



September 2026

Dear Colleagues,

The California Department of Health Care Services (DHCS), California Department of Public Health (CDPH), and California Department of Social Services (CDSS) are pleased to issue this joint letter to highlight best practices that support improved access to and utilization of home visiting programs (HVPs) for pregnant and postpartum Medi-Cal members across California.

Home visiting is a voluntary service that connects expectant parents and postpartum families with trained professionals — such as nurses, social workers, and early childhood specialists — who provide education, guidance, and support in the home and community. In California, the California Work Opportunity and Responsibility to Kids (CalWORKs) HVP and the Family First Prevention Services (FFPS) Program are administered by CDSS, while the California Home Visiting Program (CHVP) is administered by CDPH.¹ These programs use evidence-based home visiting models to support families who meet program-specific eligibility criteria, though program models vary in structure and service approach. California families may also access additional evidence-based HVPs outside of CDPH and CDSS, as well as evidence-informed programs administered by First 5 county commissions, Local Health Jurisdictions (LHJs), and community-based partners across the state.

Given the diversity of available programs and administering entities, strong cross-system coordination is essential to ensure that pregnant and postpartum Medi-Cal members are informed about and connected to home visiting services that best meet their needs and preferences.

¹ As of April 3, 2026, 57 counties and two Tribes with a Title IV-E agreement with the State have opted in to the FFPS Program.



Purpose. This letter has three primary objectives:

- Clarify existing statewide requirements for identifying, referring, and connecting pregnant and postpartum Medi-Cal members to appropriate local HVPs across Medi-Cal managed care, public health, and social services systems.
- Highlight best practices and implementation strategies to improve referral processes, maximize capacity, and support timely enrollment and sustained engagement in home visiting services. These practices are drawn from statewide and local experiences and complement the vital role of community relationships outside of these state systems.
- Support local operationalization of best practices and strategies by identifying opportunities to leverage existing Medi-Cal Managed Care Plan (MCP) Memoranda of Understanding (MOUs) and other written agreements to strengthen coordination and referral pathways.

This letter is not intended to establish new requirements or modify existing statutory, regulatory, or contractual obligations. Rather, it reiterates existing program guidance and shares best practices and lessons learned from state and local implementation across California. The Departments recognize the administrative and structural complexities that exist within HVPs and the broader health care system. The best practices below should be adapted based on local context and available resources given the varying implementation readiness, operational barriers, and capacity constraints counties face. The Departments also acknowledge that counties offer a range of complementary programs and services beyond evidence-based home visiting models to meet the needs of their communities. MCPs are encouraged to partner with LHDs and other local organizations to understand and leverage the full range of resources available to support pregnant and postpartum Medi-Cal members.

Audience. This letter is intended for organizations and partners that support pregnant and postpartum Medi-Cal members, including but not limited to:

- Medi-Cal MCPs and their contracted provider networks;
- LHJs, including those administering CHVPs and local Maternal, Child and Adolescent Health (MCAH) partners;

- County Health and Human Services Agencies (HHSAs), including those administering the CalWORKs HVP and/or FFPS and have selected HVPs as part of their Comprehensive Prevention Plan (CPP);
- Any other HVP agencies, administrators and home visitors;
- First 5 county commissions;
- Family resource centers (FRCs);
- Other community-based partners involved in maternal and infant health and family support services, as appropriate.

This letter reflects the coordinated efforts of DHCS, CDPH, and CDSS to advance equitable maternal health outcomes in California through strengthened cross-agency collaboration and improved referral and coordination pathways. The Departments acknowledge the valuable contributions of the First 5 Association of California and county commissions, whose local infrastructure and system-building efforts have informed the development of this joint agency letter and continue to support effective coordination of HVPs at the local level.

We hope this information is helpful. If you have questions regarding this letter, please email BirthCarePathway@dhcs.ca.gov.

Sincerely,

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I. EXISTING REQUIREMENTS RELATED TO LOCAL HVP REFERRALS

This section summarizes existing requirements and expectations under DHCS, CDPH, and CDSS authorities relevant to HVP referrals. These requirements govern how Medi-Cal MCPs, counties, and local partners should coordinate and facilitate HVP referrals and enrollment for pregnant and postpartum members. This consolidated reference clarifies existing roles, responsibilities, and coordination expectations supporting effective local HVP referral pathways – it does not create new requirements. Existing requirements can be reviewed in full by reviewing the formal guidance from each department for its respective programs.

A. DHCS Requirements

DHCS establishes requirements that guide how Medi-Cal MCPs coordinate with local partners to identify, refer, and connect pregnant and postpartum members to community-based programs, including HVPs. While home visiting is not a standalone Medi-Cal benefit, these requirements reinforce MCP responsibilities related to care coordination, referrals, and warm handoffs. The provisions below summarize applicable DHCS requirements.

1. Managed Care Contract (Boilerplate) Requirements

The Medi-Cal Managed Care Contract requires MCPs to coordinate and collaborate with local entities to address members' whole-person needs and support access to community-based services. These provisions include strengthening referral pathways and coordination with county and community programs serving pregnant and postpartum members.

