Opportunities for CalAIM to Support Community Living

The Intersection of the Institutional Long-Term Care Carve-In and Community Supports

May 19, 2022
CalAIM and Institutional Long-Term Care Carve In

Carrie Graham, PhD, MGS, Director of Long-Term Services and Supports, Center for Health Care Strategies

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Goals of CalAIM

- Identify and manage comprehensive needs through whole person care approaches and social drivers of health
- Improve quality outcomes, reduce health disparities and transform the delivery system through value-based initiatives, modernization and payment reform
- Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility
What is the Institutional LTC Carve-In?

• As of January 1, 2023 institutional care will be a mandatory benefit for all Medi-Cal managed care members
  
  → In the 31 counties where institutional LTC is already carved in, Enhanced Care Management and Community Supports will be a value added

  → In the 27 counties where the carve in will be new, all Medi-Cal members who are in institutions (most currently in FFS) will be enrolled in a managed care plan (MCP)
CalAIM and Institutional Long-Term Care: Lessons for Medi-Cal Managed Care

• Goal
  → Inform the implementation of the Institutional LTC Carve-In in California by describing the challenges, opportunities, and lessons from California and other states

• Approach
  → Key informant interviews
  → Literature review

• Authors
  → CHCS, Chapman Consulting, Decipher Health Strategies

The Intersection of LTC Carve-In, Enhanced Care Management, and Community Supports

- **Community Supports** for promoting independent living
  - → Respite services
  - → Transition services
  - → Personal care/homemaker
  - → Home modifications
  - → Nutrition/meals

- **Enhanced Care Management** for institutionalized and at-risk population
### Opportunities for LTC Carve-In

- **Improve access**
- **Improve quality of care**
- **Promote equity**
- **Improve ability to transition or divert from institutions to lower levels of care** *(alignment with Community Supports)*
LTC Carve-In Opportunities: Improve Access

✓ Using proactive care coordination to secure a placement for a member at risk for homelessness
  → The MCP met with hospital discharge planner, facility, and housing services provider before hospital discharge
  → Ensured that the facility would have a safe place to discharge the patient after post-acute care was complete

✓ Using financial flexibilities to secure a placement for a member who needs round the clock supervision
  → The MCP allowed the facility to hire a “bedside sitter” and invoice the MCP directly
LTC Carve-In Opportunities: Improve Quality of Care

✔ Payment strategies to incentivize quality
  → MCPs reported using value-based payment incentives to pay facilities higher rates when they meet certain quality standards
  → Regional uniformity is important

✔ Adding a layer of oversight
  → Some MCPs partnered with the Long-Term Care Ombudsman Office
    • Joint site visits
    • Technical assistance on chart review to identify poor quality or neglect
  → Using quality data to be selective about provider networks
    • State and federal survey data
    • Payroll Based Journal staffing data
LTC Carve-In Opportunities: Promote Equity

- Using data to monitor staffing and quality
- Better data reporting on race/ethnicity, as well as other social drivers of care
- MCP contracts can codify expectations for addressing disparities
- Increased oversight of facilities that have a high percentage of residents who are Black, Indigenous, and people of color

LTC Carve-In Opportunities: Improve Ability to Transition/Divert from Institutions

✔ Lessons Learned in California

⇒ Before admission to a nursing home, coordinate with hospital and nursing home discharge planners to establish a discharge plan
⇒ Proactively assess for members who are at risk for homelessness after a post acute stay
⇒ Partner with community-based organizations (LTC Ombudsman) to identify members who are good candidates for transitions

✔ Recommendations

⇒ Include in Health Risk Assessment members’ preferences for post-acute care before any hospitalizations occur
⇒ Use data! The Minimum Data Set 3.0 Section Q allows SNF residents express interest in learning about possibilities for living outside of the nursing facility
⇒ Establish MCP review boards with placement criteria to vet/authorize placement decisions prior to institutionalization
⇒ Financial incentives/rate setting
⇒ Identify, assess, and support informal caregivers
Incentives to Promote Lower Levels of Care: Rate Setting

Massachusetts Senior Care Options

→ Higher rates for people living in the community who meet a nursing home level of care

→ Upon institutionalization, the payment rates that the MCP receives for those members do not increase for 90 days

→ Higher institutional payment rate continues for 90 days after transition to the community
Incentives to Promote Lower Levels of Care: Incentives and performance metrics

- **Illinois** offers MCPs incentive payments when a member returns to the community from a nursing home due to care coordination efforts by the MCP.

