CHCF

CalAIM Community Supports:
Promoting Independent Living Among Older Adults and People with Disabilities

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About the Authors

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Acknowledgments

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About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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Contents

CalAIM for Seniors and People with Disabilities is a series of reports focusing on elevating experiences from California and other states to ensure CalAIM reforms impacting Medi-Cal's seniors and people with disabilities build on past efforts to integrate and improve care.

Key Terms

Select Medi-Cal Programs

Assisted Living Waiver Program (ALW). A Section 1915(c) Medicaid waiver that provides personal care services, housekeeping, intermittent skilled nursing care, and care coordination for transitions from a nursing facility to an assisted living facility in 15 counties.[1] Eligibility is limited to Medi-Cal enrollees age 21 or older meeting nursing facility level of care (NFLOC) who are willing and able to safely reside in an assisted living facility or in publicly subsidized housing. Medi-Cal managed care plans are responsible for coordinating services with ALW program providers.

Cal MediConnect. California's capitated Financial Alignment Demonstration, which integrates Medicare and Medi-Cal for people eligible for both programs ("dually eligible enrollees"). Implemented in 2014, this program is scheduled to end December 31, 2022.

California Advancing and Innovating Medi-Cal (CalAIM). A multiyear initiative led by California's Department of Health Care Services (DHCS) to better integrate the Medi-Cal program with other social services for a more person-centric, equitable, and coordinated experience. Community Supports discussed in this report are a key provision through which CalAIM seeks to improve outcomes for people with medically and socially complex care needs.

California Community Transitions (CCT). California's *Money Follows the Person (MFP)* Demonstration, CCT is a Medi-Cal funded program operating since 2007 that helps certain Medi-Cal enrollees living in institutions transition into the community. Medi-Cal receives enhanced federal funds for supplemental services not offered under the Medicaid State Plan or other waivers, such as payment for security deposits and other costs to setting up a household. CCT was recently extended through December 31, 2023.[2]

Community-Based Adult Services (CBAS). (Formerly known as Adult Day Health Care.) Offered through a Section 1115 Demonstration, CBAS is a Medi-Cal benefit available to older adults and adults with disabilities enrolled in managed care in 27 counties.[3] CBAS support greater independence in the home or community, and delay or prevent unnecessary or unwanted institutionalization. Examples of services provided on-site at CBAS centers include physical, occupational, and speech therapies; social services; behavioral health services; personal care; and nutritional counseling.

Health Homes Program. An optional Medicaid State Plan benefit, California's Health Homes Program coordinated care for Medi-Cal enrollees with complex medical needs and chronic conditions. Health Homes providers integrated and coordinated all primary, acute, behavioral health, and long-term services and supports (LTSS). This program ended December 31, 2021.

In-Home Supportive Services (IHSS). A statewide program providing personal care and other services to enable eligible Medi-Cal enrollees who need assistance with activities of daily living or other supports to remain safely in their homes as an alternative to longer-term facility-based care. Eligibility is limited to people with medical, cognitive, or behavioral conditions or other disabilities.

Multipurpose Senior Services Program (MSSP). A Section 1915(c) Medicaid waiver that provides home and community-based services (HCBS) as an alternative to nursing facility placement for Medi-Cal enrollees age 65 or older determined to require NFLOC. Medi-Cal managed care plans are responsible for coordinating services with MSSP providers.

Whole Person Care Pilot. A program launched in 2017 that used locally administered initiatives to coordinate medical, behavioral health, and social needs for Medi-Cal enrollees with complex needs. This program ended December 31, 2021.

Select Providers and Facility Types

Assisted living facility (ALF). A variety of California facilities that provide both housing and personal care but not medical care. These include facilities serving adults under age 60 (**adult residential facilities [ARFs]**) and facilities primarily serving adults age 60 or older (**residential care facilities for the elderly [RCFEs]**).

Community Supports providers. A term inclusive of the broad spectrum of provider and facility types that MCPs may engage and partner with to deliver Community Supports. These include community-based organizations (e.g., Area Agencies on Aging, Aging and Disability Resource Connections), direct care workers, assisted living facilities, and skilled nursing facilities. Providers such as meal service delivery vendors, plumbers, carpenters, and other contractors are also included.

Direct care workers (DCWs). An essential workforce providing hands-on assistance with activities of daily living (e.g., meal preparation, bathing, dressing) and other tasks for older adults and people with disabilities. DCWs provide care in facilities (e.g., nursing facilities and ALFs) and in people's homes. Personal care attendants providing the Personal Care and Homemaker Community Support are included in this definition.

Skilled nursing facility (SNF). Provides 24-hour skilled nursing care or rehabilitative services to residents whose primary need is skilled nursing on an extended basis, and whose care needs cannot be met in a residential care setting (e.g., ALF). California regulation also includes the terms "skilled nursing home," "convalescent hospital," "nursing home," and "nursing facility" in its definition of SNF. Use of "SNF" and "nursing facility" in this report follows how they appear in DHCS's ***Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide*** (PDF).[4]

Introduction

California allows Medi-Cal managed care plans (MCPs) to offer Community Supports that provide person-centered supports and services to address a variety of social drivers of health; several of these services can help older adults and people with disabilities live independently. Community Supports are one component of the CalAIM (California Advancing and Innovating Medi-Cal) initiative, a multiyear plan launched on January 1, 2022, by the California Department of Health Care Services (DHCS) to transform the Medi-Cal program. Community Supports provide Medi-Cal MCPs with greater flexibility to invest in community-based interventions to support older adults and people with disabilities to remain in their own homes, participate in their communities, and lead lives in their setting of choice.

MCPs may offer any of **14 preapproved Community Supports** (PDF),[5] referred to nationally as In Lieu of Services (ILOS).[6] Community Supports are optional for MCPs to provide. With state approval, MCPs can add new Community Supports every six months or stop offering them on an annual basis. Enrollees similarly have the flexibility to accept or decline these services.

MCPs may offer any of 14 preapproved Community Supports, referred to nationally as In Lieu of Services (ILOS). This report focuses on and provides an overview of six Community Supports most relevant to supporting independent living for older adults and people with disabilities.

