COMMUNITY VOICES AND PERSPECTIVES ON CalAIM

Stakeholder Health
Health Through Community Partnership

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COMMUNITY VOICES AND PERSPECTIVES ON CalAIM: EXECUTIVE SUMMARY

BACKGROUND

California Advancing and Innovating Medi-Cal or CalAIM is a long-term commitment to improve Medi-Cal for people with complex needs by extending care beyond hospitals and other health care settings into communities. Providing Access and Transforming Health (PATH) is a five-year initiative to build up capacity and infrastructure of on-the-ground partners like Community Based Organizations (CBOs) and others, to become Enhanced Care Management (ECM) or Community Supports (CS) providers in the Medi-Cal delivery system under CalAIM. The current study attempted to understand CBOs' awareness, experience, and infrastructure readiness for CalAIM participation.

RESULTS

Forty-six CBO key informant representatives participated in interviews from June 15 - July 27, 2023. Informants held various executive level positions, including executive director, program director, CEO, and board member. 45.7% (n=21) of the sample had less than 50 total employees and 52% (n=24) had an annual budget of less than five million dollars. Collectively, the sample of participant CBOs covered 60.3% (n=35) of total counties in California, with San Joaquin, Yolo, San Francisco, Kern and Nevada County most represented. Housing-related services were the most represented types of service in the CBO participant sample, with 45.7% providing housing transition services. All fourteen CS services were represented, except for asthma remediation. 41.3% of participant CBOs were already approved as either an ECM or CS provider, 34.8% were taking steps in becoming an ECM or CS provider, 8.7% were thinking about becoming an ECM or CS provider, while 15.2% of CBOs were not engaged or actively considering becoming part of the initiative. CBO participants ranked five different areas of support needed to engage further with CalAIM: IT & Security is the area where most support is needed, followed by Strategic Planning, Contract Management and Operations, and Leadership Buy-in needing the least. Interview findings consisted of several themes and subthemes, with themes organized into four categories: Overall Perspectives, Information Flow and Communication, Operational Issues, and Participant Recommendations.

CONCLUSIONS

The current study provides unique perspectives by interviewing participants that were not yet an approved ECM or CS provider. Participant perspectives offer insights into their decision-making process regarding CalAIM participation and recommendations to improve CalAIM implementation. Findings point to the need for intentionally including CBOs as partners in all phases of designing CalAIM implementation; more support for CBOs thinking about or taking steps to become an ECM/CS provider, such as peer-to-peer mentoring and earlier community level engagement; and shared services among CBOs who are taking steps or are already providers to alleviate administrative burden. Taking steps to improve CBOs' program experience with CalAIM will ultimately allow CBOs to more effectively provide holistic services to the historically marginalized populations they serve.

This study was commissioned and funded by CommonSpirit Health (CSH) and conducted by Stakeholder Health (SH), in conjunction with the Camino Research Institute (CRI).

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FULL REPORT

Background

California Advancing and Innovating Medi-Cal or CalAIM is a long-term commitment that intends to improve Medi-Cal for people with complex needs who are facing difficult life and health circumstances by extending care beyond hospitals and other health care settings into communities. CalAIM goals include implementing a whole-person care approach, addressing social drivers of health, improving quality outcomes, reducing health disparities, driving delivery system transformation and creating a consistent, efficient and seamless Medi-Cal system.

Enhanced Care Management (ECM) and Community Supports (CS) are two ways in which CalAIM seeks to transform healthcare in California. ECM is a new statewide Medi-Cal managed care benefit available to select "Populations of Focus" that will provide clinical and non-clinical services to the highest-need and highest-cost members through intensive coordination of health and health-related services and comprehensive care management. CS are new statewide services provided by Medi-Cal managed care plans as medically appropriate and cost-effective alternatives to utilization of traditional medical services or settings (e.g., hospital or skilled nursing facility admissions). Members will have connections to CS to meet their social needs.

The CalAIM initiative, and particularly, the introduction of the 14 pre-approved CS, prompted Managed Care Plans (MCPs) to work and contract with a new set of "non-traditional" providers that offer services and supports that historically have not been well integrated into the health care system. These providers include many community-based organizations (CBOs), such as housing service providers, home modification providers, sobering centers, and organizations that prepare and deliver medically supportive food and nutrition to build up the capacity and infrastructure of on-the-ground partners, such as CBOs, public hospitals, county agencies, Medi-Cal Tribal and designees of Indian Health Programs, and others, to successfully participate in the Medi-Cal delivery system under CalAIM. Some leaders describe PATH as a bridge to help CBOs become ECM and CS providers. More information can be found about CalAIM and PATH here: https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx https://www.ca-path.com/.

Anytime such a large and ambitious initiative like CalAIM moves forward, it is normal to incorporate opportunities for iterative changes to continually improve the experience of stakeholders involved and deepen the intended impact of the initiative. The California Department of Health Care Services (DHCS) has taken steps to elicit feedback from organizations involved and implement changes. At the same time, anecdotal feedback suggests that participation in PATH capacity and infrastructure building opportunities among CBOs and other local organizations has been varied, and perhaps not fully representative of the

depth and breadth of local organizations that could potentially engage in contracting opportunities as providers of ECM and CS. As such, a formal investigation of their participation and experience in CalAIM implementation thus far can inform future iterations of the implementation roll-out and intentional efforts to engage historically marginalized CBOs (and therefore the populations they serve). Additionally, this study can provide insights into the reasons behind CBO decisions to participate in CalAIM or not, and recommendations to increase their participation as CalAIM providers, tailored to CBOs, based on their level of engagement.

This study was commissioned and funded by CommonSpirit Health (CSH) and conducted by Stakeholder Health (SH), a learning collaborative of over 50 health systems, other institutions and networks advancing the profound changes needed for just, equitable, and effective healthcare by uniting partners from numerous sectors. SH convenes partners at scale to maximize learning and impact, works with a lens of science, their faith, and a commitment to anti-racism, as their members help each other learn what matters in achieving health equity, always in partnership with community. Teresa Cutts, PhD, the academic liaison for SH, served as the Principal Investigator (PI) on this study. Gary Gunderson, MDiv, DMin, the Co-Chair of SH, served as additional project consultant. Ji Im, MPH, of CSH, served as the internal project lead, while Marc Rosen, MPH, System Director, Community Impact, Operations, and Partnerships, CSH, provided internal project oversight and management. CSH funded this study to elevate the voices of CBOs and therefore the views expressed in this report are those of the participating CBOs.

Camino Research Institute (CRI), a bilingual hub for community-driven research that focuses on the social determinants of health to inform the development and implementation of services and policies for Latino families, led the analysis of the qualitative interviews and report production. Qualitative analysis was conducted by a team of CRI researchers, including Lennin Caro, MA, a cultural anthropologist with extensive training and experience in qualitative research, Vicky Hadley, BA, a trained community research student, and Keri Revens, PhD, Director of CRI. Dr. Revens, an expert in community-based research, provided oversight to the qualitative analysis, including coding, the development of themes, and writing up findings.

Research Questions: the proposed research project aims to address the following research questions:

- What are the levels of participation of local organizations in PATH capacity and infrastructure building opportunities to date?
- What are the facilitators and barriers to participation in PATH capacity and infrastructure building initiatives?
- What are the perspectives of local organizations in California that are potential ECM/CS providers?
- What are potential improvements that can be made to PATH capacity and infrastructure building initiatives from the perspectives of organizations with varying levels of participation in PATH?

To address these research questions, the following 3 domains/areas were explored in key informant interviews with a variety of CBO stakeholders in California. See Table 1 for a summary.

Table 1. *Summary of Domains Explored.*

Participant Type	Domains		
	Awareness of CalAIM	**Experience with CalAIM**	**Infrastructure Readiness**
CBO Program Staff /Leadership (jointly identified by CSH and CBO partners)	• Role of CBOs in CalAIM • Relevance • Interest	• Facilitators/barriers to participation in learning opportunities, Technical Assistance Marketplace, PATH • Usefulness of learning opportunities, Technical Assistance Marketplace, PATH • Recommendations for future engagement opportunities	• Excitement and concern about participating in CalAIM • Leadership buy-in • Contracting • Strategic Business and partnership development • Financial acumen • Program readiness • Information technology and security

Methods

This project used qualitative methods to address the research questions. Key informant interviews were conducted with representatives from CBOs in California involved in the CalAIM implementation process. Not all CBOs possessed the same level of engagement with PATH. The continuum of engagement (Figure 1) includes no engagement, attending introductory meetings, thinking about becoming an ECM or CS provider, taking steps to become an ECM or CS provider, or already an ECM or CS provider or both.

Figure 1. *Continuum of CBO Engagement*

The use of qualitative methods allowed us to capture how a variety of diverse CBOs relate to CalAIM across the three domains of awareness, engagement, and infrastructure readiness. This information was useful in capturing data on how the CalAIM rollout is perceived by CBOs thus far, potentially informing mid-course changes/corrections of the process that would increase the uptake of CBOs in terms of becoming ECM or CS providers.

Selection of Key Informants

Based on recommendations from CSH Community Health Directors, other CSH staff and SH partners, key informants were selected from CBOs in California involved in the CalAIM implementation process. This purposive sampling of key informants included executive directors, program managers, and other leaders directly engaged in CalAIM initiatives within the CBOs. We aimed for diversity in terms of organizational size, geographic location, levels of engagement with CalAIM, and populations served, to

ensure a comprehensive representation of CBOs. We also targeted CBOs that provide a variety of core services (e.g., housing, utility assistance, food, health navigation). This process took place between June 1, 2023- June 30, 2023.

An email invitation was sent to each of the potential CBO representatives by their local CSH Community Health Directors or other outreach staff, who ideally, already had established relationships with potential interviewees, aiding in enlisting more participants. Those who responded in the affirmative were sent a Calendly link from the PI to set up an interview time.

The PI scheduled interviews with the selected key informants, ensuring their availability and willingness to participate. The target sample size for interviews was N=50. Due to a requested final report due by mid-September 2023, the period for conducting interviews was relatively short: June 15, 2023- July 31, 2023. Given the brief timeline for conducting interviews, the PI and other local CSH staff expanded the invitation list beyond the initial recommended invitees through mid-July, to obtain the expected number of interviews. When uptake in scheduling of the interview process was slower than expected, the PI and local CSH staff sent a second request to those who agreed to participate as a reminder to place themselves on the interview calendar. All interview subjects received a gift card valued at $150 for their participation.

Interview Content

A semi-structured interview script was developed using each of the three domains: awareness of CalAIM, experience with CalAIM, and infrastructure readiness to engage CalAIM. See Appendix A for more details on domains.

The interview questions/script (See Appendix B) addressed these three domains. Additional questions included in the script investigated potential perceived risks and opportunities for CBO participation in CalAIM, specific recommendations offered to CalAIM leadership to improve the process, and inquiries about conversations with other CBOs about CalAIM.

Questions were open-ended, except for one embedded survey question administered via Google Forms. The survey item asked key informants to rank areas in which they would need help/support, from least to most. This survey item was accessed and completed in real-time during the interview with each key informant, except for the first five interviewees, due to difficulty in initially setting up on-line responses. However, data for these five interviewees were captured manually and included in the final data set, with a final N=50 of rankings rendered.