Under the contract, MCPs must:

- Engage with Local Health Departments (LHDs), county social services departments, and other local agencies to treat the whole person and prevent avoidable negative health and social outcomes;²
- Establish and maintain MOUs with local entities (including but not limited to LHDs, county social service departments, and First 5 county commissions) and

² [DHCS Managed Care Boilerplate Contract](#) August 2026, Exhibit A, Attachment III, Section 5.0 ("Services – Scope and Delivery"), p. 330

operational processes that facilitate care coordination and referrals to community-based resources;³

- Ensure that members are connected to appropriate community services, including preventive and supportive programs. Specifically, this means that MCPs must proactively identify, reach out to, and connect pregnant and postpartum members to these services if the individual is amenable.⁴

2. Local Health Department Memoranda of Understanding (LHD MOUs)⁵

DHCS requires Medi-Cal MCPs and LHD MCAH programs to maintain MOUs that delineate how the parties will collaborate on MCAH programs, including CHVPs.⁶ MOUs are template documents that reflect existing requirements established elsewhere and are intended to facilitate initial discussions and collaboration between two parties. The goal is to leverage MOUs to meet the needs of both organizations, which includes supporting clear coordination roles, timely information sharing, and efficient referral and enrollment processes for pregnant and postpartum Medi-Cal members.⁷

Under the MCP–LHD MOU required by DHCS, among other responsibilities, MCPs must ensure the information necessary for eligibility assessment and enrollment is shared in a timely manner, and that operational barriers to referrals and follow-up are identified and addressed collaboratively with LHD partners.⁸ MCPs must also designate staff responsible for overseeing compliance with the MOU and ensure appropriate

³ [DHCS Managed Care Boilerplate Contract](#) August 2026, Exhibit A, Attachment III Section 5.6 (“MOUs with Local Government Agencies, County Programs, and Third Parties”), p. 448

⁴ [DHCS Managed Care Boilerplate Contract](#) August 2026, Exhibit A, Attachment III, Section 5.0 (“Services – Scope and Delivery”), p. 330

⁵ DHCS Local Health Department [MOU](#) Template

⁶ DHCS [APL 23-029](#), p. 2

⁷ DHCS has also established MOUs between MCPs and First 5 Commissions, WIC programs, and County Social Services Departments; while these MOUs do not explicitly include language detailing requirements related to HVP referrals, they do reference referrals and care coordination for needed services, which DHCS implies to mean HVPs when eligible and applicable.

⁸ [DHCS Managed Care Boilerplate Contract](#) August 2026, Exhibit A, Attachment III Section 5.6.2 (“MOUs with Local Government Agencies, County Programs, and Third Parties – MOU Requirements”), p. 450

governance, staffing, training, and leadership engagement to support effective collaboration with LHDs and MCAH programs, including CHVPs.⁹ MCPs are also required to maintain regular, ongoing coordination with LHDs through designated points of contact (“LHD Responsible Person and LHD Program Liaisons”), including meeting at least quarterly to support implementation of the MOU.¹⁰ Finally, per the MOU, MCPs and LHDs may agree to additional (optional) requirements, such as the exchange of data and member enrollment information in MCAH Programs and member information related to prevention, wellness, and home visiting activities, or services designed to minimize health disparities.

3. CalAIM Population Health Management (PHM) Policy Guide¹¹

Under DHCS’ [PHM](#) Initiative, MCPs and their networks and partners must respond to individual member needs within the communities they serve while working within a common statewide framework and set of expectations. The [CalAIM: Population Health Management \(PHM\) Policy Guide](#) outlines DHCS expectations for how MCPs operate their PHM Program.

DHCS’ PHM Initiative emphasizes whole-person, community-informed care and requires Medi-Cal MCPs to partner with local agencies and public benefit programs to support members’ holistic needs. Effective January 2024, MCPs were required to enter MOUs with First 5 county commissions and other entities to facilitate care coordination and information exchange.¹² Effective January 2025, MCPs were also required to coordinate

⁹ [DHCS Managed Care Boilerplate Contract](#) August 2026, Exhibit A, Attachment III Section 5.6.3 (“MOUs with Local Government Agencies, County Programs, and Third Parties – MOU Oversight and Compliance”), p. 453

¹⁰ [DHCS Managed Care Boilerplate Contract](#) August 2026, Exhibit A, Attachment III Section 5.6.2 (“MOUs with Local Government Agencies, County Programs, and Third Parties – MOU Requirements”), p. 450

¹¹ DHCS [PHM Policy Guide](#) July 2026

¹² DHCS [PHM Policy Guide](#) July 2026, Section E. Providing PHM Program Services and Supports: Basic Population Health Management (BPHM) and Care Management Programs 1. Basic Population Health Management (BPHM), a. Required BPHM Elements and Processes, ii. Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports, p. 41.

warm handoffs with LHDs and other public benefits programs, including but not limited to CalWORKs.¹³

Under PHM and in line with CalAIM, MCPs are accountable for providing Transitional Care Services (TCS) for all members across all settings and delivery systems, ensuring members are supported from discharge planning through successful connection to all needed services and supports.¹⁴ Per DHCS' Pregnancy and Postpartum TCS policy, MCPs must complete a [TCS Birthing Supports Checklist](#), which includes connection to local HVPs in alignment with member preferences for members who have need and meet eligibility criteria, in addition to other required medical, behavioral health, and whole-person supports.¹⁵

4. CalAIM Enhanced Care Management (ECM) Policy Guide

ECM, another component of DHCS' PHM Initiative, is a whole-person care management benefit required under the [MCP Contract](#)¹⁶, [APL 23-032](#), and DHCS' [ECM and Community Supports Standard Provider Terms and Conditions](#). Pregnant and postpartum Medi-Cal members may qualify for ECM under applicable Populations of Focus, including but not limited to Birth Equity. The ECM Policy Guide is intended to serve as a comprehensive resource for MCPs administering ECM, as well as for other key stakeholders involved in ECM, including Providers, counties, and community-based organizations (CBOs).

¹³ DHCS [PHM Policy Guide](#) July 2026, Section E. Providing PHM Program Services and Supports: Basic Population Health Management (BPHM) and Care Management Programs 1. Basic Population Health Management (BPHM), a. Required BPHM Elements and Processes, ii. Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports, p. 41.

¹⁴ [DHCS Managed Care Boilerplate Contract](#) August 2026, Exhibit A, Attachment III Section 4.3.10 Transitional Care Services, p. 226 & [PHM Policy Guide](#) July 2026 F. Providing PHM Services & Supports: Transitional Care Services (TCS), p. 49.

