BluePath HEALTH

DHCS | PATH
Providing Access & Transforming Health

CenCal Health Plan: Closed-Loop Referrals

CenCal HEALTH®
Local. Quality. Healthcare.

CenCal Health | CalAIM & Closed-Loop Referrals

Ariel Land, Community Supports Program Manager
Heather Te, Enhanced Care Management Manger and Justice Involved Liaison

Agenda

- CalAIM Overview
- Closed Loop Referrals
- CCH Plan Updates
- Looking Ahead

CenCal HEALTH®
Local. Quality. Healthcare.

What is CalAIM?

1

Launched January 1, 2022 to transform Medi-Cal through delivery, payment, and data reforms.

2

Core programs: **Enhanced Care Management (ECM)** and **Community Supports (CS)**.

3

Focus: Address *social drivers of health* through services such as housing, food, and in-home supports.

4

Goal: Improve quality of life and reduce avoidable hospitalizations and ED visits.

CenCal HEALTH®
Local. Quality. Healthcare.

Community Supports and Enhanced Care Management

Community Supports

Cost-effective alternatives to traditional Medi-Cal services.

Optional for plans (*except Transitional Rent, required 1/1/26*).

15 approved services such as housing, meals, respite, and in-home care.

Builds on the Whole Person Care and Health Homes programs.

Goals: Address social needs that impact health, reduce hospitalizations, and improve overall well-being.

Who qualifies: Members who could benefit from supports like housing assistance, meal delivery, or help managing daily living needs.

Enhanced Care Management

Provides **intensive, whole-person care coordination** for high-need members.

Each member works with a **lead care manager** who coordinates:
- Medical and behavioral health care
- Social services and community resources.

Goals: Improve health, reduce hospital visits, and connect members to needed supports.

Who qualifies: Members with complex medical or social needs such as homelessness or serious mental illness. There are 9 Populations of Focus.

CenCal HEALTH®
Local. Quality. Healthcare.

How ECM and Community Supports Work Together

- **ECM** identifies members with high medical utilization or social needs and creates an individualized care plan.
- When social or housing barriers are identified, **Community Supports (CS)** provide the service solution (e.g., housing navigation, meals, respite).
- **Two-way collaboration:** CS providers can also identify unmet needs and submit referrals back to ECM for care management, or to other CS programs when members could benefit from multiple supports.
- This coordination ensures members receive **both care management and direct social supports**, reducing fragmentation and improving outcomes.

CenCal HEALTH®
Local. Quality. Healthcare.

Closed Loop Referrals (CLR):Connecting Care Across CalAIM

CenCal HEALTH
Local. Quality. Healthcare.

What Are Closed-Loop Referrals (CLR)?

- A **Closed-Loop Referral** tracks every step of a member's referral — from creation to completion — with a *known outcome*.
- Goal: Ensure members are connected to services and no referral "falls through the cracks."
- Required for **Enhanced Care Management (ECM)** and **Community Supports (CS)** starting **July 1, 2025.**

Track	Support	Monitor
Track referrals and data elements	Support the member and referring entity	Monitor outcomes for closure.

CenCal HEALTH
Local. Quality. Healthcare.

Why CLR Matters

BUILDS ACCOUNTABILITY BETWEEN MCPS, PROVIDERS, AND COMMUNITY ORGANIZATIONS.

REDUCES DELAYS, LOST REFERRALS, AND DUPLICATED WORK.

IMPROVES CARE COORDINATION AND SUPPORTS DHCS' POPULATION HEALTH MANAGEMENT (PHM) GOALS.

ENABLES DATA-DRIVEN INSIGHTS TO IDENTIFY SERVICE GAPS AND STRENGTHEN PROVIDER NETWORKS.

CenCal HEALTH®
Local. Quality. Healthcare.

The CLR Process at CenCal Health- ECM

Referral Intake

- Confirm completeness within **2 business days**.
- Save and log referral in CenCal Health Electronic Health Record.
- Send **email confirmation** to referring entity.

Referral Assignment

- Match to appropriate ECM provider based on capacity and ability to accept external referrals.
- Provide ECM Referral to ECM Provider.
- Notify referring entity once we assign the ECM Provider.