Interview Process

All interviews were conducted by the PI, Teresa Cutts, PhD, using video conferencing or phone, depending upon the preference of each key informant. Consent to participate voluntarily and record the interview was obtained from each participant. All audio-visual and/or audio recordings were captured via Zoom.

The PI conducted 46 semi-structured interviews, using the script found in Appendix B, during the mandated interview time frame of June 15-July 31, 2023. Interviews were predominantly conducted individually, although some interviews were conducted with multiple staff members, as requested by CBO leaders.

Transcription of Interviews

Interview recordings were sent to Rev.com to be transcribed via automatic transcription. The PI then edited the transcriptions to ensure more accuracy and quality in the interview information. Personally identifiable information was removed to ensure the anonymity of the participants to maintain confidentiality, with the exception of identifying CBOs' characteristics. All data are reported in aggregate.

Qualitative Data Analysis

Camino Research Institute conducted data analyses, with CRI's Director and the PI providing oversight of that process. Recorded transcriptions and notes were uploaded into the qualitative data analysis software Dedoose. CRI developed an initial short list of codes and used a multi-step iterative approach to revise the list and apply the codes to all the interview data. A codebook based on the three domains was generated: awareness of CalAIM, experience with CalAIM, and infrastructure readiness. The process began with an open coding approach, allowing for the identification of initial themes and patterns in the data.

Camino Research Institute analyzed the transcribed interviews systematically, applying the identified codes to relevant segments of the data, using Dedoose features to annotate, categorize, and organize the coded data effectively. Two CRI analysts independently coded a subset of interviews and compared their coding results to ensure consistency and agreement, establishing inter-coder reliability. The codebook was refined and modified as needed throughout the analysis process.

Preliminary findings were presented by the PI and Research Team to the Internal Project Lead and other CSH staff at the midpoint reporting session held virtually on August 17, 2023. At that presentation, CRI and the PI gathered feedback and insights from CSH and other stakeholders to validate the findings, identify any gaps or alternative interpretations, and ensure that the analysis accurately represents the experiences of the CBOs. That feedback resulted in a more fine-grained approach to coding and the reporting of findings.

Results

Sample Characteristics

Staff from 46 different CBOs were interviewed in this study. While most interviews (n=41) were conducted with only one representative from the CBO, some interviews (n=5) were conducted with two or more participants from the same CBO. Of those interviews that did not have a single participant, one interview was conducted with six participants in a group setting and the remainder were conducted with two interviewees per session from unique CBOs.

Of the CBOs sampled, 45.7% (n=21) had less than 50 total employees and 52% (n=24) had an annual budget less than five million dollars.

The CBO representatives that were interviewed held various executive level positions, including executive director, program director, CEO, as well as board member. 45.7% (n=21) of the sample had less than 50 total employees and 52% (n=24) had an annual budget of less than five million dollars. More detailed characteristics of CBO participants are provided in Appendix C.

Collectively, the sample of participant CBOs covered 60.3% (n=35) of total counties in California, with San Joaquin, Yolo, San Francisco, Kern and Nevada County most represented. See Figure 2 for a heat map of counties represented in interviews.

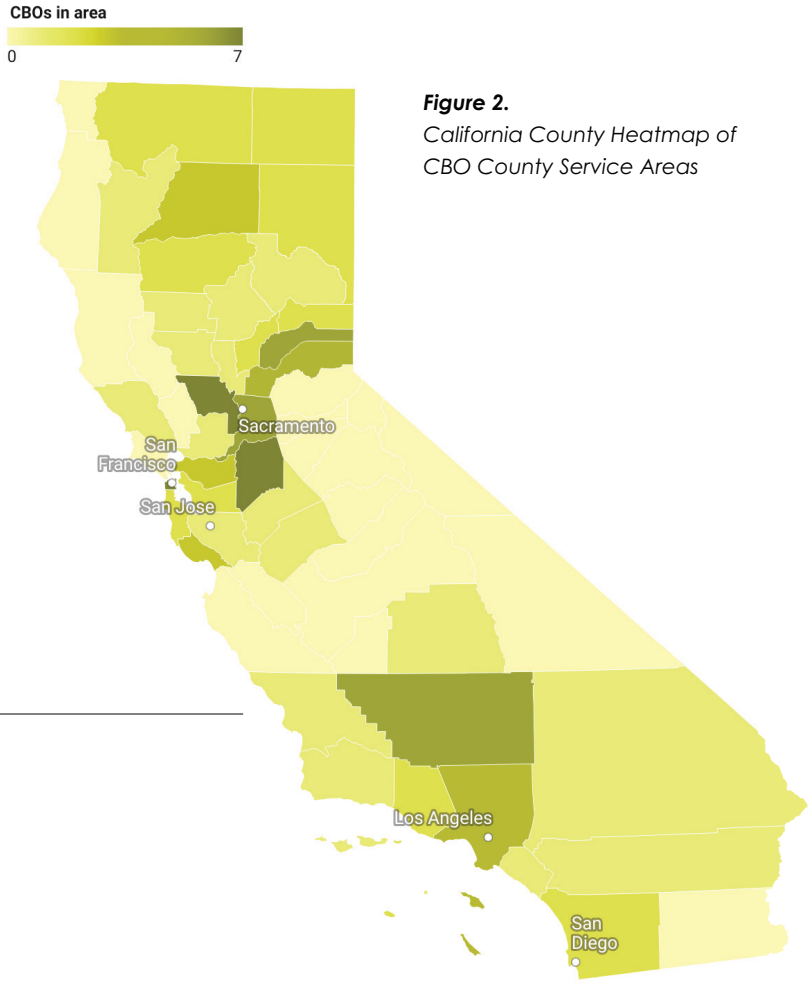


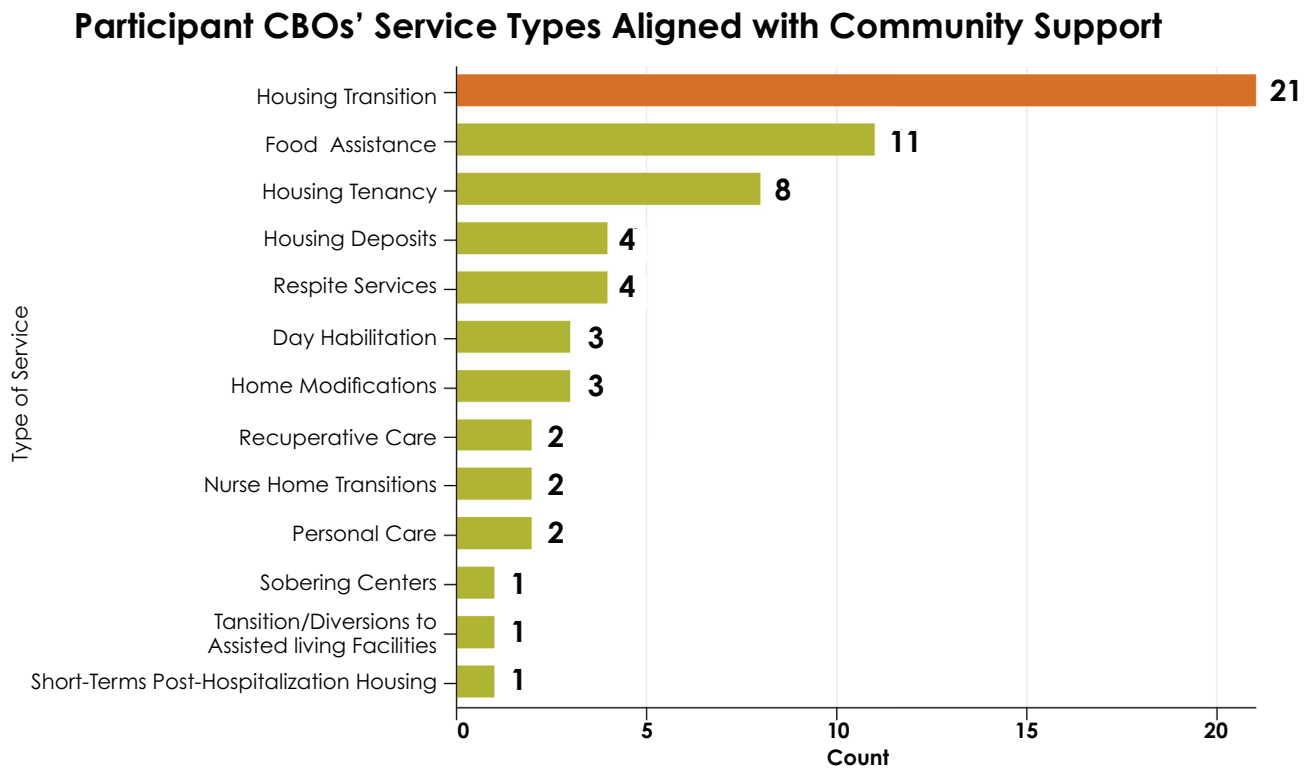
Figure 2.
California County Heatmap of CBO County Service Areas

Participant CBO County Service Area

Heatmap showing counties where participant CBOs are located. Darker colors indicate multiple participant CBOs in the same county

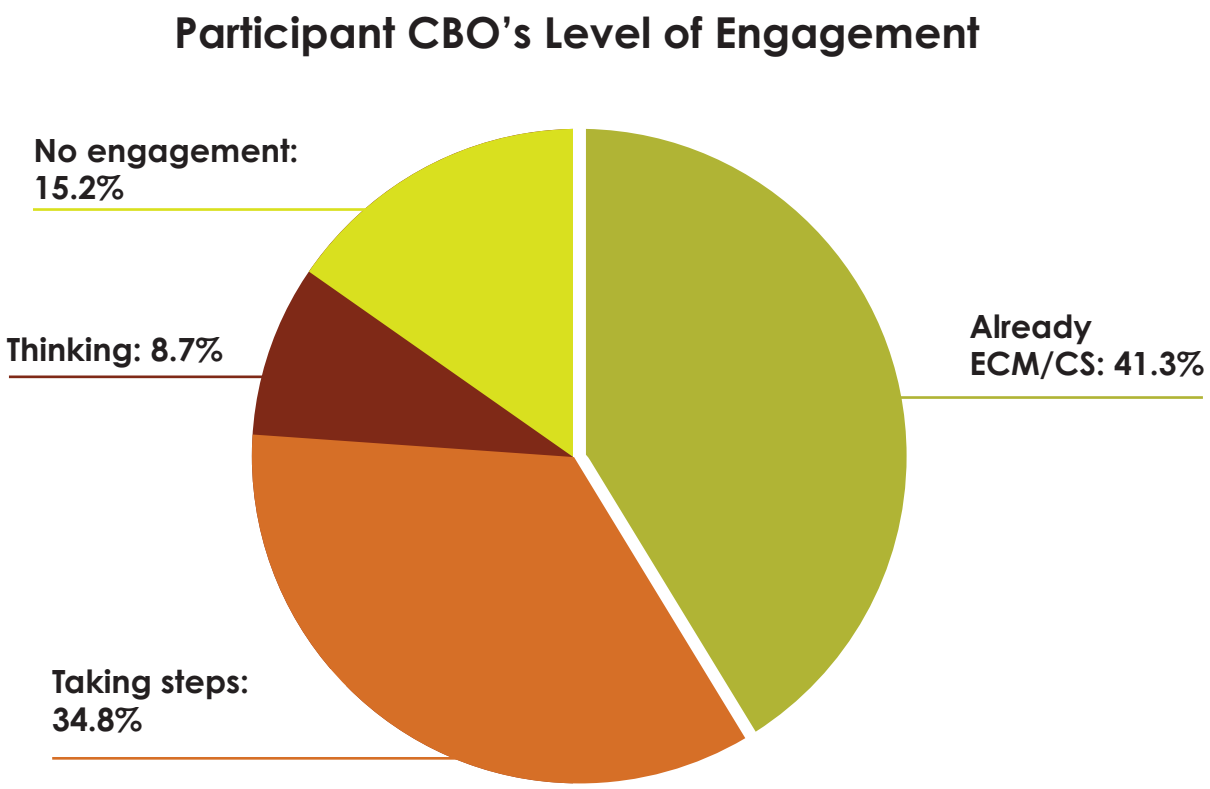
Housing-related services were the most represented types of service in the CBO participant sample; nearly half (45.7%; n=21) of participant CBOs provide housing transition services. All fourteen CS service were represented, except for asthma remediation. This data is presented in Figure 3.

