

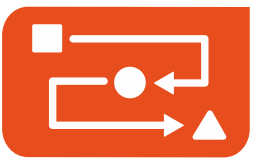
CalAIM Experiences: Implementer Views After First Year of Reforms

July 2023

GOODWIN · SIMON
STRATEGIC RESEARCH

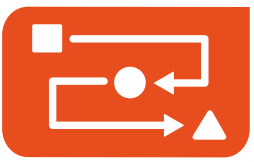


California Health Care Foundation



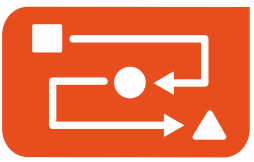
Goodwin Simon Strategic Research (GSSR) is an independent opinion research firm with decades of experience in polling, policy analysis, and communications strategy for clients in the public and private sectors. GSSR Founding Partner Amy Simon, partner John Whaley, and research analyst Andrea Hackl all contributed their thought leadership on this focus group research in collaboration with the California Health Care Foundation. For more information, visit www.goodwinsimon.com.

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- Explore how CalAIM has improved access to integrated, holistic services for patients/clients/members from the perspective of implementers
- Find out whether CalAIM has changed the profile of who is getting services or made it more or less equitable
- Gather feedback on other intended or unintended effects of CalAIM
- Surface current bright spots where things are going well, as well as potential solutions where things are not going well

Phase 1 — Qualitative Focus Groups



- Six online focus groups among 37 CalAIM implementers from March 28 and April 27, 2023. Participants were divided into the following categories for groups. The shortened version in parentheses denotes how participants of that group will be referred to in this presentation.



Enhanced Care Managers working in primary care — all FQHCs (ECM)



Acute hospital discharge planners (Discharge Planner)



Homeless service providers and Medical Respite / Recuperative care providers (Homelessness or Med. Respite)



Managed care plans (MCP)



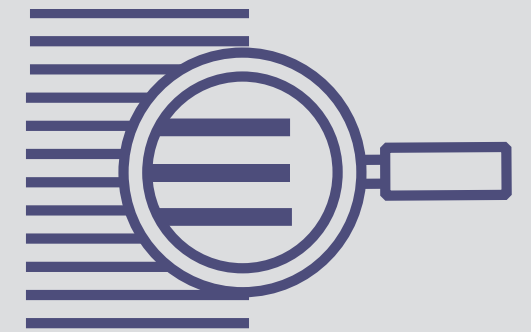
Community-based organizations providing other Community Supports — mostly asthma remediation (CBO)

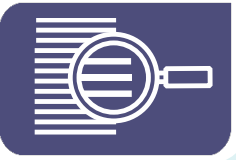


Behavioral health leaders — mix of county and county-contracted providers (BH)

- Participants were recruited through CHCF outreach and offered an honorarium for participating.
- This phase involves in-depth qualitative — not quantitative — research. As such, these findings are suggestive only, and are not statistically generalizable to the entire universe of CalAIM implementers.
- This deck includes direct quotes from participants, with only minor edits for readability.

Key Findings

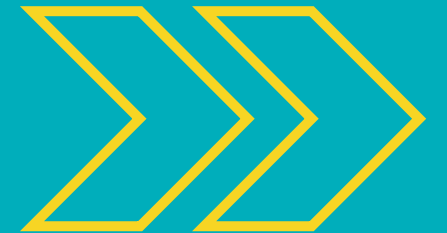




While Many Are Optimistic About the Future of CalAIM, Participants Identify a Range of Roadblocks and Challenges

