California Health Care Foundation

Opportunities for CalAIM to Support Community Living

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

Webinar Transcript — Thursday, May 19, 2022

Kate Meyers: Well, hello, everyone. And welcome to today's webinar on Opportunities for CalAIM to Support Community Living, The Intersection of the Institutional Long-Term Care Carve-In and Community Supports. My name is Kate Meyers, and I'm a senior program officer at the California Health Care Foundation, or CHCF. We are a philanthropy based in Oakland, California, focusing on improving the health care delivery system for Californians with low incomes and those not well served by the status quo.

I just saw a question coming in about, will this be captioned? And so I'm going to just take a moment to see if in real time we can do closed captioning for this event. Let's see. At this point, live, I'm not sure that we can enable closed captioning. So I apologize for that. What I'd like to do is reassure everyone that we are recording this and we can look into whether we can get a closed caption or scribed version of it done after the event. So thank you for that question.

As we get started here, I wanted to mention that at CHCF, I'm leading the development of some new work for our organization focused on California's older adults with complex needs. The overarching goal of this work is to support the provision of well-coordinated medical, behavioral health, and supportive services to this population to help them safely age in place, reducing unmet need and reducing avoidable hospitalizations and institutionalization.

As many of you probably know, CalAIM, or California Advancing and Innovating Medi-Cal, includes a number of reforms aimed at doing just that. And CHCF is in the process of supporting a variety of work to help stakeholders learn from past efforts in California and similar efforts in other states as we implement these reforms that can help support independent living and safely aging in place for California's older adults. We really are faced with a unique opportunity with CalAIM to provide Medi-Cal enrollees with care that's more comprehensive, more coordinated, and more integrated. And we want to make sure we're learning from past efforts and similar efforts so that we make the most of this opportunity in California.

Today, we're focusing on two reforms, the statewide carve-in of the institutional long-term care benefit to managed care that will begin in January 2023, and on Community Supports, which launched in January of 2022, but where Medi-Cal managed care plans can continue to add different Community Supports over time. And specifically today, we'll be focusing on a subset of six Community Supports that can promote independent living. CHCF published papers on each of these topics in March and April. And in a moment, I think my colleague Carol will be pasting links to those publications in the chat so that you can access those papers. Actually, I'll try to do that after we get going on our presentation today. Carol's having some technical difficulties there. But we will paste the links to the papers into the chat. So you can take a look at those after today's webinar.

And we're excited today to have the primary authors of both of those papers here with us to highlight what they learned in their deep dives into these different reforms and how they can improve care quality and quality of life for enrollees, and really to help us think collectively about how Medi-Cal

managed care plans and their partners at the facility level — provider organizations and community-based organizations — can really think about how these two specific reforms can work together and be synergistic to provide the best care for enrollees. We're really fortunate today to have, as I said, the lead authors from both of these papers with us. I'm going to briefly introduce each of them so you know a little bit about their background, and then we'll dive in.

Carrie Graham, PhD, is the director of Long-Term Services and Supports at the Center for Health Care Strategies. In this role, she oversees their portfolio of work to improve care delivery for older adults and people with disabilities who need long-term services and supports, or LTSS. Dr. Graham has been working in the field of aging research, health policy, and evaluation research for over 25 years. Prior to CHCS, she was the principal investigator of several studies examining how different aspects of health reform in California have impacted health care and LTSS for seniors and people with disabilities. Most recently, she supported the California Department of Aging in the development of the Master Plan for Aging.

Our second speaker, Brianna Ensslin Janoski, is a director at ATI Advisory, focusing on issues related to Medicaid LTSS and dually eligible populations. Prior to this, she was an independent consultant who supported clients on projects related to managed care, Medicaid, Medicare, State Health Insurance Assistance Programs, and integrating care for some of our nation's most vulnerable populations. Prior to consulting, Brie served in multiple roles at Molina Healthcare, working on national- and state-level Medicaid and duals policy and Medicare product development. Brie has a decade of experience supporting states and plans to advance Medicaid and integrated Medicare-Medicaid models to reach more people and to provide better care.

So in a moment, we'll start with Carrie. But before that, I just wanted to mention a few logistics. We are recording this webinar, and we will make the recording and slides available on CHCF's website within the next 7 to 10 days. And as I mentioned earlier, I will look into whether we can get the content transcribed. And we'd love to hear your questions and comments and reactions for our presenters. We will have a couple of chances where we'll pause and take some of those questions from the chat. So, please, at any time that a question occurs to you, or a comment, you can enter that into the chat. And please send it along to host and panelists so all of us can see those questions. And if for any reason you don't want us to attribute your question to you when we raise it, just note that in the chat, and we'd be happy to do that. So with that, I will turn it over to Carrie. And, Carol, you can advance to the next slide.

