Joint Informational Hearing
Senate Health and Public Safety Committees
California Advancing and Innovating Medi-Cal (CalAIM): Enhanced Care Management, Community Supports, and Justice Involved Reentry Initiatives
Wednesday, February 26, 2025 – 1:30 p.m.
1021 O Street, Room 1200

This hearing of the Senate Health and Public Safety Committees will provide an update on the implementation efforts thus far of three of the initiatives that are part of Medi-Cal's California Advancing and Innovating Medi-Cal (CalAIM): Enhanced Care Management (ECM), Community Supports, and the Justice-Involved Reentry Initiative. The hearing will include representatives from the Department of Health Care Services (DHCS), the California Department of Corrections and Rehabilitation (CDCR), Medi-Cal managed care plans (Medi-Cal plans), counties, providers, and consumers to examine the successes and challenges of these initiatives and the impact to Medi-Cal enrollees.

Background

I. CalAIM

CalAIM is a collection of Medi-Cal initiatives aimed at addressing social drivers of health, reducing program complexity, increasing program flexibility, and modernizing payment structures to promote better outcomes. The CalAIM proposals were originally intended to start in 2021, but given the COVID-19 public health emergency and considerable stakeholder input, CalAIM did not start until January 1, 2022. CalAIM was authorized by AB 133 (Committee on Budget, Chapter 143, Statutes of 2021), which incorporated two policy bills introduced in 2021 and the approval of a federal Section 1115 demonstration waiver and a Section 1915(b) waiver. These waivers, named for the section of the Social Security Act authorizing each, allow DHCS to waive certain federal Medicaid and Children's Health Insurance Program requirements. Section 1115 waivers generally test innovating program improvements in a budget neutral manner, while Section 1915(b) waivers allow for the use of a managed care delivery system provided it is cost-effective. Both waivers require that changes to the state program be consistent with the objectives of the Medicaid program. DHCS received approval on December 29, 2021 for both waivers, effective through December 31, 2026. Some elements of CalAIM were also added to California's Medicaid state plan as ongoing program changes which do not need to be reauthorized when the waivers end.

The three CalAIM initiatives included in this informational hearing are designed to provide additional services to Medi-Cal enrollees with high needs: ECM, which provides enrollees with high health needs a care manager who can coordinate all of their health care and health-related care and services; Community Supports, which helps address enrollees' health-related social needs (such as food, housing, environmental, and other supports); and, the Justice-Involved Reentry Initiative, which provides Medi-Cal services to justice-involved enrollees as they transition from incarceration to their communities.

Another related initiative, Providing Access and Transforming Health (PATH) created a $1.85 billion funding stream to invest in the capacity and infrastructure of local community-based organizations, hospitals, county agencies, tribes, and others to successfully participate in these three initiatives. Because many of the services provided under the three aforementioned initiatives are not traditional health services, many intended providers had no experience in contracting with a health plan or submitting claims for services. PATH funding was designed to enable these local partners to add additional staff, billing systems, and data exchange capabilities, and otherwise address gaps in organizational capacity that would prevent these organizations from participating in the Medi-Cal program. The PATH funding was meant for technical assistance and collaborative planning efforts, as well as direct funding to providers for service provision.

Despite these efforts, a 2023 analysis of 19 Medi-Cal plans by Health Affairs found that more than half of the plans opted to contract with national for-profit companies to offer ECM or Community Supports services.[1] These companies are able to benefit from economies of scale and have access to large pools of capital, leaving local community-based organizations at a disadvantage. In some cases, these contracts may have been necessary, as there simply were no local organizations providing a given service. In other cases, these contracts may have simply been more convenient as contracting with local organizations likely meant more contracts to manage and more technical support.

