MAY 2021

CHCF Executive Summary

CalAIM and Health Data Sharing:
A Road Map for Effective Implementation of Enhanced Care Management and In Lieu of Services

In 2022, the California Department of Health Care Services (DHCS) will launch an ambitious and innovative program designed to address the complex physical, behavioral, and social needs of Medi-Cal's most vulnerable members. The California Advancing and Innovating Medi-Cal (CalAIM) program will build upon the plan-based Health Homes Program (HHP) and county-based Whole Person Care (WPC) pilots that use whole-person care approaches to address underlying social determinants of health (SDOH). CalAIM envisions enhanced coordination, integration, and information exchange among managed care plans (MCPs); physical, behavioral, community-based, and social service providers; and county agencies by establishing new benefits and services including:

- **Enhanced Care Management (ECM)** benefit, which will provide intensive whole-person care management and coordination to address the clinical and nonclinical needs of Medi-Cal members with complex needs. MCPs will administer and oversee ECM benefits, identifying members in each of the ECM target populations and assigning them to "ECM providers" who will be responsible for conducting outreach and for coordinating and managing care across a broad spectrum of physical, behavioral, and social service providers. ECM services will be community-based, with high-touch, on-the-ground, face-to-face, and frequent interactions between members and ECM providers.
- **In Lieu of Services (ILOS)**, which are cost-effective, health-supporting services that may be substituted for existing State Plan–covered services to reduce hospitalization and institutionalization, reduce cost, and address underlying drivers of poor health. DHCS will allow 14 ILOS categories, including housing transition and navigation services, respite care, day habilitation programs, and nursing facility transition support to assisted living facilities or a home. MCPs may choose which ILOS to cover, in which counties, and to which members.

The ECM and ILOS programs will engage a broad set of MCPs, providers, county agencies, and community-based organizations (CBOs). Many of these organizations, especially CBOs, do not currently interact extensively with the health care system and have limited information technology capacity. Nevertheless, their participation in the program and ability to share and use administrative, health, and social service information will be vital in carrying out ECM and ILOS program functions including:

- **ECM member identification, review, and authorization**, where MCPs will identify target ECM populations by compiling and analyzing data and information received from counties, providers, members, and others.
- **ECM assignment and member engagement**, where MCPs will assign members to an ECM provider based on their previous provider relationships, health needs, and known preferences, and ECM providers will use available information to reach and engage members into the ECM benefit.
- **ECM care plan development, sharing, and use**, where ECM providers will develop care plans using data acquired from the MCP, the member, and other sources, and make the care plan available for use by a member's care team.
- **ECM care coordination and referral management**, where ECM providers will support coordinated and transitional care, and engage MCPs' referral network for community and social services, including ILOS.

- **ECM and ILOS billing and encounter reporting practices**, where ECM and ILOS providers will record and report services rendered to MCPs, and MCPs will report complete and accurate encounters of all services provided by contracted ECM and ILOS providers to DHCS.
- **ECM and ILOS quality measure and performance reporting**, where MCPs will report DHCS-specified quality and performance metrics to demonstrate ECM and ILOS program impact on member health, well-being, and costs.
- **ILOS needs assessment and referral management**, where MCPs and ECM and ILOS providers will identify members requiring ILOS benefits, and MCPs, primary care physicians, or ECM providers will connect members to ILOS through a closed-loop referral process.

This implementation road map identifies data, data exchange, and information system barriers to implementing ECM and ILOS program functions, and offers a set of recommendations and actions for policymakers, government agencies, MCPs, and providers (see Table 1 on page 3). As the road map describes, whole-person approaches to care require all parties in a community to step outside of their traditional boundaries to provide a level of collaboration and coordination that addresses drivers of health. These road map recommendations address three categories of data sharing barriers and the steps necessary to mitigate them, including:

- **Regulations and policies** to facilitate safe and secure information sharing
- **Technical infrastructure and standards** to support the efficient collection, exchange, and use of member information
- **Financing, contracting, and operations**, where aligning incentives, contracting, and tactics is crucial to institutionalizing the programs and ensuring their long-term success

Each recommendation offers a proposed set of actions, including their sequence and timing for implementation. Road map development was informed by over two dozen interviews and an advisory group composed of DHCS, MCPs, county agencies, providers, and community-based organizations.