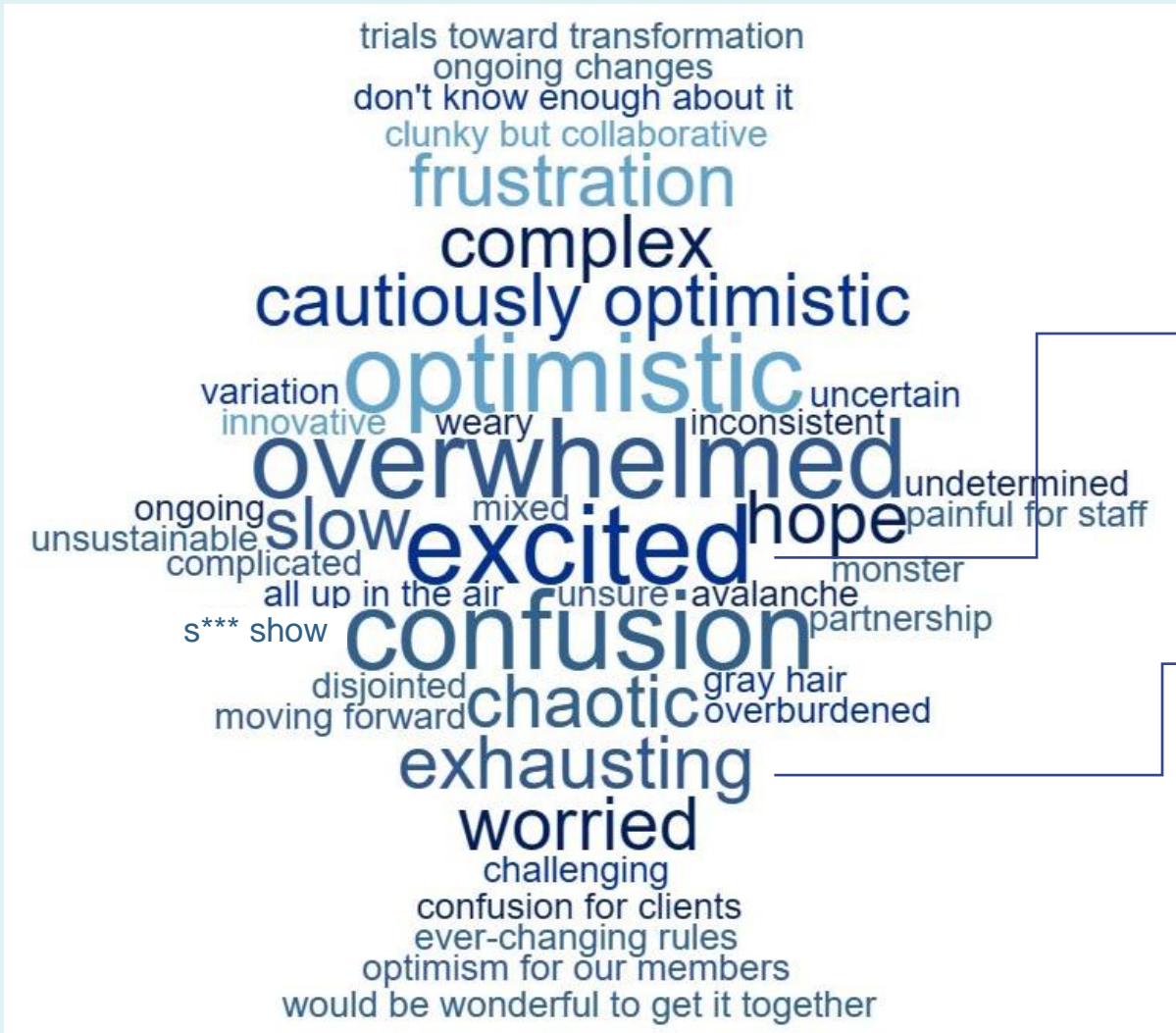
- Many are optimistic about CalAIM and express agreement with CalAIM's goals and objectives.
- However, participants also express frustration that these goals do not match the reality on the ground and discuss the many challenges they continue to face, such as a lack of standardized processes and different documentation requirements.
- While some of these challenges are universal, others are unique to individual participants' work settings and roles.
- Most are not surprised by the rocky rollout, but participants want CalAIM to start demonstrating real improvements in their work and in the lives of their patients.
- To that end, they share many recommendations and ideas about how to improve implementation.
- Despite the challenges that participants discuss, some also discuss a few places where things are going well. However, these bright spots are individual to their fields and professions; some of the organizations have found solutions or ways to make things work, but they may not always be replicable throughout the state.

Overall Impressions and Feelings About CalAIM



Participants Feel a Mixture of Optimism and Cynicism

What word or phrase best describes how you are feeling about CalAIM implementation in the counties where you operate?



ECM and MCP participants used more positive words and are more likely to say they are “excited,” while for other groups the positive words were more along the lines of “cautiously optimistic.”

While all groups used some negative words, ECM, MCPs, and BH are more likely than the other groups to say they are specifically “overwhelmed” or “exhausted.”

In Their Own Words: What CalAIM Can Do for Californians (1 of 2)

"I am super excited about CalAIM because it is the opportunity for MCPs to move into the community and partner with community advocates, community groups beyond the traditional health care delivery system. . . . This is innovative because MCPs have not had to do this. CalAIM is about changing systems and policies to address health equity and health disparities."

—MCP, Central Coast

"I mean we are super small, super rural, and brand new, and so what this looks like to us is some kind of consistent funding that would cover one of the most basic health determinants, which is housing . . . keep these folks sheltered and keep them out of the emergency rooms, keep them from having to deal over and over again with the slightest little thing that most of us would take care of in a week but keeps coming back because you live outdoors."

—Homelessness, Rural North

In Their Own Words: What CalAIM Can Do for Californians (2 of 2)

"In general, it is amazing to be able to get these services paid for. Never before have we anywhere in the nation been able to get basically case management like this paid for by CHWs or paraprofessionals."

—ECM, Bay Area

"Hope to support our community. [It is giving] us an opportunity to be the voice to implement new ways for them to receive [a service]."

—CBO, Central Valley (also Central Coast, Greater Sacramento, Southern CA, others)

"I am cautiously optimistic. I do think payment reform will make a difference; it will streamline our system and it will streamline how clinicians operate. We hope that it will make clinicians operate at the top of their discipline as opposed to a little bit of what is happening now, so that is my cautious optimism."

—BH County, Southern CA

Growing Pains Are Real and Deeply Felt by Participants (1 of 2)

Many say they recognize that ambitious and complex goals take time and coordination to execute, and are willing to provide CalAIM some time and flexibility in these early stages.

"I have been part of launching many new programs and it just seems like the first year is always the hardest. . . . It just takes time, and people know there is an ECM program out there but they don't really know what it means or how to refer and that takes a while."

—MCP, Bay Area

"I think these goals are the right goals. It is a very complicated project, and you are trying to elevate all of these providers that haven't historically played in the sandbox and so there is a lot of growing pain. I am optimistic because I think that a lot of it is being done in good faith."

—Med. Respite, Southern CA

"I think everyone is getting together. This kind of reminds me of the Affordable Care Act. When the Affordable Care Act began, everything was chaos as well. . . . There is going to be a way better system later on eventually, but it is currently frustrating for not only ourselves but for the patients as well."

