CalAIM and Institutional Long-Term Care:
Lessons for Medi-Cal Managed Care

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See Appendix A for a list of contributors.

About the Foundation

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

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Introduction

CalAIM (California Advancing and Innovating Medi-Cal)[1] is a comprehensive, multiyear effort led by the California Department of Health Care Services (DHCS) that seeks to implement broad delivery system, program, and payment reform across California's Medi-Cal (Medicaid) program.[2] Like many states, California uses managed care delivery systems[3] to administer Medi-Cal. Currently, over 8 in 10 Medi-Cal enrollees are in Medi-Cal managed care plans (MCPs),[4] and this number will increase as CalAIM further expands mandatory managed care enrollment.[5]

One CalAIM reform initiative — the institutional long-term care (LTC) carve-in — will require that care in nursing homes and other institutional settings be provided as a benefit through Medi-Cal MCPs statewide as of January 1, 2023 (see sidebar). To support the design and implementation of this initiative, this report describes the challenges, opportunities, and lessons learned from (1) California counties where institutional LTC has previously been carved in to MCPs, and (2) other states where institutional LTC has been administered by MCPs. This paper focuses on the experiences of seniors and adults with disabilities, including those with Medi-Cal only and those with both Medi-Cal and Medicare (dually eligible enrollees), synthesizing information from literature reviews and interviews with both California and national experts, and describes opportunities to design a system that achieves the following:

1. Improves access to appropriate institutional care for those who need it
2. Promotes care in home and community-based settings and diverts care away from institutions when possible and desired by the person receiving care
3. Promotes higher quality of care in institutional settings
4. Addresses equity and care disparities in California's LTC services

This report is intended to inform state officials, MCP leaders, institutional LTC providers, community providers serving individuals with LTC needs, and advocates, who will all play unique roles as this policy moves forward. Specific takeaways for these audiences are highlighted in the conclusion.

CalAIM for Seniors and People with Disabilities is a series of reports focusing on elevating experiences from California and other states to ensure CalAIM reforms impacting Medi-Cal's seniors and people with disabilities build on past efforts to integrate and improve care.

Institutional Long-Term Care Settings

- Skilled nursing facilities
- Subacute facilities
- Pediatric subacute facilities
- Intermediate care facilities (ICFs)
  - ICF/DD (Developmentally Disabled)
  - ICF/DD-H (Habilitative)
  - ICF/DD-N (Nursing)
- Specialized rehabilitative services in skilled nursing facilities and ICFs

Note: See Appendix B for the number and type of facilities by county and model.

