CalAIM Experiences:
Implementer Views in Year Three of Reforms

Additional Direct Quotes from Survey

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Early Successes

Assisting clients who need assistance with housing and having dollars to utilize to assist with deposits. Successful case management where clients "graduate" from ECM.

—Leader, home health agency, multiple regions

The services have greatly improved the health, wellness, and day-to-day living conditions of those within our unhoused population.

—Frontline provider, FQHC, Central Valley

We are able to provide more services, especially as related to SDoH, and more in-depth services to our ongoing clients, as well as to new clients. We are able to be creative and innovative in developing different ways to help our clients improve their health and well-being.

—Leader, specialty behavioral health, Bay Area

We have built an ECM program and grown from one case manager to four case managers, and have leveraged funds to allow us to provide outreach and support services to our most vulnerable patients and members.

—Leader, specialty behavioral health, multiple regions

Collaboration with community stakeholders has been our biggest success. This includes the work done through the CPI, across county departments, homeless service providers, hospital districts, nonprofits, city jurisdictions, elected officials, and many more.

—Leader, specialty behavioral health, Central Valley

We have 2,000 people with housing Community Supports — the partnership building and joint learning with the managed care plans that goes into this is tremendous.

—Leader, county, Bay Area

That we are able to organize and appropriately discharge patients to get appropriate care and resources to keep them out of the ER.

—Frontline provider, hospital discharge planner, Southern California

Barriers to CalAIM Addressing Racial and Ethnic Health Inequities

Services 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

The populations receiving these services still appear to be somewhat apprehensive about the approach. For example, some of the Latino population we work with are reluctant to have us provide services for them.

—Leader, home modification services, Central Coast

The eligibility files from the health plans are primarily based on utilization of health care services, so they may miss those who are completely disconnected, which means CBOs need to do robust outreach to underserved communities to enroll those members in this benefit.

—Leader, social service organization, multiple regions

We know that certain communities experience discrimination and bias when seeking medical care. To require clinical diagnosis in the eligibility criteria for some CalAIM Community Support services biases authorizations for housing Community Supports toward White, medically connected members and biases services against community members who have less access to nondiscriminatory health care services and/or who are not able to get connected to care due to provider shortages and lack of BIPOC providers. Access to housing and housing-related services should not be dependent on if someone is able to get to a primary care [provider] and then a specialist to receive a diagnosis to then prove eligibility for housing supports. Additionally, we know from Coordinated Entry Systems that the assessments and prioritization processes do not result in equitable placements. So to align housing-related Community Supports with already biased systems may contribute to more inequities in access. . . .

—Leader, advocacy organization, statewide

CalAIM is contracting with agencies in the communities and providing a revenue stream for these companies to continue the services to their already established patients. Addressing the needs of ethnic populations would need new providers to serve the populations in the communities they live.

—Frontline provider, hospital discharge planner, Northern California

There are many services that are now not covered, which reduces equitable access to care. For example, now that travel time is not reimbursable, purportedly to see more families in clinic, there are some families with transportation issues that have more limited access to care. This has also caused some programs in our counties to shut down due to their models of care.

—Leader, specialty behavioral health, Bay Area

Satisfaction: Although Many Implementers Remain Enthusiastic About the Goals of CalAIM, Many Also Feel Overwhelmed, Underresourced, and Underfunded

As a health care professional who has served vulnerable populations for over 20 years at our safety-net organization, I do believe CalAIM has the potential to eliminate health care disparities and enable integration of health-related social needs and tie in community sector with health care. . . . [However,] I do worry that the approach is too complex — the MCPs are allowed to create such variable systems and data requirements — leaving end users to often change systems or be held accountable to deliver care without any reimbursement. As an example, we signed a contract to build out a capitation ECM payment methodology, which we spent time building within our front-end registration systems and revenue cycle along with EHR, then to have to change it six months later to another construct through an amendment. This not only is extra work [and] costs additional money but is time wasted and causes frustration and undue administrative burden.

—Leader, primary care provider, Southern California

CalAIM is bold and has good goals, but its design and implementation are overly complex. . . . We are all sitting in way too many CalAIM meetings during the workday trying to get too many programs off the ground.

—Leader, specialty behavioral health, Southern California

The ability for a CBO to be part of the health care system is a tremendous opportunity. However, the process has been extremely challenging — financially and programmatically.

—Leader, social service organization, Southern California

We would like for our local CBOs to become providers through CalAIM to serve people experiencing homelessness, but the onboarding and preparation and reimbursement rates pose challenges to their opting in.

