CHCF

CalAIM Experiences:
Implementer Views in Year Three of Reforms

DECEMBER 2024

AUTHOR
Goodwin Simon Strategic Research

Contents

Acknowledgments

CHCF thanks the 2024 CalAIM Implementation Advisory Group members for their time, guidance, and support of this project.

Cathryn Couch
CEO
Ceres Project

Van Do-Reynoso
Chief Health Equity Officer
CenCal Health

Alex Fajardo
Executive Director
El Sol Neighborhood Educational Center

Christie Gonzales
Chief Program Officer
WellSpace Health

Ruben Imperial
Assistant Executive Officer
Stanislaus County

Nancy Kalev
Senior Director
Systems of Care, Health Net

Sabra Matovsky
CEO
Healthcare LA IPA

Chris Myers, DO FACS
Chief Clinical Officer
United Indian Health Services, Inc

Shamsher Samra, MD, MPhil
Assistant Professor of Emergency Medicine
Harbor-UCLA Medical Center

Katelyn Taubman
Community Health Worker
Inland Housing

About the Authors

Goodwin Simon Strategic Research (GSSR) is an independent opinion research firm with decades of experience in polling, policy analysis, and communications strategy for clients in the public and private sectors. GSSR founding partner Amy Simon, partner John Whaley, and senior research analysts Nicole Fossier and Yule Kim all contributed their thought leadership on this survey research in collaboration with the California Health Care Foundation.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make

care more just and to drive improvement in a complex system. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Introduction and Summary of Key Findings

In January 2022, the California Department of Health Care Services launched CalAIM (California Advancing and Innovating Medi-Cal), a multiyear initiative with the potential to improve outcomes for the millions of people enrolled in Medi-Cal, California's Medicaid program. It also offers an unprecedented opportunity to move to a more integrated and people-centered approach to care for people with the most complex health and social needs, such as those with behavioral health conditions and people experiencing homelessness, among others.

As implementation continues, alongside other major changes to Medi-Cal, including the transition of more than 1.2 million enrollees in 21 counties to new plans in January 2024, much can be learned from people on the ground launching and running a multitude of new programs. Throughout this report, they are referred to as implementers. This report highlights both shared and differing perspectives from the staff and leaders of a broad range of health and social service providers, including managed care plans and local government agencies. Encouragingly, implementers continue to share successes in improved access and more comprehensive care for people with complex needs. At the same time, implementers also surface significant challenges and important improvements that must be made to increase CalAIM's effectiveness in the coming years.

On behalf of the California Health Care Foundation, Goodwin Simon Strategic Research (GSSR) conducted qualitative and quantitative research among CalAIM implementers in 2023 to gain a clearer picture of how implementation was occurring on the ground. A quantitative online survey was conducted in the summer of 2023 among 1,196 CalAIM implementers, with results published in December 2023. To assess how implementation was proceeding in the next year, GSSR conducted a second online survey, again on behalf of the California Health Care Foundation and with additional support from the Lucile Packard Foundation for Children's Health. The survey was conducted August 9 to September 16, 2024, among 948 CalAIM implementers at least "a little familiar" with CalAIM (implementers who reported being "not at all familiar" or "unsure" were not asked to complete the rest of the survey). The 2024 survey includes tracking questions from the first survey as well as new questions shaped by three online focus groups conducted May 9 to May 30, 2024, among implementers serving newer populations of focus. In addition, questions on Behavioral Health Payment Reform were added, as there were many comments in the 2023 survey on this topic.[1] In addition to quantitative questions, respondents were offered the opportunity to provide open-ended responses to some questions, and quotes from those are distributed throughout the report, sometimes alongside data interpretation and insights from members of the CalAIM Implementation

Advisory Group. Additional direct quotes from the survey are available for download as a separate document on the CHCF website. Quotes have been lightly edited for clarity and brevity.

The 2024 survey reveals important changes in CalAIM implementation from the 2023 survey. However, it should be noted that the 2023 and 2024 survey samples and questionnaires differ in key ways. For example, much of the survey was revised to accommodate continued programmatic reforms to CalAIM as well as new populations of focus added to the program. In addition, the 2024 survey includes more implementers who work at government agencies and larger organizations, and it includes fewer implementers who work at social service organizations. It also includes more organizations that did not participate in Whole Person Care or Health Homes Programs, the precursors to CalAIM, perhaps reflecting the growth in providers participating in CalAIM as the California Department of Health Care Services (DHCS) has reported.

> *When we last presented the survey, CenCal Health had a handful of providers. Two years later we've grown our provider network by I would say three- or fourfold. So it's not a static group of people that are being revisited. A lot of the survey responders, this could be their first time.*
>
> —Van Do-Reynoso, CHCF CalAIM Advisory Group member and Chief Health Equity Officer, CenCal Health

Findings in this report refer to findings from the most recent (2024) survey, except where specified.

This report highlights differences among sectors, including perspectives from the staff and leaders of managed care plans (MCPs), social service organizations, Federally Qualified Health Centers (FQHCs), and behavioral health organizations. It differentiates between those organizations that are contracted to provide Enhanced Care Management (ECM) or Community Supports and those that are not. In addition, it includes the perspectives of two linchpin roles in the delivery of care for people with complex needs: primary care providers and hospital discharge planners. Across sectors, the report also adds the perspectives of implementers associated with the newer ECM populations of focus added to the program: reentry, older adults, and child/youth populations. A narrow definition is reported out for the group of implementers providing care to the reentry population, which includes those providing ECM only to the reentry population of focus as well as those not providing ECM but working in jails and prisons or providing legal services. Not all questions were asked of all respondents. For example, some questions were asked only of leaders or of people implementing specific aspects of CalAIM. A breakdown of who is included in each subgroup can be found in the full

methodology, available as a separate download on the CHCF website. Throughout the report, data discussed but not illustrated in a figure are noted as "not shown."

Key Findings Overall

- Familiarity with CalAIM has increased since 2023, and two-thirds of implementers now say they are "very familiar" or "somewhat familiar" with the program.
- Many implementers (65%) can name a specific success due to CalAIM, an increase from 59% in 2023. Examples cited by implementers vary considerably, with each describing different aspects of the program and its implementation.
- As implementation continues, a majority of implementers (53%) report that CalAIM has made the "overall experience of care" better for the people they serve.
- When asked how CalAIM has impacted their organization, there has been little change since 2023. A slight majority of implementers (52%) say that their ability to manage the comprehensive needs of the people they serve has gotten better as a result of CalAIM, while 38% say that it has stayed about the same or that they are unsure.
- Almost half of implementers (49%) say that their ability to grow the number of new people they serve has gotten better as a result of CalAIM, while 40% say that it has stayed about the same or that they are unsure.
- The same proportion (49%) say that their ability to coordinate with other organizations serving the same people has gotten better as a result of CalAIM, while 41% say that it has stayed about the same or that they are unsure.
- Some implementers are still struggling with the administrative burden of participating in CalAIM. When asked about their ability to balance the time spent on documentation and administration versus time spent providing services as a result of CalAIM, 28% say things have gotten better, while 29% say things have gotten worse (reflecting an increase from 23% worse in 2023).
- Satisfaction with CalAIM implementation is moderate, with an average satisfaction rating only slightly higher than the midpoint (5.5 on a scale of 0 to 10 where the midpoint is 5.0). This represents a slight decrease from 5.9 in 2023.
- Specialty behavioral health implementers are the only sector in which satisfaction ratings increased (average of 5.6 in 2024 compared to 5.2 in 2023).
- Encouragingly, however, implementers contracted to provide ECM or Community Supports are significantly more satisfied (average of 5.9) than implementers not contracted to provide either (average of 4.6). Moreover, implementers who are contracted also report a more improved experience of care for people they serve and report receiving more complete and accurate information about the people they serve than implementers who are not contracted.

- Satisfaction with CalAIM's initial programs (ECM and Community Supports) are higher than satisfaction with other CalAIM programs. The newest programs, Justice-Involved Initiative and Carve-In of Institutional Long-Term Care, have a large proportion of implementers who say they are unsure and are unable to give a rating (32% and 31%, respectively). This suggests that opinions on these components have not yet fully formed and may fluctuate significantly over the coming years.
- Many respondents report that they are often still exchanging data outside of portals and electronic health records (EHRs), although there has been an increase in use of health plan portals and EHRs since 2023. However, the completeness, accuracy, and timeliness of data exchange have not improved since 2023.
- Overall, many implementers are optimistic that CalAIM implementation will improve over time — in about the same proportions as in 2023.

Highlights: ECM and Community Supports

- Many ECM and Community Supports implementers say they intend to increase the scale or scope, or both, of their organization's services over the next year (63% say they plan to increase ECM services they provide, and 69% say they plan to increase Community Supports services they provide).
- However, many implementers report relying on other funding sources. Only 8% say that MCP payment rates cover their costs of providing services under CalAIM, while 79% say payment rates do not cover their costs.
- Providers report a number of challenges they face with implementing ECM and Community Supports, but the most commonly reported challenge for both programs is that payment rates do not cover the full cost of services, which is cited as challenging by more implementers in 2024 than in 2023.
- Variability in requirements from different MCPs, delays in receiving reimbursements, and payment structure not fitting the way their organization provides services all appear in the top challenges for both ECM and Community Supports.
- Managed care plans report challenges as well, with many (62%) saying that Individuals Experiencing Homelessness is the population of focus that has presented the most challenges, and that housing supports are among the most challenging supports to provide.
- Many ECM providers are primarily delivering ECM services face-to-face (45% at the client's location and 28% at the provider's location), but some (21%) are primarily delivering ECM services through telehealth phone or video.
- Among those not currently contracted to provide ECM or Community Supports, the most commonly reported barriers to entry are low payment rates, lack of capacity to meet requirements, and not being sure how to participate.

Highlights: Behavioral Health Payment Reform

- Behavioral Health Payment Reform has not yet improved conditions for many, and more implementers say things have gotten worse than say things have gotten better when it comes to ease of billing, difference between the cost of delivering services and reimbursement, and time spent on documentation.
- A majority of specialty behavioral health implementers (54%) say that payment rates under Behavioral Health Payment Reform are not covering the cost of providing services, and only 11% say that rates are covering the costs of providing services in full.

The remainder of this report presents the results in more detail.

Section 1. Implementer Views on Current State of Implementation

Familiarity with CalAIM

Among implementers surveyed, two-thirds (66%) say they are familiar (36% say "very familiar") with CalAIM, which reflects an increase from 58% familiar in 2023. However, there is room to continue to increase familiarity among implementers, as a third of implementers (33%) still do not have much familiarity with the program (18% "not familiar at all" and 15% "a little familiar"; not shown). Note that for this question only, respondents saying they were not at all familiar are included (total *n* = 1,180). Those not familiar at all with CalAIM were not included in the remainder of the survey. "Familiar" refers to those who said they were "very familiar" or "somewhat familiar."

Subgroup Findings

- Specialty behavioral health providers (83% familiar in 2024 compared to 68% in 2023), primary care providers (59% familiar in 2024 compared to 47% in 2023), and social service providers (80% familiar in 2024 compared to 70% in 2023) report the highest increases in familiarity.
- Interestingly, MCPs reported the highest familiarity (98%) in 2023, but dropped to 70% in 2024. This decrease could be due to differences in respondent pools.[*]
- Discharge planners' familiarity (48%) with CalAIM did not change.
- High proportions of respondents associated with the newest populations of focus report being "very familiar" or "somewhat familiar" with CalAIM. However, it is important to note

[*] Some variance may be due to small sample sizes: 2023 (*n* = 54) and 2024 (*n* = 56). Additionally, it is possible that staff from more commercial MCPs, who do not serve as many Medi-Cal members, entered the survey in 2024.

that the recruiting for this survey relied on organizations within the networks of CHCF and Lucile Packard Foundation for Children's Health sending out the survey.*

- Implementers serving the California Children's Services population (92% "very familiar" or "somewhat familiar") and serving the child welfare population (93%)
- Implementers serving the reentry population (83%)
- Implementers serving older adults (67%)

Early Successes

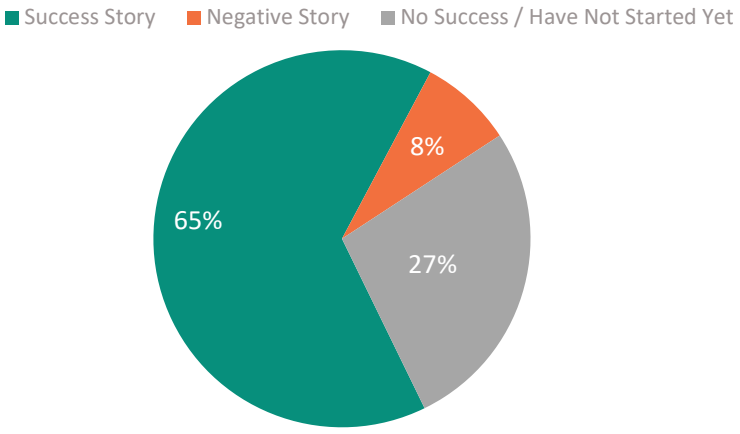
> *It has helped so many patients in need who may otherwise have no other resources or options.*
>
> —Frontline primary care provider, Southern California

At this point in implementation, most implementers can cite some sort of organizational success due to CalAIM. In an open-ended question, 65% of respondents describe a success due to CalAIM (Figure 1), representing an increase from 59% in 2023 (not shown).

Figure 1. Most Implementers Share At Least One Success Story Due to CalAIM

Q: IN A FEW SENTENCES OR LESS, PLEASE SHARE WHAT YOU PERCEIVE AS YOUR OR YOUR ORGANIZATION'S BIGGEST SUCCESS TO DATE IN TERMS OF CALAIM.

Showing the percentage who shared a . . .



Notes: See detailed topline document for full question wording. Totals may not sum due to rounding. Figure shows open-ended responses coded into categories.

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

* It is possible that those survey respondents who were reached were more likely to already be familiar with CalAIM than the total population of those working at organizations like schools, child welfare agencies, jails, and courts.

Implementers cite a broad range of successes, including providing resources for people experiencing homelessness, serving more patients, providing more comprehensive care, and collaborating with other organizations.

> *Successfully integrating medical and social service resources to provide more comprehensive support for high-risk patients requiring complex care. Through cross-sector collaboration, we have been able to better address the full spectrum of patient needs, leading to improved treatment outcomes and patient satisfaction.*
>
> —Frontline primary care provider, Southern California

At the same time, there are some implementers (8%) who say that things are not going well when they are asked about their biggest success under CalAIM.

> *There is very little success; one week you think that all the issues are resolved, and the next week only half the clients that were billed are paid. There are constant comments of "this issue has been escalated." Okay, so when does the escalation result in a fix?*
>
> —Leader, medical respite, Southern California

Impacts on Those Served — from the Point of View of Implementers

> *While implementation has been challenging, things are gradually improving, and we are making a difference in the lives of vulnerable clients every week. I can't imagine this program not existing. Helping clients develop skills to access the health care system, getting someone glasses for the first time, moving a homeless family into housing, seeing an A1C improve over time are just a few of the regular highlights we experience each week.*
>
> —Leader, social service organization, Northern California

As early implementation continues, a majority of implementers (53%) report that CalAIM has made the overall experience of care "somewhat better" or "much better" for the people they serve. Although the results are not directly comparable with the 2023 survey because the question was asked in a different way, there still appears to be very little, if any, change in this sentiment.

