

Complex Care Management

Orange County's Behavioral Health Plan (BHP) provides Complex Care Management (CCM) through a variety of services, as all members served by the Plan's specialty services are eligible given multiple complex needs that exist in the population served. All CCM services are available to members enrolled in services as medically necessary.

The following CCM services are provided in outpatient and residential settings:

1. Targeted Case Management (TCM)

TCM is a service that assists a member to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include but are not limited to communication, coordination, and referral; monitoring service delivery to ensure patient access to service and the service delivery system; monitoring the member's progress; placement services and plan management.

TCM services are provided at Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) county and county-contracted sites. Members must meet access criteria to receive SMHS or DMC-ODS services with Orange County BHP. TCM is available for all members enrolled in SMHS and/or DMC-ODS services and is discussed with the members upon intake. The complexity of the care management provided is determined based on the members' needs.

2. Intensive Care Coordination (ICC)

ICC is a targeted case management service that facilitates assessment of care planning for, and coordination of services to members under 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria to access SMHS. ICC service components include assessing, service planning and implementation, monitoring and adapting, and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family, and involved child-serving systems. The CFT is comprised of as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, clergy, and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child and family in attaining their goals.

ICC also provides an ICC coordinator who:

- Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/child driven, and culturally and linguistically competent manner and that services and supports are guided by the needs of the child;
- Facilitates a collaborative relationship among the child, their family and systems involved in providing services to the child;

- Supports the parent/caregiver in meeting their child’s needs;
- Helps establish the CFT and provides ongoing support; and
- Organizes and matches care across providers and child serving systems to allow the child to be served in the community

ICC services are provided at SMHS county and county-contracted sites that provide services to members under 21 years old who are in, or at risk of, placement in residential or hospital settings, but could be effectively served in the home and community. Members must meet access criteria to receive SMHS services with Orange County BHP. ICC is discussed with the member upon intake. In addition, the member must meet criteria for Pathways to Well-Being or Intensive Services. The complexity of the care management provided is determined based on the member’s needs.

The following CCM services require a referral:

1. **Enhanced Care Management (ECM)**

ECM is a Medi-Cal managed care benefit that addresses clinical and non-clinical needs of high-need individuals through the coordination of services and comprehensive care management. ECM is available to select members with complex health and/or social needs. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services. ECM makes it easier for members to get the right care at the right time in the right setting, and receive comprehensive care that goes beyond the doctor’s office or hospital.

ECM services are provided to members who meet the criteria for at least one of the following Populations of Focus:

- Adults, unaccompanied youth and children, and families experiencing homelessness
- Adults, youth, and children who are at risk for avoidable hospital or emergency department care
- Adults, youth, and children with serious mental health and/or substance use disorder needs
- Adults living in the community and at risk for long-term care institutionalization.
- Adult nursing facility residents transitioning to the community
- Children and youth enrolled in California Children’s Services (CCS) or CCS Whole Child Model with additional needs beyond their CCS condition(s)
- Children and youth involved in child welfare (foster care)
- Adults and youth who are transitioning from incarceration
- Pregnant and postpartum individuals; birth equity population of focus

Currently, Orange County BHP is contracted with CalOptima Health to provide ECM services to a select population of members 21 years and over within SMHS. Referrals can be submitted to CalAIMSupport@ochca.com.

ECM services are also available through CalOptima Health and Kaiser Medi-Cal, contracted

providers. Referrals can be submitted directly to CalOptima Health via email at CalAIMReferral@caloptima.org or by fax at (714) 338-3145. Referrals for Kaiser Medi-Cal can be submitted by email to RegCareCoordCaseMgmt@KP.org.

2. External Service Requests (ESR)

ESRs are initiated when Orange County's BHP does not offer a medically necessary service within the existing system of care. In these cases, the request is completed by the Plan Coordinator to ensure the member receives medically necessary care from an external provider. ESRs are submitted to the Utilization Management and Complex Care Coordination (UMCCC) under Quality Management Services (QMS). UMCCC processes the ESRs and assists with linkage, utilization review, and care coordination.

