CHCF PERSPECTIVES FROM THE FIELD

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by J. Duncan Moore, Jr

Counties Lean into CalAIM

The state of California's comprehensive Medicaid reform effort, known as CalAIM (California Advancing and Innovating Medi-Cal), is one of the nation's most comprehensive and far-reaching efforts to make Medicaid truly patient centered. The need for these reforms is felt most strongly by people with complex health and social needs, such as those with medical conditions who are also experiencing homelessness, living with serious mental illness or substance use disorder, or returning to the community after incarceration. Prior to CalAIM, California's counties piloted innovative approaches to better serving people with complex needs through an initiative known as Whole Person Care (WPC). Under WPC, each pilot was administered directly by counties that opted in and contributed local dollars to match federal resources to fund the program. Each county developed its own approach, and most counties provided direct services in addition to administering the pilot.

The most promising services piloted in WPC have since been scaled up statewide through CalAIM in the form of two programs: Enhanced Care Management (ECM) and Community Supports. However, the responsibility for administering those services has been passed from the counties to managed care plans (MCPs). Funding now flows through Medi-Cal MCPs and has moved away from a grant-like structure under WPC to fee-for-service, capitated, and bundled payment structures under ECM and Community Supports. Yet, California's counties still have important contributions to make. They are critical providers of care, as well as partners to both the MCPs and local organizations that support this high-need group of enrollees.

This brief highlights how select counties have adapted to CalAIM and are now acting as intermediaries between MCPs and local providers while also continuing to care directly for people with complex health and social needs.

Promising Approaches for Californians with Complex Needs

The kernel at the heart of the CalAIM reforms for people with complex needs is a new capability to cover services that address health related social needs in people's lives that, left unaddressed, may result in the need for more intensive health care services down the road. Over half of Medi-Cal spending is attributable to the 5% of enrollees with the highest needs. By integrating medical services and social services, CalAIM's Enhanced Care Management and Community Supports aim to improve health outcomes. They may also reduce the likelihood that Medi-Cal enrollees will have to be hospitalized later. For example, until someone's housing insecurity is addressed, it may be difficult for them to get their health under control. Therefore, CalAIM seeks to scale up the delivery of integrated services that address health-related social

About the Perspectives from the Field Series

As California's Department of Health Care Services administers changes to the Medi-Cal program, especially those that are part of the CalAIM initiative, CHCF is intermittently publishing short reports that highlight the perspectives of those in the field who are implementing the changes. These "Perspectives from the Field" seek to inform policymakers and other health care leaders about insights and experiences from people on the ground who work directly with patients.

needs, which have been shown in pilots to improve outcomes while reducing spending.

That scale-up is taking the form of Enhanced Care Management (ECM) and Community Supports.

- **Enhanced Care Management (ECM)** is a new statewide benefit designed to address the clinical and non-clinical needs of complex enrollees in nine "populations of focus" through the intensive coordination of health and related services.[1] The program will meet people wherever they are — "on the street, in a shelter, in their doctor's office, or at home," per the state's Department of Health Care Services.[2] Each patient who qualifies will have a single lead care manager — in effect, a navigator or concierge — who will coordinate physical, behavioral, dental, developmental, and social services. For patients with very complex needs, and who are possibly not in optimal care settings, the intervention of a care coordinator who will advocate for them and weave together a net of services can literally be a life saver.[3]
- **Community Supports** are optional new services that can be provided by Medi-Cal managed care plans as cost-effective alternatives to medical care. There are 14 Community Supports designed to address social determinants of health. These include such offerings as medically supportive meals or housing supports. Medi-Cal members may qualify for Community Supports regardless of whether they qualify for ECM services.[4]

ECM and Community Supports are outgrowths of Whole Person Care, which was piloted by 25 counties between 2016 and 2021. Under the program, counties proposed structures and services for their pilots and were awarded funding, similar to grants, to develop and lead programs to coordinate social services, care management, outreach, and engagement for people with complex needs. Concepts that yielded favorable results in those selected counties have been incorporated into these two programs, which are both administered by MCPs. ECM is a benefit, while Community Supports are optional add-ons that plans can choose to offer. As a result, in some cases, services that were bundled under a WPC pilot are now divided into two separate programs.

Moving services into this structure is foundational to these services becoming permanent parts of the Medi-Cal program, but the changes in approach and funding have proved challenging for many providers of services. The changes have imposed a particularly steep learning curve on health program administrators and providers in California's county governments, who by and large are supportive of these new initiatives but have faced obstacles in the first year of implementation.