—CBO, Southern CA

Growing Pains Are Real and Deeply Felt by Participants (2 of 2)

At the same time, many are overwhelmed by the complexity and administrative burden of new processes, or worried about the confusion and currently unsolved problems with the rollout.

"Meeting people where they are on the street providing medicine . . . but how does that really work? How do you really think through contracting and for those of us [with] delegated entities, how do they get paid? How do we do claims? There is just a lot of complexities, and I think that is what is exhausting."

—MCP, Southern CA

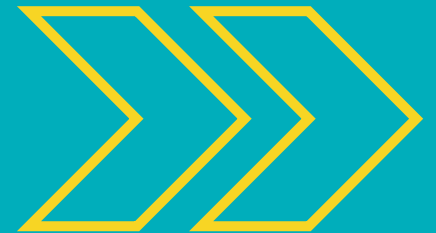
"We are used to wearing lots of hats and overwhelm is always a part of everyday life, but this just really compounds all of that."

—ECM, Greater Sacramento

"What to come? What are we going to be anticipating? How is this going to affect discharge planning, discharge coordinating? Who are we to talk to when it comes to the insurances versus the IPA [independent practice association]? . . . We need more knowledge in terms of how to utilize CalAIM."

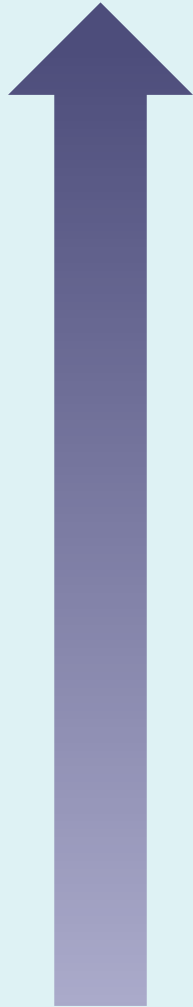
—Discharge Planner, Bay Area

Challenges Faced by CaAIM Participants



Challenges That Participants Express: Overview

More common
across groups



- ✓ Lack of standardized processes
- ✓ Lack of local information about CalAIM
- ✓ Lack of trust between providers and managed care plans
- ✓ Little new collaboration
- ✓ Tension about who owns different processes
- ✓ Reimbursements don't cover costs
- ✓ Concern CalAIM is not set up for unhoused members
- ✓ Delays in DHCS guidance, or changing guidance paired with fast pace
- ✓ Lack of local CalAIM infrastructure and reliance on regional ECM (in rural areas)
- ✓ Low rate of engaging and enrolling members into ECM
- ✓ County concerns about documentation reduction
- ✓ Inconsistency with No Wrong Door policy
- ✓ Lack of referrals for CBOs

Participants Across Groups Are Concerned About the Lack of Standardized Processes Between Different Entities (1 of 2)

Different processes and requirements by managed care plans

"It is really challenging to navigate all these different micro differences between the plans. Just a quick example: For one plan you just have to have one encounter a month [and] you are good for your per member per month rate, but then for another plan, they want two hours of patient time per month for that EPM. I don't know how that will work, and they can't answer it. . . . That is a huge barrier for us."

—CBO, Greater Sacramento

"The confusion about process. You do it like this if it is this insurance. You connect here. It is rather convoluted, and it is not easy to navigate even for professionals like us."

—Discharge Planner / Behavioral Health, Southern CA

"Every managed care plan has its own portal, so it is hard to navigate that and that is complex in its own right. The data that the managed care plans have if there already is an ECM is nonuniform and also not so accurate."

—Med. Respite, Southern CA

"With the different managed care plans there are different platforms, different reporting structures, different payment structures, and so having to keep all of this straight with different auditing processes there is a fire hose of information we are trying to keep track of."

—ECM, Greater Sacramento

Participants Across Groups Are Concerned About the Lack of Standardized Processes Between Different Entities (2 of 2)

Different processes and requirements by county

"Even how two counties are going to demand, and I use the word demand on purpose, we use the same procedure code that has a federal definition but the two counties are going to use it differently. . . . The inconsistency of implementation across the state from a county that said, 'Yes, we are going to go to the state minimum documentation' . . . to another county that has said, 'Yes, documentation reduction is just not a priority of ours so we are not going to do that right now.' That is the discrepancy range that we're dealing with here, and I don't think we can climb the mountain . . . with 58 different trails up."

—BH, Bay Area, Central Valley, Southern CA

"I think the transition has been rough in a lot of different ways. . . . We feel like the expectations and the rules change all the time in terms of what documentation we're required to have and how eligibility is handled. There is variation from one county to another."

—ECM, Bay Area

Many Participants Across Groups Say They Don't Have Enough Information About How to Work Within CalAIM Locally

Across groups, many are concerned that they (and other implementers) do not have and cannot get the information they need to work within CalAIM in their area. Some participants also feel that the burden to educate has been placed on providers when it should not be, or when they themselves are not equipped to do the educating.

"We thought we put all this effort into building capacity, doing all these contracts with these nontraditional providers . . . why aren't people using them? One of the things that we've heard is that for providers, even though I know lots of us have done provider training, a lot of providers are not really clear about how to refer people. Some are. Some are really up to speed on it, but others are like, 'Well, I don't know how to do it.'"

—MCP, Southern CA

"Waiting for everybody to get their ducks in a row leaves us undetermined . . . like, what do we do? You are asking the care management plan how to do specific things because they want us to report or seek authorizations or this and that. And the part that I come across is you need to talk to this person because we don't really know yet, so they don't even know all of their guidelines and qualifications."

