ITUP
Insure the Uninsured Project

Issue Brief

Leveraging Data to Advance Health Equity and Success in CalAIM

APRIL 2024

EXECUTIVE SUMMARY

Data exchange is integral to identifying and connecting populations to health and social services, modernizing delivery systems, and improving quality of care for all Medi-Cal patients. This issue brief explores how improved health and social services information exchange through the California Health and Human Services (CalHHS) Data Exchange Framework (DxF) is essential for the foundational success of California's Advancing and Innovating Medi-Cal (CalAIM) Initiative. Data sharing through the DxF directly supports CalAIM's goals to improve whole person care by addressing social determinants of health (SDOH), improving systems of care for Medi-Cal members, generating better health outcomes and advancing health equity.[1] Data sharing is a vital element to measure the impact on health care access and health outcomes for Medi-Cal members.[2] This brief further examines data sharing needs for **five major CalAIM Initiatives**:

Connect
Medi-Cal Members to Community Supports

Transition
Dual-Eligibles to Managed Care

Transform
Behavioral Health Services

Identify and Address
Health and Social Needs of Justice-Involved Medi-Cal Members

Establish
Statewide Population Health Management

ACRONYMS 101: Lingo To Know

BIPOC = Black, Indigenous, and Other People of Color

CalAIM = California Advancing and Innovating Medi-Cal

CIE = Community Information Exchange

CBO = Community-Based Organization

DxF = Data Exchange Framework

DSA = Data Sharing Agreement

ECM = Enhanced Care Management

EHR = Electronic Health Record

HIE = Health Information Exchange

HIO = Health Information Organization

HSSI = Health and Social Services Information

MCP = Medi-Cal Managed Care Plan

QHIO = Qualified Health Information Organization

SOGI = Sexual Orientation and Gender Identity

SDOH = Social Determinants of Health

CalAIM & DxF TIMELINE

January 2022
Enhanced Care Management (ECM) and Community Supports Initiative launches; Mandatory Managed Care Enrollment for dual-eligibles launches.

JULY 2022
CalHHS establishes Data Sharing Agreement (DSA) and Data Exchange Framework (DxF) as mandated by AB 133, and releases a final version of the DSA and an initial set of policies and procedures to govern the DxF.

July 2022
Behavioral Health No Wrong Door Policy goes live.

November 2022
DSA signing begins.

January 2023
Deadline for DSA to be signed by required signatories in California.

January 2023
Justice-Involved Initiative launches, releasing applications for county jail and youth correctional facilities.

January 2023
Population Health Management (PHM) Initiative launches. Full statewide launch of PHM is still being determined.

January 2024
Most required DXF signatories must begin to exchange health information for treatment, payment, health care operations, and public health activities.

January 2024
Qualified Health Information Organizations (QHIOs) for the DxF are announced.

April 2024
Beginning of 24-month phase-in period for Justice-Involved pre-release Medi-Cal services.

January 2026
All required DxF signatories must begin sharing health information.

Equity in Data and Data Sharing is Essential to Drive CalAIM's Success Forward

Access to actionable health and social services information (HSSI) is foundational to a successful health care system; however, HSSI is not often shared between different Medi-Cal providers.[3,4] California's current state of data sharing lacks a centralized system, resulting in data silos and barriers limiting communications and access to critical information for providers to address patients' needs. The reliance on data like claims and cost data is insufficient to accurately identify and address disparities in historically underserved and underrepresented communities.[5,6] Studies show that 80% of health outcomes are related to social determinants of health (SDOH) , and communities of color are more likely to experience multiple compounding social needs.[7] Without adequate HSSI exchange, both health and social service providers cannot communicate to identify and connect patients to necessary services further exacerbating health disparities.[8]

Data exchange can also improve quality of care by preventing missed referrals, avoiding incomplete, duplicative, or contraindicated clinical information, and integrating and coordinating care between different providers.[9] California Advancing and Innovating Medi-Cal (CalAIM) Initiative implementation has been hampered by difficulty with inconsistent data exchange practices, social service referrals, Enhanced Care Management (ECM) care coordination, and identification and care for the justice-involved population.[10] Equity-focused statewide data policy is needed to bolster CalAIM's implementation and is possible through the California Health and Human Services' statewide Data Exchange Framework (DxF).[11] Opening channels of communication can create a team of multiple organizations and/or provider types that cares for a single patient, thus decreasing the patient's responsibility for communicating across multiple providers and increasing their overall health outcomes.[12] Data exchange within the DxF will increase data availability, ensure those who need services are connected, improve quality of care, and allow for more robust tracking of health disparities.[9]

DxF

The California Health and Human Services (CalHHS) Data Exchange Framework (DxF) established California's first-ever statewide data sharing agreement (DSA) with a common set of policies and procedures. The DxF provides a governance structure to privately and securely exchange health and social services information (HSSI) between health care providers, entities, government agencies, and social service programs in California, with the goal of improved health equity and outcomes. See ITUP's DxF 101 Fact Sheet for more information on the DXF.

