CHCF

PERSPECTIVES FROM THE FIELD

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by Claudia Boyd-Barrett

CalAIM Perspectives: How to Improve Enrollment in Enhanced Care Management

A first-of-its-kind convening in October brought together Medi-Cal managed care plans, health care providers, and community-based organizations from across the state to swap insights, share innovations, and develop ideas for boosting uptake of Medi-Cal's ambitious new Enhanced Care Management benefit.

Enhanced Care Management (ECM) is foundational to California's efforts to transform Medi-Cal under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.[1] Launched in 2022, the goal of ECM is to ensure Medi-Cal members with complex needs receive comprehensive care and support by assigning a lead care manager to coordinate all their health and health-related care, including social services.

As with most major initiatives, the implementation of ECM is challenging. Managed care plans (MCPs) must recruit and partner with a wide range of providers, many of whom have never worked within the Medi-Cal system before. Together they must create new workflows, build mutual understanding and trust, and hire and train qualified staff to ensure a sufficient workforce.

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>
> -Belén Arangure, ECM program manager, Northeast Valley Health Corporation

Above all, MCPs and ECM providers are tasked with figuring out how to effectively reach the Medi-Cal members that ECM is intended to help and deploy the benefit in a way that truly enhances these patients' care and wellbeing.

The two-day October meeting, titled CalAIM Implementation Share & Learn, presented an inaugural opportunity for MCPs and ECM providers from various regions to discuss these challenges collectively, listen to each other's perspectives, and engage creatively in identifying solutions. Organized by CalOptima Health and Health Plan of San Mateo, facilitated by the Center for Care Innovations, and sponsored by CHCF, the event incorporated hands-on, dialogue-based activities that encouraged idea sharing and collaboration.

Kelly Bruno-Nelson, executive director of Medi-Cal and CalAIM with CalOptima Health, said that while there have been other CalAIM conferences organized by the Department of Health Care Services (DHCS), these tend to follow a more traditional, didactic approach.

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.

Inspired by networking practices she engaged in during her previous role as president of the nonprofit National Health Foundation, she wanted to create an opportunity for the organizations involved in the ECM rollout to interact and collaborate. Organizers also said they hoped the structure would encourage more open and honest discussion among attendees, who may feel less comfortable being candid in the presence of state regulators.

"Never once has there been an effort to bring the group together to build community, build colleagues and space for us to be transparent, honest, learn from each other, share what's working, what's not working," Bruno-Nelson said. "That's what this is."

In addition to CalOptima and Health Plan of San Mateo, participating health plans included Anthem Blue Cross, Blue Shield Promise, Central California Alliance for Health, San Francisco Health Plan, HealthNet, Inland Empire Health Plan, Partnership Health Plan of California, and Santa Clara Family Health Plan. MCPs met on the first day of the convening, and then joined in discussions with providers on the second day. Providers present on the second day included four social service organizations and 15 health care organizations, among them representatives from Federally Qualified Health Centers and community clinics, mental health and substance use disorder treatment providers, organizations serving people experiencing homeless and other specific populations, and community health workers.

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-April Watson, director of learning,
Health Plan of San Mateo

David Hoang, a CHW and case manager with Asian Health Services in Oakland, said he attended the event hoping to learn how other providers are approaching common challenges with ECM implementation, such as how to design their workflows, get training, and deal with new administrative requirements.

"We developed a workflow, but it wasn't easy, we had to start from scratch," he said of his organization. "I like speaking with other folks to learn about their programs and what's their best approach to solve issues… then it's easier for me down the road."

Belén Arangure, ECM program manager with Northeast Valley Health Corporation, a Federally Qualified Health Center in Los Angeles, said she wanted to network with ECM providers from other counties and gather new ideas to advocate for in her local setting — especially those related to streamlining documentation and data reporting. This has been particularly challenging for providers in LA County where there are four MCPs, all with different requirements, she said.

During the first year of ECM implementation, Arangure experienced a sense of isolation and frustration. There were many gray areas in regard to billing, ongoing program deliverables, and reporting across different MCPs, which contributed to a limited understanding of the program within her organization. Since then, she's been actively seeking out other ECM providers in her community to talk to.

"It wasn't until I began collaborating with other ECM providers outside of my organization that things began to really click," she said.

