CHCF Fact Sheet

CalAIM Explained: Overview of New Programs and Key Changes

California Advancing and Innovating Medi-Cal — more commonly known as CalAIM — is a far-reaching, multiyear plan to transform California's Medi-Cal program and enable it to work more seamlessly with other social services. Led by the California Department of Health Care Services (DHCS), the goal of CalAIM is to improve outcomes for the millions of Californians covered by Medi-Cal, including those with the most complex needs. Pending federal approval, CalAIM would add new programs and make important reforms to many existing programs, bringing in significant federal matching dollars in addition to the $782 million allocated from the general fund in the 2021–22 budget and more in future budget years. This explainer provides an overview of all the changes proposed.

Who CalAIM Will Help

CalAIM's broad reach is intended to help all Medi-Cal enrollees through a focus on population health and greater emphasis on prevention and overall wellness. In addition, there are several specific reforms to improve care for people with the most complex needs. In general, this group includes:

- ➤ People with significant behavioral health needs, including people with mental illness, serious emotional disturbance, or substance use disorder
- ➤ Seniors and people living with disabilities
- ➤ People experiencing homelessness who also have complex physical or behavioral health needs
- ➤ People transitioning from jail or prison back to the community who also have complex physical or behavioral health needs
- ➤ Children with complex medical conditions, such as cancer, epilepsy, or congenital heart disease
- ➤ Children and youth in foster care

For examples of how CalAIM will impact the lives of Medi-Cal enrollees, see *CalAIM Explained: A Five-Year Plan to Improve Medi-Cal*.[1]

New Programs

Under CalAIM, DHCS would create several new Medi-Cal programs to improve care for populations with complex health needs. These build on the Whole Person Care Pilots[2] and Health Homes Program,[3] which are ending in 2021.

- ➤ **Enhanced Care Management (ECM).** Today, Medi-Cal is highly fragmented, with some enrollees needing to access care paid for by six or more delivery systems, which can make it difficult for people to navigate across providers and services. For example, a person living with agoraphobia who is unable to leave their home but needs dental care, medical care, and mental health care would need to seek authorization for home-based care from three organizations. In response, a new ECM benefit would provide a high-touch care coordinator for Medi-Cal managed care enrollees with multiple complex needs. If successfully implemented, this benefit would ensure that enrollees with complex needs are identified and engaged by someone who understands their goals, develops a plan in partnership with them and their providers, and actively connects them with the clinical and nonclinical services and resources that help them meet those goals. DHCS has designated a dozen specific populations of focus[4] (PDF) for the ECM benefit, and managed care plans can add to that list at their discretion.

- ➤ **Community Supports (or "In Lieu of Services").** Medi-Cal's coverage may be comprehensive when it comes to health care services like doctor's visits, hospital or nursing home stays, or medications and equipment. There are, however, situations where traditional health care services on their own are not enough to support well-being. For example, a person experiencing homelessness who is diagnosed with cancer may not be able to tolerate chemotherapy if they don't have a safe place to stay, rest, and recover from treatment. Traditionally, Medi-Cal has not covered that safe place

to recuperate, instead only covering a nursing home or hospital, which is more than what is needed. In response, DHCS is proposing to give managed care plans the option to substitute new clinical and non-clinical services for traditionally covered services like care in a nursing home or hospital. This would give plans the financial flexibility to meet the needs of members in new, more patient-focused ways. These services, selected based on evidence that they can improve outcomes, are also intended to prevent or limit the kinds of health complications that require more expensive interventions.

DHCS has given plans the option of providing the following community supports[5] (PDF):

Housing supports
➤ Housing transition navigation services (e.g., assistance applying for and finding housing, signing a lease, securing resources for setup, utilities, moving in)

➤ Housing deposits

➤ Housing tenancy and sustaining services (e.g., early intervention around behaviors that might jeopardize housing, dispute resolution with landlords and neighbors, recertification support)

Short-term recovery supports
➤ Short-term, posthospitalization housing

➤ Recuperative care[6] (medical respite)

➤ Respite services for caregivers (such as those caring for people with dementia or children with disabilities) who need short-term relief

➤ Sobering centers[7]

Independent living supports
➤ Day habilitation programs (e.g., training on independent living skills like cooking, cleaning, and shopping)

➤ Nursing facility transition/diversion to assisted living facilities, such as residential care facilities for the elderly and adult residential facilities

➤ Community transition services / nursing facility transition to a home

➤ Personal care and homemaker services

➤ Environmental accessibility adaptations (home modifications)

