Research Brief

The Impact of Cal MediConnect on Transitions from Institutional to Community-Based Settings

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EXECUTIVE SUMMARY

In 2014 California implemented a Dual Alignment Demonstration called the Coordinated Care Initiative (CCI).[1] One part of this demonstration integrated Medicare and Medicaid benefits through a capitated managed care system. In California, Medicaid (Medi-Cal) managed care health plans in seven demonstration counties created a new product called "Cal MediConnect" (CMC).[2] Dually eligible beneficiaries in those counties were passively enrolled into CMC plans, with the option to "opt out." Those who were enrolled received all Medicare and Medi-Cal benefits, including medical services and managed long-term services and supports (LTSS) through one health plan. One goal of the program was to decrease expenditures through incentives to redirect care away from institutional settings and toward more home- and community-based services (HCBS).

Researchers from University of California have conducted an evaluation of the impact of the CMC program on beneficiaries and health systems.[3] The following research brief includes results from an in-depth examination of the efforts of CMC plans to redirect care away from institutions and into home- and community-based settings.

Data collected for this research brief built on Phase One results and included 16 additional interviews with stakeholders, including CMC health plans, long-term care (LTC) facilities, and community-based HCBS agencies that serve dually eligible beneficiaries.

Findings fall into five broad categories, including:

1) Successful strategies for LTC facility transitions
2) Communication efforts among CMC health plans
3) Cost savings
4) Housing
5) Person-centered planning

Key findings are:

- **Many CMC health plans have created specific programs to facilitate transitions for their members out of LTC facilities into lower levels of care or community-based settings.** Programs created by CMC health plans vary. Some models leverage collaborations with HCBS agencies (many of whom are lead organizations in the California Community Transitions Program[11]), while other models focus more on developing internal capacity for transitions within the CMC plans' care coordination program. These programs have been successful in transitioning members to lower levels of care who may not have otherwise been able to leave the institution.

- **Financial incentives for CMC plans to transition members out of LTC facilities are working.** Most plans reported that efforts to transition members to lower levels of care or community settings are saving money. But they also reported that the cost calculations are not simple and must include ongoing consideration of re-admissions and hospitalizations over time. Some financial disincentives remain, especially when CMC members move to residential care or assisted living after discharge.

- **Increased communication and collaboration among CMC health plans, LTC facilities, and HCBS agencies has been a key factor in promoting LTC transitions**. Health plans, LTC facilities, and HCBS agencies all reported efforts to promote communication and collaboration across organizations, including: collaborative meetings, site visits, and conference calls throughout the implementation of the CMC program.

- **Challenges and barriers remain.** Many HCBS agencies that work with dually eligible beneficiaries are still frustrated by the lack of collaboration around mutual clients, especially agencies that do not have contracts with CMC health plans. Both HCBS agencies and plans report that it is challenging for CMC health plans to maintain awareness of all of the HCBS resources in the county, and that CMC health plans still have much to learn about providing LTSS. Finally, LTC facilities, CMC plans, and beneficiaries themselves often have biases or disincentives that prevent them from considering transitioning to the community as a viable option.

- **Housing for beneficiaries after transition is a major barrier.** The cost of housing, the lack of affordable housing, and challenges in paying for assisted living all contribute to the challenge in locating and supporting beneficiaries in community-based settings.

Six recommendations were drawn from these results and are discussed more fully in the report. Recommendations are:

1. State and local partners should continue to invest in education, outreach, and communication to support transitions out of institutions and into the community.
2. CMC health plans should use a variety of methods to identify beneficiaries for LTC facility transitions, including long-term care ombudsmen and care teams.
3. HCBS providers should take advantage of business acumen training to build effective working relationships with CMC health plans.
4. Promote strategies to increase the availability of affordable housing options to enable successful transitions into the community.
5. Policy changes are needed to increase incentives for CMC plans to discharge LTC residents to community-based settings.
6. The state should promote person-centered planning to motivate beneficiary engagement in LTC transition planning.

INTRODUCTION

In 2014 California became one of 13 states to implement a Financial Alignment Demonstration called the Coordinated Care Initiative (CCI).[1] One part of this demonstration integrated Medicare and Medicaid benefits through a capitated managed care system. In California, Medicaid (Medi-Cal) managed care health plans in seven demonstration counties created a new product called "Cal MediConnect" (CMC).[2] Dually eligible beneficiaries in those counties were passively enrolled into CMC plans, with the option to "opt out." Those who were enrolled received all Medicare and Medi-Cal benefits, including medical services and managed long-term services and supports (LTSS), through one health plan. CMC plans were also required to provide care coordination services and coordinate behavioral health care.[4] Beneficiaries who opted out of the program still received Medi-Cal and LTSS through a Medi-Cal managed care health plan, but kept their fee for service (FFS) Medicare, with access to those providers.

