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Targeted Use of Agencies for Personal Care Services

Analysis of a Health Plan's Natural Experiment

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About the Author

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About the Foundation

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Contents

Executive Summary

CalAIM (California Advancing and Innovating Medi-Cal) and other initiatives to advance care for Medi-Cal enrollees present an important opportunity to improve the personal care services that help older adults and people with disabilities remain in their homes and communities. For over a half million Medi-Cal enrollees who need help with activities of daily living, personal care services are essential for health, well-being, and independence. However, ultimately, the effectiveness of these personal care services hinges on an individual's ability to secure and retain a reliable provider — which is difficult for many.

In California, most personal care services are delivered through the In-Home Supportive Services (IHSS) Program. While most IHSS care recipients do successfully hire an independent provider (often a family member or friend), many people who need help at home struggle to find a reliable person to help them.[1]

While the vast majority of IHSS recipients find, hire, and manage their own provider — a core and unique feature of the program's design since its inception — IHSS can also be provided through an agency that employs IHSS providers and connects them to care recipients. This delivery model is known as contract mode IHSS. However, access to contract mode IHSS is very limited, with only one county in California currently offering this option.

This report describes findings from an analysis of the experiences of a small group of high-need, high-cost Medi-Cal enrollees in San Mateo County who were receiving contract mode IHSS but then lost access due to policy changes. In this group, the discontinuation of contract mode IHSS was associated with higher per-member use of institutional long-term care, and more inpatient admissions. These developments translated to higher spending on selected categories of medical services and long-term services and supports.

This small observational study affirms the importance of personal care services and demonstrates how disruptive changes to the provision of that care can be for Medi-Cal enrollees. Medi-Cal stakeholders should thus plan carefully for any changes that impact the provision of personal care services, particularly changes that decrease or limit existing options. Importantly, this study suggests that although contract mode may be a more expensive model for delivering IHSS, in this selected population it may be associated with lower overall costs due to lower utilization of institutional long-term care and lower rates of hospitalization. More broadly, in the context of CalAIM, these findings suggest that agency-mediated personal care services could play an important role as a cost-effective alternative to institutional long-term care. Given these findings and the critical role personal care services play in keeping people in their homes and communities, Medi-Cal stakeholders should consider opportunities and policies to strengthen access to these services, through all modes of delivery, for all consumers who need them.

Introduction

CalAIM (California Advancing and Innovating Medi-Cal) is a far-reaching, multiyear plan to transform California's Medi-Cal program and improve integration with other social services. CalAIM and the state's Master Plan for Aging seek to improve access to services and create a more equitable and integrated system of care for older adults and people with disabilities. Strengthening access to personal care services should be an important priority in the effort to improve care for Medi-Cal enrollees who need long-term services and supports (LTSS). A study in Los Angeles County found that roughly one of every 20 eligible In-Home Supportive Services (IHSS) recipients did not have a provider in January 2013, and eight months later, 17% of these recipients were still without a provider.[2] A

2021 report by the state auditor noted that the number of recipients statewide who lacked care increased from January 2015 through December 2019, from 33,000 to more than 40,000 on average each month.[3] A recent statewide poll found that in the past 12 months, 14% of Californians tried to get home-based support for themselves or a family member. Of those who tried to get home-based support, 35% were unable to do so.[4]

Much is still to be learned about how best to deliver personal care services. This report describes a natural experiment that occurred when an agency-mediated mode of delivering IHSS was eliminated in a particular county, and examines the effects of that change on cost and utilization for selected medical services and long-term services and supports. This information may help inform policies that support and strengthen the availability of various modes of personal care service delivery for Medi-Cal enrollees going forward.

Background

California's flagship personal care services program, IHSS, had an average monthly caseload of more than 586,000 Medi-Cal enrollees in fiscal year (FY) 2021–22, providing in-home assistance with essential activities such as feeding, dressing, bathing, and toileting.[5] (An overview of IHSS is available in the California Health Care Foundation fact sheet *In-Home Supportive Services 101: Opportunities and Challenges Under CalAIM*.)[6] IHSS has enabled many Californians to remain in their homes, rather than in nursing homes, and upholds a commitment to self-direction, which prioritizes participant choice, control, and flexibility.

In addition to supporting the preferences of many older adults and people with disabilities, home-based care is typically less costly than institutional care. In California, where nursing home beds are in short supply in many communities, the availability of in-home care for Medi-Cal enrollees could also create capacity, potentially reducing prolonged inpatient hospital stays due to bottlenecks for post-acute care.[7]

Funding and administration of IHSS in California relies on federal, state, and county government participation, with all three levels of government contributing to program funding.[8] The federal government contributes just over half (54%) of costs. The remaining nonfederal share of IHSS costs is covered by the state and counties, with counties paying for about 10% of IHSS costs in FY 2022–23.[9]

At the state level, the program is administered by the California Department of Social Services and the Department of Health Care Services. At the county level, county human services departments determine consumer eligibility for IHSS and assess service needs. County IHSS public authorities establish a registry of IHSS providers, investigate the qualifications and background of potential providers, establish a referral system to connect providers and consumers, provide training for consumers and providers, and collectively bargain with IHSS workers over wages and benefits.

