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Center for Health Care Strategies

Braiding Medi-Cal Funds to Sustain Aging, Disability, Housing, and Behavioral Health Services

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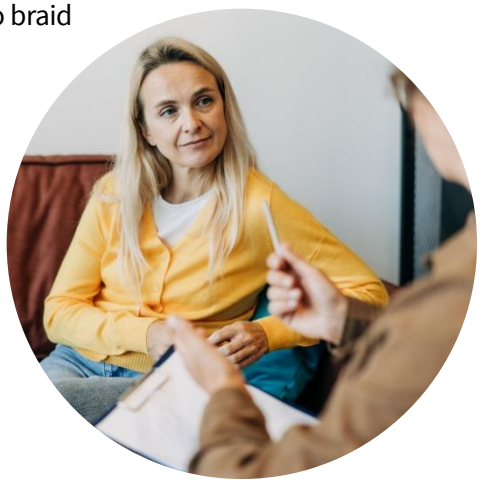
TAKEAWAYS

- Many social service and health care organizations in California are braiding Medi-Cal (Medicaid) and non-Medi-Cal funds to serve more people, offer more comprehensive and integrated services, and build financial stability.
- Organizations use different approaches to braiding based on their goals, funding requirements, and the needs of the people they serve.
- This brief features profiles of three organizations that have effectively braided different funding sources to better serve their clients.

Braided funding strategies can support health care and social service organizations to provide more comprehensive services and achieve greater financial stability. Braiding is defined as combining funds that originate from multiple sources and support a common goal, while carefully tracking each funding source to ensure adherence to all requirements. This is important with restricted funds, which can only be used for their designated purpose.

California's CalAIM initiative, particularly its Enhanced Care Management (ECM) and Community Supports, has expanded the types of services and organizations that are eligible for Medi-Cal reimbursement.[1,2] Health care and social service organizations that deliver ECM and Community Supports have new opportunities to braid these Medi-Cal funds with other funding sources they already use, including other Medi-Cal funds. Braiding can be an effective strategy for supporting Medi-Cal members with complex needs by enabling more integrated delivery of a wide range of services for people navigating multiple systems or experiencing fluctuating levels of acuity and need. However, organizations need to carefully design their braiding strategies to meet all funding and compliance requirements while ensuring that the approach advances goals for person-centered care delivery.



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With support from the California Health Care Foundation, the Center for Health Care Strategies (CHCS) interviewed health care and social service organizations to explore braiding strategies. The focus was on organizations serving people with complex needs — specifically those offering housing services, aging and disability services, and specialty behavioral health care. This brief builds on CHCS' 2024 publication, *Braiding Medicaid Funds to Support Person-Centered Care: Lessons from Medi-Cal*, that provided an overview of braiding and featured the approaches of three California organizations.[3] This brief profiles three organizations to explore the complexities of braiding an array of different funding sources. These organizations include:

1. **RH Community Builders**, a housing development/management company based in the Central Valley that provides access to affordable housing, supportive services, and community resources;
2. **Choice in Aging**, an adult day health care organization in northern California that serves people with disabilities and older adults; and
3. **Children's Institute**, an organization that offers an array of behavioral health, educational, and social services for children and adults in Los Angeles County.

Overview of Braiding Approaches and Terminology

Organizations use different braiding approaches based on their specific goals, the criteria of funding sources, and the underlying needs of the people they serve. Guidance from the California Department of Health Care Services (DHCS) states that new services cannot supplant services received by Medi-Cal members through other federal, state, or locally funded programs.[4] As a result, organizations that braid in the context of CalAIM's new services must avoid supplantation — defined as replacing an existing funding stream with a new one to provide the same service.[5] Instead, organizations may provide new services or use new funds to expand service delivery. The organizations featured in this brief apply different strategies to braiding that can be instructive for other organizations interested in leveraging CalAIM and Medi-Cal funding to enhance service delivery.

- **Braiding:** Braiding can take place at two levels: (1) at the level of services delivered to a client and; (2) at the level of funding for a staff member. Under the first level, clients may receive services at a specific point in time that are funded by a single source or by multiple sources. Under the second level, staff members who deliver services may be funded by a single source or by multiple sources. Organizations that fund a staff member with multiple sources, while having clients receive concurrent services funded by multiple sources, must meet the most stringent requirements for

documentation and tracking. Organizations may use different approaches depending on the requirements of specific funding. Exhibit 1 *(below)* illustrates the braiding strategy featured in this brief by each profiled organization, although each organization may employ different strategies for specific programs or populations.