CalAIM

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative by the Department of Health Care Services (DHCS) to enhance care coordination and improve the quality of care provided to Medi-Cal members. The CalAIM Initiative strives to advance health equity and quality, integrate SDOH into care, and modernize the delivery system for vulnerable Californians, with a specific focus on BIPOC communities, justice-involved population, and those with compounding social needs. See ITUP's CalAIM Resources and Timeline Fact Sheet for more information on CalAIM.

How Does Sharing Through the DxF Advance CalAIM's Goals?

Successful Medi-Cal transformation, promised by the goals and vision of CalAIM, requires robust data collection, use and sharing across the health care and social care delivery system. The DxF presents an opportunity to support CalAIM by establishing common data exchange procedures to accelerate information sharing across California.

Health information exchange advances health equity, care coordination, quality of care, and modernizes health systems.[13]

For more information on the benefits of data sharing, click here.

CalAIM Goal 1

Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health[1]

The DSA contains policies and procedures (P&Ps) that define specific elements to be between clinical and social service providers, such as electronic health information, clinical and encounter data, and social services data. The P&Ps also include data privacy, security, and information blocking provisions. The process of integrating trading partners involved in providing care for Medi-Cal members allows for clinical decision-making that takes SDOH into account and can ensure continuity of care between clinical services and social services.

Corresponding DxF Guiding Principles:

- *Advance Health Equity*
- *Support Whole Person Care*
- *Make Data Available to Drive Decisions and Outcomes*
- *Establish Clear and Transparent Terms and Conditions for Data Collection, Exchange, and Use*

CalAIM Goal 2

Make Medi-Cal a more consistent and seamless system by reducing complexity and increasing flexibility[1]

To comply with the DSA, Medi-Cal entities must adhere to data exchange interoperability standards set forth in the P&Ps. These standards specify how signatories must request and be able to exchange data in real-time. This provides a common language with which separate entities caring for the same individual can coordinate care and adapt to the patient's needs in a timely manner. Streamlining this data exchange decreases the administrative burden for patients, providers, health care systems, and other entities. In addition, data exchange with multiple providers increases flexibility in care coordination and patient options.[14]

Corresponding DxF Guiding Principles:

- *Make Data Available to Drive Decisions and Outcomes*
- *Promote Individual Data Access*
- *Reinforce Individual Data Privacy and Security*
- *Establish Clear and Transparent Terms and Conditions for Data Collection, Exchange, and Use*
- *Adhere to Data Exchange Standards*

CalAIM Goal 3

Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform[1]

Data exchange gives providers access to timely and accurate patient data, and thereby reduces medical errors. More accessible and comprehensive demographic data ensures patients receive care in a safe, inclusive manner that is culturally relevant. Providing culturally competent care is foundational to reducing health disparities, especially for Medi-Cal members.[15] Increased data collection and exchange provides accountability to reduce health care disparities and improve quality of care.

Corresponding DxF Guiding Principles:

- *Advance Health Equity*
- *Make Data Available to Drive Decisions and Outcomes*
- *Support Whole Person Care Ensure Accountability*

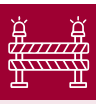
How Data Sharing Can Advance Equity & Efficiency in Major CalAIM Initiatives: Community Supports

Connecting Medi-Cal Members to Community Supports

CalAIM's Enhanced Care Management (ECM) and Community Supports Initiative provides additional case management and community-based social supports to high-need, complex Medi-Cal members where they are; whether they are at home, in a shelter, unhoused, or at a clinic. The ECM model uses a care management team that coordinates services between physical, behavioral, dental, developmental, and social services delivery systems. Examples of community supports offered include housing supports and medically supportive foods.[16] This is essential to advance health equity, as many high-need members experience compounding social and health needs that can be overlooked if care is not tailored and coordinated.

Data exchange between community supports, clinical providers, and care management teams is necessary to ensure members receive appropriate services.