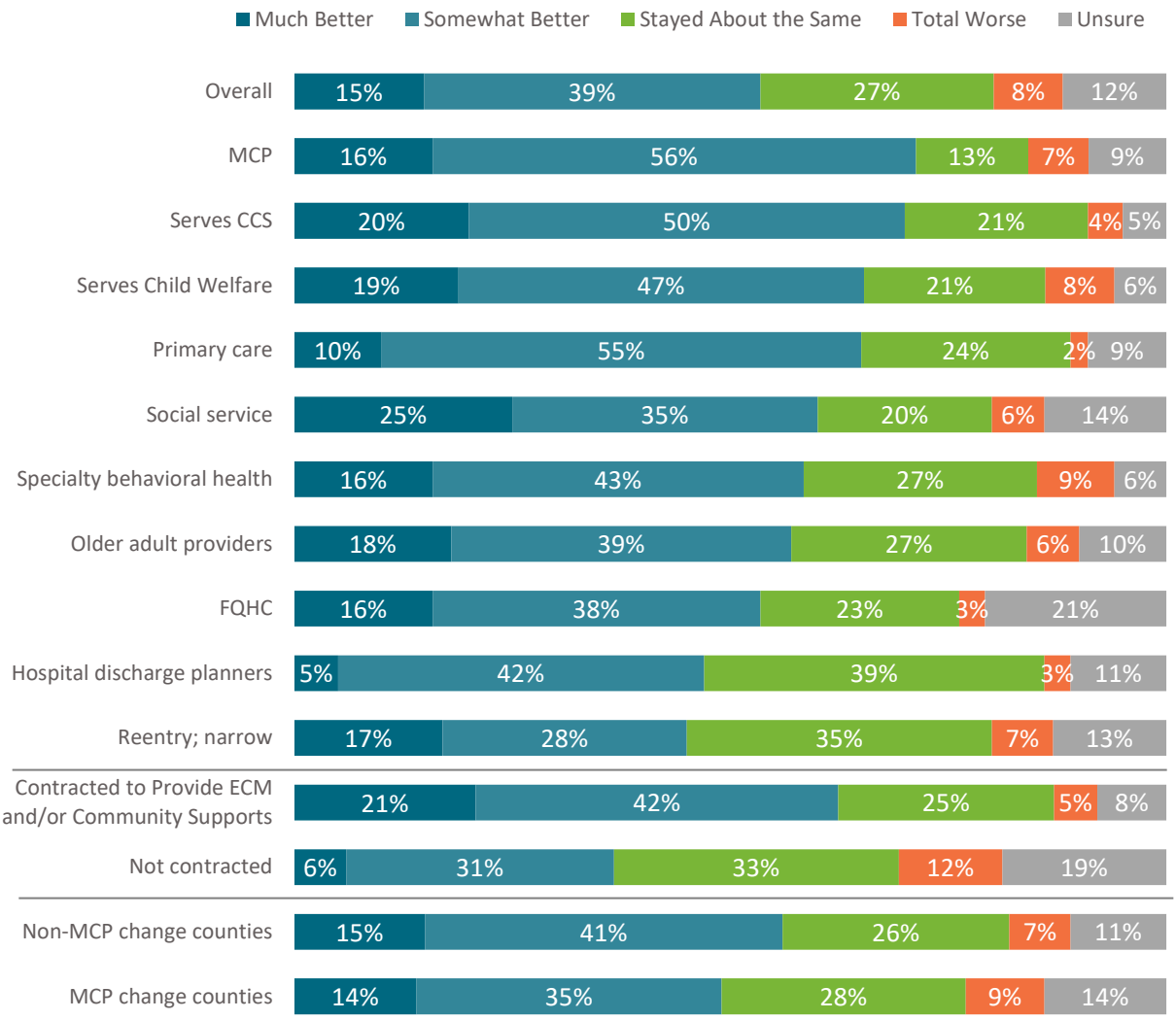
Subgroup Findings

- Managed care plans report the most improvement for the people they serve, with 71% reporting the overall experience of care has gotten better.
- Hospital discharge planners are one of only two sectors where less than a majority (47%) report the overall experience of care for people they serve has gotten better. Many (39%) report that the overall experience of care is still the same.
- Less than half of implementers (45%) serving the reentry population report the overall experience of care for people they serve has gotten better. Many (35%) report that it is still the same, which may reflect the fact that many CalAIM reforms for the reentry population, notably coverage of prerelease services, were not yet live when the survey was being conducted.
- Implementers contracted to provide ECM or Community Supports are more likely than implementers not contracted to provide either ECM or Community Supports to report that the overall experience of care for people they serve has gotten better (62% compared to 37%).
- A divide also exists between implementers in counties affected by the January 2024 managed care plan change (21 counties and over one million members impacted) and implementers in counties not affected by that change. Implementers in counties affected by the change (49%) are less likely than implementers in the rest of the state (56%) to report that the overall experience of care for people they serve has gotten better (Figure 2).[2] One CHCF CalAIM Advisory Group member describes what happened locally when the managed care change was implemented:

> *DHCS moving so many members during the holidays was really unprecedented unless the plan was exiting the market. These kinds of large-scale changes create chaos on the ground. . . It took [the health plan] a while and a fair amount of their resources to get their feet back under them when their LA population for us went from about 16,000 to almost 90,000 overnight. And so it has been hard to get their attention to make this ECM project a priority when they were onboarding so many members, but we are getting to the bottom of it. It is improving . . . but I'm not sure that that's really been felt yet by the people on the ground.*
>
> —Sabra Matovsky, CHCF CalAIM Advisory Group member and CEO, Healthcare LA IPA

Figure 2. A Majority of Respondents Report Improvements in Overall Experience of Care for the People They Serve

Q: THINKING ABOUT THE EXPERIENCES OF THE PEOPLE YOU SERVE (E.G., PATIENTS, MEMBERS, OR CLIENTS), PLEASE INDICATE WHETHER YOU PERSONALLY THINK THEIR OVERALL EXPERIENCE OF CARE HAS GOTTEN BETTER OR WORSE AS A RESULT OF CALAIM'S IMPLEMENTATION AS A WHOLE (E.G., ECM, COMMUNITY SUPPORTS, BEHAVIORAL HEALTH PAYMENT REFORM, JUSTICE-INVOLVED INITIATIVE, INSTITUTIONAL LONG-TERM CARE CARVE-IN)—OR IF IT HAS STAYED ABOUT THE SAME. IF YOU ARE UNSURE, JUST SELECT THAT.



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Ranked within each set by "Much better" + "Somewhat better." "Total worse" is "Somewhat worse" + "Much worse."

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Impacts on Those Served — by Race and Ethnicity

Assessments of the impacts of CalAIM on the experience of care of specific racial and ethnic groups (among implementers who have some experience with those groups) are largely unchanged since 2023. However, more implementers report improvements in experience of care for Latino/x populations (40% "much better" or "somewhat better"), reflecting an increase from 33% in 2023 (not shown).

In open-ended responses, survey respondents report barriers that must be lowered for CalAIM to more fully address racial and ethnic health inequities.

> *The health care system, housing providers, and benefits and resource providers still discriminate based on race and ethnicity. Mental health crisis intervention is still linked with police, which is less likely to be effective or lead to lasting treatment interventions for people of color, and Black individuals in particular.*
>
> —Frontline provider, social service organization, Bay Area

> *Services are not available at all in rural areas where large numbers of families who work in the agricultural field live. The overwhelming number of these families are Hispanic or Asian, and are not being served.*
>
> —Frontline provider, legal services organization, multiple regions

Organizational Impacts

> *What I'm seeing across the board is that it's such a drive to obtain those high numbers and have the program grow so quickly, that maybe those other things are not doing well or not getting any better because the focus is just more on growth. . . . You want to grow and you want to get more patients and you want to help more people, but sometimes there's messes that are occurring that haven't been fixed. And then you're so busy and there's so many more patients to serve that those things get left behind, and then it gets worse.*
>
> —Katelyn Taubman, CHCF CalAIM Advisory Group member and community health worker, Inland Housing Solutions

When it comes to organizational impacts related to the ability of the organization to serve people, more implementers report improvements rather than declines due to CalAIM. Specifically, similar proportions perceive their organization's abilities in the three areas below as being "much better" or "somewhat better" as a result of CalAIM (shown below in Figure 3):

- Managing the comprehensive needs of the people you serve (52%)
- Growing the number of new patients/members/clients you serve (49%)
- Coordinating with other organizations serving the same people (49%)

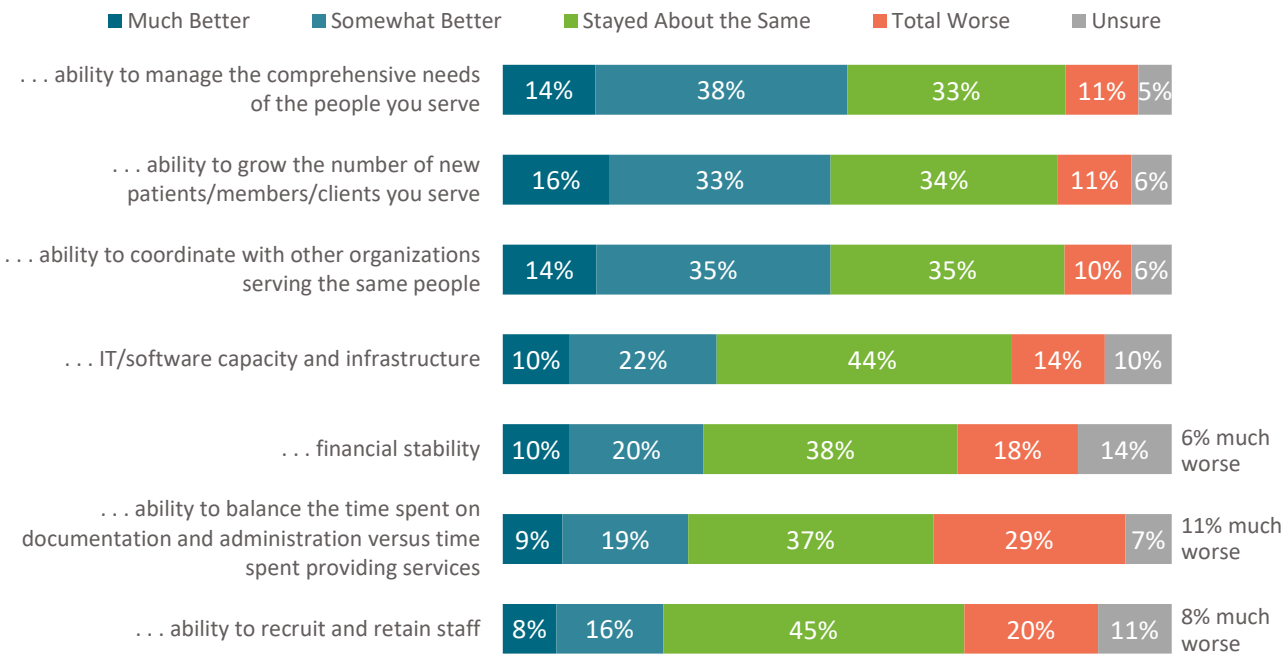
However, there has been little change in these dimensions relative to 2023.

Small but notable groups say certain administrative and internal organizational items have gotten worse. In particular, some implementers are struggling with their "ability to balance the time spent on documentation and administration versus time spent providing services," where 28% of implementers say things have gotten better, while 29% say things have gotten worse (an increase from 23% worse in 2023). In addition, when it comes to their "ability to recruit and retain staff," 24% of implementers say things have gotten better, while 20% say things have gotten worse (Figure 3).

Figure 3. Implementation Is Improving Ability to Serve, but Implementers Still Struggling with Documentation and Administrative Burden

Q: NOW THINKING ABOUT YOUR OWN ORGANIZATION, PLEASE INDICATE WHETHER YOU PERSONALLY THINK EACH OF THE FOLLOWING HAS GOTTEN BETTER OR WORSE AS A RESULT OF CALAIM — OR IF IT HAS STAYED ABOUT THE SAME.

YOUR ORGANIZATION'S . . .



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. "Total worse" includes "Somewhat worse" and "Much worse." Ranked by "Total better"; excludes those who answered "Not applicable" for each item.

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Subgroup Findings

- Implementers from social service organizations (29% worse in 2024 compared to 19% worse in 2023; not shown) show a larger increase than other sectors in the proportion of implementers who say that their "ability to balance the time spent on documentation . . ." has gotten worse.

Current Satisfaction with CalAIM Implementation Experience

> *These programs have a natural learning and implementation curve that should allow for flexibility and time to get results wanted by DHCS.*
>
> —Leader, social service organization, multiple regions

- Satisfaction with the CalAIM experience overall is moderate, with an average satisfaction rating only slightly higher than the midpoint (5.5 on a scale of 0 to 10 where the midpoint is 5.0). This represents a slight decrease from 5.9 in 2023 (shown in Figure 4 below). One CHCF CalAIM Advisory Group member suggests this could be a temporary decrease due to continuing minor issues with implementation that impact implementers' day-to-day and have become more frustrating, as they have not improved.

> *People just don't have the time to create that structure to make it smoother. . . . The same issues are occurring, and we haven't found solutions to those little hiccups. They're minor, and the desire to collaborate is better — but how to do that seamlessly is kind of the hangup.*
>
> —Katelyn Taubman, CHCF CalAIM Advisory Group member and community health worker, Inland Housing Solutions

In open-ended survey responses, implementers are balancing both the importance of the work and the successes of the CalAIM program so far with the complexity of implementation.

> *We love the work we do, and our community is thriving because of it. The program is so complex. It takes a while to understand what we can do and where we can help. As soon as we think we have it mastered, we enroll a new member who requires support we have not yet provided to anyone else. We continue to learn and grow as we complete this important work.*
>
> —Leader, local health district, Northern California

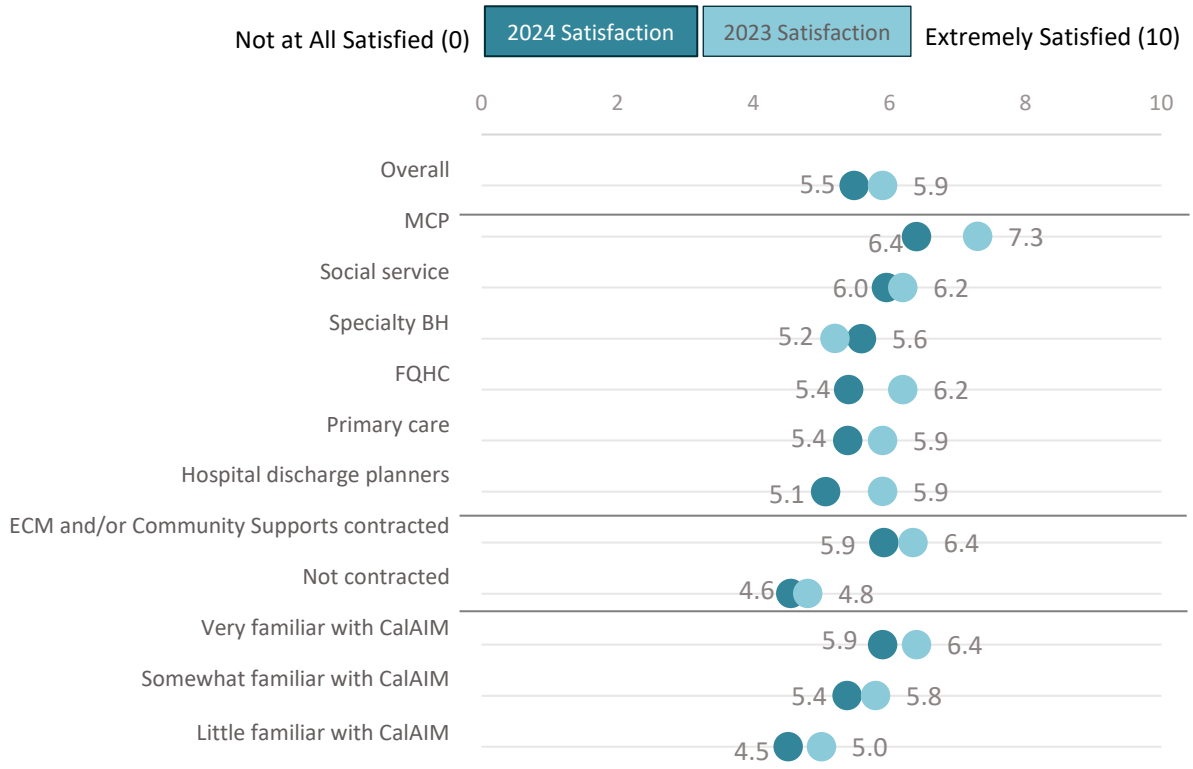
Subgroup Findings

- Specialty behavioral health implementers are the only sector to have higher satisfaction with their organization's experience with CalAIM than last year (5.6 in 2024 compared to 5.2 in 2023 on a scale of 0 to 10).