This report focuses on and provides an overview of six Community Supports most relevant to supporting independent living for older adults and people with disabilities, including:

- **Respite Services.** Short-term services aimed at providing relief to caregivers of those who require occasional or temporary assistance or supervision.
- **Nursing Facility Transition/Diversion to Assisted Living Facilities.** Services that help people remain in the community by facilitating transitions from a nursing facility back into a home-like, community setting (e.g., an ALF), or prevent nursing facility admissions for those with imminent need.
- **Community Transition Services/Nursing Facility Transition to a Home.** Nonrecurring support, including set-up expenses, to avoid further institutionalization and help people remain in the community as they return home from a licensed facility.
- **Personal Care and Homemaker Services.** Supports for people needing assistance with daily activities, such as bathing, dressing, cooking, eating, and personal hygiene.
- **Environmental Accessibility Adaptations (Home Modifications).** Physical adaptations to a home when necessary to ensure health, welfare, and safety, or promote greater independence at home through improved functionality and mobility.
- **Medically Supportive Food / Meals / Medically Tailored Meals.** Meal services to help people achieve their nutritional goals at critical times (e.g., after a hospital or nursing facility stay) to regain and maintain their health.

Special Considerations: Day Habilitation Community Support

Of the 14 preapproved Community Supports, the majority are geared toward people who have behavioral health conditions, are experiencing homelessness, or otherwise have complex chronic conditions and social needs — those Community Supports were not included in this report focused on older adults and people with disabilities. The authors explored Day Habilitation as a service to feature in this report but ultimately elected not to include it. "Day habilitation" is a commonly used term nationally for programs that promote independence and community integration, often used interchangeably with adult day health for older adults or people with intellectual or developmental disabilities. As a Community Support, this service has a similar intent, but the populations of focus are experiencing or have recently experienced homelessness. Other people whose housing stability could be improved through participation in a Day Habilitation program are also eligible as defined in the January 2022 DHCS guidance. While this latter cohort may include older adults and people with disabilities, since the Community Support is not primarily focused on this population, it was ultimately excluded from this report.

Through Community Supports, CalAIM builds upon existing and prior Medi-Cal waivers and programs, such as the Whole Person Care pilots and the Health Homes Program (see descriptions of relevant waivers and programs in the "Key Terms" section on page 3). MCP and Community Support provider experiences with Medi-Cal waiver and pilot programs informed decisions and capacity to offer Community Supports when the program launched on January 1, 2022. Looking ahead, experience with Community Supports over the coming years will enhance capacity to expand Medi-Cal managed long-term services and supports (MLTSS) by 2027 as part of CalAIM.

This report discusses key considerations for and barriers to MCP uptake of Community Supports for independent living as MCP executives and state policymakers look to expand use of these services. To inform this report, ATI Advisory (ATI) conducted eight interviews with MCPs in California, as well as national plans with experience implementing the services of interest for older adults and people with disabilities. ATI also reviewed existing literature, state reports, MCP publications, and federal and state regulations to better understand the existing evidence base on the effectiveness of these services as well as opportunities and barriers to promote uptake.

Remaining sections provide an overview of the six Community Supports that help promote independent living, examples of MCPs and providers successfully implementing these services, and recommendations for DHCS and MCPs as they advance Community Supports and broader CalAIM reforms.

Key MCP Considerations for Offering Community Supports

Effective January 2022, nearly all (21 of 26) MCPs offered at least one of these six Community Supports, with two MCPs offering all six.[7] As seen in Table 1, MCP uptake for initial implementation generally varied across Community Supports with the exception of Medically Supportive Food / Meals / Medically Tailored Meals ("Meals"), which the majority of MCPs elected to offer. Meals are also offered in most counties (46 of 58), with Environmental Accessibility Adaptations ("Home Modifications") closely following (34 of 58). Several MCPs will launch new Community Support offerings on July 1, 2022. DHCS has shared future **Community Supports elections** (PDF) through 2024.[8]

Effective January 2022, nearly all (21 of 26) Medi-Cal managed care plans offered at least one of these six Community Supports, with two MCPs offering all six.

MCP considerations around and decisions to offer specific Community Supports varied but included similar themes. Some early considerations reflected general uncertainty that comes with operationalizing new services; however, others will likely persist as MCPs determine future Community Supports elections. Table 2 on page 8 summarizes the early considerations most frequently raised by interviewed MCPs.

Table 1. MCP Community Supports Elections for Implementation Starting January 1, 2022

	RESPITE SERVICES	NURSING FACILITY TRANSITION / DIVERSION TO ALFs	COMMUNITY TRANSITION SERVICES / NURSING FACILITY TRANSITION TO A HOME	PERSONAL CARE AND HOMEMAKER SERVICES	HOME MODIFICATIONS	MEALS
MCPs	5	6	6	6	10	21
Counties	4	6	6	8	34	46

Note: *ALF* is assisted living facility; *MCP* is managed care plan.

Source: ***CalAIM Community Supports – Managed Care Plan Elections*** (PDF), DHCS, last updated January 25, 2022. Counts are out of 26 MCPs and 58 California counties. Tabulations include MCPs offering a Community Support in at least one county. Some Community Supports may not be available to all members or in all areas of the county.

Table 2. MCP Key Considerations for Community Support Elections

	DETAILS AND EXAMPLES
Cost-effectiveness of the Community Support	Geography influences the cost of delivering Community Supports, and the lack of clear guidance on reasonable variation to determine cost-effectiveness based on cost of living created ambiguity for MCPs seeking to offer services. Conducting cost-effectiveness estimates for services in Los Angeles, for instance, was and remains challenging given the high cost of living there compared to the state overall.
Availability of experienced Community Supports providers	Limited access to DCWs providing personal care services (PCS), especially in rural areas of the state, limited uptake of PCS Community Supports despite MCP interest in offering the service. The stress of COVID-19 on DCWs further burdened a limited workforce.
Responsibility for other LTSS or care settings	MCP responsibility for the services that a Community Support is "in lieu of" played an important role in determining offerings. Accordingly, greater uptake of Community Supports is expected following the January 1, 2023, statewide institutional long-term care carve-in, as shown in DHCS' recently released **future Community Supports matrix** (PDF).[9]
Duplicative or overlapping services	The availability of Medi-Cal services similar to Community Supports deterred some MCPs from prioritizing certain options. MCPs must also discern a member's eligibility for alternative services, such as the CCT program, before offering the similar Community Support, such as services focused on nursing facility transitions.
Experience offering services under prior programs or models or in other markets	MCP decisions to offer certain Community Supports were supported by prior experiences operationalizing similar services through other programs (e.g., Cal MediConnect, Whole Person Care, Health Homes). In some instances, MCP experiences in other markets stifled uptake. For example, one MCP operating in multiple states elected not to immediately offer Respite Services in California after experiencing low member uptake when it was offered in another state.
MCP staff and provider staff operational capacity	Implementing new services requires dedicated staff capacity; a staggered implementation of new Community Supports can allow MCPs to dedicate appropriate staff to oversee launch. One MCP reported that Community Supports providers, many of whom are small community-based organizations, often did not have existing infrastructure to support contracting with MCPs, such as the ability to file claims for reimbursement or to exchange required data.
Uptake of Community Supports by delegated MCPs	In regions with a delegated MCP model — in which one MCP subcontracts to perform functions for another MCP — both the primary and subcontracted MCPs must implement the same Community Support offerings. This requirement creates a barrier when there are differences in the primary MCP's and subcontracted MCP's service areas and available provider partners.
Ability to make additions to Community Supports every six months	The flexibility that DHCS provides to MCPs to add new Community Supports every six months has allowed plans to stagger implementation and focus limited internal capacity on those services perceived as easier to implement while remaining open to adding new services in the future.
Timing of guidance and incentive funds	Guidance informing MCP and provider implementation of Community Supports was shared on a rolling basis up until the month before launch, which created some uncertainty and hesitation around early implementation. Similarly, the Incentive Payment Program, designed to encourage MCP uptake of Community Supports, did not go into effect before the implementation of Community Supports, so it did not impact early adoption.