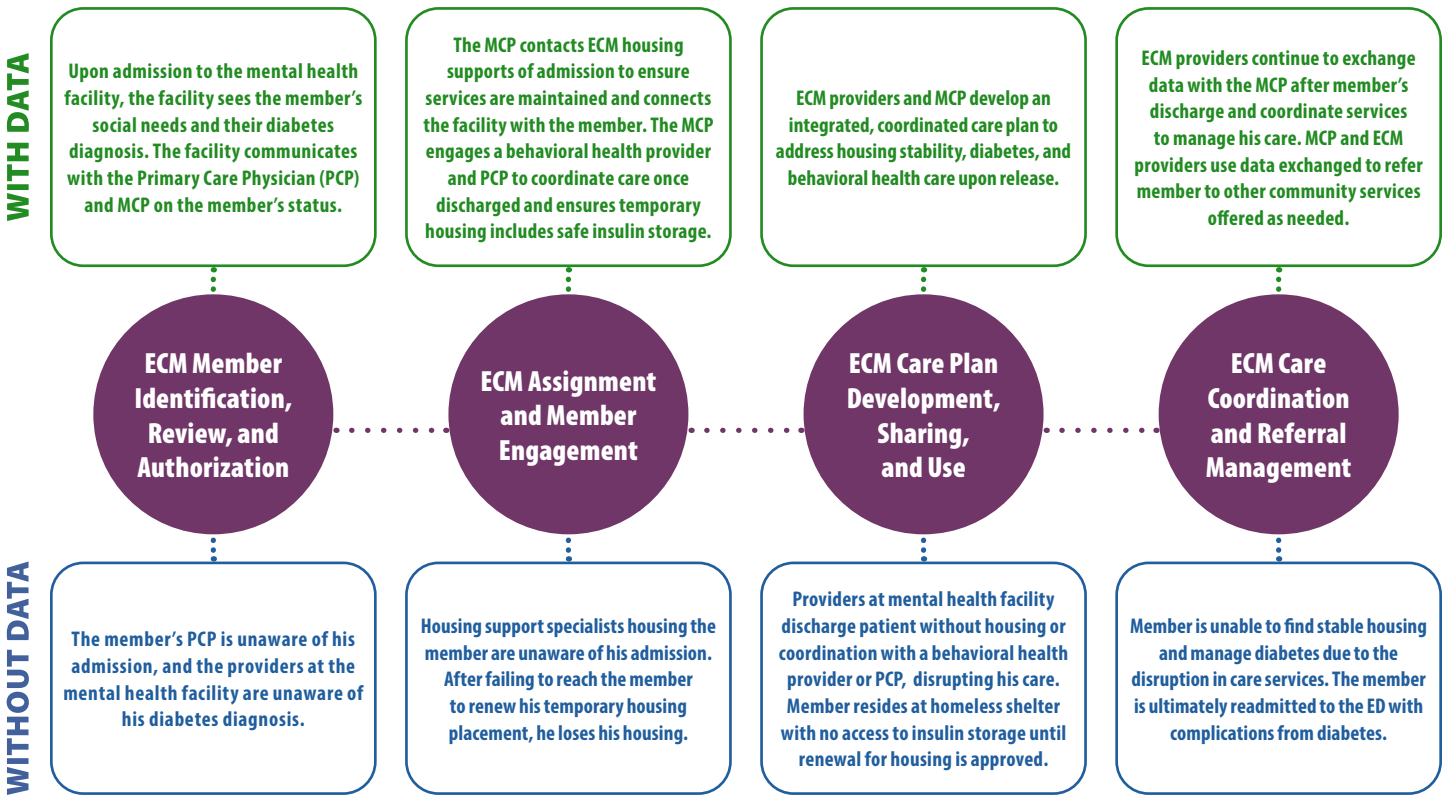
Barriers to Success: Policy Considerations



- Many social service providers are unfamiliar with Personal Health Information (PHI) and the Health Insurance Portability and Accountability Act (HIPAA) compliance. Technical and infrastructural assistance is needed to ensure that social service providers have safeguards in place to protect and maintain PHI.[10]
- Financial support for onboarding and infrastructure development for smaller community-based organizations (CBOs) is necessary to ensure they can participate alongside larger organizations and reduce the digital divide.[17]
- Policy guidance for standardized data collection is needed for SDOH and expanded demographic data, such as sexual orientation and gender identity (SOGI) data, and race and ethnicity data.

Enhanced Care Management (ECM) Scenario[18]

A 40-year-old Latino male on Medi-Cal with schizophrenia, diabetes, and experiencing housing instability is admitted to a mental health facility following an acute episode of schizophrenia.

