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Can CalAIM Solve the Systems Integration Challenge?

Identifying Key Facilitators of Cross-Sectoral Care Coordination

Strategies to Achieve Alignment, Collaboration and Synergy across Delivery and Financing Systems

Research-in-Progress Webinar
June 12, 2024
12pm ET

colorado school of public health

Agenda

Welcome: Systems for Action

Framing: Laura Miller, MD, Medical Consultant
Division of Quality and Population Management
California Department of Health Care Services

Presenters: Caroline Fichtenberg, PhD, Co-Director SIREN, UCSF
Rohan Rastogi, MD, MPH, National Clinician Scholars Fellow and Clinical Instrutor, UCSF

Commentary: Karis Grounds, MPH
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Project Team

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SIREN/UCSF

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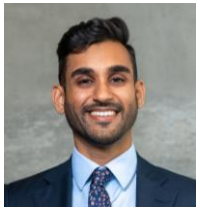

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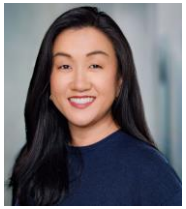

Sheena Nahm McKinlay, PhD MPH

Health Leads

Background: What is CalAIM?

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DHCS

California Advancing and Innovating Medi-Cal (CalAIM)
Our Journey to a Healthier California for All

Medicaid reform in California

Began January 2022

- Implement a whole-person care approach and address social drivers of health.
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation.
- Create a consistent, efficient, and seamless Medi-Cal system.

Source: CA Department of Health Care Services

Two key features of CalAIM

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Enhanced Care Management (ECM)

- Intensive care management for medical and social services
- High-need high-cost members
- Managed care benefit: plans *have* to cover

Community Supports (CS)

NEW!!

- 14 **non-medical** services
- In lieu of services: strongly encouraged but not required (plans choose what to cover)

- Builds on previous Whole Person Care and Health Homes pilots
- Plans contract with community-based providers
- Also includes $ for building up data sharing and cross-sector coordination capacity among ECM and CS providers

Source: CA Department of Health Care Services

Total Number of Members Who Received ECM by Population of Focus in the Last 12 Months of the Current Reporting Period (October 2022 – September 2023)

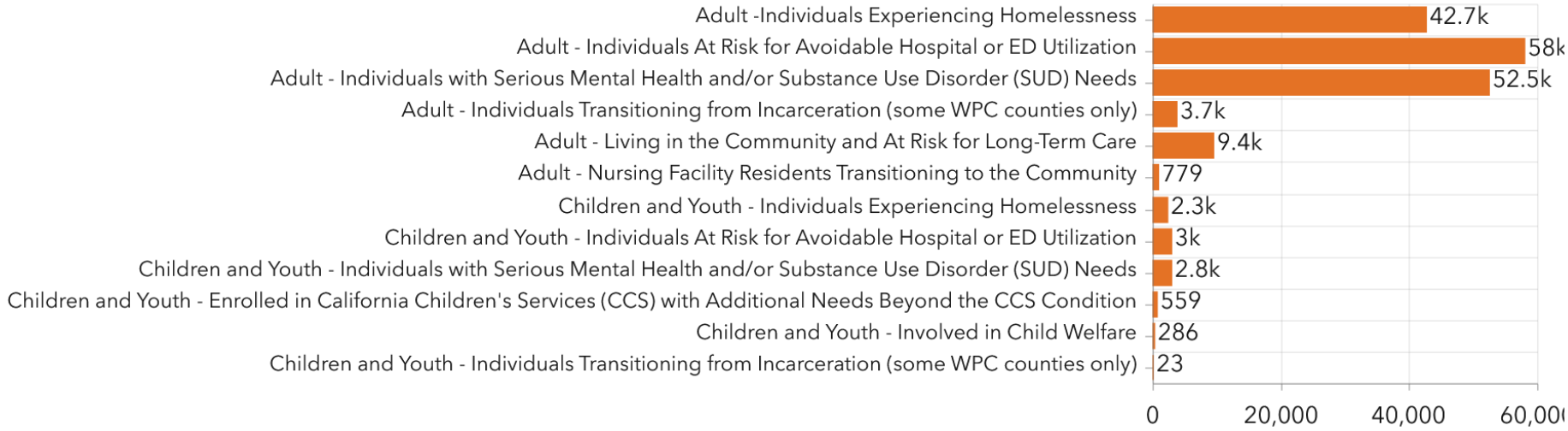

Chart 1.3.1

In 2022 and 2023, members transitioning from incarceration were eligible for ECM only in select counties. The POF launches statewide in 2024.

