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CHCF Issue Brief

Early Lessons from CalAIM Initiatives to Address Behavioral Health Needs

Behavioral health conditions are widespread among Californians, and many struggle to access behavioral health treatment.[1] One in 25 adults in the state has a serious mental illness, and the proportion of adults with substance use disorders is higher than the national average (9.2% compared to 7.7%).[2] During the COVID-19 pandemic, rates of drug overdose rose sharply in California, as did rates of self-reported serious psychological distress among adults enrolled in Medi-Cal.[3] People with serious mental illness (SMI) and substance use disorder (SUD) are less likely to receive preventive care, have higher rates of chronic physical conditions, and are more likely to visit emergency departments.[4] They also have higher rates of housing and food insecurity.[5] Initiatives that coordinate across medical, behavioral health, and health-related social needs — also known as whole-person care — are needed to improve outcomes for these populations.

Historically, Medi-Cal has provided services to people with behavioral health conditions through several different, often uncoordinated, systems, making whole-person care delivery challenging. Medi-Cal managed care plans (MCPs) manage physical health services and a limited set of non-specialty mental health services for adults with mild to moderate mental health distress or impairment. The non-specialty mental health services may be delivered by primary care providers, if within their scope of practice, or by mental health providers in the MCP's network. County behavioral health agencies — operating through mental health plans (MHPs) — manage specialty mental health services (SMHS) for adults with complex behavioral health needs including SMI. In most counties, SUD services are delivered through separate managed care plans in the Drug Medi-Cal Organized Delivery System (DMC-ODS), also under the purview of county behavioral health agencies. People with co-occurring conditions must navigate these separate systems for care, and their various providers often cannot easily access information about their diagnoses and treatment across these different systems.

CalAIM (California Advancing and Innovating Medi-Cal) is a multiyear effort of the California Department of Health Care Services (DHCS) to transform the Medi-Cal program by offering whole-person care and addressing fragmentation of care, including for people with behavioral health needs.[6] Two recent initiatives to better support people with complex needs, including those with serious behavioral health conditions like SMI and SUD, are Enhanced Care Management (ECM) and Community Supports. These initiatives build on the Health Homes Program and the Whole Person Care pilots, previous intensive care coordination programs in Medi-Cal.[7]

MCPs, county behavioral health agencies, and other community-based ECM and Community Supports providers will play important roles in making sure ECM and Community Supports deliver on the promise of reducing fragmented care for people with serious behavioral health conditions and supporting better outcomes. To understand lessons from the early implementation period and what refinements may improve care coordination for adult Medi-Cal members with SMI or SUD, the Center for Health Care Strategies, with support from the California Health Care Foundation, conducted interviews with behavioral health stakeholders in five counties from December 2022 to March 2023. Interviewees included leaders of MCPs, county

behavioral health agencies, and community ECM and Community Supports providers. The counties selected represent a diversity of regions and managed care models, including some that participated in the Health Homes or Whole Person Care initiatives and some that have active ECM and Community Supports contracts. Drawing from these interviews, this issue brief outlines considerations for:

- Developing contracts between MCPs, county behavioral health agencies, and community ECM providers
- Identifying members eligible for ECM
- Addressing duplication across care management programs
- Delivering ECM to eligible members
- Contracting and delivering Community Supports

CalAIM Initiatives to Address Behavioral Health Needs

Multiple CalAIM initiatives are changing how members with behavioral health conditions receive care, how providers deliver and are paid for care, and how county behavioral health agencies administer care.[8] These initiatives include No Wrong Door, which aims to ease access to mental health care for members across the county behavioral health and managed care delivery systems; Standardized Screening and Transition Tools, which are designed to streamline mental health care delivery through a standardized set of mental health screening and care transition tools; and Behavioral Health Payment Reform, which redesigns the long-standing payment system for county behavioral health to simplify administration and reward better SMHS and SUD care.[9]

ECM and Community Supports are among these initiatives and aim to better support people with complex needs, including those with serious behavioral health conditions.

