Can CalAIM Solve the Systems Integration Challenge?

Identifying Key Facilitators of Cross-Sectoral Care Coordination

Strategies to Achieve Alignment, Collaboration and Synergy across Delivery and Financing Systems

Research-in-Progress Webinar
June 21, 2023
12pm ET
Agenda

Welcome: Carrington Lott, MPH, Systems for Action

Presenters: Caroline Fichtenberg and Abigail Arons, SIREN, UCSF
            Karis Grounds, 211 San Diego
            Sheena Nahm McKinley, Health Leads

Commentary: Glen Hilton, PATH (People Assisting the Homeless)

Q&A: Carrington Lott, MPH, Systems for Action
Background: What is CalAIM?

California Advancing and Innovating Medi-Cal (CalAIM)
Our Journey to a Healthier California for All

Medicaid reform in California
Began January 2022

- Implement a whole-person care approach and address social drivers of health.
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation.
- Create a consistent, efficient, and seamless Medi-Cal system.

Source: CA Department of Health Care Services
Background: What is CalAIM?

...a once-in-a-generation opportunity to completely transform the Medicaid system in California.

Governor
Gavin Newsom
Two key features of CalAIM

**Enhanced Care Management (ECM)**
- Intensive care management for medical and social services
- High-need high-cost members (9 “populations of focus”)
- Managed care benefit: plans have to cover

**Community Supports (CS)**
- 14 non-medical services
- In lieu of services: strongly encouraged but not required (plans choose what to cover)

- Builds on previous Whole Person Care and Health Homes pilots
- Plans contract with community-based providers
- Also includes $ for building up data sharing and cross-sector coordination capacity among ECM and CS providers

Source: CA Department of Health Care Services
MCPs are required to have a broad range of programs and services to meet the needs of all Members organized into the following three areas, at different levels of intensity:

**Enhanced Care Management (ECM)** is for the **highest-need Members** and provides intensive coordination of health and health-related services.

**Complex Care Management (CCM)** is for Members at **higher- and medium-rising risk** and provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions.

**Basic Population Health Management (BPHM)**. BPHM is the array of programs and services for all MCP Members, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care.

**Transitional Care Services** are also available for all MCP Members transferring from one setting or level of care to another.

# ECM Populations of Focus

<table>
<thead>
<tr>
<th>ECM Population of Focus (POFs)</th>
<th>Adults</th>
<th>Children &amp; Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Individuals Experiencing Homelessness</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>2 Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly “High Utilizers”)</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>3 Individuals with Serious Mental Health and/or SUD Needs</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>4 Individuals Transitioning from Incarceration</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>5 Adults Living in the Community and At Risk for LTC Institutionalization</td>
<td>✔️</td>
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<tr>
<td>6 Adult Nursing Facility Residents Transitioning to the Community</td>
<td>✔️</td>
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</tr>
<tr>
<td>7 Children and Youth Enrolled in California Children’s Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>8 Children and Youth Involved in Child Welfare</td>
<td></td>
<td>✔️</td>
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<tr>
<td>9 Individuals with I/DD</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>10 Pregnant and Postpartum Individuals; Birth Equity Population of Focus</td>
<td>✔️</td>
<td>✔️</td>
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Community Supports

Pre-Approved DHCS Community Supports

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations
12. Meals/Medically-Tailored Meals or Medically-Supportive Foods
13. Sobering Centers
14. Asthma Remediation

Source: CA Department of Health Care Services
**ECM and CS providers**

**Enhanced Care Management (ECM)**
- FQHCs
- Behavioral health orgs
- County agencies
- Homeless service providers
- Justice-involved service providers
- Care coordination organizations/Hubs

**Community Supports (CS)**
- Providers of:
  - Homeless services
  - Supportive housing
  - Recuperative care
  - Medical respite
  - Home-based services
  - Medical nutrition
  - Home modifications
  - Asthma remediation

Source: CA Department of Health Care Services
Enhanced Care Management (ECM)
- Care coordination organizations/Hubs

Community Supports (CS)
- Homeless services
- Supportive housing
- Recuperative care
- Medical respite
- Home-based services
- Medical nutrition
- Home modifications
- Asthma remediation

Key to CalAIM success:
Coordination between health and social service organizations, including cross-sector contracting, data exchange, coordination to avoid duplication of services, etc.