Figure 3. *Participant CBOs' Service Types*



In terms of level of engagement with the CalAIM initiative, the following coherent categories emerged: 41.3% (n=19) of participant CBOs were already approved as either an ECM or CS provider, 34.8% (n=16) were taking steps in becoming an ECM or CS provider, 8.7% (n=4) were thinking about becoming an ECM or CS provider, while 15.2% (n=7) of CBOs were not engaged or actively considering in becoming part of the initiative. Levels of CBO engagement are presented in Figure 4. Refer to Appendix D for more detailed descriptions of each individual participant in the current study.

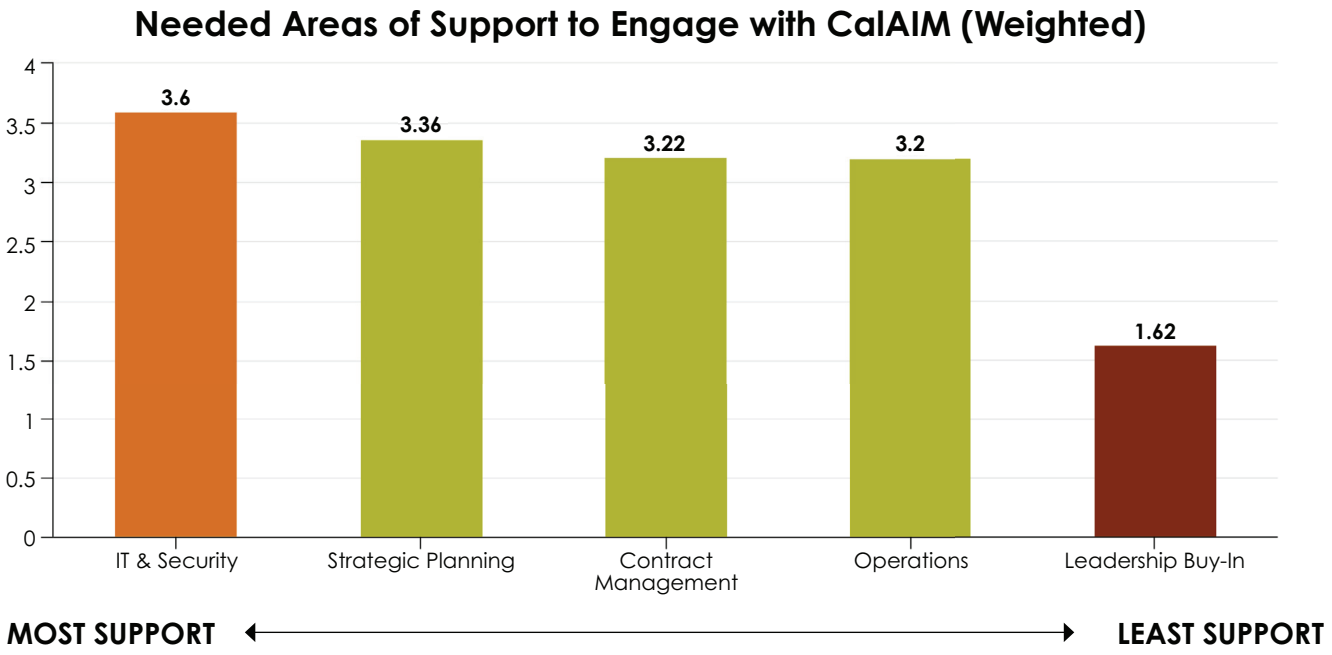
Figure 4. *Participant CBOs' Levels of Engagement*



Quantitative Results

During interviews, participants were asked to rank five different areas of support from most (ranked 5) needed to least (ranked 1) needed in a Google Form, with a forced choice format (i.e., each rank number could only be used once). The areas of support include IT & security, strategic business development, contract management, operations, and leadership buy-in. Figure 5 shows the average weighted ranked scores for each area of support of the 50 rankings obtained. IT & Security had the highest average score (3.6 out of 4), which indicated that most CBOs in the sample need the most support in that area. In contrast, leadership buy-in had the lowest average score (1.6 out of 4), indicating that many CBO participants reported that their leadership was already "on-board" with the idea of working with CalAIM in some fashion.

Figure 5. *Needed Areas of Support to Engage with CalAIM*



Qualitative Results

Interview findings consisted of several themes and subthemes. These themes are organized into four categories: Overall Perspectives, Information Flow and Communication, Operational Issues, and Participant Recommendations. Three subthemes related to how participants viewed the CalAIM initiative in general are presented under the category "Overall Perspectives." The first subtheme is the aspiration that CalAIM is helping create a more holistic healthcare system. The second and third subthemes both describe two major concerns about the CalAIM initiative, which are the medicalizing of social care/CBO services, including level of bureaucratic paperwork required, and CalAIM's long-term sustainability in terms of both political viability and impact on CBOs investment in the initiative. Within the "Information Flow and Communication" category, subthemes related to understanding about CalAIM are presented, which include the confusion and lack of clarity that participants experienced when learning about the program and the practice of asking other CBOs about CalAIM. Within "Operational Issues," subthemes related to billing difficulties, inadequate and slow reimbursement rates, and lack of financial capacity are presented. Finally, under "Participant Recommendations", common participant suggestions to improve CBO participation in CalAIM are presented.

Supporting data in the form of italicized quotations from CBO key informants, along with their title and level of CalAIM engagement are also noted below. See Figure 6 for a summary of themes and sub-themes.

Figure 6. *Summary of Interview Themes and Subthemes.*

THEME 1: OVERALL PERSPECTIVE

Subtheme: Towards a Holistic Approach in Healthcare. When participants were asked about the most exciting aspect of the CalAIM initiative, numerous participants commented that they are excited that the State of California is making efforts to make their healthcare systems more holistic by incorporating services not traditionally covered by funding. According to P16 [Organizing Director, no engagement, urban area], the "biggest barrier" of healthcare is self-contained silos, and that "breaking through these barriers of seeing the work as more holistic" is perceived as a "win". Similarly, another participant thinks the changes to the CalAIM initiative will "open up a conversation" that will bring the social determinants of health into focus:

> ***I like to think that it will open up a conversation between CBOs and healthcare providers around the further social determinants of health. So when someone's going into their medical provider or bringing their child into the pediatrician, we're not just looking at the symptoms that the child was brought in for,*** *but is it, are there signs of something bigger that's going on with the family and if the pediatrician suspects so, do they have a clear pathway for referring the family to additional services to meet those needs? So, I'm really hopeful that will happen. It's historically been hard, because pediatricians are so busy and doctors are so busy to even get a meeting on the schedule to say like, can I give you 10 minutes to tell you what we do and how you can share this information with families? Because when they're seeing a family, they've got such a teeny tiny window to talk about all of the health concerns, let alone anything else that's going on for them.*
>
> *- P35 [Executive Director, thinking about becoming an ECM/CS provider, rural area]*

In addition to the possibility of improving the structure of California's healthcare system, participants also expressed excitement in the possibility of receiving additional funding streams to support their current services and activities. As one participant said,

> *What's exciting, and I think I touched on this earlier, is you know the sustainability aspect of it where we are able to draw down these funds to support folks out in the community to get the care that they need in addition, not just medical care. It's that social health and those other social drivers that impact health. So that's really exciting to be able to have a sustainable funding stream there.*
>
> *- P13 [Director of Strategic Initiatives, already an ECM/CS provider, both urban and rural areas]*

Within this theme, another participant hopes they can sustain their community health worker program with CalAIM funds:

> *We'll be able to hopefully get funding for our promotores, which are health workers in the Latinx community so that they'll be able to have a broader reach [for…] our home visitors who are with our Sierra Native Alliance, so that our native families will have access to healthcare without having to go to the clinic, you know?*
>
> *- P44 [Executive Director, thinking about becoming an ECM/CS provider, rural area]*

Subtheme: Concerns Around Medicalizing Social Care/CBO Services. While participants shared their insights on the positive potential of the CalAIM initiative, they also shared concerns about participating in the program. The potential of being overburdened through bureaucratic activities related to the program was the most common. According to P19, [Director of Senior and Supporting Services, taking steps to be an ECM/CS provider, both rural and urban area] most providers and CBOs are "not set up to be bureaucratic" and that it is a "huge ask" to expect organizations to adapt new compliance processes. Similarly, P6 [Public Health Officer, rural area] mentions that although their organization is already an ECM and CS provider, they have not submitted any invoices because they are not prepared for the "pretty substantial paperwork" due to "internal bureaucratic changes" if they begin and try to sustain a community health worker program using CS contracting funds. P5 provided a detailed account of their experience with the CalAIM paperwork,

> ***There were all [these] problems I found with the whole CalAIM thing. We were waiting for them to define what it is they were going to pay for. And we finally got it and we were okay with that. Then we were waiting for how much you're actually going to pay. And we finally saw that. I was like, yeah, okay, that was better than nothing. We're doing this anyway.*** *So like I mix payments, you know, actually getting paid by the agencies and the departments that are benefiting, which is all the better. And then, the next hurdle was going to be how do you do Medi-Cal billing? Which is a huge hurdle. Then they came back with, oh, here you have to fill out this application before we can finalize you. And it's like a 20-page application. And they want us basically to be a provider of all services from job development to job placement, to resume building to transportation, to everything that you can imagine a 20 year old sitting down on the internet, writing up a list of services that they demand of an agency and different domains. And we had to have job descriptions and we had to have insurance coverage, proof of insurance coverage for all these services. It was written just as if the health insurance underwriter [wrote it].*
>
> *- P5 [Executive Director, taking steps to be an ECM/CS provider, urban area]*

Related to the concern of bureaucratization, participants were also wary of how the bureaucratic and regulatory requirements of being part of the CalAIM initiative can draw staff time and energy away from properly serving their clients. When asked about the potential challenges and concerns on joining the program, P1 [CEO, taking steps to become an ECM/CS provider, urban area] highlighted the risk of not serving clients in a prompt manner:

> *My organization is run by different legal standards than a hospital. And so, it can create a lot of barriers for clients. It can slow down the process for clients to get the necessary services they need.* ***And it can impact my staff by creating more paperwork and case management files that they don't have the time to unfold or unpack.***

Likewise, P15 [CEO, urban area], whose organization is already contracted with CalAIM, expressed concern over the possibility that their "staff are having to do a lot more documentation than they used to" in order to comply with CalAIM requirements, which "takes away from their relationship with the client." P42, [Executive Director, thinking about becoming ECM/CS provider, rural area] whose organization is currently deciding whether to join CalAIM, also expressed concerns on being limited by the program, explaining that "every grant that we get, there are certain restrictions and certain requirements and it does put us in a very small box sometimes… I fear that would happen if we work with CalAIM."