Spotlight on Six Community Supports for Independent Living

MCPs are offering a range of the six Community Supports that help promote independent living for older adults and people with disabilities. Many MCPs elected to phase in certain services, launching a select number of services in January 2022 and rolling out additional services in July 2022 or further in the future. MCP uptake varied across services, with greatest uptake for Meals (nearly all MCPs offered it across the state in January 2022) and most limited uptake for Respite Services (five MCPs offered Respite in January 2022). (See Table 1 on page 7 for trends across all MCPs.)

The following profiles of each of the six Community Supports include an overview of the services, experiences and considerations learned from MCP interviews and research, highlights of evidence regarding each service, and a case study or member story. Overviews of each service summarize the detailed guidance provided in the most recent DHCS ***Medi-Cal Community Supports, or In Lieu of Services (ILOS) Policy Guide*** (PDF).[10] Appendix A of this report further synthesizes evidence across the six Community Supports. Detailed considerations and limitations are also **available online for download** in a full-evidence compendium tool serving as a companion to this report.

SPOTLIGHT ON COMMUNITY SUPPORTS

Respite Services

OVERVIEW

The Respite Services Community Support provides caregivers (such as those caring for a loved one with dementia or complex care needs) a temporary rest from caregiving responsibilities. Caregivers can use these services to take care of errands, exercise, or relax with the peace of mind that their care recipient's basic needs (e.g., help taking medications, preparing meals, or getting dressed) and overall safety are supported. Evidence suggests that Respite services, by reducing caregiver burden and burnout, may help avoid or delay institutional placement for certain people needing assistance with activities of daily living (ADLs) such as eating, getting dressed, walking, or bathing.

For caregivers to receive the Respite Services Community Support, care recipients must receive services in the home or in an approved out-of-home location (e.g., CBAS centers, RCFEs, ARFs). Regardless of setting, MCPs must choose providers with experience and expertise in Respite services.

To be eligible, caregivers must support an MCP member with ADL limitations who is dependent on the qualified caregiver for most of their support. Caregivers supporting people with other complex care needs may also be eligible.

> This form of Respite is distinct from the Recuperative Care or Medical Respite Community Support that provides short-term residential care for people who are being discharged from a hospital but still need to recover and do not have stable housing.

EXPERIENCES AND CONSIDERATIONS

Some MCPs reported anticipating challenges working with facility-based providers to deliver Respite, which may impact broader uptake and use of this Community Support. One MCP noted that their current inability to assess facility-based providers' capacity to deliver Respite services by the day or hour was an operational challenge that impacted uptake. Considerations for providing Respite also varied based on cohorts of people being served. For example, one national MCP representative found Respite to be especially helpful for caregivers supporting people with cognitive impairment, dementia, or intellectual or developmental disabilities. People with these conditions can be particularly sensitive to changes in their normal schedules and routines, so it is critical for MCPs to engage appropriately trained Respite providers.

> According to one national MCP, Respite is the most underused of the six Community Supports profiled here and could add a great deal of value to the health care system if it had wider uptake.

DHCS Opportunity

DHCS requires that MCPs offer Respite in both home and facility settings. One MCP hesitated offering Respite as a Community Support because in their experience, operationalizing this benefit with facility providers can be challenging. DHCS could consider decoupling home and facility-based Respite.

EVIDENCE SPOTLIGHT

Respite can reduce caregiver burden over time — affording caregivers more personal time to engage in social activities and household management — which may translate to improvements in their physical and mental health. Benefits of Respite, however, vary based on the number of hours provided, whether they are delivered in-home or in a facility, the intensity of the care recipients' functional and health needs, and whether other supports are offered. Respite is most impactful when the preferences of both the caregiver and care recipient are honored.

Key findings from studies of Respite include:

- Caregivers who received four or more Respite hours per week reported a significant decline in caregiver burden over time.[11]
- Respite most improved caregiver burden among those whose care recipients were in poor physical health, as opposed to care recipients with less intensive physical health needs.[12]
- Respite among caregivers of people with dementia resulted in improved sleep and emotional well-being among caregivers. The significance and magnitude of these improvements were greater when Respite was combined with other caregiver supports such as education and counseling.[13]
- The statistics in the right column describe findings from the Senior Companion Program caregiver study. Caregivers were surveyed before the start of Respite services and one year later. Caregivers were grouped into critical, essential, and moderate categories based on personal and family needs. Those in the critical-needs group had the highest needs. Perceived improvements were greatest among the critical-needs group.

Feedback on Senior Companion Respite Services Among Caregivers in the Critical-Needs Group

Were **helped "a lot"** with both personal time and household management

Were helped "a lot" or a "great deal" to be **more involved in social activities** and enjoy time with their friends or relatives

Rated their health as fair or poor before Respite support, **now rate their health as good**[14]

* Approximation.

See Appendix A for a brief evidence summary for all six Community Supports featured in this report.