An abundance of research has shown that Medicaid-covered institutional care is more costly than providing home and community-based services (HCBS).[5-7] Furthermore, most people prefer to continue living in their homes and neighborhoods, rather than in institutions.[8] The CCI addressed this by structuring "managed" LTSS benefits so that the CMC health plans became financially responsible for LTSS, including both institutional care and less costly HCBS. Because CMC health plans were paid a "blended rate" for all members in both settings, this created an incentive for these health plans to move as many members as possible out of institutional care and into community-based settings.

A previous report from Phase One of this evaluation released in July 2016 examined the early impacts that CMC had on various health system stakeholders,[9] including long-term care (LTC) facilities and CMC plans, in the first 18 months of program implementation. In those early interviews CMC health plans noted the strong incentives to transition members out of institutions and into home and community-based settings, but also identified challenges related to the complexities of negotiating new contracts with LTC facilities and HCBS agencies, as well as the lack of affordable housing options for beneficiaries leaving LTC facilities. During the Phase One interviews, many plans also described new programs to promote LTC transitions that were in the planning or early implementation stages. Some plans had identified high utilizers for more intensive care coordination, to help prevent LTC facility placement. Other health plans also discussed the expanded role of various health professionals, including hospitalists, nurses, care managers, and specially trained "care transitions" care coordinators to help address care transitions or identify beneficiaries for less-costly community placement.

As part of the University of California's three-year evaluation of the CMC program, this research brief examines the efforts of CMC health plans to identify and transition members from LTC institutions to home and community-based settings. Findings describe the progress many CMC plans have made in accelerating transitions out of institutional care, including successful strategies and challenges encountered in the process, as well as the barriers that still remain.

METHODS

Data collected for this research brief included 16 interviews with stakeholders from CMC health plans, LTC facilities, and community-based agencies providing HCBS to help facilitate transitions out of LTC facilities for dually eligible beneficiaries. In addition, several interviews were conducted and follow-up documentation was gathered to develop two case studies describing CMC health plan transition programs.

Online survey with CMC health plans: In January 2017 CMC health plans were emailed a survey asking targeted questions about how they work with HCBS agencies and LTC facilities to facilitate transitions from institutional to community-based care. CMC health plans were asked to describe 1) any specific LTC transition or diversion programs they may have implemented, 2) existing collaborations with HCBS agencies and LTC facilities to facilitate transitions, and 3) the greatest challenges or barriers they continue to face in this area. Six of 11 CMC health plans in four of the CCI counties completed the survey. Subsequent email and telephone follow-up interviews were conducted with selected plans to clarify responses.

Telephone interviews with key informants: Between the fall of 2016 and winter of 2017 researchers conducted 10 in-depth telephone interviews with key informants from all seven CCI counties. Individuals represented independent living centers (ILCs), LTC facilities, county agencies, health services providers, senior service agencies, and other HCBS agencies that provided services and LTC transition support to dually eligible beneficiaries in CCI counties. Interviews were conducted with various individuals within the organizations who had firsthand knowledge of and experience with facilitating LTC transitions, especially those who had worked with CMC enrollees. Interviews were transcribed and content analysis was conducted. Key themes emerged and are summarized below.

FINDINGS

The CMC health plans, LTC facilities, and HCBS agencies were asked to describe successful strategies for promoting transitions to community-based settings for institutionalized beneficiaries.

Successful Strategies for Promoting LTC Facility Transitions in Cal MediConnect

Creating specific programs to facilitate LTC transitions: As CMC health plans have taken responsibility for LTSS for their members, many have focused on promoting transitions from LTC institutional settings to lower cost community-based care. All of the CMC health plans that responded to the survey reported that they had engaged in specific efforts to transition or divert beneficiaries from institutional to community-based care, with four creating specific transitional care programs. Some were unique pilot programs that focused on creating collaborations with outside HCBS networks (see Case Study 1), whereas others were programs that developed internal capacity for transitional care (see Case Study 2). Three of the CMC plans were able to estimate the number of members for whom they had facilitated transitions since the implementation of CMC. One had transitioned 10 members, another transitioned 80 members, while another transitioned 144.

Some HCBS agencies reported that having CMC health plans responsible for both medical and LTSS has helped to improve the continuity of care for dual beneficiaries moving from institutional to community-based settings. This was primarily because it was now clear that the CMC health plan was the one entity responsible for all care.

> *"I remember before Cal MediConnect, where there was a lot of confusion where people were dual eligible, and who was going to pay what and where they were supposed to go and whether they were supposed to have co-pays or not. I think a lot of that has gone away. I know that when I used to work with clients that were Medi/Medi, they were oftentimes feeling stuck and confused between the two systems."*
>
> *—Housing Agency*

CASE STUDY 1: Health Plan of San Mateo: Community Care Settings Pilot

The Community Care Settings Pilot (CCS) is a transitional care model that employs a collaboration among the Health Plan of San Mateo (HPSM), San Mateo County Health System, Institute on Aging (IOA, a HCBS provider), and Brilliant Corners (a housing agency) serving CMC and CCI beneficiaries in San Mateo County. A unique aspect of this program is the regular in-person meeting of a Core Group. The Core Group includes staff from HPSM, IOA, and Brilliant Corners, as well as physicians, staff from other County agencies involved in transition assistance, and the beneficiary and family as appropriate. This group meets twice each month to identify and discuss beneficiaries who might benefit from transition services and assistance, and to develop, monitor, and modify transition plans as needed. Potential candidates for the pilot are identified through various sources: LTC facilities, HPSM case managers, and other HCBS agencies. The Core Group continues to follow the beneficiary after transition to problem-solve any new issues and ensure that all needs are being met.