ECM Populations of Focus

- People experiencing homelessness:
  - Adults without dependent children/youth living with them experiencing homelessness
  - Homeless families or unaccompanied children/youth experiencing homelessness
- People at risk for avoidable hospital or emergency department utilization (formerly "high utilizers")
- People with serious mental health and/or SUD needs
- People transitioning from incarceration
- Adults living in the community and at risk for long-term care institutionalization
- Adult nursing facility residents transitioning to the community
- Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model with additional needs beyond the CCS condition
- Children and youth involved in child welfare
- People with intellectual/developmental disabilities
- Pregnant and postpartum people

Source: *CalAIM Enhanced Care Management Policy Guide* (PDF), DHCS, last updated December 2022, 9.

Enhanced Care Management and Community Supports Definitions, Timelines, and Eligibility Criteria

- **Enhanced Care Management (ECM)** provides intensive care coordination of health and health-related services across clinical and nonclinical needs and is delivered by providers contracted with MCPs. Medi-Cal members with serious mental health and/or SUD needs are among 10 populations of focus for ECM.[10]
  - **Timeline.** ECM had a phased launch for most populations of focus. For adults with serious behavioral health conditions, ECM began in January 2022 in counties that participated in the Health Homes Program or Whole Person Care pilots, and in July 2022 in all other counties. ECM for children and youth began in July 2023.
  - **Eligibility criteria under the population of focus of people with serious mental health and/or SUD needs.** Medi-Cal members are eligible for ECM under these criteria.[11]
    - **Adults who:**
      1. Meet the eligibility criteria for participation in, or obtaining services through:
         a. SMHS delivered by MHPs
         b. The Drug Medi-Cal Organized Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) program
      2. Are experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, high measure [four or more] of adverse childhood experiences based on screening, former foster youth, or history of recent contacts with law enforcement related to mental health and/or substance use symptoms)
      3. Meet one or more of these criteria:
         a. Are at high risk for institutionalization, overdose, and/or suicide
         b. Use crisis services, emergency department (ED) or urgent care visits, or inpatient stays as the primary source of care
         c. Experienced two or more ED visits or two or more hospitalizations due to serious mental health or SUD in the past 12 months
         d. Are pregnant or postpartum (12 months from delivery)
    - **Children and youth who:**
      1. Meet the eligibility criteria for participation in, or obtaining services through one or both of these:
         a. SMHS delivered by MHPs
         b. The DMC-ODS or the DMC program
- **Community Supports** are 14 services (including medically tailored meals, housing transition navigation services, medical respite, and sobering centers, among others) designed to support the needs of people with complex needs. MCPs can choose whether to offer any of these services, which are intended to be medically appropriate, cost-effective alternatives to services covered under the Medicaid State Plan.[12]
  - **Timeline.** All MCPs could begin offering Community Supports as of January 2022; the number of MCPs offering each Community Support varies based on the service.[13]
  - **Eligibility criteria.** Eligibility criteria differ depending on the service. Some Medi-Cal members who qualify for ECM may not qualify certain Community Supports; some people who qualify for certain Community Supports may not qualify for ECM.[14]

ECM and Community Supports for the SMI/SUD population of focus are offered by MCPs and delivered through county behavioral health agencies and community providers who choose to contract with their MCPs for these services. MCPs are required to offer ECM and expected to develop their provider networks over time.[15] Since many ECM-eligible members under the population of focus of "people with serious mental health and/or SUD needs" will already be receiving services from county behavioral health agencies, MCPs must focus on contracting with these agencies and their respective subcontracted providers.[16] County behavioral health agencies may choose not to contract for ECM.[17] By contrast, Community Supports are optional for MCPs to offer, though they are encouraged to offer all 14 services and to develop provider networks to implement them.[18] County behavioral health agencies can become contracted providers of any of the Community Supports available under their MCP(s).[19]

Developing ECM Contracts with County Behavioral Health Agencies and Other Community Providers

ECM is a "high touch" comprehensive care management and care coordination service intended to engage members in person "wherever they are — on the street, in a shelter, in their doctor's office, or at home."[20] Effective ECM delivery requires contracting with providers who have trusted relationships and expertise in connecting with the respective population of focus. County behavioral health agencies and their network providers have these connections with many adults with serious behavioral health needs, and a DHCS fall 2022 survey of county behavioral health agencies found that half of the responding counties either had a contract or were negotiating a contract for ECM for a population of focus. County behavioral health interviewees reported that the main barriers to contracting included workforce and bandwidth issues as well as payment rates. These barriers affect how county behavioral health agencies navigate individual MCP contracting requirements (particularly in counties with multiple MCPs) and how they view ECM in the context of other county-administered behavioral health programs.