CASE STUDY EXAMPLES

For Eric and his wife, Jodi — primary caregivers for Darlene, Eric's 91-year-old mother — short-term Respite allowed them to attend their daughter's wedding while knowing that Darlene was cared for at home. In another case, Michael, a faithful caregiver for his wife, Patti, received nine hours of Respite — three hours a day, three days a week — to prioritize his needs and to rest and recharge.[15] In both cases, Respite provided these caregivers space for personal and social activities, enabling them to support their loved ones in the home for longer.[16]

SPOTLIGHT ON COMMUNITY SUPPORTS

Nursing Facility Transition/Diversion to Assisted Living Facilities

OVERVIEW

Services through the Nursing Facility Transition/Diversion to Assisted Living Facilities Community Support help people remain in the community by both facilitating transitions from nursing facilities and preventing nursing facility admissions for those with imminent need. Depending on a person's needs, this service will either facilitate a transition from a nursing facility into a home-like setting (i.e., RCFE or ARF) or prevent a skilled nursing facility (SNF) admission if the person is expected to "imminently" require a nursing facility level of care (NFLOC). RCFEs and ARFs must offer help with ADLs and instrumental activities of daily living (IADLs) including meals, transportation, medication administration, and therapeutic social and recreational programming. Room and board are not included in coverage.

Eligibility requirements include the following:

- For transition services, people must have resided in a nursing facility for more than 60 days and be willing and able to reside in an RCFE or ARF.
- For diversion services, people must be willing and able to reside in an RCFE or ARF with supports, and must be receiving medically necessary NFLOC services and prefer to receive medically necessary care in the RCFE or ARF (Home Health agencies are allowable providers).

EXPERIENCES AND CONSIDERATIONS

RCFEs/ARFs can provide people with more support and engagement than may be available in the home while offering greater independence than living in a nursing facility. People with significant cognitive or ADL needs, for example, may especially benefit from RCFEs/ARFs, which can provide supervision and personal care to residents with those needs. RCFEs can also be excellent options for people to "step down" into after residing in an institution for many years, to ease an eventual transition to a home setting.

Medi-Cal recipients interested in moving to an RCFE/ARF must pay their ongoing room-and-board expenses, which can be prohibitive for many people. Access to an RCFE/ARF is often out of reach for Medi-Cal recipients unless they can leverage their Supplemental Security Income (SSI) payment to cover room-and-board expenses. MCPs reported several other considerations that led to hesitancy in offering this Community Support initially, including:

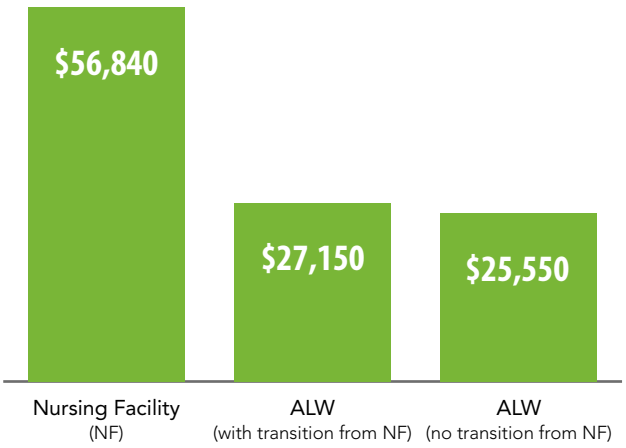
- Difficulty developing a large enough network of RCFEs/ARFs to meet countywide need equitably since facilities that accept Medi-Cal SSI payments are limited in many regions of the state. RCFEs/ARFs must also be willing to contract with MCPs to provide the Community Support.
- Concerns about Medi-Cal enrollment changing monthly, which would put the person at risk of losing coverage for the Community Support and subsequently leave them in an unsafe or unsustainable community living environment.
- High daily costs at RCFEs/ARFs in some areas that make it hard to find placements.
- Large distances people must travel in many rural areas to access an RCFE/ARF, which would likely create hesitancy for some to access this option.

Overall, MCPs expect people to be interested in this service, but it is a more complex offering, so additional time and guidance will allow for wider expansion of this Community Support.

EVIDENCE SPOTLIGHT

Use of assisted living services in lieu of nursing facility services cuts costs in half for DHCS under the existing Assisted Living Waiver (ALW) program.[17] Currently, the ALW program costs DHCS about $25,550 per user per year for diversion cases and $27,150 for transition cases (transition services add costs of $1,600 per case, on average). If this Community Support were to lead to Medi-Cal RCFE/ARF service use comparable to the long-standing ALW program, it would reduce costs by $29,690 to $31,290 (52% to 55%) per user per year compared to nursing facility stays, which on average cost DHCS $56,840.[18]

DHCS Cost per Covered Facility User, 2022



Notes: Costs are based on state projections. *ALW* is assisted living waiver; and *DHCS* is California's Department of Health Care Services.

Source: Author analysis of DHCS' January 2022 Assisted Living Waiver Amendment cost-neutrality projections, using estimated utilization and costs for March 2022 through February 2023. ***Application for a §1915(c) Home and Community-Based Services Waiver, CA.0431.R03.09*** (ZIP), Centers for Medicare & Medicaid Services, January 10, 2022.

In addition, many ALF residents have positive views of their residence. One industry-sponsored survey found that 73% of ALF residents say they "feel at home in their community" most of or all the time (as opposed to sometimes, rarely, or never).[19]

See Appendix A for a brief evidence summary for all six Community Supports featured in this report.

CASE STUDY EXAMPLE

Kojo experienced a series of mental and physical health illnesses that led to and were worsened by a decade of homelessness. He was transferred to a nursing facility after a hospitalization for a stroke that limited his communication. By this time, Kojo had become a member of Health Plan of San Mateo and was enrolled in the MCP's Community Care Settings Program (CCSP). The CCSP social worker ensured Kojo was stable and helped connect him to key resources such as an electric wheelchair to promote his independence. Following his stroke, Kojo required assistance with ADLs, and after several months in the nursing facility, he and his care team determined he could transition to a lower level of care. Through a recommendation by his social worker, Kojo transitioned to an RCFE with a licensed nurse on-site who provides him immediate help around the clock. This environment provided assistance with Kojo's everyday tasks while allowing greater autonomy, privacy, and access to recreational opportunities.

SPOTLIGHT ON COMMUNITY SUPPORTS

Community Transition Services / Nursing Facility Transition to Home

OVERVIEW

Community Transition Services / Nursing Facility Transition to Home provide people with nonrecurring support as they return home from a licensed facility to avoid further institutionalization. Services available through this Community Support include:

- Providing connections to housing (including referral to other Community Supports that MCPs can elect to provide under CalAIM, such as Housing Transition Navigation Services or Housing Tenancy and Sustaining Services or both)
- Linking to or funding for nonmedical transportation
- Identifying the need for connection to the Home Modifications Community Support
- Funding expenses that aren't room and board, such as first-month utilities, cleaning, or pest control and provision of in-home hospital beds and lifts (including referral for the Housing Deposits Community Support)

To be eligible for this Community Support, people must be receiving medically necessary NFLOC services and choose to move back home to receive these services. They must have also lived more than 60 days in a nursing facility or medical respite setting and be both interested and able to move safely to the community with the appropriate supports and services.