Counties Serve as Central Players

By history, tradition, and law, California's 58 counties are responsible for a subset of services for their residents. They enroll people in Medi-Cal and other programs; administer — and in some cases provide — behavioral health care and care for children with special health care needs; and provide social services related to homelessness response, child welfare, aging, and disabilities. Counties also play an important role in local law enforcement and correctional services.

California is somewhat unique in the freedom that the state has permitted its counties and the obligations it imposes on them. Counties fund much of the non-federal share of the Medicaid-covered services they administer. As a result, they have been allowed to develop and manage services according to local needs and resources, within the frame of federal and state regulations. Not surprisingly, urban and suburban counties with high household incomes have been able to offer a richer array of services, while smaller or rural counties have fewer resources and services.

Some counties have public hospitals and clinics, which have served as the hubs around which counties have organized services for people with Medi-Cal coverage and those without insurance. In recent years, as part of health reforms, these provider systems have moved services out of hospitals and into various community settings that are closer to patients.

In short, counties have the potential to serve as linchpins in the delivery of whole-person care. This paper highlights the perspective of counties that participated in the Whole Person Care program, with the intent of identifying lessons learned and insights gained that may be useful for those counties that are newer to this work and may be overwhelmed by the timelines, managed care requirements, and heightened expectations coming from the state. It will focus on four counties in particular – Alameda, Placer, Ventura, and Contra Costa – whose officials support the goals of CalAIM and have insights they want to share.

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– County official

To find out how counties have navigated these changes, we talked to people on the ground who have been charged with implementing ECM and Community Supports. These public servants have been working long hours against difficult headwinds, first to introduce Whole Person Care, then to transform themselves into emergency pandemic response organizations, and finally to reconfigure their programs to meet the requirements of CalAIM. It has left many of them worn out and depleted.

Yet there remains a spirit of optimism. Nobody we spoke to wishes to return to the status quo. As one county official told us, "Expanding these programs so they serve more people – it's a good thing, I think. Enhanced Care Management and Community Supports are going to help a lot of people in California."

Commentary from the counties revolves around certain themes:

- Services
  - Housing needs to be a top priority.
  - Integrating behavioral health into a seamless web of services is critically important.
- Administration
  - Work force hiring, training, and retention is a challenge.
  - Data exchange and a strong information technology infrastructure are essential.
- Cost and Billing
  - Billing for services is different than under WPC.
  - Payments do not cover the costs of services provided.

In the pages that follow we will hear from these county health administrators as they describe what has worked and what remains to be refined in CalAIM implementation.

Alameda County

In Alameda County, across the bay from San Francisco, the transition from Whole Person Care to CalAIM has gone relatively smoothly. While it has not been a copy-and-paste pivot, the county's pre-existing strong relationships with MCPs have eased the way forward. The foundation the county had in place – supportive health plans, strong data collection tools, confidence from the board of supervisors, and high morale among staff – ensured a high level of trust and capability. It was thus straightforward to set up regular weekly meetings between county officials and health plans and to coordinate on data exchange.

"As we started CalAIM, there would be times when we submitted a file, and it had errors. However, our MCPs wouldn't flat-out reject our files, leading to no payment. We would work with them to resubmit with new information," said Kimia Pakdaman, a program specialist for CalAIM at the Alameda County Health Care Services Agency. "They have been very flexible in adjusting their systems to work with our systems and processes. A lot of counties have difficulty reaching their health plans or coming to agreement with the health plans. That is not the case in Alameda County."

Two Medi-Cal managed care plans operate in Alameda County: Anthem and the Alameda Alliance for Health, a local not-for-profit entity. The Alliance covers the majority of Medi-Cal enrollees and has a broader network of local community-based providers. It is also very flexible in its operations. Anthem, a national plan, brings helpful capacity, particularly on IT and data exchange, as well as a statewide perspective on what's important to prioritize, Pakdaman said.

Pakdaman described her role as "to work across departments — Public Health, Office of Homeless Care and Coordination, and Behavioral Health — to make sure we're coordinated in implementation and communications with health plans and the state."

The county's Social Health Information Exchange (SHIE) was a major legacy left from the Whole Person Care pilot program. This repository receives data from 19 sources across organizations that work in the areas of behavioral health, homelessness, managed care, physical health, criminal justice, and public health. The SHIE can assist in rounding out a complete picture of each person's engagement with the safety net and other aspects of the care delivery system.

