NATIONAL HEALTH FOUNDATION

PLANNING FOR A LEARNING NETWORK AMONG LOS ANGELES MEDICAL RESPITE PAYERS & PROVIDERS

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MEDI-CAL MANAGED CARE PLANS – LOS ANGELES COUNTY

- LA Care Health Plan - Dr. David Kagan, MD, Medical Director; Tiffany Hayes, Social Worker III; Allison Klurfield, Director, Safety Net Programs & Partnerships & Gabriella Bonilla, Program Manager
- Blue Shield of California PROMISE Health Plan - Jocelyn Smart-Sanchez, Social Worker; Susie Ravo; Michell Nielsen; Julie Tellier-Fairey
- Anthem Blue Cross - Dr. Mark Talavera, MD, Medical Director; Beau Hennemann, Director, Special Programs, CA Medicaid Health Plan
- Kaiser Permanente – Martha Shenkenberg, Senior Manager, Medi-Cal & State Programs and Cody Ruedaflores, Manager, Community Health Programs
- HealthNet – Edward Mariscal, Director, Public Programs/Long Term Services & Supports
- Molina Healthcare of California – Hannah Kim, Director, Long Term Services & Supports
- SCAN Health Plan - Lisa Roth, Vice Pres. Care Coordination and Jill McGougan, Medi-Cal Operations

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- Cedars Sinai Medical Center - Sari Steinberg, Social Worker CommonSpirit Health/Dignity - Kimm Hurley, System Director, Clinical Health Equity
- Providence St. Joseph – SoCal Region- Jill Schuyler, Executive Director, Care Management
- UCLA Health System - Mary Noli Pilkington, Manager of Care Coordination & Clinical Social Work

LOS ANGELES MEDICAL RESPITE PROVIDERS

- A Brighter Day Recuperative Care, LLC (ABD), Paul Schafer, CEO
- Blue Manor Recuperative Care, Rochel Malaca
- Golden State Recuperative Care, Michael Gonzalez, Director of Operations
- Hola Recuperative Care, Alex Mitchell, CEO & Kelly Landers, Director of Care Management
- Horizon Recuperative Care, Beverly Gibbs, RN, Founder& CEO; Steven Atlas, President; Aaron Kordorkovsky, Director of Operations and Colleen Del Valle, Director of Homeless Programs
- Illumination Foundation, Paul Leon, CEO & Pooja Bhalla, Executive Director of Healthcare Services
- Serenity Recuperative Care, Katina Holliday, FNP, Chief Nursing Officer
- Wesley Health Centers and JWCH Institute, Al Ballesteros, CEO & Jerry Santos

LOS ANGELES HOMELESS SERVICES AUTHORITY (LAHSA) & DEPARTMENT OF HEALTH SERVICES (DHS)

- LA Department of Health Services (DHS) Housing for Health, Elizabeth (Libby) Boyce, Director
- Los Angeles Homeless Services Authority (LAHSA), Daniel Ortiz Reti, Healthcare Integration
- Brilliant Corners, Christine Leahey, Danielle Wildkress & Sophi Li

FOUNDATIONS

- California Community Foundation, Rose Veniegas, Senior Program Officer & Brittany Daniel, Program Officer
- California Health Care Foundation (CHCF), Michelle Schneidermann, MD, Director of Advancing People-Centered Care
- UniHealth Foundation, Jennifer Vanore, President & CEO

ASSOCIATIONS

- National Healthcare for the Homeless Council, National Institute for Medical Respite Care, Julia Dobbins, Director

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INTRODUCTION

The California Department of Health Care Services (DHCS) has announced that Recuperative Care also known as Medical Respite will officially become a Medi-Cal In Lieu of Service (ILOS) effective January 1, 2022, which will allow Medi-Cal Care Plans (MCPs) to pay for Medical Respite with Medi-Cal funds. There are several Medical Respite providers in the greater Los Angeles County that are interested in exploring how to best partner with Medi-Cal payors. To help streamline the adoption of these partnerships and support their success, California Health Care Foundation (CHCF) is funding this planning project where National Health Foundation (NHF) and Pamela Mokler & Associates (PMA) are creating a plan for a potential Los Angeles Medical Respite Payor/Provider Learning Network. Through the Network, payors and providers will be able to discuss characteristics of payor/provider partnerships such as contracting, reporting, data sharing, outcomes measures and general communications – and ideally find ways to improve the partnership experience. NHF and PMA conducted interviews and focus groups with Medi-Cal Managed Care Plans, Recuperative Care/Medical Respite providers and other stakeholders to identify how to support successful relationships between healthcare payors and providers of medical respite services and how best to convene these stakeholders.

PROJECT TEAM

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OVERVIEW OF MEDICAL RESPITE IN LOS ANGELES COUNTY

California has the largest number of individuals experiencing homelessness in the nation, with more than 151,000 individuals living on the streets and in shelters. People experiencing homelessness suffer from poorer health, have life expectancy rates 20 to 30 years lower than the general population, and have less access to needed health care services. The high prevalence of chronic physical health conditions, behavioral health needs, and acute and infectious illnesses has only been exacerbated during the COVID-19 pandemic.

According to the Los Angeles Homeless Services Authority (LAHSA),[1] there are approximately 60,000 Los Angeles residents identified as homeless in 2019. According to the 2019 count by LAHSA, LA County had approximately 44,000 unsheltered people, with 16,528 people living in cars, vans and RVs/campers; 11,086 living in tents and makeshift shelters; and 16,600 people in other unsheltered conditions. Approximately 67% of the homeless individuals are male, 31% are female, 2% identify as transgender and .4% as gender non-conforming. The race/ethnicity of homeless individuals are approximately 35% Hispanic/Latino, 32% Black/African American, 24% White, 2% American Indian/Alaska Native, 1% Asian and 1% Native Hawaiian/Other Pacific Islander.

