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Launching CalAIM: 10 Observations About Enhanced Care Management and Community Supports So Far

CalAIM (California Advancing and Innovating Medi-Cal) is a multiyear care delivery and payment reform initiative led by the California Department of Health Care Services (DHCS). CalAIM focuses on improving health equity and quality of care and well-being for California Medicaid (Medi-Cal) enrollees by enhancing population health; expanding access to coordinated, whole-person care; and addressing health-related social needs.[1] Launched in 2022 and rolling out over multiple years, two key components of CalAIM include (1) Enhanced Care Management (ECM) and (2) Community Supports (also known as In Lieu of Services). DHCS designed these two initiatives to support people with complex health and social needs and to sustain and expand person-centered, whole-person care coordination in the state's Whole Person Care (WPC) pilots and Health Home Program (HHP), especially for those experiencing homelessness and those transitioning from incarceration.

DHCS seeks to advance ECM and Community Supports initiatives with significant incentives for managed care plans (hereinafter called "plans") to invest in the capacity of community-based organizations and other providers. Specifically, the Incentive Payment Program (IPP) will reward plans $1.5 billion between 2022 and 2025 for meeting capacity-building milestones relating to delivery system infrastructure, equity, and workforce capacity, and building upon a needs assessment and gap-filling plan submitted in December 2021.[2] While DHCS will pay IPP incentives to plans, and will not direct how that money should be spent, DHCS anticipates that plans will make significant investments in ECM and Community Supports provider organizations to achieve IPP milestones.

The Roots of CalAIM

To develop CalAIM, DHCS learned from and built upon previous programs, including the Medi-Cal Health Homes Program (HHP) and Whole Person Care (WPC) pilots:

Health Homes Program. Launched in 2018, HHP provides intensive care management and coordination to eligible Medi-Cal members with complex medical needs. HHP services coordinate physical, behavioral health, and long-term services and supports.

Whole Person Care pilots. Launched in 2016, WPC pilots, typically led by counties, tested interventions providing patient-centered care coordination of physical, behavioral, and social services. Interventions also addressed health-related social needs and developed infrastructure for local multistakeholder collaboration to improve health outcomes.

Sources: ***CalAIM Enhanced Care Management Policy Guide*** (PDF), DHCS, September 2021; and "**Whole Person Care Pilots**," DHCS, last modified March 24, 2022.

These incentives are not the only resources supporting capacity development and CalAIM initiatives. ECM and Community Supports providers will be able to access funding and technical assistance directly through the Providing Access and Transforming Health (PATH) program.[3] Additional sources of funding include the Housing and Homelessness Incentive Program (HHIP) and the Behavioral Health Quality Improvement Program (BHQIP).[4]

This brief shares 10 observations from the first months of Community Supports and ECM implementation, some opportunities related to promising practices, and what to watch in the coming months as CalAIM implementation moves forward. To develop this brief, the Center for Health Care Strategies (CHCS) conducted 13 interviews from January 2022 to April 2022, including with plans; a plan association; community-based organizations; organizations representing or providing technical assistance to Community Supports providers, including Meals, Medical Respite, and Asthma Remediation providers; a Federally Qualified Health Center; and county behavioral health agencies. In addition, CHCS reviewed notes from seven managed care plan interviews conducted by ATI Advisory.

What Are ECM and Community Supports?

Enhanced Care Management

ECM is a required benefit for all plans, and intended to coordinate all physical health, oral health, behavioral health, and health-related social services of Medi-Cal enrollees with the highest needs. ECM is designed to be interdisciplinary, primarily in-person care management[5] and will be rolled out to distinct populations of focus (see Table 1) in phases to smoothly transition from prior programs, to allow plans time to build new capabilities, and to align timing with other CalAIM reforms.