Workforce and Bandwidth Challenges

Widespread county and behavioral health workforce shortages — stemming, in part, from staff burnout experienced during the COVID-19 pandemic — have hampered the capacity of county behavioral health agencies to contract for ECM, according to agency interviewees. Some reported vacancies for over 25% of their positions. These shortages are more acute in rural and frontier parts of California.[21] The concurrent introduction of other behavioral health initiatives (within and outside CalAIM) has further stretched the capacity of county behavioral health staff, who are also managing their existing behavioral health programming. Some interviewees acknowledged that while the aggressive timeline for the initial contracts with ECM was a deterrent in the short term, they expected to pursue contracts as ECM providers in the future.

Payment Challenges

County behavioral health agency interviewees described the payment rate structures set by MCPs — who are working under rates set by the state — as being too low to adequately cover the costs of delivering ECM effectively to the population of focus of Adults with Serious Mental Health and/or SUD Needs. To encourage more contracting for ECM, county behavioral health and provider interviewees said that a more optimal care model and corresponding payment structure are needed, to reflect the higher acuity levels of this population and the complexities of delivering ECM primarily through in-person interactions to people who may have transient or unstable housing and sometimes harbor deep mistrust of health and social services.

One former Whole Person Care (WPC) county provided an example: Based on the ECM rate structure and conversations with their MCPs, they estimated that ECM case managers would provide four to six interactions per month for members of this population of focus, compared to WPC, which assumed at least 12 case management interactions per month — and sometimes far more. Other interviewees said that the rate structure constrains the time that ECM care managers require to fully address the needs of members who may be experiencing a crisis or who may be transitory and require more extensive outreach in the community.

Interviewees also described ECM administrative burdens, which contribute to concerns about the rates and contracting for ECM, particularly in counties with multiple MCPs and for providers operating in multiple counties. As of 2019, under Medi-Cal managed care, 35 of 58 counties have at least two MCPs, each with unique contracting, billing, and service procedures.[22] In those counties, behavioral health agencies and community ECM providers may have to negotiate ECM contracts with multiple MCPs and navigate different rate structures and requirements. According to interviewees, most MCPs have structured ECM rates as a "per engaged member per month," but others use fee-for-service payment for ECM. Since MCPs have different policies, processes, portals, tools, and delegation arrangements, county behavioral health agencies and behavioral health providers (especially smaller providers) can struggle to navigate these differences, given workforce shortages and limited resources.[23] Even completing the provider applications for multiple MCPs can be a substantial hurdle. MCP interviewees also described administrative challenges to establishing ECM. For example, one former WPC MCP leader described the financial and administrative burdens relating to "unbundling" the single rate for WPC into multiple services and funding streams for different components of ECM and Community Supports.

Opportunities to Refine This Process

- **Support a uniform model of care and contracting approach.** In counties with multiple MCPs, a unified contracting approach can provide more predictability and continuity. For example, MCPs can coordinate to align workflows and payment approaches to ease contracting for county behavioral health agencies, as has taken place in at least one county.[24]
- **Develop a consistent payment rate structure.** Consider developing a more standardized rate structure, indexed to geography and need. Special consideration should be given to outreach challenges in rural counties, given provider shortages and travel times. Consider including direct payments for outreach activities, and/or enhanced payment for enrollment that more meaningfully factors in the costs associated with outreach and engagement for this population of focus.
- **Incentivize staff to enroll ECM members.** Encourage staff to outreach and enroll members in ECM by developing performance targets and rewarding staff who exceed those targets, such as with gift certificates.