II. Enhanced Care Management

ECM is a statewide benefit available through Medi-Cal plans to provide care management to enrollees with the highest needs. ECM identifies these enrollees as "Populations of Focus" which include:

- Adults, unaccompanied youth and children, and families experiencing homelessness;
- Adults, youth, and children who are at risk for avoidable hospital or emergency department care;
- Adults, youth, and children with serious mental health and/or substance use disorder needs;
- Adults living in the community and at risk for long-term care institutionalization;
- Adult nursing facility residents transitioning to the community;
- Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model with additional needs beyond their CCS condition(s);
- Children and youth involved in child welfare (foster care);
- Adults and youth who are transitioning from incarceration; and
- Pregnant and postpartum individuals.

[1] Available at https://www.healthaffairs.org/content/forefront/cbo-health-plan-contracting-under-calaim-and-competitive-social-care-market

As described by DHCS, enrollees are to have a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services. That lead care manager is to meet enrollees where they are—on the street, in a shelter, in their doctor's office, or at home—to meet their needs, build a trusting relationship, and provide intensive coordination of health and health-related services.[2]

In the most recently published data on utilization[3], in the second quarter of 2024, just under 126,000 Medi-Cal enrollees received ECM (out of 14.89 million total enrollees). While this service is intended for enrollees with the most complex medical and social needs, the penetration rate by county (percentage of Medi-Cal enrollees who received the service in the last 12 months) varies from .39% in Mono county to 3.39% in Santa Cruz county - a nearly ninefold difference. The variation by plan is even greater. Excluding plans serving specialized populations, the penetration rate varies from .43% to 4.57%, a nearly elevenfold difference.[4]

III. Community Supports

Community Supports are optional Medi-Cal plan services offered as cost-effective alternatives to traditional medical services or settings. DHCS has a pre-approved list of 14 Community Supports, building off previous pilot programs such as Whole Person Care, Health Homes, and a medically tailored meals pilot program. These services address health-related social needs of Medi-Cal enrollees, such as support to secure and maintain housing, access to medically tailored meals, and various transitional services when moving out of certain facilities. While DHCS encourages Medi-Cal plans to offer all of the Community Supports services, these services are not entitlements, and are offered at the option of the plan to any eligible Medi-Cal enrollee. In obtaining federal approval for Community Supports, DHCS was required to show that these services would allow Medi-Cal enrollees to avoid higher, costlier levels of care. For example, with regards to the Medically Tailored Meals/Medically Supportive Food benefit, DHCS presented findings that the average annualized health care expenditure was $1,863 greater for individuals assessed as food insecure relative to those not found to be food insecure, after adjusting for age, gender, race/ethnicity, education, income, insurance, and residence area.[5] These higher health care costs can be linked to more time spent in the hospital. For persons who have been recently discharged from hospitals or with chronic conditions, the report cited literature of specific patient populations showing significant reductions in emergency department visits, inpatient hospitalizations, reductions in readmissions, and improvements in health outcomes and well-being such as improved control of diabetes or fewer falls when provided meal delivery services.

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[2] See DHCS's ECM fact sheet: https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-ECM-a11y.pdf
[3] https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117?item=4
[4] https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117?item=4
[5] CalAIM In Lieu of Services: Cost-Effectiveness and Medical Appropriateness of ILOS. Available at https://www.dhcs.ca.gov/Documents/MCQMD/CA-ILOS-Evidence-Library-Executive-Summary-August-2021.pdf

The 14 Community Supports currently offered by Medi-Cal plans are:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Day Habilitation Programs
- Caregiver Respite Services
- Personal Care and Homemaker Services
- Nursing Facility Transition/ Diversion to Assisted Living Facilities
- Community Transition Services/ Nursing Facility Transition to a Home
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Tailored Meals/ Medically-Supportive Food
- Sobering Centers
- Asthma Remediation

Twelve of these services were authorized by a federal rule[6] dating back to 2016 that formally recognized states' and managed care plans' abilities to cover services or settings that are substitutes for services or settings covered under the state plan. That federal rule allows for such services when the service 1) advances the objectives of the Medicaid program, 2) is cost effective, 3) is medically appropriate, 4) is provided in a manner that preserves enrollee rights and protections, 5) is subject to appropriate monitoring and oversight, and 6) is subject to retrospective evaluation. The short-term post hospitalization housing and recuperative care services were authorized under the CalAIM 1115 waiver. Recently, through a separate 1115 waiver known as BH Connect, DHCS also obtained approval for a fifteenth community support, Transitional Rent, which provides up to six months of rent for specified populations that will start rolling out later this year.

