San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

# CalAIM

## California Advancing and Innovating Medi-Cal

Health Commission

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# Objectives

Confirm a high-level understanding of CalAIM goals, initiatives, and populations of focus

Learn the benefits of DPH continuing to lead CCSF CalAIM implementation

Develop awareness of focus areas moving forward including impact of federal / state regulations

# CalAIM Overview

# CalAIM Strengthens Medi-Cal

Started in 2022, **California Advancing and Innovating Medi-Cal (CalAIM)** is a long-term commitment to **transform and strengthen Medi-Cal**, making the program more equitable, coordinated and person-centered to help people maximize their health and well-being.

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

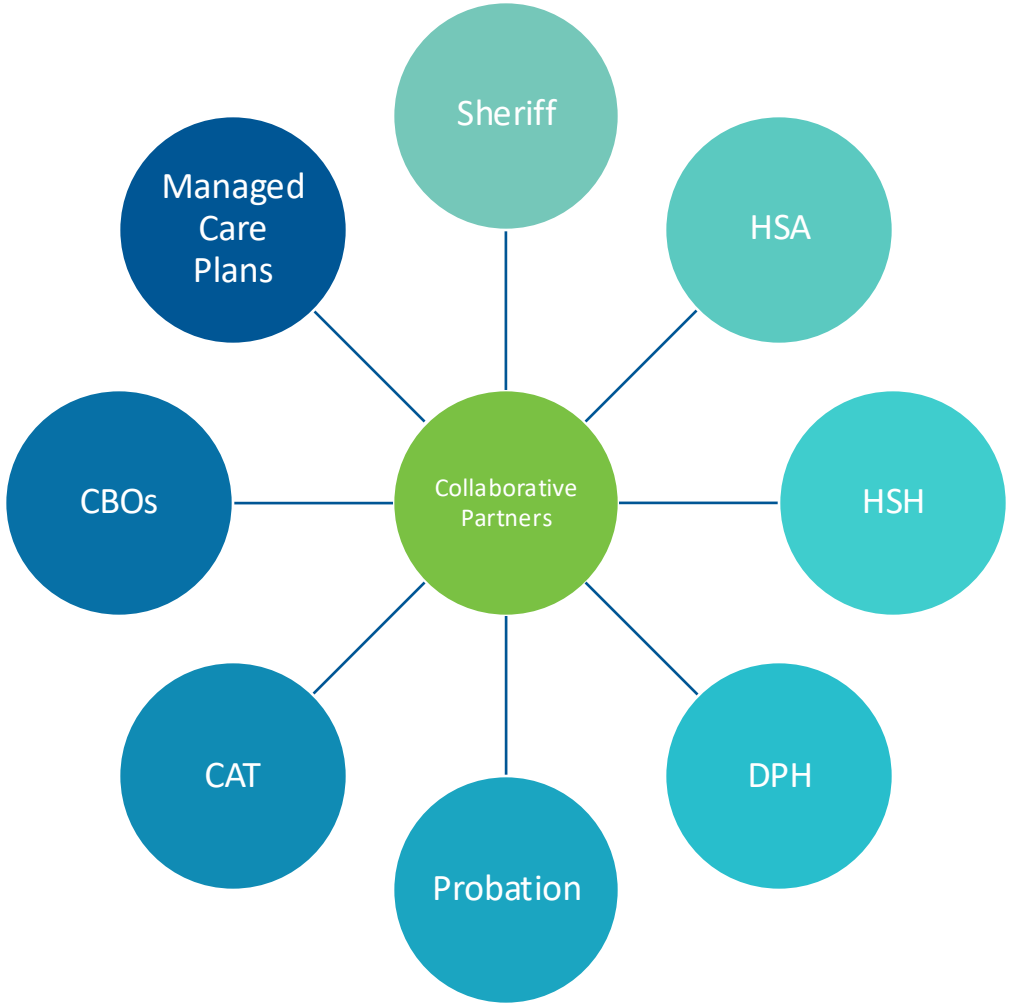
# Who CalAIM serves

**Eligible CalAIM Populations of Focus (PoF) include, but are not limited to, Medi-Cal members who are:**

- Experiencing homelessness
- Diagnosed with a serious mental illness (SMI) and/or substance use disorder (SUD)
- High utilizers of care
- Transitioning to the community from incarceration
- Foster youth
- At risk for institutionalization
- Black, American Indian or Alaska Native, or Pacific Islander and who are pregnant or postpartum

# Key CalAIM Initiatives and Collaborative Partners

- Behavioral Health Delivery System Transformation
- California Children's Services
- Community Supports
- Dual Eligible Special Needs Plans
- Enhanced Care Management
- Justice-Involved
- Managed Long Term Services & Supports
- Population Health Management
- Providing Access and Transforming Health



# CCSF CalAIM Timeline

## 2022

- Community Supports (DPH)
- Enhanced Care Management (ECM) (DPH)
- Providing Access and Transforming Health
- Incentive Payment Program
- Behavioral Health Quality Improvement Program