Ongoing Monitoring

- Monthly follow-ups until authorization or closure.
- Document every status update or provider inquiry to ensure compliance with DHCS timelines.

Closure

- Update EHR and notify referring entity via secure email when referral is:
  - **Approved** (service received)
  - **Closed** (rescinded, no needs, ineligible, or unable to contact)

The CLR Process at CenCal Health- CS

Referral Intake

- Confirm completeness within **2 business days**.
- Save and log referral in CenCal Health Electronic Health Record.
- Send **email confirmation** to referring entity.

Referral Assignment

- Match to appropriate CS provider based on capacity and ability to accept external referrals.
- Change status to Approved
- Notify referring entity once we assign the CS Provider.

Ongoing Monitoring

- Monthly follow-ups until authorization or closure.
- Document every status update.

Closure

- Update EHR and notify referring entity via secure email when referral is:
  - **Approved** (service received)
  - **Closed** (rescinded, no needs, ineligible, or unable to contact)

Notification Timeframes

Notification Type	When to Notify	Who to Notify	Method
Referral Received	Within 2 business days	Referring Entity	Secure Email/ Fax
Incomplete Referral	Within 5 business days	Referring Entity	Email & phone follow-up
Referral Follow-Up	Within 1 business day	Referring Entity	Secure Email
Referral Closed (Approved/Ineligible/No Contact)	Within 1 business day	Referring Entity	Secure Email
PRFT Report	Within 7 business days	Referring Entity	Secure Email

CenCal HEALTH®
Local. Quality. Healthcare.

If You Are a Referring Entity

PCPs, CBOs, Hospitals, County Partners

Submit complete referrals using the CenCal Health form.

Include all required details: member info, program, and contact.

Watch for updates — confirmation and closure emails will be sent securely.

Respond quickly to any requests for missing information.

Follow up if you don't receive an update within expected timeframes.

Share any member changes (like relocation or withdrawal).

Goal: Support a seamless handoff to the provider and ensure the member connects to care quickly and effectively.

CenCal HEALTH®
Local. Quality. Healthcare.

If You Are a CS Provider Receiving a Referral

Your Role in the Closed-Loop Referral Process

- **Acknowledge receipt** of the referral within **2 business days**.
- **Confirm capacity** and member eligibility; notify CenCal Health if unable to accept.
- **Outreach to the member** promptly to begin engagement and document all contact attempts.
- **Update referral status within 14 days** in your communications (e.g., outreach started, scheduled, unable to reach).
  - **Submit monthly progress updates** until the referral is resolved or closed.
  - Respond to CenCal Health within 1 business day of status inquiry of referral.
- **Report closure outcomes** (e.g., member declined, unable to contact) within 1 business day of determination.
- If submitting an **authorization**, no additional communication is required that submission serves as your referral update.

Goal: Provide timely feedback so CenCal Health can complete the loop and report accurate data to DHCS.

CenCal HEALTH®
Local. Quality. Healthcare.

If You Are a ECM Provider Receiving a Referral

Your Role in the Closed-Loop Referral Process

- **Acknowledge receipt** of the referral within **2 business days**.
- **Confirm capacity** and member eligibility; notify CenCal Health if unable to accept.
- **Respond to CenCal Health** within 1 business day of status inquiry of referral.
- **Outreach to the member** promptly to begin engagement and document all contact attempts.
- **Update the referral status** on the Provider Return Transmission File due the 20th of each month (e.g., outreach pending, initiated, unable to reach).
  - **Submit monthly progress updates** until the referral is resolved or closed.
- If submitting an **authorization**, provide closure reason status on the Provider Return Transmission File.

Goal: Provide timely feedback so CenCal Health can complete the loop and report accurate data to DHCS.

CenCal HEALTH®
Local. Quality. Healthcare.