Table 1. Road Map Recommendations Overview: CalAIM and Health Data Sharing

RECOMMENDATIONS LEGEND ➤ Regulations/Policies ➤ Technical Infrastructure/Standards ➤ Financing/Contracting/Operations	ROAD MAP ACTIONS		
	2021	2022–24	2025+
1. Legal and regulatory alignment for data exchange: Sharing physical, behavioral, and social service information implicates a broad cross-section of federal and state privacy rules and regulations, with differing levels of associated consent policies, and financial and criminal penalties.			
➤ Extend WPC authorizing legislation to apply to all entities participating in ECM, ILOS, and other Medi-Cal care management programs.	State lawmakers should work with DHCS to develop legislation and subsequent guidance that permits information exchange activities in support of CalAIM and Medi-Cal program objectives.		
➤ Develop "universal consent" guidance.	DHCS should establish a workgroup to support the development of standard consent form elements and case examples.	The DHCS workgroup should develop recommendations that address federal law and refine state law to create a statewide universal consent form. Depending on the findings of the workgroup, the California Health & Human Services Agency (CHHS) should work with stakeholders and the legislature to craft legislation or an executive order to facilitate creation of a universal consent form.	
➤ Remove statutory barriers to a universal consent form.	CHHS should establish a multi-department workgroup to assess statutory barriers to implementing a universal consent form, and required actions to resolve them.[1]		
➤ Develop legal guidance for health information exchange (HIE) for ECM and ILOS stakeholders.	California Office of Health Information Integrity (CalOHII) should work closely with DHCS to draft and refine State Health Information Guidance (SHIG) to clarify laws and regulations that affect disclosure of physical, behavioral, and social service information, and should offer technical assistance to advise when various data may be shared to support program functions.		
➤ Develop member condition or status identifiers to reduce unnecessary sensitive data sharing.	MCPs should work with ECM/ILOS providers to determine where standard proxy indicators may be shared in lieu of full patient data.	MCPs and ECM/ILOS data sharing providers should implement proxy measures where DHCS/CalOHII exchange tactics indicate that full release of patient data may not be feasible.	
➤ Implement electronic consent management systems.	MCPs should develop and test data sharing consent management systems with ECM, ILOS, county, and other providers.	MCPs should implement consent management systems, refining access and utilities as needed.	
➤ Integrate ECM participation and data sharing consent in the Medi-Cal enrollment application.	DHCS should assess options to acquire ECM and other program and data sharing member consents during enrollment.	DHCS should implement collection of ECM participation and data sharing consent during enrollment and redetermination and share consent information with MCPs.	

*The multidepartment workgroup should also include California Department of Corrections and Rehabilitation and representatives from county sheriff's offices.

Table 1. Road Map Recommendations Overview: CalAIM and Health Data Sharing, *continued*

RECOMMENDATIONS LEGEND ➤ Regulations/Policies ➤ Technical Infrastructure/Standards ➤ Financing/Contracting/Operations	ROAD MAP ACTIONS		
	2021	2022–24	2025+
2. Statewide infrastructure for data exchange: Many ECM and ILOS participants including providers, county agencies, CBOs, and payers do not have information technology capabilities necessary to support robust cross-sector data exchange. Standards, data sharing specifications, and infrastructure are needed, especially for housing, justice, and other social data. ECM and ILOS program participants will build on the WPC pilot infrastructure to advance ECM and ILOS objectives.			
➤ Develop a legislative mandate requiring participation in HIE activities and care transition notifications.	The governor's office, DHCS, CalPERS (California Public Employees' Retirement System), Covered California, and other stakeholders should work with the legislature to craft legislation that defines a vision for statewide information exchange, including use cases, financing mechanisms, and types of data and providers that should be required to share information.	➤ State agencies should be required to implement and enforce legislative requirements that specify goals, funding and incentives program opportunities, reporting requirements, and penalties in subsequent regulatory guidance. ➤ State agencies should report progress against goals and identify remaining barriers and additional actions that can be taken. ➤ State agencies should provide additional implementation guidance and support development of necessary amendments.	
➤ Develop requirements for correctional facilities to send health information to the next provider of record upon member release.	CHHS, the Board of State Community Corrections (BSCC), the California Department of Corrections and Rehabilitation (CDCR), county jails and sheriff's departments, and other stakeholders should work together to identify funding sources and define HIE requirements for correctional facilities to share health information with community providers.	CHHS, BSCC, and CDCR should implement HIE funding programs for correctional facilities and enforce data sharing requirements.	
➤ Develop standards and guidance for the exchange of SDOH information.	DHCS, CalOHII, and other stakeholders should establish standards for the collection and sharing of SDOH information.	➤ DHCS and CalOHII should develop SDOH coding guidance. ➤ MCPs should provide training on how to use new standards and ILOS billing codes.	
➤ Establish working groups to develop state standards and recommend guidance for nonmedical event notifications (e.g., housing, incarceration, employment status changes).	CHHS, CalOHII, DHCS, and other stakeholders should establish a workgroup to define requirements for sharing nonmedical event notifications and develop plans to test nonmedical event notification.	➤ CHHS, CalOHII, and DHCS should develop California-specific implementation guides, guidance, and case studies. ➤ The state and workgroup participants should test event notification protocols.	