Carrie Graham: Hello. I thank you so much. It's wonderful to see so many people here. And really excited in the opportunity to talk about CalAIM and the institutional long-term care carve-in and all of the opportunities to improve care for Medi-Cal beneficiaries. Next slide, please. The long-term care carve-in is one of many initiatives that are part of CalAIM. As most of you are aware, California is reforming Medi-Cal, and there's many, many different initiatives. But I thought it'd be good to start with what the goals, overall goals of CalAIM are. So as we think about the long-term care carve-in and Community Supports, how those align with the overall goals. The first one is to identify and manage comprehensive needs through whole-person care approaches and social drivers of health. The second goal of CalAIM is to improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform. And we'll talk about that a little bit in the context of the long-term care carve-in. And then to make Medi-Cal more consistent and a seamless

system for enrollees to navigate by reducing complexity and increasing flexibility. We will see some of that as well. Next slide.

So what is the institutional long-term care carve-in? As of January 1, institutional care, in this context, we're really focused on seniors and people with disabilities. The majority of what we're talking about is nursing home care, skilled nursing facilities. So as of January 1, institutional care is going to be a mandatory benefit for all Medi-Cal managed care members. And as you can see from the map, different counties have had different experiences with this. There's 31 counties where institutional long-term care is already carved in. These would be COHS counties, County Organized Health Systems, or the counties that have Cal MediConnect plans that are in the CCI demonstration. And for those counties, as of January 1, not a lot's going to change, but they will have things new, CalAIM initiatives like Enhanced Care Management and Community Supports that can provide a value added for those members who are in institutions.

The real change is going to be in the 27 counties where the carve-in is going to be new. For these managed care plans in these counties, the way it's worked so far is that if someone's in their plan and is put into a nursing home, or is admitted into a nursing home, they would stay in the managed care plan for the first 60 days. But that would typically, in most cases, be covered by the Medicare Post-Acute Care benefit. And then after 60 days, they are discharged to fee-for-service. Those counties will be learning and implementing the long-term care carve-in pretty much for the first time. Next slide.

We are talking today about the long-term care carve-in and referencing some of the material from an issue brief that we just published with CHCF. The goal of this issue brief was to inform the implementation of the institutional long-term care carve-in by describing challenges, opportunities, and lessons and examples, both from California, from those counties that have already been doing it, and other states. We did key informant interviews, both in California and other states, and a lot of literature reviews. The link is at the bottom of the slide. I'm just going to touch on different things in my presentation, but really encourage you to go to that report and look, there's just a lot of examples from other states, a lot of links, if there's certain things you're interested in. CHCS was an author, Chapman Consulting was an author, and Decipher Health Strategies is also an author. Next slide.

You may be asking, "Why are we talking about long-term carve-in and Community Supports in the same presentation?" And what we're going to try to do today is talk about really focusing on how Community Supports can intersect with the long-term care carve-in to promote diversions from, transitions out of nursing homes, and making sure that individuals have the most opportunity to live in the setting of their choice. And most of the time that setting is more on the community-based side and lower levels of care. My colleague Brie is going to talk more about the Community Supports that will be implemented. They're really focused on seniors and people with disabilities around the same time as the institutional long-term care carve-in. But we'll be kind of thinking about ways that these intersect and help Californians live, for the most part, in the community or the setting they wish. Next slide.

Our report has four different things we touch on. It looks at how to improve access to, especially, high-quality nursing facilities using opportunities in the long-term care carve-in. It focuses on opportunities for the carve-in to improve quality of care. It has a whole section on equity that we'll touch on very briefly. But, really, what we're going to be talking about the most is how it can improve the ability to transition or divert and align with Community Supports. Next slide.

I just want to quickly mention that we have a whole section in the report that talks about improving access. Because we know that often in the past managed care plans may have struggled with finding a facility that would admit a Medi-Cal member, especially one with complex care needs. And so we have examples in there. How managed care plans can use things like care management, things like Enhanced Care Management, to do care coordination, engaging hospital discharge planners, facilities, housing services before the member is even discharged out of the hospital and into a facility, ensuring that the facility would have a safe place to discharge the patient. We also have examples about how managed care plans can use financial flexibilities to secure a placement for a member. And, for example, one thing we have in there is an example of a plan that was trying to find a placement for someone who needed around-the-clock supervision. They allowed the facility to hire a bedside sitter and just invoice them directly to be able to admit that member. Next slide, please.