## 2023

- Community Supports (HSH)
- ECM (HSA)
- ECM for Children & Youth and Long-Term Care (DPH)
- Behavioral Health Services (BHS) Payment Reform
- BHS Screening Tool
- Contingency Management
- Long Term Care Carve-In
- Justice-Involved Medi-Cal Enrollment (DPH, JPD, SFSO, HSA)
- PHM Population Needs Assessment

## 2024

- Community Supports (HSA)
- ECM for Justice-Involved and Birth Equity (DPH)
- CCSF CalAIM Strategic Framework
- PHM Transitional Care Services
- ECM ZSFG Complex Care Management Discharge Linkage Team

## 2025

- CCSF CalAIM Strategic Implementation Plan
- Justice-Involved Pre-Release and Reentry Services Go Live (adults)
- California Children's Services Compliance, Monitoring, and Oversight Program (delayed - DHCS)
- PHM Medi-Cal Connect
- PHM Community Health Improvement Plan Planning

**We are here**

## 2026

- Dual Eligible Special Needs Plans (D-SNP) with SFHP
- Justice-Involved Pre-Release and Reentry Services (youth)
- Transitional Rent Community Support

# CalAIM Initiatives Require Enabling Federal Authorities

| Authority | Description | Timeframe |
|---|---|---|
| Medicaid State Plan | Contractual agreement between California and Centers for Medicare and Medicaid Services. | In effect until any amendments are made by State or Federal |
| Section 1915(b) Waiver | Primarily used for authorizing Managed Care Delivery Systems. | 1/1/22 – 12/31/26 |
| CalAIM 1115 Demonstration | Primarily used to demonstrate experimental projects. | 1/1/22 – 12/31/26 |
| 1115 Demonstration BH CONNECT | Primarily used to demonstrate experimental projects. | 1/1/25 – 12/31/29 |

Section 1115 or 1915(b) authority is **not needed** to continue ECM and 12 of the 15 Community Supports. DHCS seeks to continue the state's efforts to transform Medi-Cal through the renewal of key CalAIM initiatives. Priorities for the renewals may evolve due to the dynamic federal and state policy landscape.

# Justice-Involved Initiative Behavioral Health Focus

# CalAIM Justice Involved Initiative: Jail Health Phase I Impacts & Insights

## *PHASE 1:*

### *Impacts**

- 412 unique individuals provided **Medi-Cal Enrollment Assistance**
- 3537 individuals (non-unique) found eligible for CalAIM JI Services
- Q2 **claims volume are at target**
- Pharmacy is assisting more individuals in getting **release medications** to facilitate improved care transitions

### *Insights*

- ~ 80- 85% of individuals booked into the jail have Medi-Cal benefits
- Anticipated ↓ in eligible population due to loss of eligibility for individuals with Unsatisfactory Immigration Status (UIS).
- UIS population suspected to be ~5-10%.
- Q2 claims suggest on track to **meet budget goals**.

## *PHASE 2:*

- Builds on the foundation established in Phase 1 to drive the **expansion of care coordination and release planning**—ensuring every eligible justice-involved individual receives timely and effective reentry coordination and linkage.

*(Since April 1, 2025 Go-Live- *April 1, 2025 roll out complies with Cal-AIM regulatory requirements for implementation*)

# CalAIM JI BH Links

- The Justice-Involved Behavioral Health (JI BH) Links initiative is a CalAIM-aligned strategy within SFDPH-BHS designed to **ensure timely, person-centered behavioral health linkages for individuals transitioning from custody.**
- Upon notification of a release date, JI BH Links activates **pre-release planning and post-release engagement** to reduce service gaps, prevent recidivism, and promote continuity of care.
- This work is rooted in **health equity**, recognizing that Black/African American individuals are disproportionately impacted by incarceration and behavioral health disparities.
- By operationalizing **real-time data, care coordination, and culturally responsive outreach,** JI BH Links is a key mechanism for advancing racial justice and system accountability within the SFDPH-BHS Safety Net.