Identifying Eligible Medi-Cal Members for ECM

Determining ECM eligibility is not simple. It requires information about eligibility for county behavioral health services, physical and behavioral health utilization, as well as social needs. MCPs are responsible for identifying members for ECM by establishing referral policies and procedures among all network providers, entering into memoranda of understanding with county behavioral health agencies, and reviewing member data feeds, as well as their own non-specialty mental health services member data. Updated guidance is expected to require county behavioral health agencies to share this responsibility for this population of focus.[25]

Medi-Cal Members in Specialty Behavioral Health Systems

While only a subset of adults eligible for county behavioral health programs are expected to also be eligible for ECM under this population of focus, some MCP interviewees reported starting with the county behavioral health population as they identify potentially eligible ECM members. MCP interviewees described this process as cumbersome. It includes MCPs reviewing medical, behavioral health, and social needs data and then sharing potential ECM member lists with county behavioral health agencies through protected data exchanges. However, these data are often siloed in various systems, and claims data are particularly challenging because of long lags (about 12 months for SMHS, and six months for DMC-ODS). Some MCP interviewees shared that the challenge is compounded by some county behavioral health agencies' unwillingness to share SUD data due to perceived federal and state regulatory constraints, such as 42 CFR Part 2. As a result, one MCP interviewee estimated that the plan has enrolled only about 25% of members eligible under this population of focus.

MCPs and their contracted ECM providers can also field self-referrals or other community-based referrals. To help with this approach, one Federally Qualified Health Center–based ECM provider (in a county with a single MCP) developed a screening checklist, based on their MCP's contract language, to determine if referrals from the medical side of their Federally Qualified Health Center or other community-based referrals meet ECM eligibility criteria. When they do, they pass the referral to the MCP to determine eligibility.

Some recent CalAIM changes should ease the process of identifying members for ECM for this population:

- CalAIM revised the criteria for receiving SMHS and created standardized, statewide screening and transition tools launched in January 2023 for use by MCPs and county behavioral health agencies.[26] Before this change, counties used their own tools, which led to inconsistencies.[27] Widespread adoption of these tools should create more transparency for members and providers, and may help to address the variation in ECM eligibility by county.
- The Population Health Management Service, a statewide technology service launching later in 2023, is expected to increase MCP access to comprehensive data on members' health history, needs, and risks, and to include other authorized users like counties and providers.
- Recent updates to ECM information-sharing guidance require MCPs to provide a standardized format and method for how information on potential ECM referrals is transmitted from ECM providers to MCPs.[28]
- California is piloting the Authorization to Share Confidential Medi-Cal Information Form and consent management service, a voluntary universal consent form for sharing Medi-Cal members' physical, behavioral, and social health information.[29] The form includes a checkbox that lets members share their SUD treatment information, which was added by the state, "given its sensitive nature and to ensure compliance with 42 CFR Part 2."[30]

Medi-Cal Members Not Served in Specialty Behavioral Health

Several interviewees noted that ECM can be especially valuable for reaching members with complex behavioral health needs who — for any number of reasons, including navigational challenges or refusal of care — are not yet connected to county behavioral health services. While counties have multiple care management programs serving specialty behavioral health members, the agencies interviewed reported having more limited resources for outreach to new members, especially those with SUD. ECM creates a new opportunity to proactively engage this population in behavioral health services. For example, members eligible for ECM as members of other populations of focus, such as people experiencing

homelessness, or those with high utilization of ED services, may also be adults with serious behavioral health conditions who may not previously have been served by the county behavioral health system. However, county behavioral health agency interviewees reported that to date, ECM has not led to meaningful increases in people being assessed for and referred to county behavioral health services. This disconnect may be due to an array of factors, including the relatively low uptake of ECM among people with serious behavioral health needs to date, as well as poor coordination across systems.