Exhibit 1. Braiding Strategies Profiled in this Brief

	Single Funding Source per Client	Multiple Funding Sources per Client
Single Funding Source per Client-Facing Staff Member	*(Not braiding)*	**Children's Institute**
Multiple Funding Sources per Client-Facing Staff Member	**Choice in Aging**	**RH Community Builders**

- **Sequencing:** Some organizations apply multiple funding sources in a specific sequential order. Organizations often use this strategy to provide a continuum of services as a client's needs change. For example, an organization may provide step-down services after a person finishes more intensive services.
- **Stacking** or **Layering**: This strategy enables organizations to combine multiple funding streams to support a common goal, typically by using additional "layers" of funds that supplement a core funding source. For example, organizations may use this strategy to provide services to multiple family members.

In-depth examples of these strategies and their associated requirements can be found in the **organizational profiles** in this brief.

Rationales for Braiding

CalAIM created new opportunities to use Medi-Cal funding for the delivery of social services, and organizations can apply this funding toward the goals of serving more people, offering more comprehensive and integrated services, and strengthening the financial sustainability of services or staff. Organizations profiled in this brief cited a range of benefits to braiding:

- **Serve anyone who walks in the door.** Braiding funding helps community-based organizations meet the needs of anyone who walks through their doors, rather than only serving people who are eligible for services from a specific funding source. From the client perspective, braiding avoids the frustration of going through an extensive intake only to find out you are ineligible because of some very discrete eligibility criteria, or that you must disenroll from one program and enroll in another to continue getting what you need.
- **Provide a more comprehensive set of services.** Organizations can provide a more comprehensive set of services by braiding funding (including from Medi-Cal and other sources) to support more integrated care for clients. For example, clients with complex needs often go through a set of processes to receive service at one location (e.g., behavioral health) and another set of processes to receive other needed services at a different location (e.g., housing supports). From the client perspective, braiding makes it easier by bringing multiple funding sources/programs under one roof for "one-stop shopping" and seamless transitions between programs.
- **Extend services and coordinate seamless transitions.** Braiding may extend the length of services and help coordinate more seamless transitions for clients entering or leaving services. For example, even though short-term rental assistance supported by Medi-Cal is time-limited, the client could still receive assistance from the same organization supported by a different funder. To the client, the transition of funding would appear seamless with no disruption in service.
- **Address budget gaps and support organizational and programmatic financial sustainability**. Most organizations are not paid what it actually costs to provide a service(s) from any single funding source alone. Additionally, today's health and social service system relies heavily on government funding, making it vulnerable to disruptions from budget and policy shifts. Significant changes to federal funding, such as those introduced by the 2025 federal budget reconciliation law (H.R.1), have the potential to create substantial disruptions in care. Particularly in this environment, braiding is a key strategy for diversifying an organization's funding base. Braiding may also support greater financial sustainability for specific work that is challenging to fund by identifying multiple potential funding sources to maximize impact.

Braiding Challenges

Organizations must navigate challenges to effectively braid funds and ensure compliance with the requirements of each funding source.

- **Administrative complexity related to specific contracting requirements of different funding sources.** Different or conflicting contracting requirements from funders can make it particularly challenging to braid. Some organizations, for example, contract with multiple Medi-Cal managed care plans (MCPs) — each with different reimbursement structures, billing cycles, and reporting requirements. Program exit/graduation requirements can also frequently vary between county and MCP funders.
- **Lack of integrated tools that make braiding easy.** While organizations can leverage past experience and CalAIM provider infrastructure funding to navigate expansion into new services, infrastructure challenges remain — particularly those impacting interoperability, such as databases and reporting platforms that are not integrated across funders. This can be especially challenging when clients are enrolled in a program supported by one funding source, database, and reporting structure, then disenrolled and moved to another program with a different set of systems to meet their changing needs — only to be moved back to the original program when their situation changes. Tackling this challenge requires: in-depth staff knowledge of all programs, funding sources, databases, and reporting requirements; training when new staff, funding, or requirements are introduced; careful client assessment; close partnership and communication between program and finance staff; and accountability mechanisms/precise tracking to ensure proper billing.
- **Managed care authorization and payment policies can make braiding challenging for organizations that serve people experiencing homelessness.** Receiving an MCP per-member-per month (PMPM) capitated rate allows an organization to have stable, predictable revenue. The challenge, however, is that there is currently no clear or easy way to shift MCP authorizations for clients experiencing homelessness between two different organizations.