P29 [President/CEO, already an ECM/CS provider, rural and urban areas], an organization that focuses on the development of affordable housing, exemplifies how restrictions and regulations regarding communication can negatively impact the way they operate:

> *My experience now with over a dozen managed care plans is that the interface between their members and our residents is much harder to nail down than you would expect. Address matching and other types of things, that you would expect to be easy to do, is not for many of the managed care plans. There's like, at least a couple different levels of HIPAA compliance, one being the level that you would expect a healthcare professional agency to respond to, and the other one being a community-based agency. And so, we have experienced a lot of problems with trying to kind of match the expectations of the healthcare providers to the reality of what it means to run apartment buildings.* ***[We're trying to find a way in] how can we have our staff interface with a care team inside of a provider group or inside of a managed care plan in a HIPAA compliant way while not undermining or overturning our entire business model so that everything we do is as laborious as the communication processes that exist now in medicine.***
>
> ***Interviewer:***
> *Or undermining trust, particularly with some of the people you serve?*
>
> ***P29:***
> *Well, undermining trust, but also just the painfulness of the way the interfaces work now with communicating with anyone, the degree to which you can't send a simple email, is not conducive to running a property management company or a resident services company.*

How can we have our staff interface with a care team inside of a provider group or inside of a managed care plan in a HIPAA compliant way while not undermining or overturning our entire business model so that everything we do is as laborious as the communication processes that exist now in medicine?

The excerpt above highlights how the rules, regulations, and standards of the healthcare industry can burden CBOs that provide services not traditionally associated with healthcare in the way they operate. Specifically, for P29, the medical regulatory standards of HIPAA compliance and client communication are incompatible with effectively managing and communicating with clients receiving their housing services.

Subtheme: Concerns about Long-Term Sustainability of CalAIM and Impact on CBOs. Another common concern shared by multiple participants is the overall sustainability of the CalAIM initiative. Participants were worried that the public monies provided by California state government for CalAIM could stop flowing due to political and economic changes. For example, P46 [Emergency Services Liaison, already an ECM/CS provider, rural area] said that while CalAIM has the potential to create "greater services for our community," they are worried that if

"political players on the hill" decide to no longer support CalAIM, then the community programs supported by CalAIM funds will potentially "dissolve". P3 [Program Manager, taking steps to become an ECM/CS provider, urban area] echoes this sentiment:

> *The concern I have is the politics behind it. I don't know if it's sustained or not. You know, maybe the new leadership comes in and they said, "Okay, CalAIM is stopped"… that would've been really bad. Because a lot of this is a lot of moving things to get one thing done.*

Similar to P46, P3 is concerned that changes in political leadership could undo the progress done by CBOs in trying to create and sustain programs to serve community members. The amount of time and energy invested into developing programs primarily sustained through CalAIM funds can be wasted if political sentiments shift to reduce or end the initiative. As P31 [Executive Director, already an ECM/CS provider, rural area] explained, this political anxiety appears perpetual to participants, in which it is always a threat to funding streams.

> ***P31:***
> *I think politics may be a challenge too.*
>
> ***Interviewer:***
> *And by that you mean?*
>
> ***P31:***
> *Local politics. Statewide politics, probably not federal as much, but you know… care for people that are in the system is not necessarily a popular topic in more conservative communities. And in more liberal communities it's a very big topic and everybody wants to do it, but we're not sure always how to pay for it either. So, I just think there's a political chasm there that's going to have to be navigated by a CBO, no matter who they are.*

THEME 2: INFORMATION FLOW AND COMMUNICATION

Subtheme: Confusion & Lack of Clarity. During interviews, multiple participants pointed out the difficulty in applying for and understanding aspects of the CalAIM initiative. While informational resources in the forms of virtual and in-person meetings, webinars, and online platforms were provided to CBOs, participants expressed still feeling overall confusion and uncertainty about the program. Some participants expressed challenges with understanding both how information was presented, as well as the content of what was being presented.

For example, P22 [Executive Director, thinking about becoming an ECM/CS provider, urban area] and P14 [CEO, taking steps to become an ECM/CS provider, urban and rural areas] found the content in webinars and meetings not very insightful, along with P33 [Director of Program Initiatives, urban and rural areas]:

> *I find the CalAIM webinars very confusing and it's like the people that know about it, they just spew it out and our CBOs are going like, "Oh my God, what does that mean for us? I have no idea!" - P22.*

> *So, we have had a series of meetings with our [MCP] representatives over the evolution of [CalAIM]. We've had a lot of dialogue internally about what this could do operationally and the positives and the negatives. Like I said,* ***I've seen a lot of the presentations over and over again just because of the different meetings I have to go to. And so [I have] seen a lot of information and still having a hard time digesting it****… - P33*

You can't give me all the answers about what the requirements of signing this contract with you are going to be, but I need to do that before I can get any of these dollars that might help me build a system in order to meet those requirements. But I don't know what exactly those requirements are. Because that has been pretty nebulous... that was pretty frustrating.

Some participants attribute the lack of information and expertise to the fact that CalAIM is a relatively new initiative with little precedent that others can refer to answer questions. Some participants utilized similar metaphors to describe this situation:

> *I just have a sense that it's like rolled out really quickly…The bridge is being built while we're driving over it, right? Like, there's just a lot of unknowns that people just don't have the answers until we actually try. - P26.*

> *I know everyone's sort of building this plane as we're flying it and figuring out a lot of pieces and so we've been very early in like applying for all of the resources that are available. But it's still very slow and in the meantime our program is still like fully operating and growing. - P32*

In the excerpts above, P26 [Deputy Director of Program and Impact, taking steps to become an ECM/CS provider, urban and rural areas] and P32 [Operations Director, already an ECM/CS provider, urban area] both describe CalAIM as an inherently incomplete initiative. Trying to get answers or resources related to CalAIM is hampered by the lack of detailed knowledge about the program due to the perception that the program is still being developed and implemented. P43, [Program Manager, taking steps to become an ECM/CS provider, rural area], also shared this idea:

> *You know, there was a lot of talk about* ***building the plane as we're flying in*** *and we don't know, because we haven't heard from the state, and we need this. And so, I do think that there could have been more work done upfront so that things could have been laid out with more solid information, because I think they were asking organizations to try it out and let's see how it goes. But also,* ***the other thing I think is I found it really frustrating, you know, even if we had been awarded, we need to be in contract with a plan in order to receive any of the infrastructure building.***

> *Like, so you're asking me to* ***put the cart before the horse. You can't give me all the answers about what the requirements of signing this contract with you are going to be, but I need to do that before I can get any of these dollars that might help me build a system in order to meet those requirements****. But I don't really know exactly what those requirements are. Because that has been pretty nebulous. So, I think that was pretty frustrating…But I know that there were a lot of hiccups for those organizations that did sign up pretty early on. -P43*

The participant above expressed frustration with the lack of direction and planning during their experience in applying for CalAIM; they conjecture that this may be due to the fact that the program is intentionally experimental and building procedures as more CBOs go through the process. However, the participant also details their dilemma of "putting the cart before the horse", in which they are concerned their current infrastructure does not satisfy the contract requirements to become an ECM/CS provider, but they can't get the funding to address this until they are contracted.

Subtheme: Seeking Information from Peer CBOs. In addition to seeking information about CalAIM from formal sources like meetings, webinars, and online resources, participants reported that they also asked other peer CBOs about what they know and their perspective about the program. This was especially prevalent among the participants that were either thinking about applying or taking active steps in becoming an ECM or CS provider. For example, P10, [outgoing Program Manager, urban and rural areas] whose CBO was taking active steps in the application process, said they asked other CBOs with experience in CalAIM about multiple topics:

> *Yeah mostly [asked them] "Hey, are you guys exploring this? Have you had any luck? Were you given rate information? Is it going to work for you guys? How are you going to make it work?" Just sort of understanding how others are thinking about it fitting into the structure of their organization.- P10*

Seeking information from peer CBOs was especially prevalent among the participants that were either thinking about or taking active steps in becoming an ECM or CS provider.

The feedback participants received from other CBOs varied; some CBOs said positive things while others shared more negative feedback. For example, P14 [CEO, taking steps to become an ECM/CS provider, urban and rural areas] reported hearing "a lot of positives" from organizations that are engaged with CalAIM, which helps them see "a light at the end of the tunnel" as they go through their own application process. In contrast, P1 [CEO, taking steps to become an ECM/CS provider, urban area] said that they heard concerns about CalAIM from several CBOs,

> *Yeah, I think everyone [CBOs leadership] is hesitant because of the issues I've mentioned: Staff demand and financial concerns.* ***You know, we know it's out there. No one really understands how it's being implemented, so there's a lot of uncertainty around it.*** *And then for the partners that have engaged in CalAIM on a deeper level their experience was not easy. And so, it has created a lot of hesitation for most of my partners in the homeless services world.*

Among the 3 CBOs that were deciding to become an ECM or CS provider, they reported hearing negative opinions and experiences from other CBOs that were already engaged. For example, when asked if they have been talking to other CBOs about CalAIM, P35 [Executive Director, rural area] said,

> *Yeah, in passing, like [with] the woman who referred you to me from [nonprofit organization name]. We've talked about it a couple of times, about the benefits and how scary it seems and how even though we've been on all these meetings, like do we really fully understand what it would mean? So, people are talking about it. - P35*

P22 [Executive Director, urban area] heard of similar issues related to the lack of sufficient clarity and understanding, in which other "nonprofits are confused as well" about the CalAIM initiative and suggest that it's "going too fast and it should be more gradual." Similarly, two interviewees of P43 [A=Program Manager, B=Executive Director, rural area] discussed the mixed feedback they heard from other organizations,

> ***P43A:***
> *[Name of co-interviewee], what [are] we hearing from partners these days? You're probably more in touch than I am. But I know that there were a lot of hiccups for those organizations that did sign up pretty early on.*

P43B:

I don't know. One [organization] I know is that things are rolling, and it's been working okay. And [organization], I think they're moving forward and that's been growing. And the ECM team at the county is obviously up and running pretty well. Small, but it's functioning. There was one other organization…and last I heard, probably six, nine months ago at this point, they hadn't even gotten around to billing. ***They hadn't figured out how to even send in a bill for anybody yet. And they'd been running six months, with basically not functioning*** *<laugh>*

P43A:

And, and their organization is small. I don't know, probably, they're smaller than we are even. And, so for them, I think it was definitely an even bigger issue.