—Med. Respite, Central Valley

"Yeah, so [County] is a big county and every single little [department] on this county has different processes, so it is very hard to get in contact with who knows what to do. . . . We cannot get one person to tell us what they want us to do. . . . Every person you ask, it is going to be a different response."

—Discharge Planner, Bay Area

Many Participants Across Groups Say That Organizations That Should Be Participating in CalAIM Just Don't Know About It

Many participants say they are finding that organizations like FQHCs and CBOs should know about CalAIM but don't. For example, there are CBOs offering services that could be covered, but they just do not know about CalAIM or how to get reimbursed.

"They have this organization here . . . and they are a safe parking service. . . . And they come here and they talk to the patient, explain what the program is and they are able to transition the homeless person from the car to housing. We are seeing 36 today. I don't know what they do magically. . . . What I see sometimes is those groups that help us a lot with the people in the community, they are not aware of CalAIM and how they can be linked to the service and get reimbursement."

—Discharge Planner, Bay Area

"The folks who are in the sandbox are not playing, so the FQHC, the primary care providers . . . I am shocked at how few of them even know what CalAIM is . . . a real fundamental disconnect."

—Homelessness, Central Valley

"I am happy because it definitely is beneficial for patients who are able to utilize it, but in order to get them the tools and resources to use it we need to know about it as well."

—Discharge Planner, Bay Area

Some Participants Feel They Cannot Build Trusting Relationships with MCPs

Some participants, especially in the Homelessness Services + Medical Respite group, say they do not believe most managed care plans are coming to the table with the right motives, or that they are operating in good faith, making it difficult to work with them. This distrust is felt toward for-profit MCPs especially.

"We are having problems with one of our managed care plans paying out . . . it is just incredibly frustrating. Honestly, if I'm going to be open, I understand they are managed care plans and ultimately they are a for-profit business, so anything in my view that they can do to not pay out is exactly what they're going to do."

—Homelessness, Rural North

"They are nice to you when they are desperate for providers. When they have enough providers, you won't get a call back."

—Med. Respite, Southern CA

Collaboration Depends on Individual Relationships (Not Yet “Hardwired”)

Widespread collaboration between organizations has yet to take hold. Across several groups, some say it's often dependent on one-off individual relationships that have already been built.

“For me, I have two of my staff that came from the health plan, so sometimes they call their friend and say, ‘Hey, I am sending you this referral. Can you please help out?’ . . . For the plan in [County] that I used to work there, [I’d] call my friend to say, ‘Hey, I have one of your members here, and this is what they need. Can you assign somebody?’ But it is really at this point in time almost like asking for favors. It is not something that is hardwired by any stretch of the imagination.”

—Discharge Planner, Bay Area

Tension Between Organizations Around Who Owns Processes, Outcomes, Reimbursements (1 of 2)

- Some providers are frustrated that it is not clear who should be taking responsibility for what processes and how that lines up with credit for outcomes.
- Some say they are shouldering more of the work to ensure good outcomes while Enhanced Care Managers and managed care plans do not do enough.
- Some say they do not have enough control over outcomes because wait times can interrupt engagement, especially for people struggling with homelessness and substance use disorders (SUD).

“When you finally get somebody who wants to go to treatment who says, ‘I am ready to go,’ they go through the process. They go through their intake and do everything they need to do, and then they are told, ‘Well, we’ll see you in eight to 10 weeks,’ and that is the reality. . . . But for us, the SUD thing is a big issue. Like I said, if someone wants to get clean, they are not going to wait eight weeks. They’re going to leave that meeting and they are going to go use immediately, and in eight weeks when you find them again, they are going to tell you ‘Forget it.’”

—Homelessness, Rural North

“Sometimes it is not even a clear picture on who is responsible for whatever the post-transitional care need is. . . . You’ve got your bad days where you are on the phone for . . . one case could take up to maybe 4 to 5 hours just in order to close a loop with just finding out who is the payer source, who is going to provide this, who is going to help the patient at home.”

—Discharge Planner, Inland Empire/Desert

Tension Between Organizations Around Who Owns Processes, Outcomes, Reimbursements (2 of 2)

On a related note, there is concern that reimbursements are not currently always going to the organizations based on the work they are doing, or the outcomes they are supporting.

"We haven't had a lot of success with ECMs actually being productive care team members while patients are in recuperative care. And we often do the work that they should be . . . that they are being reimbursed to do. We do it out of our own expense, and they are probably getting reimbursed for it, and it seems like that is probably not a great practice definitely from us and definitely from a policy perspective. . . . Finally, when you do get them on the phone, it is like . . . who is doing what, you know. I ask, 'Who is completing this form?' Silence. . . . They are like, 'Well, you guys have the patient. Why don't you fill it out?' Great. Thank you for telling me that. That is what we were going to do anyway before you guys were around."

—Med. Respite, Southern CA

Some Say That Low Reimbursement Rates Do Not Cover Costs (1 of 2)

Some participants are concerned that the reimbursement rates do not cover enough of their costs to continue operating sustainably. Behavioral health leaders are especially concerned about changes coming with payment reform.

"It is either cut care and not provide the scope of the services that we all show up to work every day to do, or operate at an operating deficit and clamor for grants and use precious resources to pursue these grants. It is a very delicate situation."