—Leader, advocacy organization, Southern California

I view the CalAIM as a great idea, but unfortunately, we are seeing a trickle-down effect. The funds trickle down to very little by the time the patient utilizes the fund. Managed care plans are creating programs to address a need in the community that is costing too much money and not addressing the need.

—Frontline provider, hospital discharge planner, Northern California

I am hopeful for CalAIM, but there has been so much change in a short amount of time, and change transformation is hard. It will take at least a decade to see any real change, and I fear that a decade will be too late before other changes are made to actually know if CalAIM made any real impact.

—Leader, specialty behavioral health, Central Valley

The problem here is actual availability and receipt of services. It's great to know that ECM and Community Supports are available, and it's not particularly hard to get our clients approved for services, but the vast majority of our clients who are approved for services aren't getting them. Limited number of providers, not enough staff at MCPs to coordinate care and ensure it's being received, long waiting lists for services at many providers, delays in receiving urgently needed services (rental assistance to keep someone housed arrives six weeks after the person has been evicted for lack of assistance, even though they applied timely.) The idea is great, the implementation stinks.

—Frontline provider, legal services organization, multiple regions

The idea of focusing more time and energy on direct client contact was exciting; however, this hasn't been reality. The only success I can assume is increased revenue for our services.

—Frontline provider, specialty behavioral health, Northern California

I feel our institution could be doing better with additional support. We have made strides in health equity for various populations.

—Frontline provider, specialty behavioral health, Southern California

Sustainability of Services: What Implementers Will Do When PATH-CITED and IPP Money Is No Longer Available[1]

We will supplement with other grant funds . . . but we are also constantly reviewing our financial models to work towards a fully sustainable program. Right now the models rely on minimal staff, which I worry may cause burnout and high turnover rates.

—Leader, medically supported meals provider, Bay Area

Not sure. If we can't find a way to support the cost of the program, then we will consider whether we continue to operate it.

—Leader, social service organization, Southern California

Data Exchange: Information Providers Need but Are Not Receiving

[I am not getting] contact information, staff contact info, client location, other possible contacts for clients, appropriate diagnoses.

—Frontline provider, social service organization, Bay Area

Accurate medication lists; accurate diagnosis; up-to-date nursing, physician, and therapy notes.

—Leader, skilled nursing facility, Central Coast

If they received the care they needed. I see if it was approved, but what are they actually doing? Like if someone is homeless, did you find them somewhere to stay? I do not receive any follow-up on what happened or the outcome.

—Frontline provider, social service organization, Northen California

Even when we have ROIs [releases of information], physicians are often reluctant to discuss a member's care with us. As a result, we frequently have to rely on the information provided by the members themselves, which can be challenging since they may not fully understand their medical situation.

—Leader, social service organization, Central Valley

Additional Data: Differences by Primary Mode of ECM Services Delivery

ECM providers who primarily provide services face-to-face at the client's location are disproportionately more likely to:

- Be social service providers (46% of respondents who provide services face-to-face at client's location are social service providers, while 25% of overall respondents are social service providers)
- Also provide Community Supports (67% of respondents who provide ECM services face-to-face at client's location also provide Community Supports, while 41% of overall respondents provide Community Supports)

ECM providers who primarily provide services face-to-face at the provider's location are more likely to:

- Be health care or behavioral health services providers (65% of respondents who provide services face-to-face at provider's location are health care or behavioral health providers, while 58% of overall respondents are health care or behavioral health services providers)
- Work at an FQHC (32% of respondents who provide services face-to-face at provider's location work at an FQHC, while 12% of overall respondents work at an FQHC)
- Specialize in serving people whose primary language is not English (38% of respondents who provide services face-to-face at provider's location specialize in serving people whose primary language is not English, while 29% of overall respondents specialize in serving people whose primary language is not English)

ECM providers who primarily provide services over telehealth (phone or video) are more likely to:

- Have participated in Health Homes (33% of respondents who provide services over telehealth participated in Health Homes, while 14% of overall respondents participated in Health Homes)
- Get most of their ECM referrals from MCPs (58% of respondents who provide services over telehealth get most of their ECM referrals from MCPs, while 29% of overall respondents get most of their referrals from MCPs)
- Report plans to increase the scale or scope of their services, or both, over the next year (82% of respondents who provide services over telehealth report plans to increase services over the next year, while 63% of overall respondents report plans to increase)
- Report an overall better experience of care for the people they serve due to CalAIM (73% of respondents who provide services over telehealth report a better experience, while 53% of overall respondents report a better experience of care for the people they serve due to CalAIM)

[1] For more information on PATH-CITED, visit https://www.ca-path.com/cited/. For more information on the Incentive Payment Program, visit https://www.dhcs.ca.gov/Pages/IncentivePaymentProgram.aspx.