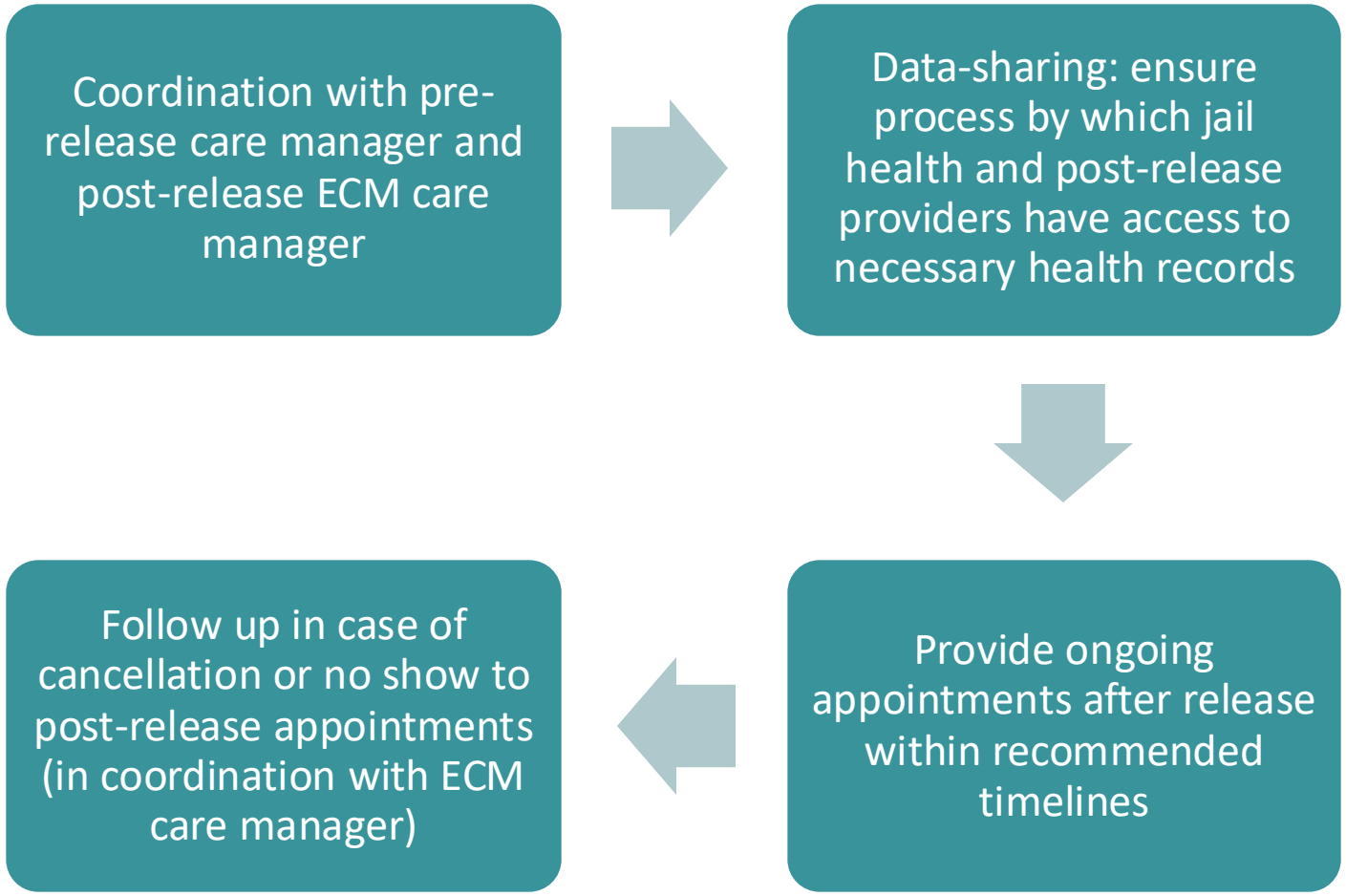
# County Behavioral Health Responsibilities: CalAIM JI BH Links

Receive referrals for and link to Specialty Mental Health Services and DMC-ODS services

Provide post-release appointment within recommended guidelines *(when release date is known)*

Professional to professional warm hand-off within 14 days prior to release *(when release date is known and particularly for clients with complex or high needs)*

# County Behavioral Health Responsibilities: Behavioral Health Links



# CalAIM JI BH Links

- Our **partnership with Jail Health Services** is central to the success of JI BH Links—ensuring that individuals transitioning from custody are met with **coordinated, timely, and person-centered care**.
- Through this collaboration, we are operationalizing CalAIM's promise of whole-person care, while **advancing racial equity** and reducing barriers for justice-involved individuals—especially those from **Black and African American communities**, who are disproportionately impacted.
- Together, we are building a more **responsive, equitable, and integrated behavioral health system**.
- JI BH Links will also be formalized under the Justice-Involved Initiative for the SF **Juvenile Justice System**.

# BHS Special Programs for Youth Leads CalAIM Expansion*

**The SF Juvenile Justice System already provides many of the services required under CalAIM to its youth.**

CalAIM Pre-Release and Reentry Initiative will introduce **additional benefits**

| Clients | CCSF |
| --- | --- |
| • Medi-Cal coverage<br>  • FY 24/25: 77% clients had Medi-Cal (275 bookings)<br>• Improved access to health and social services upon release<br>• More coordinated care and service delivery upon release | • Care coordination and data sharing opportunities between CCSF departments and with Managed Care Plans<br>• Revenue generation |

**Go Live: April 1, 2026**

*Key Partners: Juvenile Probation Dept, DPH IT and Finance; SFHN Pharmacy, Central CalAIM, Primary Care; Managed Care Plans. Jail Health Services and Sheriffs Department provide consultation and guidance.