Profiles of Organizational Braiding Approaches

This section describes the braiding approaches of three California-based organizations that provide services for Medicaid enrollees and utilize braiding strategies to leverage Medi-Cal as well as non-Medi-Cal funding sources. The profiles offer lessons that can inform health and social care organizations interested in developing or refining braiding strategies.

1. RH Community Builders

The mission of RH Community Builders (RHCB), a for-profit housing development/management company based in the Central Valley of California, is to "end homelessness" by "providing access to affordable housing, supportive services, and community resources."[6] About five years ago, RHCB noticed an increasing trend among people experiencing homelessness in Fresno County. These individuals were moving in and out of shelters because their mental, behavioral, and/or physical health needs were greater than a traditional shelter could provide. Few shelters, for example, had on-site behavioral health services, and most had "independent of ADL (activities of daily living)" restrictions that prohibit someone who needs the assistance of a personal attendant (to bathe, toilet, dress) from participating.[7,8] Any single funding source, by itself, was not sufficient to address these unmet needs.

By braiding Behavioral Health Bridge Housing (BHBH) operational funding, specialty mental health services funding from the Fresno County Department of Behavioral Health (DBH), and Medi-Cal funding from Anthem Blue Cross and CalViva Health, RHCB successfully developed two short-term housing sites — Sierra Sunrise and Phoenix Landing — that provide low-barrier shelter and services to almost any Fresno County resident experiencing homelessness with a behavioral health disability. Residents at these sites receive a comprehensive set of services *(see Exhibit 2, next page)* that meet the unique needs of this population. In less than two years, 126 Sierra Sunrise and Phoenix Landing residents have already successfully transitioned from temporary bridge housing into stable, permanent housing.

Approach to Braiding Medi-Cal Funding: Multiple Funding Sources per Client and Staff Member

Sierra Sunrise and Phoenix Landing have a combined capacity of 180 beds. BHBH operational funding support 24/7 shelter services at the sites for all residents, and all residents have access to specialty mental health services and substance use disorder (SUD) treatment covered by county DBH funding. Additionally, if residents are a member of Anthem Blue Cross or CalViva Health Medi-Cal MCPs, they can access ECM

and two Community Supports: housing transition navigation and housing deposits. Other residents not eligible for ECM and Community Supports can receive case management and housing navigation services with support from county specialty mental health funders.

Exhibit 2. Summary of Profiled RHCB Services with Braided Funding

Program/Service	Contracted Entity and Funding Source
Temporary Shelter	Fresno County DBH (BHBH operational)
Specialty Mental Health: Care Coordination, Housing Navigation, and Peer Support Services	Fresno County DBH (Medi-Cal)
Enhanced Care Management	Anthem Blue Cross and CalViva Health MCPs (Medi-Cal)
Community Supports: Housing Transition Navigation, Housing Deposits	Anthem Blue Cross and CalViva Health MCPs (Medi-Cal)

Staffing

Instead of one staff person for 20 to 30 people, care teams made up of six service providers (a lead care manager, clinician, housing navigator, two certified peer support specialists, and a certified nursing assistant) serve 30 residents per care team to ensure higher touch, higher volume service capacity with a more specialized skillset.

Some project staff are billed exclusively to one funding source, depending upon the services that they provide. Peer support specialists, for example, are only billed to specialty mental health, and more auxiliary positions for shelter operations (such as janitors, maintenance staff, drivers) are only billed to BHBH operational funds. Most project staff, however, are funded through multiple sources, such as the project director position, which is billed at 67 percent to BHBH funding and at 33 percent to Medi-Cal (either through specialty mental health or CalAIM, depending on the eligibility and demographic makeup of the current residents).

Contracting and Reporting

RHCB has three contracts that support Sierra Sunrise and Phoenix Landing: (1) a cost reimbursement contract with the county that is inclusive of services funded through BHBH operational funds, and fee-for-service specialty mental health services funded by DBH; (2) a capitated, PMPM contract with Anthem Blue Cross for ECM and Community Supports for Anthem members; and (3) a capitated, PMPM contract with CalViva Health for ECM and Community Supports for CalViva members.