We have a whole section in our report on improving quality of care, using payment strategies to incentivize quality. We know that an ultimate goal of CalAIM is to use value-based payment incentives whenever possible. And we have some examples of plans that have used value-based payment to increase the quality for their members and MCPs, with suggestions around the importance of regional uniformity and those sorts of things. Because a facility could have members in many different managed care plans, and we don't want the facilities to be reporting quality measures, you know, different ones for different plans. So importance of regional uniformity here.

We also highlight some areas where plans can add a layer of oversight. And we know that the state and the federal government provide oversight for nursing facilities. But managed care plans are responsible for ensuring the quality of their provider network. And so we posed some innovations and ideas. One is that Cal MediConnect plans in one region worked with long-term care ombudsman offices when they begin carving in long-term care. The long-term care ombudsman took to the care managers who maybe had never been in a facility before because this was brand new, did joint site visits, showed them how to read charts, how to identify things like inappropriate antipsychotic use. That's an example we pose here. And using quality data. California and Oregon both have websites that are very consumer friendly, that have joint federal and state survey data. And that way it's sort of better than the federal site. And using things like data that's available to assess staffing. And making sure that you're including in your provider networks the highest-quality facilities. Next slide.

And then I would be remiss if I didn't talk about promoting equity. I think there's a lot of opportunities to promote equity. There is a very strong evidence base that, especially facilities that have a high percentage of residents who are people of color, have historically had poor quality, lower staffing — they had more deaths during COVID. We also relied a lot on Alyssa Halperin's, a report she did for Pennsylvania that highlights a lot of opportunities and managed care delivery systems to do things like codifying expectations for addressing disparities, using data to monitor, and recommendations such as increased oversight of facilities, especially those who have a high percentage of residents who are people of color. And I really encourage you to look at the report for a little more on this, but let's go to the next slide where we start talking about diversions and transitions.

So lessons learned in California. A lot of opportunities to work both with Enhanced Care Management and Community Supports. We have examples of plans that use their care managers to coordinate with the hospital before admission to the nursing home to establish a discharge plan. And this is so important, especially when it comes to access, because we know that not only are a lot of people who

are on Medi-Cal at risk for homelessness, but just by being put in an institution, a lot of people lose their homes. They lose their apartments. And they're an increased risk for homelessness. So using assessments to proactively assess members who are at risk for homelessness after a postacute stay. And partner with community-based organizations. Again, we heard in Cal MediConnect, some plans said, "We had trouble finding good candidates for transitions." In that case, partnering with a long-term care ombudsman really helps the plans to identify members who are good candidates.

Some other recommendations from experts we interviewed were things like including in health risk assessments members' preferences for postacute care before any hospitalization occurs — getting that on the record. Using data, such as the Minimum Data Set, actually has a Section Q that assesses people quarterly who are institutionalized. It's done across the country. And it asks residents to express their interests — if they're interested in leaving the facility. One expert recommended that managed care plans could have review boards with placement criteria and to vet placement decisions. Putting someone in an institution is such a life-changing experience that a review board could review those decisions. And then we will talk in a minute about financial incentives and rate setting, and the importance of supporting informal caregivers. Next slide, please.

So some examples from other states. The financial incentives are very important. And we know during Cal MediConnect that the incentives, in terms of the rate settings, weren't necessarily there to incentivize transitions to home and community-based settings. Massachusetts, in their Senior Care Options program, which is their duals product, uses rate setting to incentivize it. First, they start with, there's higher rates for people living in the community who meet a nursing home level of care. When a person's institutionalized, that rate does not increase for those members for 90 days. They're not being financially incentivized to institutionalize. The higher institutional payment that eventually kicks in continues for 90 days after the person is discharged to the community. And so this is just an example from Massachusetts of how they ensure that the incentives are promoting more community care. And in our report, we have a lot of other examples — things like blended rates, et cetera. Next slide.

Other incentives and performance metrics. Illinois offers managed care plans incentive payments. When a member returns to the community from a nursing home, especially it has to be due to the care coordination from the MCP. Alabama provides an incentive payment toward MCPs for overall movement, overall rebalancing toward HCBS usage. And Texas has some performance metrics related to transitions. Things like rates of admissions to nursing facilities from hospitals or the community. Next slide, please.

There's examples on housing supports. And we know that in California, the Community Supports are going to provide housing supports for members. Tennessee uses their managed care contracts to require MCPs to have housing specialists to help members transition back to the community. Pennsylvania also does this, but they also require the MCPs to participate in local housing collaboratives. And many other examples in the report. Next slide, please.

And we also know that when someone's being transitioned to the community, or living in the community, Medi-Cal provides IHSS and other sorts of supports, but it is really, really important to support informal and unpaid caregivers. Florida and Rhode Island require MCPs to identify and assess caregivers for specific problems, needs, strengths, resources of the family caregiver, as well as the caregiver's ability to contribute to the needs of the care recipient. Minnesota reimburses for a family caregiver coaching and counseling that's intended to equip the caregiver with knowledge, skills, and

tools to become a stronger caregiver. I know that Brie will talk about this a little bit more in terms of the Community Supports that are going to be available. Next slide, please. So I want to pause there and see if there's any question.