—Med. Respite, Southern CA

"We've been pushing and pushing for conversations around payment reform. We are, what, eight weeks out from July 1. . . . They barely released our rates two weeks ago maybe and after discussion about how this is going to be a discussion and negotiation just said, 'Never mind.' Here they are at a point where it is not even at a breakeven point for a lot of the agencies in this county, and they are taking 35% off the top."

—BH, Bay Area

Some Say That Low Reimbursement Rates Do Not Cover Costs (2 of 2)

In particular, reimbursements do not seem to always match up with the realities of outreach and documentation. This varies across participants because different MCPs have different reimbursement structures.

“Considering the population and the complexity, designing care plans, reporting on the progress notes, reporting on outcomes . . . all that stuff is value add. It is just that it is probably offhand 20%, 30% of our staff time, and so it just needs to be built into the reimbursement in terms of having compensation for that time.”

—Med. Respite, Southern CA

“I think for me there is a structural problem with the way that ECM and community support services is set up around . . . we only get paid when people are enrolled. . . . If you hire somebody new, you are not able to actually support them with revenue from CalAIM until they've got a full caseload. You've got to get people oriented to the program. They have to be meeting clients, etc., so it is several months before they actually have a full caseload and are bringing in enough revenue to support all the expenses associated with the program.”

—ECM, Bay Area



Some Say CalAIM Is Not Set Up to Serve Unhoused Members

Participants in the Homeless Services + Medical Respite and CBO groups express concerns that CalAIM may not be able to reach its goals when it comes to people experiencing homelessness, because it is built on a medical model that does not take into account the additional challenges faced when trying to engage unhoused members.

“Lumping everything into the medical model isn't going to work for this population. I understand what the goal is, but the reality is you have to listen to your CBOs and the people providing these services and give a little bit, you know.”

—Homelessness, Rural North

“Our plans want to disenroll people when they are stable, and actually in this population stability is a pretty low bar, and a lot of times they are stable because they have a case manager. I am really worried, especially in tenancy-sustaining services, about the rug getting pulled out from under clients and also making it almost impossible to financially manage programs because of that. There needs to be some look at what is the long-term commitment to providing permanent services and permanent housing for people who really are high risk.”

—Med. Respite, Bay Area

“No food referrals yet — the members haven't been really interested in that. Some of the homeless or unhoused individuals we spoke to, once they learn more about it, they are like . . . ‘Well, I don't have any place to keep food other than for a couple of hours’ and that type of thing, so there's these unanticipated consequences.”

—CBO, Greater Sacramento



Frustration with Late and Changing Guidance

Participants in the MCP and County Behavioral Health groups say that delays in DHCS guidance and late-in-the-game changes make it difficult for them to build long-term, sustainable systems that work for stakeholders.

"I have concerns about quality with all of these programs being sort of launched at the same time . . . just in the last week we were told, basically, 'Change how you do billing and claims for your community supports and ECM because all of the plans are doing it differently, and you need to all do it the same way now.' This is after giving all of us incentive payment programs to build infrastructure and configure all of this stuff and pay our providers to do all of that. And now it is like . . . 'Guess what, you need to do it differently, so there are no more dollars to reconfigure.' That is just one example of we've done all of this work. We feel like we can finally take a deep breath and now this big change, and we are very proud of how we did this because we put tons of thought into all of it. So that is part of the exhausting part is to just start over."

—MCP, Bay Area

"There is just not enough time and we hear from DHCS this is coming, this is coming, and then the info-notice gets backdated and we are already supposed to be doing something . . . the documentation reform and behavioral health policy changes is a great plan. It is just too fast, and our workforce does not match the timing of how the state expects us to roll things out."

—BH County, Bay Area



Frustration with Aggressive Time Frames and Changing Guidance

The takeaway that managed care plan participants most wanted to include in this report is that the timelines set for implementation are too fast to allow them to build effective systems. They are especially concerned about being able to implement the upcoming justice-involved phase.

“Here is a great example: Community health workers — that program went live. We didn't get an APL until months later. Major organ transplant — we didn't get an APL until September 2022 and that went live January 2022. We are still waiting for what is the population [health] management service? . . . We are trying to build our [risk] stratification policies now, but we don't know what the state is going to roll out, so we could potentially build something that is going to be completely different than what the state builds. I mean, I really appreciate the nuance between ‘yeah, we need flexibility’ and ‘I like being able to build it my way.’ . . . I'll be creative but I need some kind of guidance, and I think that has been really frustrating, so that we don't end up . . . having to go back and totally reinvent the wheel six months later because DHCS has sort of changed their position.”

—MCP, Southern CA

“The cadence of new initiatives that are being rolled out is extremely aggressive. We are still getting our feet on the ground in terms of Enhanced Care Management, Community Supports. Now we've got to start thinking about the justice policy guide.”

—MCP, Southern CA



Rural Providers Face Additional Engagement Challenges

Participants in the Homeless Services + Medical Respite and Discharge Planners groups who work in rural areas say they do not have Community Supports organizations in their communities. This means they have to rely on regional organizations that are often based far away and have not built trust and rapport with members. Especially with unhoused members, building trust is necessary to engage them.

"In theory it sounds awesome but we are very rural, so there is just not a lot of programs here. We often send patients two hours, three hours away for skilled nursing that have managed Medi-Cal because nobody takes them up here. . . . The closest homeless shelter is 30 miles away, so we have to taxi them there, or try to arrange transportation through their managed Medi-Cal, which I can tell you just yesterday I spent one hour and seven minutes straight on a phone call trying to secure a ride."