CenCal Health Plan Updates

- **Housing Services Policy Update:**
  DHCS housing policy changes take effect January 1, 2026, with the launch of **Transitional Rent (TR)** to align housing supports and service standards.
- **Closed-Loop Referrals (CLR):**
  Launched in 2025 to improve tracking of CalAIM referrals, including those not authorized, through the **Provider Referral Tracking File (PRTF)**.
- **Provider Collaboration:**
  Ongoing training and workflow alignment to support readiness for TR and **CLR** implementation.
- **Program Updates:**
  - **Assisted Living Facility (ALF) Transitions** ending **December 31, 2025**.
  - **Housing Deposit** rental assistance ending **October 31, 2025**.

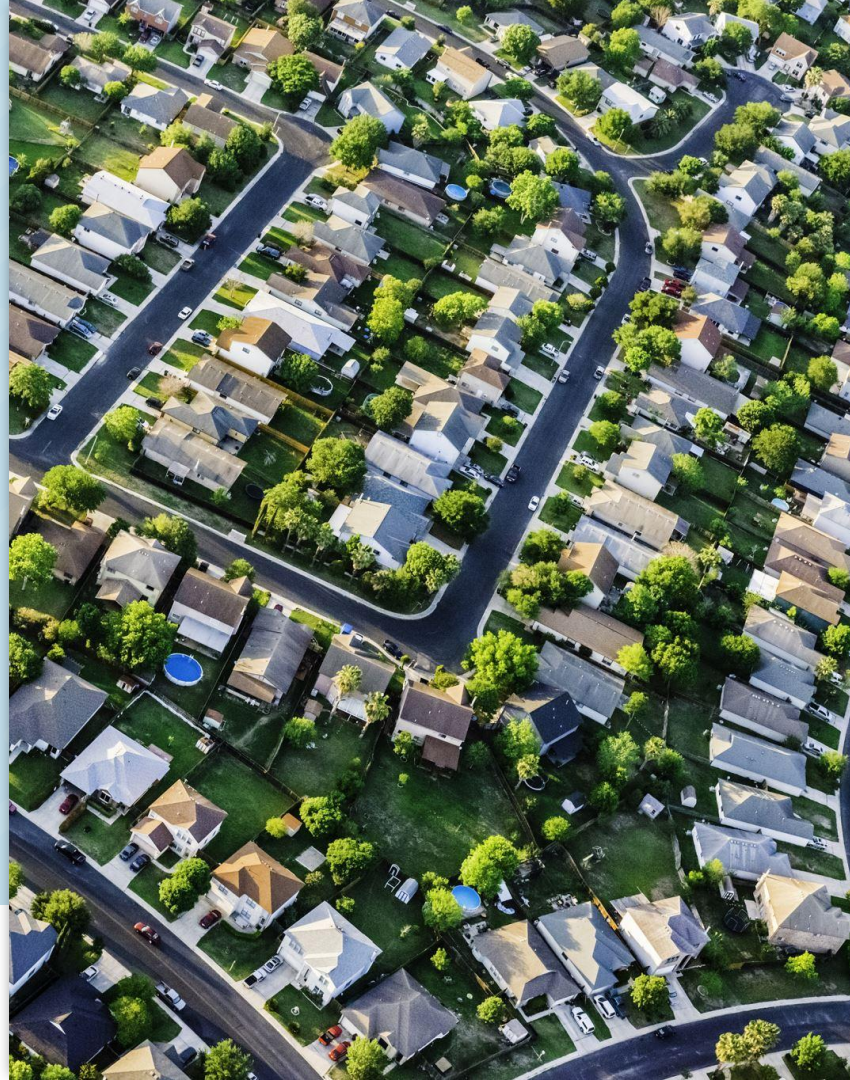
CenCal HEALTH®
Local. Quality. Healthcare.

Looking Ahead –Transitional Rent (TR)Launching January 1, 2026

What is Transitional Rent (TR)?

- A **temporary rental assistance** Community Support to help members bridge from homelessness or temporary housing into permanent housing.
- Covers **up to six months of rent per household** within a five-year period.
- Part of the statewide **Room and Board services cap** that also includes Recuperative Care and Short-Term Post-Hospitalization Housing (max 6 months combined per 12 months).

CenCal HEALTH®
Local. Quality. Healthcare.



