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Easing Transitions: CalAIM's Changes for California's Older Adults and People with Disabilities

Over two million seniors and people with disabilities (SPDs) on Medi-Cal in California will be impacted by the various reforms, initiatives, and new policies being developed through CalAIM (California Advancing and Innovating Medi-Cal).¹ In particular, one overarching goal of CalAIM is to streamline and create uniformity across the state and counties in terms of services, eligibility, benefits, and delivery systems. Currently, there is significant variation across counties in the organization and delivery of health and social care for SPDs in California.² There is also a great deal of complexity, with enrollees in some counties interfacing with multiple delivery systems and programs with various points of entry and differences in eligibility criteria.³ As CalAIM seeks to

reduce this complexity in the long term, in the short term it will involve moving or transitioning SPDs into new or consolidated delivery systems and programs.

This issue brief describes key care delivery transitions that will impact SPDs during implementation of CalAIM, and considerations for transitioning SPDs into new delivery systems with a focus on addressing health equity by engaging consumers and educating providers. As the Department of Health Care Services (DHCS), Medi-Cal managed care plans, and provider organizations work together to engage SPDs in these new systems and programs, the information in this issue brief could inform their approach.

Delivery System Transitions Under CalAIM Impacting SPDs

Under CalAIM, several policies and new initiatives shift SPDs into new programs and delivery systems. Following is a summary of potential care delivery transition impacts to SPDs as CalAIM moves forward.

Health Homes Program and Whole Person Care Pilots ► Enhanced Care Management

- **Phase I, January 1, 2022.** As part of CalAIM, California launched a new statewide comprehensive care management program for Medi-Cal managed care enrollees called **Enhanced Care Management (ECM)**.⁴ In the first phase, which began January 1, 2022, Medi-Cal managed care enrollees receiving care management through **Whole Person Care (WPC) Pilots** (23 counties) or the **Health Homes Program (HHP)** (12 counties) who also met the ECM **population of focus criteria** (PDF) were transitioned into ECM.⁵ (Additional ECM-eligible Medi-Cal enrollees in these counties could also receive ECM services, even if they had not participated in WPC or HHP.) SPDs were included in this first phase if they were experiencing homelessness, qualified as high utilizers, or if they had serious mental illness, substance use disorders, or both. SPDs in non-HHP or WPC counties who met the populations of focus criteria for the first phase were eligible to receive ECM starting on July 1, 2022.

- ▶ **Phase II, January 1, 2023.** The second phase of the rollout of ECM will impact even more SPDs, including those who did not participate in WPC or HHP. Beginning in January 2023, **eligibility criteria for ECM**⁶ (PDF) expands to include people currently living in institutions who want to transition to lower levels of care; people at risk for institutionalization; and those transitioning from incarceration.⁷

Fee-for-Service Medi-Cal ▶ Statewide Mandatory Enrollment in Medi-Cal Managed Care Plans

- ▶ **January 1, 2023.** While over 1.7 million SPDs are currently enrolled in a Medi-Cal managed care plan (MCP), over 380,000 more SPDs are currently in fee-for-service (FFS) Medi-Cal.⁸ This population includes both SPDs with Medi-Cal only and SPDs enrolled in both Medi-Cal and Medicare (dually eligible enrollees). Most of these FFS enrollees will be mandatorily transitioned into an MCP in their county in 2023.⁹ Enrollees will have the opportunity to select a plan; if they do not, they will default to enrollment in an MCP in their county using an established algorithm that takes into account continuity of care and MCP quality performance.