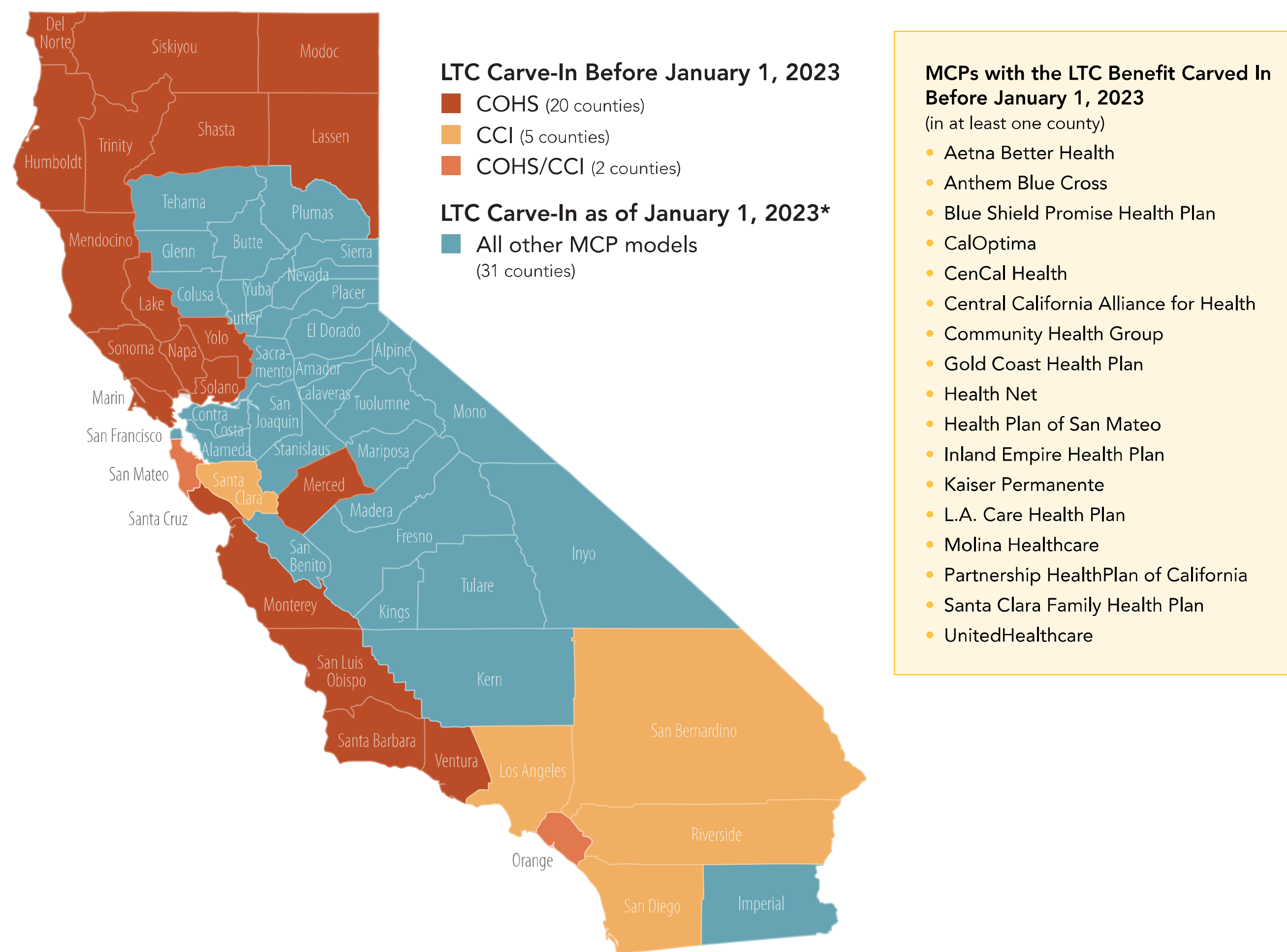
Source: "**California Advancing and Innovating Medi-Cal (CalAIM) Proposal**," California Department of Health Care Services, January 2021.

Background

Institutional LTC for Medi-Cal Enrollees Before CalAIM

Currently, Medi-Cal's institutional LTC benefit is fully "carved in" to Medi-Cal managed care in less than half (27) of California counties — including those with a **County Organized Health System**[6] (COHS) model and those participating in the **Coordinated Care Initiative**[7] (CCI). In the other 31 counties, institutional LTC beyond the first 60 days of a stay is "carved out" of the Medi-Cal managed care benefit (Figure 1). In counties where LTC is carved out, Medi-Cal managed care enrollees who are admitted to an institution such as a nursing home are disenrolled from their MCP after 60 days in the facility and enrolled in Medi-Cal Fee-for-Service (FFS). Further, in the 31 non-COHS and non-CCI counties, dually eligible enrollees, who are the majority of Medi-Cal enrollees using skilled nursing care, are not mandatorily enrolled in Medi-Cal managed care, so they may begin their nursing home stay already in Medi-Cal FFS.

Figure 1. Institutional Long-Term Care Carve-In Status in California Counties



* Will also be moving people eligible for both Medicare and Medi-Cal (dually eligible enrollees) into mandatory Medi-Cal managed care by January 1, 2023.

Note: *COHS* is County Organized Health System; *CCI* is Coordinated Care Initiative; *MCP* is managed care plan; *LTC* is long-term care.

Source: Author analysis based on California Department of Health Care Services sources

CalAIM Institutional LTC Carve-In

Effective January 1, 2023, under CalAIM, institutional LTC will become a mandatory statewide Medi-Cal managed care benefit, meaning that MCPs will be responsible for institutional care in all 58 counties. In addition, dually eligible individuals will be mandatorily enrolled in Medi-Cal managed care statewide. Thus, institutionalized Medi-Cal managed care enrollees in the 31 counties referenced above will no longer be disenrolled from their MCP after 60 days. This will also mean that Medi-Cal enrollees in those 31 counties who are currently residing in LTC facilities and currently have Medi-Cal FFS will be mandatorily enrolled into an MCP at the beginning of 2023.

