Opportunities for CalAIM to Support Community Living

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

May 19, 2022

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CalAIM and Institutional Long-Term Care Carve In

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May 19, 2022

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

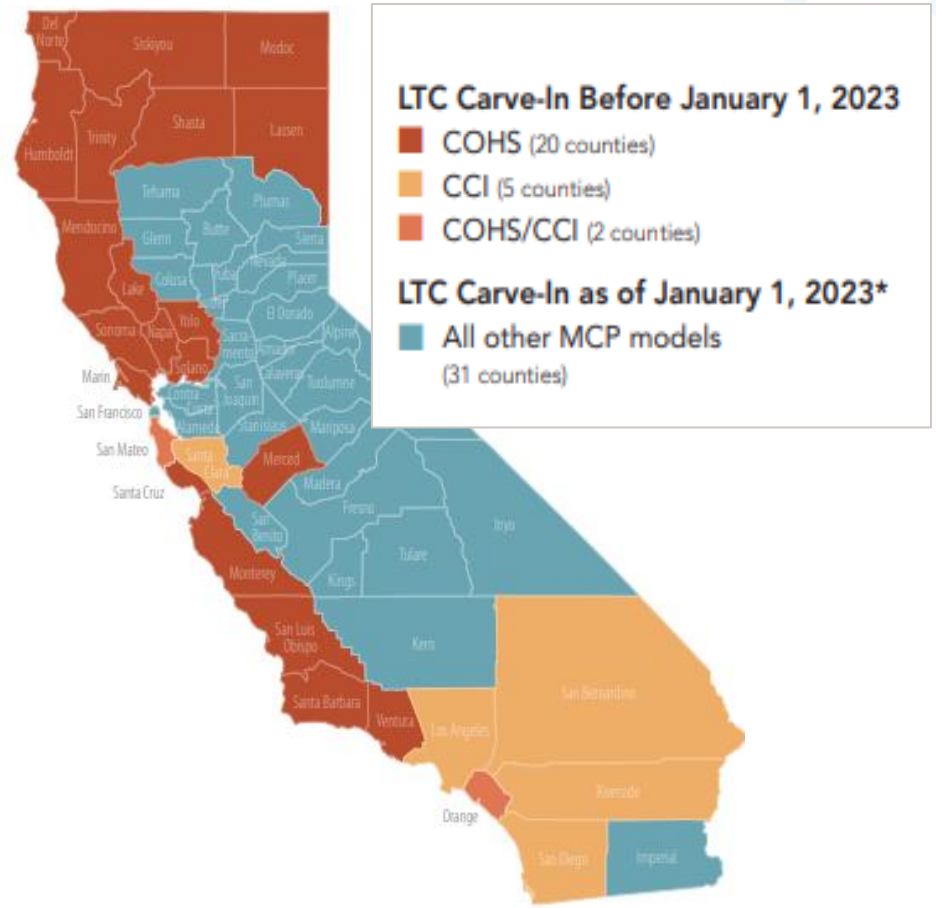
What is the Institutional LTC Carve-In?

- 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)

Institutional LTC Carve-In Status in CA Counties



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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

https://www.chcf.org/publication/calaim-institutional-long-term-care-lessons-medi-cal-managed-care/

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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

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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)*

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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

Alissa Halperin, Separate and Unconscionable: A Report on Racial and Ethnic Disparities in Pennsylvania's Nursing Homes with Recommendations for Immediate Action, Center for Advocacy for the Rights and Interests of the Elderly (CARIE), August 2021.

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.

Transitions and Diversions to Community-Based Settings: Support for Informal Caregivers

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?