EXPERIENCES AND CONSIDERATIONS

MCPs wanting to effectively provide this Community Support may look to lessons learned from nearly 15 years of the Money Follows the Person (MFP) program. States with MFP programs found success bolstering case management services in the community (e.g., assistance locating places to live, connecting utilities, or navigating relationships with landlords), improving access to affordable and accessible housing, and investing in direct care worker recruitment and retention.[20] These lessons suggest that MCPs may find similar success delivering Community Transition Services / Nursing Facility Transition to Home by offering companion Community Supports, such as Personal Care Services, or Home Modifications.

California Community Transitions (California's MFP program) is to be used before this Community Support option. As a result, some MCPs have delayed implementing this Community Support because of a perceived lack of need. One MCP believes that they have more members in their homes needing supports to prevent avoidable institutionalization than they do members in institutions who could be safely transitioned home with the right supports.

Relationship to California Community Transitions Program

Community Transition Services / Nursing Facility Transition to Home Community Supports are a unique opportunity for people who do not qualify for the California Community Transitions program (California's Money Follows the Person [MFP] demonstration) to receive a similar set of proven supports to facilitate independent living. Those eligible for California Community Transitions would use that program over this Community Support service.

EVIDENCE SPOTLIGHT

The value of the Community Transition Services / Nursing Facility Transition to Home Community Support is well-established through the long-standing MFP program, which began in 2007. A 2017 federal evaluation showed that health care spending declined after MFP enrollment and saw improvements in quality of life, lower rates of unmet functional needs, and low rates of return to nursing facilities.[21]

Money Follows the Person Program: Key Findings

Per person savings across Medicare and Medicaid from its 2007 inception through 2013.[22]

For adults age 65 or older, **spending declined** by 20% the first year after the transition and declined another 27% the second year.[23]

Overall, these savings were driven by lower LTSS expenditures, due to shifts toward lower-cost (home and community-based) LTSS.[24]

Remained in the community six months post-transition out of nursing facilities — more likely than their non-MFP counterparts (85%).[25]

Reported unmet functional needs post-transition — less likely than their non-MFP counterparts (18%).[26]

Satisfied with their living arrangements after institutional transition (vs. 62% satisfaction pretransition).[27]

See Appendix A for a brief evidence summary for all six Community Supports featured in this report.

CASE STUDY EXAMPLES

Health Plan of San Mateo (HPSM) implemented the Community Care Settings Program in 2014 to support dually eligible enrollees transitioning out of institutions into the community, as well as to help enrollees at risk of institutional placement remain in the community. Program staff work with participants to ensure they are connected to available community resources to support the transition and independent living, including stable housing and health care services. The program provides coordinated case management, purchases services not otherwise available through alternative funding streams, and identifies, secures, and provides maintenance services in community housing.

HPSM has found that the process to transition an enrollee to the community typically lasts three to six months, with regular meetings between the care manager, integrated care team, and enrollee to design a care plan and to identify appropriate housing. As of September 2019, the latest data available before the impacts of the COVID-19 pandemic, 289 enrollees had participated in the program, with 78 enrollees transitioning from a SNF to the community, 123 from custodial long-term care to the community, and 88 already in the community receiving supports to age safely at home. For the cohort remaining in the community for over six months, a 35% decrease in average per-member per-month costs has been demonstrated.[28]

SPOTLIGHT ON COMMUNITY SUPPORTS

Personal Care and Homemaker Services

OVERVIEW

The Personal Care and Homemaker Services Community Supports assist people with critical day-to-day activities they are otherwise unable to perform on their own. Such activities may include house cleaning; meal preparation; laundry; grocery shopping; personal care services such as bowel and bladder care, bathing, grooming, and paramedical services; accompaniment to medical appointments; and protective supervision for the mentally impaired. These Community Supports supplement existing services provided through IHSS and help with ADLs, IADLs, or both in the following scenarios:

- The person requires additional hours beyond approved IHSS service hours.
- The person is in the IHSS waiting period.
- The person is not eligible for IHSS. If the person is ineligible for IHSS, the benefit is intended to help avoid a SNF short stay and cannot be provided for more than 60 days.

To be eligible for Personal Care and Homemaker Services, people must be at risk for hospitalization or institutionalization in a nursing facility, have ADL needs and no other supports, or be approved for IHSS.

> As a result of the Personal Care and Homemaker Services Community Supports, DHCS expects to avoid inpatient and outpatient hospital, avoidable emergency department, and SNF services.

EXPERIENCES AND CONSIDERATIONS

Personal Care and Homemaker Services pair well with Respite to support independent living. MCPs' experiences with Personal Care and Homemaker Services through prior models eased implementation of this Community Support. There is also some notable provider overlap between Personal Care and Homemaker Services and Respite. As of January 2022, three MCPs elected to offer both these Community Supports.

Some MCPs perceived this Community Support as being too similar and overlapping with existing IHSS, which contributed to their delaying uptake. Per one MCP, Personal Care Services through IHSS are already "quite robust," suggesting they did not feel urgency to immediately launch the Personal Care and Homemaker Community Support.

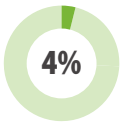
Several MCPs expressed concerns that Personal Care and Homemaker Services can be particularly hard to launch in rural areas with large distances for direct care workers to travel to support different people. This issue is compounded by the nationwide shortage in direct care workers.

EVIDENCE SPOTLIGHT

Research indicates that Personal Care Services help keep older adults and people with disabilities in their communities longer and support transitions out of nursing facilities.

Studies of Personal Care Services: Key Findings

Every additional five hours of Personal Care Services was associated with decreased risk of nursing facility placement by 5%. Every additional five hours of homemaking decreased risk of nursing facility placement by 13%. The study did not report a ceiling to this effect.[29]



End up in a nursing facility within two years if they were able to receive needed Personal Care and Homemaker Services — five times less likely than those who needed services but were on wait lists (22%).[30]

Received some help and were still in their own home two years after going on a wait list for Personal Care Services, compared to only 56% of those who received no help.[31]

See Appendix A for a brief evidence summary for all six Community Supports featured in this report.