# Enhanced Care Management

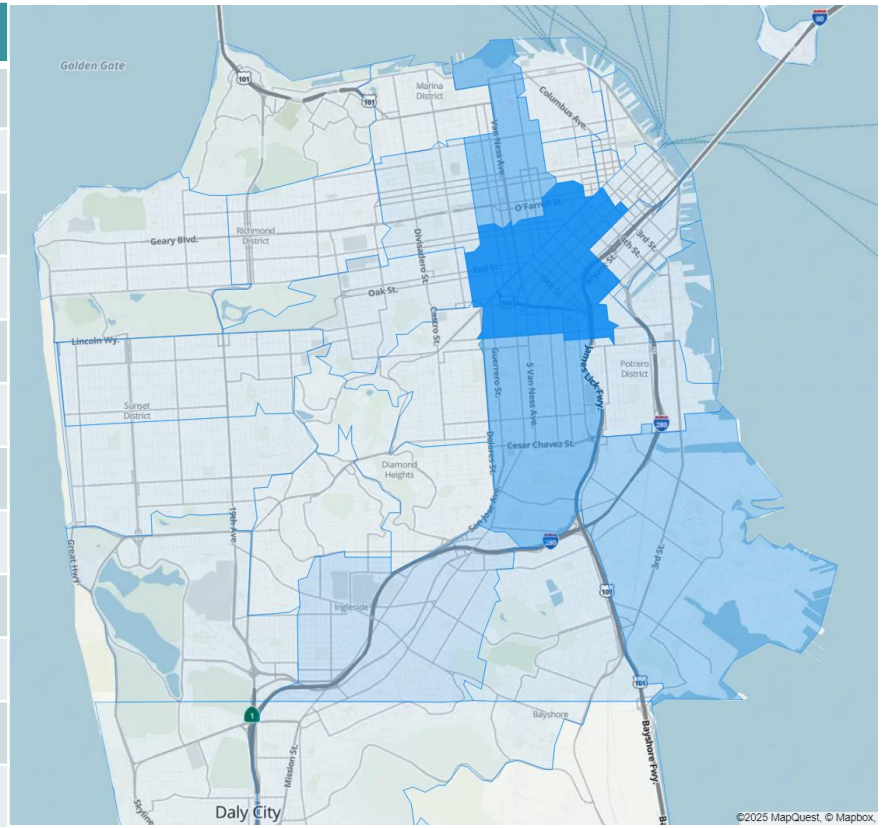
# A Patient Story – ECM Supports Recovery and Stabilization

- “Steven” is observed in distress on the street, placed on an involuntary hold by the Street Crisis Response Team, transported to ZSFG Psychiatric Emergency Services (PES), and referred to the Behavioral Health Services (BHS) Office of Coordinated Care (OCC) for follow-up care.
- OCC Bridge & Engagement Services (BEST) Enhanced Care Management (ECM) Lead Care Manager initiated care in PES and supported Steven through recovery and stabilization:
  - Hummingbird
  - Coordinated Entry
  - Residential Substance Use Treatment Program
  - Primary Care
  - Mental Health
  - Housing

# DPH ECM Teams Serve Clients Across San Francisco


## DPH ECM Clients Enrolled by Zip Code

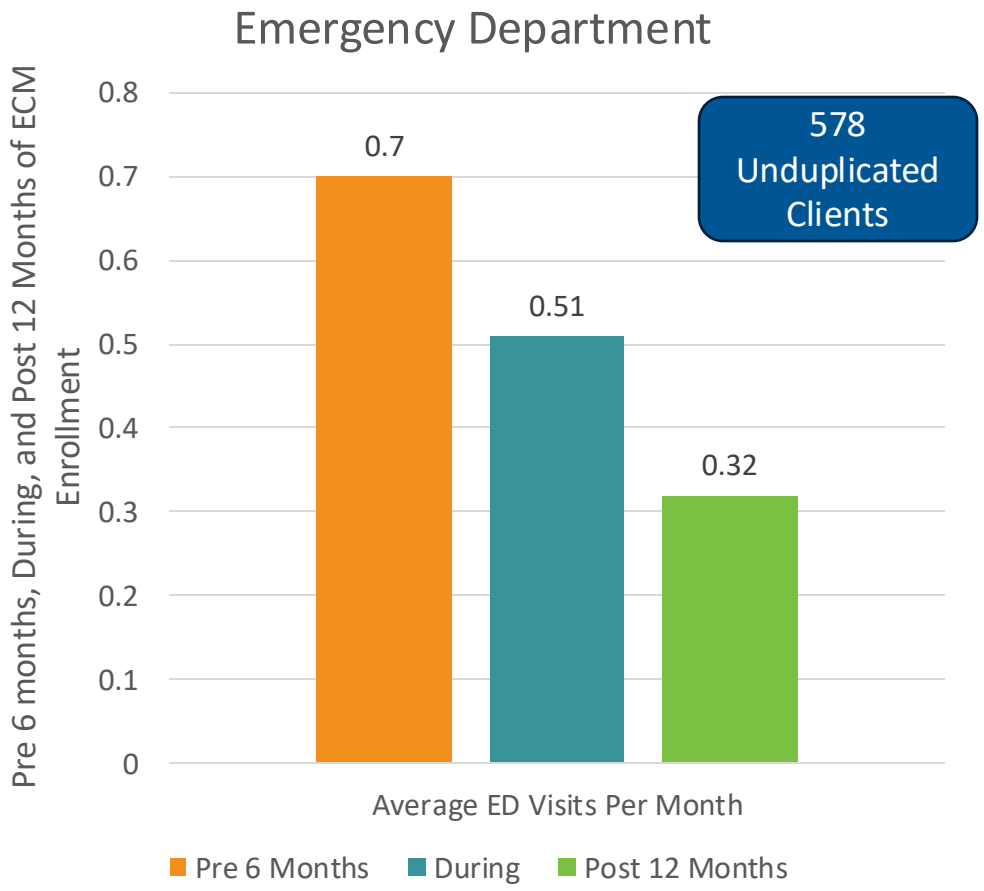
| Zip Code | # of clients |
|---|---|
| 94103 | 309 |
| 94102 | 304 |
| 94110 | 145 |
| 94109 | 139 |
| 94124 | 101 |
| 94112 | 50 |
| 94107 | 26 |
| 94158 | 26 |
| 94134 | 23 |
| 94115 | 21 |
| 94117 | 18 |
| 94116 | 12 |