- Respondents contracted to provide either ECM or Community Supports (5.9) continue to report significantly higher satisfaction than respondents not contracted to provide either ECM or Community Supports (4.6).
- Respondents who report being "very familiar" with CalAIM (5.9) continue to express significantly higher levels of satisfaction than respondents only "a little familiar" with CalAIM (4.5), suggesting that despite the current decrease in satisfaction, there may be a longer-term increase in satisfaction over time as more implementers become more familiar with the program (Figure 4).

Figure 4. Slight Decrease in Satisfaction with CalAIM Overall

Q: ON A SCALE OF 0 TO 10, WITH 0 MEANING NOT AT ALL SATISFIED AND 10 MEANING EXTREMELY SATISFIED, HOW SATISFIED ARE YOU WITH YOUR ORGANIZATION'S EXPERIENCE WITH CALAIM SO FAR?



Notes: See detailed topline document for full question wording and response options. Data shown are average values for each subgroup.

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

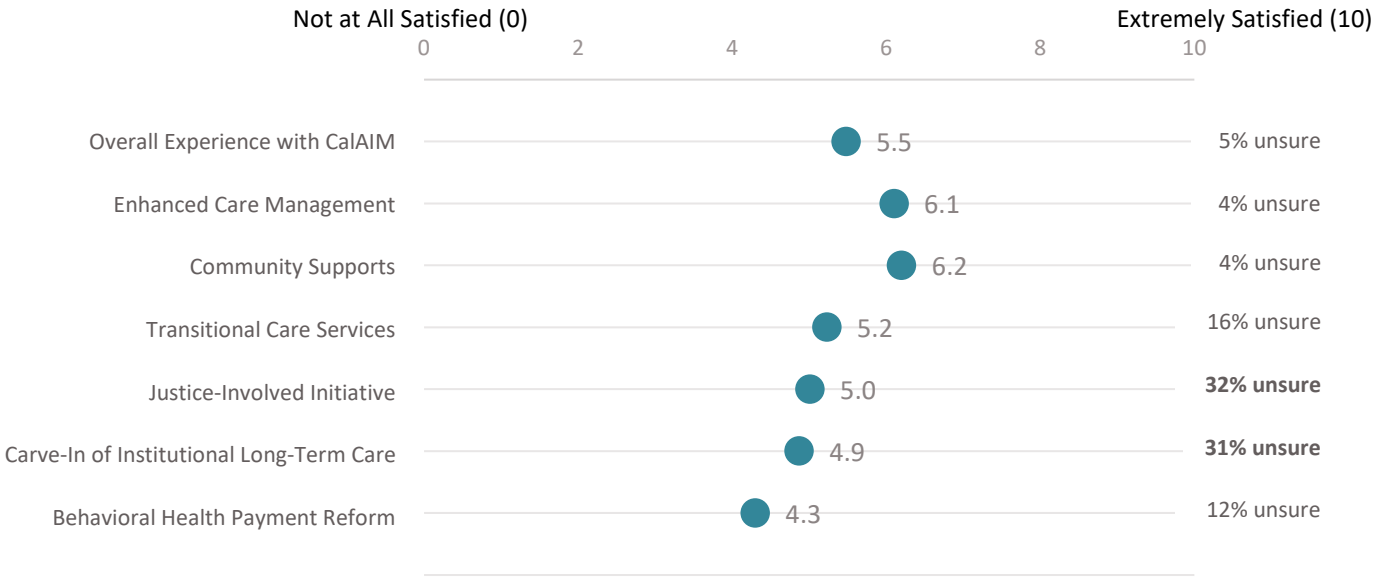
Additional Subgroup Findings

- Implementers serving newer populations of focus report similar levels of satisfaction to implementers overall, except that implementers serving the reentry population are slightly less satisfied than implementers overall (5.2 and 5.5, respectively; not shown).

CalAIM has many components, and satisfaction varies by program. The average satisfaction for ECM (6.1) and Community Supports (6.2) are the highest of all components tested, and satisfaction for ECM and Community Supports are very similar among implementers contracted to provide both (not shown). Satisfaction with Transitional Care Services (5.2) is slightly lower than satisfaction with CalAIM overall, and satisfaction with Behavioral Health Payment Reform (4.3) is below the midpoint and much lower than satisfaction with CalAIM overall. Satisfaction with the Justice-Involved Initiative (5.0) and Carve-In of Institutional Long-Term Care (4.9) are very near the midpoint. However, a significant proportion of respondents are unsure, suggesting that opinions on these components have not yet fully formed and may fluctuate significantly over the coming years (Figure 5).

Figure 5. Satisfaction Varies by CalAIM Program

Q: ON A SCALE OF 0 TO 10, WITH 0 MEANING NOT AT ALL SATISFIED AND 10 MEANING EXTREMELY SATISFIED, HOW SATISFIED ARE YOU WITH YOUR ORGANIZATION'S EXPERIENCE WITH CALAIM SO FAR?



Notes: See detailed topline document for full question wording and response options. Data shown are average values for each item in the series. Transitional care services (*n* = 129), Justice-Involved Initiative (*n* = 397), Carve-In of Institutional Long-Term Care (*n* = 521), and Behavioral Health Payment Reform (*n* = 211) asked of implementers likely to have interacted with those programs.

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Open-ended responses reveal that while many implementers remain enthusiastic about the goals of CalAIM, many also feel overwhelmed with the volume and pace of changes to implementation requirements — as well as feeling underresourced and underfunded.

> *The concept of CalAIM is excellent. But how to become a partner and provider is hard to understand. The TA [technical assistance] Marketplace has given us wonderful consultants. It's just odd that the state of California has paid them $40,000+, and we have received $0. We are giving services to mentally ill people every day, and have been for 35 years, yet we have not received any money for our work through CalAIM.*
>
> —Leader, specialty behavioral health, Southern California

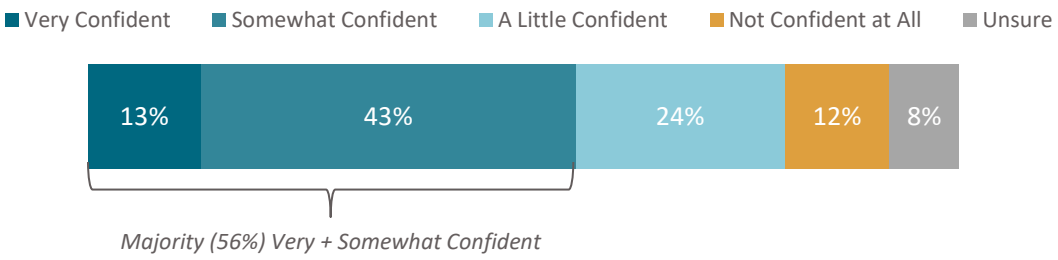
Expectations for Improvement of CalAIM Processes Over Time

> *The program will continue to grow and evolve as long as there is support from DHCS.*
>
> —Representative of managed care plan, multiple regions

Implementers share a general sense of optimism about improvement. A majority of respondents (56%) who do not already rate CalAIM processes as "very effective" are "very confident" or "somewhat confident" that CalAIM-related processes, protocols, and workflows will improve over time. A little over 1 in 10 (12%) say they are "not confident at all" that processes will improve (Figure 6). There is no significant change in optimism about improvement from 2023 to 2024.

Figure 6. There Is Optimism About Improvement

Q: AND HOW CONFIDENT ARE YOU THAT CALAIM-RELATED PROCESSES, PROTOCOLS, AND WORKFLOWS WILL BECOME MORE EFFECTIVE OVER TIME?



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. This question was asked of everyone except those who answered that CalAIM-related processes, protocols, and workflows are already "very effective" (*n* = 863).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Subgroup Findings

- Confidence that CalAIM-related processes, protocols, and workflows will become more effective over time is highest among implementers working at social service organizations (72% "very effective" or "somewhat effective"), managed care plans (69%), and implementers serving the reentry population (64%; not shown).

Section 2. Deep Dive on ECM and Community Supports

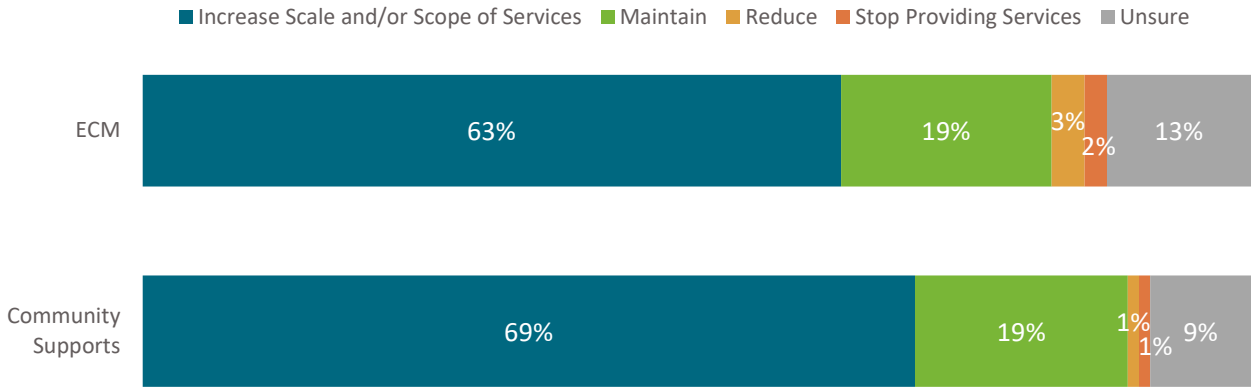
Sustainability of Services

> *Those CBOs [community benefit organizations] who were in early, in my experience, were all in because we believe these services should be covered by health care, and we're hoping that we can address the rate challenges with DHCS. . . . Most of us are supporting our work with philanthropic dollars, but the belief is that we're going to be able to work those things out over time and get rates to the point where they're actually covering full cost so we can be sustainable in this ecosystem.*
>
> —Cathryn Couch, CHCF CalAIM Advisory Group member and CEO, Ceres Community Project

When asked about their intentions over the next year, most implementers say they intend to increase the scale or scope, or both, of their organization's services. Approximately two-thirds of leaders currently contracted to provide ECM or Community Supports say they intend to increase the scale or scope of services, or both, over the next year (63% and 69%, respectively). Very few (5% of leaders who provide ECM and 2% of leaders who provide Community Supports) say they intend to reduce or stop providing ECM or Community Supports services in the next year (Figure 7).

Figure 7. Most Implementers Intend to Expand ECM and Community Supports

Q: AS YOU THINK AHEAD TO THE NEXT YEAR, WHAT ARE YOUR INTENTIONS WITH YOUR ORGANIZATION'S ECM / COMMUNITY SUPPORTS SERVICES?



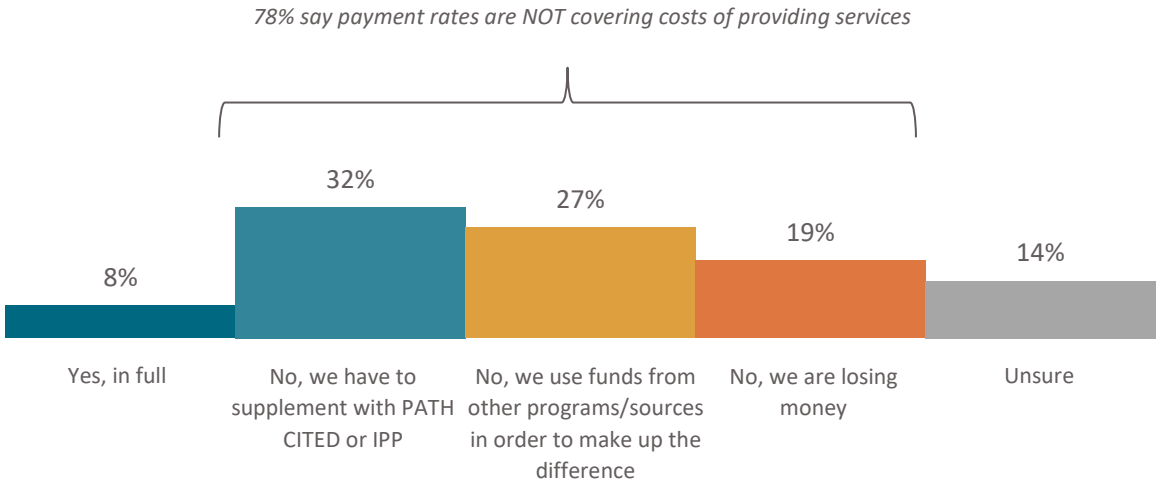
Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Question about ECM services asked of leaders contracted to provide ECM (*n* = 172). Question about Community Supports asked of leaders contracted to provide Community Supports (*n* = 154).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Whereas many implementers plan to expand the scale or scope of their ECM and Community Supports services over the next year, many also report relying on other funding sources to cover costs. Among leaders contracted to provide ECM or Community Supports, 78% say that current MCP payment rates are not covering their costs of providing services under CalAIM, and only 8% say that current payment rates are covering their costs of providing services in full (Figure 8).

Figure 8. Majority Report MCP Payment Rates Are Not Covering Cost of Services Provided Under CalAIM

Q: ARE CURRENT MANAGED CARE PLAN (MCP) PAYMENT RATES COVERING YOUR COSTS OF PROVIDING SERVICES UNDER CALAIM?



Notes: IPP is Incentive Payment Program. See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Question asked of leaders contracted to provide ECM or Community Supports (*n* = 228).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Open-ended responses among implementers who currently rely on PATH CITED or Incentive Payment Program (IPP) funds reveal a range of strategies for when those funds are no longer available.[3] Implementers hope to renegotiate rates, continue to find other sources of funding, or to scale up to become more efficient by the time PATH CITED and IPP money is no longer available. A few say that they will have to reevaluate their participation in CalAIM if their programs are not financially sustainable at that time.