Opportunities to Refine This Process

- **Align screening tools.** Align the newly launched specialty mental health screening and transition tools with the ECM requirements for identification, as is taking place in some counties.
- **Improve eligibility algorithms.** Engage county behavioral health agencies to coordinate with MCPs to develop better algorithms for eligibility.
- **Leverage the Population Health Management Service.** Align the health risk stratification tool within the CalAIM Population Health Management Service to streamline member identification.[31]
- **Track new referral data on county-managed specialty behavioral health services.** Track whether members of this population of focus are newly connecting to SMHS or DMC-ODS.
- **Encourage nontraditional providers to contract for ECM.** Encourage nontraditional providers (e.g., homeless service, street medicine) to contract with MCPs to become ECM providers, leveraging their outreach skills to reach members outside the county behavioral health system.
- **Educate stakeholders about the ECM program.** One ECM community provider discussed efforts to educate their local medical providers and hospital about the ECM program to increase community referrals. Developing marketing materials and educating partners inside and outside of ECM provider institutions could boost community ECM referrals and enhance relationship building for ECM care coordination.
- **Share best practices.** Identifying potentially eligible ECM members is a complex process that will evolve over time as new CalAIM initiatives that promise to ease some of these complexities become available. Meanwhile, as stakeholders try different approaches to identifying ECM members, consider hosting forums or establishing a resource library on ECM member identification strategies that are successful and easily replicable, for both community referrals and MCP potential member lists.

Avoiding Duplication Across Care Management Programs

Once identified, there is a strong likelihood that many ECM members will also be receiving — or eligible to receive — county behavioral health services, including other care management services (for examples of county behavioral health care management services for adults with behavioral health needs, see the "Examples of County Behavioral Health Agency Care Management Services for Adults with SMI or SUD" sidebar). Where this is the case, the ECM provider is intended to function as the "lead care manager," ensuring coordination across every component of a member's needs and services — in a role that some stakeholders call "air traffic control."[32] ECM is meant to enhance care management within these services/systems, and to address any unmet medical or social needs, with MCPs responsible for ensuring these services are not duplicative.[33]

Table 1. Examples of County Behavioral Health Agency Care Management Services for Adults with SMI or SUD

SERVICE NAME	SERVICES OFFERED (NOT EXHAUSTIVE)	ALLOWABLE OVERLAP WITH ECM? (ONLY IF ECM ENHANCES OR COORDINATES WITH OTHER SERVICE)
Specialty Mental Health Services Targeted Case Management (SMHS TCM)	Care coordination and monitoring to access needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services.	Yes
Full Service Partnership (FSP)	Funded by Mental Health Services Act; provides needs assessment and provision of shelter/housing; legal assistance; food; clothing; showers; medical, psychiatric, and dental care; alcohol and drug treatment; and social rehabilitation.	Yes
Drug Medi-Cal Organized Delivery System (DMC-ODS)	Care coordination of SUD care, mental health care, medical care, and community-based services and supports.	Yes

Sources: *CalAIM Enhanced Care Management Policy Guide* (PDF), DHCS, December 2022, 57; *MHSOAC Statewide Full Service Partnership (FSP) Outcomes Report* (PDF), Mental Health Services Oversight and Accountability Commission, June 30, 2014.

Identifying Overlapping Care Management Services

MCPs are required to check data feeds regularly to identify members with overlapping services and to develop policies to make sure contracted ECM providers ask members about participation in other services as part of the care plan.[34] County behavioral health agencies and ECM providers have incentives to do so: They benefit from understanding when members are enrolled in overlapping services so they can coordinate care management services in a nonduplicative way. County behavioral health agency and community ECM provider interviewees described how MCPs expect them to identify and flag instances of overlapping care management services with ECM, but said that in practice the lags in claims data make this difficult. One county behavioral health agency delivering ECM noted that — when ECM is not provided by their agency — they are relying only on member self-report to understand overlapping care management services because they may not receive a timely update through the MCPs or community ECM providers.

Understanding Differences Among Overlapping Care Management Services

To avoid the risks of double-dipping, MCPs must document that any overlapping care management services have distinct care management plan goals and staffing. Many interviewees noted that their MCPs are expecting to resolve these instances case by case, usually via teleconference. Interviewees emphasized that, although they have not have seen widespread instances of overlapping care management services with ECM, these anticipated activities have the potential to become time-intensive strains on their administrative capacities.