The level and type of documentation required for each funding source is different, and it would be complicated to train 74 staff on four different referral, documentation, care plan, and authorization requirements. All staff, therefore, are trained to meet the most stringent requirements for every resident in a particular area, which satisfies the other

funding requirements as well. All housing plans, for example, are created in accordance with CalAIM requirements for housing navigation services as those requirements are more stringent than DBH funding requirements for housing plans.

Front-line, resident-facing staff are not required to know the specific funding allocations for their position or where to bill for specific services. Braiding and determining what to bill to which funder is done by RHCB finance and leadership staff based on a number of factors, including eligibility codes and resident demographics. If the care team, for example, holds a care team meeting for a resident, they will document a case note in the electronic health record that is funding agnostic. RHCB finance and leadership staff cross-reference this information to determine where to bill time for that care team meeting, depending on the composition and topic of the meeting and the resident's eligibility criteria. If, for example, a client does not have an authorization for ECM and/or Community Supports or has ECM and/or Community Supports with another provider, RHCB will provide and bill for specialty mental health services case management.

For the BHBH funding, RHCB submits monthly invoices of expenses incurred to Fresno County and is reimbursed by the county. For the specialty mental health funding, an invoice is generated from the electronic health record based on the units of service provided. RHCB receives a PMPM payment from each MCP for every one of its enrolled members who receives ECM and/or Community Supports.

For BHBH and specialty mental health, RHCB submits monthly and quarterly reports to the county outlining operational and specialty mental health services provided and outcomes. RHCB also conducts an annual single audit to comply with county contract requirements that treat for-profit entities the same as nonprofit entities. MCPs routinely pull RHCB's utilization data rather than requiring RHCB to submit reports, and RHCB conducts extensive claims reconciliation activities.

Challenges and Next Frontier

One of the greatest challenges RHCB faces in braiding is what they refer to as the "attachment barrier" within CalAIM. An MCP, for example, may refer a member to an ECM provider and authorize them to receive 12 units of housing navigation services. The member may receive six units and then go "off grid." Three months later, they may show up at an RHCB shelter, but RHCB cannot get authorization from the MCP for additional units of housing navigation because an existing authorization is already open for a different ECM provider. RHCB then cannot bill for those services, which creates additional challenges because RHCB has already built assumptions into their county funding projections that assume a certain percentage of their residents (say 20 percent) will be CalAIM eligible. Twenty percent of the people RHCB serves may, in fact, be CalAIM eligible, but they are only able to bill CalAIM for 15 percent of them because of

this barrier. Not only does this result in a funding gap for RHCB, but it also creates unnecessary conflict among ECM and Community Supports providers as to who has "the billing rights" for a particular CalAIM enrollee.

Despite these challenges, RHCB attributes the success of Sierra Sunrise and Phoenix Landing to braiding and acknowledges it would be unable to provide the type of one-stop, low-barrier shelter and services for people experiencing homelessness with significant behavioral health needs without it. Because of braiding, for example, RHCB has a full-time driver who takes residents to the DMV or housing or medical appointments, which can make the difference in whether someone is permanently housed.

2. Choice in Aging

Choice in Aging is a nonprofit, intergenerational, adult day health care organization serving California's Contra Costa, Napa, Sacramento, and Solano counties with a wide range of programs that promote "independence of people with disabilities and frail older adults" and create "opportunities where people can learn, grow, and age independently with dignity in community."[9]

Since 2009, Choice in Aging has participated in DHCS' federally funded California Community Transitions (CCT) demonstration, providing institutional transition and case management for Medi-Cal members who live in skilled nursing facilities and wish to move into their own homes or other community settings with appropriate supports. As the demand for CCT services has increased, the need to braid has become more pronounced due to issues with CCT rates and eligibility restrictions.

Choice in Aging braids funding at the staff level from multiple sources — including CCT, Contra Costa County Measure X half-cent county sales tax and county Adult Protective Services (APS) case management, CalAIM ECM funding from Contra Costa Health Plan (CCHP), and Medi-Cal 1915(c) Multipurpose Senior Services Program (MSSP) funding. By doing so, the organization has expanded its institutional transition and case management services to serve nearly any older or disabled adult in Contra Costa County who wants to move out of an institutional setting or needs help coordinating their services across delivery systems. Exhibit 3 *(next page)* lists the funding sources for the Choice in Aging services profiled in this brief. Braiding these funds also allowed Choice in Aging to provide additional services not covered by CCT and extend the length of services after CCT funding ends. With these resources, to date, Choice in Aging has successfully helped 217 older adults and disabled people transition to community settings, and supported 243 individuals remain in community settings through diversion and case management. Additionally, Choice in Aging has provided complex case management to 2,374 disabled elders (65 and older), helping them to remain in the community.