There are two primary Medi-Cal Managed Care Plans in Los Angeles County that are responsible for the care of over 3 million members, LA Care Health Plan is a local initiative plan and HealthNet is a commercial plan. Approximately 2.65 million members are served by LA Care Health Plan and its plan partners: Anthem Blue Cross, Blue Shield of California Promise Health Plan and Kaiser Permanente. Approximately 942,000 members are served by HealthNet and its plan partner, Molina Healthcare.

Thousands of people experiencing homelessness in Los Angeles County cycle in and out of Emergency Departments (EDs) and inpatient hospitals, which become their default health care providers at a cost of approximately $5.204 million to hospitals and health systems throughout the county.

[1] LAHSA is a joint powers authority of the city and county of Los Angeles (LA), created in 1993 to address homelessness in LA County. LAHSA is the lead agency in the HUD-funded LA Continuum of Care, and coordinates and manages over $800 million annually in federal, state, county, and city funds for programs.

Inpatient Hospital Admissions among Homeless LA Care and HealthNet Medi-Cal Enrollees, 2017-2019[2]

Metric	2017	2018	2019
Total Inpatient Hospital Admissions	25,763	27,920	26,243
Unique Inpatient Hospital Patients	11,859	12,781	12,458
Average Number of Admissions*	2.17	5.37	5.26
Total Inpatient Hospital Cost Paid**	$147.54M	$198.65M	$191.86M

*Average number of admissions is calculated among the homeless patients who were admitted to the hospital at least once during the year, not of total homeless Medi-Cal enrollees in each plan.
**Total inpatient hospital cost paid was only available for 60-68% of admissions across the three years primarily due to the homeless patients being admitted to either DHS facilities or capitated hospitals or being covered by health plan partners.

The Post-Discharge Role of Hospitals for People Experiencing Homelessness
On September 30, 2018, California Governor Jerry Brown signed Senate Bill (SB) 1152 into law, which modified Section 1262.5 of the Health & Safety Code. Effective January 1, 2019, SB 1152 requires hospitals to modify their current hospital discharge policies by including a written homeless patient discharge planning policy and procedure. Hospitals are required to revise discharge policies to **assist homeless patients in preparing for their return to the community by helping them identify a post-discharge destination**, with priority given to identifying a sheltered destination with supportive services. Prior to discharging a homeless patient, hospitals are required to document and perform a checklist of events, such as offering the homeless patient a meal, screening for infectious disease, weather-appropriate clothing and transportation to a certain destination within a 30-mile radius. On July 1, 2019, hospitals were also required to have a written plan for coordinating services and referrals for homeless patients with the county behavioral health agency, health care and social services agencies in the region, health care providers and nonprofit social services providers. Each hospital is required to maintain a log of the homeless patients discharged from their facilities and the post-discharge destinations of each homeless patient.

Since SB 1152 was signed into law in 2018, the number of Medical Respite beds has expanded substantially with hospitals as the primary payer. According to the County of Los Angeles Department of Health Service's Recuperative Care Vendor List, there were approximately 763 Medical Respite beds available in 2018. The County estimates approximately 400 additional beds have been added since 2018, for a total of approximately 1,163 beds available at this time.[3]

[2] UniHealth Foundation and Harder+Co (July 2020). Recuperative Care in Los Angeles County: Strengths, Gaps & Opportunities.
[3] UniHealth Foundation Report, pg. 20.

Medi-Cal Managed Care Plans and Members Experiencing Homelessness

Medi-Cal Managed Care Plans in 16 California counties including Los Angeles, first began to see people experiencing homelessness in their membership when the State began shifting responsibility for approximately 380,000 seniors and people with disabilities (SPDs) from Medi-Cal fee-for-service to managed care between June 2011 and May 2012.[4] The scope of Los Angeles MCPs' responsibilities increased further beginning July 1, 2014, when the State launched the California Coordinated Care Initiative (CCI) that included a Duals Demonstration called Cal Medi-Connect. Almost all individuals who were enrolled in Medi-Cal (California's Medicaid Program) only and those who received both Medi-Cal and Medicare (dual eligibles), became enrolled in Medi-Cal Managed Care Plans (MCPs) in seven counties. The majority of individuals experiencing homelessness were auto-enrolled in a MCP. Essentially, the CCI changed the way individuals received their health care, expanding MCPs role to include financial and programmatic risk for behavioral health and long-term services and supports (LTSS), including long term care in nursing homes. The goal was to integrate the medical, behavioral health and social services to provide better coordinated care. Services and programs for individuals with Serious Mental Illness (SMI) were carved out and remained the responsibility of the County, which as the Mental Health Plan receives funding via the Mental Health Services Act (MHSA)[5] to address SMI needs. Plan members experiencing homelessness who frequented Emergency Departments (EDs) and were admitted as inpatients in local hospitals began to appear on MCPs radar, prompting the need to identify organizations, programs and interventions to help address the unique needs of this population. Heretofore, the MCPs merely addressed medical needs. Some LA MCPs began to test the waters and launched small Pilot project with Medical Respite providers, so they are somewhat familiar with the services that are provided. However, the current opportunity available via the planned launch of Medi-Cal's California Advancing & Innovating Medi- Cal (CalAIM) program on January 1, 2022, has given MCPs the opportunity to fully embrace Medical Respite by including it as an ILOS, and to use Medi-Cal funds to pay for it. The CalAIM Opportunities for Partnership section below provides more information about this opportunity.