Source: CA Department of Health Care Services
• 956 contracted ECM providers as of Sept 2022
• 88,115 total members enrolled as of Sept 2022 (cumulatively)

Source: CA Department of Health Care Services
Community Supports Implementation

- 1,212 contracted CS providers as of Sept 2022
- 27,213 members received services from Jan-Sept 2022

Source: CA Department of Health Care Services
COMMUNITY SUPPORTS BY THE NUMBERS
Number of Services Available by County as of September 2022

Number of Community Support Available as of September 2022, by county:
- Fewer than 6 Community Supports
- 6-13 Community Supports
- All 14 Community Supports

Source: CA Department of Health Care Services
Percent of county-specific plans that offer each community support as of Feb 2023 (n=105)

1. Is CalAIM improving coordination between health (health care and public health) and social services for Medicaid beneficiaries, especially for beneficiaries from historically marginalized communities (e.g. BIPOC, non-English speakers)?

2. What factors make coordination more successful, especially for organizations serving historically marginalized communities?
Research activities

Survey of social service organizations

Local case studies

Backbone organization community of practice

Summer 2023

Winter 2023-2024

2023-2026
Research Activities: Survey

○ First statewide survey about CalAIM implementation
○ Partnership with the California Health Care Foundation
○ Organizations that could implement CalAIM:
  ■ Community based organizations
  ■ Health care
  ■ Payors
  ■ Public health
○ Online survey July-Aug 2023 (possible follow-up in summer 2024)
Goals:
Organizational and environmental factors associated with
• ECM and/or CS participation
• Measures of effective coordination between social service orgs and other sectors

Specific focus on BIPOC-serving organizations
• Able to effectively participate?
• What changes would help these organizations participate more effectively?
Project Activities: Case studies

- Deeper dive to better understand survey results
- 5 counties
- Interviews with 5-10 organizations and some Medi-Cal members
- Winter 2023-2024
2-1-1 San Diego / Imperial

Free, 24/7 service, 3-digit dialing code
Access to community, health, social and disaster services
Tailored programs take the client beyond just a referral—movement towards Navigation

Community Information Exchange

Systems change that fosters true collaboration across networks
Moving towards person-centered interventions and interactions across healthcare and human services
Goal is to improve health and wellness for individuals and populations
### Project Activities: Community of Practice

**OUR VISION:**
Health, well-being and dignity for every person in every community.

**OUR MISSION:**
We partner with communities and health systems to address systemic causes of inequity and disease. We do this by removing barriers that keep people from identifying, accessing and choosing the resource everyone needs to be healthy.
Goals: Convene backbone organizations to:

1. Highlight common challenges that could be addressed through local data sharing initiatives and infrastructure
2. Create a space for sharing approaches and strategies
3. Ensure community stakeholders voices are informing local data sharing initiatives
4. Collaborate on recommendations for how to improve CalAIM’s cross-sector collaboration efforts
5. Provide an opportunity for real-time observation of lessons learned and role of backbone organizations in systems integration

Meet bimonthly starting May 2023
Project Activities: Community of Practice

United Way Bay Area (San Francisco)
Community Link Capital Region (Sacramento)
United Way Fresno and Madera Counties
Inland SoCal United Way (Riverside/San Bernadino)
211 LA (Los Angeles)
Imperial County Public Health Department
211/CIE San Diego

In process of reaching out to other California counties to participate
Community of Practice Shared Learning Topics:

- Closed-loop referral
- Streamline intake process
- Continuity of Care (Community Care Coordination)
- Provider Capacity
- Data Sharing to Support Care Coordination
Project Activities: Community of Practice

Potential Impacts of CoP

**Micro:**
- Seamless service delivery for individuals and families
- Improved Care Coordination through data sharing

**Mezzo:**
- Synergetic community infrastructure
- Shared data infrastructure
- Coordinated provider capacity

**Macro:**
- Managed care plan (MCP) Policy
- Improved population health
Expected Project Impacts

- Recommendations to state Medicaid agency
- Guidance to other organizations seeking to support CalAIM implementation
- Guidance to other states
- Help lay foundation for effectiveness evaluation

- Outputs:
  - Policy briefs
  - Academic publications
  - Presentations
Commentary

Glen Hilton - Director of Community Care, PATH

Glen Hilton joined PATH in May 2019 and has served in the roles of clinician and associate director for Whole Person Wellness/Health Homes. In his current role as Director of Community Care, Glen oversees PATH San Diego’s Whole Person Wellness, Health Homes, Community Care Coordination and Veteran and Community Services programs as well as the PATH San Diego Housing team.