Source: CA Dept. of Health Care Services

Total Number of Members Who Utilized Community Supports by Service in the Last 12 Months of the Reporting Period (October 2022 – September 2023)

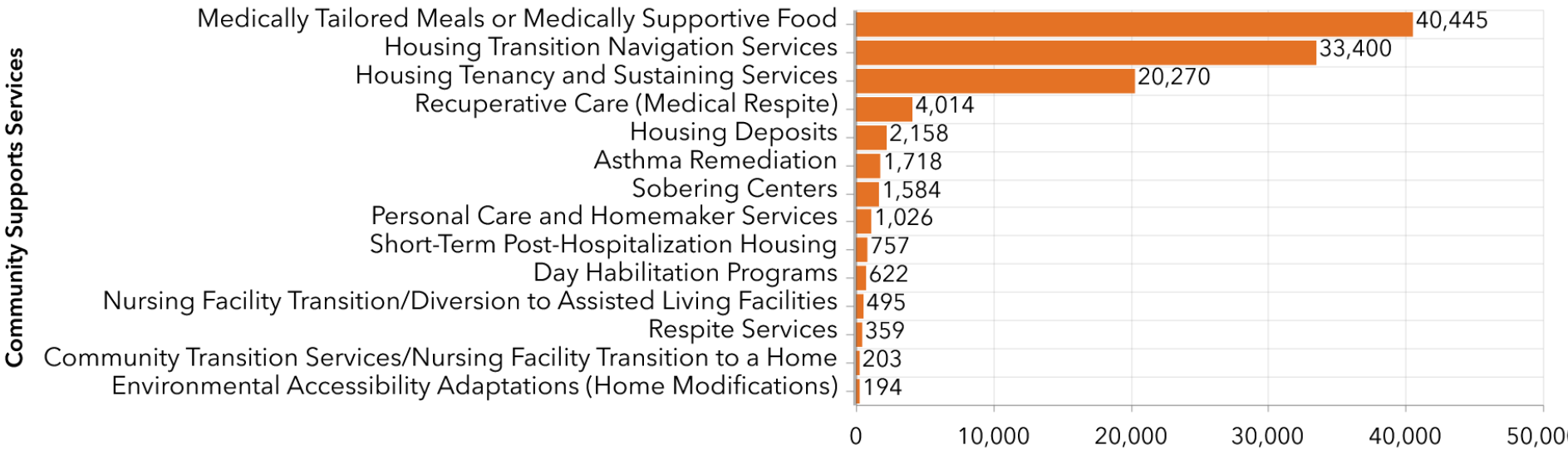

Chart 3.5.1

Source: CA Dept. of Health Care Services

ECM and CS providers

Enhanced Care Management (ECM)

FQHCs
Behavioral health orgs
County agencies
Homeless service providers
Justice-involved service providers
Care coordination organizations/Hubs

Community Supports (CS)

Providers of:
Homeless services
Supportive housing
Recuperative care
Medical respite
Home-based services
Medical nutrition
Home modifications
Asthma remediation

ECM and CS providers

Enhanced Care Management (ECM)

providers

Care coordination organizations/Hubs

Community Supports (CS)

Medical nutrition

Home modifications

Asthma remediation

Key to CalAIM success:
Coordination between health and social service organizations (SSOs), including cross-sector contracting, data exchange, coordination to avoid duplication of services, etc.

Key research questions

1. **Is CalAIM improving coordination between health (health care and public health) and social services for Medicaid beneficiaries**, especially for beneficiaries from historically marginalized communities (e.g. BIPOC, non-English speakers)?

2. **What factors make coordination more successful**, especially for organizations serving historically marginalized communities?

Research activities

Survey of social service organizations

Summer 2023

Local case studies

Winter 2023-2024

Backbone organization community of practice

2023-2026

+ Analysis of implementation data

Survey Analysis Objectives

1. What factors affect participation in CalAIM? In particular, are smaller BIPOC-focused organizations participating in CalAIM at lower rates than other social service organizations (SSOs)?

2. What factors affect whether SSOs report improvements in social services-health care coordination since CalAIM began?

Survey methods

- First statewide survey about CalAIM implementation
- Online survey fielded July-Sep 2023
- No sampling frame, survey was disseminated widely to organizations that could implement CalAIM:
  - **Social service organizations (SSOs)**
  - Health care providers
  - Payors

- Partnership with the California Health Care Foundation

Characteristics of SSO Sample (n=355)

Category	n	%
FTEs		
<50	138	42%
50-250	135	41%
250+	58	18%
Number of counties in which they operate		
1	259	73%
2-3	31	9%
3+ or statewide	57	16%
Total # counties represented	51	--
Multi-state	20	6%
Organization type		
Private	46	13%
Non-profit	290	82%
Government	23	6%
BIPOC Specialization		
Any BIPOC or LEP specialty	117	33%
Single racial/ethnic specialty	31	9%
Declare no specialization	119	34%
Multiple racial/ethnic specialty	73	21%
Specialize limited English prof.	72	20%