Homemaker Services Can Be an Effective Tool to Engage and Support Older Adults Who Have Experienced Abuse

A study of North Carolina's Project CARE, an intervention supporting underserved caregivers of those with Alzheimer's disease or other dementias, found that specific services provided by trained homemakers, such as personal hygiene, baths, and light housekeeping, were among the most successful and accepted approaches for engaging with abused older adults. The establishment of trusting relationships with older adults can help diminish social isolation and increase the empowerment of the abused person.[32]

CASE STUDY EXAMPLE

Larry lost one of his legs due to chronic health problems. He would fall out of bed every day and, because he could not get up from the floor by himself, call 911. He also stopped going outside and, as a result, stopped eating regularly. With the help of an agency, he was connected to a caregiver, Daphyne, who cooked for him and helped him learn to take care of himself. With her support, he has transformed. He has stopped falling out of bed, started eating again, and is going outside. He has not called 911 in months. Note: While this example comes from In-Home Support Services (IHSS) in San Francisco, a county that provides a model of IHSS delivered through an agency, it illustrates the value of initial caregiving support being delivered by an agency.[33]

SPOTLIGHT ON COMMUNITY SUPPORTS

Environmental Accessibility Adaptations (Home Modifications)

OVERVIEW

The Home Modifications Community Support provides people with home adaptations to improve safety and well-being, as well as to promote greater independence. Examples of adaptations include stair lifts, widening doorways to accommodate a wheelchair, ramps and grab bars, and modifications to bathrooms to make them wheelchair accessible.

To be eligible, people must be at risk of nursing facility institutionalization and have a health professional such as their primary care physician order the requested equipment or services, with evaluations of the medical need and documentation of the value to the person. The MCP may choose to require a physical or occupational therapy evaluation of the medical necessity. Regardless of the provider making the medical necessity determination, a home visit must be documented. Through implementation of Home Modifications, DHCS anticipates a reduction in nursing facility, inpatient and outpatient hospital, emergency department, and emergency medical services.

DHCS Opportunity

One MCP noted that the Home Modification Community Support includes the ability to offer Personal Emergency Response Systems (PERS), which the MCP had significant positive experience with offering previously. However, given the complexity of identifying and providing the broader array of Home Modifications, the MCP has chosen not to offer the benefit. DHCS could consider uncoupling services within the Home Modification Community Support, as PERS is a well-proven benefit that MCPs may more broadly operationalize for additional in-home safety for eligible people.

EXPERIENCES AND CONSIDERATIONS

Some MCPs have experience with services similar to the Home Modification Community Support and have found it beneficial for the right people under the right circumstances. However, members who have unstable housing and those who rent their home are unlikely to be able to access and benefit from the Home Modification Community Support.

MCPs can face challenges securing trusted providers and firm prices for Home Modification services, which has contributed to limited initial uptake. Identifying quality providers, such as carpenters or plumbers, to deliver the myriad supports under the Home Modification category is a significant barrier. Another potential limitation is the total lifetime maximum amount of $7,500 that has been placed on the Home Modification Community Support. Some MCPs with experience offering these services in Cal MediConnect found that home modifications often cost more than anticipated. As a result, modifications may be limited to ensure the ultimate cost does not exceed the allowable amount.

EVIDENCE SPOTLIGHT

Research on home modifications, including removing hazards and adding safety features to home environments, has demonstrated improvements in injury prevention, symptom management, mobility, quality of life, and cost savings. Meaningful improvements of ADL and IADL function were seen across all included studies monitoring these outcomes, with particularly strong evidence supporting CAPABLE, an integrated home visit and home modification program (see Case Study Example).

CAPABLE: Key Findings

Improved confidence in performing ADLs without falling ("falls efficacy")[34]

Potential savings per participant, far offsetting the program's cost of $2,882 per person[35]

Mean scores of **depression symptoms reduced from mild to remission**[36]

Other Home Modification Studies: Key Findings

Reduced difficulty and increased sense of safety when performing self-care tasks[37]

Particular **improvements among people who had fallen recently**, with improved mobility, ADL performance, and self-reported sense of safety and freedom[38]

See Appendix A for a brief evidence summary for all six Community Supports featured in this report.

CASE STUDY EXAMPLE

Mrs. R. is a 76-year-old retired musician who had been very active until recently. She now finds participating in daily living activities and socializing more difficult. After speaking with her doctor about the CAPABLE program, Mrs. R. was connected with her new CAPABLE team, which included an occupational therapist, a nurse, and a handy worker. After engaging Mrs. R. on her goals, the handy worker lowered cabinets so Mrs. R. could better reach items using less energy and with a decreased fall risk. A mirror was also installed above her stove so Mrs. R. could better see shelf contents while seated. These modifications allowed Mrs. R. to prepare meals as she once enjoyed without shortness of breath.[39]

SPOTLIGHT ON COMMUNITY SUPPORTS

Medically Supportive Food / Meals / Medically Tailored Meals

OVERVIEW

The Meals Community Support provides food under multiple scenarios. Meals can be delivered to a person's home after a hospital or nursing facility stay. Medically tailored meals (MTM) can be delivered at home to meet the needs associated with specific chronic diseases.[40] Medically supportive nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies, can also be provided. People may also access education on nutrition, cooking, or healthy eating habits through the Meals Community Support.

To be eligible, people must have chronic conditions, be in the process of being discharged from a hospital or SNF or be at high risk of admission or readmission to a hospital or SNF. Alternatively, eligibility may also be based on extensive care coordination needs.

As a result of the Meals Community Support, DHCS expects to avoid inpatient and outpatient hospital use and emergency department services.

EXPERIENCES AND CONSIDERATIONS

With the overwhelming need to address food insecurity in many communities today, MCPs reported the Meals Community Support as a benefit they anticipated a high proportion of eligible people using, making it a clear choice to offer from the outset. As of January 1, 2022, 21 out of 26 MCPs were offering the Meals Community Support in at least one county.[41] For many MCPs, support for healthy diet and nutrition was logically correlated with improved health outcomes.

Engaging provider partners to deliver the Meals Community Support was facilitated by existing MCP-provider relationships established through programs such as Whole Person Care and Cal MediConnect. Established, trusted provider relationships made the decision to offer this service easier for many MCPs.

EVIDENCE SPOTLIGHT

Benefits of nutritional support are well documented in the literature, especially when provided to people who experience food insecurity or who are making transitions from acute and chronic care settings to home settings.[42] Evidence shows healthy food and nutrition remains essential to preventing, managing, and treating chronic disease.[43] Some evidence may be limited by self-reported dietary intake and nutritional status and small sample sizes.