Whole Person Care Pilot Program

Around the same time, the California's Department of Health Care Services (DHCS) established the Whole Person Care (WPC) Pilot Program through its Medi-Cal 2020 Section 1115 waiver, effective January 1, 2016 – December 31, 2021, with the goal of better coordinating health, behavioral health, and social services in a "whole person" approach for Medi-Cal beneficiaries who are high users of multiple health care systems and have poor health outcomes, which included beneficiaries experiencing homelessness. Los Angeles County is one of 25 pilots selected and the County of Los Angeles Department of Health Services (DHS) accepted the challenge to collaborate with MCPs, hospitals, social services and housing providers, etc., to build the infrastructure to serve in this role, which included expanding its ownership and network of Medical Respite beds. The funding for the WPC Pilot goes directly to the County, which is currently administering 15 WPC Pilot programs for six groups of beneficiaries, including

[4] California HealthCare Foundation. Briefing — Transitioning the SPD Population to Medi-Cal Managed Care, March 28, 2013. https://www.chcf.org/event/briefing-transitioning-the-spd-population-to-medi-cal-managed-care/

[5] On November 2, 2004, California voters approved Proposition 63, which was signed into law as the Mental Health Services Act (MHSA). The MHSA levied a 1 percent tax on all California personal incomes over $1 million, resulting in a substantial investment in mental health in the state. The intent of the act was to address the urgent need for expanding accessible, recovery-based, community mental health services. California has a decentralized behavioral health system in which treatment services are provided by its 58 counties.

homeless high-risk and a partnership with Housing for Health.[6] With the support from the WPC Pilot, DHS' Housing for Health program aims to meet the following objectives: (1) end homelessness in LA County, (2) reduce inappropriate use of healthcare resources, and (3) improve health and housing outcomes for vulnerable populations. While MCPs are participating in the WPC Pilot, they are not the lead entities responsible for developing and implementing the pilots. However, the ability to partner with DHS and other providers has prepared them for the transition of the WPC Pilot Program to CalAIM, which essentially transitions the primary responsibility for providing similar services from the County to MCPs as discussed below.

[6] The Housing for Health (HFH) Program at the Los Angeles Department of Health Services (DHS) was started in 2013with a focus on creating permanent supportive housing opportunities for homeless patients within the DHS system ofcare. In 2017, HFH partnered with Whole Person Care – LA (WPC-LA) to expand its services to more people experiencing homelessness who are vulnerable and medically complex while working with other Los Angeles County agencies such as the Departments of Public Health, Mental Health, Probation, Public Social Services and the Los Angeles Homeless Services Authority.

CalAIM OPPORTUNITIES FOR NEW PARTNERSHIPS

The only thing that is constant is change. Effective January 1, 2022, DHCS will launch California Advancing & Innovating Medi-Cal (CalAIM), a broad-based delivery system program and payment reform across the Medi-Cal program. CalAIM recognizes the opportunity to move California's whole-person care approach with the WPC Pilot to a statewide level, with a clear focus on improving health and reducing health disparities and inequities.

Also, effective January 1, 2022, all Medi-Cal MCPs in counties with WPC pilots and/or Health Homes Programs, which includes Los Angeles County, will begin implementation of the enhanced care management (ECM) benefit, for those target populations currently receiving Health Homes Program and/or WPC services. All Medi-Cal beneficiaries currently receiving care management through the Health Homes Program and WPC will be transitioned to ECM through one of the target populations, which includes:

- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits
- Individuals at risk for institutionalization, eligible for long-term care

Under CalAIM, ECM and ILOS are both the responsibility of Medi-Cal MCPs. WPC Promising Practices can provide MCPs with clear examples of the services provided under WPC, the steps they took to implement, and the results they have generated thus far. However, state funding for CalAIM will be included in the rates paid to MCPs and funding to the County of Los Angeles for services and programs under WPC will sunset in December 2021.

MCPs also have the option to provide services from a menu of 14 approved in lieu of services (ILOS) under CalAIM. The list of ILOS includes Recuperative Care/Medical Respite. Bottom line, for the first time, MCPs can use Medi-Cal funds to pay for Medical Respite effective January 1, 2022.

The following is DHCS' definition of Medical Respite, together with provider requirements:

Medical Respite Description/Overview
"Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

- Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs)
- Coordination of transportation to post-discharge appointments
- Connection to any other on-going services an individual may require including mental health and substance use disorder services
- Support in accessing benefits and housing
- Gaining stability with case management relationships and programs

Medical respite is an allowable ILOS service if it is (1) necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions, (2) not more than 90 days in continuous duration, and (3) does not include funding for building modification or building rehabilitation."[7]

Licensing/Allowable Providers
Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal MCPs may choose to contract with, but it is not an exhaustive list of providers who may offer the services: Interim housing facilities with additional on-site support; shelter beds with additional on- site support; converted homes with additional on-site support; and County directly operated or contracted recuperative care facilities.

Facilities are unlicensed. MCPs must apply minimum standards to **ensure adequate experience and acceptable quality of care standards are maintained**. MCPs can adopt or adapt local or national standards for recuperative care or interim housing. MCPs are required to monitor the provision of ILOS. MCP network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, MCPs must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another MCP, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, **MCPs must credential the providers as required by DHCS**."[8]

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[7] California Department of Health Care Services (2021), *CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS) Contract Template Provisions*

[8] ibid

INTERVIEW RESULTS: MEDI-CAL MANAGED CARE PLANS PERSPECTIVES ON MEDICAL RESPITE AND CalAIM

Representatives from all six Medi-Cal MCPs[9] in Los Angeles County interviewed expressed overwhelming interest in offering Recuperative Care/Medical Respite as an ILOS on January 1, 2022. It was also mentioned that LA Care and HealthNet, the two prime MCPs in LA County, have begun meeting and are planning to require their subcontracted MCPs to all provide the same ILOS so there is consistency in services and benefits to all LA county Medi-Cal members, as well as continuity of care if members switch health plans.

Most of the MCPs have at least one contract with a Medical Respite provider, which was initiated as a Pilot within the last three years. Prior to that time, Medical Respite was paid for almost exclusively by hospitals, foundations via grants, or other sources.