Category	n	%
WPC/HH Participation	111	31%
Prior contract with a managed care plan	182	51%
Respondent role		
Frontline	70	20%
Managerial	145	41%
Senior leadership	127	36%
Services offered		
Housing/Homelessness	248	70%
Recuperative care/Medical respite	75	21%
Food-related services/Food assistance	184	52%
Sobering center/Sobering services	44	12%
Services for older adults or people with disabilities to live in the community	127	36%
General social services assistance	177	50%
Benefits navigation	151	43%
Re-entry services following incarceration	73	21%
Home modification services	50	14%
Asthma remediation services	28	8%
Child welfare services	67	19%
Legal services	34	10%
Information & Referral services	184	52%

Question 1: Outcome

CalAIM Participation	n	%
Both ECM and CS	106	30%
Just ECM	23	6%
Just CS	106	30%
None	120	34%

- 60% of SSOs provided Community Supports
- 36% provided Enhanced Care Management

Question 1: *What factors affect CalAIM participation among SSOs?*

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Odds of Participating in CalAIM (n=293)

Organizational Factors	**OR (95% CI)**
Under 50 FTEs (vs. >=50)	1.2 (0.7-2.3)
Any BIPOC/LEP specialty (vs. none)	1.2 (0.6-2.1)
Operate in one county only (vs. >1)	**0.35 (0.2-0.7)**
WPC/HH participant (vs. not)	**6.6 (2.5-17.3)**
Prior contracts with managed care plans (vs. none)	**2.9 (1.6-5.3)**

Multivariate logistic regression controlling for services offered and nonprofit vs. government or for-profit status. Bold indicates $p<0.05$.

Q1 Conclusions

- FTE size was not associated with participation
- Specialization in BIPOC or low English proficiency communities was not associated with participation.
- Single-county organizations were less likely to participate
- CalAIM participation was strongly linked to participation in WPC/HH and prior experience contracting with managed care plans

Question 2: *What factors affect whether SSOs report improvements in coordination since CalAIM began?*

% reporting the following have gotten "much better" or "somewhat better" after CalAIM	All SSOs (n=355)
Patient access to services (including social needs)	54%
Coordination of services for patients	52%
SSO's ability to manage comprehensive needs	52%
SSO's coordination with other organizations	49%
SSO's financial stability	41%
SSO's technology infrastructure	39%

Question 2: *What factors affect whether SSOs report improvements in coordination since CalAIM began?*

% reporting the following have gotten "much better" or "somewhat better" after CalAIM	SSOs participating in CalAIM (n=235)	SSOs not participating in CalAIM (n=120)	All SSOs (n=355)
Patient access to services (including social needs)	66%	29%	54%
Coordination of services for patients	64%	27%	52%
SSO's ability to manage comprehensive needs	64%	27%	52%
SSO's coordination with other organizations	59%	30%	49%
SSO's financial stability	54%	15%	41%
SSO's technologic infrastructure	52%	15%	39%

Question 2: *What factors affect whether SSOs report improvements in coordination since CalAIM began*

	Pt access to services inc social needs	Pt coordination of services	Ability to manage comprehensive needs	Coordination with other orgs	Org financial stability	Org IT infrastructure
Nonprofit	**0.40**	0.53	0.51	**0.47**	**0.50**	**0.36**

Odds ratio of reporting "much better" or "somewhat better"
Bold indicates p<0. 05, colors indicate direction and magnitude of association

Question 2: *What factors affect whether SSOs report improvements in coordination since CalAIM began?*

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- CalAIM participants are more likely to report improvements in coordination
- Other factors associated with reported improvements include:
  - Non-profit orgs LESS likely to report improvements
  - SSOs w/ fewer than 50 FTEs MORE likely to report improvements of patient-level coordination
  - Frontline workers & managers MORE likely to report improvements than senior leaders
  - Housing providers MORE likely to report improvements

Limitations

- No sampling frame so don’t know how representative the sample is
- May not have accurately captured BIPOC/LEP specialization

Which county-level factors cause variability in Enhanced Care Management (ECM) penetration and Community Supports (CS) utilization?

Rohan Rastogi, MD, MPH

Analysis Objectives

- Are implementation rates higher in counties that had **prior pilot programs**?
- Are **Medi-Cal plan** factors associated with implementation?
- Are county **demographic characteristics** associated with implementation?

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Methods

County-Level Data Sources

Data Source and Time Period	County characteristic
CalHHS Open Data Portal, FY22-23 data	Total average Medi-Cal member counts, ECM/CS counts, pilot participation, Medi-Cal plan types, Medi-Cal plan counts by county
CA Association of Counties, 2020	County urbanicity
American Communities Survey, 2021	County population, race/ethnicity, poverty rate

Implementation process outcome: Enhanced Care Management penetration rate

“Enhanced Care Management penetration rate” = $\frac{\text{\# of members receiving ECM}}{\text{\# of total Medi-Cal members}}$

Implementation process outcome: Community Supports utilization rate

“Community Supports utilization rate” = $\dfrac{\text{\# of CS services provided per member} \times \text{\# of unique members who received CS}}{\text{\# of total Medi-Cal members}}$