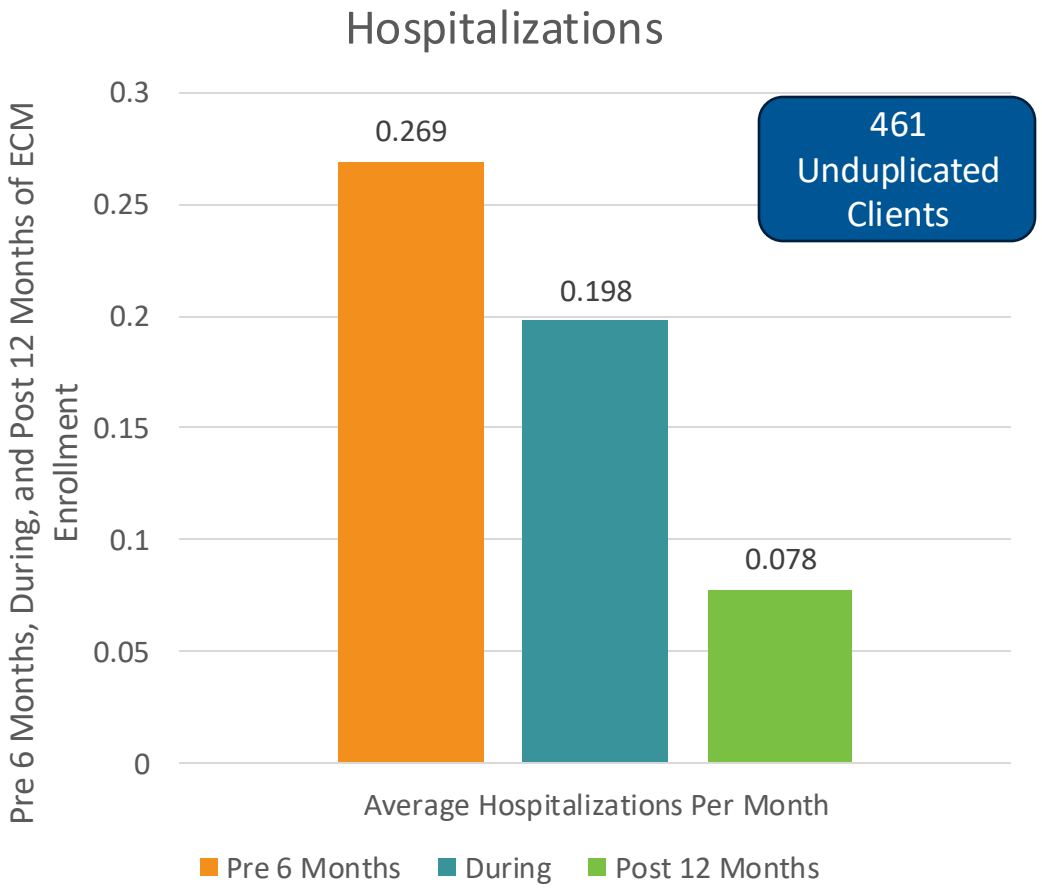


# DPH ECM Service Model has Expanded

- We now include **palliative care** within Street Medicine and **behavioral health** in Permanent Supportive Housing.
- We have expanded services for justice-involved clients from San Francisco County Jail to also now include **Out of County jails** and California Department of Corrections and Rehabilitation **State Prisons**.
- Lead Care Managers provide **care coordination** into and out of clinics, hospitals, and the community

