From CalAIM Policy to Practice: Achieving Health Equity in Medi-Cal

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Quality and Population Health Management

DHCS' 2022 Comprehensive Quality Strategy

https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx

Creating a multi-pronged foundation for Health Equity

Health Equity Domains

- Managed Care/FFS (including CCS)
- Dental
- Behavioral Health
- School Based Services
- HCBS/1915c Delivery System
- CalAIM & Quality Strategy
- Alignment With Public Health

Thinking big:

BOLD GOALS:
50x2025

STATE LEVEL

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow up for mental health and substance use disorder by 50%

- Ensure all health plans exceed the 50th percentile for all children's preventive care measures

CalAIM and PHM: Levers for Transformation

CalAIM's bold Medi-Cal transformation expands on the traditional notion of "the health care system." It is much more than a doctor's office or hospital; it also includes community-based organizations and non-traditional providers that together can deliver equitable, whole-person care.

CalAIM Transformation Means:

- Meeting the needs of the whole person
- Engaging health providers who are trusted and relatable
- Expanding Community Supports and proactive upstream services
- Promoting community engagement
- Making the best use of partners and resources

CalAIM Supports Californians' Ability to Stay Healthy in All Areas of Life

Everyone has a stake in a better Medi-Cal program; many of us know someone whose health depends on it.

- **Population Health.** One in three Californians are enrolled in Medi-Cal, with more than 65% of enrollees identifying as people of color
- **Children & Youth.** Medi-Cal covers 50% of all births in California, with about two-thirds of children enrolled in Medi-Cal identifying as Black and Latino
- **Complex Needs & Unmet Care.** More than two in three patient days in a California long-term care facility are covered by Medi-Cal
- **Justice-Involved.** At least 80% of justice-involved individuals are eligible for Medi-Cal

Why Enhanced Care Management & Community Supports?

Issues ECM is Designed to Address

Over half of Medi-Cal spending is attributable to the **5% of enrollees with the highest-cost needs**

Medi-Cal enrollees typically have **several complex health conditions**

Enrollees with complex needs must often engage in **several delivery systems to access care**

ECM, alongside Community Supports, was informed by Previous Tests

Whole Person Care Pilots (WPC)

- Limited pilot program supported by Section 1115
- Coverage and delivery system agnostic (Medicaid Managed Care, Fee For Service, or uninsured); no requirements for interfacing with managed care plans (MCPs)
- Administered by county based "Local Entities"

Health Homes Program (HHP)

- Benefit (State Plan service) in select counties
- Medi-Cal Managed Care members only
- MCP administered with care management contracted out to providers

Enhanced Care Management

- Care coordination as a MCP contract requirement
- Medi-Cal Managed Care members only
- MCP administered with care management delivered through community providers

Community Supports

- Optional services, but strongly encouraged
- Medi-Cal Managed Care members only
- MCP administered with services delivered through community providers and integrated with ECM

CalAIM Care Management Continuum

MCPs are required to have a broad range of programs and services to meet the needs of all members organized into the following three areas.

Enhanced Care Management (ECM) is for the **highest-need members** and provides intensive coordination of health and health-related services.

Complex Care Management (CCM) is for members at **higher- and medium-rising risk** and provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions.

Basic Population Health Management (BPHM). BPHM is the array of programs and services for **all** MCP members, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care.

Transitional Care Services are also available for all Medi-Cal Managed Care Plan (MCP) members transferring from one setting or level of care to another.

