also be part of future audit or pre-audit processes. Areas to include:

- HIPAA compliance and privacy/security protocols
- Data entry, collection, and use for reporting and billing
- For hubs: policies that govern subcontractor compliance and alignment to MCP contract requirements

# Part 3: Infrastructure Building


The work of building the internal infrastructure to deliver and bill for Medi-Cal services may begin before contracting and continue alongside or after it. Some of the infrastructure needs analysis will occur as part of readiness and feasibility assessments. First 5s have learned that infrastructure building is not a one-time setup, but an ongoing organizational commitment to data systems, compliance, and staffing. This section covers the core infrastructure components necessary for service delivery and claims submission.

## HIPAA COMPLIANCE AND PRIVACY/SECURITY INFRASTRUCTURE

HIPAA is the federal law that governs the privacy and security of patients' health information, and compliance is required for any organization handling Medi-Cal member data. HIPAA compliance requires three categories of safeguards that may be new to community organizations:

- Technical safeguards: such as encrypted systems, secure data storage, and access controls
- Administrative safeguards: such as secure data policies, staff training, and risk assessments
- Physical safeguards: such as secure facilities, locked file storage

Specific requirements related to compliance include:

- Cyber insurance
- HIPAA-compliant authorizations
- Business Associates Agreements (BAAs) with any vendor who has access to Protected Health Information (PHI)
- Professional liability insurance

Some First 5s and community organizations work directly with managed service organizations (MSOs); however, many do not. For those who work with MSOs, it is important to involve them as they may have experience with HIPAA compliance. MSOs typically help partners configure security infrastructure, including virus protection, account access controls, and encryption.

It is important that community organizations lean on expert support, including health privacy and security experts and potentially legal expertise.

### ELECTRONIC HEALTH RECORDS (EHR)

Data used for Medi-Cal billing is considered PHI. The system used to collect and store PHI must meet health care security standards. Organizations may be able to use their existing data system, but adjustments will likely be necessary and there are implications for any partner who also uses your data system. Organizations may also adopt systems that are already built for medical billing. Whatever system is used, it must meet DHCS data requirements, support claims billing, enable data exchange with MCPs, ensure HIPAA compliance, and generate an audit trail that tracks edits to submitted billing data.

### BILLING

A Medi-Cal provider must submit claims to be reimbursed for services rendered. First 5s have learned that billing is a process, and that it looks different depending on organizational structure (direct provider vs. hub). Beyond a compliant EHR, organizations need a pathway for submitting and managing claims. One approach is generating a report from the EHR to send to a third-party biller or clearinghouse, which receives health and encounter data and submits claims to the MCP. Some platforms integrate case management documentation and billing directly, handling both functions in one system. Some managed service organizations also bundle the EHR and third-party billing as part of a broader administrative support offering. However, this model is typically available only to direct service providers, since hub organizations are expected to take the lead on administrative functions and oversight.

### BENEFIT-SPECIFIC INFRASTRUCTURE

Beyond the systems and processes that all Medi-Cal providers must build, the CHW and ECM benefits require specific clinical and administrative infrastructure that organizations must consider before contracting for these benefits. We recommend organizations review the CHW and ECM policy guides and provider manuals published by DHCS to gain a full understanding of the unique requirements for each benefit.

Below, we discuss two key considerations that apply to both benefits:

- **Care plans and the involvement of clinical staff:** Both the CHW and ECM benefits include care plan requirements, requiring organizations to build documentation workflows and staff capacity specifically to meet them. Under the CHW benefit, members who receive 12 or more units of service must have a care plan developed by a licensed practitioner that reflects their individual health and social needs and documents planned interventions and goals. For ECM, individualized care plans are required for all enrolled members and must be developed with "appropriate clinical oversight" and updated regularly. Organizations must identify and work with appropriate providers to fulfill this role, even if that person is not otherwise involved in direct service delivery.

- **Provider credentialing:** While the contracting section of this brief addresses organizational enrollment, individual provider credentialing requires its own dedicated infrastructure. For example, CHW and ECM frontline staff must meet qualification standards established by DHCS and confirmed through the MCP credentialing process. For CHW services, this typically includes documentation of training or certification, as well as relevant work or lived experience. The CHW certificate can be issued by any organization, so long as it covers the core competencies listed in the state plan and Medi-Cal policy. It is ultimately the responsibility of the MCP or supervising provider to determine if the CHW certificate fulfills the CHW policy requirements. It is critical for organizations to thoroughly vet whichever training provider they decide to use to ensure that all training requirements have been fulfilled in the case of an audit. For ECM, lead care managers must meet defined educational and experience requirements that vary by population of focus. Organizations must establish systems to track and maintain credentialing records for all staff delivering Medi-Cal services and build internal processes to identify and address gaps.

There is also MCP discretion in both of these areas, especially for ECM. For instance, DHCS does not have standardized requirements for clinical oversight for ECM care plans. MCPs determine whether the individual is qualified to assess and review the member's health status and to make recommendations regarding service needs. Therefore, close coordination with your MCP on these topics is critical.

To learn more about the DHCS requirements for each benefit, see the associated policy guides/provider manuals:

- Medi-Cal Provider Manual: Community Health Worker Preventive Services
- ECM Provider Toolkit

# Part 4: Implementation

First 5s and community organizations are in the early stages of billing for Medi-Cal services, and implementation lessons are still emerging. The guidance in this section reflects early experiences, and more research will be needed as this work expands across the state.

Organizations should enter implementation expecting a learning curve, even after contracts are signed and billing has started. Adaptation may be needed during early billing periods, as DHCS guidance for new benefits evolves alongside organizational processes. Common early challenges have included:

- **Claims and Billing:** Claims denials and billing errors can occur as staff learn submission requirements and documentation standards. For example, issues can arise from billing for clients who are not active Medi-Cal members, or from using codes that are no longer active.
- **Referrals:** Referrals do not automatically get made when the contract is executed. Organizations need to be proactive in reaching out to the MCP care managers and other community partners to receive referrals. First 5s have encountered referral mismatches, such as teenagers being referred to programs designed for young children.
- **Updates to Policy Guidance**: Ongoing policy updates require monitoring and internal communication.
- **Revenue Generation:** Revenue lag is common; billing income can take months to materialize after services are delivered. Financial planning should account for this revenue lag well in advance.

# Concluding Thoughts

The First 5 experience distilled in this brief offers practical grounding for organizations navigating this work. However, it is important to note that each contract, MCP, and organization is different. No guide can substitute for the judgment of leaders who know their own unique context. The field is learning, relationships between community organizations and MCPs are maturing, and advocates are actively working to reduce the barriers to the contracting journey.

The state and MCPs must keep investing in **the conditions** that make community provider participation in Medi-Cal viable. At the same time, community organizations must keep engaging, even when the path is unclear. First 5s and community-based organizations are not peripheral to CalAIM; they are central to its success, and the infrastructure they are building today will benefit the providers who follow.