> *We're not entirely sure. PATH CITED, IPP, and the TA Marketplace have been a godsend. . . . We hope the state will further invest in TA to help us sustain and scale our organization financially, whether through the marketplace or otherwise.*
>
> —Leader, primary care provider, statewide

Referral Sources

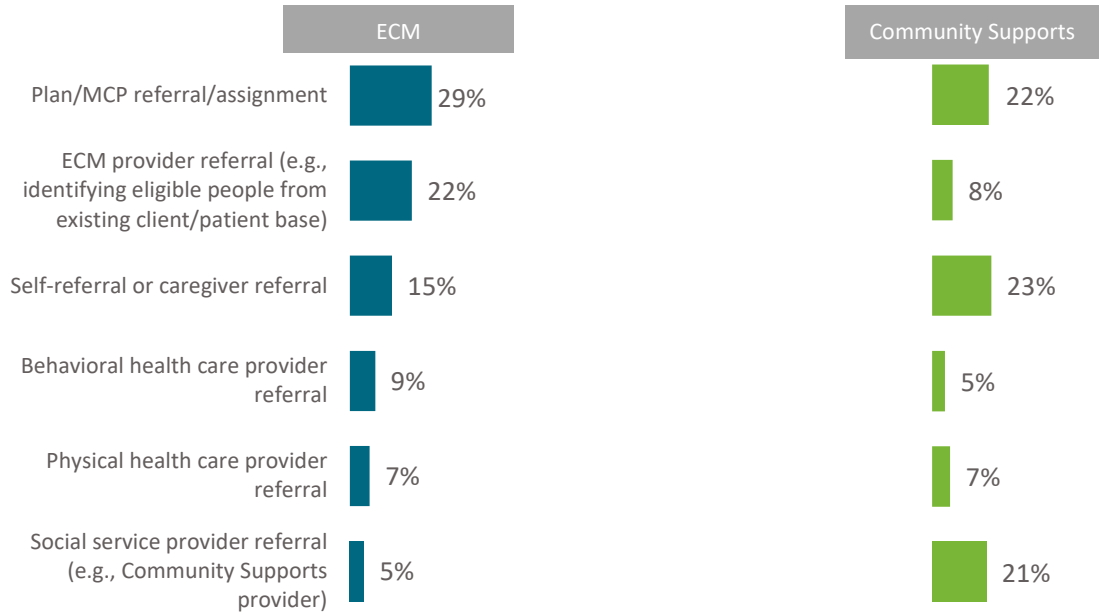
> *Referrals from the managed care plan are often very difficult to chase down: incorrect phone numbers, incorrect spelling, moved away years ago, etc.*
>
> —Leader, social service organization, Bay Area

> *[Our biggest success has been] a significant increase in community-based referrals for housing Community Supports. We began providing services in late April and have reached roughly 240 clients in September.*
>
> —Leader, social service organization, Southern California

Referrals are coming from a range of sources — though MCPs are referring the plurality for ECM and are among the top few sources for Community Supports. Referrals come from MCPs a little more often for ECM (29% of implementers saying MCPs are the most common way they get referrals) than for Community Supports (22% saying MCPs are the most common way they get referrals). Implementers report that Community Supports referrals are largely coming from self-referral or caregiver referral (23%), MCPs (22%), and other social service providers (21%) (Figure 9).

Figure 9. Referrals Come from a Range of Sources — Though MCPs Referring Plurality for ECM

Q: WHICH OF THE FOLLOWING IS THE MOST COMMON WAY THOSE YOU SERVE ARE GETTING REFERRED TO YOUR ORGANIZATION FOR ECM SERVICES / COMMUNITY SUPPORTS?



Notes: See detailed topline document for full question wording and response options. Ranked by ECM referrals. Question about ECM asked of ECM providers (*n* = 234). Question about Community Supports asked of Community Supports providers (*n* = 220).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

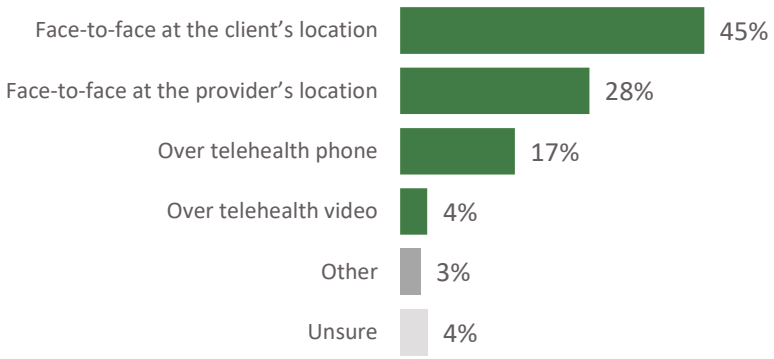
Mode of Delivering ECM Services

> *We are attempting to streamline our processes, use technology when possible (i.e., video visit over face-to-face); however, we are in conflict with the health plans, as they prefer to have us make face-to-face visits. So we have to pay mileage and time to meet participants in their home or other locations, and the current reimbursement rates do* not *pay for that service.*
>
> —Leader, specialty behavioral health, multiple regions

When it comes to ECM, the primary mode of service provision varies — though the plurality of providers delivers services face-to-face at the client's location. Face-to-face (73%) is the most common mode of delivery, either at the client's location (45%) or at the provider's location (28%). However, 21% of respondents say they primarily deliver services through telehealth (17% primarily deliver ECM services over telehealth phone, and 4% primarily deliver ECM services over telehealth video) (Figure 10). ECM providers who primarily deliver services face-to-face (regardless of location) are more likely to say they are losing money because MCP payment rates are not covering their costs of providing services under CalAIM (24% of respondents who provide services face-to-face say they are losing money compared to 6% of ECM providers who primarily provide services over telehealth; not shown). ECM providers who primarily deliver services over telehealth are more likely to say they are covering shortfalls in payment rates with PATH CITED or IPP grants. More detail on the differences between organizations that primarily deliver services face-to-face and those that primarily deliver services via telehealth are available to download on the CHCF website.

Figure 10. Primary Mode of Service Provision for ECM Varies

Q: WHICH OF THE FOLLOWING IS THE PRIMARY WAY YOU PROVIDE SERVICES? PLEASE SELECT THE ANSWER WHERE YOU SPEND MOST OF YOUR TIME, EVEN IF MULTIPLE ANSWERS APPLY.



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Asked of ECM providers (*n* = 234).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

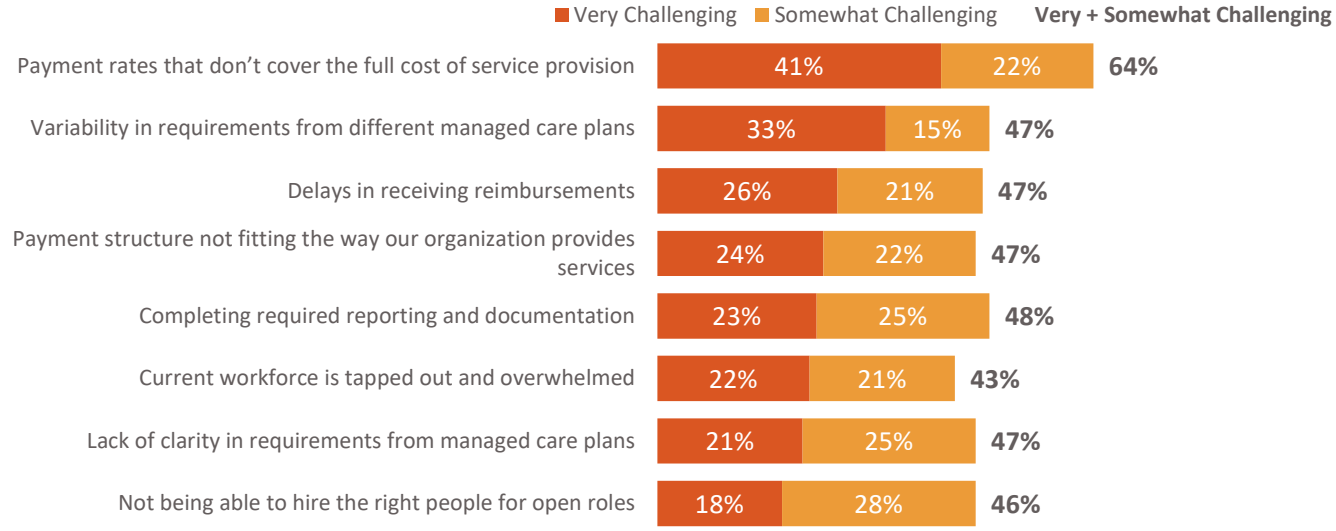
Challenges Implementing ECM and Community Supports

> *The lack of standardization amongst the MCPs makes providing ECM very difficult, especially since clients can change from MCP to MCP easily. It can get confusing to have to track the client's MCP month to month to determine what will be audited month to month. The administrative burden is extremely high, and the rates do not cover costs of the program at this time.*
>
> —Leader, specialty behavioral health, Northern California

Implementers still report many challenges that hinder their ability to implement ECM or Community Supports or both, but the most commonly reported challenge for implementing both ECM and Community Supports is "payment rates that don't cover the full cost of service provision." For ECM in particular, payment rates are rated as challenging by 64% of respondents, including 41% of respondents who rate it "very challenging" (Figure 11).

Figure 11. Implementers Report Many ECM Challenges, with Nearly Two-Thirds Reporting Insufficient Payment Rates as "Very Challenging" or "Somewhat Challenging"

Q: PLEASE INDICATE HOW CHALLENGING EACH OF THE FOLLOWING HAS BEEN WHEN IT COMES TO IMPLEMENTING ECM.



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Ranked by "Very challenging." Asked of ECM providers (*n* = 169).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Some survey respondents explain in open-ended responses that payment rates do not cover everything included in providing services, beyond the cost of providing the service itself.

> *Our agency is at financial risk because of the payment structure. We have fixed costs, re: case managers, supervisors, operating expenses. We can only pay for these expenses when our case managers have full caseloads and we are getting reimbursement from the MCPs. . . . Additionally, the ECM and HCS criteria include the highest risk, most complex patients. Most of our caseloads are primarily very high-risk individuals. Requiring case managers to have 40 active clients (to be financially sustainable) when most are homeless and/or have serious mental illness or active substance use dilutes the effectiveness of the service.*
>
> —Leader, FQHC, Bay Area

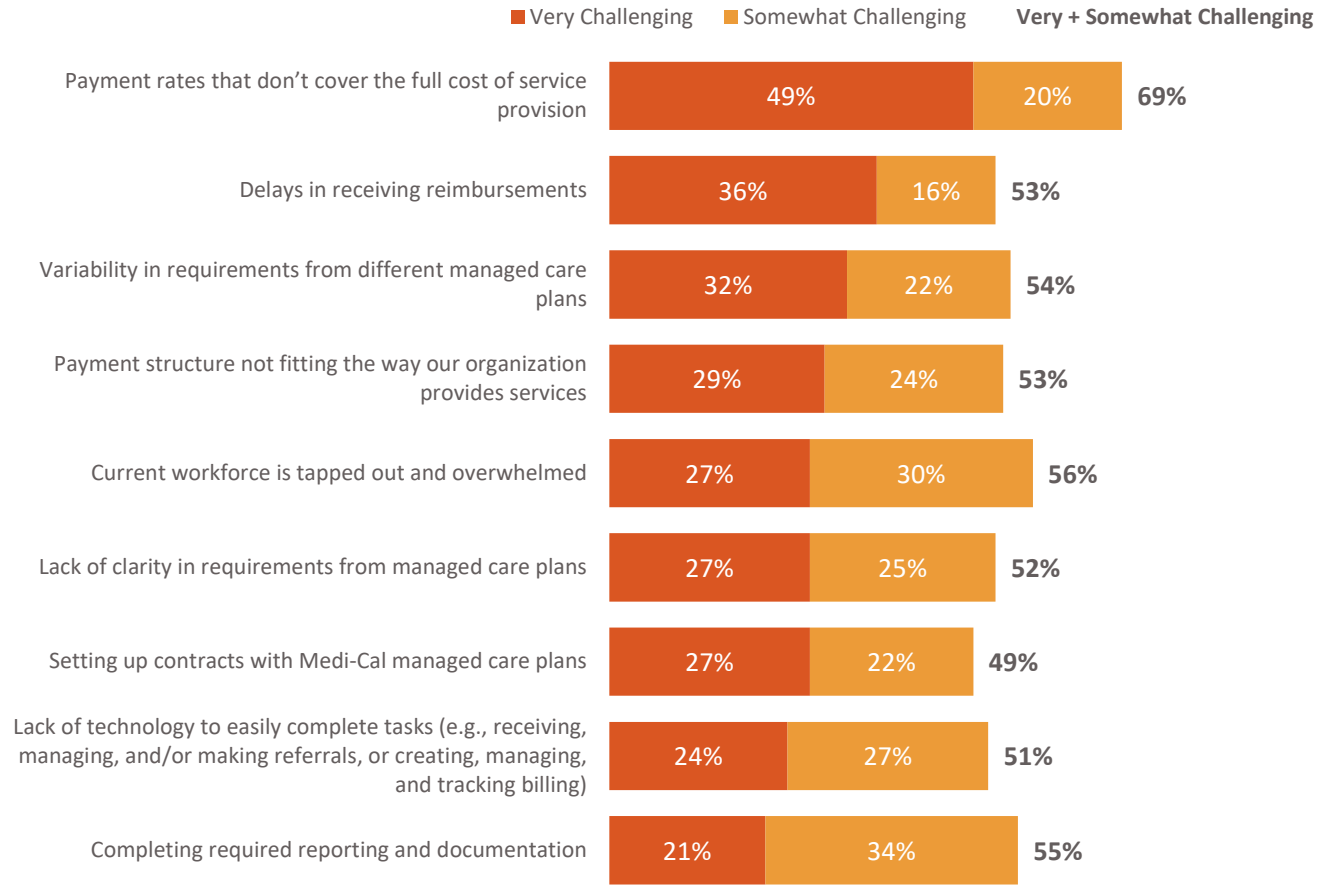
In addition to challenges with payment rates, implementers also identify challenges with other aspects of implementing ECM, including variation in MCP requirements and staff burnout and turnover.

> *The variation across MCPs in implementing ECM (e.g., some require use of their portal, some do not, different referral practices, different follow-up periods, different billing rules) makes it incredibly challenging to set up our systems to support all plans. It has also led to incredibly high frustration/burnout with our staff, and turnover has been very high. There is a significant amount of training required to get staff up to speed on how to implement with each of our plan partners, so turnover hurts because of the training time investment per new staff member.*
>
> —Leader, social service organization, multiple regions

Payment rates also rise to the top of challenges in implementing Community Supports. Sixty-nine percent of respondents rate it as challenging, including 49% who rate it as "very challenging" (Figure 12).

Figure 12. Implementers Report Many Community Supports Challenges, with More Than Two-Thirds Saying Insufficient Payment Rates Are "Very Challenging" or "Somewhat Challenging"

Q: PLEASE INDICATE HOW CHALLENGING EACH OF THE FOLLOWING HAS BEEN WHEN IT COMES TO IMPLEMENTING COMMUNITY SUPPORTS. TOP CHALLENGES:



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Ranked by "Very challenging." Asked of Community Supports providers (*n* = 154).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

As with ECM, payment rates are reported as the most challenging aspect of implementing Community Supports. However, implementers use the open-ended questions to describe a list of challenges that make implementation difficult.