California's predominant model of IHSS delivery is independent provider mode, in which consumers directly hire and manage their own personal care aides. In contrast, in contract mode services, an agency hires and manages personal care aides. While not commonly used, this model may be helpful in circumstances where consumers are unable to successfully find, hire, and manage their own aides. Contract mode services cost more on an hourly basis and tend to be reserved for those who are unable to navigate independent provider mode. While a number of counties used to offer contract mode, currently only one county (San Francisco) does.[10]

During a recent federal demonstration program, IHSS became the responsibility of managed care plans in seven counties but was later pulled back

and administered once again by the counties.[11] This report examines the cost and utilization associated with enrollees of one Medi-Cal managed care plan who were receiving contract mode IHSS but then lost access to it as a result of this transition. This Medi-Cal plan operates under an arrangement whereby it has responsibility for all Medi-Cal managed care enrollees in the county.

Analysis Methods

Population

This study examines the experiences of Medi-Cal members in San Mateo County who were using contract mode IHSS and who lost access to contract mode services. Specifically, under the Coordinated Care Initiative (CCI), Health Plan of San Mateo (HPSM) (and other Medi-Cal plans in the seven CCI counties) assumed IHSS payment responsibility for its members in 2014. Over the next few years, a small group of HPSM members eligible for IHSS could receive IHSS through an agency (Homebridge).

In HPSM's program, contract mode IHSS could be provided for people unable to self-direct their own personal care aides. These could include people who had cognitive or behavioral health challenges, coupled with a lack of family or social support. A small minority (no more than 5%) of IHSS recipients accessed contract mode. However, starting January 1, 2018, per state policy IHSS services were once again carved out of managed care in CCI counties, with responsibility for the program returned to the counties. At this juncture, in San Mateo County, contract mode IHSS was no longer offered, and members using Homebridge were largely transitioned into independent provider mode IHSS.[12]

The population for this study included people continuously enrolled with HPSM for at least the period from July 2017 through June 2018, who used contract mode IHSS services for at least three months prior to the discontinuation of contract mode services at the end of December 2017.

Who Might Use Contract Mode Services?

David is a 55-year-old man with schizophrenia and severe chronic obstructive lung disease. He can have intense paranoia and is reluctant to let anyone into his home. With contract mode services, the agency care manager helps support David to accept care from the agency's caregivers. All his caregivers have been trained to prompt him to take his medications and to allow basic personal care and some assistance to keep his apartment habitable. Before he had this support from the agency, David was not able to successfully retain his caregivers and had trouble keeping his apartment clean, putting him at risk for losing his housing.

Rosa is an 80-year-old woman who has lived alone for many decades. She has hypertension and congestive heart failure, with impaired mobility after a stroke. She lives in an isolated area without public transportation. Her daughter lives in another state and has been trying to help Rosa find personal care aides, but the small number of daily hours she's been approved for, coupled with long travel distances, makes it challenging for Rosa to find help. Through contract mode services, an agency is able to provide care to Rosa because the same caregiver can also serve other IHSS recipients who live near Rosa on the same day.

Guang is a 72-year-old woman with moderate dementia. She lived with her husband until he died a few years ago, and she is estranged from her adult children. Her dementia has worsened such that she needs prompting and supervision for feeding and bathing, and help with grocery shopping and light housekeeping. Because of her dementia, she is unable to find and manage her own caregivers. Through contract mode services, a home care agency provides caregivers to support her remaining in her home.

The population included three subpopulations:

- People eligible for and enrolled in both Medicare and Medi-Cal (dually eligible enrollees) who received both sets of benefits through HPSM's Cal MediConnect integrated plan
- Dually eligible enrollees who received Medi-Cal benefits through HPSM but Medicare benefits elsewhere
- Medi-Cal–only HPSM members

The initial population included 154 HPSM members. Members were excluded from further analysis if they received services from the Institute on Aging (IOA) after contract mode IHSS was discontinued at the end of December 2017. This exclusion was applied because IOA provides some services that are similar to those provided in contract mode IHSS. Eighteen members were excluded for this reason. Additionally, members with total costs that were greater than two standard deviations above the mean were excluded. This was done to prevent the effect of a small number of very high-cost members from skewing the results. Eleven members were excluded for this reason. The final study population thus included 125 members. (A separate analysis of the entire population showed directionally similar results to those presented here.)

Data Sources

HPSM provided claims data with utilization and cost information for the study population, starting from the study start date (January 1, 2016) or their enrollment into IHSS, whichever was later, until their disenrollment from HPSM, death, or the end of the study period (December 31, 2019). Cost information was based on paid claims and did not include non-claims-based payments or pharmacy rebates. Cost information included paid claims for IHSS, institutional long-term care (LTC), acute inpatient care, post-acute skilled nursing facility (SNF) care, emergency department (ED) services, and pharmacy.

Plan responsibility for claims varied by Medicare and Medi-Cal enrollment status, as detailed in Appendix A, Table A1. The cost analysis components take into account claims fully paid by HPSM, and vary based on Medicare and Medi-Cal enrollment status (Table 1). While plan responsibility for IHSS claims changed over the course of the study, the data source for IHSS claims was consistent, so they are treated in the same way throughout.