[9] In addition to the six Medi-Cal managed care plans in Los Angeles County, SCAN Health Plan representatives also participated in the interviews. At this time, SCAN is a Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP), which are excluded from ECM, on the basis that these plans offer comprehensive care management that is duplicative of ECM services. SCAN is waiting for further guidance from the State regarding their ability to offer In Lieu of Services (ILOS).

Primary Concern of Health Plans & Medical Respite Providers
All respondents stated it is critically important to include hospitals in the potential Medical Respite Payer/Provider Learning Network to work through payment responsibility for Medical Respite services and the number of days authorized, etc. MCPs stated there is typically a delay in becoming aware that their members are in the hospital or ready to discharge – especially in LA County because most if not all the MCPs have delegated risk/financial responsibility to the Medical Groups and IPAs. It may be important to also invite the "delegated" medical groups to the network. If we do not strongly encourage the payers, e.g., hospitals, medical groups and MCPs to come to the table to make some decisions about payment and care coordination responsibilities, we may go to a lot of trouble to get contracts in place and then there will be limited referrals." One MCP said the biggest frustration is "there is not any alignment with the medical groups around the provision of ILOS" and their potential role in cost sharing.

Some of the MCPs have had this same experience with Care Plan Options (CPOs) under Cal Medi-Connect[10], the duals demonstration. MCPs were authorized by the State to pay for, at their discretion, "a subset of long term services and supports (LTSS) that may be delivered either under Medi-Cal or an applicable waiver beyond what is required under law." While many MCPs went to the effort to contract with social service providers/community based organizations to provide CPOs, actual referrals were limited. The primary reason cited for limited referrals by MCPs is they are not reimbursed for offering these services (CPOs) to members; although according to the State, the MCPs are financially incentivized to provide such services to help members remain in the community and prevent costly institutionalization. Several MCPs stated they are hopeful they will know how the money is going to work soon – "we're still waiting for guidance from the State."

Issues of Concern to Medi-Cal Managed Care Plans
- Provision of Services
- Eligibility Criteria
- Mental Health
- Length-of-Stay
- Housing
- Training
- Rates
- Potential Cost-Shifting between Hospitals and Medi-Cal Managed Care Plans
- Delegation & Division of Financial Responsibility (DOFR)
- Transition of the Whole Person Care Pilot
- Reporting
- Technology

Provision of Services
- MCPs would like to better understand the types of services Medical Respite providers can and cannot provide in an unlicensed facility. They understand the scope of services

[10] In the California legislation authorizing Cal MediConnect, the statute offers examples of CPO services like assistance with activities of daily living and instrumental activities of daily living, and other DHCS policy guidance includes additional examples like respite care, nutrition through nutritional assessments and home delivered meals, home maintenance and minor home or environmental adaptation, personal emergency response systems, assistive technology, and other similar LTSS and home and community-based services (HCBS) waiver services. Chan, Denny, Justice in Aging Issue Brief: *Cal MediConnect - Unmet Need and Great Opportunity in California's Dual Eligible Demonstration*, February 2019.

that home health companies can provide when they go into an individual's home, noting things like wound care, administration of medications, (including through peripherally inserted central catheter lines, when necessary).

- MCPs suggested Medical Respite providers should utilize best practices for caring for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health needs.
- Additionally, MCP's noted that there is variation in the services provided across the different medical respite programs in L.A. and they would like to see some standardization in this area. They realize some providers specialize in wound care, mental health, etc., and they would like to continue to differentiate themselves from the pack.
- MCPs would like to see a hub or dashboard that lets them know which providers have bed availability. They said it can be confusing and frustrating to have to contact several different Medical Respite providers to find one that will accept a member ready to be discharged from the hospital.

Eligibility Criteria & Licensing

- MCPs think the State has set a low bar regarding the criteria to be used to determine which members ultimately get referred. "Given that ILOS must be cost-effective, we want to make sure we develop the right eligibility criteria and make sure that all the health plans and providers can use the eligibility criteria effectively and still meet the financial requirements." "We do not know what the rates are yet, so this is making financial planning challenging." "We are extremely interested in offering ILOS but there are some big programmatic and financial concerns." "Without that information from the State, it is difficult to start engaging with the Medical Respite providers."
- MCPs would like more flexibility in the type of patients providers will accept. If eligibility criteria are too limited, MCPs are left with few options to ensure safe and timely discharge. Criteria excluding people with activity of daily living (ADL) dependencies came up as a specific eligibility barrier. One example shared by a plan, "If a patient is being discharged with a hip replacement or a broken leg, he or she may need assistance getting pants on, which to some providers does not meet the ADL independence criteria."
- Some MCPs expressed concerned that the lack of licensure for medical respite limits what providers can and cannot do in terms of treatment, administration of medication, and more. For example, individuals need to be independent in their ADLs and able to self-administer medications, among other things.
- Some plans expressed an interest in being able to refer patients with more challenging needs, such as those currently discharged to a skilled nursing facility; however, there needs to be a better understanding of what *unlicensed* providers can and cannot provide, as well as what they are willing to provide with the right resources and supports in place.

Mental Health

- The lack of a license issue is of particular concern to MCPs around mental health services, especially since approximately 71% of clients admitted to Medical Respite in LA County had a mental, behavioral or Neurodevelopmental disorder diagnoses. The perception is that some individuals need a higher level of care in a licensed setting.[11]
- MCPs stated that there are only a handful of providers that have the staffing to care for clients experiencing mental health conditions in addition to their medical conditions, which can make finding the right provider at the right time challenging.

[11] UniHealth Foundation Report, p. 41.

- One hospital interviewed stated they have approximately 400 people experiencing homelessness coming through their Emergency Department monthly, and 86% are experiencing mental health and substance abuse issues.