The ECM Journey so Far

DHCS requires all MCPs to implement ECM. Along with 14 optional services known as Community Supports, it's the first new Medi-Cal benefit introduced under CalAIM, and targets the Medi-Cal members with the greatest needs.[2] These members typically have multiple health and social needs and engage with several delivery systems to access care.

By offering comprehensive care coordination and engaging with members wherever they are — whether that's the street, the doctor's office, or at home — ECM aims to make accessing care a seamless experience for these individuals that is more responsive to their full spectrum of needs.

To implement ECM, MCPs must establish and train networks of community-based providers to deliver the benefit in the regions the plan serves. DHCS has also instructed them to negotiate their own rates with providers, identify and assign members to ECM providers, oversee service delivery, and collect performance data.

Counties have gradually extended the benefit to designated populations of focus, following a schedule provided by DHCS.[3] The benefit will go live for the final groups – people transitioning from incarceration and birth equity populations of focus — in January 2024.

While the rollout has marched ahead as scheduled, ECM's implementation and uptake have been bumpy and uneven. For starters, MCPs are still working on building their ECM provider networks, which bring together a wide range of community-based entities experienced at providing culturally sensitive care management to the population of focus they serve.

In addition, while over 109,000 members received ECM in 2022, the number of people actively enrolled in the benefit declined over the course of 2022 – a trend that is mirrored by Community Supports.

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-Benjamin Kaska, street medicine physician assistant and regional manager, Healthcare in Action

In July, DHCS rolled out several changes to address these and other issues, which plans are currently in the process of implementing.

"The uptake of [ECM] services has been slow and in much lower numbers than I think people had hoped and expected," said April Watson, director of learning at Health Plan of San Mateo. "There are processes in place to get referrals to enhanced care management, and it's an 'if you build it they will come' [approach], and they're not really coming."

"If you just wait for a patient to go to the ER, hope that the emergency room provider generates a diagnosis code that flags the managed health care plan to the patient's status as homeless, that is a very passive approach for engaging with people experiencing homelessness," said Benjamin Kaska, a physician assistant and regional manager with street medicine provider Healthcare in Action. "You need to do outreach in the community."

A survey of almost 1,200 CalAIM implementers between July 21 and September 12, 2023, found that around half of respondents believed the program was improving care for members on the ground. However, the experience of implementation and its effectiveness varied by sector. Almost 80% of MCPs rated implementation as very or somewhat effective, but that percentage slid to as low as 36% among providers, with the lowest ratings coming from those in behavioral health.

Barriers to Implementation and Enrollment

Bruno-Nelson and her colleague, Danielle Cameron, director of program development for CalAIM at CalOptima Health, said MCPs and providers face several internal and external barriers. Like Bruno-Nelson, Cameron previously worked at the National Health Foundation, a community-based organization (CBO) in Los Angeles known for recuperative care programs.

The executives said their experiences on the provider and now MCP sides have given them insights into the challenges both face when it comes to ECM implementation. These include:

Challenges for CBOs:

- **Lack of experience as Medi-Cal providers.** Many CBOs joining the ECM system previously relied on grants and fundraising to operate, often on a shoestring budget. They have neither the systems in place to do medical billing nor the staffing capacity to handle it.
- **Not enough staff, facilities, or training to ramp up quickly.** ECM and Community Supports require a huge expansion of services not previously available to Medi-Cal members. Growing the infrastructure to provide these services will take time.
- **Fear.** Some nonprofits, particularly smaller ones, are wary of working with much larger, bureaucratic, and risk-adverse MCPs.

Challenges for MCPs:

- **Lack of experience acting as grantees to nonprofit organizations.** MCPs must effectively implement and manage a grant process for ECM providers, which they have to build from scratch.
- **Unfamiliarity with CBOs.** MCPs are used to working with medical providers but not grassroots community organizations. This means MCPs may not recognize CBOs' differences in structure, capacity, communication, credentialing, and documentation practices, making it more difficult for MCPs to build rapport with these organizations.
- **Insufficient empathy.** Also affecting rapport is a lack of empathy among MCP staff toward CBOs engaging with the Medi-Cal system for the first time, Bruno-Nelson said.
- **Time pressure from above.** MCPs feel pressure from DHCS to launch ECM quickly. But state expectations don't align with very real limitations on the ground, Cameron said.