- **Alabama** provides an incentive payments to reward MCPs for overall movement toward increased HCBS Usage.

- **Texas** included MCP performance metrics related to transitions that impacted payments: rates of admission to NFs.
Transitions and Diversions to Community-Based Settings: Housing Supports

**Tennessee** uses their managed LTSS contracts to require that MCPs have housing specialists to help members transition back to the community, or to help keep members in the community.

**Pennsylvania** requires MCPs to provide supports to help members at risk of homelessness. They are also required to participate in local housing collaboratives.
Florida and Rhode Island require MCPs to assess “specific problems, needs, strengths, and resources of the family caregiver, as well as the caregiver’s ability to contribute to the needs of the care recipient.”

A Minnesota Medicaid HCBS waiver provides reimbursement for a Family Caregiver Coaching and Counseling “intended to equip the caregiver with knowledge, skills, and tools to become a stronger caregiver.”
Questions?
CalAIM Community Supports: Promoting Independent Living Among Older Adults and People with Disabilities

May 19, 2022
Brianna Ensslin Janoski, ATI Advisory
Overview

- Our Work
- Community Supports Landscape and Implementation
- Moving Forward
Our Work
Overview

*California Health Care Foundation partnered with ATI to support understanding and uptake of six Community Supports promoting independent living for older adults and people with disabilities*

**Purpose**
- Better understand the opportunities and barriers to greater uptake
- Elevate early implementation experiences and considerations

**Methods**
- Interviews of national and California managed care plans (MCPs)
- Review of existing literature (peer-reviewed & grey), state reports, plan publications, and federal and state regulations

**Resources and Tools Available**
- Report providing profiles of the six Community Supports aimed at supporting independent living
- Evidence Compendium providing a detailed, sortable collection of literature reviewed for each service
Resources Available to Promote Successful Uptake and Implementation of Community Supports

Full Report

Community Supports Profiles within Report

Report, Community Support Profiles, and Evidence Compendium available at https://www.chcf.org/ or directly here
# Resources Available to Promote Successful Uptake and Implementation of Community Supports

## Evidence Compendium

<table>
<thead>
<tr>
<th>Background</th>
<th>Target Community Supports</th>
<th>Description</th>
<th>Short Description</th>
<th>Short Outcome</th>
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<tbody>
<tr>
<td>Impact of Adult Day Service on Behavioral and Physical Symptoms of Dementia</td>
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<td>Final Report: Adult Day Service Quality and Outcome study</td>
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<td>Daily Demands and Adult Day Service Use by Family Caregivers: Effects on Depressive Symptoms</td>
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<td>Benefits of Adult Day Services for Elderly Caregivers: A Systematic Review</td>
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<td>National Adult Day Service Association (NADSA) Research Committee Assisted Bibliography (October 2012)</td>
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**Report, Community Support Profiles, and Evidence Compendium available at** [https://www.chcf.org/](https://www.chcf.org/) or directly here
Community Supports Landscape and Implementation
Community Supports are Medicaid In-Lieu of Services Providing MCPs with Flexibility to Meet Member’s Non-Medical, Long-Term Services and Supports Needs

*In California, Community Supports, or ILOS, are:*

- Cost-effective, medically-appropriate alternatives for services of settings under the Medicaid State Plan,