# ED Visits and Hospitalizations are Reduced post ECM Enrollment



# Community Supports

# Menu of Community Supports/DPH Implementation

* **bold** text indicates implemented *(billing to MCPs)*

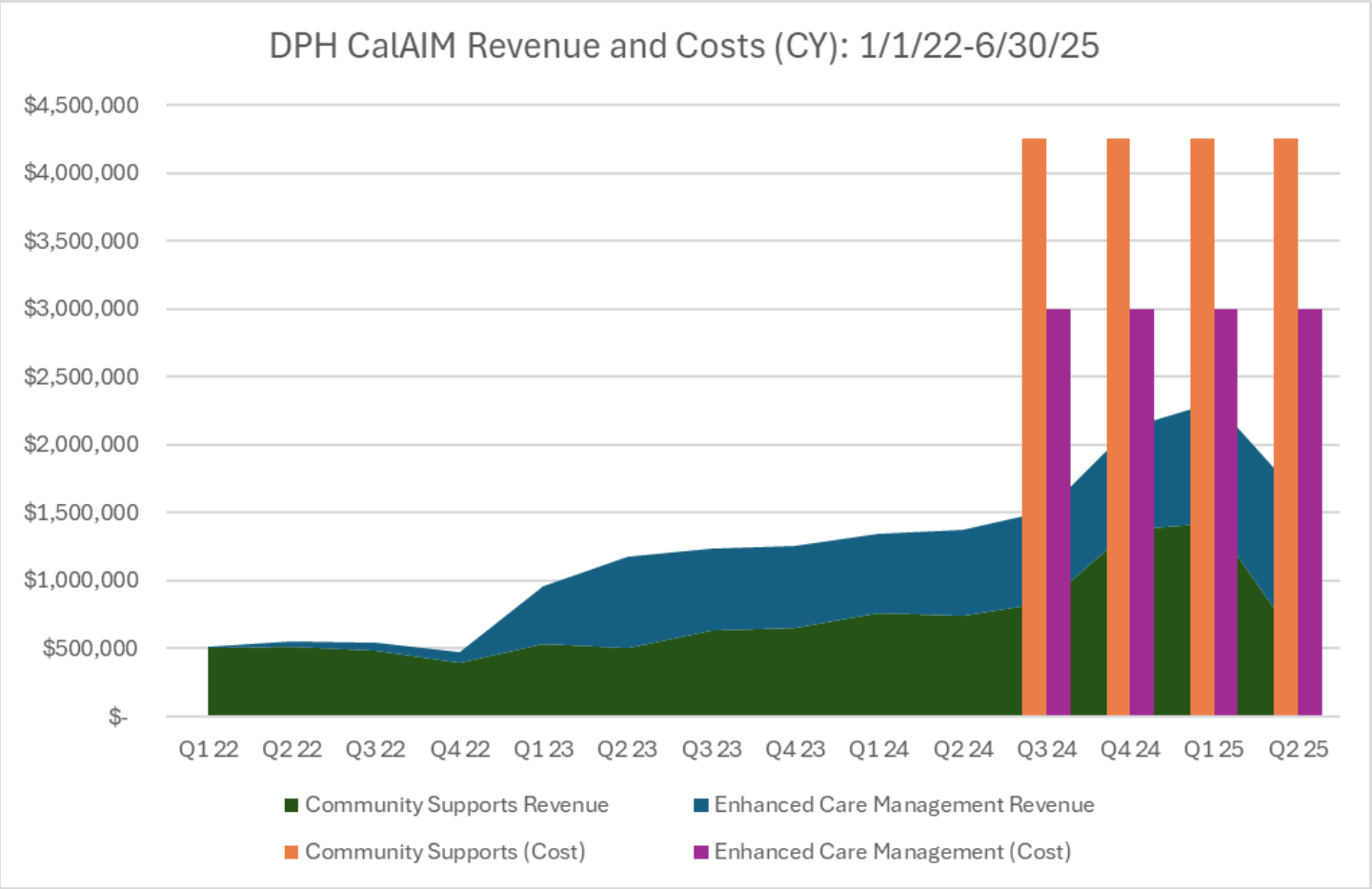
| Community Support (CS) | DPH CS Programs | DPH Implementation *(billing to MCPs)* |
|---|---|---|
| **Recuperative Care (Medical Respite)** | **Medical Respite** | **1/1/2022** |
| | **Managed Alcohol Program (MAP)** | **10/1/2023** |
| **Sobering Centers** | **Sobering Center** (alcohol and drug) | **7/1/2022** |
| | **SoMa RISE** (drug) | **7/24/2023** |
| **Housing Transition Navigation Services** | **Housing Navigation via Coordinated Entry** *(HSH under SFHN contract)* | **1/1/2024** |
| **Housing Deposits** | **Housing Deposits** *(HSH under SFHN contract)* | **10/1/2023** |
| **Housing Tenancy and Sustaining Services** | **Housing Tenancy and Sustaining** *(HSH under SFHN contract)* | **1/1/2024** |
| Transitional Rent | BHS will be the CCSF Transitional Rent provider in partnership with HSH (services) and SFHN (contracting, infrastructure, ECM) | DHCS requires MCPs to launch 1/1/2026 – BHS/SFHN/HSH/MCPs currently planning |

# FY 24-25 Community Supports Highlights

- Developed strategy and plan for **CalAIM CS expansion aligned with Mayoral Priorities -** overdoses, homelessness, distressing street behaviors, interagency collaboration
  - Partnering with HSH and BHS to **maximize CalAIM CS managed care plan (MCP) reimbursements** for shelter health treatment beds and other services aligned with CS
  - Began planning for **new Recuperative Care CS**: RESTORE 1, Eleanora Fagan Center, and Hummingbird
- Refined quality assurance/auditing standard work to **optimize revenue generation** in partnership with MCPs

# Revenue Generation

# Medi-Cal Revenue Generation Offsets General Fund




DPH CalAIM Community Supports and ECM billable revenue to date is $17M, **offsetting the General Fund**.
CalAIM Central Team collaborates with Epic IT, Patient Financial Services, and Managed Care Plans to **maximize revenue generation**.

HSH Revenue Generation = $1.8M

CCSF has been awarded **$74M in one-time funding** from DHCS and Managed Care Plans to support CalAIM implementation and expansion.