Table 1. Service Categories Included in Analysis, for Each Subpopulation Based on Medicare and Medi-Cal Enrollment Status

SERVICE CATEGORY	DUALLY ELIGIBLE ENROLLEES IN CAL MEDICONNECT (BOTH MEDICARE AND MEDI-CAL) WITH HPSM	DUALLY ELIGIBLE ENROLLEES WITH HPSM FOR MEDI-CAL ONLY AND RECEIVING MEDICARE ELSEWHERE	MEDI-CAL–ONLY HPSM MEMBERS
IHSS	✓	✓	✓
Institutional LTC	✓	✓	✓
Acute inpatient	✓		✓
Post-acute SNF	✓		
ED	✓		✓
Pharmacy	✓		✓

Source: Moss Adams data, 2022.
Notes: *ED* is emergency department. *HPSM* is Health Plan of San Mateo. *IHSS* is In-Home Supportive Services. *LTC* is long-term care. *SNF* is skilled nursing facility.

Measures

This study describes health care utilization before and after the discontinuation of contract mode IHSS at the end of 2017. Claims data were used to assess utilization and costs of IHSS, institutional LTC admissions, acute inpatient admissions, post-acute SNF admissions, ED visits, and pharmacy. Costs were based on paid claims and are reported in actual dollars; no adjustments were made for inflation.

Statistical Methods

This was a descriptive study. Cost and utilization data were tabulated for the study population before and after the transition date. Due to the small sample size, no statistical testing was completed.

Results

Characteristics of the Study Population

The study population was 72.8% female and had a mean age of 68.7 years (range: 23 to 101). Most of the population was dually eligible for Medicare and Medi-Cal, with just 21 Medi-Cal–only members. The dually eligible enrollees included 72 people who received both their Medicare and Medi-Cal benefits through HPSM's Cal MediConnect integrated plan, and 32 people who received only their Medi-Cal benefits through HPSM and received Medicare benefits elsewhere (i.e., through fee-for-service Medicare or another Medicare Advantage plan). In circumstances where individuals had a change in enrollment status during the study period, they were assigned to the enrollment status in which they resided the longest during the study period. The number of member-months for each year of the study are shown in Appendix A, Table A2.

Utilization and Spending

Utilization and spending were analyzed by service category (detailed results are provided in Appendix A, Tables A3 through A9). Per-member per-month (PMPM) utilization by service category showed an increase in utilization across all service categories except pharmacy after the discontinuation of contract mode IHSS (Table 2).

Per-member utilization of institutional LTC more than tripled in the year after the discontinuation of contract mode IHSS and was more than five times

Table 2. Per-Member Per-Month Utilization by Service Category

SERVICE CATEGORY UTILIZATION METRICS	YEARS BEFORE DISCONTINUATION OF CONTRACT MODE IHSS		YEARS AFTER DISCONTINUATION OF CONTRACT MODE IHSS		DIRECTION OF CHANGE AFTER DISCONTINUATION OF CONTRACT MODE IHSS
	2016	2017	2018	2019	
IHSS hours PMPM	39	70	82	79	↑
Institutional LTC days per 1,000 member-months	599	468	1,478	2,349	↑↑
Acute inpatient admissions per 1,000 member-months	32	41	54	42	↑
Post-acute SNF days per 1,000 member-months	492	473	663	581	↑
ED visits per 1,000 member-months	155	269	249	278	↑*
Pharmacy scripts PMPM	6.11	6.12	5.81	5.75	↓

Source: Moss Adams analysis, 2022.
Notes: *ED* is emergency department. *IHSS* is In-Home Supportive Services. *LTC* is long-term care. *PMPM* is per-member per-month. *SNF* is skilled nursing facility.
*ED visits in 2018 and 2019 were about the same as ED visits in 2017 but slightly higher when compared with ED visits in 2016 and 2017.

higher in the subsequent year (compared with the year prior to the discontinuation of contract mode). IHSS hours also increased, which may reflect improved access for those who were successful in securing and retaining an IHSS provider. The final year of contract mode IHSS (2017) was marked by significant workforce shortages for the agency providing services, which may have contributed to enrollees not receiving all of the hours they were approved for. In addition, acute inpatient admissions and ED visits increased slightly, and pharmacy prescriptions declined slightly in the years following the discontinuation of contract mode IHSS.

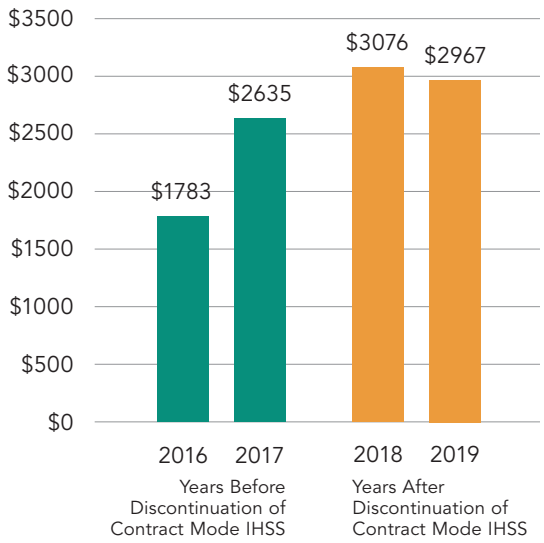
Overall weighted-average PMPM spending increased from $1,783 and $2,635 in 2016 and 2017, respectively, to $3,076 and $2,967 in 2018 and 2019, respectively (Figure 1). This increase was driven by increases in PMPM spending on institutional LTC, post-acute SNF care, and acute inpatient care (spending by service category is shown in Tables A3 through A8 in Appendix A).