Plans are responsible for identifying (or accepting referrals for) enrollees eligible for ECM, and assigning every member authorized for ECM to an ECM provider. ECM providers are responsible for reaching out to, and engaging, assigned enrollees and providing the ECM suite of services to its enrollees.[6]

Table 1. Populations of Focus for ECM, and Core Enhanced Care Management Services

Populations of Focus for ECM (adults and children/youth)
➤ Individuals and families experiencing homelessness
➤ People who receive a lot of acute services
➤ Adults with serious mental illness / substance use disorder and children/youth with serious emotional disturbance or identified to be at clinical high risk for psychosis or experiencing a first episode of psychosis
➤ Individuals transitioning from incarceration
➤ Individuals at risk for institutionalization and eligible for long-term care services
➤ Nursing facility residents who want to transition to the community
➤ Individuals enrolled in California Children's Services with additional needs beyond the qualifying condition
➤ Individuals involved in, or with a history of involvement in, child welfare (including foster care up to age 26)
Core Enhanced Care Management Services*
➤ Outreach and Engagement
➤ Comprehensive Assessment and Care Management Plan
➤ Enhanced Coordination of Care
➤ Health Promotion
➤ Comprehensive Transitional Care
➤ Member and Family Supports
➤ Coordination of and Referral to Community and Social Support Services

* ***CalAIM Enhanced Care Management Policy Guide*** (PDF), DHCS; and ***Enhanced Care Management (ECM) Provider Toolkit*** (PDF), Aurrera Health, December 2021.

Community Supports

As of January 1, 2022, plans have the option to provide 14 Community Supports designed to address Medi-Cal enrollees' health-related social needs, such as food and housing security. Unlike Enhanced Care Management, Community Supports are not formal Medi-Cal benefits and are optional for plans to provide.[7] Plans choose whether to offer a Community Supports service — and when and where and to whom. Plans may elect to provide new Community Supports every six months, can remove services annually, and may offer a different set of services for each county in which they operate.[8] If plans are unable to provide services countywide for all eligible enrollees, DHCS

expects plans to report how they will expand capacity over a three-year period.[9] DHCS developed standard service definitions and eligibility criteria for each of the 14 Community Supports, which may enable the state to transition some of these services to a statewide benefit in the future.[10]

Because Community Supports are optional services, plans have made different decisions locally, leading to variation across the state. During the first six months of implementation, the most commonly offered services include Medically Supportive Food/Meals/Medically Tailored Meals ("Meals"), Asthma Remediation, Housing Transition Navigation Services, and Housing Tenancy and Sustaining Services. Many plans will also be expanding offerings of services, particularly housing-related services, in July 2022. Some Community Supports, like Nursing Facility Transition/Diversion to Assisted Living Facilities, will align with future elements of CalAIM like the transfer of responsibility for institutional long-term care to managed care, and are more likely to be implemented in 2023 (see Table 2).[11]

Table 2. Community Supports Elections — Percentage of Plan/County Pairs Where Service Will Be Offered

	PERCENTAGE OF PLAN/COUNTY PAIRS OFFERING SERVICE			
	1/1/2022	as of 7/1/2022	as of 1/1/2023	as of 7/1/2024
Housing Transition Navigation Services	62%	92%	93%	97%
Housing Deposits	50%	90%	91%	91%
Housing Tenancy and Sustaining Services	61%	92%	92%	97%
Short-Term Post-Hospitalization Housing	18%	33%	49%	89%
Recuperative Care (medical respite)	38%	54%	59%	94%
Respite Services	6%	8%	58%	85%
Day Habilitation Programs	13%	21%	35%	68%
Nursing Facility Transition/Diversion to Assisted Living Facilities (e.g., Residential Care Facilities for the Elderly and Adult Residential Facilities)	8%	8%	59%	71%
Community Transition Services / Nursing Facility Transition to a Home	9%	10%	62%	71%
Personal Care and Homemaker Services	10%	35%	63%	84%
Environmental Accessibility Adaptations (home modifications)	53%	63%	68%	72%
Medically Supportive Food/Meals/ Medically Tailored Meals	81%	92%	93%	94%
Sobering Centers	20%	25%	30%	71%
Asthma Remediation	66%	70%	71%	73%

Note: Here, a *plan/county pair* is defined as a managed care plan offering a Community Support in a county in which the managed care plan operates.

Source: ***CalAIM Community Supports - Managed Care Plan Elections*** (PDF), DHCS, January 25, 2022.

Ten Early Implementation Observations

CalAIM is a large initiative, with many moving parts, in a large, diverse state. It is still very early in the implementation of ECM and Community Supports. Both involve significant effort by DHCS, counties, plans, and providers. No effort of this scale will be without bumps in the road, particularly just a few months into a five-year journey of transformation. What follows are 10 observations informed by the early experiences of organizations implementing ECM and Community Supports so far. They are shared here in the interest of helping all relevant stakeholders learn and improve as they go.