Meyers: Thank you so much, Carrie. So, yeah, we can take a couple of minutes now for any questions from the group before we move on to Brie. There was one question that came in so far in the chat. We'll see if any more come in, in the next couple moments. And I have a question for you as well. So one question from our participant, Ron Spingran said, "Carrie mentioned that health plans are responsible for the quality of their long-term care provider network. Is this information publicly reported? And what, if any, are the standards health plans must meet for their long-term care provider networks?" Is that something you're able to answer?

Graham: I can't answer the question necessarily about the standards, but just to be clear, the state and federal government is responsible for the quality of care in any Medicaid or Medicare certified nursing facility. The California Department of Public Health sends out surveyors to survey. And there's both state and federal standards. I think my point was more about the fact that with managed care, there's an opportunity for another layer of oversight. And, generally, in any sort of provider network, a managed care plan is responsible for making sure that they're contracting with high-quality providers and that the providers are providing high-quality care. So I just wanted to point out that there's more of an opportunity for another layer. It doesn't supplant the government oversight of this in any way. It's just another layer. Doing things like having quality measurement and using value-based payment approaches. And publicly reported — in California, if a facility has deficits, that's reported publicly. There's also a website that was originally called Cal Hospital Compare, but they've added a new module that publicly reports in a way that's really friendly for consumers. The quality measures and deficits and things like that that are found by the surveyors. It's called, I think, Long Term Care Compare. And Oregon also has a consumer site that reports that in a friendly way as well.

Meyers: Thanks, Carrie. And, yeah, in just a moment, I can look up that web URL for the site you just named and put it in. Another question just came in on the chat. Let's see. “Are the Enhanced Care Management and Community Supports also available for people who obtained Medi-Cal due to a need for long-term care but who also have other insurance, such as PERS or TRICARE For Life, and pay a share of cost?” This may be a question that is more for the state than for us, but, Carrie, I'll see if you happen to have any insight on this question.

Graham: I do not, I'm sorry. I'm sorry.

Meyer: If any of our participants are from the state, from DHCS, and have a sense of this, feel free to type your answer into the chat where I can relay it later. One quick question I'll ask before you move on to Brie, I think it's a quick question, is, you know, you've mentioned and highlighted a few different

examples and strategies of how other states or how organizations within California have made efforts to support diverting people from institutional care or transitioning people out back into the community. I'm wondering if there's one or two of these strategies that especially sort of rose to the top for you as having the greatest potential for impact as you look ahead to California.

Graham: Well, I think, obviously, financial incentives, and at least not having perverse incentives that encourage institutionalization. I think the rate setting that we highlighted from Massachusetts and other states are important to take into consideration there. Making sure that managed care plans have the financial resources to support people after discharge and into the community is just so important. And then the other thing I would just highlight here very quickly is I think the equity considerations are just really important. Even in states that do a lot of investment in home and community-based services, there's evidence to show that those privilege White people more than people of color, that there are additional barriers to living in the community. You need a home, you need a safe home, you need an accessible home, you need money for accommodations and home repair, and you need informal caregiver support. Really monitoring that and really paying attention to the kind of equity considerations, using data to monitor that and continually problem-solve in that area, I think is just so important.

Meyers: Thank you so much, Carrie. So at this point, we are going to transition to our second speaker, Brie. If you could advance the slide, Carol, to the next one, we'll turn it over to Brie.

Brianna Ensslin Janoski: Great. Thanks, Kate, and thanks, Carrie, for the wonderful introduction. And I think it really provides a good foundation for Community Supports and the opportunity of Community Supports. Even though Community Supports have already been implemented, it's interesting to see how the uptake has started and how we expect it to grow as additional CalAIM reforms like the institutional long-term care carve-in rolls out. So with that, we can go to the next slide, please.

We're going to talk very quickly. I'll give you an overview of the work that we did with the California Health Care Foundation, we'll talk a little bit about making sure everyone knows what we're talking about with Community Supports, and then early implementation experiences. And almost pre-implementation experiences was a big focus of the work that we did. And then end with a conversation around what we think and what we've learned is most needed moving forward to make sure that these Community Supports are widely available and used to their full potential. So we can go to the next slide, please. And we'll keep going to the next one.