—Discharge Planner, Rural North

"People that we do refer for ECM services that don't fall into that criteria get shipped to a regional provider who doesn't have a footprint in our area. . . . They are trying to ship them 3.5 hours away. . . . It is hard enough to get them to say yes to Community Supports when they know us, but trying to get them to go to a provider that is a regional provider and does not really have any foundation in the area. I mean it is a small rural community. It is about trust, and where you don't have that trust, they're not going to talk to them."

—Homelessness, Rural North



Managed Care Plan Participants Are Struggling with Low Engagement in ECM; This Shows Up for Others Too

A few managed care plan participants also report very low rates of engaging and enrolling members into ECM. While they're able to get people into Community Supports, they struggle to get people enrolled in ECM in some areas.

"For the Enhanced Care Management, because we are focusing on the highest need with the highest, most complicated, complex medical, social, emotional needs I think it has been difficult to engage and enroll eligible members into ECM. I was in a conversation with my colleagues across the state, and we all landed in the space of saying, 'You know what, if we are hitting 20% of engagement, that is success because we have plans in certain communities that are hitting 6%, 10%, and so 20% is the gold standard.'"

—MCP, Central Coast

"It has not changed for us under CalAIM. We haven't really seen ECM and Community Support services take off yet. I know a lot of counties are still very much in the planning phases around that."

—Discharge Planner, Southern CA



Behavioral Health Leader Participants Say That Documentation Reduction Is Not Yet Having Impact

County Behavioral Health Leader participants say they aren't reducing the amount of documentation required for themselves and their contracted providers because they're worried about being audited. In some cases this means providers are completing all of the old documentation requirements, *as well as new additional* documentation required by CalAIM.

"With the county that I work in, we were trying to go leaner, but they have continued to request extra documentation, so not only are we now doing a care plan but we are also doing regular treatment plans still. We are doing the old work and now what is being required of CalAIM simultaneously, which is really frustrating when the whole point of CalAIM was to kind of take the decisionmaking out of counties' hands, but counties are still holding us to these. . . . What you are supposed to do, and here is what the state is saying simultaneously."

—Discharge Planner / Behavioral Health, Central Coast

"Even if I can get all of my providers to do lean documentation, we are getting different responses from our county auditors that are still like working under the old way of thinking. . . . A culture shift is needed."

—Discharge Planner / BH, Southern CA



Inconsistency with No Wrong Door Policy

Some in this group have seen bumps in the road when it comes to No Wrong Door, saying either that the screening tool implementation is inconsistent, or that there are disagreements about who should be treating clients at different ends of the scale.

"We have to implement the screening tool, but if I walk into the door of a clinic, because of No Wrong Door, I don't have to get that screener. So I present the same way either at the access center or at a clinic. . . . I may get specialty mental health services at one place, or I might get transitioned to the managed care plan if I go through access."

—Discharge Planner / BH,
Central Coast

"We've actually seen a really significant shift in those referrals in the last two months since our Centralized County Call Center implemented the screening tool from DHCS. They have been screening out the mild to moderates pretty aggressively. . . . We are getting calls from [County] Health Plan, which is our managed care plan, saying, 'What is going on? . . . We need to send them to you for access. How do we get them to you because if we call the call center, they score 5 or lower and then get routed back to us?' We're saying, 'They're not supposed to be in our system. We are the specialty mental health. You handle mild to moderate.' We handle specialty mental health and they are not prepared for this. . . . I am really concerned about their ability to provide services to those clients, which we were serving . . . just fine before."

—Behavioral Health, Bay Area



CBOs Say They Are Not Getting Enough Referrals

With the caveat that this group is mostly asthma remediation, the top-of-mind challenge for participants is that they are not getting enough referrals to meet their expanded capacity, even when they have contracts in place.

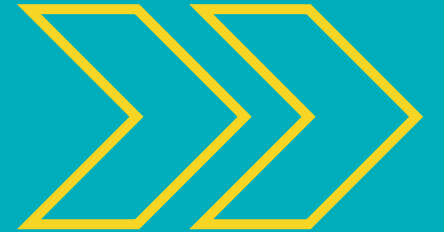
"We were kind of promised, hey, you are going to have access to a ton of members; you are not going to know what to do with them and you are going to be busy. I have seen the complete opposite of it. You don't have to sell me on the benefits of the program. . . . We've just got to get in there and do it, but I feel like there is a complete disconnect. We didn't sign up for this anticipating having to generate 100% of all our referrals from the street level and educate the community and the providers. . . . And we are standing here holding this bag, burning grant money to stay alive, and I don't have any members coming to me. I don't have one referral or member yet, and I've got trained staff ready to go."

—CBO, Greater Sacramento

"When the program was initially promised, we expected to get all of these referrals. We wrapped up, and everybody is ready and as we are sitting around. . . . It is like hearing crickets. . . . We are burning critical resources as our workers are waiting to get their referrals, grant resources. It has just been very confusing. I've been part of a lot of the CalAIM resource webinars, and it seems sometimes like the program managers really don't understand the program, I guess."

—CBO, Greater Sacramento

In Their Own Words: Participant Ideas About Solutions and What Works



Standardization May Streamline Collaboration

Challenge: Lack of standardized processes

Idea: A few ECM participants want the referral process streamlined, and they suggest letting them come up with a list of Community Supports providers so that referrals can automatically go to the correct provider.

"We should be asked or surveyed of who the Community Supports should be, and then you just streamline the referral."