Interviewees shared that staff need to understand and communicate the core differences between ECM and other care management programs to encourage more members to accept offers to enroll in ECM and to generate greater interest for community referrals. All interviewees shared that gaining this understanding and honing the "sales pitch" is still a work in progress,

as there are confusing similarities between programs. Some noted the similarities between Full Service Partnerships (FSP) and ECM, given the overlapping populations and that FSP, like ECM, emphasizes whole-person care and promotes access to comprehensive services, including community services and supports. For members of this population of focus in particular, counties and providers of both ECM and the overlapping service program (e.g., FSP, SMHS Targeted Case Management) will require training on how these services are delineated (e.g., specific treatment or recovery goals, number of interactions, case manager / provider assigned) and guidance on how to present this information to eligible members.

Interviewees expect it will take time to understand the landscape of care management programs with the introduction of ECM. Yet some county behavioral health agencies and community-based ECM providers are already starting see how ECM complements other programs, strengthening services overall. One community provider of both FSP and ECM who has clients enrolled in both programs said that the introduction of ECM in their agency initially caused some staff anxiety because FSP staff previously managed some care coordination tasks, the defining tasks of ECM. Over time, however, they are finding that the addition of ECM frees up FSP staff to focus more intensely on other goals of their members, such as mental health treatment services, as ECM takes on the intensive coordination of the members' health and health-related services.

Opportunities to Refine This Process

- **Expand on state guidance.** Provide more state guidance to MCPs, county behavioral health agencies, and community ECM providers to better differentiate the various care management programs, including how best to communicate these differences to staff and members of these programs. Include specific guidance for regional centers, which serve adults, children, and youth with intellectual/developmental disabilities, who may also have a serious mental illness or serious emotional disturbance.
- **Clearly communicate available care management services.** Consider developing a visual care management services continuum that denotes which care management services are a better fit for members depending on their needs at any given time, recognizing that members' care management and treatment needs evolve.
- **Clarify differences between available services.** Target additional education on differentiation between services to counties that were not Whole Person Care pilots, and therefore did not have a wraparound case management service model in place before ECM.
- **Leverage all available staff training opportunities.** One MCP interviewee described their ECM care manager training series that will run on an ongoing basis as new ECM care managers are hired and onboarded by their contracted county behavioral health agencies and community provider sites. Counties and providers can extend their training capabilities by making sure their staff are participating in any training offered by MCPs.
- **Develop a care management matrix at the county level.** Counties should consider concretizing their internal organizational knowledge about county-led behavioral health care management programs in a single document and use it to host discussions among stakeholders on how ECM can fill existing gaps or specifically enhance existing services. Given there may be some variation in county approaches to these programs, some areas to explore differences include specific populations served, responsibilities of the care managers, telephonic versus in-person interaction, caseload ratios, frequency of contacts, care manager qualifications and training requirements, supervision, etc.

Initiating ECM for Eligible Members

Once MCPs authorize ECM for eligible members, they assign them an ECM provider, which could be a contracted county behavioral health agency or other community ECM provider. The ECM program itself is voluntary for these identified members.[35] County behavioral health and ECM provider interviewees described the initial barriers to successful delivery of ECM for this population of focus, including obtaining consents for releases of information and the significant administrative burden in learning various MCP reporting requirements for member enrollment, progress, and filing claims.

Navigating Consents for Release of Information for ECM-Related Data Sharing

Many interviewees acknowledged that obtaining ECM consents for release of information from adults with SMI or SUD is nuanced, due to required privacy protections and, sometimes, members' distrust of health and social service systems. Although these consents are not a requirement for initiating ECM,[36] interviewees said that in practice such consents are essential for successful care coordination because the ECM care manager is responsible for coordination across all components of a member's needs and services.