Who Will Be Eligible (Mandatory Population of Focus)

- Must have a **housing support plan** identifying a pathway to long-term housing stability (e.g., transition to BHSA Housing Interventions, permanent supportive housing, or other sustainable subsidy).
- Transitional Rent is intended to **bridge the gap** from homelessness or temporary housing to permanent housing.

CenCal HEALTH
Local. Quality. Healthcare.

Key Takeaways

- **Work Together:** Every referral is a chance to change a life.
- **Stay Ready:** Transitional Rent and justice involved are coming — be part of the movement.
- **Stay Connected:** Communication keeps members from falling through the cracks.
- **Lead the Way:** Your partnership brings CalAIM to life in our communities.

CenCal HEALTH®
Local. Quality. Healthcare.

CenCal HEALTH®

Local. Quality. Healthcare.

Closed Loop Referrals Q&A

- What are best practices for CalAIM providers completing the RTF file?
- Where do you see the greatest opportunities for providers to work together to address referral tracking and communication challenges?
- How can CalAIM providers and MCPs partner more effectively on closed loop referrals?

BluePath HEALTH

DHCS | PATH
Providing Access & Transforming Health

Managed Care Plan Updates: Closed-Loop Referrals Updates

Closed-Loop Referral (CLR) Overview

Definition
Closed-Loop Referral (CLR): A referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and results in a *known closure*. A **known closure** occurs when a Member's initial referral loop is completed with a known outcome.

Background

- CLR requirements effective on July 1, 2025 solely apply for two services:
  - ❑ Enhanced Care Management – all Population of Focus (PoF)
  - ❑ Community Supports – all services upon go-live, except Sobering Centers
- The goal is to increase the share of Medi-Cal Members successfully connected to the services they need by identifying and addressing gaps in referral practices and service availability.
- DHCS intends to expand similar CLR requirements to other applicable services (i.e. CHW) over time. An official timeline has not been shared other than for BH services beginning in some time in 2026.

Requirement Components

Tracking Referral: Track a minimum set of data elements for each referral

Supporting Referral & Closure: Provide assistance with referral and processing, notifying members and referring entities and work with providers to troubleshoot challenges

Monitoring Referrals: Monitor data to resolve challenges across referral partners, internal operations, and providers

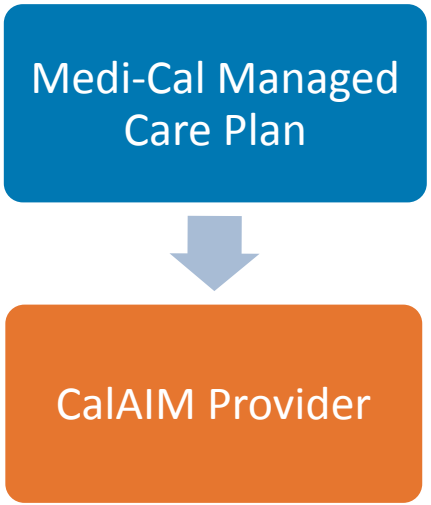
*DHCS has shared that they are giving Plans a 1-year grace period to implement systems and processes for CLR for ECM/CS after the CLR policy is effective on July 1, 2025.

Sources: CLR Implementation Guidance May 2025, Closed-Loop-Referral-FAQs May 2025

KAISER PERMANENTE

What is a Member Information File (MIF)?

Member Information Files (MIFs) contain a list of members assigned to an ECM and/or CS Provider. These files include details that can help contact and engage new enrollees, as well as information about their health and service use to support care management.



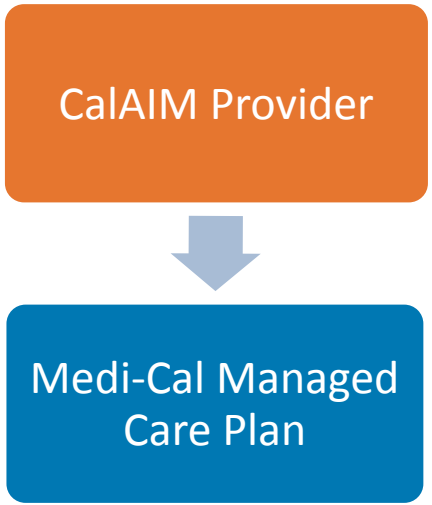
A	B	C	D	E	F	G	H	I
ECM Member Record: *(New; Continuing; Returned; Termed)*	**Member CIN#**	**Member First Name**	**Member Last Name**	**Member Date of Birth** *(MM/DD/YYYY)*	**Referring Organization Name (NEW)**	**Referring Individual Name** Last name, First name **(NEW)**	**Referring Individual Phone Number** 0000000000 **(NEW)**	**Referring Individual Email Address (NEW)**