While they know of two organizations that are likely moving in the right direction and developing within the CalAIM initiative, they also note that another organization appeared too confused to bill for their services to claim funds from the program. They attribute this issue to the fact that the troubled organization was small and might not have enough resources to address billing issues.

P43B:

Yeah. ***And I think you can look at what organizations have been successful, right?*** *So, county, well, the county knows how to bill Medi-Cal. They do it regularly. They're hooked into that system. They've got the infrastructure behind them.* ***They've also got dollars behind them. They can float costs if they're struggling to recoup.*** *But then I think we see these large organizations that go, we'll do medically tailored meals statewide. Right? Right. So again, it's like a system that's built for large capacity organizations. For us, it's more of a risk.*

There were a lot of things that the resources didn't think to say that I had to figure out the difficult way. Things like what is a service unit, how was a service unit different for these different services and where to find it.

THEME 3: OPERATIONAL ISSUES

Subtheme: Difficulty with Billing. During interviews, most participants shared issues and concerns related to medical billing. To receive funds from the CalAIM initiative as an ECM or CS provider, the CBO is required to bill for the service using a pre-existing set of billing codes. Participants that were already registered as an ECM or CS provider more readily shared challenging experiences related to billing. P37 [Contract Analyst, urban and rural areas], whose CBO was already an ECM/CS provider, shared their journey on learning how to navigate medical billing:

> ***P37:***
> *Yeah, CalAIM requires medical billing. So, the part of this contract I am doing the most is the billing side and the claim side. And there are a lot of ways that tracking services in the vocabulary of medical claims is just different from tracking services in the vocabulary of, for example, a HUD grant. And so there were a lot of things that the resources didn't think to say that I had to figure out the difficult way. Things like what is a service unit and how is a service unit different for these different services and where I could find it but the resources talking about billing for this number of service units were not the same resources that said what a service unit was. And that one is really, really basic, if you're used to the world of medical billing…*
>
> ***Interviewer:***
> *You had to dig.*
>
> ***P37:***
> *Yeah. And so there are those or things like what is a clearing house, we've never worked with a clearing house.* ***You know, when I was setting up our systems to receive payments, the subcontractor that our health plan works with just automatically asked me for the name of our clearing house. And I then had to stop for a little while and figure out what that was,*** *and do we have one and do we need one. And so, that sort of just really, really basic nuts and bolts of how things work that they assume a dentist [or] a doctor's office already knows are not obvious to me because I'm mostly working in a world of grant billing.*

The excerpt above exemplifies the kind of extra effort exerted by CBOs to grapple with medical billing once they joined CalAIM. P37 invested significant labor to learn a new system of billing. The resources and materials provided by the program were inadequate and P37 had to educate themselves on the fundamental "nuts and bolts" of medical billing. This need to overcome the "learning curve" of medical billing is also exemplified by P13 [Director of Strategic Initiatives, already an ECM/CS provider, urban and rural areas],

> *Yeah, so billing has been a challenge for a few different reasons…We're new to the billing space, the Medi-Cal billing space. And, so, there's a learning curve there. The other challenge is each plan has varying degrees of nuance on how they interpret the guidance from D H C S and we're in a county that has five managed care plans. And for an agency who is newer or a novice in Medi-Cal billing, it takes a long time to learn and catch up.*

As P13 mentioned, navigating the medical billing can be complicated by operating in a county that has multiple MCPs. While participants of more rural counties reported having only one MCP, participants from more urban locations usually have multiple MCPs with different billing requirements. When P9 [Senior Director of Behavioral Health, urban area], a CBO that was taking steps to become an ECM/CS provider, was asked why they said they need the most support in developing their IT infrastructure, they responded,

> *This will be a new thing for them [staff]. And then everyone's like, "Oh my God! How?" because they're so used to working with the county. So, it will be a different system working with multiple sites, not just not one hospital.* ***Like, you know, we'll be working with multiple managed care plans and they all have multiple systems. So that's where [staff are] going to need a lot of support.***

Similarly, P17 [President/CEO, already an ECM/CS provider, urban and rural areas], a self-described "early adopter" of the CalAIM initiative, expressed deep frustration in navigating different billing systems,

> ***P17:***
> *There's no alignment in rates. There's no alignment in billing. Every managed care plan has different rates and requirements and billing systems. And I know they're working towards, common, trying to align everything to make it easier. Mm-hmm. But, I will tell you that I wish I had not been an early adopter.*
>
> ***Interviewer:***
> *Oh, wow. Because you had to learn as you go? Right?*
>
> ***P17:***
> *It has been expensive...It has not [been] reimbursed. And to be completely and frankly honest with you, we are thinking of dropping contracts****...Yeah, it's not cost effective. And we're getting 65 cents on the dollar we bill.***

For P17, the lack of a consistent method of medical billing applicable across all MCPs compounded by its lack of return makes them regret being an early adopter in becoming an ECM/CS provider to the point they are considering canceling contracts.

Subtheme: Low or Inadequate Reimbursement Rates and Misalignment in Payment Timing. The excerpt above from P17 touches on another theme present across interviews: reimbursement. This was especially present among participants that were already an ECM or CS provider. While many participants expressed difficulty in navigating new billing procedures, participants also commonly mentioned that they were dissatisfied with the reimbursement rates of the contracts. Participants claimed that the rates did not sufficiently cover the costs they incurred for delivery and billing of services and establishing contracting and billing infrastructure. P29 [President/CEO, urban and rural areas], an organization that was previously involved with CalAIM in its early stages that then later decided to pull out of the program, described the low reimbursement rates as a "big risk" for CBOs,

The other big risk, frankly, right now, which we're seeing all over the state, is that case management providers are refusing to compete for contracts because the reimbursement rates are so low. So, [organization name] works with a dozen, maybe 20 case management entities, and we are finding that there are such bad reimbursement rates from many agencies, not just one, that they're having trouble sourcing staff, retaining staff, and they ultimately aren't getting paid enough for the, I'll just say the corporate interface, with the plan or the government….There's so much work involved in actually just being in contract with someone in these programs, and I think that gets short changed as well. So, I think those are the parts of the system that really need the most immediate attention.

There's so much work involved in actually just being in contract with someone in these programs, and I think that gets shortchanged as well. I think those are the parts of the system that really need the most immediate attention.

The low reimbursement rates were also mentioned as a limitation by P32 [Operations Director, urban area], a CBO that was already an ECM/CS provider:

And I think the limitation to the partnership is that we don't get reimbursed for nutrition education besides like a $33 once in 12 weeks, ***which is not at all sustainable for us to like work at this rate or in this field if that's the rate*** *that we're getting reimbursed at. So I think if you want to encourage more collaboration, I think providing sort of a, okay, these are all the people that could be a part of this work and this is what each player would need to like be receiving and like funding in order for it to be a usable resource for them would be good.*

Participants also shared issues related to the length of time waiting for reimbursements. Within CalAIM, CBOs must first spend funds for service delivery and then claim those funds through medical billing. Participants indicated that after submitting their billing, reimbursement typically took months to arrive back to their organization. This was especially difficult for participants with limited financial capital on hand to cover costs while waiting for reimbursement. P28 [COO, rural area], a CBO already registered as an ECM and CS provider, highlighted how the reimbursement process of CalAIM can make it difficult for smaller CBOs to participate,

The other challenge that CBOs have is they have to front the cost oftentimes for up to a year. And so, over the years, it's just been growing partly because of our success, but I think this last year we had outstanding accounts receivable of like a million dollars. We're waiting on people to pay us. I mean, and those CBOs can't float that for sure. No. And so, even with Drug Medi-Cal, which falls under CalAIM, I guess, but you know, you have to incur the cost, and you have all this pressure to provide better services, be more compliant, do all this stuff, but we have to front the cost of that for at least a year and to get it built into rates. And that's very challenging to do. And so, the other challenge can be, just generally right across the board, but it adds up because it is such a common challenge: that the contracting process is so slow…

Like, so that's why we have all these outstanding receivables and challenges with cash flow, yeah. So, it depends on the level of risk that CBOs are willing to take and if there's enough of a benefit for them to take it on. So, we happen to be large enough, and our mindset is really adventurous <laugh>. We really just want to meet the needs of folks, and we're up to new opportunities and so we go for it. But I don't know that that's always the case, especially for smaller CBOs.

THEME 4: PARTICIPANT RECOMMENDATIONS

During interviews, each participant was asked to share recommendations that would help improve CBO engagement with the CalAIM initiative and encourage them to register as an ECM or CS provider. Participants mostly shared recommendations that addressed the themes presented above, including improving the informative content of CalAIM, decreasing the amount of paperwork, simplifying the billing process, and increasing reimbursement rates to adequately cover the cost of delivering services.

More of the providers who received that funding, perhaps bringing us together to share our experiences from the beginning, [would be good]. For example, the proposal, the application, the actual application process was tough.

One prominent suggestion shared by multiple participants was the need to consult with other peer CBOs that have already been through the process and were actively serving as an ECM or CS provider. This is exemplified by P8 [Board Chair, taking steps to become an ECM/CS provider, urban area] and P31 [Executive Director, already an ECM/CS provider, rural area],

P8:
And I think just more of the providers who received that funding, that perhaps bringing us together to share our experiences from the beginning. For example, the proposal, the application, and the actual application process was tough.

Interviewer:
So, peer support, kind of sharing, peer support among CBOs?

P8:
Peer support for sure…it was a very intense application process to put together. And just technically how it was laid out was mind boggling…

P31:

You know, probably some mentoring*, having a mentor, having somebody… You know, I was a school board member for many years. And one of the things they do with superintendents is when there's a new superintendent that's promoted up, you can get a mentor, somebody that's been doing superintendent work for a long time, and they can just help you navigate some of those things. I think that could be an opportunity for ECM. Obviously, there was no expert because it's a new program, but I think having the mentors might be helpful.* ***That might be something that's in the marketplace, but I don't want somebody that's like theoretical. I need somebody that's doing it.***

For complete documentation of supporting quotations, see Appendix E.

Discussion

The themes presented above illustrate how CBOs of different levels of engagement currently navigate the CalAIM initiative. Overall, the themes presented no significant differences between sub-groups in terms of levels of engagement.

Participants feel that CalAIM can have a potential positive impact for Californian healthcare. They look forward to the possibility of sustaining and/or expanding their current services with CalAIM funds. More generally, they welcome the state's adoption of a broader conceptualization of health that integrates services like housing and food assistance into the healthcare system, which stays true to CalAIM's intentions to "address the fragmentation in physical and behavioral systems and ensure that all members can experience the benefits of integrated care" (Kelly, 2022).