¹⁵ DHCS [PHM Policy Guide](#) August 2026, F. Providing PHM Services & Supports: Transitional Care Services (TCS) (Updated January 2026) F. Providing PHM Services & Supports: Transitional Care Services (TCS), p. 49.

¹⁶ [DHCS Managed Care Boilerplate Contract](#) August 2026, Exhibit A, Attachment III Section 4.1 Enhanced Care Management, p. 252.

MCPs are expected to coordinate with local programs serving pregnant and postpartum members—including CDPH’s CHVP and CDSS’ CalWORKs HVP—to identify eligible members.¹⁷ If these programs serve as the ECM provider, services may occur through those programs; if not, ECM providers are expected to consult and coordinate with them.¹⁸ Each MCP must outline its coordination and provider partnership approach in its ECM Model of Care, including policies for ECM provider contracting, oversight, and network capacity.¹⁹

B. CDSS Requirements: CalWORKs HVP

The CalWORKs HVP is a voluntary program supervised by CDSS and administered by participating California county HHSAs that partner with local home visiting agencies to provide high-quality, evidence-based home visiting services to CalWORKs recipients for the purpose of supporting positive health, development, and well-being outcomes for pregnant and parenting individuals, families, and infants born into poverty.²⁰ CDSS supervises the CalWORKs HVP in accordance with state statute and programmatic requirements; the provisions below summarize existing CDSS requirements for participating county HHSAs and partnering CalWORKs HVP agencies that are relevant to local referrals, coordination, and connection of eligible pregnant and postpartum Medi-Cal Members to CalWORKs HVPs.

1. Request for County Plan (RFCP) Application

CDSS accepts one CalWORKs HVP funding application per county HHSA via the [Request for County Plan \(RFCP\)](#) when the county initially seeks to participate in the program. Applications must describe county partnerships with local home visiting providers and how they will maximize capacity to meet program requirements and deliver CDSS-approved home visiting services effectively. Counties must also describe their data sharing agreements with partner home visiting agencies – including how all partners and service providers will protect the privacy and confidentiality of client personal information against loss, unauthorized access, and illegal use or disclosure – and how

¹⁷ DHCS [ECM Policy Guide](#) May 2026, IV. ECM Populations of Focus 9. Birth Equity Population of Focus, p. 54

¹⁸ DHCS [ECM Policy Guide](#) May 2026, XI. DHCS Oversight of ECM, p. 110

¹⁹ DHCS [ECM Policy Guide](#) May 2026, XI. DHCS Oversight of ECM, p. 110

²⁰ [W&IC 11330.6 - 11330.9](#)

client consent will be obtained in order to share both aggregate program and identified client-level case management data with contracted partners and CDSS. CDSS encourages participating HHSA and their local CalWORKs HVP partners to participate in a local multi-disciplinary group that focuses on home visiting to share best practices, improve service delivery, ensure systems integration, and address emerging issues.

CDSS requires county HHSA and their home visiting partners to establish local home visiting recruitment, outreach, and enrollment strategies; the CalWORKs HVP application must describe the plan for identifying, screening, and recruiting participants, including modalities used, who will conduct outreach, and best practices and lessons learned for current outreach efforts. CDSS encourages counties to evaluate local outreach strategies on an annual basis. When a participant is enrolled in CalWORKs HVP, the county HHSA and home visiting agency shall collaboratively establish a case management plan, including assessing family needs, developing and monitoring the case plan, and ensuring the provision of identified services.

2. County HHSA – Local Home Visiting Agencies MOU

An MOU between the participating county HHSA and its program partners, including the local home visiting agencies and regional partnerships, must be submitted to CDSS with the RFCP application and executed prior to commencing service provision. This agreement must include, but not be limited to each agencies' specific roles and responsibilities, data sharing and reporting, claiming funds, enrollment and outreach policies, and communication expectations.²¹ The agreement must also describe how each party will engage in consultation and collaboration through attendance at ongoing local community advisory committee meetings that have a focus on home visiting, and how advisory committee members shall share best practices, improve service delivery, ensure systems integration, and develop solutions to issues that may arise in HVPs. The county HHSA must serve as the fiscal lead and agree to participate and collaborate with all partners within the MOU and provide CDSS with current copies of all MOUs.

C. CDSS Requirements: Family First Prevention Services Act (FFPSA) Part I - Local Joint Written Protocols and Comprehensive Prevention Plans

²¹CDSS reserves the right to review and accept security and privacy procedures that are relevant to its data.

The FFPSA Part I is an optional state program that provides Title IV-E reimbursement for prevention services for children at imminent risk of entering foster care and for pregnant or parenting foster youth. California opted in and codified the program in state law as the Family First Prevention Services (FFPS) Program, expanding beyond federal requirements to include primary and secondary prevention strategies aimed at supporting families upstream and reducing reliance on the child welfare system. Assembly Bill 153 (2021) formally established the FFPS Program and authorized California's participation in FFPSA Part I.

The FFPS Program is optional for counties and the two Tribes with Title IV-E agreements, and supports them in providing primary, secondary, and tertiary prevention services, offering flexibility beyond what FFPSA Part I alone allows. The program sets requirements for Title IV-E agencies related to identifying eligible children, youth, and families; developing and implementing Comprehensive Prevention Plans (CPPs); and coordinating with cross sector partners to ensure access to evidence based programs and other supportive services. In California, FFPS is administered primarily by CDSS, in partnership with counties.

As part of FFPS in California, counties that opted in to the program created a Comprehensive Prevention Plan. Comprehensive Prevention Plans specify which Evidence-Based Practices identified in [California's Five-Year State Prevention Plan](#) can draw down Title IV-E funds, which may include (but are not limited to) HVPs such as Healthy Families America, Nurse Family Partnership, and Parents as Teachers. Access to Title IV-E prevention services vary by county based on the Evidence-Based Practice(s) they have selected to implement, but access pathways may include referrals by the child welfare agency, probation department, or a community provider contracted with the county.