Sources include CalAIM Data Guidance: Member-Level Information Sharing Between MCPs and ECM Providers and ECM Provider Return Transmission File template.

KAISER PERMANENTE

What is a Return Transmission File (RTF)?

Return Transmission Files (RTFs) contain updates from ECM and/or CS Providers about services delivered to assigned members. These files help Managed Care Plans (MCPs) track member progress, understand service outcomes, and close the loop on referrals. They include details such as whether services were provided, if the member could be reached, and reasons for referral closure.



A	B	C	D	E	F	G	H	I
Member CIN#	Member First Name	Member Last Name	Member Date of Birth *(MM/DD/YYYY)*	Member New Address *(1=Yes; 0=No)*	Member Homelessness Indicator *(1=Yes; 0=No)*	Member Residential Address	Member Residential City	Member Residential Zip

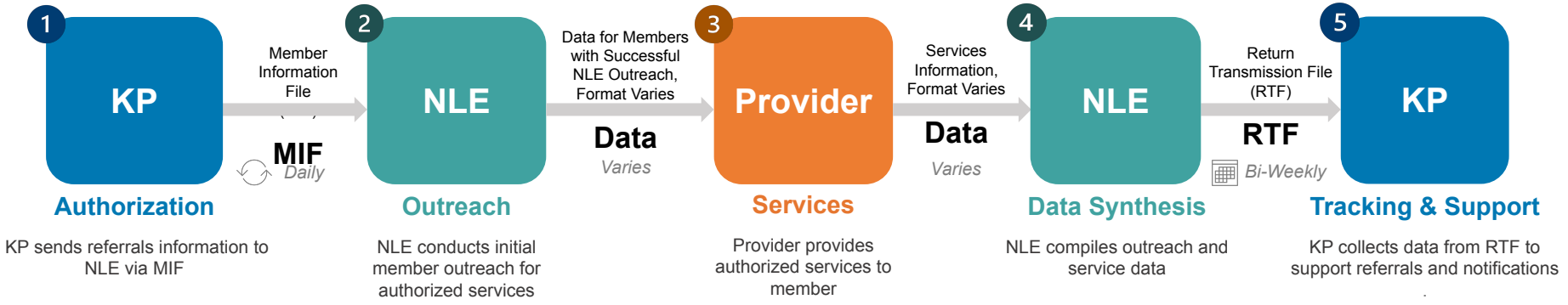
Sources include CalAIM Data Guidance: Member-Level Information Sharing Between MCPs and ECM Providers and ECM Provider Return Transmission File template.

KAISER PERMANENTE

Kaiser Permanente ECM & CS Provider Reporting Changes Due to CLR Guidance

- Data elements will be updated on the MIF and RTF to meet Closed Loop Referral (CLR) data requirements, *including but not limited to*:
  - Contact Information for Referring Organization / Person
  - Referral Status: Pending, Accepted, Declined, Outreach Initiated, Referral Loop Closed
  - Reason for Referral Loop Closure: Services Received, Service Provider Declined, Unable to Reach Member, Member No Longer Eligible for Services, Member No Longer Needs Services or Declines, Other, Authorization Denied *(determined only by KP)*
- For more information on how **CLR** and **MIF/RTF** updates may impact your organization, please contact your contracted **Network Lead Entity** (Full Circle Health Network, Independent Living Systems, Partners in Care).