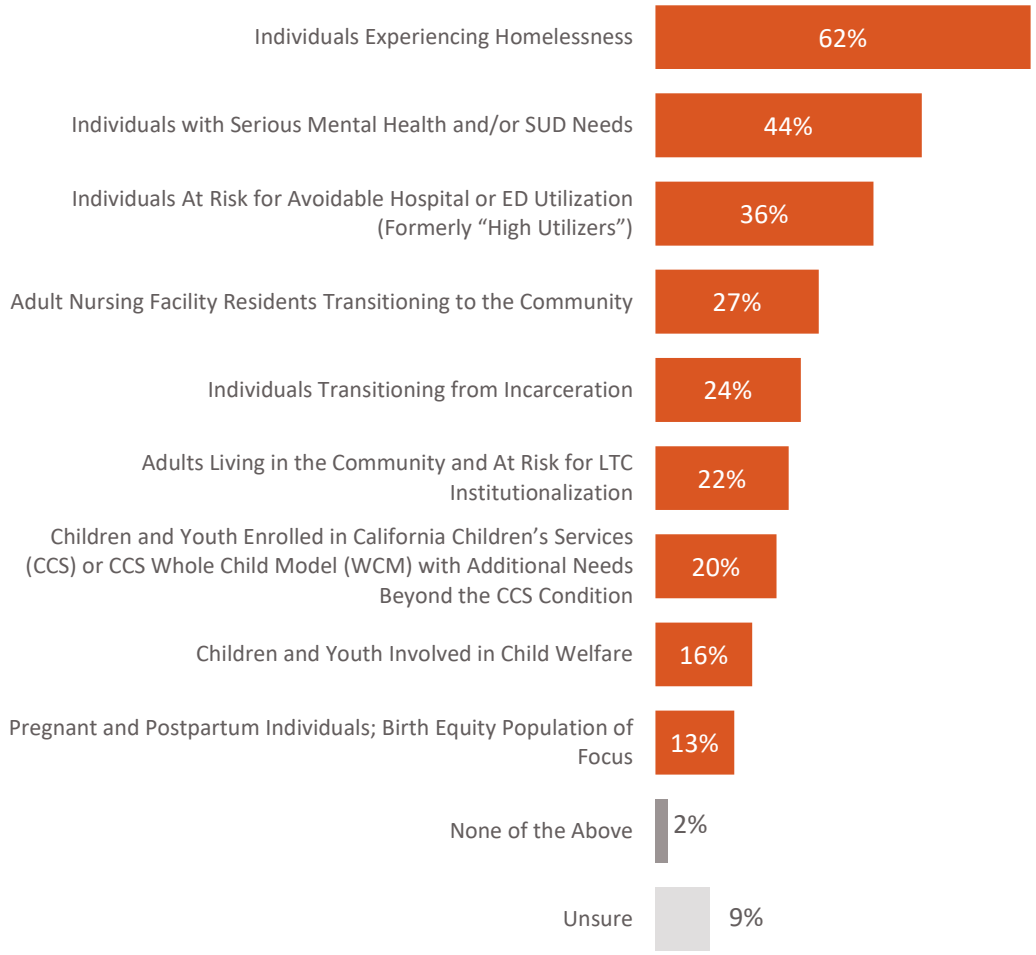
> *Lack of clarity on program deliverables, billing structure, and duplicate efforts with so many initiatives that overlap.*
>
> —Leader, FQHC, Southern California

> *In addition to outdated contracting processes and differences in communications, infrastructure required, and policy among plans — some of which appear to go against DHCS policy (for example, we recently saw a [name] communication indicating that eligibility for the SMI/SUD [substance use disorder] population required active engagement in specialty MH [mental health] or addiction care, rather than just being eligible for it) — we've noted how often the populations of focus require BH [behavioral health] services but can't get them.*
>
> —Leader, primary care provider, statewide

Managed care plans also report challenges in implementing ECM and Community Supports. When asked about different ECM populations of focus, MCPs report that Individuals Experiencing Homelessness (62%), Individuals with Serious Mental Illness and/or Substance Use Disorder (44%), Individuals At Risk for Avoidable Hospital or ED Utilization (36%), and Adult Nursing Facility Residents Transitioning to the Community (27%) are the populations that have presented the most challenges (Figure 13).

Figure 13. MCPs Report the Most Challenges Serving Homeless Population as an ECM Population of Focus

Q: PLEASE INDICATE WHICH OF THE FOLLOWING ECM POPULATIONS OF FOCUS YOU FEEL HAS PRESENTED THE MOST CHALLENGES IN IMPLEMENTATION OF ECM. YOU MAY SELECT ALL THAT APPLY.



Notes: See detailed topline document for full question wording and response options. Asked of MCPs (*n* = 45).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

In open-ended responses describing the challenges serving each of these populations, MCPs say that:

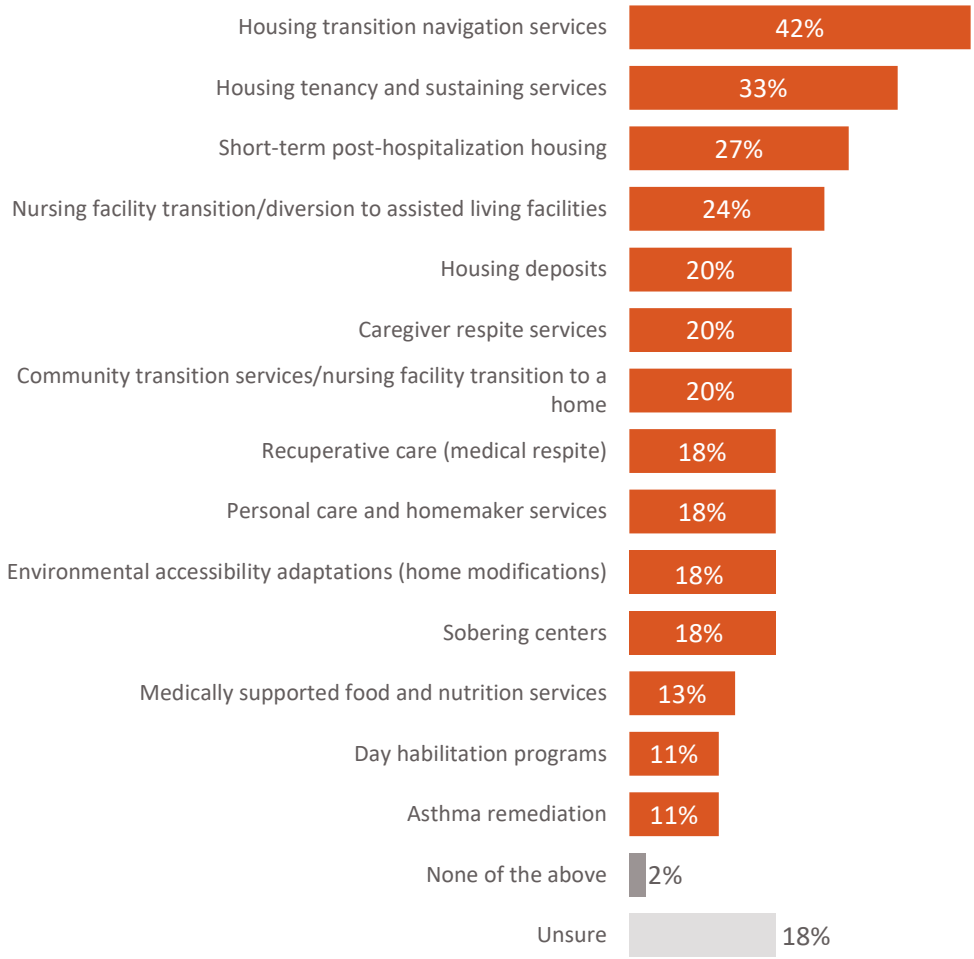
- Difficulty reaching members and lack of housing supply cause challenges in serving Individuals Experiencing Homelessness.
- They have trouble getting timely behavioral health services to Individuals with Serious Mental Health and/or Substance Use Disorder needs.
- Lack of data sharing makes it difficult to serve Individuals Transitioning from Incarceration.

- Child custody issues within families and lack of cooperation from schools can complicate serving children (CCS and Child Welfare).
- Difficulty contacting members and their care teams causes challenges serving Adults Living in the Community and At Risk for Long-Term Care Institutionalization.

When asked about different Community Supports, MCPs report that housing transition navigation services (42%), housing tenancy and sustaining services (33%), short-term post-hospitalization housing (27%), and nursing facility transition/diversion to assisted living facilities (24%) have been the most challenging services (Figure 14).

Figure 14. MCPs Report the Most Challenges with Housing Services Community Supports

Q: PLEASE INDICATE WHICH OF THE FOLLOWING COMMUNITY SUPPORTS YOU FEEL HAS PRESENTED THE MOST CHALLENGES. YOU MAY SELECT ALL THAT APPLY.



Notes: See detailed topline document for full question wording and response options. Asked of MCPs (*n* = 45).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

A few MCPs say that there are challenges across multiple Community Supports, including a lack of funding needed for services and insufficient guidance leading to implementation challenges and questions.

In open-ended responses describing the challenges for specific supports, MCPs say that:

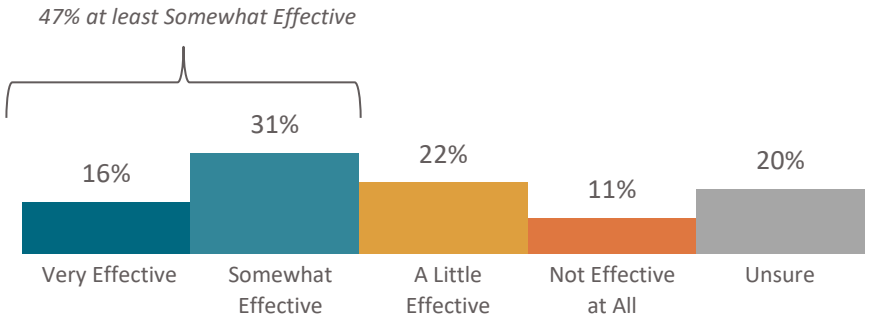
- Knowledge gaps and limited housing stock cause challenges for all housing-related supports.
- Provider backlogs cause challenges with nursing facility transition/diversion to assisted living facilities or other home-based settings.
- Delays for In-Home Supportive Services applications cause challenges with personal care and homemaker services.
- It is difficult to find local providers for asthma remediation, and existing providers are beyond capacity.

DHCS Policy Refinements

It is important to note that to decrease administrative burdens, DHCS began implementing policy changes in July 2023, between when the 2023 and 2024 surveys were conducted. Nearly half of implementers (47%) report that the changes have been "very effective" or "somewhat effective" (Figure 15).

Figure 15. Nearly Half of Implementers (47%) Say Policy Changes Have Been at Least "Somewhat Effective"

Q: DHCS MADE POLICY REFINEMENTS IN JULY 2023 TO INCREASE AVAILABILITY AND UPTAKE OF ENHANCED CARE MANAGEMENT AND COMMUNITY SUPPORTS. . . . HOW EFFECTIVE WOULD YOU SAY THESE CHANGES HAVE BEEN?



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Asked of implementers who provide ECM or Community Supports (*n* = 323).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Survey respondents explain that the refinements were helpful, but plans have not universally adopted them.

> *One plan increased our payment rate for outreach and is paying fee for service instead of a onetime fee. This is a huge help. None of the other three plans made a change regarding outreach payment. [One] plan adopted presumptive eligibility. This has eased the burden of having to have authorization and reauthorization for clients, but there are still technical issues the MCP has with correctly assigning clients to us. It is better than before but still a work in progress.*
>
> —Leader, social service organization, Northern California

One survey respondent explains that even positive changes can make implementation more difficult because organizations have to dedicate resources to adapt to the changes.

> *We spend way too much time responding to some little change. . . . At this point, any minor change is like moving a massive ship. . . . At this point, the program has rolled out, and it needs to mature and work out without any more administrative changes, which are much too many.*
>
> —Leader, managed care plan, Bay Area

Implementers Not Currently Providing ECM or Community Supports

> *We heard you need to have very large caseloads to make it worth the effort, and we don't have a structure to make that work. I have also heard providers are not getting paid in a timely manner.*
>
> —Leader, specialty behavioral health, Bay Area

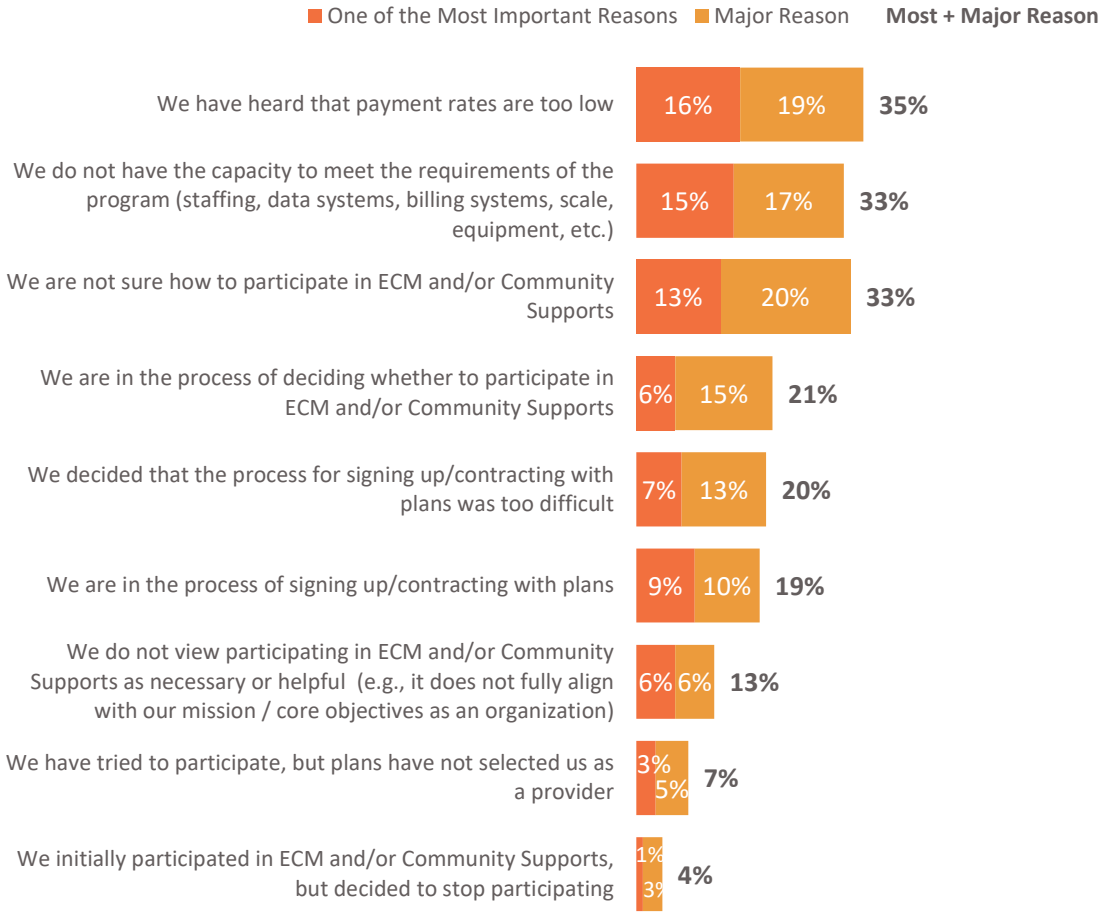
> *Without a streamlined application process, seeking out each individual medical provider and completing their application process is arduous and time-consuming. Many reject your request without an explanation, stating they are not contracting.*
>
> —Leader, assisted living services, multiple regions

The primary reasons cited by implementers for not providing ECM or Community Supports or both are low payment rates (35% say it's "one of the most important reasons" or a "major reason" they are not providing ECM or Community Supports), inability to meet the requirements (33%), and lack of information about how to participate (33%). Inability to meet the requirements has increased as a reason since 2023 (33% say it's a reason they are not providing ECM or Community Supports in 2024, compared to 22% in 2023; not shown).