—ECM, Bay Area

Bright spot: A Medical Respite participant says the state requirement for timely responses for authorizations has helped the coordination between their hospital and the MCPs.

"I will give credit to CalAIM because . . . our intake process has improved significantly since January 2022. I would say it is fundamentally different in a very positive way. The hospitals get the program now, and they understand the process working with managed care plans. Managed care plans are doing your best to expedite placements. Authorizations — I think they are mandated by the state to respond within 72 hours. That is still not quick enough to be honest, but it is definitely a much better improvement than the way it was."

—Med. Respite, Southern CA

Sharing Information and Data Exchange Solutions

Challenge: Lack of information

Bright spot: A couple of managed care plan participants say that having a dedicated CalAIM team as part of their organization has helped them keep open lines of communication with providers.

"We created what we call the CalAIM [physician assistance team], and so those individuals report to me, and they interact directly with all of the providers. . . . They have either biweekly or even sometimes weekly calls with the providers, but that is also going to play into quality, like ensuring that we have a pulse on how effective they are being, what are we seeing in terms of their metrics, and all that good stuff."

—MCP, Southern CA

Bright spot: Participants in several groups talk about data exchange that has given them easy access to data they might not otherwise have had.

"We are very fortunate that our Epic system is connected with our local hospitals and our regional hospitals, so we can actually read the hospital notes. We also have access to a special Epic portal to be able to reach other hospitals with even more information on there. . . . You can as yourself, as a care team member, and ask for you to be notified about admission and getting any lab results, that type of thing."

—ECM, Bay Area

Bright Spot for Trust and Collaboration

Challenge: Lack of trust between providers and managed care plans

Bright spot: A Discharge Planner says they have had positive experiences working with a managed care plan around postacute placement.

"I have had some success with [MCP] in terms of how they are able to navigate a lot of their patients and how to utilize the resources that they do have. . . . I have been able to contact one of the enhancement, high-risk case managers who is out in the field. . . . I have had positive outcomes with [one MCP] with them reaching out to skilled nursing facilities, reaching out to transitional housing to see what they can do in order to help and facilitate."

—Discharge Planner, Inland Empire/Desert

Cross-Sector Collaboration Is Emerging (1 of 2)

Challenge: Little new collaboration

Bright spot: A psychiatric care organization is partnering with a housing agency to offer joint services to each other's clients.

"We started partnering with a housing agency where we provide the mental health services to the individuals who are placed in the housing program there, so that has been a new partnership. . . . So we contract to provide assessment — case management assessments to understand what we can do to link them to other social supports, other health-related social need items. We provide counseling in groups and support groups and some socialization activities. It has worked out really nicely."

—Discharge Planner / Behavioral Health,
Southern CA

Bright spot: A local committee is bringing together different stakeholders.

"We actually now have a steering committee that is made up of members from our managed care plan, which I've never seen . . . before, and it is amazing to have relationships with them now. Our local hospitals, our primary care clinics, our Drug Medi-Cal, people we don't even have contracts with but people who are in our system."

—BH County, Central Coast

Cross-Sector Collaboration Is Emerging (2 of 2)

Challenge: Little new collaboration

Bright spot: A managed care plan talk about HMIS data exchange helping them keep track of and manage different services unhoused members are receiving.

“Previous to CalAIM, we were not getting data from our HMIS system in our service area, and CalAIM facilitated that and allowed us to work with the continuum of care — the county departments who oversee that with regards to what kind of services our homeless members are receiving. . . . If we can model the HMIS system and apply that to our behavioral health or other systems, that would be wonderful.”

—MCP, Central Coast

Reducing Discharge Bottlenecks

Challenge: Tension about who owns different processes

Idea: Some Discharge Planner participants recommend accountability for MCPs to provide speedier authorizations, especially over weekends, so that patients are not staying in hospitals longer than is medically necessary.

"How to get the DME more on time, or how to utilize the authorizations, or when to get the authorization, especially when we're heading into the weekend. . . . Sometimes they are waiting in the emergency room until Monday just to make sure we can process skilled nursing facility, home health needs if it is IV antibiotics or what have you, or maybe they are waiting because they are waiting on medical equipment that just for whatever reason — it was after 3:00 and the insurance just did not want to provide anything."

—Discharge Planner, Inland Empire/Desert

Idea: They also recommend facilitation of more skilled nursing facilities and home health agencies accepting more managed care plans. They say placement has been very difficult because facilities are not accepting some plans, and they feel caught in the middle without a way to help their patients.

"Just SNF taking the patient as well as home health agency. I can't get a home health agency to take an [MCP] patient. . . . And it is the patient that suffers."

—Discharge Planner, Southern CA

Earlier Guidance and Extended Deadlines

Idea: Managed care plan participants want specific guidance to come earlier in the process because they feel there is not enough time to implement it on current timelines. They are especially concerned about getting the next phase (justice involved) “right” and want to extend deadlines for that phase.

“The justice one is going to be a really thorny one, and I think that is one that the train is not too far down the track so that would be a good delay, delay, delay until we figure it out. . . . Let’s do that one right, because a lot of eyes are on us with that [lever] and California being the lead on this. . . . Let’s do it right and not rush to get something done. That would be my parting thought.”

—MCP, Central Coast

Spotlight on Homelessness Services

Challenge: CalAIM not set up for unhoused members

Idea: Participants who work in homeless services want DHCS to show providers that CalAIM is built for their challenges and to put an increased focus on how important housing is to improving outcomes.