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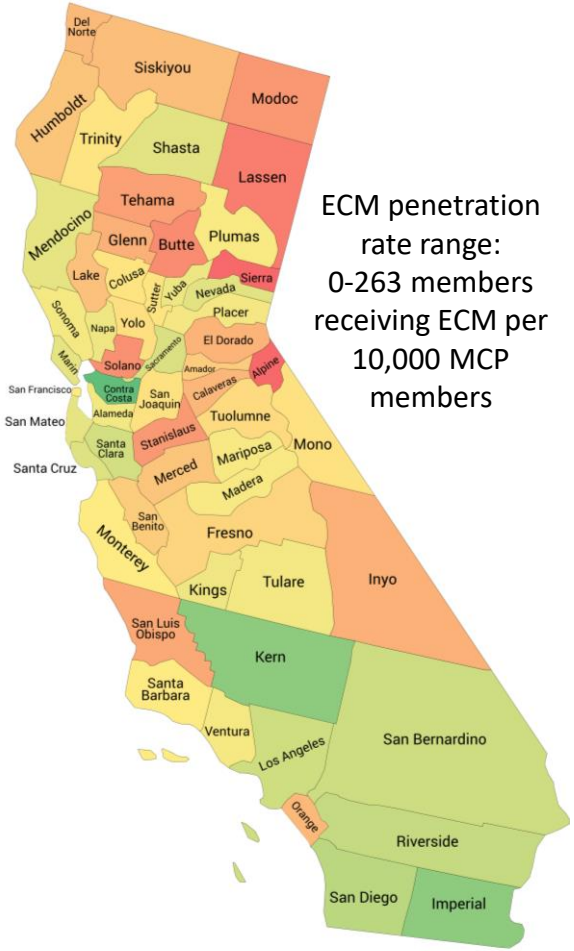
Results

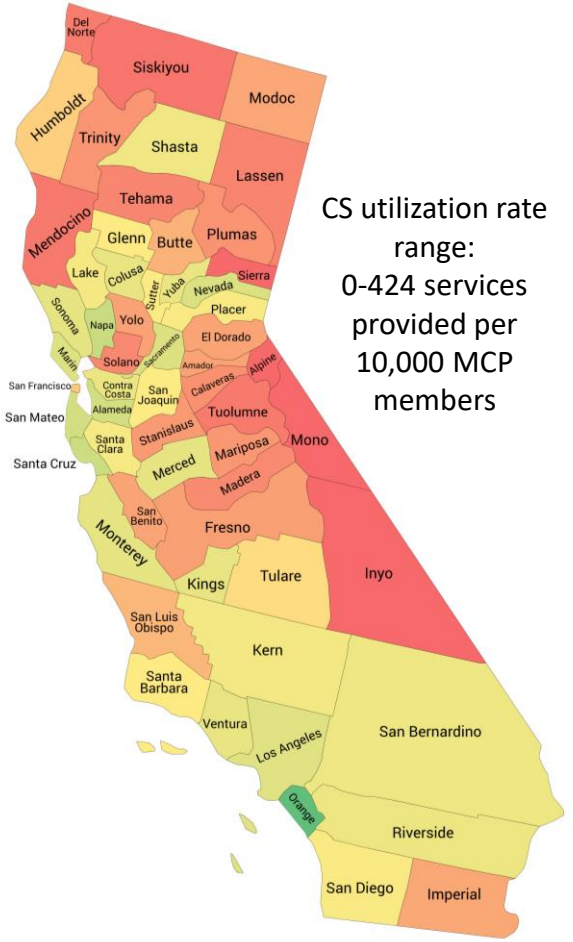
Enhanced Care Management penetration rate and Community Supports utilization rate by county in FY22-23