HIPAA (the Health Insurance Portability and Accountability Act) and 42 CFR Part 2, as well as other federal and state laws, are among the health information security requirements relevant to this population of focus. While acknowledging the value of these privacy protections, many interviewees also emphasized how the laws can make it arduous to enroll members into ECM. One community ECM provider described how members with SUD have sometimes been reluctant to enroll in ECM and sign consents to share information about SUD treatment for care coordination due to fears about stigma and retaliation, despite assurances of confidentiality and privacy. Many members of this population of focus have previous negative interactions with the health care system, resulting in mistrust of health care services. For these reasons, along with the ECM program being voluntary and — in some instances — like other care management services the member may already be enrolled in, many interviewees described needing to make several visits with the member before being able to obtain consents for release of information.

One community ECM provider interviewee noted that they do not expect their staff to obtain consents for release of information in the first few visits, but instead to focus on developing rapport with the member and listening to their concerns, hoping trust can be earned (and consents obtained) over weeks or months. This provider said they capitalized on their work in WPC by carrying over the universal release of information form developed with the one MCP operating in their county for use in ECM enrollment. That form is HIPAA and 42 CFR Part 2 compliant and lets members opt in or out of sharing information with the county behavioral health agency and a list of other partner agencies in the community that might be engaged to work with the member over the course of the care plan. Other interviewees without such an existing approach described their hopes for the Authorization to Share Confidential Medi-Cal Information Form, which is being piloted in some counties and should be available for all Medi-Cal members in 2024.[37]

Sharing Information After ECM Enrollment

Being able to share information smoothly — while ensuring confidentiality — is necessary for ECM from the outset and throughout the care plan. While many interviewees shared that they have taken the first steps toward engaging in effective data exchanges among their program partners through memoranda of understanding, most interviewees said that their systems for

documenting ECM member progress through these exchanges are still being refined. The administrative burden associated with learning the data systems of each plan was a theme raised by many county behavioral health agencies and community ECM providers and is exacerbated in counties with multiple MCPs. One county behavioral health interviewee described having to train staff to write case notes differently based on the rate structure agreed upon by the members' MCP (per engaged member per month vs. fee-for-service). County behavioral health agencies and community ECM providers also emphasized a lack of common data standards across MCPs, including what data must be in the care plan.

Recently updated guidance on member-level information sharing between MCPs and ECM providers promises to address some of these concerns. DHCS now requires MCPs and ECM providers to adopt common standards related to information flow to ease administrative burden, especially for ECM providers.[38] Some interviewees also expressed hope in terms of other CalAIM policies, such as the Population Health Management Service, which will include a statewide technology service for authorized users to have access to comprehensive member data.[39] This service promises to address the siloed nature of data capture as well as improve the timeliness of the data.

Opportunities to Refine This Process

- **Develop a standard, customizable release form.** As Medi-Cal stakeholders await the Authorization to Share Confidential Medi-Cal Information Form in 2024, consider developing an optional, interim universal release of information paper form that MCPs, county behavioral health agencies, and providers can adapt, with attachments that encompass local entities unique the county/region that could be engaged during a member's care plan.
- **Encourage stakeholder input.** Sponsor discussion forums for stakeholders, including community-based ECM providers, to raise issues and problem solve in a cooperative group setting.
- **Provide technical assistance.** Develop technical assistance resources specific to ECM providers, including billing guides, one-on-one support with billing experts to help reconcile different processes between MCPs, information about clearinghouses and billing software, etc.[40]
- **Emphasize developing rapport in staff training.** Given the mistrust of the health care system that some members of this population of focus harbor due to negative past experiences, it is important to invest in training opportunities that will support ECM staff's ability to gain trust and build rapport with ECM members.

Contracting and Delivering Community Supports

Community Supports are designed to complement ECM by providing an array of clinical and nonclinical services to address the needs of the ECM populations of focus comprehensively, particularly regarding the social determinants of health. MCPs were encouraged to offer all 14 Community Supports (see "Types of Community Supports" sidebar). Because Community Supports are optional for MCPs, counties will see a mix of Community Supports, depending on their MCPs.[41] Providers of each Community Support should have experience and expertise in delivering these services. Because the lack of housing stability is a major social driver of health for people with SMI and SUD,[42] and that counties have special expertise working with this population of focus and providing housing services, interviews focused on the housing-related Community Supports.