To understand the overall observed change in spending, total and PMPM spending were calculated separately for each of the three subpopulations: Cal MediConnect enrollees, dually eligible enrollees receiving only Medi-Cal benefits from HPSM and receiving Medicare elsewhere, and Medi-Cal–only enrollees. The results were calculated separately for each of these groups because information for certain service categories was not available for all of them.

For Cal MediConnect enrollees, where HPSM was responsible for both Medi-Cal and Medicare benefits and costs, total spending and spending on a PMPM basis increased markedly from the 2016–2017 period to the 2018–2019 period.

Total PMPM spending by HPSM declined slightly during the study period for dually eligible individuals enrolled with HPSM for Medi-Cal only (receiving

Figure 1. Overall Weighted-Average PMPM Spending by Year



Source: Moss Adams analysis, 2022.
Note: *PMPM* is per-member per-month.

Medicare elsewhere). For this group, institutional long-term care spending rose substantially after the discontinuation of contract mode IHSS, but this was offset by even larger decreases in IHSS costs.

For Medi-Cal–only enrollees, there was an increase in total and PMPM spending in 2018. Total and PMPM spending declined from 2018 to 2019 but remained above 2017 levels.

The PMPM results are summarized in Table 3 (see next page); results for total spending, as well as detailed results by service category, can be found in Appendix A, Table A9.

Limitations

This study examined the experience of a very small population. Results could be skewed by individuals with extreme patterns of utilization. To address this concern, members with the highest costs were removed from the study population (a separate

Table 3. PMPM Spending by Subpopulation

	YEARS BEFORE DISCONTINUATION OF CONTRACT MODE IHSS		YEARS AFTER DISCONTINUATION OF CONTRACT MODE IHSS	
SUBPOPULATION	2016	2017	2018	2019
Dually eligible enrollees in Cal Medi-Connect (both Medicare and Medi-Cal) with HPSM (*n* = 72)	$1,639	$3,032	$3,480	$3,636
Dually eligible enrollees with HPSM for Medi-Cal only and receiving Medicare elsewhere (*n* = 32)	$2,017	$2,032	$1,965	$1,887
Medi-Cal–only HPSM members (*n* = 21)	$1,941	$2,103	$3,370	$2,283

Source: Moss Adams analysis, 2022.
Notes: *HPSM* is Health Plan of San Mateo. *IHSS* is In-Home Supportive Services. *PMPM* is per-member per-month.

analysis was conducted using the entire population without exclusions, and the results were directionally similar to those presented in this paper). Even within the remaining population, however, there can be large amounts of utilization driven by a small number of members.

This study is observational in nature, and there was no control group. The observed trends that showed increases in spending over the four-year period could thus reflect the increasing needs of a frail population, rather than solely the impact of the discontinuation of contract mode services. The study also did not adjust for medical trends or inflation. Similarly, the observed trends could also be influenced by policy shifts or other factors shaping health care delivery or payment, such as the severity of the flu season of 2017–18.

The analyzed claims in this study varied depending on whether enrollees were dually eligible for Medicare and Medi-Cal, and on whether they were enrolled with HPSM for Medi-Cal only or for both Medicare and Medi-Cal. The study analyzed claims provided by a health plan and thus did not capture spending on services that the health plan was not responsible for. For dually eligible enrollees who were receiving only Medi-Cal benefits from the health plan, the costs of their medical care would largely have been paid for by their Medicare payer, and thus were not captured in this study.

Learnings and Implications

This study describes the utilization and spending for certain medical, pharmacy, and long-term services and supports of a population using IHSS, before and after the discontinuation of contract mode services.

The high utilization and spending associated with the study population confirms that this is a high-need, high-cost population, similar to patterns seen in other studies.[13]

This study adds to prior research that has predominantly compared outcomes related to independent provider mode versus contract mode.[14] This study differs in that it examines the experience of a population specifically identified as benefiting from agency services, who then lost access to those services.

Within a small population, this study demonstrates an increase in overall PMPM spending during the study period, with some variation between subpopulations. There were especially pronounced increases in spending for institutional LTC admissions after the discontinuation of contract mode services. For the study population as a whole, this increase in spending outweighed the reduction in

IHSS costs associated with the transition from contract mode to individual provider mode.

These findings suggest that contract mode is a distinct and noninterchangeable mode of delivery for IHSS. Within the highly selected population identified as benefiting from contract mode IHSS, contract mode was not readily replaced by individual provider mode services. The high utilization and spending after the discontinuation of contract mode services also underscores the vulnerability of this population to disruptions to care delivery, even with careful transition planning.

Implications for Policy and Care Delivery

This small observational study affirms the importance of personal care services and demonstrates how disruptive changes to the provision of that care can be. Policymakers should thus plan carefully for any changes that impact the provision of personal care services, particularly changes that decrease or limit existing options.

Further, this study describes increases in utilization and spending that were temporally associated with the discontinuation of contract mode services. These preliminary findings support the need for deeper examination of not just whether but how to deliver personal care services to a high-need population. This examination should encompass payment, the delivery model, and the scope and quality of services received. Understanding which components of the contract mode model are most valuable could help support replication of those components across the care delivery system.