Exhibit 3. Summary of Profiled Choice in Aging Services with Braided Funding

Program/Service	Contracting Entity and Funding Source
California Community Transitions (CCT)	DHCS (Money Follows the Person Federal Rebalancing Demonstration)
Enhanced Care Management (ECM)	Contra Costa Health Plan MCP (Medi-Cal)
Multipurpose Senior Services Program (MSSP)	DHCS (Medi-Cal 1915(c) waiver)
Case Management (for those not in CCT, ECM, or MSSP)	Contra Costa County (Measure X half-cent county sales tax)
ECM Capacity and Infrastructure	Providing Access and Transforming Health Capacity and Infrastructure Transition, Expansion and Development (PATH CITED)

Approach to Braiding Medi-Cal Funding: Primarily Single Funding Source per Client and Multiple Funding Sources per Staff Member

Many older adults and disabled people could benefit from CCT's transition and case management services, but CCT's eligibility restrictions limit access for this population. Braiding county Measure X funding allows Choice in Aging to provide CCT-like services to a wider population not eligible for CCT, such as those who wish to transition but have not been in a nursing home or institution for 60 consecutive days or longer.[10] There are also many older Californians who are not eligible for Medi-Cal (and hence not eligible for CCT and CalAIM-funded services), but are at risk of institutionalization and still need support to remain in a community setting. In Contra Costa County, Measure X funding provides case management services to meet these needs.

Given funding restrictions — such as on eligibility or supplantation — most, but not all, participants in Choice in Aging's transition and case management services are supported by a single funding source at any one time. Braiding allows Choice in Aging staff the flexibility to shift clients between different funding sources for the same or an enhanced level of service as their needs, circumstances, or eligibility change. For example, CCT participants have 50 hours of post-transition support that must be used within 365 days of transition. After those 365 days, Choice in Aging provides ECM under CalAIM for these participants, if it is needed, if they have Medi-Cal, and they are a member of CCHP.

Clients referred to ECM will usually continue ECM services unless they develop a need not covered by it, like the need for something supported by purchase of service funding. Through braiding, a client's lead Choice in Aging case manager can seamlessly transition them from ECM to MSSP (which allows purchase of service) or other general case management, and from the client's perspective, nothing has changed. They still get the services and support they need without realizing they were disenrolled and re-enrolled in a different program, and braiding on the back end makes that possible.

Staffing

Some funding sources and client volume are sufficient to support dedicated staff, so in those instances, Choice in Aging transition and case management staff are billed exclusively to one funding source. ECM staff, for example, are billed only to the MCP and carry a case load of only ECM clients. The last CCT provider rate increase, however, was in 2008. The 2008 rate is insufficient to meet current staffing and service needs, such as drive time, mileage, billing, recruitment, onboarding, and fringe benefits.[11] Most CCT staff, therefore, are funded by multiple sources and can have a caseload of CCT and Measure X APS case management clients at the same time. Given how frequently clients transition between programs, all staff are rigorously cross-trained in the full range of Choice in Aging transition and case management services. This ensures that CCT Transition Coordinators are familiar with Measure X and MSSP case management processes and vice versa.

Contracting and Reporting

Choice in Aging has four active contracts funding transition and case management services: (1) a fee-for-service contract with DHCS and the Centers for Medicare & Medicaid Services for CCT; (2) a cost reimbursement contract with the Contra Costa County Board of Supervisors that is inclusive of services billable by the hour through Measure X (APS and general case management); (3) a capitated, PMPM contract with CCHP for ECM provided to health plan members; and (4) a fee-for-service contract with DHCS for MSSP in Contra Costa County.

Every funding source requires that Choice in Aging use different systems for client documentation, record keeping, and billing. Notably, CalAIM's PATH CITED grant is the only funding source that provides support for this type of infrastructure development. Under PATH CITED Choice in Aging received a grant to recruit/retain/hire ECM staff, do a needs assessment, purchase computers, and develop a custom database. The database tracks ECM services and hours, which are cross-referenced by the finance staff and submitted through the CCHP portal. For CCT, staff keep progress notes in a program, MedCompass, and then finance staff submit Treatment Authorization Requests through the Medi-Cal website based on specific services/codes. Choice in Aging staff use a county portal for Measure X and APS, GetCARES, to input demographic information and submit cost reimbursement claims. Choice in Aging uses an internal drive, accessible by the finance staff, to track progress notes and care plans. Choice in Aging invests extensive time to train transition and case management staff on all systems, ensuring they understand what an appropriate referral is for each funding source, and are proficient in the specific documentation, assessment, and care planning tools used for each.