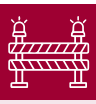


How Data Sharing Can Advance Equity & Efficiency in Major CalAIM Initiatives: Dual-Eligibles

Transitioning Dual-Eligible Members to Managed Care

Starting January 2023, CalAIM requires nearly all dual-eligibles (members eligible for both Medi-Cal and Medicare) to receive their Medi-Cal benefits through Medi-Cal managed care plans (MCPs). As part of CalAIM, services for dual eligibles will be delivered through a Managed Long-Term Services and Supports (MLTSS) and Dual Eligible Special Needs Plans (D-SNPs) structure. Dually eligible Californians are disproportionately people of color that have complex needs who receive their Medicare and Medi-Cal benefits from different delivery systems, resulting in uncoordinated and fragmented care.[19] Data exchange will be a vital component to identify members not currently enrolled in an MCP and to facilitate care management and care integration between the MCP and Medicare benefits. For more information, see ITUP's fact sheet focused on advancing health for California's older adults.

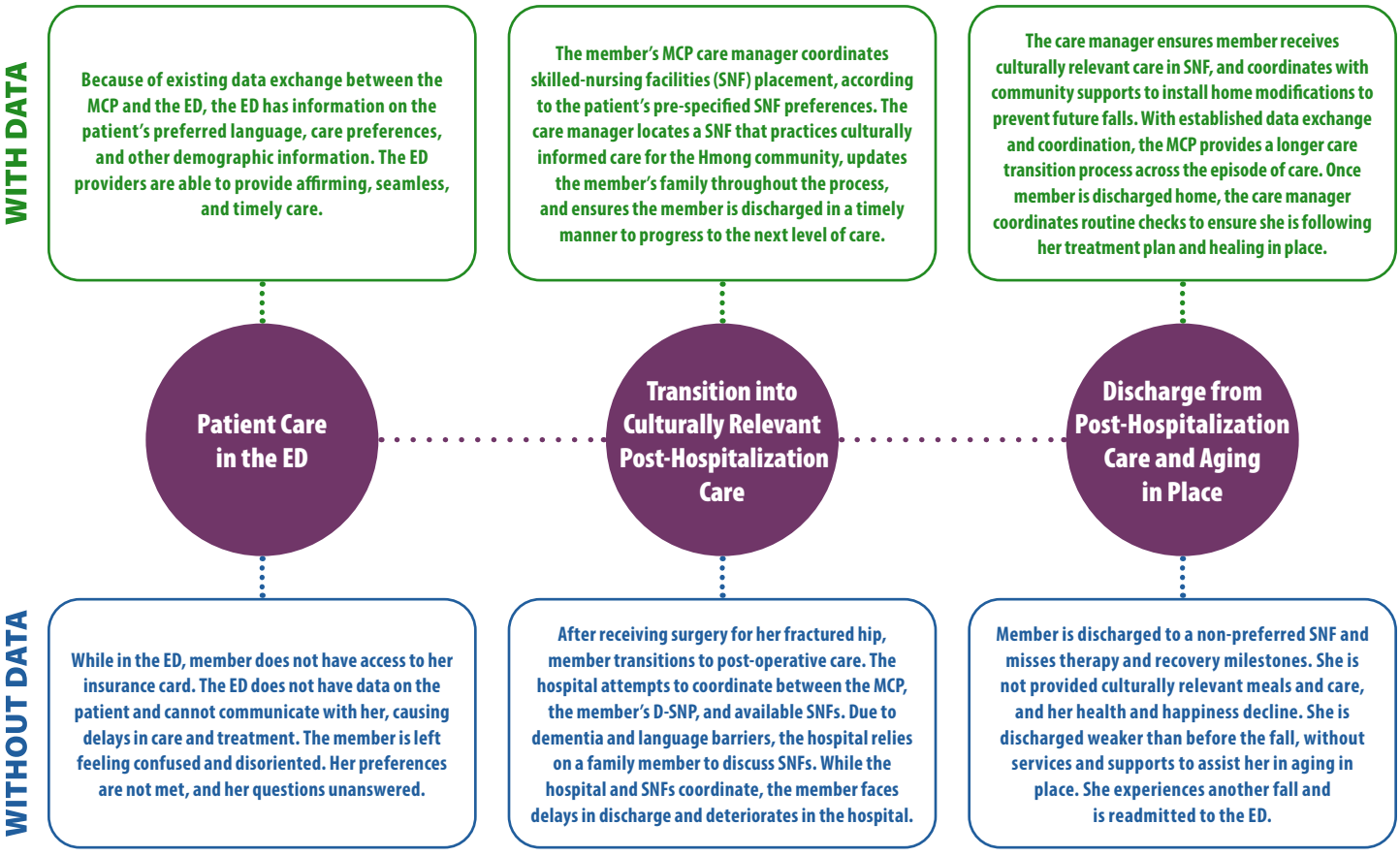
Barriers to Success: Policy Considerations



- Changing health plans can be challenging, confusing, disorienting, and daunting for many, but especially for non-English dual-eligible members. Some members may not wish to transition to an MCP for fears that their current PCPs are not in-network with their MCPs.