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– Kimia Pakdaman, Alameda County Health Services Agency

Every month, the county health agency sends its health plans a population health file that details key information gathered from various systems of care for each of their members. "This type of data exchange has been very important in CalAIM, given the need to work across the system, and also [to educate] the health plan on non-clinical data," Pakdaman said.

Internally within the county's health services agencies, morale is high, reports Pakdaman. "There's an energy around making CalAIM work for us. We want to advocate for what helps people the best. We are excited about CalAIM being a way to work across our departments in a way we don't normally. We have weekly meetings with our homelessness, public health, and behavioral health CalAIM teams. This is a different level of coordination than we have had to do before. CalAIM requires that."

The county's board of supervisors has been highly supportive of the CalAIM transformation, particularly when it comes to the criminal legal aspects of the program. "They have safety net responsibilities," said Aneeka Chaudhry, Assistant Director of the Alameda County Health Care Services Agency. "Community-based organizations are such a big voice in our local community, our board wants to make sure there is diversity in the provider base. They want to make sure the providers resemble the people who need services."

Many of these small community-based organizations (CBOs) are providers of housing services, one of the anchors of the CalAIM model. Often, they do not have experience billing Medi-Cal. This is where the county can offer real value by helping new providers understand billing and claims — which has benefits for MCPs, CBOs, and the clients themselves.

"In the managed care space, they are supposed to deliver care in a certain way. Then there is the homelessness space, a separate system of care," Chaudhry said. Housing is very often the key to stabilizing a patient's health status; without it, they can lurch from emergency to emergency, and for Medi-Cal patients, the MCP is expected to coordinate the care and foot the bill.

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– Aneeka Chaudhry, Alameda County Health Care Services Agency

"We have had to do a lot of work with our partners to understand the homelessness system of care," she said. For example, the US Department of Housing and Urban Development requires housing providers to have coordinated entry, that is, a single assessment of health, housing, and income factors. Linking the services surrounding homelessness and health care has been a useful role for the county to fill.

"If we focus on people who have high needs or are behaviorally complex, housing is often also an issue," Chaudhry said. "We can't use the Medicaid money for rent, so we work [with] our health plans to find different pathways to housing. Health plans and the housing system speak different languages and have different things to report to the state. But the state has put out a couple of incentive programs that have given us a chance to work with our managed care plans on key homelessness services."

The county administration gets a lot of inquiries from providers that offer services to meet the social needs of the Medi-Cal client base and want to learn about and understand CalAIM. The county offers education and training for small providers to help them connect to the MCPs and considers this capacity-building and infrastructure support to be critical for its local CBOs.

Placer County

For many years, Placer County has placed an emphasis on housing people with complex needs, which set it in good stead for the rollout of Whole Person Care. Building on that foundation made for a smooth transition under CalAIM, with little disruption for Medi-Cal enrollees.

Geoffrey L. Smith, the program lead for CalAIM, is especially proud of Placer County's success in finding permanent housing for people experiencing homelessness. "When Whole Person Care finished, we were at about 180," he said. "A few months later we got to 200. I only counted people as housed when they were permanently housed. It was a pie in the sky goal, but we actually reached it!"

Smith came to Placer to start the WPC program. "I would hear these programs saying, 'We housed eight people this month.' They'd house somebody in unsustainable fashion," by throwing a lot of money around that wouldn't be available in three to six months. "I made it a focus to follow our clients. If they became unhoused, we uncounted them," he said. He sees many of Placer's innovations incorporated into the statewide rollout of ECM and Community Supports.

Smith cites the flexibility of the WPC program as a key to its success; every county established its own priorities and customized its program to address them.

Placer's program was tailored to people coming out of jail or prison, people experiencing homelessness, people with mental health conditions, and people who use a lot of acute or crisis services. To support them, Placer's WPC pilot had four service bundles: 1) medical respite, 2) comprehensive complex care coordination, 3) outreach and engagement, and 4) housing. The housing program included dedicated housing coordinators who worked directly with clients to assist with rent subsidies, all in a bundled rate. And those bundles left more money to work with, which afforded favorable staff ratios.

"It was really nice to be a part of that [Whole Person Care] program that was so well funded, have all the success, see people get housed. … For it to switch — small picture, that's been difficult. Big picture, a lot of people need these services. But it's not sustainable to provide those [whole-person care] services at that level to this many people."