Each Comprehensive Prevention Plan reflects a cross-sector, collaborative approach to the planning and implementation of an array of primary, secondary, and tertiary prevention strategies. The Comprehensive Prevention Plan outlines local coordination requirements across county agencies and their community partners – including child welfare, probation, behavioral health, local Office of Education, community-based service providers, local Child Abuse Prevention Council, family resource centers, parents and youth with lived experience, and tribal representatives – to ensure alignment in

service delivery, referral pathways, and funding responsibilities.

Counties are encouraged to braid and blend their funding to support comprehensive prevention services, as Title IV-E operates as the payer of last resort.²² To meet this requirement, county Comprehensive Prevention Plan teams must agree on which entity – the child welfare agency, probation department, behavioral health agency, and other appropriate entity – will be the payer for all or part of each prevention service, as documented in a local joint written protocol.

D. CDPH Requirements: CHVP

The CDPH CHVP administers the federal Maternal Infant & Early Childhood Home Visiting (MIECHV) Grant Funds and State General Funds to implement five evidence-based and innovative home visiting programs. CHVP services promote maternal health and well-being, improve infant and child health and development, strengthen family functioning and cultivate strong communities. These services are voluntary and provided by a Public Health Nurse or paraprofessional to pregnant and newly parenting families in the family's home or alternate agreed-upon location. Services are typically offered for two to five years.

While each HVP model has individual program requirements, CDPH/CHVP funded LHJs have the flexibility to tailor implementation to local community and family needs, including selecting which CHVP supported evidence-based home visiting model to implement and setting their own program eligibility criteria based on selected model developer guidance. This flexibility operates within a framework of coordination and integration requirements that are embedded across both CDPH/CHVP requirements (Policies & Procedures: [500-10 Early Childhood Systems Integration](#) & [200-40 Family Transition Plans](#)) and program priorities and evidence-based home visiting model standards.

²² Under federal requirements, "payer of last resort" means that any other available public or private funding source that would have covered a service prior to the FFPSA Part I program must be used before Title IV-E can be claimed. For more information on the guidance of payer of last resort, read the [CDSS All County Letter No. 25-12](#).

1. CDPH/CHVP Program Priorities and Requirements²³

CDPH/CHVP program priorities include ensuring that families receive essential early childhood services through a coordinated, community-wide system of care. An early childhood system brings together health, early care and education, child welfare, and other family support program partners, community leaders, families, and other partners to reach agreed-upon goals for thriving children and families. To achieve this, CDPH/CHVP LHJs are required to develop collaborative relationships with other agencies that serve families from pregnancy through kindergarten entry and coordinate services families need to thrive. Examples of other early childhood services agencies include but are not limited to:

- Local medical providers, hospitals, medical clinics, and MCPs
- CalWORKs and other HVPs
- Women, Infants and Children (WIC)
- Early/Head Start Programs
- Mental health/behavioral health providers and resources

Pursuant to P&P [500-10 Early Childhood Systems Integration](#), CDPH/CHVP LHJs must convene or participate in a Community Advisory Board (CAB) that serves in a consultative and/or governing capacity in the planning, implementation, and evaluation of program activities and systems integration. The CAB will assist CDPH/CHVP LHJs with participant recruitment, establish linkages with community services, link to other HVPs in the community, and integrate the program into the local early childhood system of care. The CAB includes members from agencies that represent a variety of community resources that could benefit home visiting participants and families.

Furthermore, CDPH/CHVP LHJs must adhere to the referral, coordination, and program eligibility requirements of the evidence-based home visiting models they implement. CDPH/CHVP LHJs must develop mechanisms to ensure service referrals are completed and effective feedback and communication occurs. This includes developing and maintaining MOUs and/or other written agreements with community agencies and service providers that the HVPs partner with. CDPH/CHVP LHJs have the autonomy to determine which organizations they establish MOUs or similar agreements with. This

²³ The [CDPH/CHVP website](#) provides a directory of all CHVP-funded sites, including local coordinator contact information for CHVP home visiting inquiries.

determination is based on the unique needs of their communities and their existing relationships with local partners and service providers. In addition, CDPH/CHVP LHJs must develop and implement a transition plan for families according to EBHV model guidance, including assessing the needs of families approaching program completion or when exiting home visiting services and providing support in the transition to community services.²⁴

II. Best Practices to Strengthen Utilization of Local HVPs by Medi-Cal Pregnant and Postpartum Members

This section highlights best practices across California counties that support referrals to and utilization of HVPs for pregnant and postpartum Medi-Cal members. These practices were identified through engagement with statewide stakeholders, including county-level program administrators, First 5 Association of California and county commissions, and Medi-Cal MCPs. The practices described are intended to support implementation of the existing requirements outlined above and strengthen local referral pathways; they do not establish new requirements. The Departments recognize the complex structural and administrative complexities within home visiting programs and the broader health care system. The best practices below should be adapted to local context and available resources given the varying implementation readiness and operational barriers counties face, including data-sharing and referral workflows, provider capacity, funding, and varying HVP structures. Please refer to illustrative examples of county partners implementing these best practices, which are outlined in detail in Appendix B.

A. Establish Local Forums to Strengthen County-Level Coordination and Collaboration for HVPs

County partners are encouraged to establish or sustain regular coordination forums and/or inclusive cross-agency collaboratives focused on supporting pregnant and postpartum Medi-Cal members in accessing home visiting services. These local forums can facilitate ongoing communication, collaboration, and problem-solving among Medi-Cal MCPs, MCAH programs, local HVPs (including CHVP, CalWORKs HVPs, and other county-level HVPs), and other relevant partners such as First 5 county commissions,

²⁴ See CDPH/CHVP [P&P 200-40 Family Transition Plans](#) for additional requirements.