Mandatory MCP for Dual-Eligibles (Older Adults) Scenario

A 76-year-old, non-English speaking Hmong female with chronic obstructive pulmonary disease (COPD), arthritis, and dementia experiences a fall at home, fracturing her hip. A visiting family member calls Emergency Medical Services and she is admitted to a nearby Emergency Department (ED). The patient is a dual-eligible enrolled in an MCP and eligible for a Dual-Eligible Special Needs Plan (D-SNP).



How Data Sharing Can Advance Equity & Efficiency in Major CalAIM Initiatives: Justice-Involved

Identifying and Addressing the Health and Social Needs of Justice-Involved Medi-Cal Populations

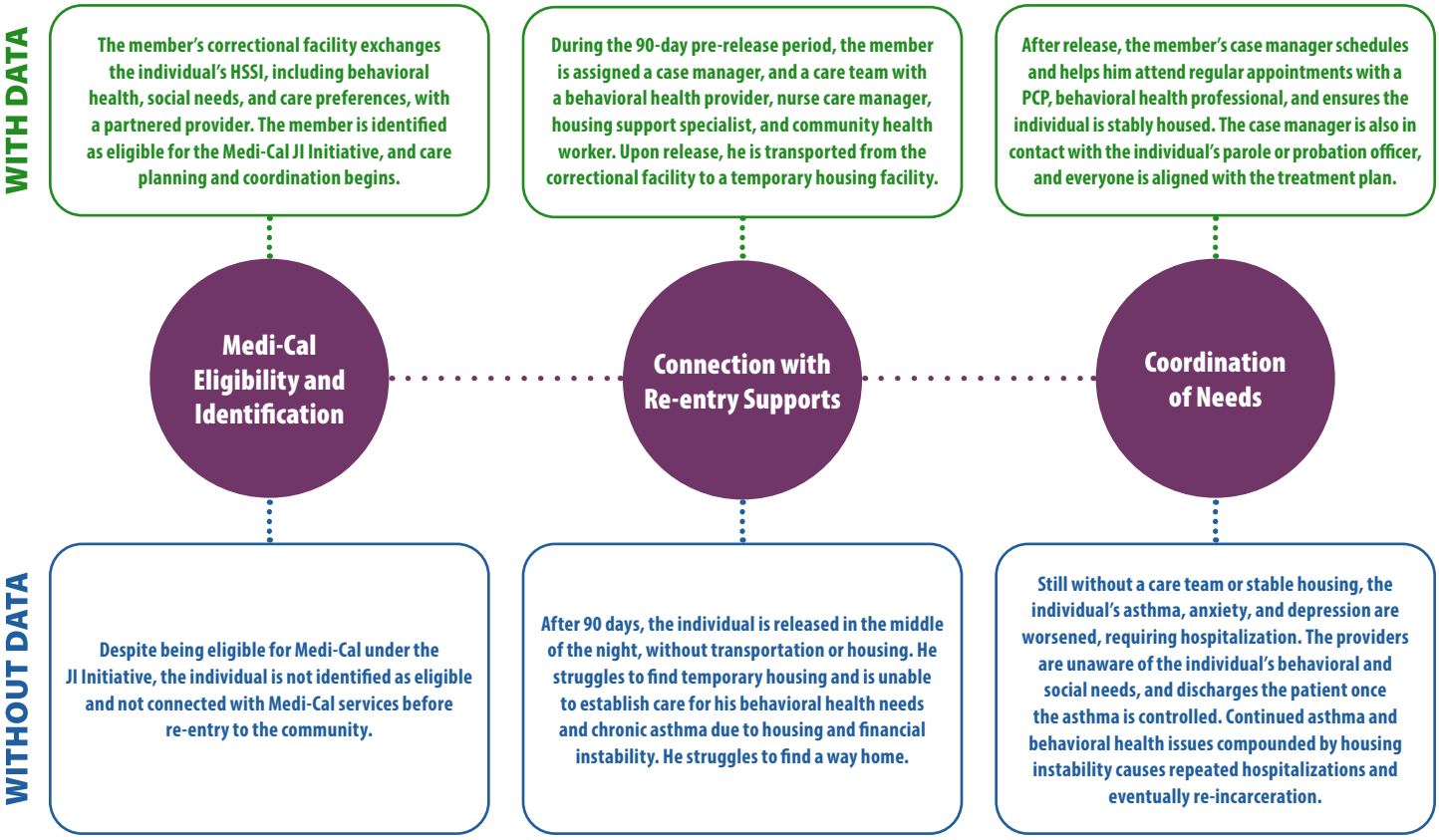
CalAIM's Justice-Involved Initiative offers Medi-Cal services to youth and eligible adults in state prisons, county jails, and youth correctional facilities for up to 90 days before being released.[20] The justice-involved population face significantly higher burdens of social needs, chronic illnesses, mental health issues, and substance use disorders compared to the non-justice-involved population.[21] Coordination with correctional facilities, CBOs, clinical delivery systems, and government agencies will be key to addressing such health disparities. Data sharing, under the DxF, can help communicate vital information to support CalAIM pre-release services and ensure continuity of care for this high-risk population after release. See DHCS' Justice-Involved Initiative Fact Sheet for more information.