Referral Information Workflow



KAISER PERMANENTE

Last updated: July 2025

Gold Coast Health Plan℠
A Public Entity

Closed-Loop Referrals (CLR)

GCHP Staff

Integrity

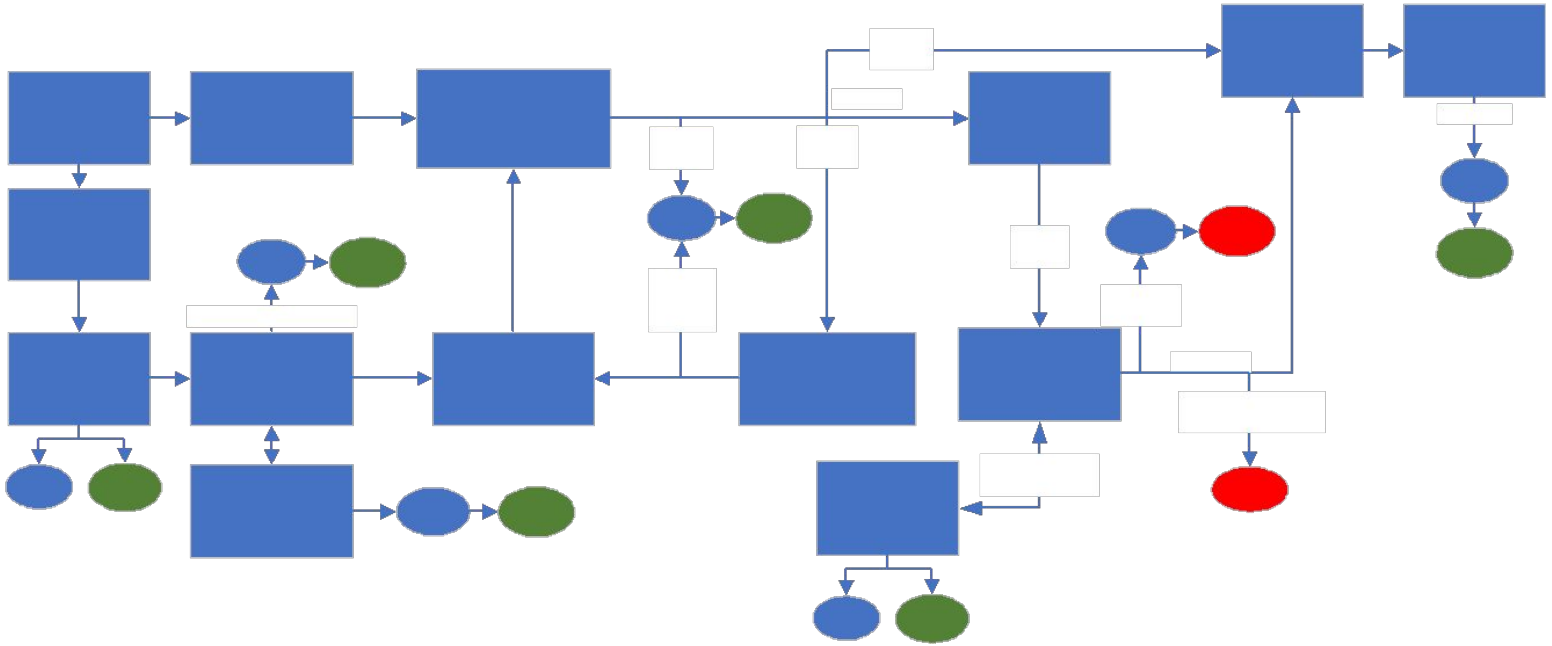
Accountability

Collaboration

Trust

Respect

Closed Loop Referrals - Process



CLR Minimum Data Elements

- 45 minimum data elements
  - **Member Information** (CIN, Gender Code, Race/Ethnicity Code, Guardian or Conservator, etc.)
  - **Referral Initiation** (Date of Referral, Referring Organization, Referral Type, etc.)
  - **Referral Authorization** (Date Request Received, Referral Authorization Status, Authorization Effective Date)
  - **Referral Processing** (Date Referral Sent to Servicing Provider, Referral Status, Date of Referral Status, etc.)
  - **Referral Loop Closure** (Reason for Referral Loop Closure and Date Referring Entity Notified of Referral Loop Closure)
- Referring Agency, Member, MCP, and ECM/CS Provider all play a role in the data collection process!!