"The person is represented to the Core Group prior to transition for final approval and coordination, setting a final date. Then after they transition, if things start to fall apart a little bit, or the individual is struggling a little bit in the community, then that group of providers is tasked with trying to see if there are other services, or a different community living plan that we should be working on together. It gives a level of shared risk and responsibility there."

—HCBS Provider

Each member of the Core Group has a different role. The Institute on Aging (which is also a lead organization for the California Community Care Transitions program in the county) provides intensive case management to transitioning beneficiaries, linking them to an array of services available in the community. Brilliant Corners is a community-based housing organization that works with HPSM and Institute on Aging to pair beneficiaries with appropriate housing, including independent living or other lower levels of care (such as supported housing or residential care facilities). As one Institute of Aging partner stated, *"This is innovative because health plans don't typically purchase [services connected to] housing resources."*

A key contributor to the program's success is the flexibility of the CMC plan to purchase services that might be needed to help with successful transitions using Care Plan Options, a flexible spending option that allows CMC plans to purchase goods or services that are not normally covered by Medi-Cal or Medicare.

We have a purchase-of-service component to our program (Care Plan Options) where we have the ability to purchase services for someone that are not otherwise available, but are necessary to make community living successful. We can purchase a service from an independent living center if that's really what's going to be key for someone's success. We can fill a short-term caregiver gap if their IHSS is taking too long to get initiated. A number of things that we've tweaked around that to particularly smooth out the transition process."

—HCBS Provider

To date, the Community Care Settings Pilot has enabled nearly 150 LTC facility residents to transition to community setting.

Providing supplemental care in the home to fill the gaps after discharge from a hospital or LTC facility: A key benefit of managed LTSS is that the CMC plan can fill the gaps in care during care transitions. CMC health plans can use Care Plan Options (CPO), which are flexible monies that can be used for services and needed by the beneficiary but that are not a covered benefit. Some examples of goods and services that have been provided with CPOs in the past include minor home modifications, appliances, utilities, cleaning, and medical equipment not otherwise covered.[9] All of these services can be useful for someone who is transitioning to a community setting. Additionally, CPOs can be used to cover services that may take some time to set up after discharge, such as home health care.

> *"Typically, when a member discharges from long-term care back home or to a less restrictive setting… [CMC health plan] utilizes Home Health agencies to ensure a safe transition of care." —CMC Health Plan*

Related challenge–lengthy enrollment processes and misperceptions about assessment rules can cause delays in LTSS after discharge: When a member is discharged from either a hospital or LTC facility to a community setting, the complexity of the current system often causes delays in accessing needed services. Referrals to county LTSS services such as In-Home Supportive Services (IHSS, California's Medi-Cal home care program) or CBAS (Community-Based Adult Services, or adult day health care) can often be complicated and lengthy. For example, some CMC plans noted that counties are resistant to beginning the IHSS assessment process before the beneficiary is back in the home setting. Though the state has specifically provided guidance letters that require IHSS assessments be made while beneficiaries are in facilities,[10] misperceptions about this remain.

> *"From a systems perspective, historically services have been fragmented and rules or barriers connected to many supportive services were not well suited to discharge from a facility setting. A good example would be that many services such as IHSS, behavioral health, CBAS, and other programs cannot be deployed while the member is still in the facility, and therefore there are often delays in those services which can jeopardize the success of the transition. We have overcome many of these challenges, but it remains an area we continually strive to improve."*
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> *—CMC Health Plan*

Another example of enrollment being a challenge is that CBAS centers (which provide occupational and physical therapies) may be resistant to enrolling certain members. For example, the CBAS center may have certain language capabilities and prefer enrolling certain beneficiaries over others, making it difficult to enroll a member quickly.

> *"They [seem to] have cultural biases... [It's hard because] they serve Vietnamese and we want to put a Latino in there."*
>
> *—CMC Health Plan*

Strategic partnerships with local HCBS providers to facilitate transition to community settings: Many health plans had little experience providing LTSS before the implementation of CMC because they traditionally focused on medical care rather than social services and supports. On the other hand, most of the HCBS agencies interviewed had extensive experience working with dually eligible seniors and people with disabilities, providing services in community settings. Many had specific missions or programs related to promoting community living over institutional care. The HCBS agencies that were interviewed had been in existence from 20 years to more than 100 years. With their established histories, they all had years of experience serving their communities and identifying needed resources for beneficiaries transitioning to community settings. A majority of the HCBS agencies that were interviewed had contracting or referral relationships with CMC health plans related to LTC transitions.