Barriers to Success: Policy Considerations

- Clarification is needed as to how health care delivery systems, government agencies, and correctional facilities will collaborate to locate and engage eligible youth and adults.
- Relationships and information sharing must be established and maintained between MCPs, local health care providers, and correctional health care providers.
- In California, the jail system is less organized and integrated with health care supports than the prison system.[22] Due to the relatively quicker turnover of justice-involved individuals in jails compared to prisons, special attention may be needed to build infrastructure in jails.[23,24]

Justice-Involved Scenario[22]

A 25-year-old incarcerated Black male in a prison with chronic asthma, anxiety and depression is within 90 days of his release date, and eligible for Medi-Cal's Justice-Involved (JI) Initiative.



How Data Sharing can Advance Equity and Efficiency in Major CalAIM Initiatives:

Behavioral Health Initiative

Transforming Behavioral Health Services to Better Meet the Needs of Medi-Cal Members

CalAIM's Behavioral Health Initiative centers equity through transforming Medi-Cal's behavioral health delivery system, payment models, and programs to pursue integrated whole-person care:[25]

- **Drug Medi-Cal Organized Delivery System (DMC-ODS) Policy Improvements**: Allows for expanded e-consults between licensed clinicians and reimbursement for Peer Support Services, which requires the capabilities to access and exchange behavioral health data between various providers.
- **Behavioral Health Documentation Redesign**: Streamlines behavioral health documentation requirements to meet interoperability and data exchange standards.
- **No Wrong Door & Co-Occurring Treatment**: Ensures members are provided behavioral health services regardless of the delivery system (e.g., county behavioral health, MCPs, or the fee-for-service delivery system). Substantial communication and data exchange between various behavioral health delivery systems is critical to ensure successful care coordination for Medi-Cal members.
- **Mobile Crisis Services**: Establishes mobile crisis units to meet people where they are in the community and de-escalate behavioral health crises. Data exchange between CBOs providing the mobile crisis services, behavioral supports, and other providers across the delivery system are integral to ensure members have access to the services needed.

Population Health Management Initiative

Establishing Statewide Population Health Management for the Medi-Cal Population to Identify Disparities and Drive Preventative Care

The Population Health Management (PHM) Initiative uses population level health data to assess the needs and risks of individuals and communities and connect them with resources and preventative services. Many Medi-Cal MCPs utilize PHM for their own patient pool, but there is no state-level PHM for the entire Medi-Cal population.[26] Currently, many Medi-Cal members miss basic preventative and wellness services, leading to poorer health outcomes and contributing to existing health inequities. Key aspects of the PHM Initiative require MCPs to gather data for risk stratification and prediction, upstream supports and prevention strategies, care management, and reducing disparities through addressing SDOH.[26,27]

For PHM to succeed there must be communication and meaningful data exchange across health plans, county and state health departments, other government agencies, CBOs, correctional facilities, educational facilities, social services, delivery system providers, and more.[28] This data exchange must pay specific attention to the needs of vulnerable and historically overlooked communities.

The PHM Initiative also aims to further member ownership and equity, giving members easy access to their own data, the power to edit their data as needed, and control how their data is used.[28] For more information on the PHM Initiative, see Connecting 4 Better Health's discussion on the Population Health Management Initiative.

Barriers to Success: Policy Considerations

BEHAVIORAL HEALTH

- Definitions for behavioral health and social service data elements are limited, resulting in confusion over what information can be shared between health care entities.
- Additional data exchange supports may be needed for behavioral health providers reporting that the behavioral health system has not changed significantly compared to other CalAIM sectors since implementation.