Ultimately, the effectiveness of IHSS hinges on an individual's ability to secure a reliable, high-quality IHSS provider. There are a variety of policy and programmatic solutions that could support IHSS recipients in finding independent providers, ranging from centralized data systems for locating and contacting potential providers, to changes in roles or payment structures that might attract more care providers to IHSS. The recently established permanent backup provider system is another example of a strategy to support individuals' access to care.[15] In addition, for people who may face more challenges in finding a provider, whether due to the impacts of their illness or disability, or because of their social circumstances, personal care services mediated through an agency appears to provide an important option.

Fragmented policy and payment approaches further complicate efforts to ensure that individuals receive the form of assistance that they need. This is a version of the "wrong pocket problem": Counties contribute to the cost of IHSS but don't reap savings that might accrue to Medicare or Medi-Cal if more robust, but expensive, services are delivered. Thus, counties may not seek out investments in more expensive models of delivery of IHSS like contract mode for specific subpopulations, even if those investments might result in overall, system-wide savings. Medi-Cal managed care plans would benefit from reductions in institutional long-term care spending but don't directly pay for IHSS services, and the state bears only some of the costs of the IHSS program because of federal and county contributions.

Given this fragmentation, policymakers and Medi-Cal stakeholders should support the implementation of strategies to establish clear lines of sight across all entities involved in the payment and delivery of all long-term supports and services, including public authorities, county agencies, health plans, and community partners. The new managed care contract that takes effect in 2024 develops a framework for collaboration, with requirements around care coordination and data sharing across entities in each county. In addition, the Enhanced Care Management benefit creates accountability

for case management across all services for people who are at risk of nursing home placement. In addition to practical supports to foster collaboration, commitment from leaders across these entities will be needed to solve identified challenges and overcome barriers to collaboration.

In addition, the option of Community Supports under CalAIM presents an important opportunity to expand the availability of agency-mediated personal care services, as a complement to and augmentation of existing personal care options. CalAIM's Community Supports are services that Medi-Cal managed care plans may provide in lieu of services traditionally covered by Medicaid. CalAIM currently includes a menu of 14 preapproved Community Supports, including personal care and homemaker services, and caregiver respite. These services are above and beyond any approved county IHSS hours and might be used when additional hours are required and IHSS benefits are exhausted, during an IHSS waiting period, or to help members who are not eligible to receive IHSS avoid a short-term stay in a skilled nursing facility. These services are provided through agencies. However, under Community Supports, contract mode cannot be provided in the way it was used in San Mateo County, as an alternative delivery mode for IHSS for those unable to hire and retain an independent provider. Nonetheless, the relationships established between plans, counties, and service agencies, and the alignment of incentives for plans, could create a platform for broader expansion of contract mode services beyond CalAIM. As of November 2022, 97 plans by county and 53 of the 58 counties in California have elected to offer both the personal care and homemaker services and the caregiver respite Community Supports by January 2024.[16]

Given the observations from this limited study, Medi-Cal stakeholders could also consider where and how targeted use of contract mode personal care services might benefit care recipients who are unable to thrive in independent provider mode IHSS or need a bridge to it. Managed care plans might have an aligned interest in collaborating with counties to provide contract mode services for this subset of the plan's members. This could occur through a financing mechanism in which managed care plans might be allowed to pay the difference between contract mode and independent provider mode, in order to offer contract mode to certain specific populations.

Ultimately, personal care services are, at their core, intensely personal. While independent provider services are understandably the preferred and

POLICY OPPORTUNITIES

To improve access to and delivery of personal care services to Medi-Cal enrollees, stakeholders should consider taking the following actions:

- Examine current challenges and support opportunities to strengthen the ability of IHSS recipients to identify and secure providers under independent provider mode.
- Support research into how best to pay for and deliver personal care services, including how to identify the delivery mode that works best for each consumer.
- At the county level, support efforts to ensure clear lines of sight across all entities involved in the care of people with complex and overlapping medical, behavioral health, LTSS, and health-related social needs.
- Monitor and learn from the use of agency services in CalAIM Community Supports, and support relationship building between plans and agencies.
- Explore policies to allow plans to collaborate with IHSS public authorities to offer contract mode IHSS for certain beneficiaries.

predominant model for most personal care recipients, a one-size-fits-all approach can leave behind those who have difficulty managing their own care. Figuring out how to get people the personal care services they need — such as by strengthening the systems supporting independent provider mode IHSS, increasing the availability of contract mode IHSS, and augmenting IHSS with the Community Supports personal care services in CalAIM — will be essential to help the growing aging population in California thrive in their homes and communities.

Appendix A. Additional Data

Plan Responsibility for Claims

This study analyzed claims data provided by Health Plan of San Mateo (HPSM) for the study population. Utilization and cost information was obtained from paid claims for In-Home Supportive Services (IHSS), institutional long-term care (LTC), acute inpatient care, post-acute skilled nursing facility (SNF) care, emergency department (ED) services, and pharmacy. Plan responsibility for claims in each of these service categories varied by Medicare and Medi-Cal enrollment status, as shown below in Table A1.