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

May 19, 2022

Brianna Ensslin Janoski, ATI Advisory

ATI ADVISORY
IDEAS TO ACTION IN HEALTHCARE & AGING

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

CHCF

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

APRIL 2022

AUTHORS
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RECOMMENDATIONS

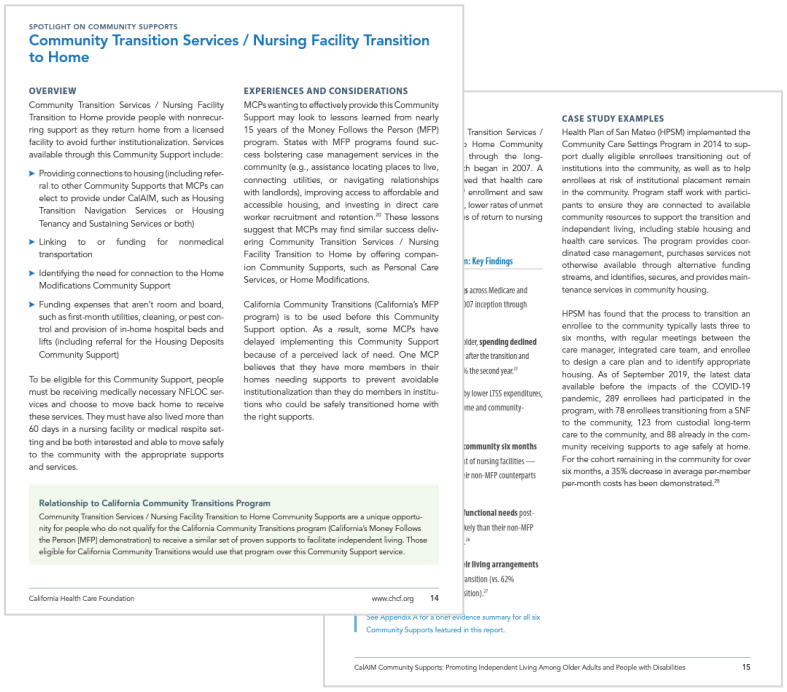
California Department of Health Care Services

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.

California Health Care Foundation www.chcf.org 22

Community Supports Profiles within Report



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.

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.

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.[25] 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.

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]

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

CalAIM Community Supports: Promoting Independent Living Among Older Adults and People with Disabilities 15