Enhanced Care Management penetration rate



ECM penetration rate range: 0-263 members receiving ECM per 10,000 MCP members

Community Supports utilization



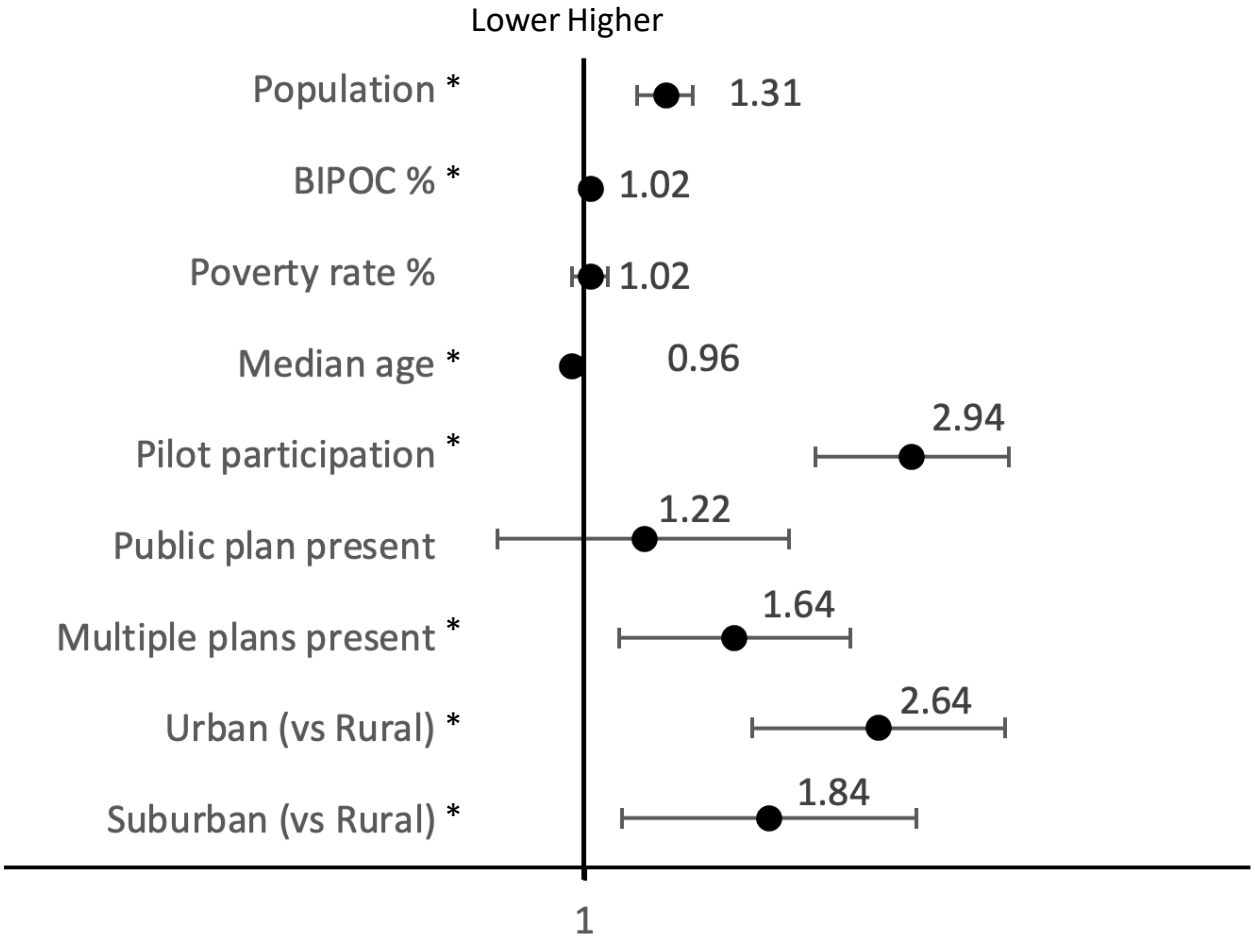
CS utilization rate range: 0-424 services provided per 10,000 MCP members

Legend

Low Penetration/ Utilization

High Penetration/ Utilization

Bivariate analysis of Enhanced Care Management penetration across county characteristics



* Indicates p<0.05

Multivariable stepwise Enhanced Care Management analysis

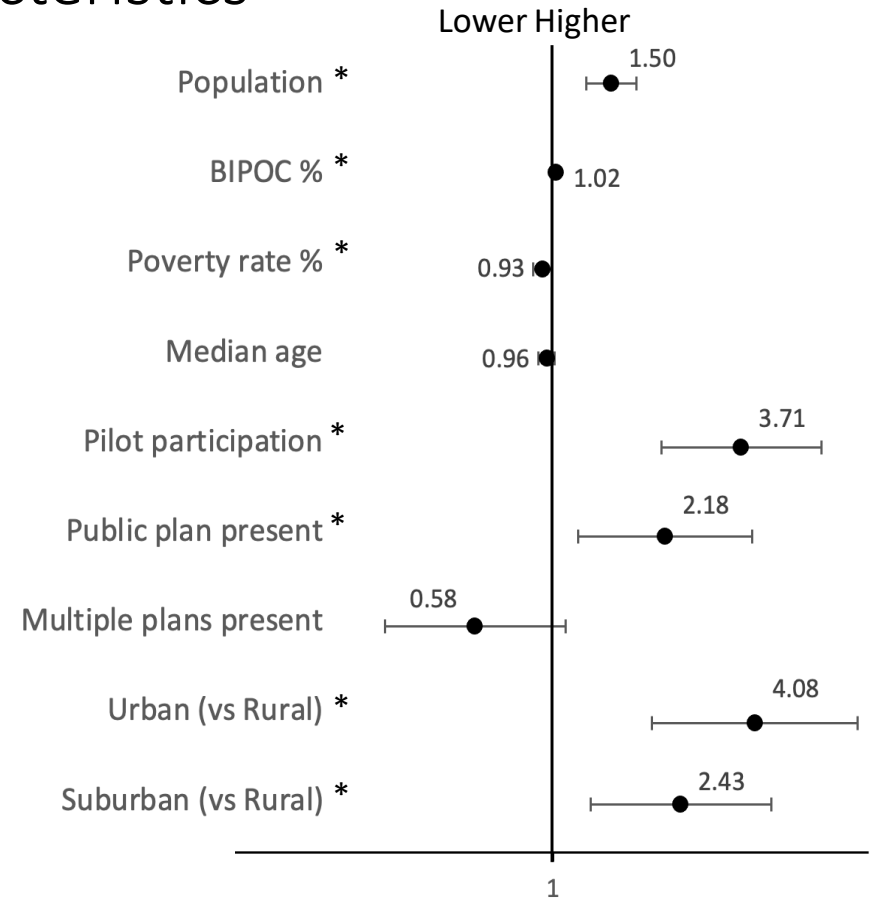
Characteristic	Adjusted RR	95% CI	p-value
Pilot participation	2.9	2.2-3.8	<0.001
Multiple plans present	1.6	1.2-2.0	0.011