One notable difference in Community Supports services compared to other Medi-Cal services is that the services are provided at the plan option instead of as an entitlement to every Medi-Cal enrollee who qualifies. While Medi-Cal plans must offer the services to every eligible enrollee if they offer the service at all, they can opt out of offering the services entirely. Additionally, while DHCS has defined the eligibility criteria for each service, some of that criteria is still subject to plan interpretation determining who gets the service or is subject to provider availability as the networks are built out. According to DHCS, as of June 30, 2024, every county has at least eight of the Community Supports available, 40 counties have at least 10 Community Supports available, and 19 counties have all 14 Community Supports available. In counties with more than one plan, obtaining these services might require changing plans as not all plans in a county have the same selection.

In the most recently published data on utilization[7], in the second quarter of 2024, , just over 124,000 used a Community Support. Over 79,000 used medically tailored meals or medically supportive food, while less than a thousand enrollees used each of seven of the services.

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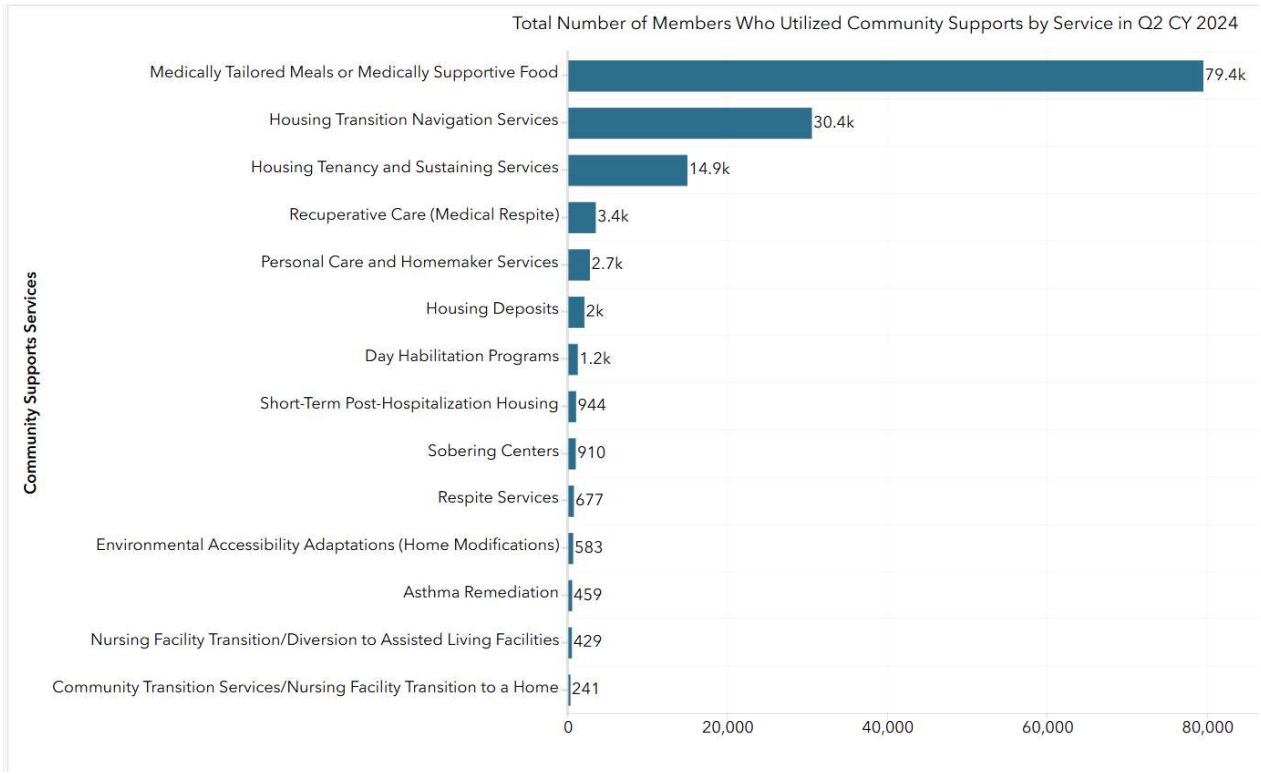
[6] 42 CFR § 438.3(e)(2)