Far fewer respondents (13%) attribute their decision not to provide ECM or Community Supports to the belief that these services are not helpful (Figure 16)—though this does represent an increase from 6% in 2023 (not shown).

Figure 16. Low Payment Rates, Lack of Capacity to Meet Requirements, and Lack of Information Are Top Reasons ECM or Community Supports Not Provided

Q: BELOW ARE SOME REASONS WHY AN ORGANIZATION MIGHT NOT BE PROVIDING ECM OR COMMUNITY SUPPORTS. FOR EACH REASON, PLEASE INDICATE HOW BIG A REASON IT IS IN YOUR ORGANIZATION FOR NOT PROVIDING ECM OR COMMUNITY SUPPORTS.



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Ranked by "One of the most important reasons" + "Major reason." Asked of FQHC leaders, behavioral health leaders, and social service leaders not providing ECM or Community Supports (*n* = 110).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

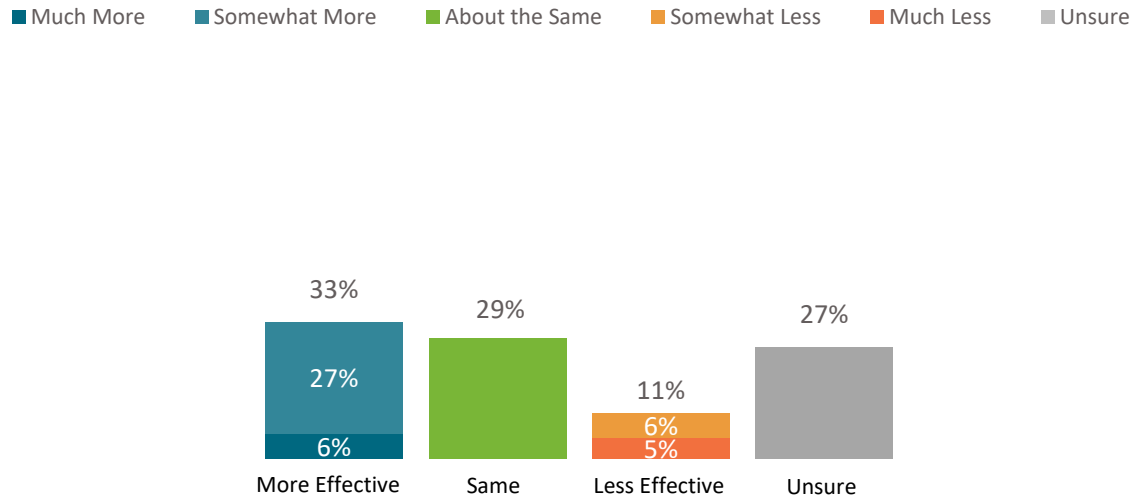
ECM for Older Adults and People with Disabilities

> *[We have] successfully reduced transitions to long-term care and skilled nursing facilities by approximately 30%.*
>
> —Leader, primary care provider, multiple regions

There is some improvement reported in MCPs helping patients stay out of nursing facilities. One-third of implementers serving older adults (33%) say that MCPs have been more effective at helping patients transition out of or stay out of nursing facilities since January 2023, and most of the remainder either say that MCPs' effectiveness has not changed (29%) or that they are not sure (27%) (Figure 17).

Figure 17. Some Improvement Reported in MCPs Helping Patients Stay out of Nursing Facilities Since January 2023

Q: WOULD YOU SAY THAT MEDI-CAL MANAGED CARE PLANS (OR THEIR DELEGATES) HAVE BEEN MORE OR LESS EFFECTIVE AT HELPING PATIENTS TRANSITION OUT OF (OR STAY OUT OF) NURSING FACILITIES SINCE JANUARY 2023 — OR ABOUT THE SAME AS BEFORE?



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Asked of implementers serving older adults (*n* = 481).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Behavioral Health Perspectives on ECM

> *The precursor to ECM was Whole Person Care [WPC], a demo project that paid BH agencies $1,000 a month per client and did not involve the managed care plans. ECM was a whole new design, mandating contracts with managed care plans and intense collaboration on admin processes. Why do a large-scale demo like WPC and then come up with a completely different design for ECM?*
>
> —Leader, specialty behavioral health, Southern California

There is room to expand ECM enrollment among behavioral health clients. A quarter of specialty behavioral health providers (25%) say that just a few or none of their clients are currently receiving ECM, 36% say some of their clients are currently receiving ECM, and only 14% say that most or all of their clients are currently receiving ECM. A quarter (25%) are unsure (not shown).

In open-ended responses, specialty behavioral health implementers say that they do not have more clients enrolled in ECM because of difficulty reaching clients, lack of local ECM providers, or rejections and lack of follow-up by MCPs and ECM providers.

> *Many have declined, we can't reach many who are enrolled, and still others are not eligible due to the 1915(c) waiver.*
>
> —Frontline provider, specialty behavioral health, Bay Area

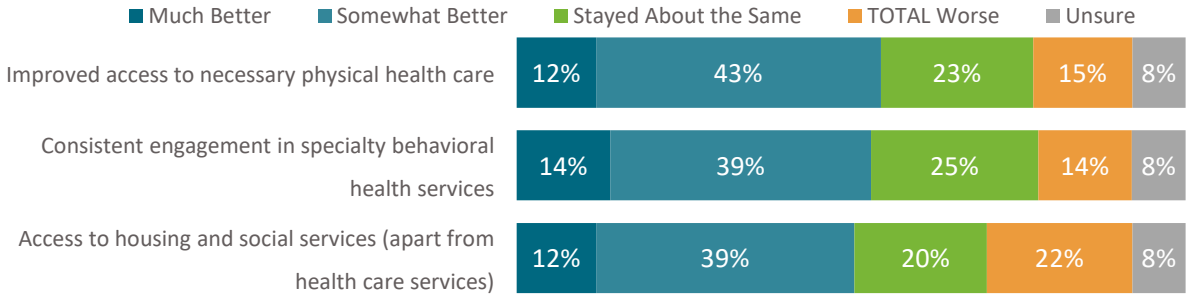
> *We have made several referrals, and none of them have been accepted despite the criteria which fit our population quite well. There has been no communication about the refusals or any type of dialogue to assist with future referrals. . . . We have stopped referring clients to ECM.*
>
> —Leader, specialty behavioral health, Bay Area

When asked about those clients with serious mental illness or substance use disorders (SUD), a majority of specialty behavioral health implementers say that ECM is improving their all-around care, including physical, behavioral health, and social services. Specifically, similar proportions perceive the three areas below as being "much better" or "somewhat better" as a result of ECM for their clients with serious mental illness or SUD who are eligible for the program (shown below in Figure 18):

- Improved access to necessary physical health care (55%)
- Consistent engagement in specialty behavioral health services (53%)
- Access to housing and social services (51%)

Figure 18. Specialty Behavioral Health Providers Report Improvements for Clients Due to ECM

Q: THINKING ABOUT YOUR CLIENTS WITH SERIOUS MENTAL ILLNESS OR SUBSTANCE USE DISORDER WHO ARE ELIGIBLE FOR ENHANCED CARE MANAGEMENT (ECM), PLEASE INDICATE WHETHER YOU PERSONALLY THINK EACH OF THE FOLLOWING HAVE GOTTEN BETTER OR WORSE AS A RESULT OF ECM — OR IF YOU THINK THEY HAVE STAYED ABOUT THE SAME.



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Ranked by "Total better." "Total worse" is "Somewhat worse" + "Much worse." Asked of specialty behavioral health implementers who have at least some clients receiving ECM (*n* = 102).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Section 3. Deep Dives on Other CalAIM Programs

Population Health Management Initiative: Discharge Planners' Perspectives

> *[I do not have information about] if the patient is being followed by ECM or Complex Case Management; if the patient is connected with Substance Use/Behavioral Health Treatment Team; if the patient is connected with a homeless outreach team / housing navigator. I need contact name and numbers to facilitate continuity of care.*
>
> —Frontline provider, hospital discharge planner, Southern California

A majority of hospital discharge planners (57%) report that MCPs have been more effective at supporting discharge planning for Medi-Cal patients after the Population Health Management Initiative expanded Transitional Care Services requirements to all patients transitioning between settings of care. Many of the remaining respondents (30%) say that MCPs' effectiveness has not changed, and only a few (8%) say that MCPs' effectiveness has gotten worse (not shown).

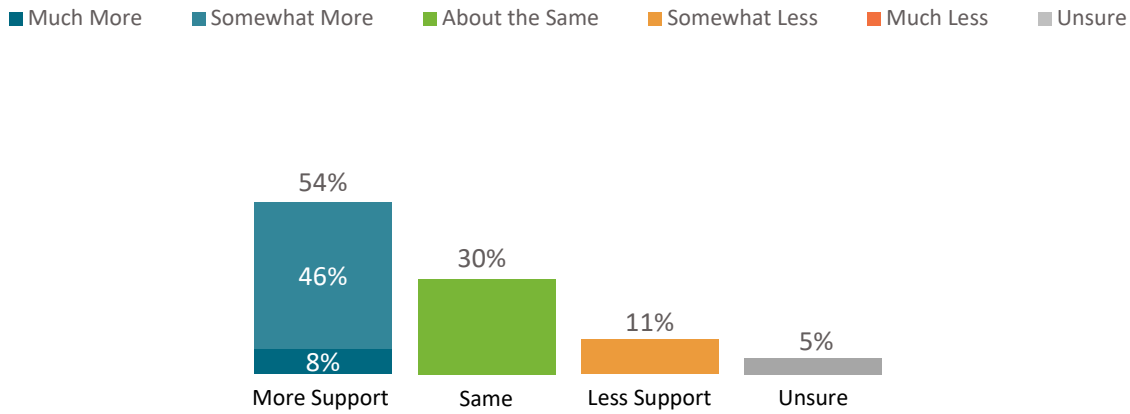
Hospital discharge planners report MCPs as more effective at supporting discharge planning generally, and there has been an increase since 2023 in the proportion of discharge planners who report having a point of contact for at least some plans in their area (73% in 2024

compared to 66% in 2023) (not shown). However, most hospital discharge planners still lack a point of contact at each MCP they work with to assist with challenging transfers or cases. Only 14% have a point of contact for all plans they work with, while a majority (59%) have a point of contact for some, but not all, MCPs. Fourteen percent say that they do not have a point of contact for any of the MCPs they work with, and another 14% are not sure (not shown).

Hospital discharge planners report that Medi-Cal patients are receiving more support accessing needed services postdischarge this year. A majority (54%) say that Medi-Cal patients are receiving "much more" or "somewhat more" support since January 2024, and most of the remainder (30%) say that the amount of support remains the same (Figure 19).

Figure 19. Discharge Planners Report More Support for Patients This Year

Q: WOULD YOU SAY THAT MEDI-CAL PATIENTS ARE RECEIVING MORE SUPPORT ACCESSING NEEDED SERVICES **POSTDISCHARGE** SINCE JANUARY 2024 — OR ABOUT THE SAME AS BEFORE?



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. No respondents chose "Much less." Asked of hospital discharge planners (*n* = 37).

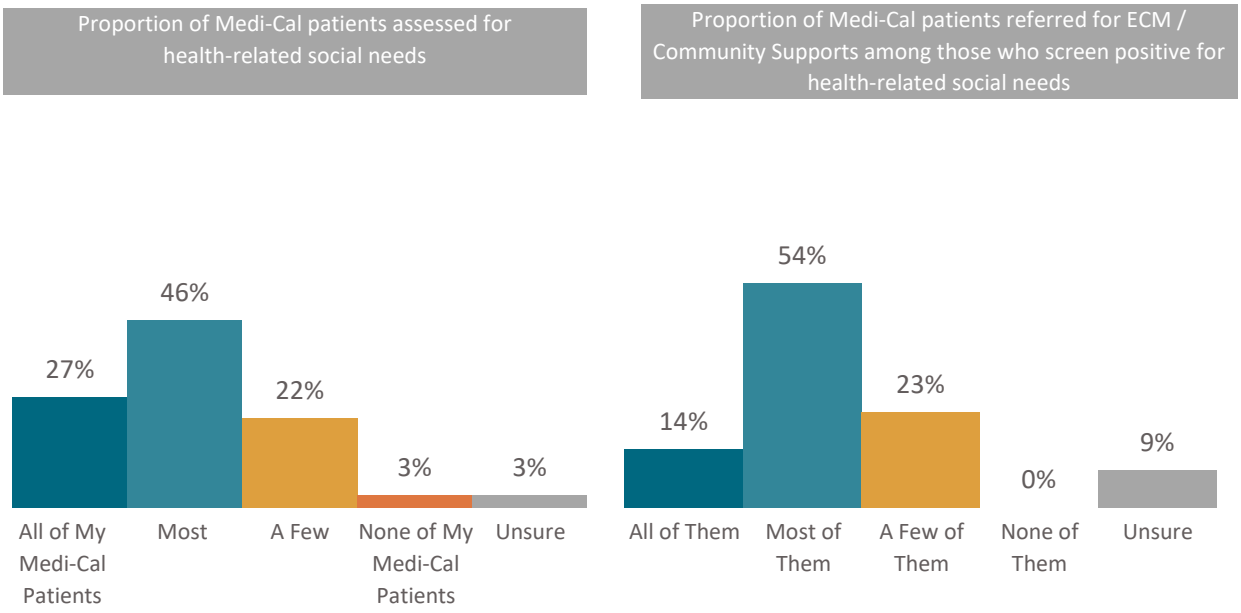
Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Whereas almost two-thirds of hospital discharge planners (65%) say they can discharge at least most of their Medi-Cal patients when they no longer need acute hospital care, only 8% say they can discharge *all* of their Medi-Cal patients. Also, a sizable proportion of hospital discharge planners (30%) say they are not able to discharge more than a few of their Medi-Cal patients at the time they no longer need acute hospital care.

A quarter of hospital discharge planners (27%) report assessing all of their Medi-Cal patients for health-related social needs, and another 46% are assessing most of their Medi-Cal patients. For hospital discharge planners assessing patients, 68% are referring all (14%) or most (54%) of their patients who screen positive for health-related social needs (Figure 20).

Figure 20. Discharge Planners Report Most Patients Are Assessed for Health-Related Social Needs and Referred for ECM or Community Supports

Q: ABOUT WHAT PROPORTION OF YOUR MEDI-CAL PATIENTS DO YOU ASSESS FOR HEALTH-RELATED SOCIAL NEEDS (E.G., FOOD INSECURITY, HOMELESSNESS, NEED FOR HELP AT HOME WITH ACTIVITIES OF DAILY LIVING, NEED FOR HOME MODIFICATIONS TO ADDRESS ASTHMA TRIGGERS AND/OR MOBILITY ISSUES, ETC.)? / HOW MANY MEDI-CAL PATIENTS THAT SCREEN POSITIVE FOR HEALTH-RELATED SOCIAL NEEDS ARE YOU REFERRING FOR ECM OR COMMUNITY SUPPORTS?