Counties that participated in a pilot program had an estimated **2.9x** higher ECM penetration rate than non-pilot counties.

Counties with multiple MCP's had an estimated **1.6x** higher ECM penetration rate than single-plan counties

* Excluded from final stepwise model as not statistically significant: population, BIPOC %, poverty rate, age, public plan presence, urbanicity

Bivariate analysis of Community Supports utilization across county characteristics



* Indicates p<0.05

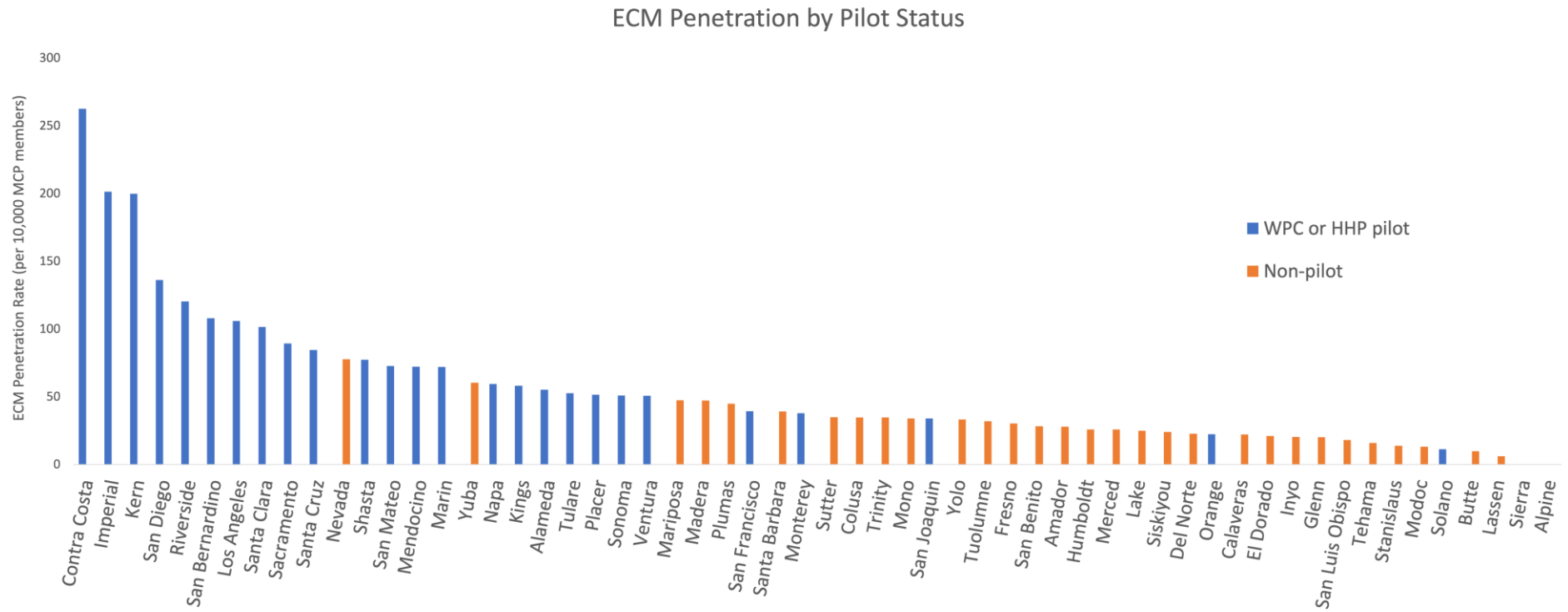
Multivariable stepwise Community Supports analysis