Unfortunately, it appears that the current structure of CalAIM ECM/CS initiatives are not very accessible for smaller CBOs. There are concerns related to its bureaucratic tendencies, uncertain sustainability, opaqueness, and its current billing and reimbursement systems. Many participants indicate not having sufficient technical, legal, and financial capacity and support to navigate these complexities and become an effective ECM or CS provider. This is similar to the assessment of CalAIM by Wong et al. (2023), which observed that although "smaller CBOs play a critical role in supporting the social safety net and contributing to place-based health equity and health outcomes," their participation may be hampered by "limited resources and scope." Findings suggest that without assistance or simplification of billing systems and higher reimbursement rates to better cover costs, the current structure of CalAIM may lead to the exclusion of smaller nonprofits, and cede space to only large, well-resourced organizations.

Study Limitations and Considerations

While this study provided insight into the perspectives of CBOs with different engagement levels within the CalAIM initiative, it is important to recognize its limitations. First, CBOs that provide housing services were overrepresented in the study. CBOs that deliver other types of services like asthma remediation, respite services, and personal care were not well represented in this study sample. In addition, the CBOs in this sample only covered around sixty percent of the state of California, with San Joaquin, Yolo, and San Francisco Counties as the most represented geographic areas. Since the experience of CBOs with CalAIM is dependent

on relationships with county health departments and MCPs, caution should be taken when generalizing the themes presented in this study to all CBOs across all counties in California.

The thematic findings of this study overlap with another study conducted by Goodwin Simon Strategic Research in collaboration with the California Health Care Foundation (2023). Through online focus groups with CBOs that were already approved as an ECM or CS provider, many focused on asthma remediation, issues related to lack of information and confusion about CalAIM, inadequate reimbursement rates, and burdening paperwork were also shared by participants. Given that the Goodwin Simon team of researchers captured feedback mostly from CBOs who were already approved as an ECM or CS provider working in the asthma remediation service type, the current study may be seen as providing different, yet complementary data in the field of CalAIM engagement and/or participation.

For example, the current study provides unique perspectives by interviewing participants that were not yet an approved ECM or CS provider. Furthermore, those participating CBOs represented a range of CalAIM engagement levels, from not knowing very much about the initiative to actively taking steps to become an ECM or CS provider. Interviewing participants from CBOs in this liminal, or transitory stage between being and not being an ECM or CS provider offers a unique opportunity to better understand how organizations decide to join programs and evaluate what aspects they prioritize in their decision-making. Study findings demonstrate that hearing positive or negative feedback from peer organizations can influence a CBO's decision to participate in CalAIM. The circulation of negative feedback among CBOs can cause other CBOs to hesitate to engage, possibly leading to less overall CBO engagement with the program. Additionally, peer feedback also influenced the timing of participation. Some smaller CBOs elected to be later adopters in early stages of CalAIM based on peer feedback, thus saving resources in terms of costs and time as they learned from early adopter CBOs how to engage in steps to become an ECM/CS provider.

Recommendations

Many of the subthemes in this study point to an overarching desire from CBOs to have a voice in how CalAIM is designed and implemented. In large part, the design of the CalAIM social care ecosystem is based on the existing medical care ecosystem. CBOs have been asked to learn, implement, and adopt systems and processes that are commonplace among MCPs, but not used widely in the community-based sector. This is not to say that MCPs have not also had to adjust to working more formally with CBOs, but that the CBOs are the ones that have had to integrate into the MCPs' medical care system, and not the other way around. This has resulted in the challenges identified through many of the subthemes in this study.

These findings can inform multiple recommendations to improve future CalAIM implementation efforts, starting with a renewed intention to include CBOs at every stage of the design process. Because CBO participation in CalAIM is so critical to the initiative's ultimate success, it is only right that their perspective should inform the design of the implementation process. Rather than MCPs having autonomy to establish processes regarding systems of record, member eligibility, documentation, billing rates, and others that are largely predicated on their existing practices and vastly different from existing CBO ones, the preferences of CBOs in these areas should be accounted for and incorporated into the policies and procedures. In this way, CBOs will be more equitable partners in the process and more likely to feel like a new initiative is not pushed on them without their ability to inform its design.

Study findings also point to a need to segment the roll out of CalAIM to CBOs based on their stage of engagement. Some CBOs are still contemplating the opportunity to participate while others have already decided to participate and are attempting to navigate how to implement. The tactics used to engage CBOs at disparate points of participation, or lack thereof, should be tailored to the needs of that specific CBO segment. This can include the following types of intentional engagement tactics paired with CBOs based on their current engagement levels: 1) engagement at the community level that targets CBOs not engaged with CalAIM or those thinking about becoming CalAIM providers, would explore the opportunity to become ECM/CS providers in an environment among trusted peer organizations. 2) peer-to-peer mentorship, potentially from larger CBOs with more experience and resources, to smaller CBOs.

For example, early engagement at the community level with CBOs who are deciding whether to become CalAIM providers could be offered at local sites in smaller venues rather than virtual meetings attended by hundreds of participants. Likewise, peer-to-peer mentorship could be led and sponsored by larger, more experienced CBOs in a more personalized and individualized manner, versus some presentations that have been offered to date that are not germane to some of the smaller CBOs' work or current level of engagement. This might address what some key informants suggested as a need for a more "hands-on" approach to learning about CalAIM.

Fortunately, DHCS has been eliciting feedback from various stakeholders engaged in CalAIM efforts, including CBOs, and has made iterative improvements to the initiative to improve the experience of participating organizations. More small group, peer-to-peer facilitated discussions have been integrated into the Collaborative Planning Implementation groups throughout the state so that CBOs can learn from each other in trusted and less intimidating spaces. In addition, DHCS revised their policy on access to the PATH TA marketplace by allowing CBOs not contracted with a MCP to also access this support and not just those that are contracted. DHCS also issued guidance in April 2023 to MCPs and providers allowing for invoice-based reimbursement methods in cases where providers lacked the technical capabilities to generate and submit claims. Likewise, they also updated ECM and CS Transition policies to promote timely payment of claims to providers. It will be important for DHCS to hold MCPs accountable to the provider payment policy time frames listed in the revisions in their 2024 policy revisions. Yet, it is worth mentioning that many well-intended and meaningful updates related to member eligibility, authorization of services, and billing and invoicing (among others) are very technical in nature. Even for CBOs that have some staff responsible for tracking, translating, and implementing these updates into their operations, it can often feel like learning a new language. This can be expensive and burdensome for CBOs.

Along these lines, study findings also indicate a need to alleviate CBOs from administrative burdens that are required to participate in CalAIM. Specifically, CBOs need additional capacity to navigate the application process, compliance, contracting, technology, and billing. Shared service arrangements among many CBOs can alleviate these burdens and help emerging ECM or CS providers take steps to become a provider while also assisting those already contracted to perform key functions more efficiently. This shared service approach is called out by Wong et al. (2023) as a way to "centralize the administrative functioning and streamline funding from multiple private and public sources, allowing smaller, important CBOs to thrive in a landscape dominated by large national organizations." Ultimately, this could make CalAIM more accessible for smaller CBOs that do not have robust resources or financial capacity to overcome barriers.

Conclusion

Findings from this study provide insight into CBO participation and experience in CalAIM implementation that can help inform future iterations of the implementation and roll-out. Hearing directly from key stakeholders involved in or thinking about becoming involved in the CalAIM initiative provides first-hand accounts of the challenges faced by CBOs. Taking their perspectives and proposed recommendations into consideration increases the likelihood CBOs will continue to participate and engage in CalAIM efforts and help build a sustainable initiative to align and integrate health and social care. Taking steps to improve the CalAIM initiative experience of CBOs, ultimately allows CBOs to more effectively provide holistic services that will engage and impact the historically marginalized populations they serve.

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Appendix A:

Domain Details

The awareness domain included the role of CBO's in CalAIM, such as the general level of engagement with CalAIM to date, relevance of CalAIM to CBO's and interest in learning about and/or participating further in CalAIM. The experience domain explored facilitators and barriers to participation in CalAIM learning opportunities, such as the Technical Assistance Marketplace and/or PATH, usefulness of learning opportunities with regard to Technical Assistance Marketplace and/or PATH, as well as recommendations for future engagement opportunities. The infrastructure readiness domain encompassed excitement and concern about participating in CalAIM, leadership buy-in, contracting administration and compliance, strategic business and partnership development, information technology and security, financial acumen and program readiness.

Appendix B:

Interview Scripts

Hello. My name is (interviewer name) and I'll be conducting your interview today. Before we get started, let me share some information about this project.

The purpose of this research study is to gain a better understanding of the participation, experience and readiness of community-based organizations' (CBOs) in DHCS' CalAIM implementation, specifically as it pertains to becoming Enhanced Care Management (ECM) or Community Supports (CS) providers. The intent is to elevate the voices of CBOs and identify any barriers to their participation in CalAim learning, technical assistance and capacity building initiatives.

We wish to ask you questions about your professional experience and insight in the work of your collaborative or organization, specifically around CalAIM engagement. We will be speaking to leaders across a number of different CBOs and findings will be reported in aggregate, summarizing insights and best practices, to help provide recommendations for improvements in CalAim efforts in the future. Local Dignity Health or community leaders will not see your individual responses. You will receive a copy of these findings to help inform your work and share with your team and/or other stakeholders.

There are minimal risks associated with participation in this interview and your participation is voluntary. The questions will be open-ended and ask you to reflect on your professional experience. You may choose to not answer any question for any reason or to terminate the interview at any time. For your participation in this study, your organization will receive an eGift card incentive valued at $150, even if you wish to end the interview early.

If you have any questions or concerns about this study, please contact Ji Im: ji.im@commonspirit.org

As a part of this research, we would like your consent to audio record you for the purpose of obtaining more complete notes. Do you consent to be recorded? [If "no": "Would it be possible for the researcher to take notes, instead?]

Do you also consent to participate voluntarily in this study?

_____ Yes, I consent to participating in this research study Name _____
Today's Date [noted in Zoom recording) _____

Interview Scripts

Thanks for giving consent to record and participate. Just to confirm: You are Ms./Mr./Dr. (if so named) xxxxx and serve as the (title) in (organization name). Your experience with CalAIM falls along this spectrum (e.g., no experience, thinking about getting more involved/learning more, attended intro meetings, taking steps to be CS and/or ECM or both, already a CS and/or ECM or both, other). Your organization serves the (xxxx area, e.g., statewide, county, region, etc.). The populations you serve include xxxx (rural/urban, tribal or not, racially and ethnically diverse or low income or working-class communities) and a primary focus of care is (housing, other). Your organization also serves: (Medi-Cal patients; private payer, etc.), correct?

Thanks for your confirmation (if correct) or clarification (if corrected by interviewee).

Introduction

1. Can you share more about your organization and your role?
2. What do you enjoy most about your work?
3. Can you name which local Managed Care Plans or MCPs your organization currently works with (if applicable)?

Awareness of CalAIM

Let me know if you need a brief working definition of CalAIM.