**For more information, see the Population Health Management (PHM) Strategy & Roadmap*

Member Vignette: PHM & Data Exchange in Action

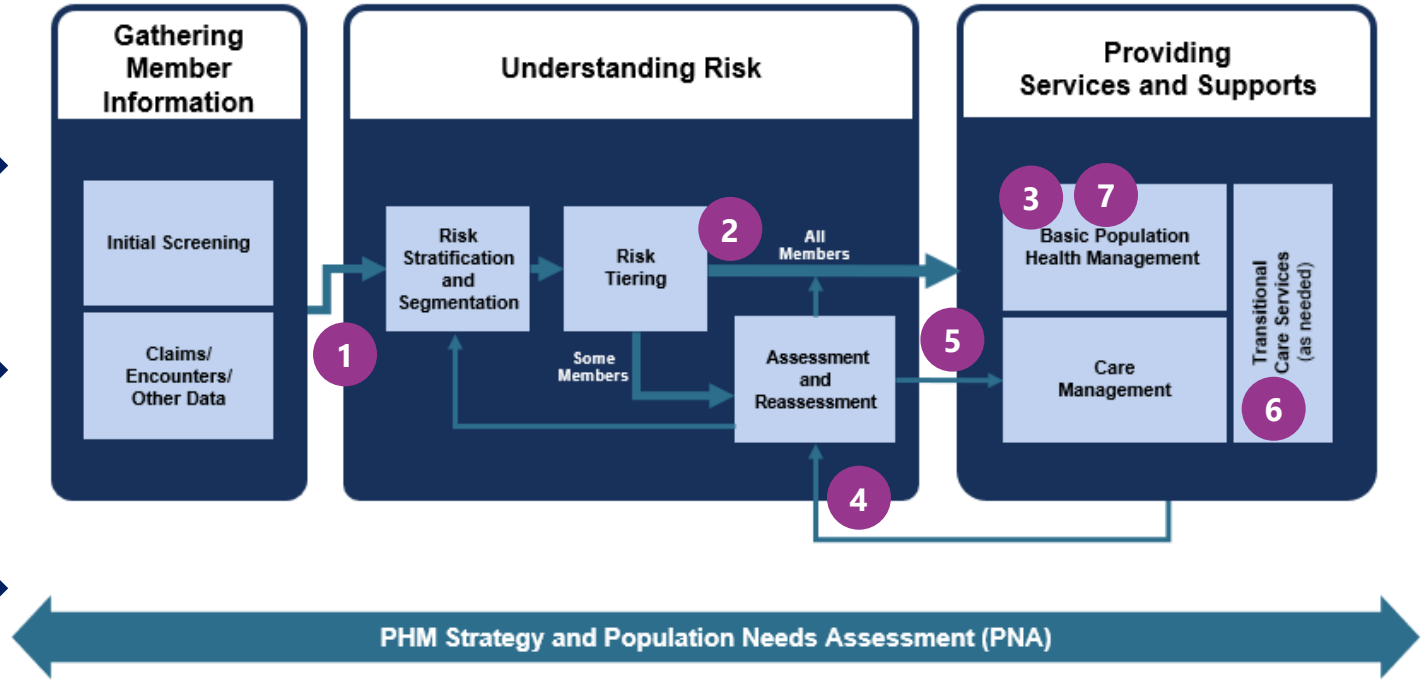
1 2 Linda has her first prenatal appointment; Her provider does a history and physical, diagnosing her with gestational diabetes. Her health plan receives the information.

3 A care coordinator from Linda's health plan reaches out and connects Linda to WIC services and a doula

4 5 At 28 weeks, Linda is diagnosed with high blood pressure and depression, referred to high risk pregnancy specialist and is enrolled in CCM.

6 At 37 weeks pregnant, Linda is diagnosed with preeclampsia and admitted for labor induction. Supported by her doula, she delivers her healthy son, Jacob. Her CCM care manager helps with the transitions from hospital

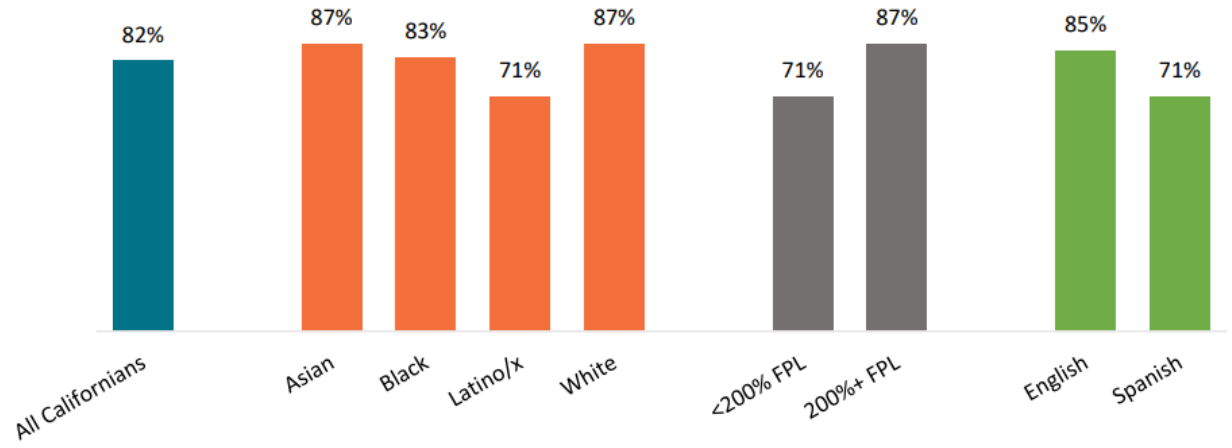
7 Linda's health conditions have resolved. Linda and Jacob receive dyadic services during Jacob's well child visits. Linda no longer needs support from CCM. Her plan continues to monitor and support her family through BPHM.



Re-Centering Primary Care

Figure 19. Majority of Californians Have a Primary Care Provider, with Latino/x Californians and Californians with Lower Incomes Reporting Lower Rates

PERCENTAGE WHO REPORT THEY HAVE A PRIMARY CARE PROVIDER



Notes: CHCF/NORC California Health Policy Survey (September 30–November 1, 2022). See topline for full question wording and response options. *FPL* is federal poverty level.

- Financing & primary care spending
- Engagement and utilization, especially for health equity
- MCO Accountability