– Geoffrey L. Smith, Placer County

With ECM and Community Supports, the MCPs set many of the parameters. In some cases, the funding from plans has required changes in care and staffing models. At Whole Person Care's peak, Smith ran a team of 20 health professionals and community health workers. "Now it's about seven, a huge diminution," he said. ECM and Community Supports each have 3.5 full-time staffers. Reimbursements from the plan don't cover the program costs for staff, IT, and administration, so the county has shifted staffers to other programs.

Care managers who had a case load of 12 to 15 people under Whole Person Care are now expected to handle 40 people based on the MCP's approaches and funding levels. This alters the relationship between care manager — the navigator whose job it is to link Medi-Cal patients to services and benefits, make phone calls, and organize doctor's visits — and client. "Before, we'd have four or five staff helping somebody moving into a new place. Now we can do a little bit of that but not nearly the same. You have to be more judicious about the services you provide. That's been a difficult transition for my team, to be able to provide intensive individual services and then go to a model that is not the same," said Smith.

"It was really nice to be a part of that program that was so well funded, have all the success, see people get housed," Smith continued. "It's inspiring to be a day-to-day part of their lives, to make a difference. They are forever grateful."

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Ventura County

If there's a sweet spot for the implementation of ECM and Community Supports, Ventura County seems to have found it. The programs that the county had previously set as priorities for Whole Person Care have been expanded under CalAIM. Solid MCP relationships were already in place, and the county had a trained and engaged social services work force ready to pick up the gauntlet. Continuity of care was preserved and enhanced.

"Enhanced Care Management looks remarkably like our case management model," said Rachel Stern, MD, the county's chief medical quality officer for ambulatory care, who came from San Francisco to help implement CalAIM. It's designed to offer high-intensity, high-touch services for the 1%–5% of people with severe health problems, she said, adding: "We did not have to change the clinical structure at all."

That clinical outreach was directed toward people with extremely high use of acute services and people with substance use disorders, people experiencing homelessness, or people recently released

from incarceration. The menu of Community Supports fits right into their model. "Case management, housing services — we had pretty rapid standup capacity for those," said Deanna Handel, director of complex care coordination and system integration for the Ventura County Health Care Agency. They were already doing recuperative care as well, also known as medical respite, and two county buildings are being retrofitted for recuperative care and housing.

Because patients were so familiar with the array of services and providers in Whole Person Care, the county decided not to change the name of the service. "We had good brand recognition," Stern said. "We didn't want people to have the sense they are losing their service" by rebranding it.

Patients like the multidisciplinary approach that the county offers, Handel said. "If you have a behavioral health condition, you have someone assess your mental condition. If you have a substance use disorder, you have access to a trained professional. They work together in a coordinated way to address the entirety of needs for our patients."

Medically tailored meals are one of the new services under Community Supports that have enjoyed broad uptake, with well over 500 people in the county receiving meals. The service was implemented by the county's Agency on Aging, which came into CalAIM with strong vendor connections after having distributed thousands of meals to people in need during the pandemic.

That agency lost its funding when COVID-19 relief money ended, however. "We said, your expertise is in providing meals. There is a Community Support for this," Stern recalled. "To do this, you have to learn how to accept referrals from the managed care plan and learn how to bill for the services. That's the hardest thing for agencies and vendors to learn to do under CalAIM."

"They are having a hard time learning to bill. We are asking them to do something that other professional people identify as a major source of burnout."

– Rachel Stern, Ventura County Health Agency

Handel and Stern provided technical help to their agency partners to teach them how to bill. MCPs, they pointed out, expect to get information through medical billing and claims. Thus, the county officials had to take a social services model and turn it into a medical billing model. That has been a huge lift. Just getting it set up required biweekly meetings with county IT and health records staffers and another set of meetings with the MCPs.

"It is extremely difficult to ask non-medically trained people to learn to do medical billing," Stern said. Citing an example outside of CalAIM, she added "a doula is used to being paid a lump sum at the beginning for their services. Now that person has to bill in increments and provide diagnosis codes."

As a physician, Stern learned the importance of billing early in her medical career. But that is not something a community health worker expects to have to do. "Our community health workers are exceptional," she said. "They come from a similar background as the people they serve. Many are bilingual. They are so tied to the community. They are having a hard time learning to bill. We are asking them to do something that other professional people identify as a major source of burnout."