1. There is strong support for the goals of both programs.

Interviewees expressed appreciation for DHCS's vision for CalAIM and the goals and objectives of Enhanced Care Management and Community Supports, naming that the reforms met important needs for both enrollees and the delivery system. They largely appreciated DHCS's willingness to publish programmatic documents, like policy guides, webinars, and toolkits, online. They also expressed enthusiasm for the amount of capacity-building funds supporting ECM and Community Supports implementation.

"[Enhanced Care Management] gives us the ability to have continuity of care…when you have a single person being managed by an entire organization for their mental health, substance use, their case management, and their housing."

— Federally Qualified Health Center representative

"Some Community Supports are things that we did as pilots, or things we've hoped that we could do for many, many years. But because of the way the financial structure was set, it didn't always work out. This is a significant value-add."

— Plan representative

"We think that this is huge! California can really lead the way. Moment of tremendous opportunity to integrate health and social care."

— Community Supports provider

"From a very high level, being able to address SDOH [social determinants of health] is tremendous. Big push on quality. Move the needle on HEDIS [Healthcare Effectiveness Data and Information Set] metrics — preventive, chronic care. Very difficult to get diabetes under control if they're homeless and they don't have food. I think it is about time we get to take care of the whole patient. This is what the community is struggling with. [Incentives] are 'icing on the cake' — certainly helps our providers with their capacity and helps with new areas, like sobering centers."

— Plan representative

2. The biggest initial priority has been continuity with prior programs.

DHCS established a phased rollout to ensure continuity for two prior programs, and that has shaped the initial implementation, with plans building upon existing partnerships to transition services and encourage continuity of care. On January 1, 2022, ECM went live in counties with an existing HHP or WPC pilot for only three ECM populations of focus: (1) individuals and families experiencing homelessness; (2) adult enrollees who have used an emergency department, hospital, or skilled nursing facility a specified number of times in a six-month period; and (3) adults with serious mental illness / substance use disorder (SMI/SUD).[12] Other counties will provide ECM to these populations of focus in July 2022. ECM will be available to all adult populations of focus in January 2023, and all remaining children and youth populations of focus in July 2023.

DHCS designed Community Supports and ECM to sustain innovations relating to HHP and WPC, and encouraged plans to build upon this local capacity to implement ECM and Community Supports. As a result, plans worked with counties to transition enrollees already receiving services from these programs to ECM and Community Supports, and naturally built upon existing partnerships for this transition. Plans may not restrict the authorization of Community Supports only to enrollees transitioning from the prior programs but must ensure that those enrollees continue to receive comparable services.[13]

Tracking where these enrollees were, and how to introduce them to new services, sometimes presented challenges, especially after the COVID-19 pandemic began — with some plans and providers coming together to resolve these problems. In addition, because eligibility criteria for the old programs differs from eligibility for ECM and Community Supports, this transition and translation was sometimes challenging. Several providers warned that the more specific and narrow criteria for ECM, as compared to HHP and WPC, may exclude people that need help and support.

> *"One of my biggest concerns is that we're not going to be reaching all the people that need to be reached. Health Homes and Whole Person Care had wider arms to grab those folks that need the support. The criteria have gotten very specific and leave a lot of people out that actually need that help."*
>
> — Provider

3. New partnerships are necessary, and they take time.

The vision of ECM is "to meet enrollees wherever they are — on the street, in a shelter, in their doctor's office, or at home."[14] To do this well, plans have to work closely with ECM providers that have close connections with eligible enrollees. These ECM providers may include a range of organizations, including some without prior experience with managed care: county behavioral health providers, organizations serving people experiencing homelessness, and organizations serving justice-involved people. Similarly, offering Community Supports has required plans to engage nontraditional Medicaid providers that specialize in housing navigation services, and to learn more about services that are not traditional Medicaid services, like asthma remediation. This relationship building has involved developing a shared vocabulary across health care and social services contexts, navigating new processes and service components, and understanding local resources. Interviewees often stressed the importance of ECM and Community Supports providers that have robust, trusted relationships with the communities in which they work and recommended that plans approach network gaps creatively, building on local solutions (e.g., using asthma remediation or home-delivered meal providers to also perform home modifications).