ESRs can be submitted for any member who is enrolled in, or eligible to enroll for, SMHS or DMC-ODS services in Orange County BHP.

CCM is a required component of the following Evidence Based Practices. Referrals are required where indicated:

Evidence Based Practices (implementation: July 2026)

1. Assertive Community Treatment (ACT)

ACT is an Evidence-Based Practice (EBP) for members with complex and significant mental health needs. ACT supports recovery through an assertive, person-centered approach that assists members to cope with the symptoms of their mental health condition and acquire skills necessary to function and be integrated in the community. ACT is a community-based, multidisciplinary team-based service. ACT may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment needs of the member. Services include one or more of the following: assessment, crisis intervention, employment and education support, medication support, peer support, psychosocial rehabilitation, therapy, and treatment planning.

Further guidance pending for referral and prior authorization pathway.

2. Forensic Assertive Community Treatment (FACT)

FACT is an adaptation of ACT for members involved with the criminal justice system, with specialized adjustments to address criminogenic risks and forensic needs.

Further guidance pending for referral and prior authorization pathway.

3. Full-Service Partnership Intensive Case Management (FSP ICM)

FSP ICM offers a comprehensive array of community-based services and can be provided either as a step-down from ACT or as an intervention to avert the need for ACT-level care. FSP ICM is delivered by a multidisciplinary team that incorporates core case management functions with low staff-to-client ratios, assertive outreach, and direct service delivery. FSP ICM is for individuals who may not meet ACT eligibility criteria but still have significant behavioral health needs and can benefit from FSP supports. Services include one or more of the following: assessment, crisis intervention, employment and education support,

medication support, peer support, psychosocial rehabilitation, therapy, and treatment planning.

Further guidance pending for referral pathway.

4. High Fidelity Wraparound (HFW)

HFW provides a comprehensive, holistic, evidence-based, youth and family-driven process for responding when youth experience significant mental health or behavioral challenges, including children and youth involved in multiple youth-serving systems. HFW is a team-based EBP that includes an “anything necessary” approach to care for youth with the most intensive behavioral health challenges and is the most frequently used EBP to support this population. The key functions of HFW are: HFW Facilitation and Care Coordination, Care Planning and Documentation; CANS Updates; Crisis Support and Safety Planning; Strengths-Based Psychoeducation and Psychosocial Skills Coaching for the Youth; Parent/Caregiver Peer Support; Youth Peer Support; Referrals and Coordination; and Care Transition Support. HFW is delivered in community-based settings, and, as necessary, to support continuity of care during transitional periods into and out of inpatient and residential settings.

HFW requires a CANS assessment to be completed by a qualified practitioner, for youth age six years or older, to confirm that HFW is medically necessary and clinically appropriate. Referrals can be made directly to an HFW program. The HFW LMHP compares CANS scoring against the HFW DSC to inform clinical decision-making about appropriateness of HFW. In rare cases where the HFW DSC is not met, the LMHP may choose to recommend HFW based on clinical judgment. The rationale for this recommendation must be clearly documented in the youth’s records.

5. Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)

CSC for FEP is an EBP for members experiencing a first episode of psychosis. CSC addresses the symptoms of psychosis to reduce the risk of psychiatric hospitalization, emergency room visits, residential treatment, involvement with the criminal justice system, substance use, and homelessness. CSC is a person-centered EBP that helps members cope with the symptoms of their mental health condition and to function and remain integrated within the community. CSC is a community-based, multidisciplinary team-based EBP. CSC may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment needs of the member. Services include one or more of the following: assessment, crisis intervention, employment and education support, medication support, peer support, psychosocial rehabilitation, therapy, and treatment planning.

Referrals can be made directly to a CSC for FEP program

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