Characteristic	RR	95% CI	p-value
Pilot participation	3.7	2.1-6.5	<0.001

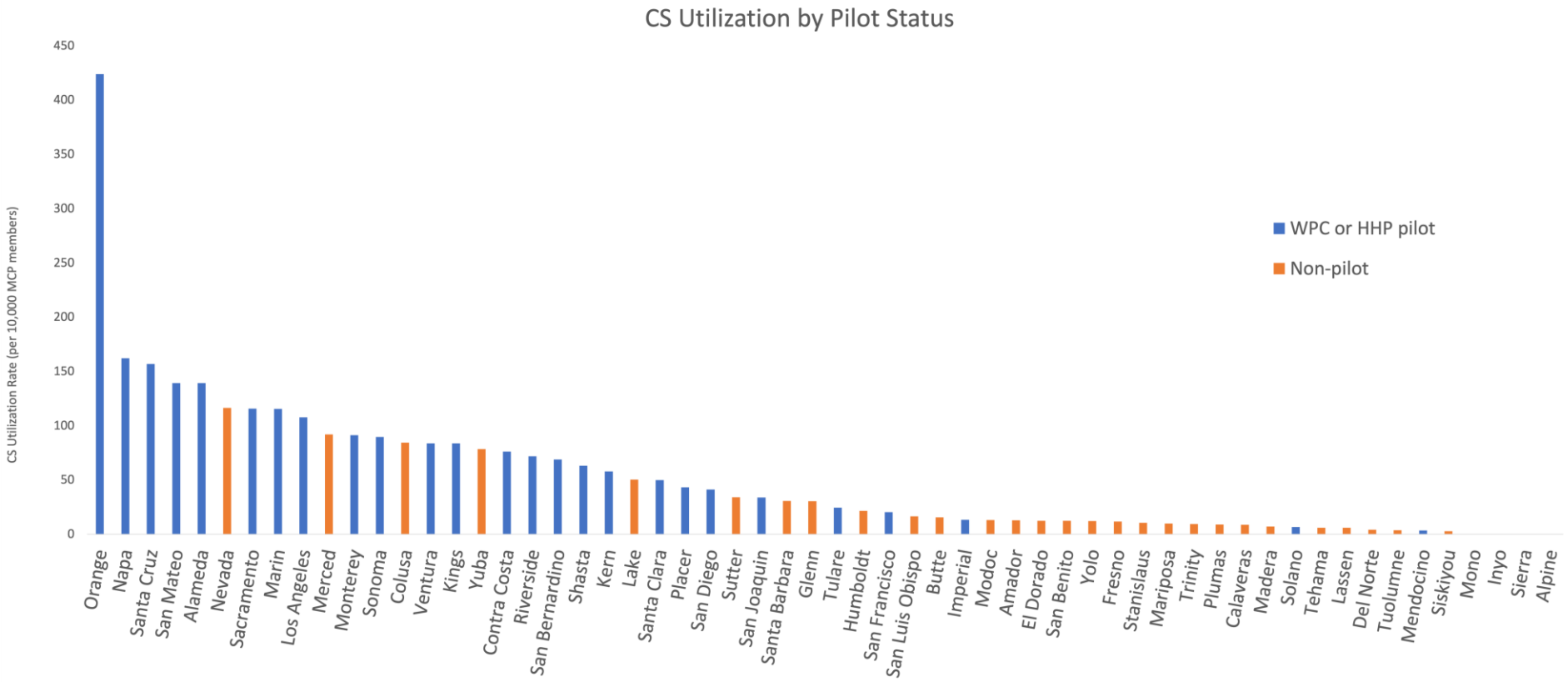
Counties that participated in a pilot program had an estimated **3.7x** higher CS utilization rate than non-pilot counties

* Excluded from final stepwise model as not statistically significant: population, BIPOC %, poverty rate, age, public plan presence, multiple plan presence, urbanicity

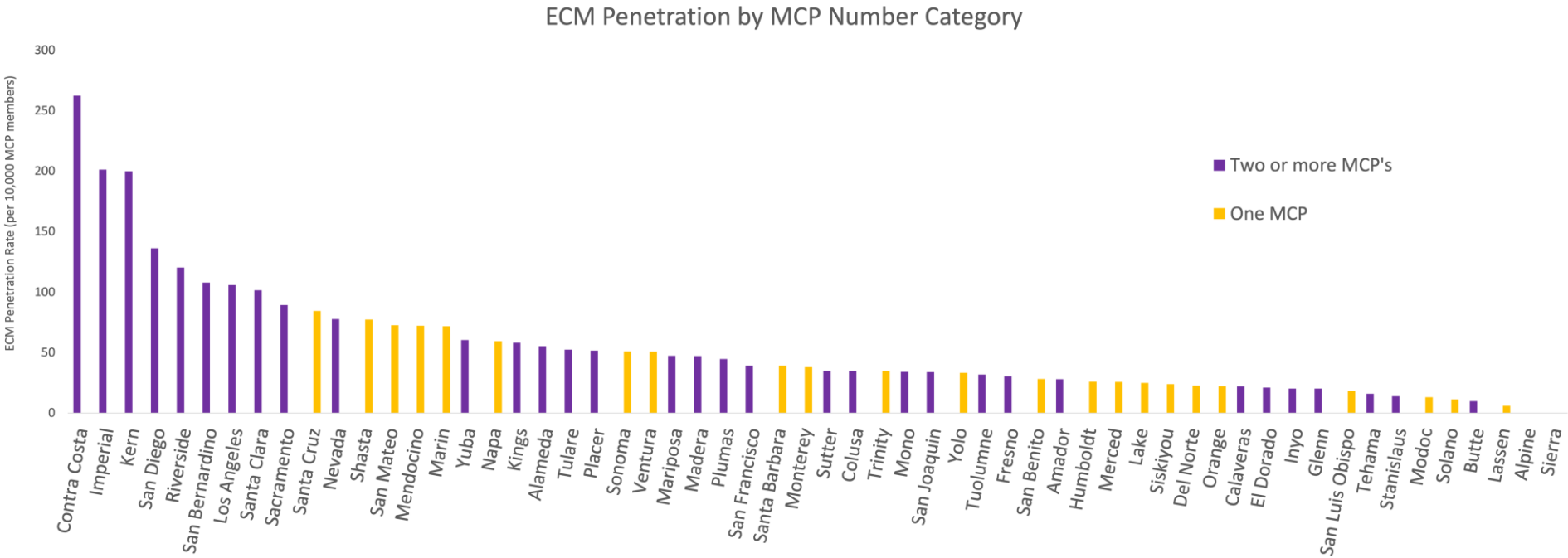
Counties that participated in a pilot program had an estimated **2.9x** higher ECM penetration rate than non-pilot counties