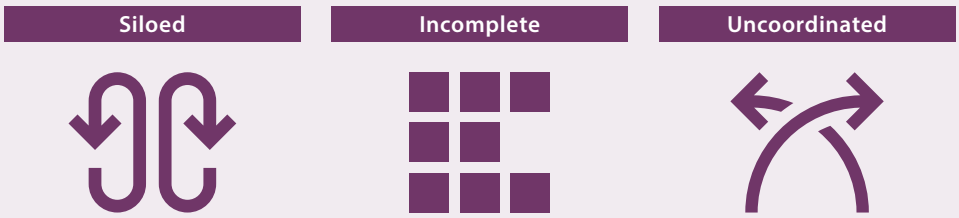
POPULATION HEALTH MANAGEMENT

- The PHM Initiative cannot function without sufficient DxF signatories; PHM relies on aggregate population level data representing the entire Medi-Cal population. Without buy-in from all entities, it cannot meet its intended goals. Greater financial and policy incentives, and penalties for information-blocking and non-compliance are needed.
- Appropriate workforce is needed for increased data analytics. Health care and social service providers may be unaccustomed to using population-level data to drive decision making.
- Population-level demographic data, such as SOGI and ethnicity/race data is needed on an aggregate level.

Conclusion

The success of the CalAIM Initiative is dependent on accessible, equitable data policy and infrastructure, which can be driven by the DxF. CalAIM's specific focus on BIPOC communities, justice-involved population, and those with compounding social needs aims to decrease current health disparities for vulnerable Californians on Medi-Cal. CalAIM requires significant care coordination across health care providers, social service providers, community supports organizations, government agencies, and other Medi-Cal stakeholders to properly integrate SDOH into care.

The CalHHS DxF represents a vehicle for robust, equitable HSSI exchange between key stakeholders in CalAIM implementation. Core CalAIM initiatives rely on cross-provider communication to identify needs, refer members to clinical and social services, measure health disparities, reduce medical errors, and empower members with data ownership. CalAIM's focus on advancing health equity is bolstered by widespread adoption of the DxF. Data silos, incomplete community datasets, and a lack of coordination between social services and clinical care disproportionately impact low-income BIPOC communities.



Despite most health care providers being required to sign the DSA and engage in data exchange under the DxF, social service providers and government entities are not required by AB 133 to participate. Joining the DxF is voluntary but strongly encouraged for these providers as receiving and exchanging HSSI can be immensely beneficial in their work. Health care providers should continue to work with social service providers to collect and integrate SDOH data to coordinate whole person care.[29] Social care providers are also not familiar with data exchange, particularly with health providers, and require technical support. DxF grant funding and QHIO organizations will assist in bridging this gap but may not reach all social service providers. In addition, the DxF currently lacks enforcement mechanisms for signing the DxF, and many required signatories have yet to sign. Further legislation should be considered to add DxF governance, enforcement, and accountability to ensure required signatories sign on and adhere to the DxF. Data sharing through the DxF is vital to CalAIM and other state health care delivery system transformations.

Equity-focused data policy such as the DxF provides an essential foundation for CalAIM's goals of whole person care and integration of SDOH, increasing flexibility in the Medi-Cal program, and advancing equity and quality for vulnerable Californians. Continued work from policymakers on developing equitable and anti-racist data policies for those in the Medi-Cal program is necessary to advance health and equity for low-income Californians.

Key Terms

Anti-Racist Data Collection: In order to better develop and implement policy for people with marginalized identities and advance health equity, more nuanced data on race, ethnicity, and other demographic factors must be collected.[30] Data collection and data policy must be actively anti-racist to ensure that biases and disparities are not exacerbated in policy. See additional information from the Center for the Study of Social Policy for more information on anti-racist data collection.

Data Exchange Framework (DxF): The Data Exchange Framework (DxF) is a set of rules and policies that govern the exchange of HSSI data in California, and make this exchange mandatory between certain signatories.[31]

Health and Social Services Information (HSSI): Data on health and social services as defined in the P&P: Data Elements to be Exchanged. This includes electronic health information, clinical data, encounter data, claims data, and social services data.[32]

Interoperability: Interoperability is the ability of different entities to communicate and exchange information. Currently, separate organizations utilize separate systems, and data is not easily shared across these systems.[33]

Protected Health Information (PHI): PHI is health information collected and maintained by covered entities for patient care and other purposes. Health data is considered PHI if it contains HIPAA Identifiers. Patients' PHI is federally protected through the HIPAA Privacy Rule, which also allows for the disclosure of PHI for certain uses.[34]

Qualified Health Information Organization (QHIO): A QHIO is a Health Information Organization (HIO) that is qualified for use for the DxF by Center for Data Insights and Innovation (CDII). HIOs must apply to become a QHIO through CDII's application portal. These QHIOs will provide health information exchange capacity to signatories who lack the capacity to exchange data.[35]

Signatories: Also referred to as DSA Participants or Entities, 'Signatories' are entities or participants that sign the DSA.[36]