[7] https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117?item=5



The utilization rate also varied widely by county and plan in the past 12 months of the data. Counties ranged from 0 services provided per 10,000 enrollees to 1,755 services per 10,000 enrollees. Plans ranged from 35 services per 10,000 enrollees to 3,513 services per 10,000 enrollees.[8]

IV. Justice-Involved Reentry Initiative

The Justice-Involved Reentry Initiative (Justice-Involved Initiative) allows eligible Californians who are incarcerated to enroll in Medi-Cal and receive a targeted set of services in the 90 days before their release. This initiative aims to ensure continuity of health care coverage and services between the time they are incarcerated and when they are released. It also provides people who are reentering the community with the prescribed medications and medical equipment they need, and access to programs and services to support this important transition. Federal Medicaid law prohibits the provision of most Medicaid services to individuals who are incarcerated, [9] thus California has long tried to ease this transition by suspending an individual's Medi-Cal during incarceration, or enrolling them in Medi-Cal effective upon release. This system still required individuals to navigate the managed care system and find providers, often with breaks in medication if they managed to navigate the system at all.

[8] https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117?item=5
[9] 42 U.S.C. § 1396d(a)(29)(A); 42 C.F.R. §§ 435.1009-1010.

In 2018, Congress passed the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, which contained a direction to the Secretary of Health and Human Services to issue guidance on opportunities to design Section 1115 waiver demonstrations to improve care transitions for individuals who are about to be released from a public institution and are otherwise eligible for Medicaid. In 2023, California was the first state in the nation to receive approval for a reentry initiative, doing so even before the federal guidance was issued. California's incarceration system is quite complex, with every county running its own jail system and a state prison system with locations often outside of incarcerated individuals' home counties. This circumstance, along with the need for these systems to build more integrated connections with Medi-Cal and community providers, meant that the implementation of this initiative started in October of 2024 with just three counties (Inyo, Santa Clara, and Yuba), and will be rolling out until January 2026. CDCR just began to implement elements of its program this February for state prisons with expected full operations in April 2025.

Pre-release services are available to all youth and adults who meet one or more of the following health needs criteria: confirmed or suspected mental health diagnosis; a substance use disorder or suspected diagnosis; a chronic clinical condition or significant non-chronic clinical condition; a traumatic brain injury; intellectual or development disability; a positive test or diagnosis of HIV/AIDS, or pregnancy or being within a 12-month postpartum period. The pre-release services include:

- Reentry care management services;
- Physical and behavioral health clinical consultation services provided through telehealth
- or in person, as needed, to diagnose health conditions, provide treatment as appropriate,
- and support pre-release care managers' development of a post-release treatment plan and
- discharge planning;
- Laboratory and radiology services;
- Medications and medication administration;
- Medication Assisted Therapy for all FDA-approved medications,
- including coverage for counseling; and,
- Services provided by Community Health Workers with lived experience.

In addition to the above pre-release services, qualifying Medi-Cal enrollees will receive any necessary Medi-Cal-covered outpatient prescribed medications, over-the-counter drugs, and medical equipment.

Issues for Consideration

1. What additional guidance is needed from DHCS to ensure that Medi-Cal plans and providers can work together more efficiently?
2. What is needed to increase the participation of more community-based providers with culturally relevant experience in these initiatives?

3. How can plans and providers better identify Medi-Cal enrollees who would benefit from these services?
4. What barriers exist that prevent Medi-Cal enrollees who are identified as eligible for these services from getting these services?
5. How will Medi-Cal plans be evaluated to ensure that these initiatives are successful?