[If yes: CalAIM is a long-term commitment that intends to improve Medi-Cal for people with complex needs who are facing difficult life and health circumstances by extending care beyond hospitals and other health care settings into communities. Their goals include implementing a whole-person care approach, addressing social drivers of health, improving quality outcomes, reducing health disparities, driving delivery system transformation and creating a consistent, efficient and seamless Medi-Cal system.]

4. What type of information have you heard or received about the role of community-based organizations in CalAIM?
5. In what ways do you think changes around CalAIM are impactful or relevant for community-based organizations, if at all?

6. What specific funding or capacity building opportunities are you aware of for community-based organizations in CalAIM?

a. Probe: What have you heard about the TA marketplace?

*[**Definition:** Technical assistance provided to providers, CBOs, county agencies, public hospitals, tribal partners and others.]*

b Probe: What have you heard about PATH funding?

*[**PATH Definition:** Providing Access and Transforming Health or PATH is a time-limited pilot initiative designed to enhance the State's system transformation to the next phase, refocusing its uses to achieve the CalAIM vision, to maintain, build and scale the infrastructure and capacity necessary to insure successful implementation of Enhance Care Management or ECM or Community Supports. Essentially ramps for CBOs to become ECM or CS.]*

*[**ECM Definition**: A Medi-Cal managed care benefit that will address high-need, high-cost individuals through the coordination of services and comprehensive care management]*

*[**Community Supports Definition:** Services that Medi-Cal managed care plans are strongly encouraged, but not required to provide as medically appropriate and cost-effective alternatives to utilization of other services or settings, such as hospital or skilled nursing facility admissions.]*

c. Probe: What have you heard about the Collaborative Planning Group in your county?
*[**Collaborative Planning and Implementation Initiative or CPI Definition:** Support for collaborative planning and implementation groups to promote readiness for Enhanced Care Management and Community Supports.]*

7. In what ways did your organization try participating in the CalAIM transformation process?

Awareness of CalAIM

8. What has helped your organization participate in the process of learning about CalAIM?
Probe: Which learning opportunities were most helpful to you?

a. What learning opportunities/information were missing that would have been more helpful to you?

9. In what ways did your organization try participating in the CalAIM transformation process?
Probe: Unable to spare employees to attend events, as needed to provide core functions?

a. Belief that CalAIM participation was not feasible or of limited value to your organization.

10. What steps did your organization take to determine if you could be an Enhanced Care Management or Community Supports provider through CalAIM?

11. What steps did your organization take to determine if you could be an Enhanced Care Management or Community Supports provider through CalAIM?

Probe: Collaborative planning group in your county

a. Probe: CalAIM technical assistance marketplace
b. CalAIM funding opportunities, like PATH CITED or IPP funding from local Managed Care Plans?

[CITED Definition: Capacity and Infrastructure Transition, Expansion and Development Initiative: Grant funding to enable the transition, expansion and development of capacity and infrastructure to provide ECM and CS. IPP Definition: Incentive Payment Program supports the implementation and expansion of Enhanced Care Management (ECM), Community Supports, and other CalAIM initiatives by providing incentives to Medi-Cal managed care plans (MCPs).]

Infrastructure Readiness

12. What makes you **excited or concerned** about the opportunity for community-based organizations, like yours, to contract with Managed Care Plans for delivery of services?

Key informants access Google Docs poll here:
https://docs.google.com/forms/d/1TCdKAWbgYkWa5rZpLE_CkUYGgyZR8FCTM4e8HUUUmiY/edit?ts=64946008

13. In which of the following areas do you think your CBO would need the least (1) to most (5) support/ capacity building if you were to pursue further contracting opportunities with Managed Care Plans? Please rank these areas below in terms of your CBO needing the least (1) support/capacity building to the most (5).

Poll response options:

i. Leadership buy-in
ii. Strategic business development
iii. Contract administration and compliance
iv. Operations (e.g., managing referral lists, quality assurance, etc.)
v. Information technology and security (e.g., referral systems, documentation systems, etc.)

Probe: you ranked x as the area your organization would need the most support around. How come?

Probe: you ranked y as the area your organization would need the least support around. How come?

14. How would you like to see **CalAIM structure the way they engage community-based organizations differently** to ensure they're connected to opportunities to learn about CalAIM, and receive funding and capacity building support through CalAIM.

Discussion: Potential questions if time (not organized into the domains)

a. What do you see as potential opportunities to be gained from participating in CalAIM?
b. Are there any other suggestions or comments that you'd like to share with the leadership of CalAIM?
c. Have you had conversations with other CBOs about CalAIM? If yes, can you share briefly about those discussions?

Thanks for your help today. We'll be in touch with your eGift card within the week and feel free to reach out to me via e-mail with any questions or ideas in the future.

Appendix C:

Detailed Characteristics of CBOs

Characteristics of Community-Based Organization Participants

CBO Characteristic	n	%
Annual Operating Budget		
Less than $1M	7	15.2%
$1M - $4.9	17	37.0%
$10M - $19.9	7	15.2%
$20M - $100M	5	10.9%
More than $1M	1	2.1%
N/A	4	8.7%
Workforce Size		
Less than 10	9	19.06%
10 - 19	6	13.1%
20 - 49	6	13.1%
50 - 99	9	19.6%
100 - 199	5	10.7%
200 - 399	4	8.7%
400 or ore	4	8.7%
N/A	3	6.5%
Type of Service		
Housing Transition	21	45.7%
Food Assistance	11	24.0%
Housing Tenancy	8	17.4%
Housing Deposits	4	8.7%
Respite Services	3	6.5%

Type of Service		
Day Habilitation	6	6.5%
Home Modifications	3	6.5%
Personal Care	2	4.3%
Recuperative Care	2	4.3%
Nurse Home Transition	2	4.3%
Sobering Centers	1	2.2%
Transition/Diversion to Assisted Living Facilities	1	2.2%
Short-Term Post-Hospitalization Housing	1	2.2%

Engagement with CalAIM		
Already an ECM/CS	19	41.3%
Taking steps to become ECM/CS	16	34.8%
Thinking to become ECM/CS	4	8.7%
Not engaged	7	15.2%

Appendix D:

Individual Interview Participant Characteristics

Participant CBO Code	Stage of Engagement	Number of CBO Representatives Interviewed	Interviewee Position	Urban/Rural
P1	Taking steps to become an ECM and/or CS	1	CEO	Urban
P2	Taking steps to become an ECM and/or CS	1	Executive Director	Both
P3	Taking steps to become an ECM and/or CS	1	Program Manager	Urban
P4	Taking steps to become an ECM and/or CS	1	Program Manager	Both
P5	Taking steps to become an ECM and/or CS	1	Executive Director	Urban
P6	Already an ECM and/or CS	1	Public Health Officer	Rural
P7	Already an ECM and/or CS	5	Supervisor; Outreach Case Managers	Both
P8	Taking steps to become an ECM and/or CS	2	Board Chairman; Vice President	Urban
P9	Taking steps to become an ECM and/or CS	1	Senior Director of Behavioral Health	Urban
P10	Taking steps to become an ECM and/or CS	1	Outgoing Program Director	Both
P11	No Engagement	1	Executive Director	Urban
P12	Taking steps to become an ECM and/or CS	1	Director of Quality and Patient Engagement	Both
P13	Already an ECM and/or CS	1	Director of Strategic Initiatives	Both

Participant CBO Code	Stage of Engagement	Number of CBO Representatives Interviewed	Interviewee Position	Urban/Rural
P1	Taking steps to become an ECM and/or CS	1	CEO	Both
P1	Already an ECM and/or CS	1	CEO	Urban
P1	No Engagement	1	Organizing Director	Urban
P1	Already an ECM and/or CS	1	President/CEO	Both
P1	No Engagement	1	Executive Director	Both
P1	Taking steps to become an ECM and/or CS	1	Director of Senior and Supporting Services	Both
P20	Already	1	Director	Both
P21	Taking steps to become an ECM and/or CS	1	Program Director of Food Access	Both
P22	Thinking	1	Executive Director	Urban
P23	No Engagement	1	Executive Director	Both
P24	No Engagement	1	Board Member	Urban
P25	Already an ECM and/or CS	1	Vice President of Residential Services	Urban
P26	Taking steps to become an ECM and/or CS	1	Deputy Director of Program and Impact	Both
P27	Already an ECM and/or CS	1	CalAIM program manager	Rural
P28	Already an ECM and/or CS	1	CEO	Rural

Participant CBO Code	Stage of Engagement	Number of CBO Representatives Interviewed	Interviewee Position	Urban/Rural
P29	Already an ECM and/or CS	1	President/CEO	Both
P30	No Engagement	1	Executive Director	Urban
P31	Already an ECM and/or CS	1	Executive Director	Rural
P32	Already an ECM and/or CS	1	Operations Director	Urban
P33	Already an ECM and/or CS	1	Director of Program Initiatives	Both
P34	Taking steps to become an ECM and/or CS	2	Executive Director; Director of Research and Development	Rural
P35	Thinking of Becoming an ECM and/or CS	1	Executive Director	Rural
P36	Already an ECM and/or CS	1	Program Director for Community Bridges	Both
P37	Already an ECM and/or CS	1	Contract Analyst	Both
P38	Already an ECM and/or CS	2	CEO; Program Director	Urban
P39	Already an ECM and/or CS	1	Chief Initiatives Officer	Both
P40	Already an ECM and/or CS	1	CEO	Urban
P41	No engagement	1	Board President	Rural
P42	Thinking of Becoming an ECM and/or CS	1	Executive Director	Rural
P43	Taking steps to become an ECM and/or CS	2	Executive Director; Program Manager	Rural

Participant CBO Code	Stage of Engagement	Number of CBO Representatives Interviewed	Interviewee Position	Urban/Rural
P44	Thinking of Becoming an ECM and/or CS	1	Executive Director	Rural
P45	Already an ECM and/or CS	2	Chief Program Officer; VP of CalAIM Program and Services	Both
P46	Already an ECM and/or CS	1	Senior Systems Change/ Emergency Services Liaison	Rural

Appendix E:

Full Supporting Quotations

Themes		Example Interview Excerpts	
Thematic Group	**Subthemes**	**CBO that is not yet an ECM or CS**	**CBO approved as ECM or CS**
Overall Perspectives	Toward Holistic Healthcare	Well, you know, I think the idea of, community supports, especially in thinking about healthcare and people, who, for lack of better term, are really… in great need. It's great that there is this opportunity for us to provide services to people who are leaving the hospital or, the doctor's office, that kind of thing. [Services for those] who wouldn't be able to get services otherwise. To me that is a great opportunity to help someone and to get somebody on the right path too, because, if you leave there, you don't know where to go. - P2	Lives are changing in a way that you couldn't have if you hadn't had public health over here, you know? And there was no bridge. So actually, worrying about and realizing social determinants of health matters, because people are whole people and holistic. So, for me, that integration and that ability to move forward is very powerful. And I don't think we could have done that had this not been a part of that transformation. - P45
Overall Perspectives	Toward Holistic Healthcare	I like to think that it will open up a conversation between CBOs and healthcare providers around the further social determinants of health. So when someone's going into their medical provider or bringing their child into the pediatrician, we're not just looking at the symptoms that the child was brought in for… It's historically been hard, because pediatricians are so busy and doctors are so busy to even get a meeting on the schedule to say like, can I give you 10 minutes to tell you what we do and how you can share this information with families? Because when they're seeing a family, they've got such a teeny tiny window to talk about all of the health concerns, let alone anything else that's going on for them. - P35	Well, obviously the excitement is to have a true funding source to do the kind of work that we do. Because right now, we cobble together monies from foundations and individuals and next year it goes away. So, we hire somebody and it goes away. So having a sustainable funding source that seemingly has much bigger pockets than these small city or local foundations is exciting. And the idea that it's looking at our clients needs in a holistic way, you know, together, that's exciting... I mean versus everybody doing their own things in silos and not really moving forward. - P25