His background includes 13 years as a licensed mental health professional focusing on work with adjudicated and at-risk youth, LGBTQIA+ TAY individuals and people experiencing homelessness.
California Advancing & Innovating Medi-Cal (CalAIM): PATH Commentary

Glen Hilton, LMFT
ABOUT US

Across the state, we help people find permanent housing and provide case management, medical and mental healthcare, benefits advocacy, employment training, and other services to help them maintain their homes stably.

Our mission is to end homelessness for individuals, families, and communities. PATH envisions a world where every person has a home. Our values include creative collaborations, strategic leadership, empowerment for all, and passionate commitment.
# SAN DIEGO PROVIDERS

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
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<tbody>
<tr>
<td>CalAIM Providers (any benefit/service)</td>
<td>33</td>
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<tr>
<td>Enhanced Care Management</td>
<td>12</td>
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<tr>
<td>Housing-Related Community Supports</td>
<td>17</td>
</tr>
<tr>
<td>Recuperative Care / Short-Term Post-Hospitalization</td>
<td>5</td>
</tr>
<tr>
<td>Other Community Supports</td>
<td>21</td>
</tr>
</tbody>
</table>
## PATH’S CalAIM PROGRAM OVERVIEW

<table>
<thead>
<tr>
<th>County:</th>
<th>Los Angeles</th>
<th>Orange</th>
<th>San Diego</th>
</tr>
</thead>
<tbody>
<tr>
<td># Health Plans at Start</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td># Health Plans Today</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Start Date</td>
<td>1/1/22</td>
<td>10/1/22</td>
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</table>

### Services:

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<tbody>
<tr>
<td>Enhanced Care Management</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes (1/22 - 9/22)</td>
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<tr>
<td>Housing Transition Navigation Services</td>
<td>Yes</td>
<td></td>
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<td>Short-Term Post-Hospitalization Housing</td>
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PROGRAM GOALS

- Continue supporting Whole Person Care and Health Homes clients
- Support staff retention
- Increase capacity for community-based referrals
- Participate actively in client-centered whole person care for clients
IMPLEMENTATION CHALLENGES

- Multiple plans, multiple services, different rates / units of pay
- Complex referral and authorization workflows
- Different billing systems and processes
- Separation of ECM from Community Supports
- Lack of pairing with rental assistance
- Diminishing supply of low-cost housing
- Sustainability of client base
SUCCESES

- Transitioned 200 members from grant-based to fee-for-service
- Served nearly 300 clients, with 150 currently enrolled
- Provider / Community Information Exchange collaboration
- Acquired expertise in referral, authorization, claims billing, service transition processes
- Significant grant funding to assist in start up and infrastructure costs
- Increasing data sharing:
  - ASCMI (Authorized Sharing of Confidential Medical Information)
  - Data Exchange Framework
LESSONS LEARNED

- Outsourced claims billing and collection
- Simpler start-up (fewer plans; fewer services)
- Importance of braided Medicaid funding and services
  - Considering ECM at PSH sites
OPPORTUNITIES

- Greater collaboration with Managed Care Plans
- Greater transparency in clients’ ECM enrollment and Lead Care Managers
- Targeted outreach into hospitals
- Planned re-entry into Enhanced Care Management services
THANK YOU
Questions?

www.systemsforaction.org

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One will be emailed to you.
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https://systemsforaction.org/research-progress-webinars

Achieving Reach in Youth Behavioral Health and Wellness through Catchment-Area Community Governance

July 5
12pm ET
Systems for Action is a National Program Office of the Robert Wood Johnson Foundation and a collaborative effort of the Colorado School of Public Health, administered by the University of Colorado Anschutz Medical Campus, Aurora, CO.