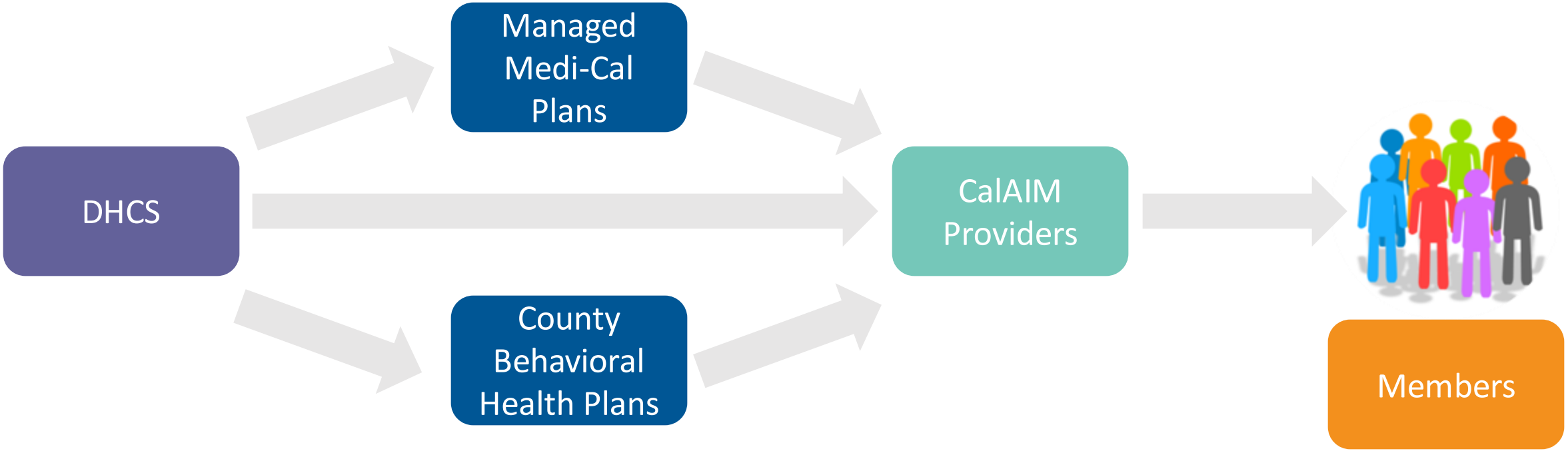
| CCSF Department | Total $ Awarded |
|---|---|
| DPH | $30,288,989 |
| HSA | $1,702,073 |
| HSH | $40,268,574 |
| SFSO | $1,189,921 |
| ADP | $1,500,000 |

# Focus Areas Moving Forward

# Thank You!

# Appendix

# CalAIM Resources and Funding Flow



# DPH CalAIM Initiatives, Federal Authorities, Legal Requirements, and Revenue Generating Status

| DPH CalAIM Initiative* | Medicaid State Plan | 1915(b) Waiver | CalAIM 1115 Demonstration | 1115 Demonstration BH CONNECT | Legally Required | Revenue Generating |
|---|---|---|---|---|---|---|
| Behavioral Health | X | X | X | X | X | X |
| Community Supports | | X | X | X | | X |
| Enhanced Care Management (ECM) | | X | | | | X |
| Global Payment Program | | | X | | | X |
| Incentive Payment Program | | | X | | | X |
| Integrated Care for Dual Eligibles | | X | | | | |

# DPH CalAIM Initiatives, Federal Authorities, Legal Requirements, and Revenue Generating Considerations

| DPH CalAIM Initiative* | Medicaid State Plan | 1915(b) Waiver | CalAIM 1115 Demonstration | 1115 Demonstration BH CONNECT | Legally Required | Revenue Generating |
|---|---|---|---|---|---|---|
| Justice-Involved | | | X | | X | X |
| Managed Long Term Care | | X | | | X | |
| Population Health Management | | X | X | | X | |
| Providing Access and Transforming PATH | | | X | | | X |
| Supporting Health and Opportunity for Children and Families | X | X | | | X | |