For example, county behavioral health plans provide specialty behavioral health services for adults with serious mental illness and substance use disorder, a target population for ECM. Because of this overlap, plan and county behavioral health partnerships, in their view, were not a "nice to have," but a "must-have." However, it was important not to just "build a new thing" because of a "new dollar," but rather to proactively build upon the strengths of other initiatives, like intensive case management with wraparound services for people with serious mental illness — braiding and blending funds as necessary. County behavioral health plans see CalAIM as an untapped opportunity for DHCS to name explicit quality goals for adults with SMI/SUD and to seek to reduce drastic disparities in early mortality rates for these adults through clinical integration of physical and behavioral health, among other strategies.

"Since our sobering center works to engage, it's not just a place where you just put people, they just sit there, they sober up, and they move on. Now, it's about, 'Are you willing to consider some sort of treatment?' We can actually go ahead and immediately move people into [county] detox if there's a space."

— ECM and Community Supports provider

In addition, in some counties, certain Community Supports providers simply did not exist. For example, several plan interviewees noted that a subset of their counties had no sobering centers, and the ability to provide this service would have to be fostered and developed over time. In another example, one plan representative noted that it initially had to limit (with state approval) Nursing Facility Transition/Diversion to Residential Care Facilities for Elderly to 15 enrollees in the first six-month period of Community Supports rollout but planned to build out local capacity in the future using IPP funds. Plan and provider interviewees also brought up difficulties with staffing and labor shortages, which could present issues in scaling up these services over time.

"Even if there's not a program in the location, [plans] should still look locally for a local solution. It's not just like, 'Alright, here's the program, and you just can drop it in.' The programs that are really effective are really grounded in the community. I think the plans need support too. They are totally new to this . . . they are also learning how to work with other organizations. "

— Representative of organization providing technical assistance to specialized Community Supports providers

"This is really, really exciting work. But transformation doesn't occur overnight. It's a long-term goal."

— Plan representative

All these activities required concerted, sustained efforts across plan departments — on top of the day-to-day work of providing traditional Medicaid services, rolling out other CalAIM initiatives, and preparing for an upcoming statewide managed care procurement. Some interviewees expressed weariness of the complexity and fast pace of the initial rollout period, which could create a program difficult for Medi-Cal enrollees to understand and navigate.

4. Providers struggle to navigate each plan's administrative requirements.

As with other core Medicaid services and benefits, plans have the responsibility to develop a network of Community Supports providers and to have their own independent credentialing or vetting processes, as applicable.[15] These processes can introduce additional administrative steps for Community Supports providers interested in providing services, like questionnaires and site visits, and can delay the organization's ability to provide services. This navigation of different plan processes may be new to some Community Supports and ECM providers that have previously not billed for Medi-Cal services. Provider interviewees sometimes described significant up-front investments (at their own expense) to meet plans' readiness, vetting, and credentialing requirements, and to remain competitive and responsive in the first year of CalAIM rollout.

In addition, Community Supports and ECM providers in counties with multiple plans, like Sacramento and Los Angeles, face challenges contracting with multiple plans, referring enrollees to services, and billing and invoicing for Medi-Cal services. Each plan has unique policies, processes, portals, tools, and delegation arrangements with other plans, and navigating these differences can be time-intensive and particularly challenging for small organizations with limited staff and resources. Interviewees noted that this administrative burden can impact staff morale, drive turnover, and take time away from individual care and services.

> *"I've lost a few staff already because they were spending more time figuring out the system than providing care."*
>
> — ECM and Community Supports provider

5. Outreach to enrollees is key, and worth paying for.

Outreach is a core ECM service. DHCS compensates for outreach in capitation rates paid to plans and requires them to reimburse for outreach as part of the benefit. Plans have begun to send out lists of assigned enrollees to ECM providers, and to collaborate on resolving related issues. ECM providers noted that these lists have included inaccuracies and outdated contact information, which can make initial outreach to enrollees like those experiencing homelessness even more time-intensive. Interviewees often described the crucial role of people with lived expertise, community health workers, and peer support providers in these outreach and engagement activities.

Based on a limited subset of interviews, plans are using different approaches to paying for outreach. Some do a better job of covering the up-front cost of outreach than others. If reimbursement for outreach activities is not commensurate with the effort involved, ECM providers bear financial risk when seeking to contact assigned enrollees, such as unsheltered people experiencing homelessness — especially when assignment lists include inaccuracies.