Choice in Aging conducts an external audit annually, including an additional single audit due to the amount of federal funding, and has the MSSP books audited by the state every two years.

Challenges and Next Frontier

According to Debbie Toth, Executive Director of Choice in Aging, the time and resources required to implement different funding databases/systems and train staff on how to use them is time-consuming and inefficient. Braiding in a technologically disjointed environment requires a high investment of time by finance and leadership staff that can be burdensome for community-based organizations.

While PATH CITED infrastructure grants are designed to build the capacity of community-based organizations to successfully receive Medi-Cal funding by fronting some of the infrastructure costs necessary to do the work, the funding required that Choice in Aging complete a milestone (and a quarter's worth of work) before they were paid. This meant that even though the organization's grant was supposed to cover pre-implementation costs, to get that funding, the organization had to have an alternative source of revenue to pay up front for a quarter's worth of work.

Deinstitutionalization and diversion services are very time and resource intensive. Braiding helps Choice in Aging close the budget gap for these services. Still, even with braiding, current funding amounts for these services rarely meet actual service costs, which requires that Choice in Aging conduct extensive fundraising to operate these programs and services.

3. Children's Institute

Founded in 1906, Children's Institute is a multi-service organization that offers a wide array of behavioral health, educational, and social services to children and adults in Los Angeles County. Children's Institute has a long history of leveraging state and federal funding for early education programs and has brought that experience to inform strategies to braid health care funding including for CalAIM initiatives. Notably, Children's Institute participated in the Health Homes Program that was a precursor to ECM and helped it prepare to contract with and be reimbursed by MCPs for ECM and Community Supports.

Health care programs or services include specialty outpatient mental health, prevention and early intervention, Full Service Partnership, ECM, and three Community Supports — housing transition navigation services, housing deposits, and housing tenancy and sustaining services — known as the "housing trio." Children's Institute contracts with the Los Angeles County Department of Mental Health for specialty mental health services,

prevention and early intervention programs, and Full Service Partnership services. The organization also contracts with MCPs to provide the housing trio and ECM for most populations of focus. A summary of the profiled services and funding sources for Children's Institute are listed in Exhibit 4 *(below)*.

Exhibit 4. Summary of Profiled Children's Institute Services with Braided Funding

Program/Service	Contracting Entity and Funding Source
Specialty Outpatient Mental Health	Los Angeles County Department of Mental Health (Medi-Cal)
Prevention and Early Intervention	Los Angeles County Department of Mental Health (Behavioral Health Services Act)
Full Service Partnership	Los Angeles County Department of Mental Health (Behavioral Health Services Act)
Enhanced Care Management (ECM)	Anthem Blue Cross, Blue Shield, HealthNet, L.A. Care, Molina, and Kaiser Permanente MCPs (Medi-Cal)
Community Supports: Housing Transition Navigation, Housing Deposits, and Housing Tenancy and Sustaining Services	Anthem Blue Cross, Blue Shield, HealthNet, L.A. Care, Molina, and Kaiser Permanente MCPs (Medi-Cal)
ECM and Community Supports Capacity and Infrastructure	Providing Access and Transforming Health Capacity and Infrastructure Transition, Expansion and Development (PATH CITED); Incentive Payment Program; ACEs Aware

Approach to Braiding Medi-Cal Funding: Multiple Funding Sources per Client, Single Funding Source per Staff Member

Children's Institute describes their approach as "stacking" Medi-Cal funds for ECM and Community Supports with other funding sources to advance their goals. Some of Children's Institute key goals related to braiding include: (1) offering a more comprehensive array of services based on client's changing needs; and (2) offering services to new populations, including family members of existing clients, to enhance a multi-generation approach.