Hybrid Managed Care / FFS Institutional Long-Term Care (LTC) Benefit ▶ Institutional LTC Carved in to Managed Care Statewide

- ▶ **January 1, 2023.** Over 43,000 Medi-Cal enrollees currently receive care in institutions, including facilities providing skilled nursing, subacute and intermediate care, and services for people with developmental disabilities.¹⁰ In the 31 counties where institutional LTC is not already carved in to managed care, Medi-Cal members are typically disenrolled from managed care and revert to FFS Medi-Cal after 60 days in the facility. After the LTC carve-in is implemented in every county, institutionalized Medi-Cal members will no longer revert to FFS and will instead be enrolled in a Medi-Cal managed care plan.¹¹ The statewide LTC carve-in will occur in two phases, with the majority of SPDs in skilled nursing facilities transitioning on January 1, 2023, and those in facilities for the developmentally disabled or subacute facilities transitioning on July 1, 2023. For detailed information about the institutional LTC carve-in, see *CalAIM and Institutional Long-Term Care: Lessons for Medi-Cal Managed Care*.¹²

Cal MediConnect ▶ Medicare Medi-Cal Plans (formerly called Exclusively Aligned Enrollment Dual Eligible Special Needs Plans)

- ▶ **January 1, 2023.** Currently, nearly 115,000 dually eligible SPDs are enrolled in Cal MediConnect (CMC), managed care plans that integrate both Medicare and Medi-Cal benefits. These plans were created in seven counties as part of California's **Financial Alignment Initiative**¹³ demonstration. In January 2023, these enrollees will be automatically transitioned into Medicare Medi-Cal Plans (MMPs) — formerly called Exclusively Aligned Enrollment Dual Eligible Special Needs Plans¹⁴ — and Medi-Cal managed care plans under the same parent company (typically the same as the CMC plan).

Nonaligned Medi-Cal and Medicare ▶ Medicare Medi-Cal Plans

- ▶ **January 1, 2026.** All Medi-Cal managed care plans will be required to launch an MMP (described above). Over 1.5 million dually eligible SPDs in California will have the option to enroll in those MMPs.¹⁵ People who choose to enroll in an MMP will also be automatically enrolled in the matching Medi-Cal managed care plan. There are several “**matching plan**”¹⁶ (PDF) scenarios that aim for alignment between Medicare and Medi-Cal plans where possible. While Medicare enrollees will be encouraged to enroll in an MMP, **federal rules**¹⁷ (PDF) require that they continue to have the option to enroll in a nonaligned Medicare plan or to choose original (FFS) Medicare. The complexity of these enrollment scenarios could create confusion and complicated transitions for enrollees.
- ▶ The MMP program is proposed to be phased in statewide by 2026. However, the DHCS has established a process whereby plans may request a three-year postponement of the requirement to implement the MMP program to 2029.

Each of the five transitions described above provides major opportunities to improve the consistency, integration, and effectiveness of care for SPDs — but transitions also come with challenges. In the following sections, some of the challenges these transitions may present are explored, as well as opportunities to ensure these transitions are as smooth and straightforward as possible for SPDs, their caregivers, and their providers.

Easing Delivery System Transitions for SPDs Through an Equity Lens

A key goal of CalAIM is to advance health equity and thereby create systems, accountability frameworks, and services that redress, and don't perpetuate, the inequities that many Californians face.¹⁸ Program transitions under CalAIM such as those described above offer both opportunities and potential challenges regarding equitable care delivery. One of the most important ways that policymakers can put equity at the center of program design is to seek out, engage, and respond to enrollee and provider voices and perspectives throughout the design and implementation of new programs. Along these lines, this issue brief highlights lessons learned and best practices to focus on equity and to ameliorate some of the disruption transitions can present through:

- ▶ Communicating with and engaging diverse enrollees
- ▶ Engaging, educating, and establishing buy-in with an array of trusted providers

Different Medi-Cal enrollees are vulnerable to transition-related disruptions in care in different ways. In addition to engaging consumers and providers, it will be important for the state to collect accurate data to monitor the impact that these transitions may have on enrollees' access to services and health outcomes. Data on race, ethnicity, language, sexual orientation, gender identity, and disability status will help policymakers, providers, and advocates understand where inequities may be experienced during transitions and to address any issues promptly.