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. The question on the left is asked of hospital discharge planners (*n* = 37), and the question on the right is asked of hospital discharge planners who report assessing at least a few of their patients for health-related social needs (*n* = 35).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Perspectives on Behavioral Health Payment Reform

> *The counties need more support on payment reform. Our billing office staff are not medical coders. Our job descriptions don't align with them becoming medical coders. Our HR system won't change fast enough for us to get medical coders in the right positions to keep us financially safe.*
>
> —Leader, county mental health plan, Central Valley

Payment reform has not yet improved conditions for many specialty behavioral health implementers, and a notable proportion say that aspects of delivering services have gotten worse due to payment reform. For every aspect besides "reducing audit risk," more

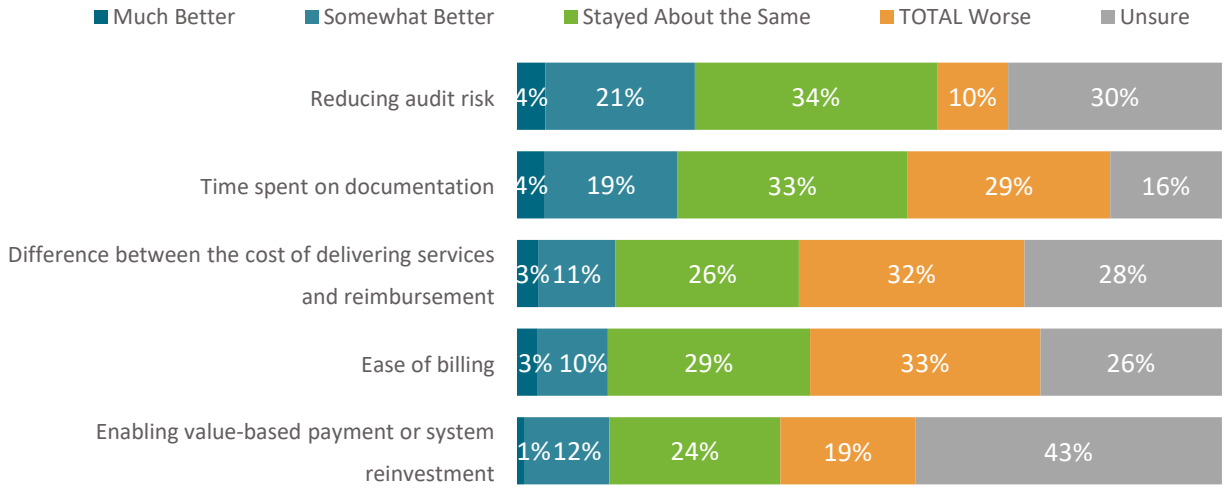
implementers say things have gotten worse than say they have gotten better. The highest reported declines are for:

- Ease of billing (13% better and 33% worse)
- Difference between the cost of delivering services and reimbursement (14% better and 32% worse)
- Time spent on documentation (23% better and 29% worse)

However, there is also a notable proportion of specialty behavioral health implementers who say they are not sure about impacts of the reform (Figure 21).

Figure 21. Behavioral Health Payment Reform Has Not Yet Improved Conditions for Many

Q: PLEASE INDICATE IF EACH OF THE FOLLOWING HAS GOTTEN BETTER OR WORSE OR IF IT HAS STAYED ABOUT THE SAME AS A RESULT OF THE BH (BEHAVIORAL HEALTH) PAYMENT REFORM POLICIES.



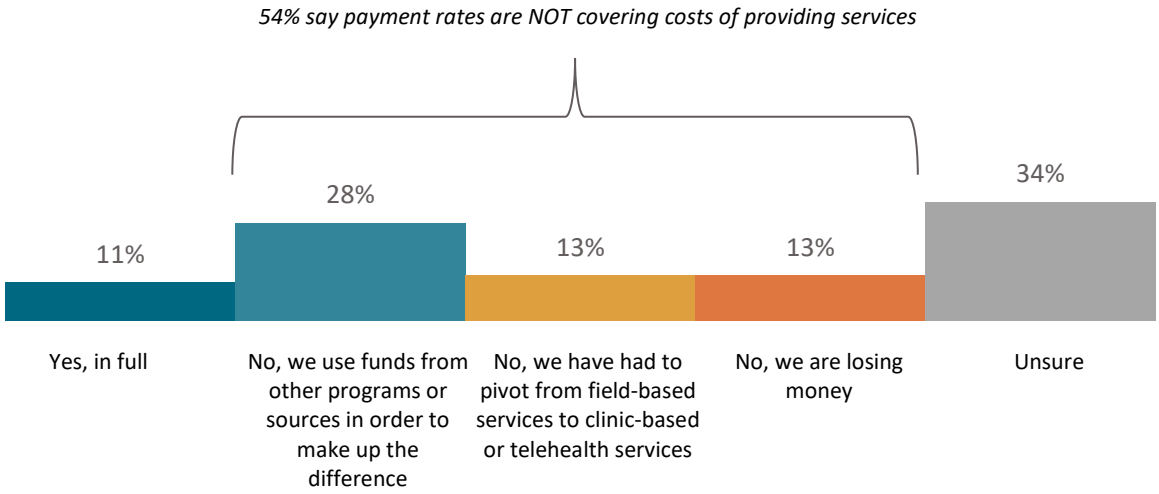
Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Ranked by "Total better." "Total worse" is "Somewhat worse" + "Much worse." Asked of specialty behavioral health implementers (*n* = 203).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

A majority of specialty behavioral health implementers (54%) report that payment rates under Behavioral Health Payment Reform do not cover the cost of providing services. Few (11%) say that payment rates are covering the costs of providing services in full. Whereas some (28%) say they are using funds from other programs or sources to make up the difference in payment rates and the cost of providing services, others say their organization is pivoting away from providing in-person services (13%) or that they are currently losing money (13%) (Figure 22).

Figure 22. Payment Rates Under Payment Reform Not Covering Cost of Services

Q: ARE PAYMENT RATES UNDER BH PAYMENT REFORM COVERING YOUR COSTS OF PROVIDING SERVICES?



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Asked of specialty behavioral health implementers (*n* = 203).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Perspectives of Implementers Working in Reentry or Criminal Legal System

> *Our organization, a non–health care county department that serves the justice-involved population, has been successful in submitting two ECM Certification Applications to two MCPs in our county. We have successfully moved through the gap-closure process with one MCP and are in ECM contract negotiations with that MCP. . . . DHCS should continue its efforts to ensure that MCPs standardize the mandatory elements/standards of ECM so ECM providers that contract with multiple MCPs do not have to meet varying requirements imposed upon them by MCPs for the same work product.*
>
> —Leader, reentry ECM provider, Southern California

In both the focus group and the survey open-ended questions, some implementers serving the reentry population discuss barriers to enrolling and providing care for formerly incarcerated people when there is no prerelease contact.

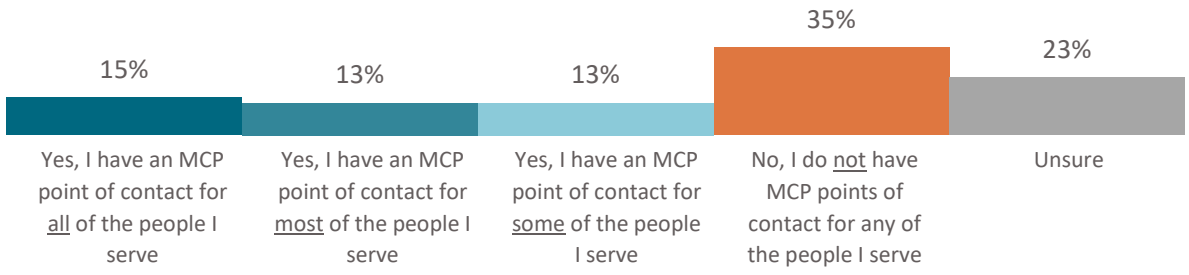
> *It is understood that each county has its own standard regarding "Jail Clearance" protocols. It would be great if DHCS could partner with counties or their various associations to support Jail Clearances being provided for community health workers (CHWs) with justice-involved [JI] histories so they can engage in warm handoffs while an individual is still incarcerated. CHWs are a critical part of the ECM JI provider network, and the ongoing barriers to receiving Jail Clearances negatively impact them from engaging in warm handoffs that can serve to build rapport.*
>
> —Leader, reentry ECM provider, Southern California

Most implementers serving the reentry population lack a point of contact at an MCP for all the people they serve to help get those people linked to ECM or Community Supports. Only 15% have a point of contact for all of the people they serve, and 26% have a point of contact for some or most, but not all, of the people they serve. Another 35% do not have a point of contact at any MCP, and 23% are not sure (Figure 23).

> *We very much need ECM providers to respond to clinicians sending the referrals. We are unclear if clients are receiving services, if so, which services. Also, would love a more efficient ECM referral form/process — and again, a contact person.*
>
> —Frontline, carceral provider, Southern California

Figure 23. Few Reentry Implementers Have an MCP Point of Contact for All the People They Serve

Q: DO YOU HAVE A POINT OF CONTACT AT A MEDI-CAL MANAGED CARE PLAN (MCP) FOR THE PEOPLE YOU SERVE THAT CAN ASSIST YOU WITH GETTING THAT PERSON LINKED TO ENHANCED CARE MANAGEMENT OR COMMUNITY SUPPORTS UPON RELEASE?



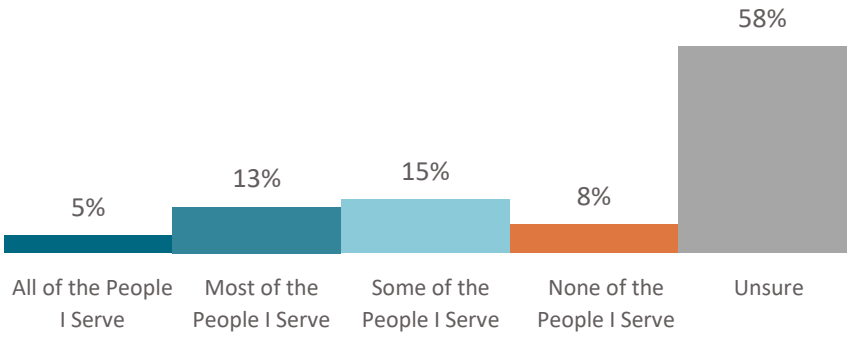
Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Asked of reentry providers (*n* = 60).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Not all aspects of the CalAIM Justice-Involved Initiative are live. Indeed, at the time of the survey, CalAIM's prerelease services were not yet live in any counties. However, some places were already doing some of the required activities. As a result, the following perspective should be viewed as a preimplementation baseline: A majority of reentry implementers (58%) are unsure about whether the people they serve are being released with a 30-day supply of needed outpatient medication, as will be required under CalAIM when prerelease services go live (Figure 24).

Figure 24. Majority of Reentry Implementers Unsure If Patients Are Being Released with Needed Medications

Q: WHAT PROPORTION OF THE PEOPLE YOU SERVE ARE CURRENTLY BEING RELEASED WITH A 30-DAY SUPPLY OF NEEDED OUTPATIENT MEDICATIONS IN-HAND?



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Asked of reentry providers (*n* = 60).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Implementers serving the reentry population are much less likely than those in other sectors to say that they get "all" or "most" of the information they need about the people they serve (18% among implementers serving the reentry population compared to 40% overall). Some open-ended responses highlight the difficulty in data exchange. See the next section for more on data exchange.

> *It is difficult to create connections with different agencies and vendors that did not have connected interfaces to begin with. Sharing data and personal info on individuals is nearly impossible both legally and through current databases.*
>
> —Frontline provider, reentry, Northern California

Section 4. Deep Dive on Data Exchange

Data Exchange Methods

> *Information about social services is dependent on the member providing us with information about which organizations they are receiving services from and their contact at that agency. Many members aren't clear on what agencies they are working with, so we are often in the dark about programs members are enrolled in.*
>
> —Leader, specialty behavioral health, multiple regions

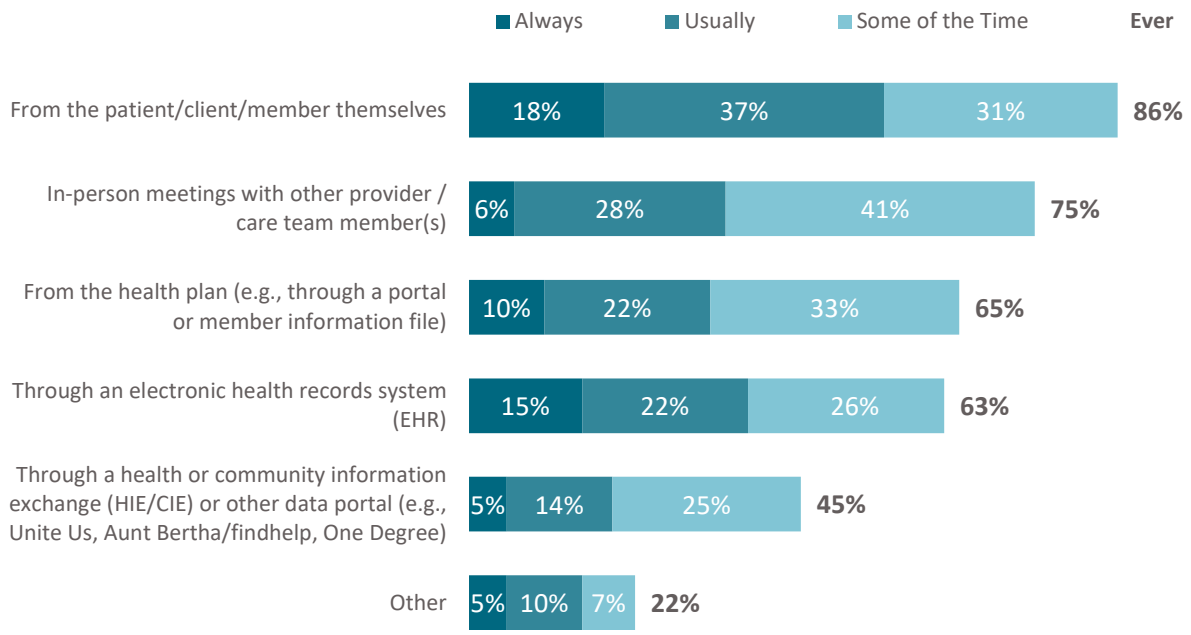
In the context of CalAIM, implementers are still most commonly getting information about the people they serve from personal contact with the enrollee themselves or in-person meetings with other providers.

To learn what care people they serve are getting from other providers, implementers say use of IT solutions like health plan portals (65% ever use them in 2024 compared to 50% in 2023) and EHR systems (63% ever use them in 2024 compared to 58% in 2023) have increased since 2023. Still, neither technology surpasses personal contact.

Additionally, 15% of implementers report “always” or “usually” getting information from “other” sources, and open-ended responses reveal that this largely involves informal communication channels with other providers (such as virtual meetings, phone calls, email, and fax) or contact with the enrollee’s family members. The proportion of implementers who report “always” or “usually” getting information from “other” sources is down slightly from 2023 (15% in 2024 compared to 19% in 2023) (Figure 25).

Figure 25. Information Still Coming Most Commonly from Personal Contact

Q: HOW DO YOU CURRENTLY GET INFORMATION ABOUT THE OTHER CARE THAT THE PEOPLE YOU SERVE ARE GETTING IN THE CONTEXT OF CALAIM (E.G., ECM, COMMUNITY SUPPORTS, JUSTICE-INVOLVED INITIATIVE)?



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Ranked by "Ever." "Ever" is "Always" + "Usually" + "Some of the Time."

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Subgroup Findings

- Implementers serving the reentry population are less likely than other types of implementers to primarily use IT solutions to exchange data in the context of CalAIM (22% "always" or "usually" use health plan portals, 12% always/usually use EHR systems, and 7% always/usually use health information exchange [HIE] or community information exchange; not shown).
- Social service organizations are also less likely than other types of implementers to primarily use EHR systems (22% "always" or "usually" use EHR systems; not shown).