6. Nonbinding pricing for Community Supports was widely used.

DHCS released nonbinding pricing guidance for Community Supports, but noted that plans and Community Supports providers have "full flexibility and discretion to agree to . . . rates that are different from those outlined in [the] document."[16] Plan interviewees often discussed picking midpoint benchmarks in the available guidance ranges published by DHCS, or occasionally modifying provider rates to reflect higher local real estate costs or a long-standing provider relationship. They noted that conforming to these ranges was important because they believed DHCS would use these ranges to develop capitation rates. In some cases, providers reviewed their rates and payment model favorably, but in other cases

noted that rates were too low, and warned that the payment level could jeopardize the quality of their services and force caseloads that are too high. One plan interviewee noted that they recognized that some of these rates were low but that the potential volume of referrals would hopefully make the rates workable.

7. It's often not clear what is covered when, and that has ripple effects.

Although DHCS defines target populations of focus, it requires plans to develop policies and procedures to verify eligibility for ECM, including processes and time frames for reauthorizing ECM and notifying enrollees and families of determinations.[17] ECM providers have stressed the need for flexibility, based on the needs of particular enrollees, and some standardization of workflows and common tools across plans (like claims portals and platforms).

"The [ECM] workflow is not necessarily working, and sometimes it works for certain populations, and it doesn't work for another population. So we have to have some flexibility in terms of turnaround time — for example, instead of 30 days can we have 40 days to coordinate with the family members? If we can't contact them because they are known to be transient, can we not terminate their services in 30 days? Can we keep them on for 60 or 90 days?"

— ECM provider

For Community Supports, DHCS has standard eligibility criteria, but plans establish their own policies and procedures describing how the service will be provided to eligible enrollees (e.g., expected duration and frequency of service) and can impose more narrowly defined eligibility criteria.[18] Some plans very clearly defined additional authorization and eligibility criteria, and others had less transparent or developed processes, especially in the early months of implementation. In counties with multiple plans and delegation arrangements, differing plan criteria made it more difficult for health care, Community Supports, and ECM providers to understand which services will be covered and when. Community Supports providers suggested that this lack of clarity drove service denials and fewer-than-expected referrals in the first months of 2022. In general, the "unbundling" of services relative to the reimbursement structures in Whole Person Care was a common theme and pain point.

In addition, plans had to determine how to authorize optional Community Supports in light of existing value-based payment arrangements and delegated relationships based on required benefits.[19] For example, existing contracts between between hospitals and plans complicate authorization of medical respite and posthospitalization housing, and introduced questions regarding which organizations should pay for what and when. For example, before CalAIM, hospitals have traditionally funded a patient's stay in medical respite facilities, primarily as a way to reduce a prolonged hospital stay. With managed care plans now involved and taking time to review and authorize services, patients are remaining in the hospital longer. To avoid this, some hospitals want to be able to pay for the first few days for eligible patients, to facilitate a faster discharge and give plans the time to review, authorize, and hopefully take over payment. Working through these negotiations and how they fit with existing risk-bearing arrangements has introduced further complexity for all parties.

8. Knowing how cost-effectiveness will be measured in the future will help plans make decisions today.

Under CalAIM, plans now can "get credit" in their rates for providing services like Meals and Asthma Remediation.[20] This approach gives plans more resources to provide these services, and can inspire plans to be less conservative than they were in prior experiments with value-added services like Care Plan Options.[21] Nonetheless, DHCS still expects Community Supports to be "cost-effective" and preventive, and the exact effect of Community Supports on future rates, Medi-Cal cost and quality benchmarks, and Medi-Cal enrollees is yet to be seen.[22] DHCS hopes that Community Supports will not only substitute for certain services (the more traditional approach to In Lieu of Services, the policy that underpins Community Supports), but to avoid services in settings like hospitals, emergency departments, and nursing facilities. Because In Lieu of Services are defined as "cost-effective," interviewees seemed to have varying understandings of the current and future financial resources that plans can access to implement Community Supports. Two interviewees noted that plans received some rate adjustments for similar services they had provided in the past in WPC pilots and were motivated to provide Community Supports because cost and utilization of the services would be factored into their rates. By contrast, one Community Supports provider explained how a plan was cautious in its initial Community Supports implementation because it was "not getting any additional funding to provide these services," and available funds for implementation would have to be "out of cost savings."