Other Related CalAIM Initiatives

Alongside the institutional LTC carve-in, CalAIM includes several initiatives, such as Population Health Management, Enhanced Care Management, and Community Supports, that will all be helpful to MCPs as they provide care to their institutionalized members or to prevent institutionalization.[8] Suggestions for leveraging these related initiatives are interspersed below.

1. Access to Institutional Long-Term Care

While DHCS's policy goal is to provide Medi-Cal recipients with home and community-based services (HCBS) instead of institutional care when desired and possible, there is still a need for some Med-Cal enrollees to receive care in institutions, at least temporarily. Thus, it is imperative for Medi-Cal enrollees to have access to high-quality institutional care when they need it. Nationally, Medicaid enrollees often have fewer choices of institutional care settings because Medicaid pays lower rates than private pay or Medicare. In California counties where MCPs carved in institutional LTC before CalAIM, it has been reported that some facilities have been reticent to contract with MCPs or admit Medi-Cal members.[9] It can be especially difficult to find the right placement for those with complex needs, behavioral health issues, or substance use disorders. In addition to payment barriers, facilities are facing a direct care workforce shortage that makes it difficult to recruit and train the additional staff needed to appropriately care for those with complex needs,[10] further disincentivizing facilities from entering into contracts with MCPs.

Payment Strategies to Promote Access

In a managed care delivery system, MCPs have the flexibility to use strategies such as payment incentives to encourage higher quality providers to contract with their plan and admit their members, especially those who require a high level of support. Some MCPs in California that currently carve in institutional care use these strategies:

- One California Cal MediConnect (CMC) program plan encourages LTC facilities to admit their members with complex needs by allowing the facilities to directly invoice the plan for additional services that might be needed. For example, if a

member requires around-the-clock supervision, the MCP allows the facility to invoice them for "bedside sitters," even though this is not a traditionally reimbursable service.[11]

- In California, to encourage contracting with a reluctant facility, one CMC plan reported offering an incentive payment for every admission; this model also built in penalties for hospital readmissions and a penalty if the facility fell below four stars in the Centers for Medicare & Medicaid Services' (CMS's) five-star rating system.[12]

Timely and Adequate Payment

Generally, managed care delivery systems can be associated with efforts at cost containment. A multistate report on Medicaid managed long-term services and supports (LTSS) found that provider organizations sometimes avoided contracting with MCPs due to concerns about low or slow reimbursement.[13] Long-term care providers in California and New York have both cited timely payment as a barrier to contracting with MCPs.[14] Consumer advocates in New York, Florida, and Illinois reported that following the transition to managed LTSS, MCPs reduced the number and duration of services for some individuals.[15] For MCPs to attract providers — especially the highest quality facilities — into their networks, detailed parameters for timely payment to facilities used across MCPs and geographies would be helpful.

- In Illinois, MCPs meet with nursing facility management companies to help them understand the authorization and billing process to prevent any billing delays.[16]

- In Florida, the Medicaid agency sends staff to nursing facilities to provide training and support to increase facility staff's foundational knowledge of billing, residents' rights, and required paperwork associated with the LTC carve-in.[17]

- California, New York, and Illinois all require MCPs to pay institutional providers the same rate as had been paid under FFS.[18]

Uniformity Across Plans

In counties that have several MCPs, one facility may have Medi-Cal residents who are each a member of a different MCP, and the facility will need to contract with all of them. Facilities are at risk for increased administrative burden if payment and quality measures are not consistent across all of the MCPs that they contract with. In California, many MCPs delegate partial or full risk to other managed care plans or medical groups. Delegation of care increases the number of entities that LTC facilities are accountable to and can further complicate the administrative burden for facilities.

As California designs its institutional LTC carve-in, the state has an opportunity to put forth consistent standards for both payment and quality metrics that can reduce the administrative burden on facilities and encourage them to contract with all of the MCPs in their county, resulting in more access and choice for Medi-Cal enrollees.