Themes		Example Interview Excerpts	
Thematic Group	**Subthemes**	**CBO that is not yet an ECM or CS**	**CBO approved as ECM or CS**
Overall Perspectives	Concerns about medicalizing social care/ CBO services	What makes us nervous is again, what I've mentioned when it comes to what does that affect your day to day, the reporting, does that change? The role of a case manager where you're not going to be able to attract the people we're attracting who really want to spend 95% of their time working with clients. And not at a computer coding each conversation they had. - P14	Well, I don't feel like they understand the investment CBOs really need to implement CalAIM services. So, I attended one of the webinars and they want you to figure out like how many of your clients in this system that you need are actually going to be receiving CalAIM services, and then only apply for the percentage of the cost of the system that will incur, right? I mean, CBOs, where's the rest of the money for that, right? And then everything has to be directly related to CalAIM services. But, at this point, because there's been really not a lot of coordination among various programs and entities, we've got so many different systems we work with now, like IT systems - P28
Overall Perspectives	Concerns about medicalizing social care/ CBO services	We have a small grant with the health department and it's around SNAP Ed, which is our food stamp program… Well, this is a grant that lasts about six months out of the year, and it's a reimbursable grant, which means I have to have enough money in the bank, right, to be able to purchase whatever needs to be purchased and then wait a month to get reimbursed. Right. As a small nonprofit, I'm always struggling with that…And I think that our government has absolutely no clue about all of this <laugh>, you know, so, it's very frustrating to me to even consider doing those grants any longer because it just, the tediousness and the consumption of my time and energy, it actually sucks the life out of me to be very honest. Okay. - P23	Yeah, I think the paperwork is pretty, pretty heavy. For this program, which is pretty standard. I mean, we were already kind of used to it with being a Partnership health provider, you know, Medi-Cal biller and having a contract. I think you know, a barrier still, I would say, is the referral process… how do they refer to me? Right? Do they just make a phone call to me? Do they fax me? Which is a lot of how medical referrals are happening is fax, not electronic. You know, but some of that work is what needs to be done amongst the leadership of those different organizations, because how do we all agree to get on the same program or how do we all agree to use the same system? That's a hard thing to do. And when you're talking about CBOs, in my mind, everybody's running a hundred miles an hour, and nobody has time to really be that strategic. It's very, very difficult to do that. - P31

Themes		Example Interview Excerpts	
Thematic Group	**Subthemes**	**CBO that is not yet an ECM or CS**	**CBO approved as ECM or CS**
Overall Perspectives	Long-term CalAIM	The concerns around CalAIM to me is that it's still in its early iterations and for me it's like you set this up and then what happens if it doesn't stick? If it's not around in five years' time or it doesn't get renewal, the state funding cuts, what's first going to go? - P19	Greater services for our community as long as the program remains viable at a federal and state level. And by viable, I mean, I do not see that there will not be some permanent subsidies coming through here. So, if we get the political players on the hill that don't support that, these programs will dissolve. – P46
Overall Perspectives	Long-term CalAIM	I think that they may have made enough changes to more effectively offer housing stabilization case management for people that are housed in our buildings. But I think the rubber will meet the road at the end of this CalAIM period and whether the state actually manages to sustain that effort. - P29	We, as with every, every organization, I think probably across the nation, sustainability is a question. And so, could this be part of our sustainability plan? With our tobacco tax revenues going down, but more and more families being eligible for Medi-Cal, would this be a good sustainable option for us? - P35
Information Flow and Communications	Confusion & Lack of Clarity	We did have a contact at [an MCP] help, that has been trying to get information out to CBOs…So that's been helpful. I've spent a whole lot of time on the state website as well, digging through all kinds of weird documents…What would be helpful is like, [this is] something that's really weird to community-based nonprofits. You know, maybe this is something that the Red Cross can figure out because they're a larger organization, but for us, a small nonprofit, it's really hard to kind of figure out. - P26	Since then, we're on everything, but the fact is the conversations are happening in too many places. It's too ridiculous. We're in the one for YOLO County, we're in the one for Sacramento County. And there's not an opportunity to actually address CBO problems in those meetings. Those meetings are talked at us, giving us information, PowerPoints are delivered and at no time is there space to talk about the real issues that we're having, which I hope is part of your questioning too, which is billing. The billing systems have been horrible, and there's been no place to deal with that. – P40
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Information Flow and Communications	Confusion & Lack of Clarity	We've had a lot of dialogue internally about what this could do operationally and the positives and the negatives. Like I said, I've seen a lot of the presentations over and over again just because of the different meetings I have to go to. And so seen a lot of information and still having a hard time digesting it, [even with] that. – P14	There are a couple of specific webinars that the Alliance has put together that I've found moderately useful, but sadly this gets into the part, which is harder, which is that this program has been changing under us while we try to implement it. And so, the resources that were useful, accurate, and authoritative in July of 2022 are now hopelessly outdated, <laugh> and just keeping track of what is current, what is authoritative, what is real, is requiring a certain amount of attention as the program shifts. - P37
Information Flow and Communications	Seeking information from peer CBOs	So, I think when I hear from some of my partners, other small CBOs and they're saying, Hey, this is worthwhile investing in. I think those are the things that get me then look more deeply into it. So, I think it's interesting because if I think of myself personally, I'm an early adopter usually around things, but I've also learned that I just don't have the capacity to run after every single grant. - P23	A friend of mine and former colleague has taken a role, leading an ECM and Community Supports program at another organization. And so, I've been sharing resources and talking about what she's seeing from the very beginning of the implementation process. And we've been, you know, meeting up as friends. It's just with a couple, couple other people. - P37

Themes		Example Interview Excerpts	
Thematic Group	**Subthemes**	**CBO that is not yet an ECM or CS**	**CBO approved as ECM or CS**
Information Flow and Communications	Seeking information from peer CBOs	Interviewer: What has helped your organization participate in the process of learning about CalAIM? P5: The healthcare community has been more helpful than anyone else has, as parts of the healthcare community cares. You know, there's chunks of the healthcare community that doesn't care, sure.	I mean, if there's already round tables happening, I think that'd be a good opportunity for us to meet with other CBOs, partnering with CalAIM to see what they're struggling with. And I think it'd be a good opportunity for us to also provide, potentially, some resolutions to some of the challenges that you and other CBOs are going through and vice versa. We could all help each other out and collaborate. We could learn together. - P33
Operational Issues	Difficulty with Billing	So, you know, we've been talking a lot internally about this, our executive director is interested in the financial work. I think she would be. And then in terms of what I said, that's primarily because we don't have mechanism for doing billing or you know, HIPAA or, you know, we just don't have that. - P26	I think eventually CalAIM is going to require us to bill per hour and not bill per service. And I can see that shift happening rather soon as they see more and more CBOs like billing for one client visit per month…that's going to create a whole new billing process for our team. And so, I'm kind of like expecting some changes to shift there. I'm a little concerned about the dual enrollment and the auditing process with our state and federal funded contracts… How is that auditor going to look at our billing and say, well this case manager was doing this amount of hours and that amount of hours, and is it going to actually be acceptable? So I think that's a huge risk when it comes to like next year's auditing. - P7
Operational Issues	Inadequate or Slow Reimbursement and Misalignment of Payment Timing Lack of CBO Financial Capacity	I feel like there was a lot of courting that happened very early on from the managed care plans: "You guys are a CBO, we know you do this great work, we want to get with you, you should be a provider!" It was very much like, "Rah! Rah! Rah! Yes! Yes! Yes!" We had our big meetings. They were so supportive of us, all the things. It was a very good courting…but what are you going to pay us? We have to get paid for our services. And at that point it was a steep downhill. And so quite frankly, that is why we are not participating at this time, because I still don't know what they're going to pay us. - P10	I guess I think a big kind of like elephant in the room, too is that the CHW benefit just came out within Medi-Cal and the rates are significantly higher for very, very similar services. So one of the things we have to talk about internally is should we even do CalAIM or should we focus on the CHW benefit because the rates are almost twice as high. - P6

Themes		Example Interview Excerpts	
Thematic Group	**Subthemes**	**CBO that is not yet an ECM or CS**	**CBO approved as ECM or CS**
Operational Issues	Inadequate or Slow Reimbursement and Misalignment of Payment Timing Lack of CBO Financial Capacity	Yeah, I think capacity, honestly, right? So, I think folks that live in the government world don't necessarily understand that a small nonprofit is holding on by bare threads, right? One check delayed or one assignment too many can just totally make it impossible to accomplish what needs to get accomplished, right? - P2	Or it's like the rate is the rate is the rate. And so, they came back and they gave me the rate I wanted. And recently, because of cost-of-living increases and stuff like that, we've had to renegotiate rates again. And this time, I'm like, we need to raise rates to this. And they're like, okay. So, there was no more. And it's like, I'll show you the breakdown of where this is and you can see that I am not making money. Right. I'm just asking not to lose money. - P20
Participant Recommendation	Peer Mentorship and Learning	I've been saying, I've been articulating to allies, that someone should step up as a filtering agency. I think that's a really smart strategy that would solve a lot of issues...The thing that's benefited me most is for [others] filtering information to me. But if there was actually an agency that was filtering the patients to me and I don't have to deal with health plans, that would be the coolest thing…And so for all these PATH collaboratives, if they just recognized the value of that and that being led by a CBO, right? Not being led by a state person or health plan person, but a CBO, because a CBO could filter for multiple health plans, so then you'd be getting to like volume. - P21	Yeah, other than like increasing the rates there, that would be I think really important. If they had an example, an exemplar, especially like an exemplar tribally affiliated organization, that could speak to how they've done this. – P6
Participant Recommendation	Peer Mentorship and Learning	Just need help. Just need help doing the work. You know, figuring out, you know, that's where we are now is just like we want, we know what we want to build. You know, leadership's bought in on it. We already have all the systems in place to do it because those were mostly preexisting. Now it's the nitty gritty, right? It's how exactly are we going to do a shared care plan? How exactly are we going to do the home visits and, visits out in the field? It's really just down to operations at this point. Like that's where we need, where we would take the most help in from places that already maybe have an idea of how to do some of this stuff and can teach us. - P12	I think just more of the providers who received that funding, that perhaps bringing us together to share our experiences from the beginning. For example, the proposal, the application, the actual application process was tough. – P8

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