Local Childcare Planning Councils, and Head Start.²⁵ If possible and where productive, these forums can leverage existing cross-agency coordination structures and avoid creating duplicative processes. For example, LHJ Community Advisory Boards (CABs)—which may overlap with or be integrated into First 5 or other local forums—can serve as an effective mechanism for engaging LHJs and convening partners.

Although many county partners already convene home visiting or early childhood collaboratives, opportunities remain to strengthen and expand MCP participation across these forums. MCP participation can strengthen referral pathways, enhance coordination across Medi-Cal and social services, streamline local processes and operations, and improve health and social outcomes for pregnant and postpartum Medi-Cal members and their families. Participating entities, including MCPs, are encouraged to share leadership responsibilities, such as planning, facilitation, or presentations for learning.

1. Topics and Activities for Local Home Visiting Forums

Local coordination forums may address a range of topics to support effective referral and triage systems and shared accountability to maximize county-level program capacity, including but not limited to the following topics:

Topics	Details
Engagement of Medi-Cal MCPs and Providers	Consistent MCP engagement in local forums helps MCPs understand and convey information to network providers about the various types of HVP programs available, HVP eligibility, referrals, and enrollment, as well as mechanisms in place for warm handoffs and closed loop referrals (CLRs). ²⁶ During these forums, MCPs may engage local entities about how MCPs can more effectively leverage existing community-based resources, rather than duplicating services or engaging new partners in ways that may undermine existing local capacity.

²⁵ The [California Integrated Core Practice Model \(ICPM\)](#) published by CDSS, DHCS, and other agencies, is a framework and practice manual that outlines how children, youth, and families should be served effectively across multiple public service systems in California. While it does not establish formal requirements, it provides best practices for system collaboration and can serve as a useful resource for cross-agency coordination.

²⁶ [Addendum to The PHM Policy Guide: Closed-Loop Referral Implementation Guidance.](#)

Topics	Details
	Forum participants can identify and share strategies for involving MCPs, perinatal care providers, federally qualified health centers (FQHCs), hospitals, and other partners in outreach, referrals, enrollment, and warm handoffs. Forums can identify and address barriers to provider and member participation, such as limited awareness of HVPs, administrative or workflow challenges, or communication or language access gaps. MCPs may further engage with their county partners by inviting them to present at their Community Advisory Committees (CACs) to raise awareness of available Home Visiting services among members. MCPs may also highlight these services through member and provider newsletters or work with local entities to develop member-facing materials for distribution in providers' offices.
Ongoing Education to Facilitate Improved Coordination	Local forums offer a venue for cross-agency education among health care, public health, social services, and community partners. As noted above, forums can educate MCP staff and providers about home visiting benefits in maternal and child health; locally available programs, including those designed specifically for populations that experience inequities; eligibility criteria; how to refer; and contact information for each program. With this shared understanding, MCP staff and providers are better equipped to discuss HVPs with pregnant and postpartum Medi-Cal members before making a referral, helping ensure members know what to expect and can make informed decisions. Forums can also strengthen county partners' understanding of MCP roles, managed care processes, and covered benefits that support care coordination and reimbursement. Shared learning across these partners — including opportunities for HVPs to share information about eligibility criteria and referral processes with one another — promotes timely referrals and reduces confusion.

Topics	Details
Referral Sharing and Capacity Management	Referral Process Clarification. Forums can help partners clarify referral processes for each HVP, including key contacts, eligibility and enrollment requirements, and how referrals should be submitted (e.g., through standardized forms, electronic systems, or by phone). County partners may also use forums to establish structured referral systems that ensure consistent referrals through shared processes and coordination rather than centralized intake (see below). Cross-Program and Cross-County Referrals. Forums can facilitate sharing of best practices for cross-program and cross-county referrals, including warm handoff approaches, understanding of program capacity, and strategies for coordinating care across programs to minimize service disruptions. Capacity Management. Where appropriate and consistent with data sharing agreements, forums may support sharing of enrollment data, capacity, waitlists, and eligibility to help maximize capacity, reduce gaps, and ensure appropriate referrals based on family circumstances and preferences. Forums can also serve as a place to establish clear communication pathways when capacity issues arise, helping ensure families are connected to the most appropriate HVP as efficiently as possible. MCP Data to Conduct Eligibility and Risk Assessments. Forums may explore how MCP claims or population health data can further enhance identification of pregnant and postpartum members who may benefit from home visiting and facilitate timely referral, enhancing proactive outreach and alignment between Medi-Cal and community services. Additionally, DHCS' PHM Service Risk Stratification, Segmentation, and Tiering (RSST) system and pregnancy and postpartum TCS requirements will create new opportunities for MCPs to gain insight into member risk, thereby prioritizing who may benefit most from HVPs. MCP Data to Tailor Member Outreach. Forums may also facilitate sharing of Medi-Cal managed care accountability set (MCAS) measures, which can help HVPs to better align outreach and tailor conversations with families around key

Topics	Details
	care milestones and service gaps to support improved maternal, postpartum, and early childhood metrics and outcomes. • Utilization of Existing Systems. Forums provide an opportunity to discuss leveraging existing referral and coordination systems rather than creating duplicative processes, which can streamline referrals, reduce burden, and promote consistency across programs. • Needs and Risk-Informed Referrals. Forums provide a venue to discuss how shared information can be strategically used to prioritize referrals and maximize participation and access, particularly for programs with restrictive eligibility or limited funding. Given limited HVP capacity, risk-informed referrals can help ensure that members with the greatest need are prioritized for access, optimizing resources and promoting equitable access. See recommendations for the use of MCP population health data to support risk-tiering above.
Home Visiting as a Priority for Ongoing County or State Planning Processes	Local coordination forums can be used to identify and elevate funding, staffing, and infrastructure needs to sustain collaborative home visiting coordination activities. Partners involved in key county planning processes – such as the Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), Behavioral Health Services Act (BHSA) Integrated Plans, and social service Comprehensive Prevention Plans – are well-positioned to participate in these discussions and leverage forums to help to ensure that home visiting is included in these foundational priority-setting county processes. In many California counties, First 5 commissions serve as backbone entities and fiscal intermediaries to braid resources and support system functions alongside CalWORKs HVP, CHVP, and child welfare partners.