The county's close relationship with its local MCP, Gold Coast Health Plan, which is the sole public Medi-Cal MCP in Ventura, has made the work move along more smoothly than it might have. "One thing we've done well, we had a strong partnership with our plan," Handel said. "They recognized the fount of expertise in the county to provide the services. They partnered with us in implementation of CalAIM."

"You'd think it would be easy for us to do this, but it has not been easy," Stern said. Handel added: "There has been one new change after the next in a six-month cycle. It's a lot to implement in a short time, and a lot to digest. That's been a struggle for both the counties and the plans."

Contra Costa County

Contra Costa County's enthusiastic embrace of Whole Person Care produced real results that have been incorporated into ECM and Community Supports. The loose, entrepreneurial spirit behind Whole Person Care – and the flexibility in funding – allowed the county to rapidly innovate and do things that otherwise wouldn't have been possible under normal government procedures.

"We gave out cell phones and saw how homeless patients could use cellphones to get appointments," said Elizabeth Hernandez, quality director for the Contra Costa Health Plan.

"We purchased Uber and Lyft for patients to get to social services and medical appointments. If somebody needs to get to court or to the Medicaid office, Medicaid doesn't traditionally cover non-medical transportation. Or housing deposits. We were paying first month's rent for patients."

"Waivers are waivers, and they have an end; that was Whole Person Care," Hernandez said. "The main advantage to CalAIM is that ECM is a benefit now. It's codified."

– Elizabeth Hernandez, Contra Costa Health Plan

These innovations worked. Hernandez and her colleagues published a large-scale study of 58,000 Medicaid enrollees looking at whether the case management program in Whole Person Care reduced medical care and expenses for the cohort.[5] The study, published in July 2022, found that the intervention reduced total inpatient admissions by 11% and reduced emergency department visits by 4%. The program appeared to be particularly effective at reducing avoidable hospital admissions for diagnoses such as hypertension and diabetes complications. The greatest reductions in ED and inpatient admissions were seen for patients under 40 years old. In addition, relative to other groups, Black patients experienced the greatest reductions in inpatient admissions. Feedback from case managers suggested that the program "helped patients build trust with the health system, resolve basic social needs, and better navigate the care landscape."

By formalizing the best of these innovations across the state and ensuring a dependable line of money, CalAIM has implicitly offered all Californians covered through Medi-Cal the possibility of achieving similar advances.

"Waivers are waivers, and they have an end; that was Whole Person Care," Hernandez said. "The main advantage to CalAIM is that ECM is a benefit now. It's codified. Oftentimes grants make us lean on short-term structures and workarounds. Now there is sustainability and structure, and it's part of the benefit package. And there is longevity, with a permanent funding stream. This allows us to create long-term system design for our county."

For county administrators the length and breadth of the state, that permanent funding creates a real opportunity to make solid gains in their local population's health status.

Conclusion

CalAIM's Enhanced Care Management and Community Supports build upon the successes and lessons learned from the Whole Person Care pilot programs implemented by various counties. The transition to CalAIM has not been without its challenges, particularly in the reconfiguration of funding streams and the shift of responsibilities from counties to managed care plans. However, leaders in counties like Alameda, Placer, Ventura, and Contra Costa have adapted to these changes, leveraging their prior experience, data infrastructure, and trust-based relationships to forge strong partnerships with managed care plans to ensure continuity of care. Counties play a critical role in delivering patient-centered care, combining medical and social services to enhance health outcomes, and potentially reducing long-term healthcare costs.

About the Author

J. Duncan Moore, Jr, is a freelance writer based in Chicago who has been writing about health care for more than 25 years.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. ***Medi-Cal Transformation: Enhanced Care Management*** (PDF), California Department of Health Care Services (DHCS) , accessed October 18, 2023.
2. "**Enhanced Care Management and Community Supports**," DHCS, last modified August 28, 2023.
3. J. Duncan Moore, Jr., "**How a Managed Care Plan Helped a Young Man Move Out of a Nursing Home**," CHCF Blog, December 13, 2022.
4. For a detailed history and evaluation of the transition from Whole Person Care, see: Nadereh Pourat et al. ***Final Evaluation of California's Whole Person Care (WPC) Program*** (PDF), UCLA Center for Health Policy Research, December 2022.
5. Daniel M. Brown et al. "**Effect of Social Needs Case Management on Hospital use Among Adult Medicaid Beneficiaries a Randomized Study**," *Ann Intern Med.* 175, No. 8 (Aug. 2022): 1109-1117.