So our work we did over the last six or seven months, really, we started maybe a month or two before the managed care plans were about to implement Community Supports for the first time in January. So we heard the last few months of experience and then maybe the first month of implementation experience. And what we did was really talk to managed care plans in California as well as nationally to understand the experience of Community Supports, thinking through why we're going to offer certain services, why it might be challenging to offer others. We looked at literature to understand the data behind these various services, both nationally as well as internationally, and how that can feed into a

plan's desire, ability to move forward with community support. We looked at state reports, we looked at federal and state regulations to see if there were certain barriers built into the regulations that might impede or promote uptake of Community Supports. And, ultimately, what we did is we put together two resources. And we can go to the next slide since that one shows the first resource.

And this is a pretty robust report that we put together. Again, linked here, I think, through chat, and then here on the slide, it's at CHCF's website. And it's a full report detailing experiences, lessons from early implementation, or pre-implementation, from managed care plans both in California as well as nationally with these six Community Supports that we focused on most applicable for independent living. We also did two-page profiles that you'll find in the middle of this report that give you a deep dive. If you're particularly interested in really understanding personal care services, you can dig in there — it has lessons, it has key data. So I encourage you to take a look at the report.

And then the next slide shows our evidence compendium, which is also available on CHCF's website. And I think this is a pretty cool resource. We looked at, I think, it's just over 100 different pieces of literature. And we broke it out into this really cool Excel. If you're interested to dive in, I encourage you to do so. And you can filter by respite, you can filter by personal care homemaker, by community transition. And within that, it will then populate and you can then look to the right and say, "Ooh, respite, is that associated with improvements in caregiver burden? Is that associated with cost savings? Is that positive, neutral, negative cost savings?" And you can dig in really deeply here. And this is intended for managed care plans who are maybe on the fence, maybe considering implementing these services to better understand the experiences. There's some considerations here for when respite might have better uptake, which populations might respond better, or different considerations for implementation. So there's a really rich resource here I encourage you to look at if you're interested. We can go to the next slide.

All right, so now we're going to talk actually about Community Supports, to make sure everyone is on the same page with regards to what these are. We can go to the next slide.

So Community Supports, if you're in California, that's what you call them. If you are national, in any other state, you'd refer to them as an In Lieu of Service. And this is a mechanism really for Medicaid managed care plans to offer some additional flexibility to meet members' nonmedical LTSS needs, in this case, in terms of the services that we're looking at.

And it's really special, what California has done. We looked nationally at what other states have done. There are pockets where states have done preapproved services that give plans the flexibility to really dig in and offer these services to beneficiaries. But we haven't found another state that made such a robust push to encourage plans to offer these services and particularly to offer services that are related to individuals with disabilities and older adults. A lot of the services that we see nationally are related to behavioral health, which, of course, overlaps a bit. But pretty cool what California is doing, and I want to acknowledge that.

So for these Community Supports, what they have to be, they're cost-effective, and they must be medically appropriate alternatives for services or settings under the Medicaid state plan. Managed care plans have the option to offer them, and members have the option to accept them. So no one has to offer these, no one has to use them. They're able to be added by MCPs every six months and removed annually. And we heard that this, from plans, was a really great aspect to how the state designed

Community Supports. It allowed them to assess everyone's capability to launch, and launch well. So that you'll see a staggered rollout of many of these services as a result. California put together a list of 14 preapproved Community Supports. Although MCPs also have the ability to suggest alternative Community Supports that they want to offer as well and go through an approval process with the state to be able to offer those. And we learned in the beginning that that preapproval process of having those 14 Community Supports was really appreciated by the plans and it led to significantly greater uptake, I think.

And all of this is really built, the Community Supports are built on and leverage that existing infrastructure experience of prior Medi-Cal programs and services, such as Whole Person Care and health homes. We heard that consistently that a lot of the early implementation of these Community Supports were as a result of a lot of lessons from those earlier programs and Cal MediConnect and others. Okay, we can go to the next slide, please.

So here's your list of the 14 preapproved Community Supports in California. And this chart reflects January 2022 implementation. So this is the first round of offerings broken out. And you see here in red or in the orange boxes indicate the Community Supports that we focused on that we have deemed to be most important for independent living for individuals with disability and older adults. Not to say that some of these other services — housing supports — aren't critical, but this is what we focused on. And what you'll see here is that with the exception of [Medically Supportive Food/Meals/Medically Tailored Meals], the other five are at the lower end of uptake, of early implementation. And we see this, we expect when you look at, if you click the link at the bottom there, that brings you to an updated chart with anticipated offerings from managed care plans that indicated, "I plan to offer these services in June of '22, in January of '23, and so forth, into," I think it goes through 2024 and planned implementation. And what you see is a tremendous increase in plans, intentions to offer these services in particular as the months and years go on. And that coincides with many of these other CalAIM reforms rolling out. Okay, so we can go to the next slide, please.