Table A1. Plan Responsibility for Claims by Service Category, for Each Subpopulation Based on Medicare and Medi-Cal Enrollment Status (*N* = 125)

SERVICE CATEGORY	DUALLY ELIGIBLE ENROLLEES IN CAL MEDICONNECT (BOTH MEDICARE AND MEDI-CAL) WITH HPSM (*N* = 72)	DUALLY ELIGIBLE ENROLLEES WITH HPSM FOR MEDI-CAL ONLY AND RECEIVING MEDICARE ELSEWHERE (*N* = 32)	MEDI-CAL–ONLY HPSM MEMBERS (*N* = 21)
IHSS	Yes	Yes	Yes
Institutional LTC	Yes	Yes	Yes
Acute inpatient	Yes	Partial: only crossover claims* that are not consistently submitted	Yes
Post-acute SNF	Yes	Partial: only crossover claims that are not consistently submitted	No: There is no distinction in Medi-Cal between short-term skilled and long- term custodial care in a skilled nursing facility; thus, this category does not apply.
ED	Yes	Partial: only crossover claims that are not consistently submitted	Yes
Pharmacy	Yes	Partial: includes claims for Medicaid-covered drugs, with crossover claims for Medicare-covered drugs	Yes

Source: Moss Adams data, 2022.
Notes: In circumstances where members had a change in enrollment status during the study period, they were assigned to the enrollment status in which they resided the longest during the study period. *ED* is emergency department. *HPSM* is Health Plan of San Mateo. *IHSS* is In-Home Supportive Services. *LTC* is long-term care. *SNF* is skilled nursing facility.
*"Crossover claims" are claims for a member who is eligible for both Medicare and Medi-Cal, where Medicare pays a portion of the claim and Medi-Cal is billed for any remaining deductible and/or coinsurance.

Member Months by Subpopulation

The study population included three subpopulations: (1) people eligible for and enrolled in both Medicare and Medi-Cal (dually eligible enrollees) who received both sets of benefits through HPSM, (2) dually eligible enrollees who received Medi-Cal benefits through HPSM but Medicare benefits elsewhere, and (3) Medi-Cal–only HPSM members. Table A2 shows the number of people in each subpopulation, as well as the corresponding number of member-months associated with each subpopulation in each study year. In circumstances where individuals had a change in enrollment status during the study period, they were assigned to the enrollment status in which they resided the longest during the study period.

Table A2. Member-Months Included in Analysis, by Subpopulation and Study Year (*N* = 125)

	YEARS BEFORE DISCONTINUATION OF CONTRACT MODE IHSS		YEARS AFTER DISCONTINUATION OF CONTRACT MODE IHSS	
SUBPOPULATION	2016	2017	2018	2019
Dually eligible enrollees in Cal MediConnect (both Medicare and Medi-Cal) with HPSM (*n* = 72)	794	862	857	743
Dually eligible enrollees with HPSM for Medi-Cal only and receiving Medicare elsewhere (*n* = 32)	347	372	372	323
Medi-Cal–only HPSM members (*n* = 21)	212	222	227	216
Total, all subpopulations (N = 125)	**1,353**	**1,456**	**1,456**	**1,282**

Source: Moss Adams analysis, 2022.
Notes: *HPSM* is Health Plan of San Mateo. *IHSS* is In-Home Supportive Services.

Observed Utilization and Spending for Long-Term Services and Supports (In-Home Supportive Services and Institutional Long-Term Care)

In-Home Supportive Services (IHSS) Utilization and Spending

Utilization of in-home supports and services, as measured by IHSS hours received per member per month, increased during the study period. However, the expenses associated with IHSS decreased after 2017, likely due to the lower payment rates associated with independent provider mode relative to contract mode (Table A3).

Table A3. In-Home Supportive Services Utilization and Spending (*N* = 125)

	YEARS BEFORE DISCONTINUATION OF CONTRACT MODE IHSS		YEARS AFTER DISCONTINUATION OF CONTRACT MODE IHSS	
IHSS UTILIZATION AND SPENDING METRICS	2016	2017	2018	2019
Total number of hours	53,003	101,513	118,909	100,963
Number of hours PMPM	39	70	82	79
Total spending	$1,142,888	$2,264,401	$1,801,132	$1,602,533
Spending PMPM	$845	$1,555	$1,237	$1,250

Source: Moss Adams analysis, 2022.
Notes: *IHSS* is In-Home Supportive Services. *PMPM* is per member per month.

Institutional Long-Term Care (LTC) Utilization and Spending

The study population had high and increasing utilization of institutional long-term care during the study period. LTC admissions increased from 15 in 2016 to 37 in 2019. The total number of institutional LTC days dramatically increased after the transition to independent provider mode: from 810 in 2016 and 682 in 2017, to 2,152 in 2018 and 3,012 in 2019. The increase in utilization was accompanied by an even larger increase in expenditures on an absolute and per-member per-month basis, with total spending increasing from $57,595 in 2016 to $726,894 in 2019. This reflects an increase in per-member per-month costs from $43 and $56 in 2016 and 2017, respectively, to $316 and $567 in 2018 and 2019, respectively (Table A4).