Table 1. Road Map Recommendations Overview: CalAIM and Health Data Sharing, *continued*

RECOMMENDATIONS LEGEND ➤ Regulations/Policies ➤ Technical Infrastructure/Standards ➤ Financing/Contracting/Operations	ROAD MAP ACTIONS		
	2021	2022–24	2025+
➤ Develop Homeless Management Information System (HMIS) and correctional facility data exchange contracting requirements and financing programs.	CHHS should convene state and county agencies and stakeholders to develop template contract language requirements for data sharing.	➤ State and county health agencies including HMIS Lead Agencies and correctional facilities should incorporate data exchange requirements into vendor contracts. ➤ Agencies should identify and use funding to defray HMIS and state and county correctional facility HIE implementation costs.	
➤ Develop financing and incentive payment programs to invest in delivery system infrastructure, build care management and In Lieu of Services capacity, and improve quality performance and measurement reporting that can inform future policy decisions.	➤ DHCS should establish an incentive payment program and provide MCPs with guidance for plans to include incentive payments in their program structure. ➤ DHCS should work with legislators, MCPs, and other stakeholders to identify additional funding for needed HIE, ECM and ILOS providers, HMIS Lead Agencies, correctional facilities, and others to support capacity building and infrastructure investments.	DHCS, MCPs, and other stakeholders should enable identified incentive and funding programs.	
➤ Develop contractual requirements to participate in data exchange.	DHCS, CalPERS, and Covered California should define contractual obligations for MCPs that require contracted providers to participate in data sharing activities.	➤ DHCS, CalPERS, and Covered California should incorporate requirement into MCP contract language, providing a glide path for implementation, and assess whether further expansion of requirements is warranted. ➤ Public and private payers should develop patient visit summary, ADT (admission, discharge, transfer), and other nonmedical alert notification requirements into MCP contracts. ➤ MCPs should develop processes for sharing patient visit summary and ADT data with ECM providers and support training on use of ADT data.	

Table 1. Road Map Recommendations Overview: CalAIM and Health Data Sharing, *continued*