Social Determinants of Health (SDOH): Also referred to as structural drivers of health, SDOH are the social and environmental factors that influence health. These include aspects such as health care access, education access, socioeconomic status, food insecurity, housing insecurity, environmental hazards and exposures, and other structural factors that impact health downstream. Marginalized communities face an unequal experience of SDOHs compared to White communities, due to systematic and structural inequities.[37]

Appendix

Administrative Actions and Funding Support to Integrate CalAIM and DSA:

Both the Department of Health Care Services (DHCS) and the Department of Managed Care (DMHC) have issued All Plan Letters (APL) regarding DSA compliance, in addition to a Population Health Management Policy Guide from DHCS:

DHCS APL (September 5, 2023):[38,39]

This APL from DHCS issued September 5, 2023, requires that all Medi-Cal Managed Care Plans (MCPs) as well as any subcontractors or network providers sign and comply with the CalHHS DxF Data Sharing Agreement. These signatories must begin sharing data by January 31, 2024, or January 31, 2026, if otherwise specified. DHCS will monitor MCPs for compliance with the DSA and can impose corrective action plans (CAPs) as well as administrative and/or monetary sanctions for non-compliance. By January 1, 2024, MCPs are required to track DSA signature data and compliance for all subcontractors and network providers and submit to DHCS.

This APL will require MCPs to ensure that all their subcontractors and providers comply with the DSA. Entities, such as ECM providers, must comply with the DSA. In addition, signing the DSA will provide legal cover for these providers, as well as create an opportunity for CalAIM funding.

DMHC APL (April 24, 2023):[40]

This APL from DMHC requires all health plans in California to sign and comply with the DSA. Signatories must begin sharing data by January 31, 2024, or January 31, 2026, if otherwise specified. The DHMC APL does not specify any penalties for noncompliance, but still requires health plans in California to sign the DSA.

DHCS Population Health Management Policy Guide (January 2024):[41]

This policy guide requires any DSA signatories, including MCPs (required signatories) and Local Health Jurisdictions (LHJs) (optional signatories) to comply with DxF provisions and technical requirements. The policy guide recommends DSA signatories follow DxF provisions when deciding how to exchange data with LHJs that have not signed the DSA but are still required to exchange data for the PHM Initiative.

Support for Infrastructure and Capacity Building:[42]

CalAIM Providing Access and Transforming Health Initiative (PATH Initiative)

- The PATH Initiative provides funds for community-based organizations (CBOs), public hospitals, county agencies, tribes, and other CalAIM partners to build capacity and infrastructure for CalAIM implementation. Specifically, PATH funds cover:
  - **ECM and Community Supports Initiative**
  - **Justice-Involved (JI) Initiative**

  Within the ECM and Community Supports Initiative, PATH can fund whole person care and managed care transitions, technical assistance through a virtual "marketplace", collaborative planning and implementation, and Capacity and Infrastructure Transition, Expansion, and Development (CITED).

  Within the JI Initiative, PATH can fund collaborative planning as well as capacity and infrastructure building for stakeholders like correctional agencies, institutions, and other justice-involved entities.

DxF DSA Signatory Grants[43]

CDII offered two types of grants for DSA signatories working on DxF implementation. Round 3 for DxF Grants is now closed and a Round 4 is not anticipated. For more information on the DxF DSA Signatory Grant Program, see ITUP's DxF 101 Fact Sheet, or email Connecting 4 Better Health for any updates to the program.

Equity and Practice Transformation (EPT) Payments Program[44]

Funded by the DHCS, these grants will launch early 2024. Aimed at decreasing disparities, these funds can be used by smaller primary care physician practices (including behavioral health providers), to update infrastructure, including data exchange capabilities. For details on provider applications to the EPT program, see DHCS' EPT program application instructions.

CalAIM Incentive Payment Program (IPP)[44]

The CalAIM IPP aims to support ECM and Community Supports within the CalAIM program by providing funds to MCPs if they meet certain goals, including promoting equity and building sustainable infrastructure and capacity. DHCS does not direct how MCPs spend their incentive payments. MCPs can use these funds to support data exchange infrastructure for ECMs and Community Supports and bridge gaps between clinical providers in their network.

Behavioral Health Quality Incentive Program (BHQIP)[44]

The BHQIP funds are provided to county-operated behavioral health plans. Funds are given if these plans achieve certain milestones, including data exchange. Funds can be used for staffing, technology and infrastructure, technical assistance, and other program transformations.

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About ITUP

ITUP is an independent, nonprofit, health policy institute that has been a central voice in the California health policy landscape for more than two decades. ITUP serves as a trusted expert, grounded in statewide and regional connections with a network of policymakers, health care leaders, and stakeholders. The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of all Californians.

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