Table A4. Institutional Long-Term Care Utilization and Spending (*N* = 125)

INSTITUTIONAL LTC UTILIZATION AND SPENDING METRICS	YEARS BEFORE DISCONTINUATION OF CONTRACT MODE IHSS		YEARS AFTER DISCONTINUATION OF CONTRACT MODE IHSS	
	2016	2017	2018	2019
Total number of admissions	15	25	31	37
Number of admissions per 1,000 member-months	11	17	21	29
Total number of days	810	682	2,152	3,012
Number of days per 1,000 member-months	599	468	1,478	2,349
Total spending	$57,595	$81,686	$460,182	$726,894
Spending PMPM	$43	$56	$316	$567

Source: Moss Adams analysis, 2022.
Notes: *IHSS* is In-Home Supportive Services. *LTC* is long-term care. *PMPM* is per member per month.

Observed Utilization and Spending for Medical Services (Acute Inpatient, Post-Acute Skilled Nursing Facility, Emergency Department, and Pharmacy)

Acute Inpatient Utilization and Spending

Utilization and spending for acute inpatient care were assessed in the combined Cal MediConnect and Medi-Cal–only subpopulations. Dually eligible enrollees receiving Medicare elsewhere were not included in this assessment, because HPSM claims for acute inpatient admissions for this population include only crossover claims, which are not consistently submitted.

The number of acute inpatient admissions per member per month was higher in the 2018–2019 period than in the preceding two years. Spending associated with these admissions was also higher on a per-member per-month basis in 2018–2019 than in 2016–2017, rising from $447 and $626 in 2016 and 2017, respectively, to $1,187 and $743 in 2018 and 2019, respectively (Table A5).

Table A5. Acute Inpatient Utilization and Spending, Cal MediConnect and Medi-Cal–Only Enrollees (*n* = 93)

ACUTE INPATIENT UTILIZATION AND SPENDING METRICS	YEARS BEFORE DISCONTINUATION OF CONTRACT MODE IHSS		YEARS AFTER DISCONTINUATION OF CONTRACT MODE IHSS	
	2016	2017	2018	2019
Total number of admissions	32	44	58	40
Number of admissions per 1,000 member-months	32	41	54	42
Total spending	$450,027	$678,642	$1,286,832	$712,378
Spending PMPM	$447	$626	$1,187	$743

Source: Moss Adams analysis, 2022.
Notes: *IHSS* is In-Home Supportive Services. *PMPM* is per member per month.

Post-Acute Skilled Nursing Facility (SNF) Utilization and Spending

Trends in utilization of and spending on post-acute SNF care were assessed only for the Cal MediConnect population, as post-acute SNF is not categorized separately in Medi-Cal, and HPSM claims for SNF for dually eligible individuals enrolled with HPSM for Medi-Cal only would consist only of crossover claims, which are inconsistently submitted.

In the Cal MediConnect population, there was an upward trend in post-acute SNF utilization across the four-year period, with an increase in post-acute SNF admission days from 492 and 473 per 1,000 member-months in 2016 and 2017, respectively, to 663 and 581 per 1,000 member-months in 2018 and 2019, respectively. Per-member per-month spending on post-acute SNF care also trended upward during the study period, from $272 and $256 before the transition, to $415 and $337 after (Table A6).

Table A6. Post-Acute Skilled Nursing Facility Utilization and Spending, Cal MediConnect Enrollees (*n* = 72)

POST-ACUTE SNF UTILIZATION AND SPENDING METRICS	YEARS BEFORE DISCONTINUATION OF CONTRACT MODE IHSS		YEARS AFTER DISCONTINUATION OF CONTRACT MODE IHSS	
	2016	2017	2018	2019
Total number of admissions	15	21	24	19
Number of admissions per 1,000 member-months	19	24	28	26
Total number of days	391	408	568	432
Number of days per 1,000 member-months	492	473	663	581
Total spending	$215,598	$220,291	$355,281	$250,578
Spending PMPM	$272	$256	$415	$337

Source: Moss Adams analysis, 2022.
Notes: *IHSS* is In-Home Supportive Services. *PMPM* is per member per month. *SNF* is skilled nursing facility.

Emergency Department Utilization and Spending

Data for ED utilization and spending were examined for the Cal MediConnect and Medi-Cal–only populations. The population of dually eligible members enrolled with HPSM for Medi-Cal but receiving Medicare elsewhere was not included in this assessment, because HPSM claims for ED services would reflect only crossover claims, which are not consistently submitted.

ED visits and spending on a PMPM basis trended higher from the 2016–2017 period to the 2018–2019 period. However, utilization and spending were particularly high in 2017, which was the year with the highest number of total ED visits as well as the highest total ED spending (Table A7).

Table A7. Emergency Department Utilization and Spending, Cal MediConnect and Medi-Cal–Only Enrollees (*n* = 93)

	YEARS BEFORE DISCONTINUATION OF CONTRACT MODE IHSS		YEARS AFTER DISCONTINUATION OF CONTRACT MODE IHSS	
ED UTILIZATION AND SPENDING METRICS	2016	2017	2018	2019
Total number of visits	156	292	270	267
Number of visits per 1,000 member-months	155	269	249	278
Total spending	$18,625	$37,584	$34,073	$37,306
Spending PMPM	$19	$35	$31	$39

Source: Moss Adams analysis, 2022.
Notes: *ED* is emergency department. *IHSS* is In-Home Supportive Services. *PMPM* is per member per month.

Pharmacy Utilization and Spending

Data for pharmacy utilization and spending were examined for the Cal MediConnect and Medi-Cal–only populations. The population of dually eligible individuals enrolled with HPSM for Medi-Cal and receiving Medicare elsewhere was not included in this assessment, because HPSM claims for this category of service consist of crossover claims, which are not consistently submitted.