- In New York's LTC carve-in, MCPs were able to retain some local control over their own quality standards, which created confusion and administrative burdens for providers that were trying to meet the multiple, distinct quality standards of all their contracted MCPs. This stood in contrast to the more unified experience in the FFS model. More standardization of quality expectations from the state could have created a smoother implementation experience.[19]

2. Care Transitions

Most older adults and people with disabilities would rather receive LTSS (see sidebar) at home than in an institution such as a nursing home.[20] The country's Medicaid system, however, has long exhibited an institutional bias — meaning that the federal government requires Medicaid State Plans to provide care in nursing homes while HCBS are optional Medicaid services that often have limited slots and waiting lists.[21] One significant opportunity offered by the new institutional LTC carve-in in California is the ability to structure the managed care benefit to incentivize and promote care for Medi-Cal enrollees in community settings, where appropriate, instead of in more costly institutional care. This is often called "**rebalancing**"[22] toward HCBS.

Long-term services and supports (LTSS) are defined as an array of services that can be provided to older adults and people with disabilities who need assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). They can include personal assistance services, transportation, meal preparation, and homemaking assistance. LTSS can be provided in institutional settings such as nursing homes, or in home and community-based settings such as assisted living or in a person's home. When policy is designed to make it easier to provide these services in community settings, that is called "rebalancing."

Source: Erica L. Reaves and MaryBeth Musumeci, ***Medicaid and Long-Term Services and Supports: A Primer***, Kaiser Family Foundation, December 15, 2015.

California has a long history of rebalancing toward HCBS services and is ranked 8th in the nation based on the percentage of care in community settings versus institutions.[23] California has a robust, self-directed HCBS personal assistance services program called **In-Home Supportive Services**[24] that allows eligible Medi-Cal enrollees with LTSS needs to hire a caregiver and direct their own care at home. But there is still room for improvement. According to the **AARP LTSS Scorecard**,[25] 1 out of every 10 residents in a California nursing home has "low care needs" and could be served in the community if the right supports were available.[26] Some nursing home residents also remain institutionalized, not because they physically need institutional care, but because they lack affordable or accessible housing or lack access to the HCBS that they need to live well in community settings.[27] This section of the report explores examples and insights from California, other states, and national experts on important considerations for structuring an LTC carve-in benefit to ensure that, wherever possible, care is being provided in home and community settings rather than in institutions.

Financial Design and Managed Care Contracting

In managed care delivery systems, multiple financial design and contract elements can impact where and how care is delivered, such as payment rate-setting, payment for non-traditional services, and payment incentives.[28] These strategies are not mutually exclusive, and states often implement multiple strategies simultaneously.

Rate-Setting

When MCPs are paid less for members receiving LTSS in community settings than those in institutional settings, it can create a financial incentive for plans to keep members in institutional settings. It can also mean that there are fewer resources

available to cover the costs of transitioning members to the community and supporting them in that environment. States that are committed to rebalancing try to avoid structuring their payments in ways that incentivize institutional care. In California counties where institutional LTC is currently carved in, MCPs typically receive a higher capitation payment for members receiving institutional care than for those living in the community, even when they require a similar level of care. This arrangement does not incentivize transitions out of or diversions from institutional settings.[29] The structure of the new CalAIM LTC carve-in presents an opportunity to change these incentives.

In order to incentivize HCBS over institutional care, several states design long-term care payment rates so that functional status or level of service need, rather than setting of care, drives payment. These are often called "**blended**" rates.[30]

- Arizona and Virginia are two of many states that employ blended rate-setting approaches where the same capitation rate is used for people who meet criteria for a nursing facility level of care, whether they reside in a nursing facility or in the community.[31]
- Massachusetts uses a variety of rate-setting strategies to incentivize transitions to home and community-based settings in their **Senior Care Options**[32] plans for dually eligible enrollees. These strategies are intended to both reduce financial incentives that might inappropriately encourage institutional care and channel resources to enable effective community transitions.
  - The state pays MCPs a specific rate for people living in the community who meet a nursing home level of care, which is higher than their typical community rate.[33]
  - When people who meet criteria for a nursing home level of care move into a nursing home, the payment rates that the MCP receives for those members do not increase for 90 days.[34]
  - When people transition out of nursing homes to the community, the state will continue to pay a higher institutional payment rate for 90 days to support any additional resources to reestablish them in the community.[35]
- **This guide**[36] for states and MCPs can be used to create more accurate risk-adjustment methodologies for populations requiring LTSS. The guide considers the challenges inherent in designing and implementing managed LTSS rate-setting processes for diverse LTSS populations and suggests approaches for states interested in pursuing risk-adjustment methods based on functional status. **Another resource**[37] reviews risk-adjustment strategies that consider functional and cognitive factors alongside health care claims to establish accurate capitation rates.