- Optional for MCPs to offer; optional for members to accept,

- Able to be added or removed by MCPs at defined intervals: every 6 months for an addition and annually for a removal,

- Pre-approved by DHCS for MCPs to offer, though MCPs may apply to obtain approval for additional services,

- Built on and scale existing Medi-Cal programs and services (e.g., Whole Person Care, Health Homes).
## Initial Community Supports Uptake

*Uptake of independent living supports are overall more limited*

<table>
<thead>
<tr>
<th>Service</th>
<th># Medi-Cal MCPs</th>
<th># Counties</th>
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<tr>
<td>Housing Transition Navigation Services</td>
<td>24</td>
<td>39</td>
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<td>Housing Tenancy and Sustaining Services</td>
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<td>39</td>
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<td>Medical Respite</td>
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<td>Meals</td>
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<td>Housing Deposits</td>
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<td>Asthma Remediation</td>
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<td>NF Transition/Diversion to ALFs</td>
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<td>Community Transition Services/NF Transition to a Home</td>
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<td>Personal Care and Homemaker Services</td>
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<td>Respite Services</td>
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<td>Day Habilitation</td>
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Source: [CalAIM Community Supports - Managed Care Plan Elections](https://www.dhcs.ca.gov/CalAIM/CommunitySupports/Pages/MCP-Elections.aspx) (PDF), DHCS, last updated January 25, 2022.
MCP Considerations of and Decisions to Offer Specific Community Supports Varied but Included Similar Themes

- Cost-effectiveness
- Availability of experienced Community Supports providers
- Responsibility for other LTSS or care settings
- Duplicative or overlapping services
- MCP staff and provider staff operational capacity
- Uptake of Community Supports by delegated MCPs
- Ability to make additions to Community Supports every six months
- Timing and clarity of guidance and incentive funds
Using Community Supports to Promote Independent Living
Scenario 1

Michael, an 80-year-old Medi-Cal MCP Member, has been in a nursing facility for 45 days (less than 60 consecutive days) and is thus ineligible for the California Community Transitions (CCT) Program. His MCP uses community transition services to transition him home, also providing home modifications, meal services and respite for his wife who is his primary caregiver.
Scenario 2

Maria, a 75-year-old Medi-Cal MCP Member, lives at home but is at imminent risk for nursing facility placement. She may be eligible for In-Home Supportive Services (IHSS), but the approval process could take several months. Maria’s MCP diverts institutionalization through Community Supports, providing meals, personal care, and making her home more accessible with ramps and grab bars.
Moving Forward to Advance Community Supports
The Opportunity of the Providing Access and Transforming Health (PATH) Program

DHCS will issue $1.44 billion in funding through PATH to maintain, build, and scale the capacity necessary to ensure successful implementation of CalAIM, from 2022 through 2026.

$1.29 billion will go toward:

- **Bridge funding** payments in 2022 and 2023 to former WPC providers delivering similar services under Community Supports
- Planning and implementing **cross-sector efforts for collaboration** needed for ECM and Community Supports among MCPs, Community Supports providers, and others
- **Technical assistance** to Community Supports providers and to county and tribal agencies
- **Developing infrastructure** among ECM and Community Supports providers
DHCS Recommendations for Consideration

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

1. Continue assisting and sharing **detailed guidance and information** for MCPs and providers interested in offering Community Supports (e.g., detailed guidance on reasonable variation to determine cost-effectiveness based on cost of living).

2. Explore opportunities to offer **Technical Assistance to Community Supports providers** to strengthen their infrastructure around coding for claims and encounters.
MCP Recommendations for Consideration

To foster successful implementation, MCPs should continue engaging and collaborating with DHCS, other MCPs, and providers in the following ways:

1. 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.

2. Identify potential gaps in services and **collaborate with other MCPs to collectively solve shared issues**.

3. Engage with Community Supports providers to help them **access PATH dollars** to build equitable capacity across the state.

4. **Work with health care providers** to integrate Community Supports into the standard care planning process.