Studies of Home-Delivered Meal Services and Programs: Key Findings

Participating in a MTM intervention for at least six months was associated with:

Fewer emergency department visits

Lower inpatient hospital admissions

Yearly net savings per participant[44]

A separate study also found MTM associated with:

Up to 1.5 fewer SNF admissions per person per year[45]

Nontailored food interventions, despite not resulting in fewer inpatient admissions, were also associated with:

Fewer emergency department visits

Yearly net savings per participant[46]

See Appendix A for a brief evidence summary for all six Community Supports featured in this report.

CASE STUDY EXAMPLE

Maureen, age 70, lives with multiple chronic conditions, including diabetes, cardiac illness, and asthma. Maintaining an eating schedule that allows her to control her diabetes is a challenge. To help manage her chronic conditions, she received MTM through her MCP, Commonwealth Care Alliance. Maureen credits her 50-pound weight loss and ability to maintain an eating schedule that keeps her diabetes under control to the MTM program. She uses the five days per week of medically tailored lunches, dinners, and snacks provided to spark ideas for other healthy meals to make on her own.[47]

Moving Forward to Advance Community Supports

Flexibility to tailor services to best address the unique needs of older adults and people with disabilities being served by Medi-Cal has great potential to improve health, improve quality of life, and keep people living safely in the community. As CalAIM transforms the health care and social service delivery landscape across California in coming years, partnerships developed by MCPs and Community Supports providers will continue to strengthen state capacity to address not only medical needs, but also the nonmedical LTSS and social supports necessary for independent living.

MCPs and Community Supports providers faced initial barriers to launching Community Supports in January 2022 that are likely to dissipate over time. These preliminary hurdles included both MCP and provider capacity to implement the services, particularly in the context of COVID-19 workforce concerns, and the timing of guidance and incentive funds for Community Supports. Moving forward, developing Community Supports provider networks will be most pressing for MCPs to consider as they decide whether to offer new Community Supports. Additionally, enrollee education and engagement are likely to require additional MCP and provider resources to ensure people understand the availability of and their eligibility for Community Supports.

ATI outlines a series of recommendations for consideration by DHCS and MCPs to support the successful adoption and ongoing provision of Community Supports that help promote independent living.

RECOMMENDATIONS

California Department of Health Care Services

To further promote uptake of Community Supports, DHCS could consider several opportunities to support implementation:

- Continue to assist and share detailed guidance and information for MCPs and providers interested in offering Community Supports:
  - Share data on the impact of Community Supports, as well as lessons and success stories of early implementers. This will be particularly important for the Community Supports with less initial uptake by MCPs, such as Respite Services. Data and lessons should highlight opportunities to improve the equitable reach of Community Supports across the state.
  - Provide detailed guidance on reasonable variation to determine cost-effectiveness based on cost of living.
  - Develop comparison tools that describe how Community Supports can complement and work alongside existing services and programs. This would help fully integrate Community Supports into the delivery system and prevent the creation of new silos of care.
  - Develop, share, and continually update a compendium of providers that deliver the various Community Supports across MCPs in various counties.
  - Engage and educate Medi-Cal providers to integrate Community Supports as core elements of care plans.
  - Develop templates or other supports for MCPs and providers to better communicate with people about the opportunity of Community Supports, including eligibility and other important nuances.

- Explore opportunities to offer technical assistance to Community Supports providers to strengthen their infrastructure around coding for claims and encounters. While some MCPs have done this, statewide support would encourage broader uptake.
- Consider uncoupling some services. For instance, PERS are included within the Home Modification Community Support. While home modifications may not be feasible or right for every person, PERS is a well-proven benefit that MCPs could offer more broadly to provide additional in-home safety for eligible people.

PATH Funding

With support from the Centers for Medicare & Medicaid Services (CMS), DHCS will issue $1.44 billion in funding through the Providing Access and Transforming Health (PATH) program to build provider capacity, from 2022 through 2026.

Of this PATH funding, $1.29 billion will go toward the following:

- Payments in 2022 and 2023 to former Whole Person Care providers that will deliver similar services under Community Supports, to cover any loss in reimbursement for continued service delivery, until the Community Support is implemented by the MCP.
- Technical assistance to Community Supports providers and to county and tribal agencies.
- Planning and implementing cross-sector efforts for collaboration needed for Enhanced Care Management (ECM) and Community Supports among MCPs, Community Supports providers, and others.
- Developing infrastructure among ECM and Community Supports providers, including information technology to exchange data on behavioral health and social needs.

RECOMMENDATIONS

Medi-Cal Managed Care Plans

To nurture the successful implementation of Community Supports, MCPs should continue engaging and collaborating with DHCS, other MCPs, and providers in the following ways:

- Share with DHCS and other MCPs best practices and successes with early implementation, as well as challenges and barriers to uptake and use of Community Supports.
- Identify potential gaps in services and collaborate with other MCPs to collectively solve shared issues.
- Engage with Community Supports providers to help them access PATH dollars, especially those meeting the needs of underserved people and communities. Equitable access to PATH dollars is crucial to building state capacity to address disparities across the state.
- Work with health care providers to integrate Community Supports into the standard care planning process.

Conclusion

As DHCS implements CalAIM over the coming years, it is critical to support MCPs and providers to fully leverage and integrate Community Supports into the health care and social service delivery systems. PATH funding will help build provider capacity but ensuring equitable distribution of these dollars will be critical and will require collaboration across DHCS, MCPs, and providers. Community Supports are important tools for serving people in the least restrictive setting possible and can make significant impacts on independent living if widely implemented.

Appendix A. Community Supports Evidence Summary

Provided below is a synthesis of relevant and recent evidence on the six Community Supports supporting independent living with a particular focus on evidence examining impact and implementation considerations for older adults and people with disabilities. Detailed considerations and limitations are **available online for download** in a full-evidence compendium tool.