When approving CalAIM, the Centers for Medicare & Medicaid Services (CMS) noted that it will require a future independent evaluation of Community Supports, to be defined in more detail later in 2022. Plan and provider interviewees worried how the cost-effectiveness of these services would be evaluated, over what time frame, and at what level of aggregate analysis (e.g., statewide or at the county level or plan level). While some plan reps noted that some Community Supports services had stronger evidence cases than others, the plan reps interviewed did not typically link decisions to not provide a service, or to delay provision of a service, to available evidence about the intervention (or DHCS's evidence summary, created to support DHCS's CMS request).[23] Plan interviewees generally believed in the potential of these services to improve health outcomes and member experience of care but noted that studying their effect can be complex.

9. Capacity-building dollars are vital. They have also been hard to interpret.

Plan interviewees noted that capacity-building funds were very important to the long-term success of the program and described initial efforts to onboard Community Supports and ECM providers. For example, representatives from several plans explained how they created portals for Community Supports and ECM providers to submit claims and offered related technical assistance, and would build upon these efforts in the future. However, plan interviewees described some challenges with the IPP. They noted that baseline data were sometimes hard to measure, with multiple options for numerators and denominators. They guessed that DHCS would want to make the IPP funds accessible but noted that it was difficult to predict how DHCS would adjust the IPP and its lengthy list of novel target measures, based on initial plan responses. For example, one plan rep noted that their reported delivery system infrastructure measures would start at close to 100% because they would not contract with Community Supports or ECM providers without basic billing capabilities. Perhaps because of this uncertainty in early 2022, few Community Supports and ECM providers could identify how plans would use IPP funds to help their individual efforts with specificity. Several interviewees described lengthy readiness forms, with questions about potential gaps and needs (which would be used to inform IPP-related capacity-building initiatives) at the end of the form. Community Supports providers worried that the way

in which plans asked for provider needs may have made it more likely that providers either missed the question or glossed over needs in an effort to stress their strengths and capabilities. (Plans in at least one of these counties have since released an additional request for applications for IPP funding.) At the time of interviews, information on PATH and other initiatives like the Housing and Homelessness Incentive Plan and the Behavioral Health Quality Improvement Program was limited.

10. Up-front costs and challenges can create risk and cash flow problems.

Community Supports and ECM providers often described integration into CalAIM-related initiatives as an essential step for long-term sustainability of their programs and organizations. Yet some provider interviewees described significant up-front investments (at their own expense) to meet plans' readiness, vetting, and credentialing requirements, and to remain competitive and responsive in the first year of CalAIM rollout. In addition, fewer-than-expected reimbursable services, low rates, and delayed capacity-building funds added to the stress of initial ECM and Community Supports implementation for providers. Some Community Supports providers hoped that the volume of referrals would make up for lower rates, and fewer-than-expected referrals introduced financial worries. In addition, difficulties locating and engaging enrollees who could benefit from ECM have also presented cash flow issues for ECM providers — when fewer-than-expected enrollees were found, engaged, and enrolled, and payment was contingent on enrollment.

"I'd say our experience so far has cooled our interest in large-scale CalAIM growth initiatives. The variability and uncertainty of census demands coupled with the rate compression seem to be doing more to shift risk to the provider level than incentivizing growth. We're on the hook now if enrollment is delayed or volume growth is otherwise behind anticipated need — yet we have less control of the pipeline than we used to. And we're expected to carry on-demand capacity, which leaves us feeling perpetually 'overstaffed.'"

— ECM and Community Supports provider

Opportunities to Build on What Is Working

Collectively, these observations often relate to early and budding partnerships among ECM providers, Community Supports providers, and plans. Many are to be expected, given the scope and scale of the reforms being implemented. Still, these challenges have the potential to hinder member access to Community Supports and ECM and impact care if they are not resolved. The following are just some of the opportunities to build on what is working in the field.

Standardize Processes to Eliminate Unnecessary Complexity

Some provider organizations warned that their peer organizations may not have the patience, willpower, or resources to navigate the maze of different credentialing, vetting, claims submission portals, authorization processes, and referral platforms — which could affect the availability of services in the long term. Plans in the same county could help by standardizing their workflows and requirements for ECM and Community Supports providers.