➤ Medically tailored meals / medically supportive food

➤ Asthma remediation

➤ **Prerelease/in-reach care for people who are incarcerated.** People who are incarcerated are much more likely to be living with chronic illness and/or behavioral health conditions — like mental illness and substance use disorder — compared to people who are not incarcerated. Federal law prohibits Medi-Cal coverage for people while they are incarcerated. Instead, the jail or prison health service delivers and finances most care in facilities. However, people transitioning from incarceration face increased risk of adverse health events, including death. Research shows former prisoners are 129 times more likely than the general public to die of a drug-involved overdose in the two weeks after release,[8] and are also at higher risk for suicide after release.[9] As part of CalAIM, DHCS is seeking federal authority to expand coverage for key Medi-Cal services in the 90 days prior to release from jail or prison to ensure adequate planning for a smooth transition. Services while incarcerated include care management / care coordination, physical and behavioral health consultation services, and medication-assisted treatment for addiction. Following release, DHCS proposes to provide a 30-day supply of medication as well as durable medical equipment needed post-release, such as a walker or a glucometer. In addition, DHCS would mandate that counties implement a prerelease application process by January 1, 2023. The hope is that by enrolling people in Medi-Cal nearing their release and providing some targeted services early, CalAIM can help ease transition back to the community and prevent physical health and behavioral health complications, including the risk of post-release homelessness.

➤ **Providing Access and Transforming Health (PATH).** To successfully implement CalAIM, many providers will need to increase capacity and capabilities up front. For example, many of the providers that serve CalAIM's populations of focus have never contracted

with managed care plans. In fact, many have never interacted with the Medi-Cal program. Some parts of California may not even have enough providers, and those that do may need to train their workforce in delivering care and services in a coordinated way. The data sharing needed to support that coordination will also require investment in technical infrastructure. To address those needs, DHCS is seeking federal support for infrastructure improvements and technical assistance for community-based providers and correctional facilities. This PATH initiative would be able to cover assistance with contracting and payment processes, workforce development, and staff training. It would cover investments in delivery system infrastructure, such as certified electronic health record technology, care management document systems, closed-loop referral, billing systems and services, and onboarding and enhancements to health information exchange capabilities. PATH would also provide resources for county sheriff departments and state prisons to help with the design and launch of prerelease services. These services include IT services and infrastructure to enable jails and prisons to more easily enroll people in Medi-Cal and to begin coverage and care before they are released.

▶ **Population health management.** While many of CalAIM's reforms are focused on those with the most complex needs, getting to equitable outcomes requires identifying and addressing issues before they become bigger problems. With that in mind, DHCS has proposed requiring managed care plans to develop a comprehensive population health management program. Plans would need to prioritize prevention and wellness in the following ways: assessing member risk consistently and equitably, ensuring effective care coordination to safeguard members during transitions across settings and systems, and ensuring that plans provide services to address social risk factors (e.g., housing, nutrition) and to meet needs outside the managed care delivery system (e.g., behavioral and oral health). DHCS has also recognized that with data housed in many different places, it can be difficult to proactively identify who needs what services. In response, the agency proposes developing a new technology platform to expand access to medical, behavioral, and social service data — both

at the individual member level and for aggregate use by plans.

Key Changes to Existing Programs

CalAIM also proposes other key changes to Medi-Cal, including the following:

▶ **Behavioral health reforms.** The Medi-Cal behavioral health system today is divided three ways, with substance use services and specialty mental health services administered by counties, often across different departments or agencies, and non-specialty mental health services for people with mild to moderate illness administered by managed care plans. These divisions, and the different rules for payment and documentation surrounding them, make it difficult for patients to find the care they need, and for providers to respond in a patient-centered way. While maintaining the fundamental structure of behavioral health services in Medi-Cal, DHCS proposes reforms to ensure that patients can get treatment wherever they seek care — even before they receive a formal diagnosis — and to clarify the division of responsibility for mental health services between managed care plans and county mental health plans. It would also introduce a reimbursement system for behavioral health services based on the type of care provided, rather than the cost of the care, similar to reimbursement in the physical health system. DHCS also proposes streamlining clinical documentation requirements for specialty mental health and substance use disorder treatment services, with the goal of reducing administrative burden and supporting clinicians to focus more on patient care. Finally, CalAIM would help facilitate the integration of specialty mental health and substance use services at the county level into one behavioral health managed care program and proposes a new benefit — known as contingency management — for people with stimulant use disorder.