Here, I'm not going to go through each one of these. You can read about them more in the report, and I think we've touched on them here and there. But what we've heard from plans, these are some of the key considerations that we heard time and time again in terms of decisions to launch a particular Community Support or not launch a Community Support at the outset. And I think the orange one here is probably the most important, or the biggest one that we heard most consistently was both plan capacity and provider capacity. And the idea that they could roll out services that they are familiar with, that they have those early connections with, such as Meals. You saw that was the highest uptake and most offered community support that we focused on. A lot of plans relay that they already had those relationships with Meals vendors. They trusted those Meals vendors to implement well and equitably. So it was an easier opportunity for them to launch those benefits while working towards and knowing that they're able to, in six months, roll out some other Community Supports that might take a little bit more time to build out operationally.

So that, and then I think the one on the top right, responsibility for other LTSS or care settings, that's this conversation in the link with the broader CalAIM reforms. As MLTSS rolls out across the state, as the institutional long-term care carve-in rolls out, as D-SNP alignment rolls out, we anticipate all of these services becoming more and more critical. And the fact that plans have implemented this early on is really great 'cause I think we'll see additional uptake and we'll see additional, we'll talk about this in a

little bit, but the next step from here is really making sure that beneficiaries that need these services are getting access to them. And that will come with time, too. So coincide nicely with additional responsibility for LTSS and care settings. All right, we'll go to the next slide.

Now, going forward, the next slide here, talking a little bit about, what does this look like in practice, and what are these Community Supports, and how do they fit in with the broader ecosystem? There are a lot of programs and services already available to beneficiaries. We can go to the next slide, please. And see an example.

So this is Michael. He's an 80-year-old Medi-Cal managed care member. He's been in the nursing facility, but he hasn't been in the nursing facility for 60 days. And because he hasn't been in the nursing facility for 60 days, only 45, he's not eligible for California Community Transitions, which is California's Money Follows the Person program. Money Follows the Person could provide many of the supports that he would need to help transition him back into the community. But he's not yet eligible for that. So his care manager connects him with Community Supports. He's able to access the Community Transition Services/Nursing Facility [Transition to a] Home Community Support to help make those connections, to bring him back home, get him those resources. He's also transitioning back home to live with his wife, and his wife will serve as his primary caretaker. But [Medical] Respite services for her as an older adult will also be critical, caring for someone with complex needs. So care manager connects them with Respite services to make sure that it's a smooth transition for her as well as the member. Home Modifications are offered and delivered to accommodate the new wheelchair that he'll be in. And Meals will be there as well, are offered to support his chronic conditions and successful quality of life during his transition home. So that's an example in terms of how this could interface and play in and supplement an individual who might not be eligible for Money Follows the Person. This is when Community Supports would step in. We can go to the next slide.

And we have a different scenario here. So Maria is a 75-year-old Medi-Cal managed care plan member. She lives at home, but there's some concerns about her declining state and potential imminent risk for nursing facility placement. So her care manager has put in and helped her apply for in-home supportive services. But there is a wait period there. So she has yet to be approved for IHSS. So in that interim, care manager connects her with Community Support so she's able to access the Personal Care and Homemaker Services to give her that in-home support that she needs. Home Modifications as well for some ramps and grab bars so that she's able to navigate her home more easily and more safely, reducing risk of institutionalization. And then Meals, again, to keep her healthy in her home. So that's an example, too. I think all of these are paired really well together, and in an ideal world oftentimes are together for the best chance of supporting community living, depending upon each individual's unique circumstances. We can go to the next slide.

All right, so that's Community Supports in a quick nutshell, let's talk a little bit about moving forward. We're five-and-a-half months into implementation. So we can go to the next slide, please.

We have recommendations both for DHCS and for managed care plans to consider based off of our research but want to start here because PATH is a pretty exciting opportunity, and it could be a resource that would help address almost all of our recommendations. So if you are not familiar with PATH, it's an opportunity for DHCS to potentially receive over a billion dollars. A good amount of those dollars would go towards efforts to support Community Supports and Enhanced Care Management implementation. So there'd be some bridge funding payments, potentially. There'd be planning and implementation for

cross-sector efforts for collaboration across Community Supports providers, managed care providers, ECM providers, developing infrastructure for ECM and Community Supports providers, and technical assistance for Community Supports providers. All of these things, we heard consistently with every conversation that we've had, are critically needed. So this is very exciting for the outlook of Community Supports moving forward. And we can talk a little bit more about our specific recommendation found on the next slide.