Engaging Enrollees and Caregivers to Promote Effective Transitions

In all the transitions for Medi-Cal SPDs described in the previous section, it is critical to communicate effectively with Medi-Cal enrollees, their families, and paid

and unpaid caregivers to ensure they have accurate and understandable information about the coming changes, how those changes may impact their care, the choices they have, and the actions they can take. Below are potential barriers that may hinder effective communications with enrollees and their caregivers, as well as best practices to support clear communication.

Barriers

In past efforts to transition SPDs in California to new services and delivery systems, several barriers and pitfalls have been identified, including these:

- ▶ **Notifications and enrollment materials for SPDs can be complicated, often use jargon, and are often written at a reading comprehension level that is too high.** Nearly a quarter of adults in California lack English-language literacy skills — one of the highest such rates in the country.¹⁹ Medi-Cal enrollees with disabilities may face additional challenges such as blindness or other visual impairment that impacts their ability to digest written information.
- ▶ **Enrollees may receive conflicting information from different sources.** Enrollees may receive one piece of information from a state agency but receive conflicting (or seemingly conflicting) information from another agency or an enrollment broker. This was reported in one California county where many SPD Medi-Cal enrollees received information that caused them to believe they would be eligible for the Enhanced Care Management (ECM) program, only to find out that program eligibility criteria limited services to select populations with complex needs.²⁰
- ▶ **The timing of enrollee communication makes a difference.** If a notice comes too early or too late relative to the timing of a program change, it can be less helpful for enrollees. For example, one MCP reported that they were required to send out a notice to members about the availability of ECM six months before the program went live. By the time the program was available, the MCP found

that the information had been forgotten by many enrollees.²¹

- ▶ **Plans and providers may not share or prioritize information most important to enrollees.** In the transition from FFS Medicare or Medi-Cal managed care to the integrated CMC demonstration program in 2014, many enrollees opted out of CMC plans because the notification materials lacked key pieces of information, such as how managed care works, what new benefits were available, and whether they would be able to keep their most important providers.²²
- ▶ **Mailed notifications and telephone communications may never reach enrollees.** In one survey of CMC members, only 70% of enrollees remembered receiving a notification letter about their upcoming transition to that program.²³ This can happen for a variety of reasons. One reason is that Medi-Cal enrollees who live in poverty often face housing insecurity and can be forced to move often or experience homelessness, making it difficult for plan mailings to reach them. They also may not be able to afford to maintain cell phone service, making it difficult for the plan to reach them by phone. For example, one review of a state data set of dually eligible SPDs found that nearly 30% of the phone numbers on record were disconnected.²⁴ Thus, mailed notices and even phone calls to inform enrollees of transitions may never reach them. Another reason is that mailed letters may not be opened and phone calls from unknown numbers are often disregarded. With the amount of junk mail and spam phone calls people receive, a notification from a health plan or the state may never reach the enrollee.

Promising Practices

Engaging enrollees and caregivers in the creation of any new Medi-Cal policy or program is essential to achieving person-centered and equitable care. This type of engagement can have immediate and tangible impact when used to inform program design and the content of and dissemination strategies for information and communication materials. Below is a collection of best practices and tools:

- ▶ **Engage Medi-Cal SPDs and dually eligible enrollees to learn what matters to them.** When planning for a transition, hearing the opinions of enrollees who will be impacted can be very helpful in designing the program, developing communication materials, and identifying the best communication pathways. State examples for garnering consumer feedback include:
 - ▶ When *Pennsylvania* launched a new Medicaid long-term services and supports (LTSS) program, the state hired an evaluator to perform a telephone survey of members that identified preferred engagement activities and communication pathways before the program launched.²⁵
 - ▶ As *Massachusetts* implemented a new program to bring Medicare and Medicaid benefits into a single plan for dually eligible enrollees (**One Care**),²⁶ the state created a **consumer-chaired implementation council**²⁷ that included consumer representatives, community-based advocacy organizations, and representatives of trade organizations to advise on demonstration design features. As part of the council, work groups were formed to address specific topics including encounter data, long-term services coordination, and more.²⁸
 - ▶ In *Massachusetts* the Commonwealth Care Alliance (an MCP participating in One Care) developed a **Member Voices program**,²⁹ a consumer advisory group composed of people with disabilities and others. This group reviewed communications content when the state moved

certain dually eligible enrollees from FFS into managed care. The plan continues to engage this group to identify any problems with the program and to maximize accessibility.³⁰