RECOMMENDATIONS LEGEND ➤ Regulations/Policies ➤ Technical Infrastructure/Standards ➤ Financing/Contracting/Operations	ROAD MAP ACTIONS 2021	 2022–24	 2025+
3. Care management, shared care plans, and assessment capabilities: Many ECM providers will not have robust system capabilities to unify and share care plans and to receive, aggregate, and integrate care management and care coordination information.			
➤ Develop minimum necessary care management documentation system capabilities and guidance.	DHCS should work with MCPs to develop care management documentation system expectations and requirements, and further define MCP responsibilities for ensuring ECM providers have access to such systems.		
➤ Develop shared care plan policy guidance.	DHCS should work with stakeholders to define a minimum set of sharable care plan data elements, formats, and exchange methods required to be exchanged by MCPs and their contracted ECMs.		
➤ Implement common care plan standards.		MCPs should implement DHCS guidance on minimum care plan data elements and transmission standards.	
➤ Develop accessible care management documentation systems for ECM providers lacking internal capabilities capacity.	MCPs should test care management documentation systems and options for sharing care plans with ECM providers.	➤ MCPs should deploy care management and care plan sharing platforms. ➤ MCPs should provide ongoing technical assistance (TA) to ECM and other providers to help implement care plan systems and sharing technologies and services.	
➤ Assess development of a statewide care plan repository.	DHCS, MCPs, and ECM providers should assess options to create regional or state care plan repositories.	Depending on assessment, establish regional or statewide shared care planning infrastructure.	
➤ Develop care management documentation systems and care plans training and TA programs.	MCPs should develop training program to support ECM provider adoption and use of shared care plans and care management documentation systems.		
➤ Develop financing programs to build technical capabilities for ECM and ILOS providers.	DHCS and MCPs should develop plans to access funding that supports ECM and ILOS information technology (IT) capacity.	DHCS and MCPs should implement financing programs.	
4. Community resource closed-loop referrals for social and human services: Many ILOS providers lack access to a technical platform, infrastructure, and capabilities to receive referrals and to access demographic, eligibility, and authorization information from MCPs and referring providers. Also, referring providers often do not have access to electronic directories and associated workflows to close the loop on ILOS referrals.			
➤ Develop guidance for referral and information sharing among MCPs and ECM and ILOS providers.	DHCS should develop guidance to help MCPs and providers establish closed-loop referral platforms and processes.		
➤ Develop and deploy referral service standards and platforms accessible to contracted ECM and ILOS providers.	MCPs should collaborate and deploy a standard set of closed-loop referral data elements and processes.	MCPs should test and roll out closed-loop referral platforms.	
➤ Provide training and TA to ECM and ILOS providers to support workflow changes and access to systems used to authorize, track, and close referrals.	MCPs should develop training for ECM and ILOS providers on ILOS referral processes and systems.	MCPs should update trainings to reflect evolving system designs and program requirements.	

Table 1. Road Map Recommendations Overview: CalAIM and Health Data Sharing, *continued*

RECOMMENDATIONS LEGEND ➤ Regulations/Policies ➤ Technical Infrastructure/Standards ➤ Financing/Contracting/Operations	ROAD MAP ACTIONS		
	2021	2022–24	2025+
5. Performance reporting and ECM and ILOS billing: Many ECM and ILOS providers will not have the technical capabilities or capacity to submit claims to MCPs in compliance with state and national standards, and their systems will not be configured to capture and store clinical data in a structured, standardized format to support performance reporting.			
➤ Develop guidance to support standardized ECM and ILOS invoicing and billing.	DHCS should convene MCPs and ECM and ILOS providers to develop a minimum set of data elements for invoicing and billing, including minimum requirements for ECM/ILOS providers unable to submit compliant claims.	MCPs should implement minimum billing data element requirements.	
➤ Establish clear ECM and ILOS quality and performance improvement goals, objectives, and performance metrics.	DHCS should review program goals and objectives with ECM and ILOS stakeholders and define measures to assess program efficacy.	➤ DHCS should finalize measure selection and provide MCP reporting guidance. ➤ DHCS should evaluate ECM/ILOS programs by selected measures and refine measure selection, as needed.	
➤ Develop standard ECM and ILOS billing templates.	MCPs should collaborate with other plans and providers to develop and test a standardized set of minimum billing data elements and requirements and to develop invoicing templates and processes for ECM and ILOS providers.	MCPs should implement and refine billing templates, as needed.	
➤ Define performance metric technical specifications.	DHCS should develop and refine existing performance measure specifications, as needed.	DHCS should update measure specifications, as needed.	
➤ Develop ECM and ILOS provider training and TA to support billing and reporting.	MCPs should develop ECM and ILOS training programs on coding and billing practices.	MCPs should update training programs as needed to reflect updates and changes to billing guidelines and practices.	

About the Authors

This paper was authored by the following team of individuals at Manatt Health Strategies: Jonah Frohlich, MPH, managing director; Kevin McAvey, MA, MPP, director; and Jonathan DiBello, MPH, consultant. **Manatt Health Strategies** is a consulting subsidiary of Manatt, Phelps & Phillips, and combines legal excellence, firsthand experience in shaping public policy, strategy insight, and deep analytic capabilities to provide professional services to the full range of health industry players.

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