B. Design and Implement Standardized Referral Tools and Triage Systems

County partners may consider developing or adopting standardized referral tools and triage systems to help ensure that pregnant and postpartum Medi-Cal members are connected to the most appropriate local HVP based on their individual needs, risk factors, preferences, and eligibility.²⁷ Some referral tools identify all programs for which a member may be eligible; however, they are most effective when followed by a conversation with the member to determine which program – among those with capacity – best aligns with their preferences. When leveraged in this fashion, structured tools can support consistency, reduce duplication for referring entities, and improve alignment across programs with differing eligibility criteria or enrollment timelines, while grounding referral decisions in holistic understanding of each member’s unique circumstances, goals, and support needs. These tools can also support efficient use of resources by helping ensure available HVP slots are optimally filled across programs.

When local data sharing is enabled, these referral tools can be cross-referenced with demographic and other relevant population health data and individual assessments to triage and identify the highest-risk members for program placement. Moreover, Data Use Agreements (DUAs) – with patient consent, protections regarding appropriate use, and ability to opt out and still receive services – could enable cross-program information sharing, particularly in referral workflows where a centralized tool allows members to opt in to sharing their information across eligible programs, mitigating the need for multiple referrals and streamlining communication both between programs and with the family referred.²⁸

²⁷ Counties have taken varying approaches to developing these tools and systems. Across counties, these tools were developed through local consortia or collaboratives that jointly identified the need for a shared referral approach, established MOUs or DSAs, and mapped eligibility criteria across applicable county programs into a single journey map. Some counties have automated this journey map through computerized algorithms, while others continue to use paper-based forms. The goals are to reduce duplicative referrals across multiple programs for which a member or client may be eligible, match families with best fit opportunities, and manage capacity across programs.

²⁸ Data Sharing Agreements (DSAs) are contingent on member consent; consent forms typically include language allowing contact by the “network” or permitting information sharing across

C. Leverage Medi-Cal Covered Benefits to Support Home Visiting Services and Braid with Available Funds

Billing Medi-Cal for home visiting services is an optional and supplemental reimbursement strategy for local programs that have the infrastructure and capacity to do so. While home visiting is not a standalone Medi-Cal benefit, some county partners are exploring opportunities to leverage Medi-Cal covered services—such as [Enhanced Care Management \(ECM\)](#) and [Community Health Worker \(CHW\)](#) services—to reimburse and sustain specific components of local HVPs.^{29,30} The use of ECM and CHW Medi-Cal benefits is not meant to replace or supplant existing home visiting funding streams; rather, they are intended to enhance service capacity, improve care coordination and health outcomes for families, strengthen workforce support, and improve coordination between Medi-Cal providers and local agencies.³¹

County partners, like First 5s, have also relied on capacity building supports to develop the infrastructure needed to access Medi-Cal benefits, leveraging opportunities such as Providing Access and Transforming Health (PATH) grants or technical assistance, as well as MCP grants such as through the Incentive Payment Program (IPP).

Successfully leveraging these opportunities often requires county partners to “braid” or integrate multiple funding streams to sustainably finance service delivery and the infrastructure needed to support coordinated home visiting systems. Notably, some First 5 county commissions are key coordination partners across HVPs and payers in their counties, braiding funding from First 5 Proposition 10, CalWORKs, and other state/county prevention services to efficiently manage program capacity, maximize

county agencies. Carefully structuring consent form language—consistent with HIPAA—to allow appropriate flexibility for data sharing is a best practice.

²⁹ ECM is a statewide Medi-Cal benefit available to eligible members with complex needs and includes access to a single Lead Care Manager who provides comprehensive care management and coordinates their health and health-related care and services.

³⁰ CHW services are preventive health services available to MCP members to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and well-being.

³¹ Additional coordination may be required to minimize duplication in services provided to Medi-Cal members enrolled in both ECM and Home Visiting services.

access, and reduce service disruption for families. This can be especially critical when a funding source becomes unavailable due to eligibility changes or other factors.

III. CONCLUSION

This Joint Agency letter is intended to support counties, MCPs, and local partners in identifying and strengthening referral pathways and improving coordination to ensure pregnant and postpartum Medi-Cal members are connected to HVPs. The Departments appreciate the ongoing commitment of statewide partners and look forward to continued collaboration to better support pregnant and postpartum Medi-Cal members and their families.

APPENDIX A: CalWORKs HVP, CDPH CHVP, MEDI-CAL GENERAL INFORMATION (NON-EXHAUSTIVE)

Category	CalWORKs Home Visiting Program <i>CDSS</i>	California Home Visiting Program <i>CDPH</i>	Medi-Cal <i>DHCS</i>
General Eligibility Criteria	To be eligible for home visiting services per W&IC section 11330.6(c)(2), a voluntary participant shall meet <u>both</u> of the following criteria*: ○ Either pregnant, or the parent or caretaker relative of a child less than 24 months of age at the time the individual enrolls in the program; and ○ A member of the CalWORKs assistance unit; or the parent or caretaker relative for a child-only CalWORKs case; or an individual who is apparently	CDPH/CHVP serves pregnant and newly parenting families with at least one of the following risk factors: domestic violence, inadequate income, unstable housing, education less than 12 years, substance use disorder, and depression and/or mental health related challenges. In addition, CDPH/CHVP funded LHJs establish their own eligibility criteria based on local needs and in accordance with their implementing evidence-based home visiting model eligibility requirements.	To qualify for Medi-Cal, an individual must live in the state of California and must meet certain rules.