Counties that participated in a pilot program had an estimated **3.7x** higher CS utilization than non-pilot counties



Counties with multiple MCP's had an estimated **1.6x** higher ECM penetration rate than non-pilot counties



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Key Takeaways & Implications

Key takeaways:

1. **Prior participation in a pilot program was associated with significantly increased Enhanced Care Management penetration and Community Supports utilization**

   - The impact of pilot programs persists even three years after their completion
   - Pilot counties had infrastructural investment and a foundation for plan-provider partnerships
   - Fundamental differences between pilot and non-pilot counties may exist beyond what we accounted for

Key takeaways:

2. Counties with more than one plan had increased Enhanced Care Management penetration, even after adjusting for pilot participation

- Plan count affects implementation of Enhanced Care Management but not Community Supports, which is an optional service for Medi-Cal plans to offer
- Increased competition among plans in counties with more than one plan may contribute to higher Enhanced Care Management penetration

Key takeaways:

3. **There were no significant differences in ECM/CS rates based on county urbanicity, population size, BIPOC percent, poverty rate, or age after adjusting for pilot participation**

- Pilot counties were more urban, more populous, more diverse, and younger on average than non-pilot counties, so factoring in pilot participation may account for differences in ECM/CS rates associated with those factors

- Differences in implementation rates based on demographic factors may be present on a neighborhood or community level, but not at the county level

Implications

1. WPC and HHP pilots appear to have set counties up to succeed in implementing Enhanced Care Management and Community Supports

2. Non-pilot counties may need increased attention and time to participate in CalAIM initiatives to the same degree as pilot counties

3. Further consideration is needed to understand the effect of plan count on Enhanced Care Management penetration

Limitations

- Small sample size of 58 counties results in imperfect statistical models, which was addressed by using stepwise regression modeling for this exploratory analysis
- Some data is suppressed and therefore missing, although outcomes with imputed data were not different than those with no imputation
- All data utilized for this analysis was county-level, so influences at the plan, neighborhood, provider, and patient level could not be assessed
- Unmeasured confounding from political will, budget, community-based organization infrastructure, and more
- Selection bias is present given that the counties with prior pilots had to apply and receive approval

Discussant

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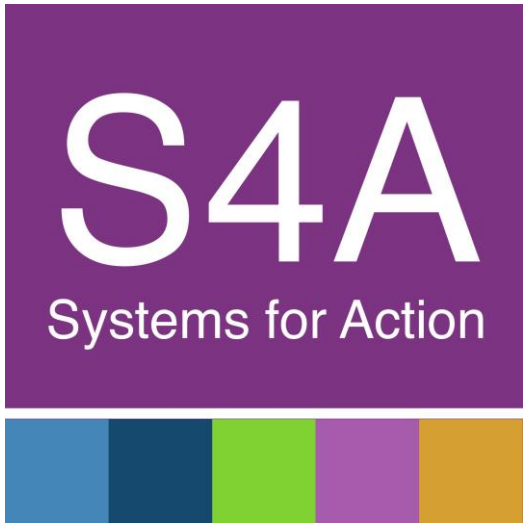
Questions?



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Upcoming Webinar

An Aligned Delivery and Financing Model to Address Food Insecurity and Social Needs of Low-Income Pregnant Women

Wednesday, July 10 | 12pm ET

Register at:
https://systemsforaction.org/research-progress-webinars

Acknowledgements

Systems for Action is a National Program Office of the Robert Wood Johnson Foundation and a collaborative effort of the Colorado School of Public Health, administered by the University of Colorado Anschutz Medical Campus, Aurora, CO.

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