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

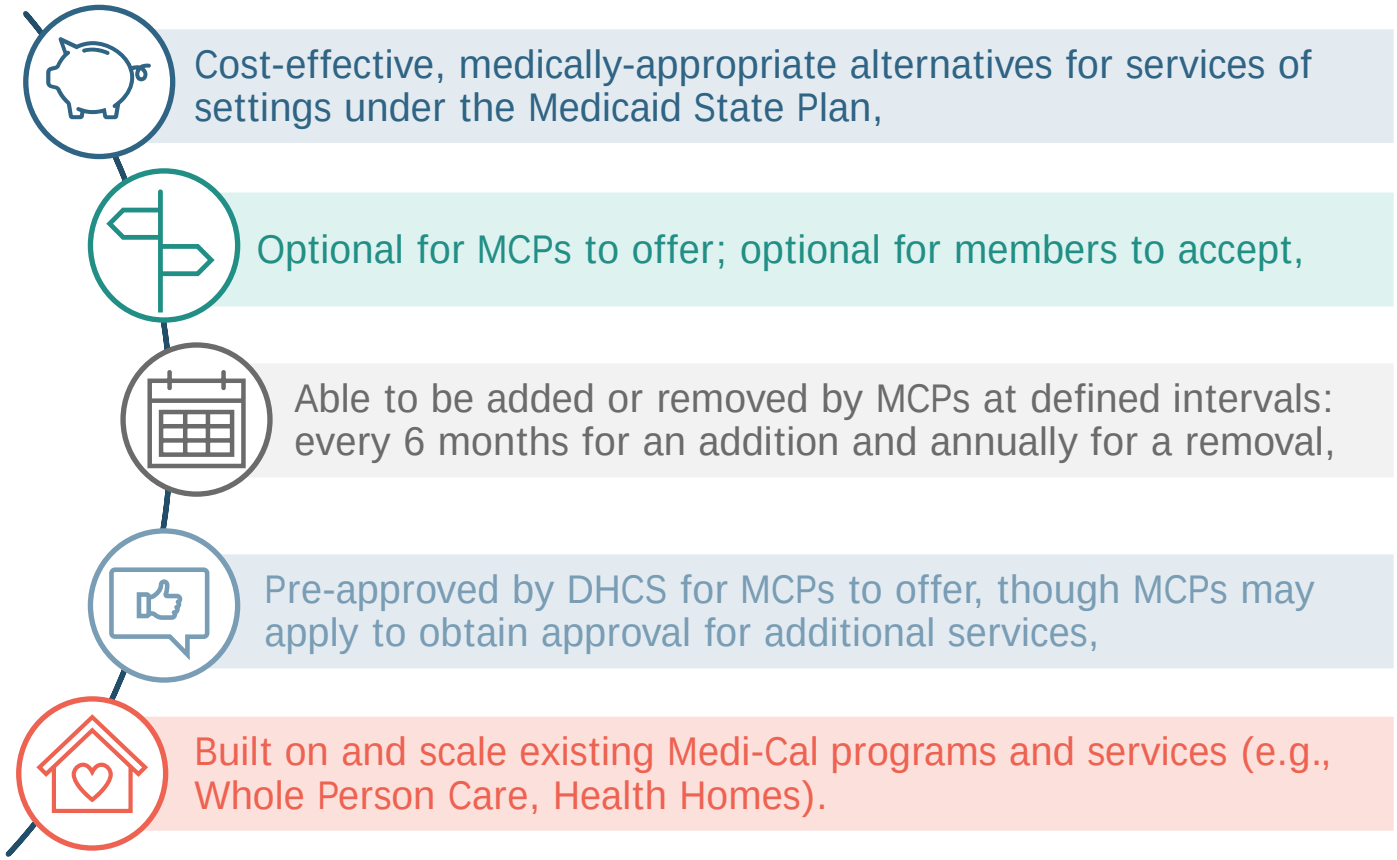
Background	Target Community Supports						Medicaid	Description	Outcomes						
Research or Program Title	Respite Services *e.g., home care to substitute family caregiving.*	Nursing Facility Transition/Diversion to Assisted Living Facilities *e.g., help moving into ALF for current NF residents.*	Community Transition Services/Nursing Facility Transition to Home *e.g., help securing rental housing in the community for current NF residents.*	Personal Care and Homemaker Services *e.g., additional personal care for people with inadequate access.*	Environmental Accessibility Adaptations (Home Modifications) *e.g., device installation in home after medical professional certifies need.*	Medically Supportive Food/Meals/Medically-Tailored Meals *e.g., people with chronic illness get meals delivered as suggested by registered dietitian.*	In-Lieu-Of Services Policies in Genel	Short Description	Short Outcome	Finding: Cost Savings	Finding: Delayed Institutionalization	Finding: Decreased Utilization	Finding: Improved Health/Function	Finding: Caregiver Benefits	Finding: Quality of Life or Satisfaction
Impact of Adult Day Services on Behavioral and Psychological Symptoms of Dementia	Yes	---	---	---	---	---	---	Researchers compared outcomes of persons with dementia attending adult day services program against those not attending, based largely on caregiver reports of behavior.	Persons with dementia attending adult day services (ADS) program had fewer sleep-related problems.	---	---	---	Positive	---	---
Volume of Home and Community-Based Services and Time to Nursing-Home Placement	---	---	---	Yes	---	Yes	---	Researchers analyzed whether volume of Home and Community-Based Service (HCBS) impacts risk of transitioning from long-term services and supports (LTSS) through HCBS to LTSS in nursing home.	Every additional 5 hours of personal care services (PCS) was associated with decreased risk of nursing home placement by 5%. Every additional 5 hours of homemaking decreased risk of nursing home placement by 13%.	---	Positive	---	---	---	---
Use of Adult Day Care Service Centers in an Ethnically Diverse Sample of Older Adults	Yes	---	---	---	---	---	---	Authors studied perceived need for and use of adult day services (ADS) in a low-income, majority Hispanic (50.2%) population.	Half of caregivers had perceived need for ADS, but only 19% of caregivers used those services. There were no significant differences in patient gender, age, ethnicity, caregiver relationship to the patient (adult child, spouse, or other), or patient income for ADS users versus non-users. However, the care recipient's functional status was related to the use of ADS in that users were higher functioning but with lower cognitive ability. Additionally, statistically significant associations were found between caregiver's income and ADS use, such that 16% of the low-income families used ADS compared to only 8% of the high-income families.	---	---	---	---	Neutral	---
Final Report: Adult Day Services Quality and Outcomes Study	Yes	---	---	---	---	---	---	Navigant helped Minnesota Department of Health Services study current and future ADS models, as mandated by state legislature. Report summarized observations and recommendations, including recommendation on how to monitor impact and outcomes of ADS.	Stakeholders identified individualized programming to meet participant needs as a key element in successful ADS but expressed challenges of offering individualized attention to participants.	---	---	---	---	---	---
Daily Stressors and Adult Day Service Use by Family Caregivers: Effects on Depressive Symptoms	Yes	---	---	---	---	---	---	Researchers studied saliva of caregivers to identify stress biomarkers and interviewed caregivers each night, to assess impact of ADS on stress levels.	Family caregivers showed increase in beneficial stress hormone DHEA-S on days of ADS use.	---	---	---	---	Positive	---
Benefits of Adult Day Services for Dementia Caregivers: A Systematic Review	Yes	---	---	---	---	---	---	Author conducted a literature review to identify benefits of ADS and whether ADS are effective as respite care.	Literature generally supported that ADS can benefit physical, emotional and psychological well-being of caregivers. The only study reviewed regarding cost found savings due to ADS for dementia patients.	Positive	---	---	---	Positive	---
National Adult Day Services Association (NADSA) Research Committee Annotated Bibliography (Infographic)	Yes	---	---	---	---	---	---	NADSA Research Committee developed annotated bibliography of research in ADS over past 10 years and created infographic to document content of bibliography.	Between 47 and 65% of ADS centers offer health care services, including skilled nursing, physical therapy. Occupational therapy, and speech language pathology services. High majority of ADS centers offer transportation.	---	---	---	---	---	---