	KEY OUTCOMES	CONSIDERATIONS
Respite Services	**Cost.** Paired with other supports and services such as home modifications, adult day services (ADS), and caregiver training/education, Respite services led to 20% lower costs than typical personal care services (PCS).[48] **Institutionalization.** Resulted in reduced and delayed nursing facility (NF) entry, especially for those receiving care from a spouse.[49] Resulted in reductions in caregivers' desires to use institutional long-term services and supports (LTSS).[50] **Utilization.** Reduced hospital readmissions when caregivers access Respite services through care recipients' posthospitalization ADS attendance, instead of postacute alternatives like skilled nursing facility (SNF) or home health without care recipients' ADS use.[51] **Health/function.** Reduced behavior disturbances[52] and sleep patterns[53] among people with dementia. **Caregivers.** Caregivers may have improved sleep,[54] mental health,[55] and reduced burden.[56] Improved self-reported caregiver health.[57] **Quality of Life (QOL)/satisfaction.** Structured national caregiver support programs had high rates of satisfaction among caregivers.[58]	Most Respite evidence comes from daytime Respite in adult day settings rather than in-home services.[59] Additionally, favorable evidence from in-home Respite programs usually entails a mix of Respite hours and caregiver training or peer counseling groups. The evidence provided in this table may reflect the effects of a mix of such services, always including Respite (in-home or facility). These suggest that, traditionally, in-home Respite occurs as part of a larger set of caregiver supports. In-home Respite is evaluated more commonly for people with dementia, and there are favorable outcomes for both caregivers and those receiving care.
NF Transition/ Diversion to ALFs, such as RCFEs and ARFs	**Cost.** Costs of California's Assisted Living Waiver are 52% less per user per year than Medi-Cal NF stays.[60] **Institutionalization.** ALF availability is associated with decreases in NF use.[61] **Utilization.** No findings. **Health/function.** No findings. **Caregivers.** No findings. **QOL/satisfaction.** No findings.	Costs of room and board at ALFs are not paid by Medi-Cal,[62] so this option for NF transitions would be possible only for Medi-Cal enrollees able to cover those costs by other means. Currently, Black Americans with long-term care needs are less likely than their White counterparts to reside in ALFs compared to NFs,[63] indicating the need to consider equity concerns with this Community Support. Once a person resides in an ALF, better staffing of licensed practical nurses and of direct care workers reduces hospitalization risk.[64] Hospitalization is especially reduced by personal care worker availability for residents with dementia.[65]

	KEY OUTCOMES	CONSIDERATIONS
Community Transition Services / NF Transition Home	**Cost.** NF-to-home transition pilot led by an MCP resulted in a 35% decrease in average per-member per-month cost.[66] **Institutionalization.** Of NF-to-home pilot program participants, 98% remained in the community for at least six months post-transition,[67] and 94% of program participants avoided NF reentry (as seen in national data from the Money Follows the Person [MFP] demonstration).[68] **Utilization.** A program targeting dementia reduced hospital stays and ED visits.[69] **Health/function.** Reduced depressive symptoms under the MFP program.[70] **Caregivers.** In a hospital-to-home transition support program, 59% of participants said the program helped their caregivers.[71] **QOL/satisfaction.** In an NF-to-home pilot, 95% of participants were satisfied.[72] Programs are in high demand and access is a concern.[73]	NF transitions reduce both Medicaid and Medicare spending but generate a more concentrated savings in Medicaid LTSS. The provision of PCS in combination with ADS may be most supportive of successful transitions from NF to home.[74] For dementia, caregiver supports further facilitate care recipients' continued independent living.[75]
Personal Care and Homemaker Services	**Cost.** No findings. **Institutionalization.** Personal care receipt reduced the likelihood of NF entry by 46%[76] to 84%.[77] Small additions in the amount of homemaker services can make a considerable decrease in risk of NF entry, with each additional five hours of PCS lowering risk of NF placement by 5%.[78] **Utilization.** No findings. **Health/function.** Two-year mortality rates reduced by 26%.[79] **Caregivers.** Reduced caregiver burden and increased well-being.[80] **QOL/satisfaction.** Recipients reported high satisfaction with PCS.[81]	PCS can be complemented with ADS to best support people who transition from NF to home.[82] Improved payment rates for PCS seem to reduce the risk of NF entry for people receiving PCS.[83] People at highest risk of NF entry need a wider variety of PCS tasks, and providing for this wide array even if in small amounts can delay NF entry.[84]
Environmental Accessibility Adaptations (EAA) (Home Modifications)	**Cost.** Strong return on investment due to reduced medical costs and fall prevention.[85] **Institutionalization.** No findings. **Utilization.** No findings. **Health/function.** Improved activities of daily living (ADL) performance.[86] (Some evidence shows sustained ADL improvements two years post-EAA.[87]) Reduced falls,[88] with one study showing 39% lower fall risk for avoidable fall types,[89] and a 7% increased two-year survival rate.[90] **Caregivers.** When provided alongside supports for caregivers of people with dementia, reduced caregiver burden and stress.[91] **QOL/satisfaction.** Increased self-rated freedom and physical safety,[92] and self-rated ability in everyday life.[93]	Home visits by occupational therapists to select areas of need for EAA are positively evaluated.[94] Targeting adults age 65 or older who recently experienced a fall has demonstrated positive impacts on function and QOL.[95] Fall risk, which EAAs seem to strongly reduce,[96] is also driven by certain diagnoses; demographics; mobility, vision, and cognitive limitations; and polypharmacy.[97] These person-level factors may be measurable by MCPs based on claims data and diagnoses, and these data may be used for targeting EAA interventions to people who could most benefit from reduced home hazards.

	KEY OUTCOMES	CONSIDERATIONS
Medically Supportive Food / Meals / Medically Tailored Meals	**Cost.** From $2,640[98] to $14,700[99] in net savings per person per year for medically tailored meals (MTM). For nontailored food (NTF), an estimated $120 of net savings per person per year.[100] **Institutionalization.** Reduced SNF admissions 40% to 99%,[101] reduced entry into NF.[102] **Utilization.** MTM reduced inpatient admissions by 20% to 78%.[103] Both MTM and NTF reduced ED visits.[104] **Health/function.** Improved nutrition,[105] blood glucose levels,[106] food security,[107] weight,[108] and physical function.[109] **Caregivers.** No findings. **QOL/satisfaction.** Improved QOL.[110]	Disease-specific medical tailoring has demonstrated cost-effectiveness (e.g., for people with heart disease and people with diabetes)[111] and reductions in ED, inpatient, SNF, and NF utilization. MTM intervention offers prevention improvements in the long term (by improving weight and nutrition), medium term (by improving blood glucose), and short term (by providing necessary nutrition and potentially freeing resources that could be used for medications or other expenses that may have associations with improved health, such as rent or transportation).[112]

Source: Author analysis of cited sources.

Appendix B. Acknowledgments

ATI Advisory would like to thank and acknowledge the following interviewees whose experiences implementing Community Supports and ILOS to improve the lives of older adults and people with disabilities helped inform this report.

Centene
Sarah Triano, Senior Director, Policy & Innovation, Complex Care

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Health Plan of San Mateo
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Molina Healthcare of California
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Hannah Kim, Director, Long-Term Services and Supports

Partnership HealthPlan of California
Amy Turnipseed, Chief Strategy and Government Affairs Officer
Katherine Barresi, Director, Care Coordination & Partnerships

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