Center for Health Care Strategies

Medicaid Braided Funding: Frequently Asked Questions

In August 2024, the Center for Health Care Strategies (CHCS) held a webinar, *Braiding Funding Streams to Deliver Integrated Care for Medi-Cal Members Under CalAIM*, that highlighted opportunities to optimize different funding streams (braided funding*) to provide person-centered care. This topic is explored further in CHCS' brief, *Braiding Medicaid Funds to Support Person-Centered Care: Lessons from Medi-Cal*. The brief includes profiles on how three organizations braided funds to advance person-centered care and the strategies they used to mitigate the risks of braiding.

Following are questions posed by participants during the August 2024 webinar and answers provided by presenters. Questions and answers are lightly edited for clarity.

1. How can health care and social service organizations ensure that existing funding sources will not reduce funding when other (new) sources are used?

Meticulous documentation and ongoing, transparent communication with funders are critical. Communicate with funders how the services and goals provided under their funding differ and complement other funding sources. When an organization receives a new funding source, demonstrate to funders how the new funding adds to, or enhances, what is available and does not replace existing services. Service documentation and clear staff roles and responsibilities are also instrumental in helping funders understand the value of their continued support. For more details, listen to the Q&A portion of CHCS' webinar.

2. What staff training is required to successfully braid funds?

Program and finance staff training are required to successfully braid funds. Arcata House Partnership (AHP) finance staff are trained in fund accounting to ensure that the organization is accurately billing to the correct programs or funding source. Additionally, AHP's program staff have clear and separate job duties and assignments based on the program and funding source. Staff are also trained to document the services they provide to each client.

Community Health Center Network's (CHCN) Community Transition Nursing Program (CTRN) staff also document services provided to eligible clients in their electronic medical records. CHCN staff overseeing the CTRN program track the budget to ensure funds are allocated and spent accordingly.

For additional strategies to successfully braid funds, please read CHCS' brief, *Braiding Medicaid Funds to Support Person-Centered Care: Lessons from Medi-Cal*.

3. Does supplantation apply to services that are privately funded?

Supplantation is the use of funds to replace, rather than supplement, existing funding that is already allocated for a particular service or program. While supplantation under CalAIM applies only to federal, state, and local government funds, and not private funds, organizations need to understand the restrictions

* *Braided funds refer to an organization bringing funding together from various sources to support a unified goal or program with careful accounting and independent tracking of how each funding source is used and spent.*

each funding source will allow and allocate accordingly. Strategies that organizations can use to organize allowable costs and services include fund accounting (i.e., an accounting system that accurately tracks expenditures and revenues by funding source), service documentation, verification of client eligibility, and appropriate billing.

4. How and where can organizations identify issues of double-dipping into funding when looking to braid funding sources across sectors?

Organizations should review program services, staffing allocations, and accounting and billing policies. AHP reviews the programs funded by each funding source and avoids service overlap. In the case of enhanced care management (ECM) services, AHP ensures that services provided are supplemental to existing case management services, so there is no risk of supplanting.

5. Can community-based organizations (CBOs) hire new staff using funding under CalAIM?

Yes, CBOs can use CalAIM funding to expand or hire new staff to provide services. CBOs can receive payments through providing and billing for reimbursable services to eligible enrollees under CalAIM. Additionally, CBOs can apply for grant funding through flexible capacity-building funds, such as the Capacity and Infrastructure Transition Expansion and Development (PATH CITED), the Incentive Payment Program (IPP), and the Housing and Homelessness Incentive Program (HHIP). IPP and HHIP are available through managed care plans (MCPs), and CBOs must apply directly with their MCPs to access these funds.

For additional details on how CBOs braid these different funding sources to hire additional staff, please read the CHCS brief, *Braiding Medicaid Funds to Support Person-Centered Care: Lessons from Medi-Cal*.

6. If a CBO has been providing one of the 14 defined Community Support services and now wants CalAIM to fund it, can it only do that if it is expanding services?

To clarify the requirement of supplementing and not supplanting, it depends on how the service was funded. If the service was governmental (i.e., federal, state, county), CalAIM cannot be used to replace the original funding source(s) of the service. If the existing service is now billable under CalAIM and used to be funded through government sources, organizations can bill for it (ensuring that service is rendered to Medi-Cal members meeting eligibility criteria). However, organizations must demonstrate that the new funds are used to enhance and/or complement the service, either by providing new services, hiring additional staff, or increasing the size, scope, and/or quality of programs being offered. On the other hand, if the original funding source was a grant from a hospital or funded through private donations, this does not apply.