The rollout of ECM at Children's Institute illustrates the goals. Children's Institute delivers ECM to most populations of focus: adults at risk for avoidable hospital or emergency department (ED) use; individuals and families experiencing homelessness; adults with serious mental health or SUD needs; adults transitioning from incarceration; children with serious mental health or SUD needs; children and youth at risk for avoidable hospital or ED use; and children and youth involved in child welfare. The state first launched ECM through adult populations of focus, and Children's Institute began offering ECM to the family members of their existing clients. When the state launched ECM for children and youth the following year, Children's Institute expanded their continuum of services for children to include ECM. ECM can support continuity of care

for clients who are transitioning from more robust specialty mental health services, such as Full Service Partnership services.

Infrastructure funding enabled Children's Institute to launch these services and develop the capacity to braid funds. They participated in the Incentive Payment Program, which was designed to support the launch of ECM and Community Supports, and received two rounds of PATH CITED grants, which supported the expansion into new ECM populations of focus. This funding allowed Children's Institute to hire staff and conduct outreach to identify clients before they started service billing, as well as to establish the necessary billing infrastructure, including customizing Salesforce to support MCP reporting requirements. They also received an ACEs Aware grant to build the infrastructure for enrollment and referral paths to increase access for ECM and community health worker services for youth with an adverse childhood experience and their caregivers.

Staffing

All staff who work on ECM or the Community Supports "housing trio" are funded entirely by either ECM or Community Supports. Children's Institute reports that this approach creates confidence that they are adhering to all requirements while maintaining clarity on roles and responsibilities. Children's Institute employs four housing navigators who work across the housing trio, changing the codes billed based on specific client need and corresponding Community Supports delivered. Children's Institute uses a case conference strategy with the ECM care management acting as the "air traffic controller" to coordinate across client services and needs. For example, case conference participants may include the ECM care manager, a housing navigator under Community Supports, and a therapist providing behavioral health services. Each position bills for their respective roles and services to avoid duplication — such as with the therapist billing under a case consultation code — and the case conference strategy ensures that client services are well coordinated from the client perspective.

Contracting and Reporting

Children's Institute contracts with six different MCPs for ECM and Community Supports, and with the Los Angeles Department of Mental Health (a mental health plan) for specialty mental health services. These contracts have different structures and require different data systems for reporting.

Specialty mental health services are billed through the county mental health plan's data system and embedded within Children's Institute electronic health record. ECM and Community Supports are documented and billed in a separate database, and the respective systems are not able to communicate. Since a single client may have multiple records across multiple databases, the case conferencing strategy is necessary to communicate care planning across the staff who are accessing these different systems.

Challenges and Next Frontier

Children's Institute reported that contracting with multiple MCPs — each with different reimbursement structures, billing cycles, and reporting requirements — can create challenges. Given the complexities of these requirements, they use a third-party billing system. They have focused on reporting and revenue cycle management planning to support financial planning, but reported that misalignment across funding sources can lead to duplicative documentation and reporting requirements, which Children's Institute must address through complex system customizations.

Another challenge is expanding to other services managed by MCPs, such as behavioral health services for people with mild-to-moderate behavioral health needs, dyadic services, and doula services. While Children's Institute can leverage its expertise in how their communities served may benefit from these services, as well as experience contracting with MCPs for ECM and Community Supports, they reported challenges with MCP contracting and inadequate rates. These challenges are exacerbated by the need to contract with multiple MCPs.

Looking ahead, Children's Institute plans to continue to refine their systems and braided funding strategies to create greater financial sustainability and to overcome these contracting and rate issues. Their stacking approach may support them to create efficiencies in delivering these services to populations that they are already engaging.

Conclusion

Organizations that deliver aging and disability, housing, and specialty behavioral health services are experienced in navigating a wide range of funding sources for programs with distinct eligibility criteria and reporting requirements. Under CalAIM, organizations have new opportunities to incorporate Medi-Cal funding through MCPs to strengthen their ability to deliver person-centered and integrated services for clients with complex health and social needs. While braiding can be challenging due to a lack of integrated infrastructure and administrative complexity, Medi-Cal payers such as MCPs, can play an important role in lessen the burdens of braiding.[12] Braiding organizations can apply lessons from the strategies profiled in this brief to mitigate risks and promote efficiencies.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

ENDNOTES

[1] Boyd-Barrett, C., Zhang, J., Pu, H., Funk, D., Al-Atassi, R., Pierluissi, E. (2024, April). *Up close with enhanced care management program providers* [Report]. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2025/04/ECMProvidersPerspectives.pdf

[2] Aurrera Health Group for the California Department of Health Care Services. (2021, December). *Medi-Cal Community Supports explainer* https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx

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