> *"We've been doing this for many, many years. We know the community, we know the local churches, we know the local benefits of that community. A lot of health plans agree that subcontracting with us to keep their members safe at home rather than in a skilled nursing facility or hospital is a good preventive measure."*
>
> *—HCBS Provider*

All CMC health plans are required to provide care coordination to members, but some plans have contracted with HCBS agencies that specialize in coordinating transitions for members when they are discharged to the community. Additionally, some CMC health plans work directly with their local California Community Transitions Project (CCTP)[11] lead organizations which are typically HCBS providers, independent living centers, care management organizations, or home health agencies that work to identify and transition beneficiaries out of LTC facilities. CCTP is a federal demonstration program that limits eligibility to beneficiaries who have resided in a

LTC facility for 90 days or longer. When HCBS agencies were contracted by CMC health plans to provide this coordination, they felt that they were able to coordinate services efficiently and successfully.

> *"I think the main thing here is coordination, coordination, and coordination. Just coordinating with everybody: The health plans, the PCP, the client or the member, and their family caregivers. All of us, all coordinating for this one specific person is the key to success. … That is the number one key to a successful intervention. We work with In-Home Supportive Services to get their IHSS hours established and other community-based services to get them out of the skilled nursing facility and back into the community [which is] much cheaper. … If the person needs housing assistance we would coordinate that with other housing providers."*
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> *—HCBS Provider*

Related challenge–some HCBS agencies were frustrated by the lack of collaboration with CMC plans, especially when they had mutual clients: Some HCBS agencies commented that they were not receiving the number of referrals they were expecting from CMC plans. Additionally, some noted that the CMC care coordinators were not communicating with them about shared clients, and they were not being asked to participate in interdisciplinary care team meetings.

> *"At the very least, for clients that we share, to have better communication and I think being a part of an interdisciplinary team, talking about these clients, that that would be beneficial to all of us. They can better understand what's happening in the home, and we can better understand what's happening medically—and those types of things I think would be huge."*
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> *— HCBS Provider*

Related challenge–some CMC health plans cite difficulties identifying and working with HCBS agencies for LTC transitions: Working with local HCBS agencies to provide services to beneficiaries can be key to successful transitions. But some CMC health plans noted barriers. For example, it can be difficult for CMC health plans to keep track of the various HCBS agencies in their county. Since HCBS agencies are often funded by short-term grants, their target populations, capacities, and services often change, making it difficult for CMC health plans to keep track and ensure appropriate referral.

> *"We've got reps whose job is to go out into the community and find [community-based organizations] CBOs that provide services to seniors and persons with disabilities, develop relationships with them, and understand who they are, what they do, and who they serve. They find what the criteria is that they are looking for, and make sure they understand what we as a health plan do to find ways to work in a mutual beneficial way. … I think we're close to 1,000 different organizations that we have a relationship with. …"*
>
> *— CMC Health Plan*

Other CMC health plans noted that a major barrier to working with HCBS agencies involved difficulties reconciling their own needs for information technology, regulatory requirements, billing procedures, oversight, and reporting with the HCBS agencies' capacities.

> *"[There are difficulties] integrating our needs for IT, regulatory requirements and reporting with what they do and managing the time for oversight and monitoring."*
>
> *—CMC Health Plan*
>
> *"CBOs need to restructure their services to support health plans' needs. Including billing, service definitions, expanded business operations and capabilities."*
>
> *—CMC Health Plan*

Related challenge–CMC health plans lacked knowledge about LTSS providers and resources: As previously noted in the Phase One report,[9] HCBS agencies continued to report that CMC health plans' lack of knowledge and expertise in the area of LTSS remained a challenge. Just as plans noted they had difficulty keeping track of the various community services and organization available, HCBS agencies likewise felt that the plans lacked an understanding of the scope and value of their services.

> *"I think a lot of plans don't know that this is a resource they can turn to. So I think, as far as I know, they have not been doing this in the past. They've been working with other resources—not ILCs. I think they are discovering we can be a good resource in the sense that we work with these people every day, face to face a lot more than they do, or even if they interact directly at all. I think it's about getting the word out about ILCs to CMC health plans. That needs to take place before anything else."*
>
> *— Independent Living Center*

CASE STUDY 2: Health Net: Repatriation Program

The Repatriation Program is a care transition model developed by Health Net for their CMC beneficiaries in Los Angeles and San Diego Counties. The Repatriation Program aims to assist Health Net beneficiaries transition to lower levels of care, largely through connecting them to LTSS benefits. As the program is run, Health Net also provides education to SNFs regarding the various LTSS benefits that are available to CMC members. For example, Health Net conducts two webinars per year on transition-related services. The Long Term Care Program Manager also frequently conducts site visits and meets with administrators and social workers for continuing education surrounding CBAS centers, Multipurpose Senior Services Program (MSSP), and other programs. The Repatriation Program team also includes a Medical Director and Registered Nurse, who supervise the various LTC nurses that review cases for Health Net. The program plans to bring on designated social workers to visit SNFs more frequently, provide ongoing education and training surrounding transitions, and serve as liaisons between Health Net and the facilities.