Some plans have already taken these steps. In one example, all plans in Los Angeles County coordinated to release one centralized questionnaire for potential Community Supports and ECM providers interested in contracting with plans, and then issued a subsequent request for applications for IPP-related funding in mid-April. In another example, multiple plans have been working together to align their payment models and workflows for one county behavioral health plan.

Plans can potentially leverage future local collaborative planning efforts through PATH to identify common ways to make policies and practices more person-centered and provider-informed. To promote health equity and to reduce racial and ethnic disparities, plans can consider alternative ways to engage community enrollees and local organizations to identify local assets and needs — beyond traditional plan tools like requests for applications and readiness assessments.

Streamline Authorizations to Deliver Care and Support Faster

As the availability of Community Supports expands, it will be critical for plans, health care providers, and Community Supports providers to build relationships and share information. Understanding each plan's authorization criteria is essential for seamless transitions of care, and appropriate, timely referrals.

To minimize care delays associated with pre-authorization processes, plans may consider a simplified, short presumptive authorization period for certain Community Supports. For example, one plan offered 14 days of presumptive authorization for Recuperative Care services, which minimized how long individuals sat in the hospital waiting for authorization.

In addition, plans, hospitals, and other providers can come together to create resources that delineate varying authorization criteria and to minimize unnecessary delays for enrollees seeking to access care and services. For example, the Los Angeles Recuperative Care Learning Network created a grid of different plans' eligibility and exclusion criteria, to help hospital discharge planners understand variation across seven plans.[24] The learning network planned to engage plans to help streamline processes, remove counterproductive exclusion criteria, and make discharge decisions that were best for individual enrollees.

Adapt Payment Models to Meet Real-World Needs of Providers

Better payment models can set the conditions under which care transformation can succeed. For example, one plan offered a payment model with up-front money to support capacity building, even before first IPP payments were made to plans. One ECM provider noted that it would not settle for a fee-for-service rate with plans, and instead pushed for (and received) a per-member per-month rate for all assigned enrollees. A county behavioral health plan described payment for outreach and engagement enrollees as a "major win" for its team-based, integrated care model in place since 2016. In another example, one Community Supports provider glowingly described a three-way contract with a plan and county, where the county agreed to reimburse for the provider's medical respite program at cost and the county received separate reimbursement from the plan.

Looking Forward

The coming months will involve many new developments for ECM and Community Supports. Here's what to watch for.

More Information on Funding Opportunities and Cost-Effectiveness

Over the next several months, DHCS is expected clarify key details related to capacity-building funds, including IPP, HHIP, BHQIP, and PATH. For example, more information about PATH is expected in fall 2022, including both direct capacity-building funds for providers and technical assistance (accessed through a

"marketplace"). The recent release of IPP Payment 1 to plans in April 2022 should also add additional clarity for providers interested in support and funding from plans. Finally, plan rate adjustments for historic utilization of Community Supports will also become apparent over the coming years, and more details about the independent evaluation of Community Supports is expected by December 2022.[25]

More Collaboration and Common Tools

Over the next five years, DHCS plans to encourage collaboration and common tools. In June 2022, plans will submit, or work together to submit, one Local Homelessness Plan per county for HHIP.[26] Later in 2022, PATH will include resources for local collaborative planning groups to work together to identify, discuss, and resolve topical implementation issues, and identify how CalAIM funding initiatives may be used to address identified gaps.[27] In 2023, DHCS's planned Population Health Management (PHM) service will centralize physical health, behavioral health, oral health, and social care data, and be accessible to plans, counties, providers, enrollees, human services programs, and other partners.[28]

More Partnerships Among Community-Based Organizations

ECM and Community Supports providers are exploring how to build coalitions and groups that can streamline work with plans and health care organizations. For example, one organization is interested in creating a network of ECM providers to (1) address the power imbalances associated with plan and provider contracting; (2) expand access to more culturally congruent providers, such as community health workers and peer supports providers; and (3) make it easier for smaller, particularly Black- and Latino/x-led organizations to do what they do best — with less administrative burden.