Payment Flexibilities for Nonmedical Supports

A recent policy shift has occurred to allow Medicare and Medicaid programs to pay for nonmedical supports that can help enrollees who need LTSS to live well in the community and avoid institutions. In Medicare Advantage plans, these are called **Special Supplemental Benefits for the Chronically Ill**.[38] Medicaid MCPs can also make use of flexibilities to purchase nonmedical services, such as furniture, meal delivery, caregiver respite, accessibility modifications in new dwellings, or to fill a gap for personal assistance services. Under CalAIM, these optional nonmedical supports will be provided through a program called Community Supports (see sidebar on page 9).

- In California's **CMC program**,[39] CMC plans had the latitude to cover nonmedical supports through an optional benefit called **Care Plan Options**.[40] But when plans invested in these supports, their expenses were not included in future rate calculations and therefore, these investments did not translate into cost savings for MCPs that invested in them. Thus, few plans took advantage of this flexibility.[41]

Related CalAIM Initiative

Community Supports,[42] like its precursor Care Plan Options (CPOs), will allow MCPs to invest in nonmedical supports that can help a member transition to and thrive in the community; the design of Community Supports seeks to remedy the financial disincentives embedded in CPOs by allowing plan investments in Community Supports to be included in future rate calculations. This will allow MCPs that invest in these services — especially those that use Community Supports to help members avoid institutions — to share in the savings. Community Supports include services such as housing placement, transition navigation, short-term post-hospitalization housing, and medically supportive food and to support those transitioning out of institutions.

Transition-Related Payment Incentives

Nationally, many Medicaid programs are turning to payment models under which payments to providers are tied to performance on process and outcome metrics.[43] Several states have explored payment designs that incentivize MCPs to prioritize home care over institutions.

- South Carolina and Illinois offer MCPs incentive payments when a member returns to the community from a nursing home due to care coordination efforts by the MCP.[44]
- Alabama provides an incentive opportunity under which Integrated Care Networks (competitively bid networks to provide case management, education, and outreach to individuals with long-term care needs)[45] can receive payments to reward movement toward increased HCBS usage.[46]
- When Texas carved the nursing facility benefit into managed care, the state initially included two MCP performance metrics related to transitions that impacted payments. These measures included rates of admissions to nursing facilities from community settings and from hospitals before and after the carve-in.[47]

CAUTIONARY NOTE. *While all of these design options hold promise, if financial incentives or external pressures to transition members to HCBS are too high or do not consider the care preferences of residents and caregivers, it could lead to scenarios where nursing home residents are discharged inappropriately. News outlets have reported on individuals who have been discharged from nursing homes against their will, potentially due to COVID-19 pressures, when they did not have adequate support at home. In some instances, these individuals were forced into homelessness.*[48]

Housing Supports for Successful Transitions

Limited availability of affordable and accessible housing is one of the most significant barriers to moving people from institutions to community settings and preventing institutionalization in the first place.[49] This challenge is particularly acute in California, where the number of people facing housing instability is growing.[50] Cultivating partnerships between MCPs and housing providers can help facilitate expedient access to safe housing and can align with housing supports included in CalAIM.

- Tennessee leverages their managed LTSS contracts to require that MCPs have housing specialists whose role is to identify and locate housing options for members transitioning back to the community, or to help keep members in the community.[51]
- Pennsylvania's **Community HealthChoices** plans are required to provide tenancy and pre-tenancy supports to help members at risk of homelessness. They are also required to participate in local housing collaboratives.[52]
- In California, **American Rescue Plan Act**[53] dollars are being used to expand the **Medi-Cal Assisted Living Waiver** by 7,000 slots.[54] While not a part of CalAIM, this expansion could provide more options for Medi-Cal enrollees to live in residential care facilities instead of in nursing homes.