The Repatriation Program has different processes depending on the length of the beneficiary's stay in a SNF. If a stay is less than 90 days, Health Net will work directly with the facilities to help with the transition. If a beneficiary's stay is greater than 90 days, Health Net will refer them to various California Community Transitions[11] "Lead Organizations," such as the Partners in Care Foundation. These Lead Organizations assist Department of Health Care Services (DHCS) in the identification of Medi-Cal beneficiaries who have resided in an LTC facility for 90 days or longer, and then either employ or contract with transition coordinators to help beneficiaries move into community-based settings.

Individuals are identified for inclusion in the program by Health Net through a review of the Minimum Data Set (MDS) assessment that is completed in the LTC facility and submitted to Health Net for LTC authorization. If a beneficiary indicates in the MDS that they want to be discharged from the LTC to the community or a lower level of care, the LTC is expected to work with the beneficiary to achieve that. However, if the LTC is unsuccessful or requires additional assistance, the LTC will contact Health Net.

"The health plans are able to identify their members that are willing to be repatriated back into the community. Then we conduct a joint face-to-face visit that includes a transition coordinator [care coordinator from a HCBS agency], and the health plan provides a transition coordinator from their end. We assess the member that is in the long-term care facility and evaluate them for appropriateness and willingness to move back into the community."

—HCBS Provider

Health Net has set a goal of transitioning 3 percent of CMC beneficiaries in 2017. Although the Repatriation Program has been successful, barriers remain. These barriers include a lack of affordable housing in Los Angeles County, lack of available mental health services, and beneficiary resistance to transition assistance and help, according to Health Net.

Improving Communication to Facilitate LTC Transitions

Identifying beneficiaries for LTC facility transition: The first step in transitioning a beneficiary out of a LTC facility is to identify residents who wish to move to a community-based setting, and communication is key to this effort. CMC health plans revealed various ways that they identified beneficiaries to target for transition services. A majority reported that they regularly reviewed the results of their institutionalized members' Minimum Data Set (MDS), an assessment conducted by LTC facility staff that regularly assesses their residents' wishes to be discharged. Two of the health plans noted that they work with the LTC Ombudsman Program to identify candidates for transition into the community.[12] Other methods included identification by LTC facility (SNF) staff, the utilization review process, and health plan physicians visiting facilities.

"Our home visiting physician consults with members in facilities."

— CMC Health Plan

Related challenge–preconceived notions about characteristics that might preclude community living: One CMC health plan described how some LTC facilities often bring a "perspective that some members will never be able to leave." In particular, advanced age was mentioned by both a CMC plan and a LTC facility as a reason why they may not consider someone capable of transitioning out of the institution and into the community.

"The population that we have is in their 70s, so probably, if they are trying to identify candidates that could go back home, it might be the younger generation."

—LTC Facility

"A majority of our nursing facility members are over 80 years old and are unable to live in the community."

—CMC Health Plan

Another health plan noted that the LTC facilities may not want to discharge a resident if they have low needs and require less staff time and resources. Additionally, residents themselves may not want to be discharged into the community, where they might encounter poverty and homelessness. Though the MDS assessment has a section (Section Q) that asks residents if they want to be discharged, one CMC health plan noted that the response is almost always "no."

> *"Some are homeless. They get 3 meals a day, so they may not be anxious to leave [the LTC facility]. One member was in a facility and the facility didn't want him anymore, he was able to take bus and walked every day. They were trying to discharge him but he didn't want to go. … Even after we found him somewhere to live, he didn't want to go. It was a very difficult situation."*
>
> *—CMC Health Plan*

Communication among health plans, LTC facilities, and HCBS agencies is key to successful transitions: Many CMC health plans, HCBS agencies, and LTC facilities have been working to improve their communication since the implementation of CMC. Monthly, collaborative conference calls among all providers have been a primary way that the CMC has improved communication across settings. These efforts have been initiated by both health plans and HCBS agencies. These improvements in communication channels between CMC health plans and LTC facilities have been identified as one of the key successes of the CMC program.

> *"[Our plan] continues to work with providers to improve communication. We host monthly conference calls with the long-term care industry associations, [and we] make visits to provider SNFs frequently."*
>
> *—CMC Heath Plan*
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> *"There are a lot more presentations on the resources in the community. … Once a month I invite community partners, whether they are federal, state, county or community, or nonprofit. I invite them to do a presentation to my team. … and then I also invite the regular IHSS worker, health plan care coordination workers, anybody who works in the CCI circle. That is the idea. They're all invited to participate in this presentation [which helps enhance] community knowledge."*
>
> *—County Aging and Adult Services*

Better communication and collaboration between health plans and HCBS agencies has improved efficiency: After the implementation of the CCI, some HCBS agencies that work with CMC health plans noted that they felt the referral process was more efficient and more direct. Also, they reported that coordination with the health plans for transition services was more streamlined under CMC.