Category	CalWORKs Home Visiting Program CDSS	California Home Visiting Program CDPH	Medi-Cal DHCS
	eligible for CalWORKs aid <i>*A county may serve additional individuals not described in the above criteria with CDSS departmental approval (for example, parents or caretaker relatives of children younger than 36 months of age at the time of enrollment).</i>		
Income Requirements	Californians qualify for CalWORKs and CalWORKs HVP, if their family's countable income is lower than the Minimum Basic Standards of Adequate Care (MBSAC), which varies by region.	CDPH/CHVP prioritizes serving families with the highest needs. CDPH/CHVP funded LHJs establish their own income requirements based on local needs and in accordance with their implementing evidence-based home visiting model income requirements.	• In general, Californians qualify for Medi-Cal benefits if they have low income or have a qualifying reason. • Further, pregnant and postpartum individuals can qualify for Medi-Cal with higher income limits than

Category	CalWORKs Home Visiting Program CDSS	California Home Visiting Program CDPH	Medi-Cal DHCS
			other Californians.
Evidence-Based Programs Employed	• Healthy Families America (HFA) • Nurse-Family Partnership (NFP) • Parents as Teachers (PAT) • Home Instruction for Parents of Preschool Youngsters (HIPPY) • Early Head Start—Home-Based Option • Promoting First Relationship-Home Visiting Intervention Model	• Healthy Families America (HFA) • Nurse-Family Partnership (NFP) • Parents as Teachers (PAT) • Home Instruction for Parents of Preschool Youngsters (HIPPY) • Family Connects International (FCI)	

APPENDIX B: COMPREHENSIVE LIST OF COUNTY EXAMPLES BY BEST PRACTICE

County Examples: Local Home Visiting Forums

- The [Los Angeles County Perinatal and Early Childhood Home Visitation Consortium](#), funded by First 5 Los Angeles and hosted by Los Angeles Best Babies Network, is a network of over 70 organizations that supports enhanced referral systems, collects countywide data, and provides workforce development opportunities. Grounded in an overarching strategic plan, the Consortium includes six work groups focused on topics such as best practices, data, advocacy, and referrals. The Los Angeles **Maternal & Child Managed Care and County Partner Meetings**, hosted by First 5 Los Angeles, convenes quarterly to strengthen relationships between First 5 Los Angeles, the county, health plans, and CBO leaders. These meetings focus on sharing best practices, supporting policy and program implementation and sustainability, and advancing data use and quality improvements. Separately, a Collaborative Leadership Council – comprised of funders, County representatives, providers, advocates and philanthropy – meets quarterly to focus on systems change, monitoring, and advocacy for home visiting.
- **First 5 Orange County** is the backbone agency for the **Home Visiting Collaborative** with 24 member agencies, all agencies either funding or providing evidence-based home visiting services. The group has developed referral pathways prioritizing existing funding streams and eligibility requirements. Additionally, the group works on performance management, system capacity, triaging, and braids funding (First 5 Proposition 10, CalWORKs, MIECHV, Head Start) and supports workforce training for home visitors.
- **First 5 Sacramento's** [Sac Family Connect](#) began as a collaborative network in 2021 to improve the physical and emotional well-being of prenatal and parenting families through a coordinated system of care, focusing on high-quality family support services – primarily home visiting – that are equitable, easily accessible, culturally responsive, and best meet the needs of those being served. As part of their collaborative efforts, over 30 agencies signed an MOU that included building stronger relationships,

improving cross-agency referrals, providing training and networking opportunities, uplifting community voice, and sharing data. As the collaborative has expanded, more than 50 agencies meet on a quarterly basis.

- The **Santa Cruz Thrive by 5 Initiative**, a collaboration between First 5 Santa Cruz County and the County's HHSA, established a home visiting collaborative that convenes quarterly to strengthen coordination among local home visiting providers and related programs. Known as Thrive by 5 Learning Collaborative, participants include representatives from CalWORKs, CDPH/CHVPs, Families Together, and Head Start Home Visiting. Each three-hour meeting features a presentation from a participating agency on a topic of shared interest, followed by facilitated networking and collaboration opportunities. While MCPs have not yet participated in these meetings, stakeholders noted that MCP engagement could further enhance coordination and referral pathways.
- **First 5 Siskiyou** leverages funding from First 5 CA and the Ford Family Foundation to serve as the lead coordinating agency for the Siskiyou County Home Visiting Coordination system. This initiative focuses on improving how HVPs work together so families can more easily access the services that best meet their needs. The Siskiyou County Home Visiting Coordination System convenes home visiting partners, strengthens cross-agency communication, and supports shared referral pathways that reduce duplication and improve access for families with young children. First 5 Siskiyou facilitates collaborative planning, promotes consistent professional development opportunities for home visitors and other family support providing organizations, and helps ensure that families experience a no wrong door approach when seeking support. Based on an evaluation report from Portland State University, this coordinated effort has increased alignment among local programs, enhanced system responsiveness, and expanded Siskiyou County's capacity to serve families more effectively.
- The **Sonoma County Department of Health Services'** Home Visiting Programs convene a Home Visiting Community Advisory Board, bringing together Home Visiting Programs, community partners, and former clients for relationship-building, and coordination to support improvements in service delivery. The group meets quarterly to discuss program offerings,

eligibility, capacity, new initiatives, and to get feedback on how to improve services to better meet community needs. Additionally, every other month, the Sonoma County MCAH team facilitates a meeting with the Comprehensive Perinatal Services Program (CPSP) Coordinators from the local FQHCs and Home Visiting staff to discuss coordination of services for pregnant and postpartum Medi-Cal families. These meetings provide a forum to share information on community resources and identify opportunities to strengthen referral pathways and processes.