Accuracy, Amount, and Timeliness of Information Received

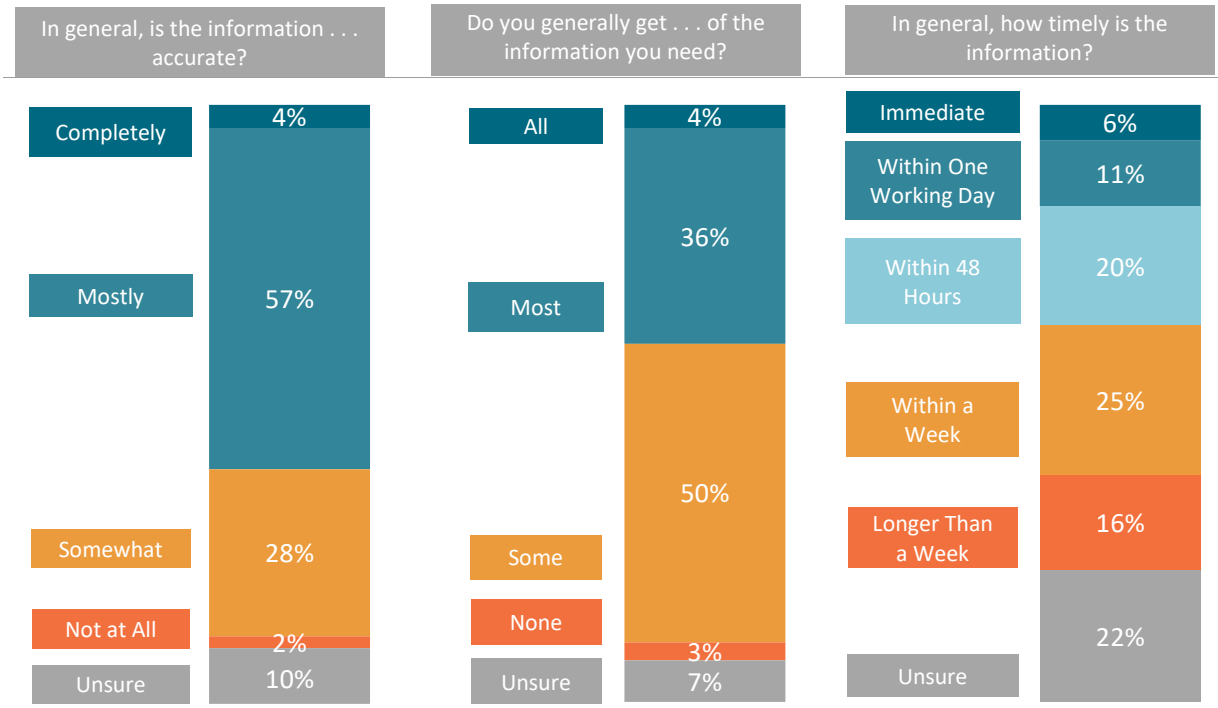
> *As more providers adopt HIE and others have access to closed-loop systems, bidirectional information exchange on the patient or member or client will happen, and the speed of information exchange will be faster, resulting in more coordinated care and better outcomes.*
>
> —Van Do-Reynoso, CHCF CalAIM Advisory Group member and chief health equity officer, CenCal Health

Despite some increase in the use of IT solutions for exchanging data in the context of CalAIM, data exchange is still far from the goal of providing complete, accurate, and real-time information to implementers, and there has not been significant improvement since 2023.

- Whereas a strong majority of implementers (61%) say the information they get about the people they serve is "mostly accurate" or "completely accurate," 30% say the information they get is only "somewhat accurate" or "not at all accurate."
- Less than half of implementers (40%) say they get at least most of the information they need, with only 4% saying they get all the information they need.
- Only 37% of implementers say they get information about the people they serve within 48 hours, with 17% saying they get information within one day or faster and only 6% saying they get immediate information (Figure 26).

Figure 26. Information About Patients/Clients/Members Could Be More Complete and Timelier

Q: STILL THINKING ABOUT THE INFORMATION ABOUT OTHER CARE THAT THE PEOPLE YOU SERVE ARE GETTING . . .



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding.

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Subgroup Findings

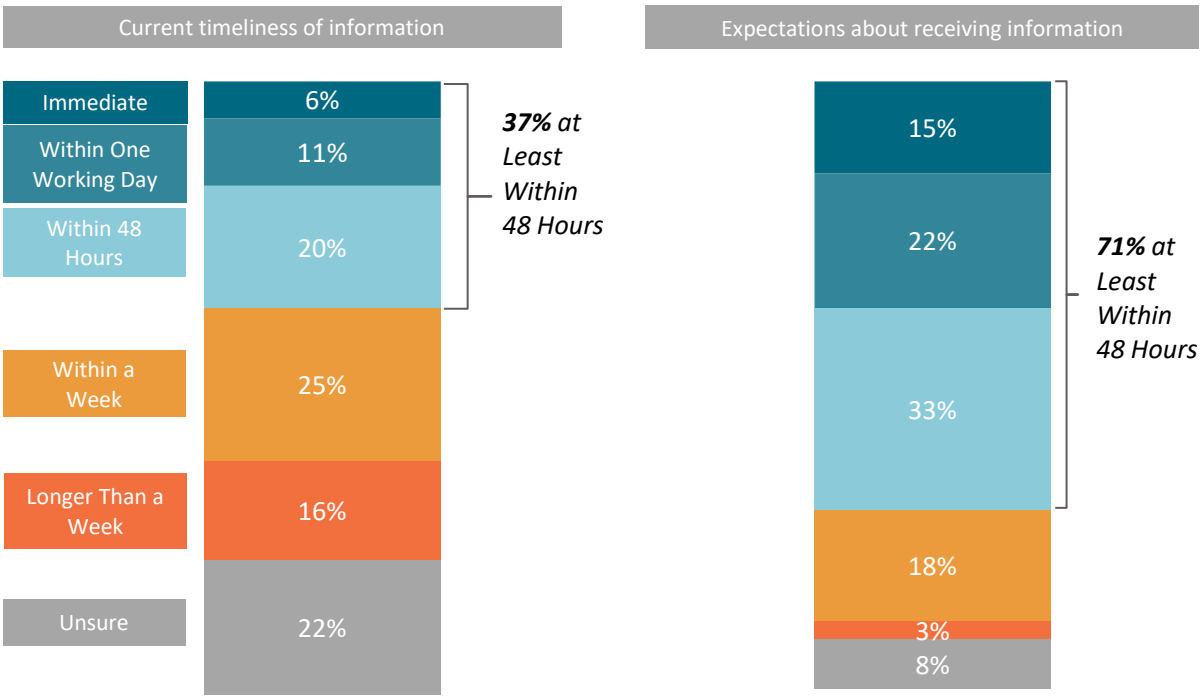
- Implementers serving the reentry population are less likely than those in other sectors to say that they get "all" or "most" of the information they need (18%; not shown).
- Implementers who are not contracted to provide ECM or Community Supports are less likely than implementers who are contracted to say they are getting "all" or "most" of the information they need (25% among those not contracted compared to 48% among those contracted) and are less likely to say they are getting information that is "completely accurate" or "mostly accurate" (52% among those not contracted compared to 64% among those contracted; not shown).
- Implementers serving the reentry population (48%) and social service organizations (58%) are less likely than those in other sectors to say they are getting information that is "completely accurate" or "mostly accurate." Similarly, implementers serving the reentry population (20%) and social service organizations (27%) are less likely than those in other sectors to say they get information within 48 hours (not shown).

In open-ended responses, survey respondents describe the types of information they need but are not getting — which generally includes contact information for the enrollee, care team contacts, the enrollee's medical information, and outcomes of referrals.

When it comes to timeliness, implementers expect to be able to get information much more quickly than they actually do. Many implementers (71%) say they expect to be able to get information within 48 hours or more quickly, but only 37% of implementers say they are getting information within 48 hours. A quarter (25%) say they generally get information between 48 hours and one week, and 16% say it generally takes longer than a week to receive information (Figure 27).

Figure 27. Many Implementers Expect to Get Information Within 48 Hours or Quicker

Q: IN GENERAL, HOW TIMELY IS THE INFORMATION YOU RECEIVE ABOUT THE OTHER CARE THAT THE PEOPLE YOU SERVE ARE GETTING? / WHAT IS YOUR EXPECTATION AROUND THE TIME FRAME TO RECEIVE INFORMATION ABOUT THE OTHER CARE THAT PEOPLE YOU SERVE ARE GETTING?



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding.

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

In open-ended responses, survey respondents describe barriers to receiving timely information about the people they serve, including reluctance to share information and the effort required to request information.

If I need information from other CBOs helping the same client, even if there is a consent, there is a lot of time that passes before I get it.

—Leader, CalAIM consultant, Southern California

Information from hospitals outside of the county [takes a long time]. The first contact is typically through a TAR [Treatment Authorization Request] rather than to coordinate services. Often the resident is discharged from the hospital before we receive the TAR, leaving us no opportunity to follow up on the resident or coordinate services after discharge.

—Leader, social service organization, Northern California

The information sharing is a disaster. MOUs [memoranda of understanding] require data sharing, but counties are refusing to share. Providers are not yet linked to the HIE. Data is (1) not thorough and (2) not timely and (3) requires individual effort to get.

—Representative of managed care plan, multiple regions

Section 5. Deep Dive on Community-Based Health Workforce

Types of Community-based Health Workers and Reasons to Employ Them

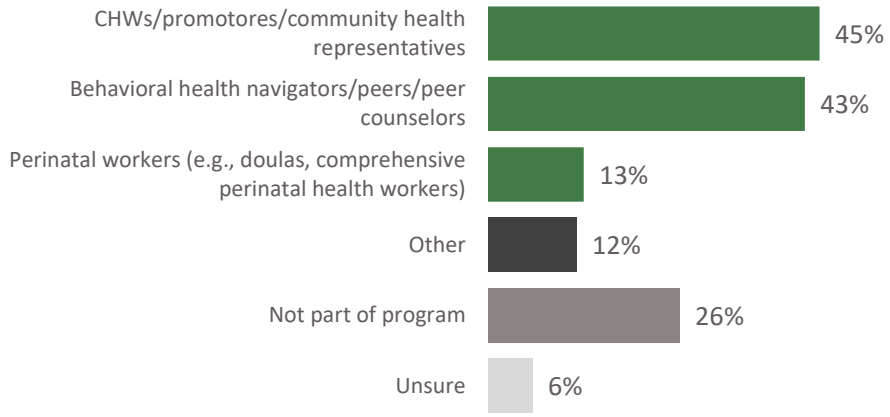
The reimbursement methodology has allowed health care to add CHW workforce into health care teams — which is exactly what is needed to begin to create diverse team-based care and trusted relationships in medicine.

—Leader, primary care provider, Southern California

About two-thirds of leaders (68%) say that their program employs some type of community-based health worker. Most commonly, leaders report employing CHWs/*promotores*/community health representatives (45%) or behavioral health navigators/peers/peer counselors (43%) (Figure 28).

Figure 28. Many Leaders Say Their Program Employs Community-Based Health Workers

Q: WHICH OF THE FOLLOWING MEMBERS OF THE COMMUNITY-BASED HEALTH WORKFORCE ARE PART OF YOUR PROGRAM? YOU MAY SELECT ALL THAT APPLY.



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to rounding. Asked of leaders (*n* = 447).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Subgroup Findings

- Social service leaders are less likely than those in other sectors to say they employ members of the community-based health workforce (36% say the community-based health workforce is not part of their program; not shown).
- Implementers contracted to provide ECM or Community Supports are more likely to include community-based health workers in their program. (Only 23% of those contracted say they do not employ members of the community-based health workforce, compared to 38% of implementers not contracted to provide ECM or Community Supports; not shown).

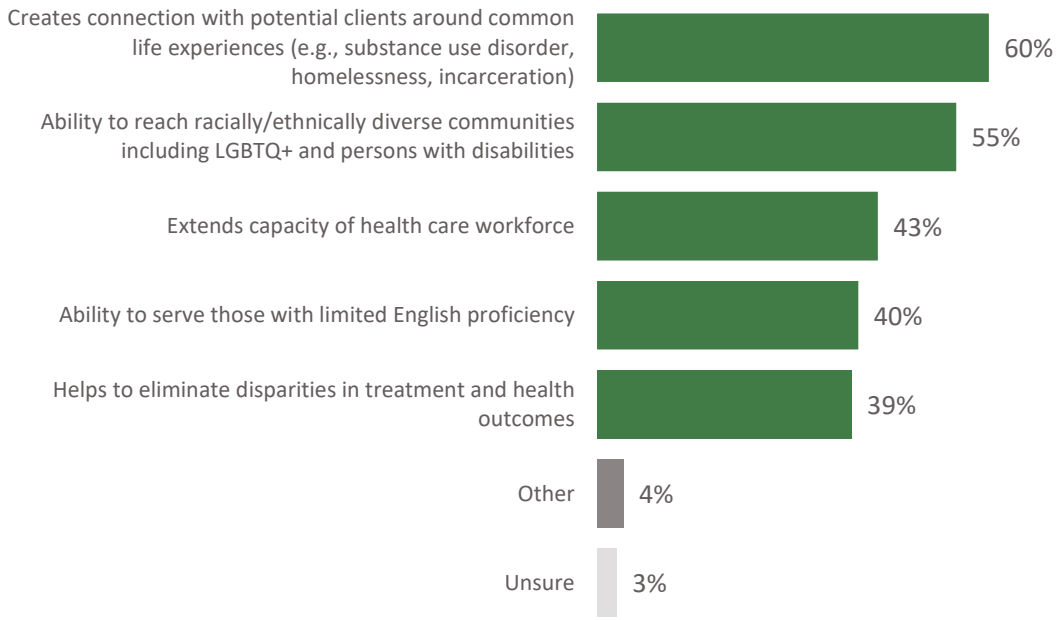
Leaders report a variety of reasons to employ community-based health workers, with the most commonly cited reasons being:

- Creates connection with potential clients around common life experiences (60%)
- Ability to reach racially/ethnically diverse communities including LGBTQ+ and persons with disabilities (55%)

Notable proportions of leaders also cite extending capacity of health care workforce (43%), ability to serve those with limited English proficiency (40%), and helping to eliminate disparities in treatment and health outcomes (39%) (Figure 29).

Figure 29. Reasons to Employ Community-Based Health Workers Vary

Q: FROM YOUR PERSPECTIVE, WHICH OF THE FOLLOWING ARE THE MOST IMPORTANT REASONS THAT YOUR ORGANIZATION EMPLOYS COMMUNITY-BASED HEALTH WORKERS? YOU MAY SELECT UP TO THREE ITEMS BELOW.



Notes: See detailed topline document for full question wording and response options. Totals may not sum due to multiple responses. Asked of leaders who report including community-based health workers in their program (*n* = 302).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

---

[1] For more information on behavioral health payment reform, visit https://www.dhcs.ca.gov/Pages/BH-CalAIM-Webpage.aspx.

[2] For more information on the January 2024 managed care plan change, visit: https://www.chcf.org/publication/medi-cal-explained-2024-medi-cal-managed-care-plans-by-county/.

[3] For more information on PATH CITED, visit https://www.ca-path.com/cited. For more information on IPP funds, visit https://www.dhcs.ca.gov/Pages/IncentivePaymentProgram.aspx.