> *"We do work really closely with the Cal MediConnect providers here. …Both of them actually reach out to our whole team here, to work even more so in 2017 to coordinate their care, because quite often the case managers from the health plan come by maybe once a week to help with a returning resident."*
>
> *—Housing Agency*
>
> *"Basically, what happens is that we have a direct link with the health plan. You get the referrals according to our various algorithms. Depending on where that member resides and what intervention the referral came for, we then look for our network partners that are in that location. We assign the case within 24 hours, we contact the member right away, we coordinate services immediately."*
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> *—HCBS Provider*

Related challenge—despite some improvements, communication difficulties still exist: Communication was still noted as a challenge by both CMC health plans and HCBS agencies during the LTC transition process. For example, one health plan reported that they are often not informed by the LTC facility when a member is discharged or undergoes a significant change in condition. On the other hand, some HCBS agencies also noted that it was often difficult to connect with the right person at the health plan.

> *"I think the challenge is when you communicate assistance from the health plan. There are so many different levels of the department, sometimes you can't get through. If I needed to go to, for example, the long-term care division, there's tiers of people that you have to go through before you get an answer. There's not just one person. You have to navigate yourself through it."*
>
> *—HCBS Provider*

Related challenge—data sharing across agencies could pose barriers to transitions: Related to communication challenges, some respondents also noted challenges with data sharing among all entities involved with the LTC transitions. Data-sharing portals were not standardized and every partner's was different, meaning staff had to learn how to use each one.

> *"I think one of the difficult things is it's all shared in different ways. [There are] some where we go into their FTP site and we download files, and others where we have to go into their website and look things up, and then pull down files that way."*
>
> *—Health Provider*

Rules around privacy and data sharing also prevented HCBS agencies from getting needed information to provide comprehensive, person-centered care.

> *"Our argument is, in order to develop a comprehensive, person-centered care plan, we would like to know what is going on in the home, and obviously what is happening with someone medically. We need to know what is happening with behavioral health, with issues in the home, with Activities of Daily Living. All these things that we're kind of blind to and the physician doesn't know about, but the health plan still won't share that information because they're under the very strict rules of delegation, saying, 'You're not delegated for it, so we are not going to share it with you.' It becomes very difficult to be person-centered or developing a comprehensive care plan when you don't have all the pieces."*
>
> *—HCBS Provider*

Do LTC Transitions Reduce Costs?

CMC health plans report that transitioning members out of institutions does save money, but it is not a simple calculation: CMC health plans do report cost savings for each member they transition to the community, but the calculation of cost savings is not straightforward. Their calculations need to account for readmission rates and potential hospitalizations after transition to the community, both of which may affect longer-term cost savings.

> *"We have definitely seen cost savings (inclusive of program costs) for LTC transitions of approximately 50 percent per member, per month..."*
>
> *—CMC Health Plan*

> *"We are in the process of determining the numbers for 2016. Any transitioned member from long-term care to a lower level should result in savings. However, we are evaluating readmission rates, hospitalizations, etc."*
>
> *—CMC Health Plan*

More HCBS agencies are measuring costs and outcomes to improve their marketability to CMC health plans: Many HCBS agencies that provide transitional care services to duals noted that they had been able to document the cost savings that plans could expect. Those that were able to conduct evaluations and measure cost savings were ones that had been in existence longer and had the time and resources to conduct these kinds of assessments. HCBS agencies that could measure cost savings felt that this had improved the CMC plans' desire to work with them, highlighting the importance of CBOs being able to measure their costs and outcomes in order to make the "business case" for partnership with health plans. Some smaller agencies with only a few CMC clients felt that they didn't have the staff, resources, or expertise to invest in the kind of evaluation that could demonstrate cost savings.

> *"I'm getting a lot of health plans and provider groups that want to contract with us. Now that we've been doing this for several years and we've proven our outcomes, they're knocking on our doors."*
>
> *—HCBS Provider*

Housing After LTC Transitions

Housing shortages and housing affordability remain among the greatest challenges to LTC transitions: Though some health plans reported working in collaborative committees to address the issue of housing for dually eligible beneficiaries in their counties, most of these efforts remain in the early stages. Some plans have innovative ideas, such as coordinating co-housing for their members by placing two members in one apartment, but most of these efforts have not yet come to fruition. Some CMC health plans are working directly with housing agencies to locate and place CMC members in appropriate housing, but the affordability of housing remains a barrier. Most dually eligible beneficiaries live at or below the poverty level and the only affordable option is Section 8 housing, which has long waiting lists.

"Other barriers are income—what members make will not cover the cost of even the most affordable housing available. Members need help with paying for housing and supportive services that help them remain housed."

—CMC Health Plan

"It's a question of capacity. Section 8 is a good program, but if they're handing out vouchers and there aren't any openings or vacancies ... we can pass out all the vouchers in the world, but if you can't use it then what good are they? I think it's an overall capacity issues, especially in XX County where there are resources with, let's say, shelters and other housing issues. … But if there is a waiting list, or if there is zero availability, it's almost like not having the resources."

