CHCF PERSPECTIVES FROM THE FIELD

CalAIM Community Supports Early Adopters
Spotlight on Nursing Home Transitions and Diversion

CalAIM (California Advancing and Innovating Medi-Cal) enables managed care plans to offer 14 Community Supports — services not traditionally covered by Medi-Cal that address health-related social needs. Some, like housing transition navigation services, housing tenancy and sustaining services, and medically tailored meals, have been readily adopted by participating health plans since the launch of Community Supports in 2022, while others have gotten off to a slower start. In this fact sheet we profile two of these services with relatively low adoption, both related to helping people live in the community, outside of nursing homes: **Nursing Facility Transition/Diversion to Assisted Living Facilities** and **Community Transition Services/Nursing Facility Transition to a Home.**

Nursing Facility Transition/Diversion to Assisted Living Facilities

Nursing Facility Transition/Diversion services help people move from a nursing home to community-based assisted living settings or avoid a nursing home altogether and move from their home to an assisted living setting. These supportive services include managing the transition itself (i.e., finding the right assisted living community, managing paperwork) as well as providing ongoing assistance with daily living activities (e.g., bathing, dressing, shopping and meal preparation, and managing medications) from a caregiver in an assisted living setting.

Assisted living is different from a nursing home in that it is a home-like environment not typically staffed by licensed health care professionals, although some facilities opt to include a licensed nurse for oversight or to care for patients with higher-acuity needs. Many assisted living communities are houses with six or fewer beds that operate as family businesses and are licensed as residential care facilities for the elderly (RCFE) or adult residential facilities (ARF). In addition to offering social connections and some recreational programming, assisted living communities have on-site caregivers who help residents with activities like dressing, bathing, remembering to take medications, and preparing meals.

Community Transition Services/Nursing Facility Transition to a Home

By contrast, Community Transition Services provide support for people to move from a nursing facility to a home and cover one-time expenses for setting up a household. Ongoing expenses are not covered, and one-time expenses are subject to a lifetime maximum of $7,500. Of note, many of the covered services are similar to those offered through the Housing Transition Navigation Services Community Support (PDF).

Community Transition Services does not cover adjustments to existing housing so that the place of residence can accommodate a person with mobility or cognitive limitations. Instead, a separate Community Support Home Modifications (PDF) can be used to make accommodations such as the installation of grab bars in a shower. Connections to other services, such as adult day health care (known

as the Community Based Adult Services, or CBAS, benefit under Medi-Cal) and In-Home Supportive Services, may also be required to help support the person in their home.

Why does the Medi-Cal managed care plan offer these services?

In 2014, well before CalAIM, Health Plan of San Mateo (HPSM) became the first health plan to pilot these services. At the time, one of the largest nursing homes in San Mateo County was about to close, which would have created a large gap in the plan's network. The plan found that 10% to 30% of its nursing home residents could move into the community if they had appropriate support. HPSM issued a request for proposals to community-based organizations (CBOs), and Institute on Aging (IOA) joined as a partner. The pilot demonstrated not only that it was possible to move people back into the community, but also that this type of coordinated, integrated care improved enrollees' lives and ultimately reduced health care costs.

The material in this fact sheet is based on a webinar hosted by the California Improvement Network on January 25, 2024, with support from the California Health Care Foundation. It has been supplemented by follow-up interviews to provide more detail on the services themselves.

Goal of the services

The goal of the two Community Supports described in this paper is to help people who might otherwise be in a nursing home live safely in a non-institutional community setting. In most cases, these supports will be delivered alongside Enhanced Care Management (ECM), a Medi-Cal benefit providing comprehensive care management to enrollees with complex needs, for two populations of focus: adults living in the community who are at risk for long-term care institutionalization and adult nursing facility residents who are transitioning to the community.

Who is eligible.

The two Community Supports have slightly different eligibility criteria based on where people are transitioning from and what setting they are transitioning to:

COMMUNITY SUPPORT	CURRENT SETTING	DESIRED SETTING
Nursing Facility Transition to Assisted Living	Nursing facility for at least 60 days	Assisted living
Nursing Facility Diversion to Assisted Living	Community	Assisted living
Community Transition Services/Nursing Facility Transition to Home	Nursing facility for at least 60 days or medical respite facility	Home

To access these Community Supports, a member must be able to live safely outside a nursing home with appropriate and cost-effective support and yet also meet criteria for nursing home level of care.

What the services include.