“I hope they are gathering long-term data on what they are saving by keeping people in housing. Again, as a housing provider . . . it is not really understood what a contribution it is to get someone off the street. It is way more valuable than they are recognizing.”

—Homelessness, Rural North

Negotiation Has Helped Overcome Rate Challenges

Challenge:
Reimbursements don't
cover costs

Bright spot: One Medical Respite participant talks about banding together with other organizations to negotiate a contract that was better than they otherwise could have gotten.

“Because we are subcontracted through our clinic consortium, they act as a mediator and negotiate contracts and submit a lot of the data for us and for seven other FQHCs in the county . . . [in another county] that was useful for recuperative care. There were only two of us who were going for contracts with county, and we banded together and told them what we had to get paid.”

—Med. Respite, Bay Area

Incentives Are Also Possible Solutions

Bright spot: Homelessness Services participants want acknowledgment of the importance and time required in outreach, and would like reimbursement to take that time into account — especially given that outreach often comes before the actual enrollment and services.

“One of our counties is offering more incentives to hire more people and paying when the person is hired when, I think, they have 15 people enrolled and, I think, when they have a full caseload or something like that — some incentive dollars. But I feel like that should be almost like a given in the program.”

—Homelessness, Bay Area

Challenge:
Reimbursements don't
cover costs

Idea: One Medical Respite participant recommended that payments be partly based on outcomes to incentivize more collaboration and outcome-focused work.

“We are okay working a little bit at risk. If you want to make 10%, 15%, 20% of our reimbursement based off outcomes, I think that would be a cool way to incentivize our industry.”

—Med. Respite, Southern CA

Making Documentation Reduction the Norm

- Idea: Behavioral Health Leader participants want clarification on documentation requirements, and for the state to assure counties that they will be able to pass audits later on if they are adhering to state minimums.
- Idea: Some participants want DCHS to work with (or even push) counties to reduce and standardize documentation requirements — in line with CalAIM's goals. Participants feel this is an urgent need, especially as documentation time is not going to be billable after a certain point.

"I really would like the state to know that they need a way of monitoring when counties are setting higher standards than the standards that they have identified through CalAIM. They should see that as a problem because it is creating a lot of confusion, and I think counties need reassurance from the state that the state is really embracing this model and that they're not going to get dinged."

—Discharge Planner / BH, Southern CA

"For years we've been going, 'Why can't the state just sort of help set a norm that all the counties can operate around?' And I think there is this balance between adaptability that counties are given and the uniformity that is needed to really create cohesion to move things forward. . . . I am hoping actually that the state moves a little bit more toward enforcing. We have counties we are working with that are saying, 'Well, the state lowered documentation standards, but we are going to add back this much,' and we really wish the state would say, 'You cannot do that.'"

—Discharge Planner / BH, Bay Area

Reducing Audits and Compliance Culture

Challenge: BH Reforms

Idea: Some Behavioral Health participants want to pause some of the auditing and monitoring requirements so they can focus on building systems rather than on compliance for now. They say this would allow a more client-driven approach because they currently feel they are being forced into a compliance-driven approach.

"I would say that administratively this is a huge, huge, huge burden. . . . It is a huge lift, and I think they need to pause on certain requirements that we have to implement with our CBOs, like auditing and monitoring, and of them auditing and monitoring us. Like this is a huge lift in a QI/QA scope, and then when they continue to audit us month after month, it takes our time away from being able to attend to all of the CalAIM activity."

—BH County, Bay Area

"Shifting to not being so compliance driven, being more client driven around what clients need. Everybody in our system is carrying around PTSD from years and years of state and county and federal audit recoupments for dumb stuff because an 'i' wasn't dotted. . . . It is like the rate changes maybe should have been three years from now when there had been time to actually make all of the cultural changes that underpin the rate changes."

—BH, Bay Area, Central Valley, Southern CA to Inland Empire/Desert

Bringing Behavioral Health CBOs to the Table — Not Just Counties

Challenge: BH Reforms

Idea: Some Behavioral Health Leader participants just generally want more opportunities for collaborative decisionmaking between counties and community-based partners. They feel that decisions were being too siloed, which leaves a big burden on counties and community-based partners trying to implement all these things.

“The need for collaborative decisionmaking between the counties and community-based partners. . . . Just to be intentional . . . have the conversations that we need to have to do this right because it is going to be hard to back walk it if we really back ourselves into a corner, and it is [coming soon].”

—BH, Bay Area

“There have been tons and tons of DHCS county meetings, and CBOs specifically and intentionally have explicitly not been invited to the table when they are the ones in California doing the bulk of the direct service work. . . . There has not been everybody at the same table for the big conversations and the big discussions, and that is creating some of the problems that we are seeing now.”

—BH, Bay Area, Central Valley,
Southern CA to Inland
Empire/Desert

Sustainable Pathways for CBO Referrals

Challenge: Lack of referrals for CBOs

Bright spot: A managed care plan is working with its existing CBO partners to expand services offered and focus on sustainable volume in response to the concern about too few referrals.

"We took the approach of not wanting to saturate the network with providers and not being able to give them enough people to create sustainable pathways, and that was very intentional on our part because we had heard from a lot of our community-based organization partners that in order to really do this, they needed 'x' number of people to keep that going. We have instead taken an approach of rather than adding new providers, expanding the services that the community-based organizations provide, and so we have a number of providers in our network who are providing both ECM and Community Supports and/or multiple community supports there as well."

—MCP, Bay Area

thank you!

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