—Health Provider

The lack of available affordable housing meant that sometimes beneficiaries were forced to stay in LTC facilities when they had the functional capacity to live in the community. Though health plans can use CPOs for one-time costs to set up a housing unit, they are prevented from using Medicaid dollars for ongoing housing costs. In addition, some housing agencies that could be helpful in finding homes for beneficiaries after discharge only focus on individuals they consider homeless, and they do not consider nursing home residents to be homeless.

"It's nasty, there's long waiting list, it takes a lot of time. You need to know all the different systems for all the different housing platforms. It's definitely a challenge. Sometimes they'll keep them ... a nursing home will keep clients longer because there's nowhere for them to go."

—HCBS Provider

"HOUSING!!!! This is one of the biggest reasons people stay in nursing homes who don't belong there. They are often not identified in the community as 'homeless' even though they are. They are not included in the local counts of homeless, nor do the homeless service providers see this as a target population. If they're in a SNF, they are considered 'housed'."

—CMC Health Plan

Related challenge–discharging LTC residents to assisted living can pose greater costs to the CMC health plan: There are some gaps in reimbursement that may reduce financial incentives for CMC health plans moving beneficiaries out of LTC facilities into assisted living or residential care facilities (RCF). As background, the four risk stratification categories in CMC include: Community Well, HCBS Low, HCBS High, or Institutional. Depending on the mix of beneficiaries in their plan, the CMC plan receives a "blended rate" for all beneficiaries. Typically a beneficiary with high LTSS needs who moves from an institution to home would go from being categorized as "Institutional" to "HCBS High" or "HCBS Low." But to qualify for the HCBS categories, the member must be receiving IHSS adult day health care (called CBAS), or MSSP. Beneficiaries who move into an RCF are ineligible for IHSS. Thus, RCF residents are categorized as "Community Well" which affects the plans' overall blended rate.

CMC beneficiaries are also not eligible for the California Assisted Living Waiver.[17] Thus, when CMC health plans move a beneficiary to a RCF, they must pay for services to support the member in an RCF through CPOs meaning these costs are then not included in the templates the state uses to set rates.

"Rate determination, shared savings, and other processes do not always factor in the investments that [CMC health plan] is making in supporting our members. An example would be the fact that the CCI/CMC population is carved out of the Assisted Living Waiver, which means that (plan) must provide those services as Care Plan Optional expenditures to members in that population. If we choose to do that for a member moving out of an institutional setting, our rate for that member changes from Institutional to Community Well—since they do not receive IHSS or other similar services in a residential care facility for the elderly (RCFE)—while at the same time we have made a long-term financial commitment (to provide RCFE services) to support this individual in the community. The benefits of our effort to move that individual from a SNF LTC to an RCFE primarily accrue as cost savings to other entities in this scenario. We choose to support these investments because we believe it is the right thing to do, and the mission of CCI/CMC, but currently we are negatively impacted financially by the current system."

—CMC Health Plan

Person-Centered Planning for LTC Transitions

The three-way contract between the California Department of Health Care Services (DHCS), the federal government, and the CMC plans specifies that person-centered planning should be used for CMC members.[13] It states that person-centered planning is intended to be "built on the enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, and linguistic and cultural competence." Furthermore, both the CMC health plan and LTC facilities are required to conduct care planning. The health plan must complete health risk assessments on all members and create individualized care plans, ideally engaging interdisciplinary care teams that include providers, care managers, and beneficiaries to ensure person-centered planning. Additionally, the LTC facility is required to conduct quarterly care planning meetings using the Minimum Data Set assessment tool, and beneficiaries should be invited to that meeting.

> *"One thing I still feel is that the challenge of involving the client in this plan can be very difficult. We'll do all the assessment, but in terms of having the clients in the plan, it's difficult because right now the clients will not be able to travel to the meeting. Some of the clients have very short memories. … Even though you tell them today [about their appointment], then tomorrow they forget. ... That's why sometimes it's very difficult to have the clients participate in the ICT group schedule to set up the plan right at that point."*
>
> *—County Aging and Adult Services*

Related challenge—it can be difficult to engage beneficiaries in their own LTC planning: Early findings on care coordination among financial alignment programs nationwide noted difficulties with health plan members' involvement with their Interdisciplinary Care Team (ICT).[4] Respondents in this study also found it challenging to involve the beneficiary in their ICT and LTC planning. As care coordination and person-centered planning are required of CMC plans,[13] the participation of the beneficiary is an integral part of the LTC transition planning process, but this was sometimes quite difficult to accomplish.

RECOMMENDATIONS

1) State and local partners should continue to invest in education, outreach, and communication to support transitions out of institutions and into the community.