"The reality is the field wasn't ready," said Bruno-Nelson. "There's so much money being infused and, while we're grateful for those dollars, it doesn't immediately fix the problems. Non-profits have to have the time and training to be able to increase the capacity to the level that we need."

Journey Mapping Ideal Solutions

Participants worked interactively in teams to create "journey maps" — flowcharts outlining how they would ideally like ECM enrollment and engagement to work from member, CBO, provider and MCP perspectives. Looking at three populations of focus — pregnant and postpartum people, justice-involved individuals, and people experiencing homelessness — participants shared experiences, identified successes and pain points, and brainstormed ideas for improvement.

Another interactive brainstorming activity encouraged participants to dig deep for ideas on how to address three questions related to ECM:

- How to onboard CBOs and providers to set them up for success in ECM enrollment
- How to use technology to allow humans to be humans

- How ECM fits into the broader Population Health Management (PHM) service delivery model within CalAIM, which aims to offer targeted, whole-person care interventions for MCP members at all levels of acuity, with ECM being the highest level of care

Numerous ideas emerged from the activities. Participants generally praised the process and health plan representatives in particular said hearing provider perspectives was eye opening.

Promising Practice

One plan has already launched an ECM Academy in partnership with their regional consortium of health centers. It's a 6-month training program for organizations that want to become ECM providers. The academy teaches them about the credentialing and contracting processes, and skills needed to provide services. At the end of the academy, they are ready to provide and bill for services.

Key Challenges and Proposed Solutions

The following six solutions emerged from the collaborative discussions MCPs and providers had regarding challenges they commonly face.

CHALLENGE #1: **Many providers feel overwhelmed by CalAIM, and there is a need to build confidence and capacity.**

PROPOSED SOLUTION: **Launch training academies to support providers with onboarding to CalAIM and ongoing management.**

Inspired by the lessons learned from one plan's ECM academy, participants envisioned an "integrated support services academy" that would help doulas and CHWs better support ECM's seven core services, which are universally available to all populations of focus. They imagined two separate tracks — one for doulas and another for CHWs — that would offer a tailored curricula focused on key services and operational structures. Participants hypothesized that such a program could be an opportunity to strengthen community engagement, trust, and capacity across regions and cultures.

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CHALLENGE #2: **CHWs are critical for community engagement, but most organizations struggle with recruitment and retention.**

PROPOSED SOLUTION: **Collaborate across MCPs and providers to train and reward CHWs.**

Participants reimagined recruitment for these critical frontline health workers. What if MCPs and providers joined forces to guarantee jobs for those who finish the CHW certification course? And what if this partnership also created three clear tracks to becoming a certified CHW? The first track would be for someone who has no experience as a CHW, the second for someone with lived experience who is well positioned to work with patients with complex needs, and the third for someone who has already been working as a CHW in their community but who hasn't yet become certified. Other participants flagged the importance of providing stipends to cover training costs and raising CHW wages to improve retention.

CHALLENGE #3: **Housing navigation services are needed, but there is not enough housing.**

PROPOSED SOLUTION: **Define measures of success for navigation with the reality of insufficient housing in mind, and introduce tiered navigation based on need.**

Participants envisioned using three separate tiers for housing navigation and reimbursement. The first tier would offer intensive support for community members who need help getting their paperwork in order to be considered for housing. The second would provide basic support for community members who have their paperwork ready but who need a regular point person they can check in with and who can match them with housing when it becomes available, such as a CHW. Intensive outreach would be given to community members in the third tier, who have the paperwork ready but are hard to find and connect with and need to be kept engaged while waiting to be matched with a housing opportunity.

CHALLENGE #4: **ECM enrollment needs to increase, and ECM engagement needs to improve.**

PROPOSED SOLUTION: **Reimagine how to identify who is eligible, match with providers, and plan for transitions.**

Conference participants drew from experience to share various creative ideas for how to achieve this, including not authorizing ECM prior to providing services, or using birth certificates to identify patients in the postpartum population of focus.

One attendee pointed out that while there are many criteria to identify "adult nursing facility residents" as population of focus, very few exist for predicting a successful transition into the community. Another participant shared that while their health plan pays different rates for different populations of focus, they do not use a population hierarchy to assign members to services or providers. For instance, if a patient is both postpartum and homeless, assigning that patient to a postpartum provider would serve their primary need at that moment, whereas a homeless provider might not be prepared to address postpartum issues.