7. What electronic billing systems and case management tools are organizations using?

AHP uses Office Ally for electronic billing to the MCP. For electronic case notes and documentation, the staff uses an internally developed Excel spreadsheet, called the client monthly engagement tracker (CMET). The CMET includes client information along with service notes so the billing team can use this data to populate invoices for ECM and Community Supports.

8. What is the caseload (ratio of case manager to client) for each program?

AHP's CalAIM program provides both ECM and Community Supports, with the goal of reaching 30 clients on each care manager's caseload. The caseload is around one to 20.

9. How are communities integrating ECM and Community Supports with Permanent Supportive Housing at a systems level to better meet operations and service funding gaps?

Existing federal and state housing-related funding for service coordination is insufficient for clients who need more intensive services or require additional support to find or retain their housing. By integrating ECM and Community Supports, communities can enhance their offerings and provide a continuum of care and services that are responsive to client needs.

Organizations like AHP and PATH San Diego are sharing their strategies for braiding to integrate ECM and Community Supports with Permanent Supportive Housing in hopes of helping communities better meet operations and service funding gaps.

10. What are some strategies for braiding funding of the community health worker (CHW) benefit that avoid the perception of supplantation? *(Many CHWs are under contract with counties to provide services, but need extra funding to help supplement the contracts.)*

CHCS will be profiling successful braiding strategies by organizations providing CHW services. Stay tuned for the upcoming publication! If you would like to share your CHW braiding model and be featured, please contact us at mail@chcs.org.

Questions Specifically for AHP

11. Has delivering CalAIM made the AHP team more efficient in the delivery of care? How have outcomes changed for AHP's clients?

For AHP clients, having access to ECM and Community Supports helps increase their stabilization. Some AHP clients receiving ECM and Community Supports have reduced their interactions with emergency departments and the criminal justice system.

12. Can staff (funded by different programs/funding streams) serve the same individual, or do they have to serve different people to ensure clean funding lines?

A client can receive multiple services, with different staff providing specific services. For example, a housing case manager might work with the client on resolving issues with property management, while the ECM program manager might link the individual with community mental health care. Even though different staff have different responsibilities for service provision, they work together to coordinate services for the client. Organizationally, AHP sets time aside for the teams to meet and discuss client cases and ensure service coordination. Team supervisors from all departments also meet weekly. AHP also houses staff in the same physical location, so that members from different teams can easily outreach to one another.

13. How does braided funding with CalAIM become sustainable if an organization keeps CalAIM funding separate from other funding sources?

AHP finds low CalAIM reimbursement rates a challenge. For now, AHP is providing ECM and two Community Supports; with reimbursement rates set by the local MCP. Separate from ECM and Community Supports reimbursements, AHP uses funding available through PATH CITED to support organizational capacity-building efforts to hire administrative staff and set up infrastructure for Medi-Cal billing.
For additional details on how AHP and other organizations braid CalAIM funding with other sources, reference CHCS' brief, *Braiding Medicaid Funds to Support Person-Centered Care: Lessons from Medi-Cal*.

14. Can AHP speak to the client experience with the division of services between the different program teams? Do clients feel they are being passed between multiple teams, or does it seem more seamless and integrated from their perspective?

AHP clients have expressed appreciation for the continuum of support available through different funding sources. AHP has seen great benefits, for instance, a client with diabetes who was served by ECM and had multiple amputations was stabilized and received an additional layer of care and support, allowing them to heal.

15. How do you account for the administrative time it takes to document services and the back and forth that can happen with medical billing and claims?

AHP's CalAIM team has a staff person dedicated to data and administrative management (32 hours/week). This individual is responsible for reports and TAR (treatment authorization requests) submissions. Reimbursement rates cover the data management staff and the care managers providing ECM and Community Supports. The medical billing piece takes about 8–10 hours per month and is still being covered by funding under AHP's PATH CITED grant. AHP hopes to expand the program and increase monthly reimbursement in the hopes of covering the medical billing time before PATH CITED grant funding runs out.