Related CalAIM Initiative

The CalAIM Community Supports initiative gives MCPs the option to cover a range of housing supports,[55] such as assistance with applying for housing, housing deposits, and tenancy-sustaining services. These services will be especially important to leverage for MCP members who seek to avoid institutionalization.

Supports for Informal Caregivers

Research shows that having informal caregivers (e.g., family or friends who provide unpaid support) is associated with reduced use of health care services and a decreased risk of institutionalization.[56] Thus, MCP investments in family caregiving supports, such as respite services and caregiver trainings, may be an important factor to help promote safe and effective transitions out of institutions.[57]

- Florida's **Statewide Medicaid Managed Care Long-Term Care**[58] contracts require MCPs to use a state-approved LTC supplemental assessment form that must include an assessment of caregiver needs. The assessment is intended to examine the availability and willingness of caregivers to participate in services and supports and any limitations that they may experience in doing so.[59]
- Rhode Island requires a Caregiver Assessment that identifies informal caregivers and gathers information "to identify the specific problems, needs, strengths, and resources of the family caregiver, as well as the caregiver's ability to contribute to the needs of the care recipient."[60]
- In Minnesota, a Medicaid HCBS waiver provides reimbursement for a **Family Caregiver Coaching and Counseling with Assessment** service, which is "intended to equip the caregiver with knowledge, skills, and tools to become a stronger caregiver."[61]

Identification of Appropriate Transition Candidates

Many CMC plans in California that have carved in institutional LTC reported having difficulty identifying candidates for transition out of institutions to home and community settings.[62] Partnerships with community-based organizations, uniform assessments, and better examination of existing data

can help plans identify appropriate members more effectively and divert members from institutions altogether.

Partnering with Community-Based Organizations

Community-based organizations (CBOs) that have expertise working with nursing home residents or older adults at risk of nursing home placement can help MCPs in this regard.

- In California, one Long-Term Care Ombudsman Program (LTCOP) partners with CMC plans in their region to help them review medical charts, meet members, and identify which members may be willing and able to transition to the community.[63] As resident advocates, LTCOPs have deep knowledge of all of the nursing homes and residential care facility options in their region and can be a good resource for MCPs.
- In California, some CMC plans partner with **Multipurpose Senior Services Programs**[64] (MSSPs), which provide specialized care management with the specific intent of supporting older adults who qualify for nursing facility care to live safely in home and community-based settings. While MSSP is a Medi-Cal HCBS waiver program with limited slots, MCPs can contract with an MSSP as an Enhanced Care Management provider to support their members on the MSSP waitlist.[65]

Using Data to Identify Candidates for Transition or Diversion

The federal **Minimum Data Set**[66] (MDS) is a data collection tool administered to all nursing home residents on a quarterly basis. The MDS includes one section to record resident preferences regarding returning home. MCPs could review this portion of the MDS for their members in institutions to help identify members who are willing to transfer to lower levels of care. Alternatively, including questions about preferences for discharge and community living is something that MCPs could collect in their health risk assessments.

Related CalAIM Initiative

CalAIM requires MCPs to develop **Population Health Management** (PHM) programs[67] that would promote comprehensive analysis of entire populations, with a goal of better targeting prevention and wellness efforts; starting in 2023, MCPs will need to comply with National Committee for Quality Assurance and additional DHCS standards. Among other requirements, MCPs will need to systematically assess member needs and risks using health care, behavioral health, and social service data. Ideally, PHM programs will identify individuals residing in institutions who might no longer meet an institutional level of care or might be worsening in the institutional setting and therefore, be optimal candidates for transition to home and community settings.

Using Care Management to Support Transitions

MCP care management staff, if they have adequate expertise and training, can help identify candidates for transition to lower levels of care. Enhanced Care Management programs, which are part of CalAIM, should be designed to ensure this.