Report, Community Support Profiles, and Evidence Compendium available at 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:



Initial Community Supports Uptake

Uptake of independent living supports are overall more limited

	# Medi-Cal MCPs	# Counties
Housing Transition Navigation Services	24	39
Housing Tenancy and Sustaining Services	23	39
Medical Respite	21	22
Meals	21	46
Housing Deposits	16	44
Sobering Centers	11	11
Asthma Remediation	11	36
Short-Term Post-Hospitalization Housing	10	16
Home Modifications	10	34
NF Transition/Diversion to ALFs	6	6
Community Transition Services/NF Transition to a Home	6	6
Personal Care and Homemaker Services	6	8
Respite Services	5	4
Day Habilitation	2	13

Source: *CalAIM Community Supports - Managed Care Plan Elections* (PDF), DHCS, last updated January 25, 2022.

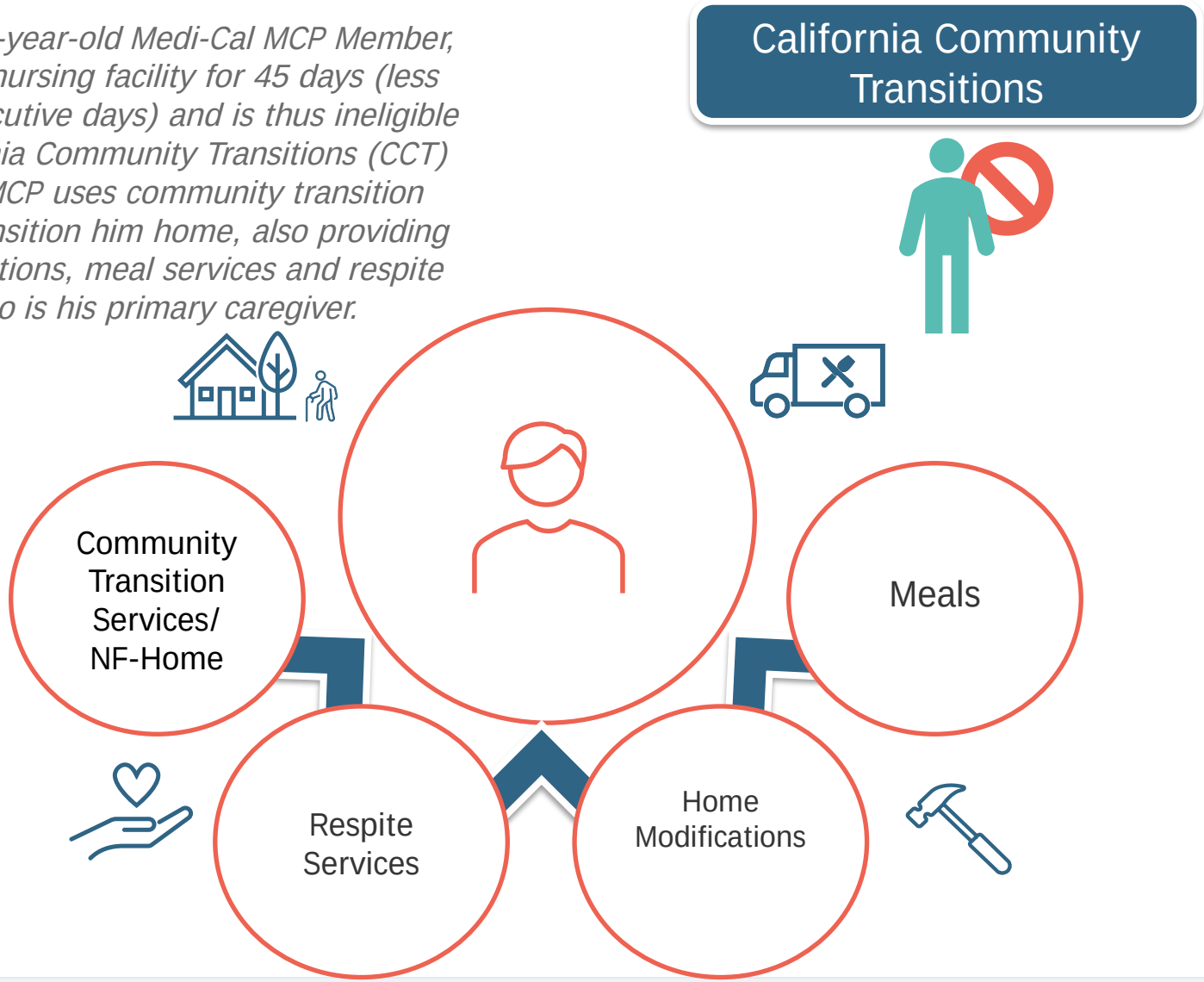
MCP Considerations of and Decisions to Offer Specific Community Supports Varied but Included Similar Themes