- ▶ In 2016, when focus groups with dually eligible SPDs revealed that *California's* CMC program was difficult for many enrollees to understand, DHCS revised program materials using feedback from consumer usability testing.³¹
- ▶ One study focused on *California's* dually eligible SPDs recommended the provision of patient navigators, similar to those required in the Affordable Care Act, to help SPDs understand transitions and make the best choice of health plan, given their specific needs.³²

Improving Notification Materials for SPDs

Dually eligible enrollees surveyed in California had many suggestions for improving written notices and other resources during the transition to Cal MediConnect:

- ▶ **Clarify benefits.** Notices should clearly describe the new benefits they would gain from the program and any benefits or flexibilities that would be lost if they enrolled.
- ▶ **Use clear language.** Some said that notices were unclear, too technical, or vague and needed to be written in a way that everyone could understand.
- ▶ **Identify provider status and options for continuity.** Enrollees wanted resources and simple tools that would tell them whether their providers were in network and how to request continuity-of-care provisions for out-of-network providers.

Source: Carrie Graham, Pi-Ju Liu, and Steve Kaye, *Evaluation of Cal MediConnect: Key Findings from a Survey with Enrollees* (PDF), UCSF, August 17, 2016.

- ▶ **Test materials with diverse consumers representing different races/ethnicities, languages, ages, education levels, and disabilities.** In California, there are at least 13 “threshold languages” that represent the most commonly spoken languages of Medi-Cal enrollees.³³ Ideally, consumers who speak all those languages, including American Sign Language (ASL), should be engaged in the development of materials.³⁴ Furthermore, enrollees with different types of disabilities may absorb information differently,³⁵ so diverse disabilities should also be represented.
- ▶ *California* engaged health literacy experts at the University of California, Berkeley, to conduct usability testing of communication materials for Medi-Cal enrollees in several languages with a variety of disabilities.³⁶ Results of the user testing were used to iteratively revise materials so they were understandable in all threshold languages and included information important to the enrollees.
- ▶ One study of diverse *California* caregivers who were assisting an older adult during a hospital discharge showed ethnic minorities, recent immigrants, and people with limited English proficiency have unique needs and challenges. This study bolstered the evidence of the importance of engaging a broad array of diverse enrollees and their caregivers in the development of communication materials.³⁷

Best Practices for Engaging People with Disabilities in Research

Many SPDs have physical or behavioral health-related disabilities that can pose barriers for them to engage in focus groups, interviews, or surveys. Thus it is important for any researcher or health care entity to review best practices for data collection with people with disabilities. The Rehabilitation Research and Training Center on Disability Demographics and Statistics (StatsRRTC) has created the Compendium of Disability Data Collection Methods, an easily accessible source of evidence-based best practices and inclusive strategies for collecting data on and engaging people with disabilities.

Source: Jason Markesich, Stacie Feldman, and William Rafferty, *2020 Compendium of Disability Data Collection Methods*, Mathematica, Jan. 31, 2020.