Pharmacy utilization, as measured by the number of filled prescriptions per member per month, declined after the end of contract mode, from 6.11 in 2016 to 5.75 in 2019. Pharmacy spending per member per month also declined over this period, from $525 in 2016 to $495 in 2019 (Table A8).

Table A8. Pharmacy Utilization and Spending, Cal MediConnect and Medi-Cal–Only Enrollees (*n* = 93)

	YEARS BEFORE DISCONTINUATION OF CONTRACT MODE IHSS		YEARS AFTER DISCONTINUATION OF CONTRACT MODE IHSS	
PHARMACY UTILIZATION AND SPENDING METRICS	2016	2017	2018	2019
Total number of scripts	6,147	6,629	6,302	5,512
Number of scripts PMPM	6.11	6.12	5.81	5.75
Total spending	$527,952	$553,672	$540,999	$474,582
Spending PMPM	$525	$511	$499	$495

Source: Moss Adams analysis, 2022.
Notes: *IHSS* is In-Home Supportive Services. *PMPM* is per member per month.

Summary of Total and Per Member Per Month (PMPM) Spending by Subpopulation and Service Category

Total and PMPM spending were calculated separately for each of the three subpopulations: dually eligible enrollees in Cal MediConnect (both Medicare and Medi-Cal) with HPSM, dually eligible enrollees receiving only Medi-Cal benefits from HPSM and receiving Medicare elsewhere, and Medi-Cal–only HPSM members. For each subpopulation, total and PMPM spending for each service category are shown in Table A9.

Table A9. Total and PMPM Spending by Subpopulation and Service Category (*N* = 125)

	YEARS BEFORE DISCONTINUATION OF CONTRACT MODE IHSS				YEARS AFTER DISCONTINUATION OF CONTRACT MODE IHSS			
	2016		2017		2018		2019	
SUBPOPULATIONS AND SERVICE CATEGORIES	Total	PMPM	Total	PMPM	Total	PMPM	Total	PMPM
DUALLY ELIGIBLE ENROLLEES IN CAL MEDICONNECT (BOTH MEDICARE AND MEDI-CAL) WITH HPSM (*N* = 72)								
IHSS	$169,502	$213	$1,233,590	$1,431	$990,189	$1,155	$878,807	$1,183
Institutional LTC	$39,321	$50	$29,419	$34	$207,463	$242	$474,463	$639
Acute inpatient	$420,314	$529	$644,395	$748	$974,843	$1,138	$673,541	$907
Post-acute SNF	$215,598	$272	$220,291	$256	$355,281	$415	$250,578	$337
ED	$10,786	$14	$17,319	$20	$13,697	$16	$14,918	$20
Pharmacy	$445,700	$561	$468,366	$543	$441,181	$515	$409,483	$551
Totals for this subpopulation	**$1,301,221**	**$1,639**	**$2,613,380**	**$3,032**	**$2,982,654**	**$3,480**	**$2,701,790**	**$3,636**
DUALLY ELIGIBLE ENROLLEES WITH HPSM FOR MEDI-CAL ONLY AND RECEIVING MEDICARE ELSEWHERE (N = 32)								
IHSS	$681,650	$1,964	$703,821	$1,892	$519,466	$1,396	$431,437	$1,336
Institutional LTC	$18,274	$53	$52,267	$141	$211,352	$568	$177,968	$551
Totals for this subpopulation	**$699,924**	**$2,017**	**$756,088**	**$2,032**	**$730,818**	**$1,965**	**$609,405**	**$1,887**
MEDI-CAL–ONLY HPSM MEMBERS (N = 21)								
IHSS	$291,736	$1,376	$326,991	$1,473	$291,477	$1,284	$292,289	$1,353
Institutional LTC	$0	$0	$0	$0	$41,367	$182	$74,463	$345
Acute inpatient	$29,713	$140	$34,247	$154	$311,989	$1,374	$38,837	$180
ED	$7,839	$37	$20,265	$91	$20,376	$90	$22,388	$104
Pharmacy	$82,252	$388	$85,306	$384	$99,818	$440	$65,099	$301
Totals for this subpopulation	**$411,540**	**$1,941**	**$466,809**	**$2,103**	**$765,027**	**$3,370**	**$493,076**	**$2,283**

Source: Moss Adams analysis, 2022.
Notes: The totals for PMPM dollar amounts may not add up exactly due to rounding. *ED* is emergency department. *HPSM* is Health Plan of San Mateo. *IHSS* is In-Home Supportive Services. *LTC* is long-term care. *PMPM* is per member per month. *SNF* is skilled nursing facility.

Endnotes

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5. *2023-24 Governor's Budget: Caseload Projections* (PDF), California Department of Social Services, accessed April 3, 2023.
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11. "2017-18 Budget: The Coordinated Care Initiative: A Critical Juncture," Legislative Analyst's Office, February 27, 2017.
12. A small group of individuals enrolled in a pilot program run by the Institute on Aging continued to receive agency personal care services. As described later in this section, they were excluded from the final study population.
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16. *CalAIM Community Supports Spotlight: Personal Care and Homemaker Services and Respite Services* (PDF), California Department of Health Care Services, November 3, 2022.