- **Ventura County Department of Public Health** holds a quarterly MCAH-focused meeting with Kaiser Permanente to review ongoing work efforts and identify areas where MCP support is needed.
- **The Yuba-Sutter Bi-County Home Visiting Collaborative** advances coordinated and sustainable home visiting systems, cross-county collaboration, and stronger integration with broader early childhood, perinatal, and family-serving systems. The collaborative supports shared planning, referral coordination, systems alignment, cross system relationship strengthening, parent leadership opportunities, accessible self-referral pathways for families, and professional learning communities. Across both Yuba and Sutter Counties, this work aligns closely with each county's Community Health Improvement Plan (CHIP) priorities, through Yuba's Healthcare Access priority and Sutter's Home visiting priority, creating stronger opportunities for home visiting access and expansion, Medi-Cal and public health integration, and coordinated family pathways. Through this shared commitment, both counties have strengthened regional learning collaboratives, deepened partnerships with public health, MCPs, and community providers, and reinforced home visiting as a core component of the broader perinatal and early childhood system.

Note: *LHJ CABs—which may overlap with or be integrated into First 5 or other local forums—can serve as an effective mechanism for engaging LHJs and convening partners. As of April 2026, counties that have leveraged their CABs to serve as local home visiting forums include Santa Cruz, Siskiyou, Yuba, and Sutter, among others.*

County Examples: Standardized Referral Tools and Triage Systems

- **Lassen Links** is a growing network of local organizations in Lassen County serving children, families, and people through collaborative community services, supports and resources. Families can complete the [Lassen Links](#) Intake Form to initiate the referral process and be connected with appropriate supports.
- **The Los Angeles County Home Visiting eDirectory**, funded by First 5 Los Angeles and managed by Los Angeles Best Babies Network, was launched in 2019 by a coalition of community organizations and hospitals to help pregnant people and families find free home visiting services. The directory has since expanded to include doula services and now features more than 35 organizations providing home visiting and doula supports. Families and individuals who work with pregnant and parenting people can answer a brief set of questions to identify programs available in their area.
- **First 5 Orange County** developed the Bridges for Newborns program, a partnership between First 5 Orange County and hospitals that accept Medi-Cal. Bridges for Newborns provides the technology for an automated risk screening to all families based on administrative data presented at registration, staffing for bedside assessment, referral to home visiting for those families that screen with highest risk, and referral to First 5 CHW for instances where home visiting is not a fit for the family. The CHW engages with the family through phone calls, text messages, and one-on-one visits to make additional referrals, link them to concrete supports, and ensure connection to a medical home or community supports (like developmental playgroups).
- **First 5 Orange County's** CLR systems track referrals into and out of home visiting, with funding capacity and eligibility embedded within the referral pathways. The systems include referrals into CalWORKs, Early Head Start, CHVP funded providers, and First 5 OC's funded programs.
- In partnership with the Sac Family Connect Collaborative, **First 5 Sacramento** developed the [Sac Family Connect Website](#), where families can see the services, they are eligible for and self-refer to the ones that interest them. Additionally, **First 5 Sacramento** developed a [short training video](#) for community partners highlighting the Home Visiting

Referral [Decision Tree](#), with a “No Wrong Door” approach to making referrals to home visiting. The intent of the Decision Tree is to help organizations make home visiting referrals that are most specialized to the family’s needs.

- **First 5 Ventura County** [Home Visiting Connections](#), developed in partnership with Ventura County Department of Public Health and Child Development Resources of Ventura County, is an online tool that helps families identify free HVPs that offer support during pregnancy and early childhood. The platform centralizes information about available programs and assists families in determining which services best align with their needs.
- **First 5 Yolo**, in partnership with Children’s Data Network, UC Davis, and local FQHC, CommuniCare+OLE, developed an evidence-informed, locally validated administrative data risk screen to establish a triage system for the perinatal Medi-Cal and uninsured population. Within First 5 Yolo’s Welcome Baby: Road to Resilience HVP, a dedicated public health nurse conducts the initial assessment to understand each family’s needs and uses that information to triage and coordinate appropriate referrals to home visiting, health care, and community resources.

County Examples: Braiding Funding

- **First 5 Los Angeles** will begin billing Medi-Cal for CHW services with their [Welcome Baby](#) HVP in the coming fiscal year and continue exploring integration of ECM with support from a L.A. Care grant.
- **First 5 Monterey (F5MC)** serves as a hub for child development-focused care coordination and home visiting services across Monterey County. Through close partnership with Monterey County’s DSS and local funded partners, F5MC braids funding to ensure cohesive and connected services for families across funding streams and eligibility requirements. This approach helps to maximize services and minimize disruption for families, particularly if eligibility shifts over time. Recently, F5MC partnered with the local MCP to bill and incorporate Medi-Cal CHW and ECM benefits into existing home visiting and care coordination services and increase availability of these benefits for the prenatal to age 5 population. This

supports the financial sustainability of the home visiting and care coordination hub as an important source of supplemental funding.

- **First 5 Orange County** is billing the Medi-Cal CHW benefit for families that are identified as home visiting eligible (through an automated hospital bedside screening) but are not comfortable engaging with home visiting services. The CHW assists with care navigation, referrals, health education, and continues to engage eligible families in home visiting services.
- **First 5 Yolo** is billing Medi-Cal CHW and ECM benefits to braid Medi-Cal, Proposition 10, CDSS, DHCS, and other state and local public funding for [**Welcome Baby: Road to Resilience**](#), a HVP that provides a central point of coordination for triage and referral for all Medi-Cal covered or uninsured birthing families. Closely managed by First 5 Yolo, the HVP provides a nurse home visit within the first two weeks postpartum, access to longer-term home visiting for eligible families, and appropriate referral to other services, coordinating care across ten medical systems and multiple community agencies.