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-Kaska, Healthcare in Action

CHALLENGE #5: **Data exchange is one of the main obstacles faced across implementation partners.**

PROPOSED SOLUTION: **Request DHCS provide clear expectations on data standards and sharing. MCPs can then lead the way to support providers and CBOs in adopting technologies and improving data flow.**

To accelerate the quality and sharing of data, MCPs, providers and CBOs can brainstorm ideas for data standards and sharing requirements together with DHCS. One particular challenge that was brought up was how to exchange data from the sheriff's office to providers outside the criminal justice system. An MCP suggested that managed care plans, which have high touchpoints with different providers, could serve as conduits of this information. In this scenario, the county jail would fax release dates to an ECM provider working with the jail. The MCP would then automate those faxes and load them onto an electronic platform that they could use to translate data to providers on the outside.

Promising Practice

One plan is helping fund a data exchange using Epic EHR software in collaboration with the county, and with input from the health plan, providers, and CBOs. As part of this effort, the plan is also working to automate the electronic transmission of jail release records from the county sheriff's office to the health plan. The data exchange is expected to launch in 2024.

CHALLENGE #6: **Staff burnout is one of the main barriers to success, while administrative burden is driving an exodus from the field.**

PROPOSED SOLUTION: **Use technology to allow humans to be humans, and minimize time consuming routine work that can be automated.**

Participants suggested collaborating across MCPs, providers, and CBOs to identify the main challenges that can be addressed with digital tools for automation. Several providers noted that they are being forced to double document their interactions with patients in both their organization's internal electronic records system and that of their MCP.

Kaska with Healthcare in Action proposed enabling a streamlined system in which information created internally would be automatically transmitted to health plans. This could be done through an application programming interface (API) that allows computer programs to communicate with each other, one participant suggested. Others built on the suggestion, proposing that providers and MCPs develop small proofs of concept to capture the benefits and refine the solutions. MCPs could then support broad adoption across provider networks.

Double documenting "is an extraordinarily burdensome task for an individual who is taking care of 40, maybe more, very, very high acuity patients," Kaska said. "When I manage my teams, I want to make sure they're spending the most amount of time in front of the patient, actually engaging in really valuable care to move the needle forward for their (health), not sitting at their computer double documenting."

Next Steps

Participants emerged from the conference energized by the prospect of future collaborative discussions around ECM and other CalAIM programs. Many expressed support for MCPs, medical providers, and CBOs continuing to work together to address common challenges.

Kristy Garan-Martinez, senior director of ECM for the Inland Empire Health Plan, said she had exchanged phone numbers with representatives from several health plans and providers at the event, and was planning to follow up on the data sharing and training academy ideas. "I feel like I can phone a friend when I'm in need of sharing thoughts," she said. "And to discuss how to operationalize guidance from the state and how to overcome barriers."

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-Kristy Garan-Martinez, senior director of ECM, Inland Empire Health Plan

Eric Schwimmer, program director for CalAIM and ECM at Anthem Blue Cross, said he hoped the conference would allow ECM implementers to present a more unified front when talking to state regulators. He sees gaps in the safety net and views siloed health and social service delivery systems as major hurdles to ECM implementation.

"Success in my program depends upon the environment that its being developed within," he said. "The value of this forum is that we can talk about this stuff and maybe, as a collective ECM voice, we can talk to DHCS and other stakeholders about that, and it's more powerful than just me."

As the day closed with participants prioritizing their takeaways, one clear winner stood out: "Everything we do needs to support the member in achieving their ideal state."

About the Author

Claudia Boyd-Barrett is a longtime journalist based in Southern California. She writes regularly about health and social inequities. Her stories have appeared in the Los Angeles Times, the San Francisco Chronicle, the San Diego Union Tribune, and California Health Report, among others.

Boyd-Barrett is a two-time USC Annenberg Center for Health Journalism fellow and a former Inter American Press Association fellow.

About the Foundation

The California Health Care Foundation (CHCF) is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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

Endnotes

1. "**Medi-Cal Transformation: Our Journey to a Healthier California for All**," California Department of Health Care Services (DHCS), accessed November 2023.
2. ***CalAIM Enhanced Care Management Policy Guide*** (PDF), DHCS, updated September 2023.
3. CalAIM Enhanced Care Management Policy Guide, DHCS, 9.