Length of Stay

- MCPs would like to see best practices around length of stays. Currently, there is wide variation in the lengths of stay with providers reporting 7, 12, 14, 15, 30, and one MCP reported they are authorizing approximately 150 days as part of a Medical Respite Pilot focused on homeless people with disabilities.

Housing Expectations

- The number one outcome MCPs would like to see is getting members experiencing homelessness from medical respite into housing. According to the medical respite providers, it can take weeks, and in some cases months, to find exits into appropriate housing and providers wondered if the MCPs would be willing to authorize enough days to achieve this goal for their members.
- The lack of adequate housing options can impact length-of-stays. Keeping clients in Medical Respite until they can get into housing can be cost-prohibitive in some cases. One MCP said, "there must eventually be a cut-off because it is too expensive to pay for a long time."
- MCPs are concerned that not all providers are connected to the HMIS system,[12] which is necessary to get in queue to obtain access to housing provided by the county. A major concern is the overwhelming need for housing for the homeless population overall and the current inventory of housing and shelter is insufficient to meet the need.

Training

- Due to high turnover in MCPs there is a need for ongoing training to ensure Plan medical directors, nurses, social workers, etc., understand what services are provided, how to make referrals, etc.
- Training also needs to happen at the provider level to ensure staff understand how to work and communicate with MCPs.

Rates & Encounter Data Submissions

- MCPs are waiting for the State to release the rates they are going to pay for 2022. MCPs are concerned that they will not receive additional funding for ILOS, noting that DHCS expects them to demonstrate cost-savings from providing Medical Respite as a substitute for another more expensive covered Medi-Cal benefit. Plans note relief that they will be able to include the cost of Medical Respite in their medical loss ratio (MLR).
- MCPs are concerned providers will have difficulty submitting encounter data, which Plans are required to submit to the State and need to demonstrate ILOS utilization and the actual costs that will ultimately be considered in developing rates.

Potential Cost-Shifting between Hospitals and Medi-Cal Managed Care Plans

- MCPs are concerned about what the hospitals are going to do when the health plans can pay for Medical Respite. The funding by the hospitals is not being included in the rate

[12] The LA HMIS is a local electronic database that securely records information (data) about clients accessing housing and homeless services within the Greater Los Angeles County.

setting. They [the hospitals] fund a significant amount of Medical Respite right now and MCPs are concerned about the size and impact of potential cost-shifting.

Delegation & Division of Financial Responsibility (DOFR)

- Los Angeles County has a unique and complex financial delegation model. The two prime plans, LA Care Health Plan (a local initiative plan) and HealthNet (a commercial plan) delegate full financial and care coordination risk to four subcontracted plans. Each of the six MCPs have various risk-sharing arrangements with IPAs and medical groups, which can include delegating financial and care coordination responsibilities to the medical providers. There is wide variation in the division of financial responsibility (DOFR) between MCPs and medical providers, which impacts who is financially at risk and therefore responsible to pay for services, including hospitalizations and readmissions. In many cases, medical providers are financially at risk to pay for hospitalizations, not MCPs. To complicate things even more, some risk arrangements are partial/shared while others are full risk. In fact, it was shared by a few MCPs that because of these risk arrangements, there is oftentimes a significant delay in being notified when members are hospitalized or discharged.

Transition of the Whole Person Care Pilot.

- Since the County of Los Angeles and the MCPs are required to transition the WPC Pilot into MCPs as part of CalAIM, there is a tremendous amount of uncertainty around how the county is going to pay for its current supply of approximately 600 Medical Respite beds, which it significantly increased as part of the WPC Pilot. The WPC Pilot funding went directly from DHCS to the counties. Funding for CalAIM will go directly to the MCPs. The MCPs that were interviewed all said they were uncertain how they are going to handle making the county whole in terms of funding to ensure there is no loss in bed capacity. Several scenarios were mentioned including: (1) having the County of Los Angeles serve as the broker for all local Medical Respite providers, which would require the County to not only administer its own beds but also contract with local Medical Respite providers that are owned and operated by both non-profits and for-profits; or (2) the MCPs would contract with the County and directly with private providers to ensure access to the maximum number of beds. If the MCPs go with option two, as most indicated, they are likely to pay a per diem rate for actual beds used for its members versus providing a lump sum grant funding, as is the case under the WPC Pilot, which could result in decreased revenue to the County and its contracted providers.

  DHCS is requiring MCPs that are in counties with a WPC Pilot to contract with each Lead Entity as an ECM Provider to ensure ongoing care coordination and continuity of care because of the transition from the WPC Pilot to CalAIM. It is not a requirement for ECM providers to administer ILOS; however, since the County of Los Angeles is currently the WPC Pilot Lead Entity, MCPs may be initially focused on working closely with the County of Los Angeles and ensuring there is no loss of bed capacity because of the transition. Additionally, the County of Los Angeles staff interviewed for this project expressed significant concern about the potential loss of funding when the county no longer receives funding for case management and Medical Respite beds directly from the State.[13]

[13] The State has announced it is applying for the Federal grant program, Projects for Assistance in Transition from Homelessness (PATH), which provides assistance to individuals who are homeless or at risk of being homeless and

Reporting

- There is wide variation in reporting from providers to MCPs. For the most part, hospitals paying for Medical Respite have not requested any data or feedback once the patient has transitioned to the facility. Their job is done; the patient is no longer in the hospital. Some MCPs have asked providers to participate in a weekly status meeting and one provider mentioned they participate in the plan's Interdisciplinary Care Team (ICT) meetings. MCPs would like to establish a consistent process for providing feedback and sharing data. A big challenge for the providers will be the submission of encounters since this is not happening at this time.
- Standardization of update reports was suggested. A few providers are now submitting weekly updates to keep the MCPs informed of their progress. One Plan noted this has improved communications by leaps and bounds and has been a great tracking tool.
- One MCP suggested each member experiencing homelessness needs a standardized Housing Plan, which can be transferred to the next provider(s), e.g., housing navigator or ECM provider, to build on the progress initiated by the Medical Respite provider in helping move individuals along on their path to permanent housing. Plans do not want to lose momentum and have to start all over again with housing navigation.