IOA's implementation of these Community Supports includes, but is not limited to, the following:

- Assessing a person's health and service needs (e.g., medical needs; needs pertaining to activities of daily living and instrumental activities of daily living; and social needs, including housing) and presenting options
- Coordinating and securing non-emergency, non-medical transportation to assess housing options prior to transition
- Developing a community living plan that takes into consideration the person's goals and desires
- Assisting in securing a community-based residence, either in an assisted living facility (also known as a residential care facility for the elderly or adult residential facility) or in an apartment
- Identifying the need and coordinating funding for environmental modifications and the installation of necessary accessibility accommodations

- Coordinating the move
- Establishing processes and contacts to retain housing and services (e.g., a contract with assisted living operator to provide ongoing services, personal care services provided as a bridge to IHSS)

For the full definitions of all Community Supports, please review the DHCS Community Supports Policy Guide.

Transitions typically take four to six months, but ongoing services in an assisted living facility may last as long as a patient is able to safely reside in the community. While the monthly cost of these wraparound services may seem high, it is typically significantly less than the monthly cost of care in a nursing home. In some cases, a person may be able enroll in the Assisted Living Waiver program to cover their ongoing wraparound costs.

How people get into care.

In San Mateo County, most referrals come from nursing homes, though some also come from community-based providers, hospitals, or members themselves. HPSM requires authorization for the services. The plan then pays an initial per-engaged member per-month rate for the transition and the first eight months of services followed by a lower per-engaged member per-month rate for ongoing services starting in month nine.

How these Community Supports fit into the continuum of care.

HPSM typically enrolls patients in ECM services first. If a patient is in a nursing home, an ECM provider helps determine whether the person can safely leave their current facility. After that, the patient is enrolled in Community Supports to help with the transition. In most cases, the health plan expects people to graduate over time from ECM to a lower tier of services. Scribner estimates that 70% of the time, the patient moves over to a Community Supports provider for continued support without ECM.

Key takeaways for others implementing the service:

- **Partner with nursing homes.** HPSM relies on facility staff to identify people who have expressed an interest in leaving the nursing home. Nursing home employees then determine who might be available for a specific service. "We get those lists either weekly or biweekly, and we put them in as 'eligible' in our system," Scribner said
- **Use capacity-building funding as a bridge to case-based payment.** Most CBOs are reluctant to build out their capacity until they are assured funding is in place, meaning they want to know that a caseload will be filled before hiring a care manager. But under CalAIM, HPSM pays a per-engaged member per-month fee. Relative to a grant that pays the full cost of the staff member, this pushes risk for filling that caseload to the provider.

  Since small CBOs usually lack the resources to handle these risks and need predictable volume to stay afloat, they need to know that health plans will allow for financial flexibility and designate funding for capacity building. "We just put in the dollars to start, to incentivize capacity building and outcomes," said Scribner, explaining that HPSM gave IOA a lump-sum in advance to help create the services and later backfilled with Incentive Payment Program dollars to continue to build capacity. IOA also received funds through the PATH-CITED program for this purpose.
- **Share communication with other stakeholders.** It is important to have a consistent and shared voice when communicating how stakeholders can navigate these changes. Many IOA referrals come from nursing homes, which needed to be educated on the changes in authorization and processes coming through CalAIM. Having a common voice from the health plan and the CBO reiterated the sense of partnership and avoided finger pointing when things did not go as planned.

Advice for Other Organizations:

Build a Network of Community Supports Providers:

"For community-based organizations that want to work with us, we created a request for information document to find out who was already providing similar services and how ready they are to partner and go live. How much support would they require as a Community Supports provider? It's a matter of building capability. The CBOs who already had the capability, we partnered with them first. The ones who need a little bit more support along the way, we established a partnership, helped to build infrastructure, and then added them to the network."

— Amy Scribner, Health Plan of San Mateo

"The first seven years of the partnership with the Health Plan of San Mateo was about developing and fine-tuning a model of care, developing best practices, and evaluating total cost of care. Could we demonstrate, by increasing home & community-based service capacity, that we could both enable people to live longer in their preferred settings and generate cost savings for the Medi-Cal system?"

— Dustin Harper, Institute on Aging

Organizations Profiled

Health Plan of San Mateo (HPSM) is a community-based health plan serving 155,000 people — one in five residents — in San Mateo County. HPSM launched Nursing Home Transition/Diversion and Community Transition Services/Nursing Facility Transition to a Home in 2022. Since then, 368 people have used them.

Institute on Aging (IOA) is a San Francisco community-based organization that serves the needs of older adults and disabled adults throughout California. It develops innovative programs intended to help clients live at home as long as possible. Fourteen-hundred people have participated in similar IOA programs throughout the Bay Area. IOA Plans to launch programs in other parts of the state by the end of 2024.

About the Perspectives from the Field Series

As California's Department of Health Care Services administers changes to the Medi-Cal program, especially those that are part of the CalAIM initiative, CHCF is intermittently publishing short reports that highlight the perspectives of those in the field who are implementing the changes. These "Perspectives from the Field" seek to inform policymakers and other health care leaders about insights and experiences from people on the ground who work directly with patients.

About the Author

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About the Foundation

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

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.