Tracking Referrals: Provider Roles & Responsibilities

- **GCHP's Responsibility:** Collect, store, and utilize the minimum data elements.
- **Provider Responsibility:** Report specific data elements to GCHP monthly via the Return Transmission File (RTF).
- Key **ECM and CS** RTF Updates/Changes (Effective July 1, 2025):
  - ADD - **Referral Status:** Accepted, Declined, Pending, Outreach Initiated, Referral Loop Closed.
  - ADD - **Date of Referral Status:** Date associated with the status update.
  - ADD - **Reason for Referral Loop Closure:** Required if status is 'Declined' or 'Referral Loop Closed' (e.g., Services Received, Unable to Reach Member, Service Provider Declined, etc.).
  - CS ONLY - ADD – **Transitional Rent:** Yes/No (1,0) flag to indicate if Member is receiving this Community Support service.
  - Continue to include field header and report as blank – **Status of Member Engagement** (ECM) and **Current Status of Member Engagement** (CS)
- **Data Timeliness:** Updates must be received by the 5th of the month are crucial for MCP support and monitoring.
- **Data Compliance:** Adherence to HIPAA, 42 CFR Part 2, etc., is essential.

Referral Status – Updates from the Provider

- **Accepted -** This status indicates that the **referral has been received and accepted** by the Enhanced Care Management (ECM) or Community Supports provider. The provider is prepared to engage with the member and deliver the referred services.
- **Declined -** A referral may be marked as **Declined** if the provider is **unable to accept the referral** for reasons such as:
  - Lack of capacity
  - The member is outside the provider's service area
  - Other operational or eligibility-related constraints
    MCPs (Managed Care Plans) are expected to document and track the reasons for declined referrals in accordance with DHCS policy
- **Pending -** This status is used when the referral has been **received but not yet acted upon**. It may be awaiting review, triage, or assignment to a care team. It reflects an intermediate state before acceptance or outreach.
- **Outreach Initiated -** This status indicates that the provider has **begun outreach efforts** to contact the member and engage them in services. It shows active follow-up is underway, even if the member has not yet been reached or enrolled.
- **Referral Loop Closed**
  This status is used when the referral has reached a **known and documented conclusion**. This could mean:
  - Services were successfully delivered
  - The member declined services
  - The referral was otherwise resolved
    Closure must be supported by data, such as confirmation from the provider or documentation in the Return Transmission File (RTF)

Tracking Referrals: Key MIF Updates for ECM

- Key **MIF** Updates/Changes (Effective July 1, 2025 – **Implementation Date for GCHP TBD**):
  - **Best Contact Method for Member/Caregiver**
  - **Best Contact Time for Member/Caregiver**
  - **Referring Organization Name**
  - **Referring Individual Name**
  - **Referring Individual Phone Number**
  - **Referring Individual Email Address**
  - **Referring Individual Relationship to Member**
  - **Referral Type**
    - One code per Member, options include: (1) Community Referral; (2) Identified by the MCP (e.g., through available data).