Technology

- Each MCP has its own data security process. One Plan mentioned providers' systems must be reviewed by its Technology Risk Office for compliance and functionality. This review process may be onerous for plans and lead to unexpected expenses for providers who need to address IT and data sharing requirements. One MCP mentioned that it would be helpful if the MCPs and providers jointly developed a data certification process for providers to demonstrate their ability to meet regulatory requirements and standards, that all MCPs would accept. Otherwise, each provider will need to go through a different process with each MCP it contracts with.

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have serious mental illnesses, together with the American Rescue Plan funding for home and community-based services (HCBS), may be available to leverage to help fill some of the funding gaps and help stabilize or expand bed capacity.

INTERVIEW RESULTS: PROVIDERS' PERSPECTIVES ON MEDICAL RESPITE AND CALAIM

Issues and Concerns of Medical Respite Providers

- Licensing & Monitoring of Quality-of-Care Standards
- Contracting
- Eligibility Criteria
- Rates
- Authorization of Length-of-Stay
- Payments – Claims Submissions
- Technology – Data Reporting
- Quality Monitoring & Oversight
- Obtaining Authorizations & Concerns about Cost-Shifting

Licensing & Monitoring of Quality of Care Standards

- Medical Respite is provided in an unlicensed temporary housing site. While two of the providers mentioned they have a licensed facility, there was concern that the State or MCPs may require providers to obtain a license. The lack of a license limits what providers can and cannot do in terms of treatment, administration of medication, etc. For example, individuals need to be independent in their activities of daily living (ADLs) and able to self-administer medications, etc. Providers believe they can meet most client's needs with home health care and partnerships with mental health and substance abuse providers, etc.; however, there is concern about what standards the MCPs will use to monitor providers and ensure adequate experience and acceptable quality of care standards are maintained.
- Most providers are aware the National Health Care for the Homeless Council developed Medical Respite Standards, which were recently finalized, and agree with these standards.

Contracting

- Almost all Medical Respite facilities are unlicensed. DHCS has acknowledged this and has put the burden on MCPs to develop a process to ensure potential providers have "adequate experience," which is not defined.
- **Credentialing is required by MCPs**. Medical Respite providers are concerned about what MCPs may require to be credentialed – especially since MCPs typically require some type of license for credentialing.
- **Transition of the Whole Person Care Pilot.** As mentioned above, the County of Los Angeles and the MCPs are required to transition the WPC Pilot into MCPs as part of CalAIM, so there is uncertainty around how the MCPs are going to handle this transition to ensure bed capacity is not decreased. Providers do not know if they will be contracting directly with MCPs or if they will need to contract with the County as a broker of all Medical Respite beds countywide.

Eligibility Criteria

- Some providers felt the eligibility criteria needs to be more fully defined and standardized so all providers are operating off similar standards and expectations regarding service models. Providers all agreed they want to work with MCPs to ensure everyone is on the same page.

Rates

- Providers' primary concern is the per diem rate(s) MCPs will offer to pay for Medical Respite. Due to the complexity of the needs of individuals experiencing homelessness, there is wide variation in the services provided to each client. There is no one size fits all. Some clients require extensive assistance with medical, behavioral health, substance abuse, social services and housing needs, and others have required less assistance. It was suggested that payers and providers work together to create a basic level of services that are provided to all clients, and then add tiered levels of services that more adequately describe the level of care and staff support needed to meet the various needs of clients.
- Providers are also concerned about how the State is coming up with a rate(s) for Medical Respite, especially if the extensive levels and subtleties in the services provided are not known by Medi-Cal actuaries and others developing the rates.
- Providers recommended the State and MCPs visit providers' facilities to better understand the complexities of the service models.

Authorization of Lengths of Stay

- Obtaining authorizations for the appropriate length of stay required to get clients into some type of housing is a constant challenge.
- There is wide variation in the number of days payers currently authorize upon referral, with a range starting with only seven days to as high as 150 days.[14] Providers stated MCPs' expectations about housing and other outcomes must be realistic and result in the authorization of a sufficient number of days stay to meet the desired outcomes.
- Providers shared each MCP has a different approach to respond to requests for length of stay extensions. One MCP is requiring a provider to submit extension requests 72 hours in advance of the current discharge date, which can be difficult due to provider staff

[14] One of the MCPs is currently conducting a Medical Respite Pilot for homeless members who have a disability and are considered high risk. The MCP shared they are in the beginning stages of the Pilot and have not made that many referrals; however, they are authorizing up to 150 days due to the complex needs of the population being served.

working to address multiple needs, e.g., referrals to mental health and substance abuse providers, referrals to medical providers and specialists, applications to various social services like In Home Supportive Services (IHSS), coordination with LAHSA and other entities to access temporary, interim or permanent housing, etc.

Payments – Claims Submissions

- MCPs require submissions of claims and encounters, which is new to most providers. Only two providers interviewed are successfully submitting claims, and they have had to hire a claims specialist.

Technology – Data Reporting

- There is wide variation in providers' perceived capacity to meet health plans' technology and data requirements. Of particular concern was the ability to submit claims and encounters.

Quality Monitoring & Oversight:

- There is wide variation in what Medical Respite providers are currently required to report to payers. While a few providers have current contracts with MCPs, the primary payer of Medical Respite has been hospitals, and most require little to no outcomes reporting. Hospitals' primary concern is getting patients experiencing homelessness discharged to an appropriate and safe location as required in SB 1152. It is not the responsibility of hospitals to be involved in care coordination and management of patients once they have discharged. All individuals interviewed for this planning project were sent a follow-up survey and asked to rank potential quality measures in order of importance. Results are presented on the following page.