- ▶ **Engage health literacy experts to ensure materials are understandable and meet plain language standards.** Some Medi-Cal SPDs may have lower levels of educational attainment — national analyses have found that 43% of dually eligible SPDs do not have a high school diploma.³⁸ This makes it especially important to ensure appropriate reading levels of written materials. Some disabilities can also make it difficult to absorb written information, especially if it includes excess jargon. Working with experts in health literacy and plain language can ensure materials are written simply and are easy to understand and act upon.
- ▶ Several organizations have developed resources to make Medi-Cal communications easier to understand. The California Health Care Foundation developed a **resource**³⁹ with recommended steps to improve Medi-Cal communication, and the Center for Health Care Strategies developed a **tool**⁴⁰ with tips to improve print and oral communication.
- ▶ In 2009, health literacy experts used participatory design methods involving interviews and focus groups with Medi-Cal-only SPDs, usability tests of materials, and input from consumer advisory groups to develop and test user materials for SPDs transitioning to managed care.⁴¹ Lessons learned from this effort resulted later in an **enrollee toolkit**⁴² for CMC enrollees that included information on available benefits, other services, how to make appointments, and more.
- ▶ **Use a variety of communication pathways and partners.** Consumers are increasingly using technologies such as the internet, email, and text messaging to access information.⁴³ As part of consumer engagement, enrollees should be queried about their preferred communication pathways, with the ability to opt in to text messages, email, and other pathways if preferred. MCPs and the state should also be prepared to use phone calls, in-person communication, and videos to explain transitions to enrollees. Finally, where possible, leveraging trusted community partners such as community-based organizations and Area Agencies on Aging can be key to ensuring that enrollees get the information they need.
- ▶ In *Massachusetts*, Commonwealth Care Alliance (an MCP) reached out by phone or through in-person visits to notify people eligible to transition into their One Care program for dually eligible enrollees.⁴⁴ This allowed them to ask questions about the program and get the information that was important to them before making a choice.
- ▶ In *California*, **Cal Duals**⁴⁵ provides educational videos called “Cal MediConnecToons” in multiple languages including ASL that clearly explain enrollee choices and options.⁴⁶
- ▶ In *Wisconsin*, Aging and Disability Resource Centers serve as a trusted source of information where enrollees transitioning into managed care can talk to a counselor by phone.⁴⁷

- ▶ **Test communications systems before launch.** It is important to make sure that member questions can be answered in real time and that language and cultural barriers do not influence the information being provided to enrollees.
 - ▶ The *Texas* state Medicaid agency used “secret shopper” strategies to test the ability of call centers or other member-facing staff to answer questions before program transitions began. The state developed scenarios to anticipate potential enrollee questions and then tested the capacity of plan staff to respond to those questions.⁴⁸
- ▶ **Create systems that allow enrollees to provide feedback to the state and MCPs in real time.** Creating efficient feedback loops is important so that the MCPs and states can quickly learn about any issues and address them efficiently.
 - ▶ When *Florida* transitioned LTC services to managed care, the state created an online, centralized complaint form and hub to monitor and respond to incoming feedback from both members and providers.⁴⁹
 - ▶ In *California* during implementation of CMC, the state employed an independent ombudsman for dually eligible enrollees to call to report problems. In the first year alone, the ombudsman was able to identify over 50 implementation issues and challenges that were reported to the state to rectify.⁵⁰
- ▶ **Ensure that MCP staff, enrollment brokers, and patient navigators receive training in diversity, equity, and inclusion.** It is essential for all staff to build skills to recognize and attend to cultural differences that impact care preferences, communication methods, or both.
 - ▶ One study of cultural competency in Medi-Cal plans found that as plans and provider organizations focused on meeting the needs of specific linguistic and cultural groups, administrators recognized the need for more staff education, and all plans and provider organizations in the study implemented training programs as a result. Although these programs focused initially on linguistic needs, all MCPs interviewed commented that they were developing or attempting to identify effective programs dealing with other cultural aspects of health care.⁵¹
 - ▶ The US Department of Health and Human Services has compiled **resources**⁵² with information on cultural competency related to general health care delivery as well as specific to individuals with behavioral health needs. Among other topics, resources outline what cultural respect is, how to promote it in the delivery of health care and related services, and National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.⁵³
 - ▶ The federal Office of Minority Health created **Think Cultural Health**,⁵⁴ an initiative and a website that provides health care professionals (such as physicians, nurses, behavioral health providers, and community health workers) with resources and continuing education / online learning opportunities on cultural and linguistic competency and implementation of the CLAS standards.⁵⁵