Conclusion

CalAIM has enormous potential to transform care for Medi-Cal enrollees. Like any Medicaid transformation initiative, the first few months of implementation can be a learning period that can shed light on opportunities for course correction and improvement. Initial struggles — like the quality of member assignment lists and the abundance of slightly different managed care policies and procedures — are common obstacles in Medicaid programs and transformation initiatives across the United States. Plans and ECM and Community Supports providers should take the long view in working through these issues and building these relationships, and engaging and partnering with Medi-Cal enrollees to improve care.

DHCS, plans, and ECM and Community Supports providers can use these early insights to continue the important change management and culture change associated with the CalAIM initiative. DHCS can also continue its track record of encouraging transparency, flexibility, and coordination throughout CalAIM implementation, tying any future changes to the Community Supports and ECM programs to its explicit goals of person-centered, equitable, and whole-person care.

About the Authors

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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**," California Dept. of Health Care Services (DHCS).
2. ***CalAIM Incentive Payment Program Frequently Asked Questions (FAQ)*** (PDF), DHCS, December 2021.
3. . ***Funding Opportunities Cheat Sheet*** (PDF), DHCS.
4. *Funding Opportunities*, DHCS.
5. "**CalAIM Enhanced Care Management, Community Supports , and Incentive Payment Program Initiatives**," DHCS, last modified May 13, 2022.
6. ***CalAIM Enhanced Care Management Policy Guide*** (PDF), DHCS, September 2021.
7. "CalAIM Enhanced Care Management," DHCS.
8. ***CalAIM Community Supports - Managed Care Plan Elections*** (PDF), DHCS, last updated January 25, 2022.
9. ***CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS): Model of Care Template*** (PDF), DHCS.
10. *Policy Guide*, DHCS.
11. *Managed Care Plan Elections*," DHCS.
12. In some counties with a relevant WPC pilot, ECM was also available to adults and children and youth transitioning from incarceration.
13. ***CalAIM Enhanced Care Management (ECM) and Community Supports (ILOS): Contract Template Provisions*** (PDF), DHCS.
14. ***California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management*** (PDF), DHCS.
15. *Policy Guide*, DHCS.
16. ***Non-Binding ILOS Pricing Guidance*** (PDF), DHCS, last updated August 5, 2021.
17. *Model of Care Template*, DHCS.
18. *Model of Care Template*, DHCS. See ***California Advancing & Innovating Medi-Cal (CalAIM) Waiver: Special Terms and Conditions — Waiver Control # CA 17.R10, January 1, 2022 Through December 31, 2026*** (PDF), DHCS. It allows plans the discretion to "adopt a more narrowly defined eligible population than the State has outlined, provided that the narrower definition(s) and eligibility standards are clinically oriented, ensure that each ILOS is medically appropriate and cost effective for the eligible enrollee, and is subject to a determination by a provider that an eligible enrollee has an assessed risk of incurring other Medicaid state plan services (such as inpatient hospitalizations or emergency department visits) for which the ILOS is a medically appropriate and cost effective substitute."
19. Sandra Newman, ***Fundamental Concepts for Managing Risk and Understanding the Total Cost of Care*** (PDF), California Health Care Foundation, Spring 2019.
20. CMS formally approved only 12 of the 14 as In Lieu of Services under 42 CFR § 438.3(e)(2) (with medical respite and posthospitalization housing approved via an 1115 demonstration). Cost and utilization of all 14 services will be included in rates.

21. ***Coordinated Care Initiative (CCI): Cal MediConnect — Policy for Cal MediConnect: Care Plan Option Services (CPO Services)*** (PDF), DHCS, June 3, 2013.

22. Cindy Mann, "**Meeting Health-Related Social Needs Through Medicaid: A New Opportunity for States**," (Manatt Health webinar, April 6, 2022).

23. ***In Lieu of Services in CalAIM: A Summary of the Evidence-Base on Cost-Effectiveness and Medical Appropriateness of ILOS*** (PDF), DHCS, August 2021.

24. "**Los Angeles Recuperative Care Learning Network**," National Health Foundation.

25. ***Providing Access and Transforming Health (PATH) Supports*** (PDF) (DHCS webinar, January 28, 2022).

26. ***HHIP Stakeholder Meeting*** (PDF) (DHCS meeting, February 25, 2022).

27. *Providing PATH Supports*, DHCS.

28. ***Population Health Management (PHM) Advisory Group Kickoff*** (PDF) (DHCS and Manatt Health webinar, March 18, 2022).