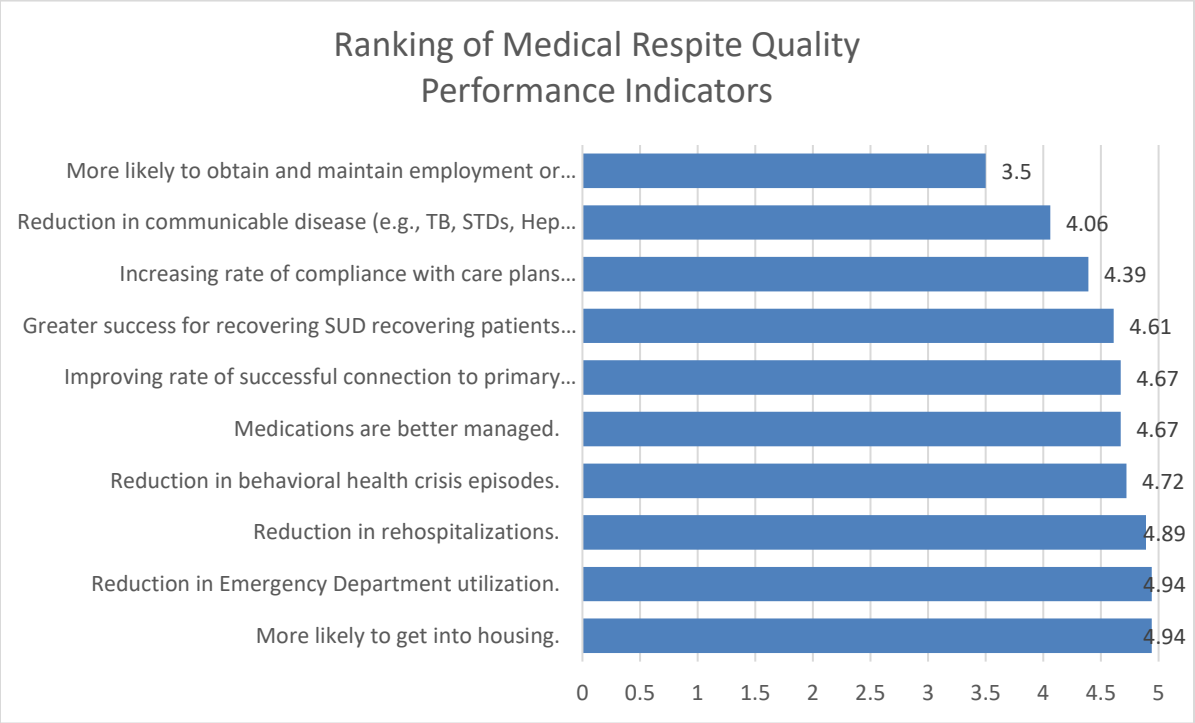
Obtaining Authorizations & Concerns about Cost-Shifting:

- There is significant concern about who will pay for Medical Respite and for how many days. Since hospitals have historically been the primary payer of Medical Respite and are required by law to attempt to discharge patients experiencing homelessness to a specific location other than back to the streets, providers are concerned that MCPs will continue the practice of denying authorization requests for patients who are discharging from hospitals. Some LA MCPs advise providers to attempt to get the hospitals to pay for the first several days of Medical Respite, and then come back to them only if there is a justified need for additional days stay to clinically stabilize the individual and move him or her on the path to housing.
- Participants mentioned that under the WPC Pilot, the County appears to be primarily focused on providing its clients experiencing homelessness with whatever services they needed, regardless of costs. Providers' experience working with MCPs is that it is oftentimes challenging to obtain MCP authorizations for clients referred to Medical Respite from hospitals unless they are "high utilizers," which can be defined differently by each MCP, e.g., three or six inpatient stays over a period of time, etc. The perception is that MCPs will only invest funds in members who are predicted to be high cost in the future.

QUALITY PERFORMANCE MEASURES

All interviewees/focus group participants were sent a follow-up email and asked to rank a list of potential quality performance indicators' that they believed were the most important to measure regarding Medical Respite Services. Below are the results:

On a scale of 1 to 5, one being not important and five being particularly important, participants rated the importance of the following outcomes measures, as follows:



COUNTY TRANSITION TO CalAIM

Whole Person Care – Los Angeles (WPC–LA) brings together health and social service agencies to build an integrated system that delivers seamless, coordinated services to LA County's most vulnerable Medi-Cal beneficiaries who are high risk, high utilizers of hospital and emergency departments. WPC–LA connects people experiencing homelessness, justice involvement, barriers to healthy pregnancy, serious mental illness, substance use disorder or complex health conditions to resources and support. To provide Members with ongoing care coordination previously provided in HHP and WPC Pilot Counties, MCPs shall contract with each WPC Lead Entity or HHP CB-CME as an ECM Provider unless there is an applicable exception.

The County of Los Angeles is primarily concerned about the transition of the Whole Person Care Pilot into CalAIM effective January 1, 2022. As stated above, the County of Los Angeles Department of Health Services (DHS) is the lead on the current Whole Person Care (WPC) Pilot. Since the WPC Pilot is transitioning into CalAIM effective January 1, 2022, there is a tremendous amount of uncertainty around how the county is going to pay for its current supply of Medical Respite beds, as well as other WPC Pilot services and programs. The WPC Pilot funding currently goes directly from DHCS to the county. Funding for CalAIM will go directly to the MCPs effective January 1, 2022. The MCPs that were interviewed all said they were uncertain how they are going to handle making the county whole in terms of funding to ensure there is no loss in bed capacity. Several potential scenarios were mentioned under "Issues of Concern to Medi-Cal Managed Care Plans" above.

MCPs are required to contract with each Lead Entity as an ECM Provider to ensure ongoing care coordination and continuity of care because of the transition from the WPC Pilot to CalAIM.