Since the early implementation of the CMC program, stakeholders have consistently identified as paramount the need for education, outreach, and communication across all partners. Even as the CMC program matures, this need for cross-agency communication remains, especially as CMC health plans seek to promote transitions across care settings. Continued efforts in the following areas are recommended:

- Promote awareness of available HCBS. Continued education and communication between CMC plans and HCBS agencies can help educate plans about available HCBS and increase coordination to facilitate transitions out of LTC facilities.
- Include HCBS agencies in care planning early in the transition process. Involving HCBS agencies in interdisciplinary care teams can reduce unmet needs once a beneficiary transitions to a lower level of care and may help prevent readmissions.
- Share information with long-term care facilities. LTC facilities need to be more aware of the CMC plans' efforts to promote LTC transitions and the resources the plans can bring to the process, such as care coordination, housing referral, interdisciplinary care teams, and transportation services.
- Assess beneficiaries for HCBS needs before discharge to prevent gaps in services. The state should re-issue the All County guidance letter to remind counties of their responsibility to assess SNF residents for IHSS needs before discharge, if necessary.[10]
- Share knowledge of best practices among health plans. CMC health plans should continue to share successful practices at learning collaborative meetings.

2) CMC health plans should use a variety of methods to identify beneficiaries for LTC transitions, including long-term care ombudsmen and care teams.

Different stakeholders have different incentives and biases that may impact how and if beneficiaries are selected for discharge. SNFs may not be anxious to discharge a resident who has low care needs and requires fewer resources. Members themselves who live in poverty or are at risk for homelessness may have legitimate concerns about being discharged. Additionally, beneficiary characteristics such as advanced age may make the facility or health plan overlook that beneficiary as a possible candidate for transition. Thus, a team of stakeholders with different perspectives, or the involvement of an objective third party such as an ombudsman, may be particularly important for eliminating biases and making sure that beneficiaries have access to services that support moving into community-based settings.

3) HCBS providers should take advantage of business acumen training to build effective working relationships with CMC health plans.

CMC health plans are regulated by the state and federal governments, so any services they provide or contract for must adhere to oversight requirements. HCBS agencies that work with CMC plans must meet health plan compliance standards, learn how to demonstrate cost savings, and provide utilization data for oversight, among other requirements. While many HCBS providers are beginning to measure outcomes and costs, accomplishing this was easier for larger, well-resourced HCBS agencies. Oftentimes, many of the services needed for successful transitions may be best provided by smaller HCBS agencies that offer more niche services, or serve a specific ethnic or language group. HCBS agencies should take advantage of business acumen training offered through programs such as The SCAN Foundation Linkages Lab Initiative[14] and the Department of Health and Human Services Administration for Community Living,[15] so they can develop the skills to conform to the oversight, data sharing, and data collection requirements needed for collaboration with CMC health plans.

4) Promote strategies to increase the availability of affordable housing options to enable successful transitions into the community.

Housing has overwhelmingly been cited as a major barrier to successful transitions into the community. In many CMC counties, housing is scarce, which forces all housing costs up and makes affordable housing very hard to find. One of the challenges is that CMC plans cannot use Medicaid funds to directly pay for housing for their members. Additionally, some housing agencies that could assist in placement provide these services only for homeless individuals, and they do not consider nursing home residents to be homeless. Therefore, efforts must be made to increase not only the availability of affordable housing for those transitioning to community living, but also to develop some innovative housing options or financing strategies to supplement this shortage. States and the federal government should also consider increased flexibility on how Medicaid dollars can be spent toward housing. The Whole Person Pilot program in California is one example of how Medicaid dollars will be directed toward improving the coordination of services and addressing homelessness[16].

5) Policy changes are needed to increase incentives for CMC plans to discharge LTC residents to community-based settings.

When beneficiaries move to a Residrntial Care Facilitys (RCF) or assisted living, CMC plans face many barriers to paying for services. For example, CMC beneficiaries are excluded from the Assisted Living Waiver and plans must pay for RCF services through CPOs that are not included in rate-setting calculations. Additionally, RCF residents often do not qualify for the "HCBS" risk categories because they cannot receive IHSS services in an RCF, which affects the plans' overall "blended" reimbursement rate. States may need to consider adjusting their policies to compensate for these disincentives. Some possibilities include:

- Adjusting risk categories so that RCF residents are either automatically categorized as "HCBS High," or creating a new risk category for beneficiaries discharged to RCFs.
- Including CPO payments for RCF in medical loss ratios, so those expenses are taken into consideration when rates are set.
- Including CMC beneficiaries in the Assisted Living Waiver[17] and increasing the cap, to help defer some of those costs to plans.

6) The state should promote person-centered planning to motivate beneficiary engagement in LTC transition planning.

Both at the national level and in California, motivating beneficiaries to be involved in their care planning by attending the ICT meeting was noted as a challenge.[4] Using more person-centered approaches in the assessment process may increase beneficiaries' sense of agency and therefore motivation to participate in their own care planning. Increasing the beneficiaries' awareness that they are entitled to care coordination and HCBS through CMC could also help to motivate them to become more involved in the ICT and be more proactive about requesting the services they need from their CMC plan after transition to the community.

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