Additional Resources on Cultural Competency

Agency for Healthcare Research and Quality
Oral, Linguistic, and Culturally Competent Services

Center for Appropriate Dispute Resolution in Special Education
Equity and Cultural and Linguistic Competence — Resources to Consider

Cigna
Cultural Competency Training

Cultural Intelligence Center
Healthcare Bias Training

Georgetown University
National Center for Cultural Competence

Michigan Department of Health and Human Services
Public Health Resource Sheet Cultural Competency (PDF)

Engaging, Educating, and Establishing Buy-in with Providers

Providers play a key role in communicating about transitions with their patients and clients. A person's trusted provider — whether it's a primary care, behavioral health, specialty care, or LTSS provider — may be the first place they go to seek information when faced with a program, service, or delivery system transition. California providers must be educated about CalAIM reforms to support their patients during transitions.

Barriers

When it comes to communicating with and educating providers about transitions, several barriers and lessons learned have been noted both in California and nationally.

- ▶ **When physicians and other providers lack awareness of the initiatives, it can be confusing to enrollees.** For example, in one study of CMC enrollees, many said their providers did not have sufficient knowledge of the CMC program and the benefits it covered. This lack of awareness often resulted in enrollees receiving conflicting information from their physician and health plan. In some cases, this caused disruptions in services.⁵⁶
- ▶ **All types of providers should be engaged and educated about transitions.** While many provider engagement efforts related to Medi-Cal may be aimed at primary care or other medical providers, SPDs often receive care outside these traditional medical settings, from social workers, behavioral health or LTSS providers, and others.
 - ▶ When states launched their Financial Alignment Initiative (Medicare/Medicaid integration) demonstrations, a report from the Centers for Medicare & Medicaid Services noted that most outreach was focused on physicians, and there was little communication to other providers such as nursing facilities.⁵⁷
 - ▶ In a key informant interview study with providers in California, physicians reported that it would

have been helpful if other frontline office staff had received information about the program due to their role in interacting with and advising patients.⁵⁸

▶ **When providers are not educated about the benefits of a program, they may explicitly or subtly encourage enrollees to opt out.**

- ▶ During the transition to CMC there were higher opt-out rates in certain counties, and it was believed that some providers encouraged members to opt out of the demonstration.⁵⁹
- ▶ Experiences with or fear of slow payment or of reimbursement denials can lead providers to resist becoming managed care providers, and to encourage their patients to opt out of managed care and stay in FFS so they can continue to stay with their current providers.⁶⁰

Promising Practices

Many states have successfully worked with an array of providers to educate them about changes to programs or delivery systems, ensuring they have the information they need to best support their patients during transitions. Some promising practices include:

- ▶ **Engage and educate providers — including clinical and nonclinical staff — before program transitions.** This will help them know what to expect and be able to share neutral information with their patients.
 - ▶ In *California*, a consultant worked to develop a **Physician Toolkit**⁶¹ to educate providers on CMC benefits and policies.
 - ▶ In *Massachusetts*, when the One Care program began, Commonwealth Care Alliance (an MCP) proactively reached out to providers to educate them about the new initiative so the providers had enough information to share with members who had questions about the program.⁶²
 - ▶ *Idaho's* Medicaid agency did a series of “road show” presentations for providers across the

state with its one Dual Eligible Special Needs Plan, Blue Cross of Idaho, to build trust through in-person discussions.⁶³

- ▶ *Ohio* engaged provider associations for more than a year before the launch of MyCare Ohio (the state’s Financial Alignment Initiative for dually eligible enrollees) to gain their buy-in and input. Several provider associations are now represented on Ohio’s advisory committee that provides feedback to the state on implementation issues.⁶⁴

- ▶ **Reach out to an array of provider types to ensure that trusted care partners can share information about transitions.** People with complex needs often receive care from multiple providers and may rely on paid personal care assistants to help with activities of daily living.⁶⁵ Because SPDs may use multiple types of health care and community-based services, the state and MCPs should go beyond medical providers to also engage social care providers, care managers, and front office staff to educate them about program transitions.