▶ **Aligned incentives and integrated care for seniors and people with disabilities.** Fragmentation of care and services is particularly acute for seniors and people with disabilities.[10] Medicare plays a significant role in paying for health care services for these populations. At the same time, they also receive important services, like nursing home care and personal care attendants,

that are paid for by Medi-Cal and are typically carved out of managed care. Under CalAIM, DHCS proposes reforms and incentives to make it easier for managed care plans to help seniors and people with disabilities stay in their homes and communities rather than move to nursing homes. It would also require plans to provide aligned Medicare and Medi-Cal plans for people eligible for both programs,[11] thereby supporting better integration and coordination of services. These reforms would build on lessons learned from the Coordinated Care Initiative.[12]

▶ **Standardized and enhanced requirements for managed care.** California has many different models of managed care today, each with a unique set of benefits and covered populations. In addition, there is variation in what plans do around population health management, data sharing, and voluntary accreditation. DHCS proposes a new requirement for managed care plans to proactively reach out to their members based on their needs, share data with other organizations and agencies providing care, and become accredited by the National Committee for Quality Assurance.[13] At the same time, DHCS would also introduce an aligned set of benefits and populations for all managed care plans to standardize their offerings and enable regional rate-setting.

▶ **More flexible payment for public hospitals that care for the uninsured.** Since 2015, public hospitals have been paid differently for care they provide to the uninsured, moving away from a system that focused on acute and emergency care to one focused on preventive care, including primary care and behavioral health. CalAIM would make the Global Payment Program a stronger tool for addressing health inequities by allowing participating public hospitals to be reimbursed for providing additional nontraditional services that address social determinants of health and improve population health outcomes and health equity. If these reforms are successfully implemented, uninsured patients would receive more preventive care, outreach, and care management services and be less likely to have complications that require an emergency room or hospital visit.

▶ **Enhanced oversight of county eligibility and enrollment processes.** Today, California delegates many functions of Medi-Cal to counties, including the determination of eligibility for Medi-Cal. There is variation in the degree to which counties successfully fulfill state and federal requirements for these functions. Under CalAIM, DHCS would do more to ensure that county eligibility and enrollment processes are compliant with federal and state regulations. The department plans to convene a workgroup to improve the collection of enrollee contact and demographic information in Medi-Cal and other public assistance programs.

▶ **Enhanced oversight of county California Children's Services programs.** The California Children's Services program is the primary way that Medi-Cal provides case management services and diagnostic and treatment services — as well as physical and occupational therapy services — to children and youth with eligible medical conditions, like cerebral palsy and diabetes. This program is administered by California's 58 counties. Through CalAIM, the state will enhance its oversight of counties to ensure they comply with applicable state and federal requirements.

▶ **Model of care for foster youth.** CalAIM would also develop a strategy for a fully integrated model of care for foster youth. DHCS has convened a workgroup[14] to determine short- and long-term policy recommendations for coordinating and improving care for this population.

Timeline for Implementation of CalAIM

DHCS maintains a calendar[15] (PDF) with updated time frames for when different reforms will go live. That should be the primary reference for those seeking more information about the timing of specific CalAIM programs.

This is the second in a series of explainers on CalAIM. The first, *CalAIM Explained: A Five-Year Plan to Transform Medi-Cal*, provides a basic overview of the initiative. Additional publications and resources from CHCF can be found in the CalAIM Collection. Additionally, the Department of Health Care Services has information on CalAIM on its website.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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.

Endnotes

1. *CalAIM Explained: A Five-Year Plan to Transform Medi-Cal*, CHCF, October 2021.

2. "Whole Person Care Pilots," California Dept. of Health Care Services (DHCS), last modified September 7, 2021.

3. "Health Homes Program," DHCS, last modified June 16, 2021.

4. *CalAIM Enhanced Care Management Policy Guide* (PDF), DHCS, September 2021.

5. *Medi-Cal In Lieu of Services (ILOS) Policy Guide* (PDF), DHCS, September 2021.

6. Jill Donnelly, Jessica Layton, and Lucy Pagel, *Medical Respite: Post-Hospitalization Support for Californians Experiencing Homelessness*, CHCF, July 2021.

7. Shannon Smith-Bernardin and Bonar Menninger, *Sobering Centers Explained: An Innovative Solution for Care of Acute Intoxication*, CHCF, September 2021.

8. Ingrid A. Bingswanger et al., "Release from Prison — A High Risk of Death for Former Inmates," *New England Journal of Medicine* 356 (Jan. 11, 2007): 156–65.

9. Daniel Pratt et al., "Suicide in Recently Released Prisoners: A Population-Based Cohort Study," *Lancet* 368, no. 9530 (July 8, 2006): 119–23.

10. Giselle Torralba et al., *Meeting the Moment: Strengthening Managed Care's Capacity to Serve California's Seniors and Persons with Disabilities*, CHCF, April 2021.

11. Amber Christ and Georgia Burke, *A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care*, CHCF, September 2020.

12. "Coordinated Care Initiative Overview," DHCS, last modified October 19, 2021.

13. "Health Plan Accreditation," National Committee for Quality Assurance.

14. "Foster Care Model of Care Workgroup," DHCS, last modified September 15, 2021.

15. *DHCS Major Program Initiatives - Go-Live Dates (pending readiness and federal approvals)* (PDF), DHCS, last updated October 13, 2021.