So here are two, we have a couple more, that we outline in the report as well, but these two really align with PATH and what we see as being critical moving forward. That technical assistance to Community Supports providers so that they can strengthen their infrastructure to contract with managed care organizations to engage in Community Supports is absolutely critical. And then the first one here is the continued sharing and is providing assistance around detailed guidance and information for MCPs and providers interested in Community Supports. And it's interesting 'cause when we started this project, we were under the assumption, or we thought this is a flexible option. Nationally, In Lieu of Services are often just presented as managed care plan. Are you interested? Do you see a need in offering alternative services to your beneficiaries? And they have flexibility, total flexibility in many, many ways. Not total. A lot of flexibility in how they design those services. So when we were talking with California plans, it was fascinating to learn that that detailed guidance and the way DHCS has approached it has been so helpful to facilitate the implementation, or the rapid implementation of Community Supports. The more guidance, the more support that DHCS can provide and continue to provide in an ongoing way. I think refining that moving forward as we see lessons from early implementation will be really important.

And we heard that and included that in some of our other recommendations in the report regarding, oh, well, decoupling some of these benefits could be really beneficial. And that's an opportunity for DHCS to learn from early implementation and say, "Ooh, maybe I can break these services apart and facilitate a wider uptake of a particular Community Support." So I think that all shows that, you know, more to come with Community Supports. And I think PATH is a great opportunity to support folks moving forward. So we can go to the next slide.

And then here we have our MCP recommendations for consideration. Again, you'll see it's pretty similar to what the PATH dollars will support in terms of having the state and having plans share best practices and successes, as well as challenges and barriers. And I know sometimes this is hard as a plan, working with competitors, but we've heard wonderful things of plans working together already. I think that can continue. And I think that could continue and be broadened into a really strategic conversation so that plans can learn from one another and that we can collect what those barriers and common challenges are and work with the state to think about systemic solutions to resolving them. And then I think the last one here, so these all kind of touched, one, two, and three are very similar. Four, I want to call out because we haven't addressed it yet.

We're talking about Community Supports as a really person-centered opportunity to deliver care to each individual depending upon their unique needs. And how we do that is working with not just the Community Supports providers, not just the plans, but the primary care providers, the folks in the clinics, the people working through care plans with these beneficiaries and making sure that you as a plan are working with your providers so that they're communicating appropriately with beneficiaries, with your members, to make sure that Community Supports are thought of not as an afterthought, but

as a piece of the care package for the beneficiaries to really integrate them into the system in a meaningful way. So I think that's the last slide for me. There we go, yeah, one more. All right, so that's it. I'm happy to take questions now. Thank you.

Meyers: Thank you so much, Brie. And, Carrie, if you want to come back on camera, too. And, Carol, I think you could actually stop screen sharing now since we're done with our slides. And we have about 11 minutes or so, or 10 minutes or so before we close. We've gotten a number of questions, and I'm going to try to cover some of them. We won't have time for all. And I'll say that some of the questions are of a more technical nature related to Community Supports that are probably best answered by people from the state or by people referencing the *Community Supports Policy Guide* information that Cleo, one of our colleagues, shared in the chat. We are saving this chat though, and we will be conveying all of the great kind of questions, ideas, areas where people have concerns or thoughts where we may not be the best people to try to address those concerns today, but we will convey them to the folks at the state who are in a better position to answer the questions or address the challenges.

But there were a couple of questions that I'm going to kind of clump together that had to do with the development of the provider network for Community Supports. Who provides these services? There was one question from a CBO that provides these types of services who wanted to know how to connect with MCPs to potentially become a provider. And then there was, I think, a kind of mirrored question about who's accountable for the selection and development of the providers for these services. And who's in charge of the contracting and credentialing and payment processes for those? So I thought, Brie, if you could just speak sort of generally to the role of the plans in building out their Community Supports provider network.

Janoski: That's a great question, it's a great question. I think it depends, depend on each plan. At each plan, we spoke to a different subset of individuals who are responsible for evaluating and then implementing and operationalizing these services. I think health care services teams and medical teams — there are community-based teams within their community engagement staff, within MCPs, who are on the ground and understand who those community partners are. If you are a CBO interested in connecting with an MCP, if you have an MCP in mind, I encourage you to, gosh, I don't know where the right places to send you. I think reaching out, you can reach out certainly to us, I think. If we know folks, we're happy to connect you. What we heard was that the plans are very interested in engaging with new providers that they might not know yet. I think early implementation — we saw MCPs working with CBOs that they already have relationships with. I think some of that other outreach has started happening. I don't know if CAHP or other organizations like that who are kind of a central point, so the Community Association for Health Plans in California, if they would be a good central resource for CBOs to go to. But, otherwise, I think connecting with the plan, most of them, I think, will be interested in working with you.