- ▶ In *California*, during the implementation of CMC, care managers from MCPs shadowed staff at **Community-Based Adult Services (CBAS)**⁶⁶ centers so that both care managers and CBAS staff were better equipped to explain LTSS services to CMC enrollees.⁶⁷
- ▶ In *California*, a consultant was engaged to create a **Hospital Case Manager Toolkit**⁶⁸ so that discharge planners and others could help their patients in CMC plans understand their options after a hospital stay.

- ▶ **Communicate often with providers, with more intensive outreach up front.**

- ▶ In *Kansas*, when behavioral health services were carved into managed care, state staff and health plans held daily “rapid-cycle response calls” with providers to deliver live support that decreased in frequency over time as providers became more

familiar with the carve-in program's expectations and details.⁶⁹

- ▶ When *Virginia* implemented a new demonstration program to serve dually eligible enrollees, the state held regional town hall meetings to address provider questions.⁷⁰
- ▶ **Focus provider education and technical assistance on program design elements most important to providers, such as workload impacts, staffing, and billing.**⁷¹
 - ▶ Consider incentives that could help improve provider satisfaction with the program and incorporate those incentives into messaging about new services (e.g., hours, extra capacity, etc.).⁷²
 - ▶ In CalAIM, MCPs are providing ongoing technical assistance to providers to ensure that they understand how to report and bill for services to avoid reimbursement delays.⁷³ As CalAIM creates more opportunities for MCPs to contract with a variety of provider types for care management and nonmedical social care, technical assistance to community-based providers will continue to be important.
- ▶ **Create opportunities for providers from different sectors to communicate, collaborate, and share information to make sure that members' multiple needs are met.** Many of the transitions in CalAIM are intended to coordinate care and integrate services across several sectors, including medical care, LTSS in homes and in institutions, behavioral health, and others. Providers from all these sectors can benefit from opportunities to form relationships, share information, and learn from each other.
 - ▶ In a study of *California* providers in various sectors involved in CMC, many providers stated that the most useful educational resources were learning collaboratives and regional coalitions that were designed to bring providers together, establish relationships across sectors, improve communication, and forge shared learning.⁷⁴

- ▶ In *Massachusetts*, LTSS providers participate in interdisciplinary care team meetings to ensure that other providers and MCP care managers are aware of enrollees' personal care needs.⁷⁵
- ▶ In *California*, one county agency that had been administering the Whole Person Care (WPC) pilot met with MCP care managers who were newly implementing ECM to explain the details of the WPC program transition and prepared scripts for MCPs on the program transition.⁷⁶
- ▶ One *California* MCP implementing CMC colocated their care coordination staff in the same offices as county agency staff administering the **In-Home Supportive Services program**,⁷⁷ a Medi-Cal Home and Community-Based Alternatives waiver program. This allowed the MCP care coordinators to more readily interact and spontaneously coordinate care between medical care and LTSS.

Conclusion

As California's SPDs experience changes to some services, programs, and care delivery systems under CalAIM, the state and MCPs could help smooth these transitions by engaging enrollees, their caregivers, and an array of providers before and during implementation of these changes. Successful practices from California and other states can inform these approaches, to optimize person-centered and equitable care, minimize disruptions in services, and move closer to more integrated, better coordinated care for seniors and people with disabilities across the state.

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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.

CalAIM for Seniors and People with Disabilities

is a series of reports focusing on elevating experiences from California and other states to ensure CalAIM reforms impacting Medi-Cal's seniors and people with disabilities build on past efforts to integrate and improve care.

Endnotes

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