HOSPITALS' ROLE & PERSPECTIVES

It is no secret that many people, including people experiencing homelessness, use the hospital and Emergency Departments (EDs) as their de facto health care provider. Hospitals expressed that SB 1152 has not necessarily been helpful – with many homeless discharging out the hospital's back door and re-entering the front door. Some hospitals are measuring how long they can keep people experiencing homelessness out of the EDs using Housing Navigators. Far too many are admitted as "social admits" or under the Failure to Thrive code.

While Medical Respite is still a relatively new service, hospitals in Los Angeles County have been discharging patients experiencing homelessness to a limited number of Recuperative Care beds for the past few years. In fact, National Health Foundation (NHF), which is affiliated with the Hospital Association of Southern California (HASC), was tasked with finding solutions for homeless hospital patients upon discharge, over 10 years ago. In response to the growing need, NHF opened its first Recuperative Care facility in 2007.

One of the biggest frustrations voiced by hospital representatives interviewed is Medi-Cal MCPs perceived unwillingness to help pay for this level of care. While hospitals have a legal responsibility to use best efforts to discharge homeless patients to an actual facility/site, they see their responsibility ending upon discharge. Medi-Cal managed care plans are responsible for care coordination, and hence, hospitals are anxious to see MCPs help pay for this post-discharge care.

- **Mental Health & Substance Abuse** - One hospital interviewed stated they have approximately 400 people experiencing homelessness coming through their Emergency Department monthly, and approximately 86% are experiencing mental health and substance abuse issues.
- **Cost of Medical Respite** – Hospitals cited the per diem rate for Medical Respite is too high, even though it is much less than an inpatient stay and is the reason they limit the length of stay they will authorize.
- **Bed Availability** - Ideally, the hospitals would like there to be a dashboard or another way to determine when providers have bed availability. Currently, they must check in with providers individually.

RECOMMENDED NEXT STEPS: POTENTIAL FOR A LOS ANGELES LEARNING COLLABORATIVE

All stakeholders interviewed overwhelmingly said, “Yes,” we are interested in the creation of a Los Angeles County Medical Respite Payor/Provider Learning Network. The MCPs are extremely interested in offering Medical Respite as an ILOS but stated there are some programmatic and financial concerns that need to be addressed. Without final guidance and rate information from the State, it is difficult to start engaging with the Medical Respite providers. MCPs wholeheartedly agreed it was important to create a learning network for Los Angeles County only, especially due to the uniqueness of the delegated relationships, the tremendous amount of work the County has done to build the infrastructure for the WPC Pilot, the large number of people experiencing homelessness who need Medical Respite services, etc. Several MCPs stated there are some topics that should be discussed with the health plans only, at least initially, and others to address with the providers. The providers expressed an interest in working through some of the issues as a group, and then meet with the payers. Recommended immediate next steps include:

STEP 1: Informal convening of interested funding entities, hosted by CHCF, to discuss potential of project. Ideally, seed funding for the project would occur in the next month or two to maintain momentum of the project while longer-term planning is conducted.

STEP 2: Invite all planning project participants to join in a kick-off session of the learning network. Facilitated discussion would present (1) the purpose of the group; (2) the commitment required of the membership (monthly work group calls with potential intermittent smaller group discussions); (3) the range of issues brought to light through the planning process and a prioritized schedule of topics would be formalized; and (4) the anticipated results of the workgroup within the first 6 months (dependent on the prioritized topics).

Beyond the initial work to be done among payors and providers, there is long-term potential for this collaborative to continually help new providers who enter the market. The association model, as a stand-alone or as part of an existing organization, should be considered as a way to provide ongoing assistance.

ATTACHMENT: INTERVIEW/FOCUS GROUP QUESTIONS

Modified depending on a health plan vs. a medical respite provider.

1) Utilization of Medical Respite
a) Have you had any experience working with medical respite providers? If so, in what capacity (e.g. contract) ?
i) Do you have anything you want to initially share about successes, challenges or frustrations?
If you contract with the county for these types of services, do you see any benefit in also partnering with independent medical respite providers?
2) Referrals & Authorizations
a) If you have contracted with providers, what is the eligibility criteria for Medical Respite services?
b) How do you determine authorized lengths of stay or extensions?
c) Would you be open to collaboratively developing that criteria?
3) Case Management/Care Coordination
a) What information and how do you share with medical respite providers about the assessment of a member's health status?
b) What information and how do medical respite providers share back to you regarding the members' care coordination?
c) Would you be willing to share the member's Health Risk Assessment?
4) PCP/FQHC/Community Clinics Assignment Issues & Preference
a) We understand individuals experiencing homelessness who are health plan members have an assigned PCP. In many cases, clients in Medical Respite have never seen their assigned PCP, and the PCP may not have experience assisting patients who are experiencing homelessness. Do you have any preferences about medical provider selection, e.g., Medical groups, FQHCs/Community Clinics?
5) Data Reporting
a) What do you currently require providers to submit and what does that communication look like?
b) What would you like to receive that you are not receiving right now?
6) Financing Options
a) How are you currently financing/reimbursing for medical respite services?
b) Is there anything you would change about that?
c) Would you be willing to share what rate you are paying?
d) Do you have any thoughts about how the variations in risk sharing arrangements could or should impact who is responsible to pay for Medical Respite?
7) Other items?
a) Are there any other topics we did not touch on that you feel are critical to the partnership between health plans and medical respite providers? (e.g. ask about impact of COVID if not touched on yet)
8) Ongoing Learning Network
a) Would you be open to participating in a learning network that brings payors and providers together to discuss these topics on a more operational level?
b) How could we best engage you in those discussions? i) Logistics - virtual gatherings, in-person meetings? ii) Frequency? iii) Health plan / provider engagement – host meetings together; separate; combo?

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