Tracking Referrals: Key CS Auth Updates for CS

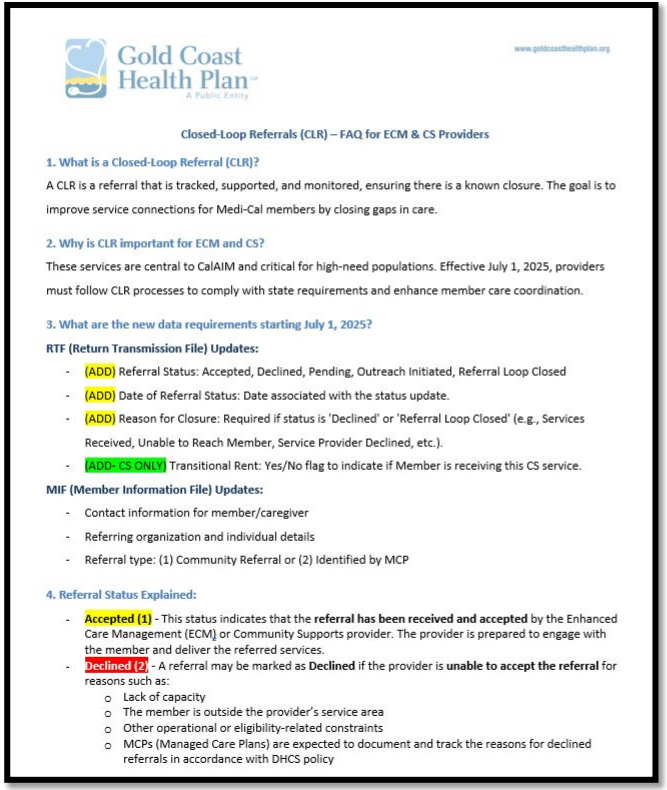
- Key **Community Supports Authorization Status File** Updates/Changes (Effective July 1, 2025 - **Implementation Date for GCHP TBD**):
  - **Authorization Effective Date (MM/DD/YYYY)**
  - **Referral Type**
    - One source code per Member. Source codes will include: 1. Community Referral; 2. Identified by the MCP
  - **Transitional Rent**
    - Listed as a data element in the Community Supports Information

Data Exchange Schedule

File Name	Frequency of Transmission	Data Flow
(ECM) Member Information File	Weekly – Mondays at 10 am	GCHP to Providers
(CS) Authorization Status File	Weekly – Mondays at 10 am	GCHP to Providers
(ECM, CS) Provider Return Transmission File	On or before the 5th every month by 5:00 pm	Providers to GCHP
(ECM) Initial Outreach Tracker File	On or before the 5th every month by 5:00 pm	Providers to GCHP
~~Member Referral File~~	~~On or before the 5th every month by 5:00 pm~~	Discontinued

Next steps, Questions, Issues, Q&A

- Questions?
- Please contact calaimreporting@goldchp.org moving forward rather than any one individual from GCHP.



Gold Coast Health Plan
A Public Entity

www.goldcoasthealthplan.org

Closed-Loop Referrals (CLR) – FAQ for ECM & CS Providers

1. What is a Closed-Loop Referral (CLR)?

A CLR is a referral that is tracked, supported, and monitored, ensuring there is a known closure. The goal is to improve service connections for Medi-Cal members by closing gaps in care.

2. Why is CLR important for ECM and CS?

These services are central to CalAIM and critical for high-need populations. Effective July 1, 2025, providers must follow CLR processes to comply with state requirements and enhance member care coordination.

3. What are the new data requirements starting July 1, 2025?

RTF (Return Transmission File) Updates:

- (ADD) Referral Status: Accepted, Declined, Pending, Outreach Initiated, Referral Loop Closed
- (ADD) Date of Referral Status: Date associated with the status update.
- (ADD) Reason for Closure: Required if status is 'Declined' or 'Referral Loop Closed' (e.g., Services Received, Unable to Reach Member, Service Provider Declined, etc.).
- (ADD- CS ONLY) Transitional Rent: Yes/No flag to indicate if Member is receiving this CS service.

MIF (Member Information File) Updates:

- Contact information for member/caregiver
- Referring organization and individual details
- Referral type: (1) Community Referral or (2) Identified by MCP

4. Referral Status Explained:

- **Accepted (1)** - This status indicates that the **referral has been received and accepted** by the Enhanced Care Management (ECM) or Community Supports provider. The provider is prepared to engage with the member and deliver the referred services.
- **Declined (2)** - A referral may be marked as **Declined** if the provider is **unable to accept the referral** for reasons such as:
  - Lack of capacity
  - The member is outside the provider's service area
  - Other operational or eligibility-related constraints
  - MCPs (Managed Care Plans) are expected to document and track the reasons for declined referrals in accordance with DHCS policy

Closed Loop Referrals Q&A

- What are best practices for CalAIM providers completing the RTF file?
- Where do you see the greatest opportunities for providers to work together to address referral tracking and communication challenges?
- How can CalAIM providers and MCPs partner more effectively on closed loop referrals?