- 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

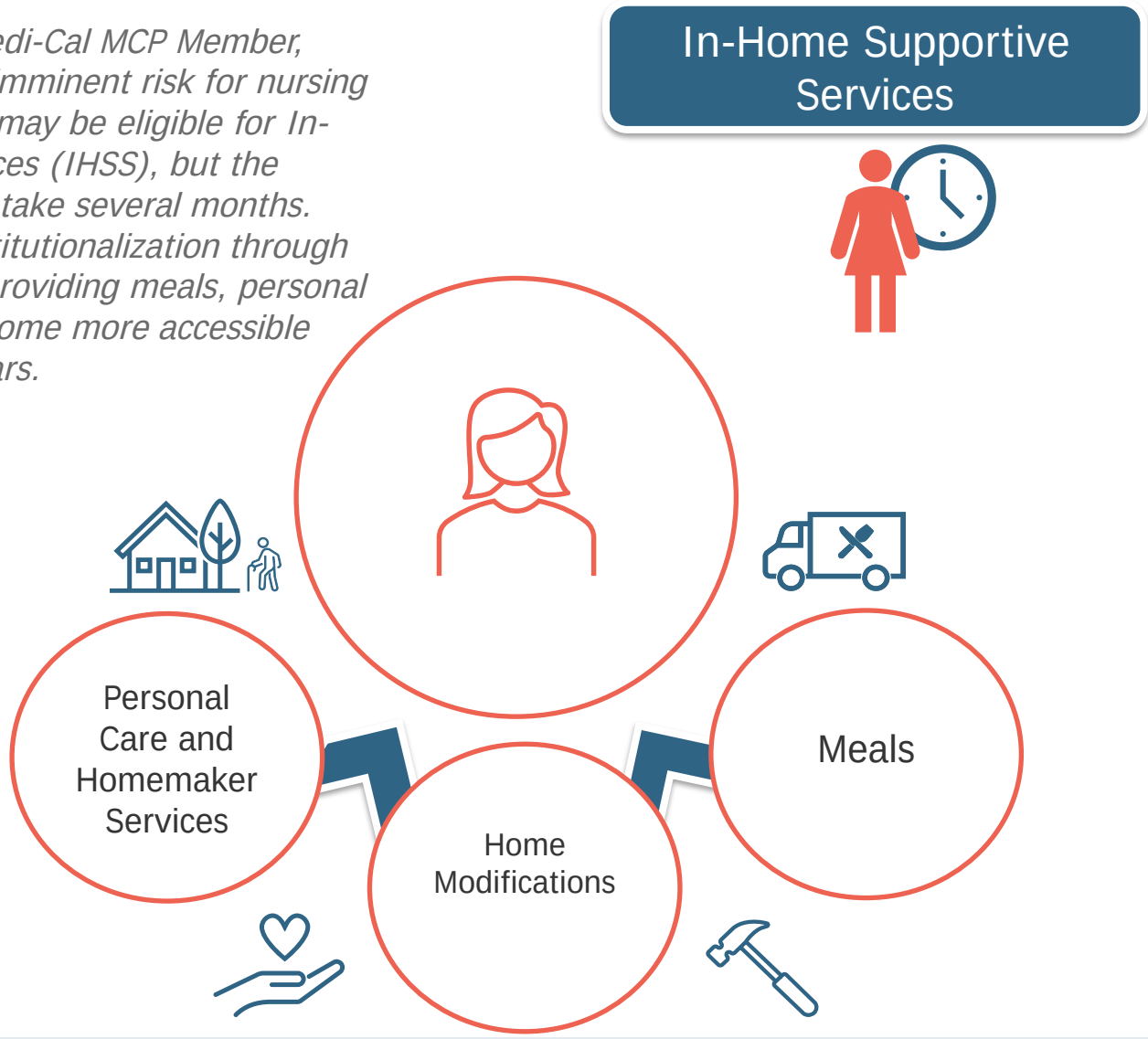
Scenario 1

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.

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