# MCP Partnerships Strengthen Population Health

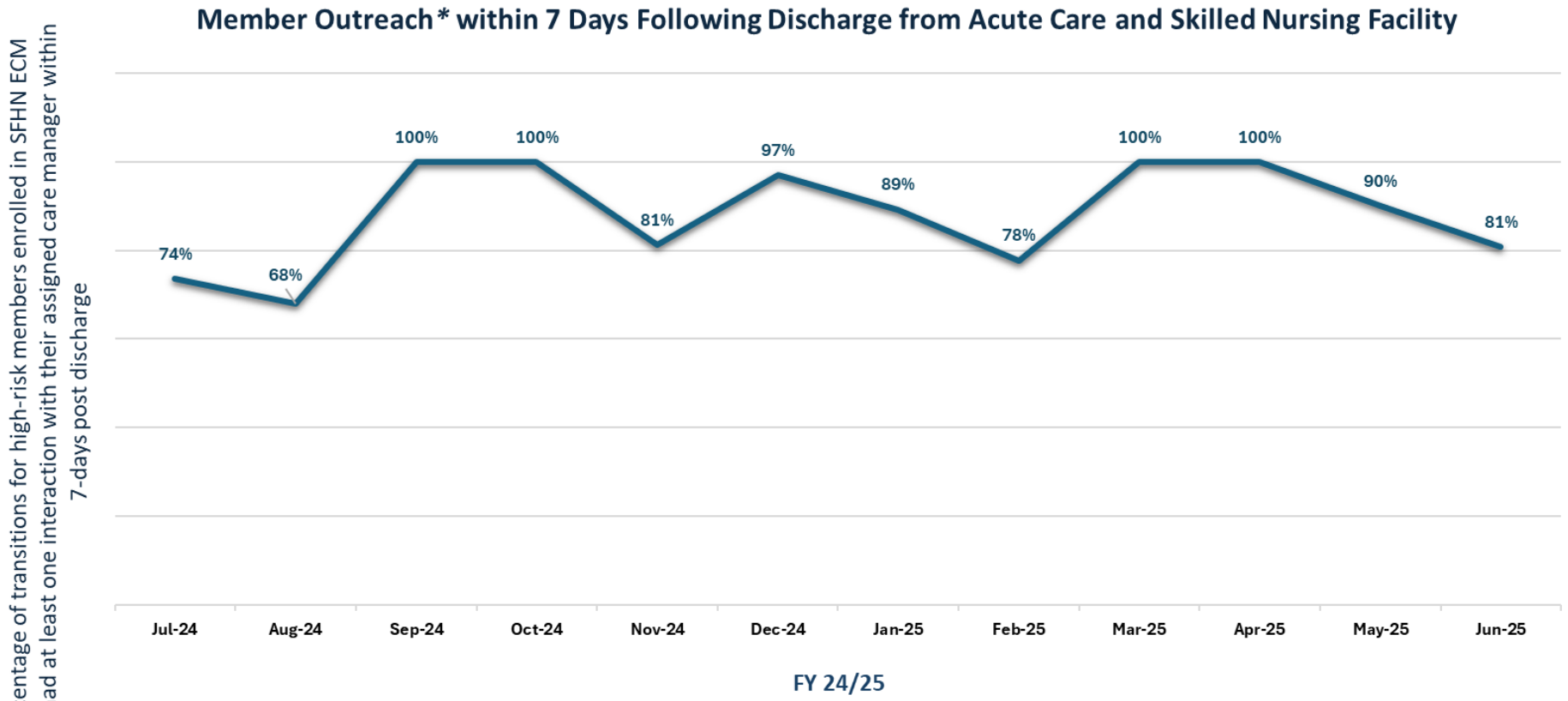
## Accomplishments in FY 24/25

- **MCPs demonstrated a high level of engagement and commitment** through supporting community events and providing input for the Community Health Assessment (CHA)
- The 2024 San Francisco **Community Health Assessment is completed**
- Clients requiring **Transitional Care Services** are identified by ZSFG, LHH and SFHN ECM Teams via daily reports; SFHN ECM Teams provide care coordination aligned with TCS requirements prior to and following hospital/SNF discharge x 30 days

## Goals for FY 25/26

- **MCPs will be engaged** in the Community Health Improvement Plan (CHIP) process
- Collaboratively develop and begin **implementation of the CHIP**
- Support CBO's in their ability to leverage the **Community Health Worker (CHW) Benefit**

# Transitional Care Services are Provided to High-Risk Clients Enrolled in SFHN ECM




Numerator: Transitions for high risk members enrolled in SFHN ECM who **received** outreach within 7 days of discharge = 279
Denominator: Transitions for high risk members enrolled in SFHN ECM who **required** outreach within 7-days post discharge = 318

*TCS Key Performance Indicator

# California Children's Services are Strengthened

## Context

- CalAIM CCS Monitoring & Oversight Program for all 1,500 SF children & youth enrolled in CCS aims to promote accessibility, transparency, monitoring, and oversight of the CCS programs statewide.

## Highlights

- Implemented pilot project with SFHP aimed at increased outreach & linkage to ECM services for high-acuity CCS clients, especially around transition planning
- Developed new workflows to improve program efficiency
- Revamped program documents to improve accessibility
- Implemented new family contact protocol

## Moving Forward

- Develop & implement Quality Assurance plan for M&O performance measures
- Refine data reports to track and monitor compliance more accurately

# Housing Community Supports are Provided by HSH

- The Department of Homelessness and Supportive Housing administers the Housing Trio — Housing Navigation, Housing Deposits, and Housing Tenancy and Sustaining Services.
- FY24/25 is the first year of full implementation for the Housing Trio. At present CCSF is in contract with SFHP for HSH to provide these services.

| CalAIM Service | Date Range | Members Authorized | Revenue (to date) |
|---|---|---|---|
| Housing Navigation | July '24 - January '25 | 3,113 | $1,595,769 |
| Housing Deposits | July '24 - Dec. '24 | 126 | $13,380 |
| Tenancy Services | July '24 - Dec.'24 | 2,072 | $226,875 |
| **TOTAL** | Q1 & Q2 FY24/25 | **5,311** | **$1,836,024** |

- Continuous Quality Improvement has boosted services documentation rates by >20% since January 2025, increasing the number of clients served through CalAIM.