Meyers: Thanks, Brie. And a couple of our participants who are knowledgeable about this put some information into the chat to us. So I'll just mention a couple of things that came in. One person noted

that providers can call the customer service number for MCPs and can be directed appropriately. That's one sort of method of trying to reach out to the MCPs. And others also reiterated that the DHCS *Community Supports Policy Guide* answers many of the kinds of questions that people were floating — again, of the sort of more technical nature and specific to plans and CBOs operationalizing Community Supports.

One question — I think this is probably for you, Carrie, or maybe both. What is the interplay between MCPs and, I assume built into this question, the opportunities within Community Supports or the long-term care carve-in, and the California Community Transitions program? There's a specific question. Isn't there an incentive for plans to wait 60 days to leverage an alternative payer source for transitions? I don't know if that's sort of too technical on the California Community Transitions program for either of you to address, but wanted to see if more specifically, or more generally you might be able to speak to the kind of the relationship between that existing program and some of the transition opportunities within Community Supports.

Graham: Carol, I'm going to need to get back to you on that one to make sure that my information is accurate. We heard a little more about, you know, going from Whole Person Care to Community Supports than the Community Transitions program. So why don't we get back to you on that one, unless, Brie, you have a better sense of that.

Janoski: No, that's it.

Meyers: Okay. The other question that I wanted to get both of your feedback on, and it was actually embedded into one of the questions from a participant, was around how we might think about understanding the impact of these reforms and what you think will be kind of most important for the state and plans and the provider and CBO community and advocates to be sort of monitoring and tracking over time to understand if these reforms are reaching their potential or achieving what we hope they will achieve. So I thought it'd be helpful just in our last few minutes to hear your thoughts on monitoring and understanding what these reforms lead to.

Graham: I think as a former evaluator, I would say that we do know that the state will be required to do an evaluation of ECM and Community Supports that looks especially at issues of access and equity. So I don't believe that the evaluation design is finalized at this point. But that's one way that the state will know what the impact has been. And then we also know that the CS and ECM providers are required to report data to the plans, and the plans are reporting that to DHCS. So there's a great deal of reporting happening as the program rolls out.

Janoski: And just to add to that, maybe it would be in development stage, but I think what would be interesting, whether or not it's feasible at least from the outset, but to really get to that question of are

these services being equitably delivered. You look at equity from a statewide perspective, and we're talking about equitable access just simply at our MCPs offering this equitably from a regional perspective. Are these services available across the board? And we see disparities already in terms of the rollout, in terms of geography. So looking at that, I think that will resolve itself as we see a lot more uptake of those services being offered across the state. But then within those areas, are these services being equitably offered and delivered? It'd be very interesting to say, "So how many beneficiaries, if you're looking at utilization, if that's what the state's able to measure in terms of uptake or utilization by beneficiaries of these various services, and if we're able to look at that by race/ethnicity, by geography, by certain condition. But then also, that won't totally capture it from a Community Supports perspective because people have the option of turning it down. So that won't necessarily show us if they are being offered and if they have access to our accessibility, to the services. So I think if there is a possibility, and I don't know if this is feasible or not, but to look at care plans and how many beneficiaries in a cohort, in a region, by race/ethnicity, by MCP, are being offered these services? And if they turn them down, okay, that is their prerogative, but we want to ensure that equitable offering and accessibility. And I think that that would be interesting to be captured if it's not.

Meyers: Thank you so much, Brie. We are just about out of time. I know we did not get to everyone's questions, but we are taking them back. And I would also just invite anyone who's on the meeting who has some wishes about what you'd want to explore further in a learning environment around these topics. I'm very open to hearing from you. I'll put my email in the chat in just a second so that we can continue to think about both the kinds of resources that we could develop and publish and put out into the world that would be helpful to you. But also to think about what kinds of forums or fora would be productive and ways to exchange ideas. Really appreciate our two speakers today. Thank you for your expertise and your time in developing the papers and being here with us today.

I did want to just remind everyone, there were a few questions about recordings and slides. Yes, we will have those available on our website hopefully within about a week, or 7 to 10 days or so. And just a reminder that our two papers that we discussed today are available on CHCF's website. The links were in the chat earlier. Hopefully, those are easy to find. And just a heads up that we are continuing to develop more resources related to CalAIM for seniors and people with disabilities in this series that helps us learn from other similar implementations, either in California or other states, so that we can make the most of these opportunities. We're anticipating releases of a couple of papers over the summer, including one at the end of July, on transitioning Medi-Cal's seniors and people with disabilities to new delivery systems. And at the end of August, focusing on ECM and Community Supports provider networks, which I know came up today a little bit.

So with that, I will thank everyone for their time and hope to hear from you if you have feedback or thoughts on how we can be helpful. Thank you.

- Thank you.