Types of Community Supports

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition / Diversion to Assisted Living Facilities, Such as Residential Care
- Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services / Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically-Supportive Food / Meals / Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Source: *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* (PDF), Department of Health Care Services, January 2023, 5.

If they choose to provide housing-related Community Supports, MCPs are expected to work closely with county/regional Continuums of Care and other partners,[43] which can include county behavioral health agencies, that have experience with housing-related issues for members with higher behavioral health needs. Some of the county behavioral health agencies and community-based Community Supports providers emphasized that while housing-related Community Supports through managed care are a welcome addition to the menu of services, these new services do not come close to matching existing need resulting from the housing crisis in California, and said that MCPs' expectations may need to be tempered. A county behavioral health interviewee — from a county where the housing vacancy rate is 2%[44] — noted that Community Supports for housing deposits are available only once in a person's lifetime, which requires staff to be conservative in using this service. Other providers said that some MCPs' expectations for housing transition navigation services are too rigid (e.g., some MCPs allow for only three months for the housing assessment stage, six months for the transition stage, and six months for the stability stage) and that they felt these expectations were unrealistic, given the complicated realities of people with SMI or SUD trying to find housing.

As with ECM, Community Supports providers mentioned low payment rates as a challenge. One county behavioral health agency emphasized how time-intensive this work is for staff: applying for housing vouchers, filling out applications for supportive housing, cleaning up credit reports, gathering documents, etc. They said it ultimately required them to spend more on the service than they could bill for. Other Community Supports providers reported similar concerns.

Several county behavioral health agencies expressed strong support for sobering centers and hoped that MCPs would focus on this Community Support service to better serve this population of focus. Sobering centers provide an alternative referral destination for people found to be publicly intoxicated, and offer medical triage and other physical and substance use counseling services. County behavioral health agencies interviewed described these recovery-oriented centers as a desperately needed crisis service, particularly as other needed services along the SUD continuum of care, such as residential facilities, often have long waitlists. Although some county interviewees expressed their inability to provide sobering center services at this time due to rate concerns and staffing shortages, they expressed great interest in being involved in the development of these centers due to their expertise working with this population of focus and desire to maximize coordination with county behavioral health services at discharge.

Opportunities to Refine This Process

- **Reassess rate structure.** Consider developing a rate structure that takes into account the challenges of supporting people with SMI or SUD, who disproportionately experience homelessness.
- **Facilitate housing-related supports to increase access.** Consider increasing the help provided for housing-related Community Supports and streamlining processes for Community Supports providers to access housing-related Community Supports.
- **Conduct time studies for activities connected to housing-related Community Supports and sobering centers.** County and community-based Community Supports providers should document the time it takes for staff to complete activities related to housing services to more specifically describe how the current rate structure is falling short for these services. Additionally, stakeholders in counties without plans for sobering centers should work with local law enforcement agencies to document, using local data, the potential impacts of opening a sobering center (e.g., time saved by law enforcement when a person is dropped off at a sobering center vs. being booked into jail, costs saved by not opening a public intoxication criminal case in the court system) to better advocate for these services in their communities.

Looking Ahead

ECM and Community Supports are promising service models for people with SMI or SUD to deliver whole-person care. Early lessons from these interviewees indicate the need for increased payment rates to reflect the realities of delivering these coordinated services for a high-need population via contracts with MCPs (sometimes multiple MCPs) and across multiple service delivery systems, as well as the need for more guidance from the state to support streamlining and reduce administrative burdens. Several new and upcoming initiatives, including No Wrong Door, Standardized Screening and Transition Tools, the Population Health Management Program service, and the Authorization to Share Confidential Medi-Cal Information Form, may help in the implementation of ECM and Community Supports for these populations so they can better meet the health and nonmedical requirements of Medi-Cal members with the most complex needs.

About the Authors

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The Center for Health Care Strategies is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We connect people and ideas to spark insights, build expertise, strengthen leadership, and spread innovations. Across sectors and disciplines, we support our partners to make more effective, efficient, and equitable care possible.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that 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.Endnotes

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