- Several California CMC plans have specialized units inside their care coordination departments whose staff receive specific training to support institutionalized members.[68]
- In Massachusetts, MCPs employ "geriatric services and supports coordinators," who help people navigate the long-term care system.[69]
- In Pennsylvania, managed care organizations are required to provide the state's Nursing Home Transition program's services through qualified staff that are employed by or contracted with the plan.[70]

- Virginia requires in their **managed LTSS program** that transition care coordinators are placed throughout the state's geographic regions. These coordinators are responsible for supporting safe transitions from nursing facilities to the community.[71]
- One California MCP that carved in LTC through the CMC program established a practice of proactively meeting with their members' hospital discharge planner, the nursing home, and housing support professionals before the member was admitted to a nursing home to ensure that a plan for post-discharge housing was in place before admission. Under CalAIM, MCPs can design their Enhanced Care Management programs to emulate this practice (see sidebar).

Related CalAIM Initiative

Through **Enhanced Care Management**[72] (ECM) programs, MCPs can contract with external organizations to provide ECM to their members with complex care needs. As MCPs choose ECM providers, it will be important to contract with entities that have experience and expertise working with older adults and people with disabilities who require an institutional level of care or those who have experience supporting Medi-Cal enrollees transitioning out of institutions to lower levels of care. Two types of organizations that should be considered include Multipurpose Senior Services Program (MSSP) providers and organizations that have been leads in **California's Community Care Transitions**[73] program. ECM providers (or MCP care managers) can work closely with hospitals, nursing homes, and housing providers both before, during, and after institutionalization to ensure access to increase the odds of successful transition out of facilities when appropriate.

Diversion from Institutions

Often when individuals — particularly those living in poverty and facing housing instability — are admitted to an institution, it can be very difficult to transition back out.[74] Given this reality, decisions to place a member in an institution should be considered carefully. It is important for MCP members, their families, and other caregivers to have a strong say in whether they are (1) admitted to an institution in the first place, or (2) ready and willing to transition to a community-based setting.

- MCP risk assessments could be designed to determine members' preferences for postacute care before any hospitalizations occur. These assessments could also proactively identify members who are at risk for homelessness after hospitalization or institutionalization to ensure MCPs are working with housing providers.[75]
- MCPs could be encouraged to establish internal review boards with specific placement criteria to vet and authorize placement decisions prior to institutionalization.[76]

3. High-Quality Institutional Care

Ample opportunities exist to improve quality of care in California's institutional settings.[77] In 2018, a California State Auditor's report identified significant quality challenges in nursing homes, including persistent concerns with low quality of care, financial practices that privilege profits over staffing, and poor statewide oversight of facilities.[78] One study of California's CMC provider network showed that CMC plans struggled to contract with higher quality facilities.[79] Quality worsened in California institutions with the COVID-19 pandemic.[80] These developments underscore the tremendous need and opportunity to improve nursing home quality under the LTC carve-in. The earlier section of this report on access to institutional LTC highlights some strategies to encourage facilities, especially higher quality ones, to contract with and admit members of MCPs. This section focuses on promoting a higher quality of care in contracted facilities.

Payment Strategies that Incentivize Quality

Quality Incentives

It is typically the responsibility of the MCP to ensure that providers in their networks are providing high-quality care. The institutional LTC carve-in provides an opportunity to consider leveraging additional quality incentives. Using value-based payment (VBP) models is one approach that has been used in California and other states.

- In California, some CMC plans use a VBP model to reward facilities with higher payments for higher quality care. They track quality outcomes, such as bedsores, adequate staffing, and hospital readmissions to determine payment rates. This model also builds in penalties if the facility falls below four stars in CMS's Five-Star Quality Rating System.[81]
- Tennessee took a phased approach to implementing a VBP model in its managed LTSS program. At the outset, the state provided transition (or "bridge") payments that rewarded facilities' quality improvement efforts rather than performance, eventually moving to a full VBP model with acuity- and quality-adjusted reimbursement rates.[82]

CAUTIONARY NOTE. *Value-based payment alone does not always increase the quality of care received in nursing facilities.[83] A federal demonstration of VBP in nursing homes between 2009 and 2012 showed that the VBP design used in that demonstration did not increase quality in the domains of nursing staffing, quality outcomes, survey deficiencies, nor in avoidable hospitalizations.[84] Any VBP strategies developed for the CalAIM institutional LTC carve-in would need to be carefully designed with stakeholder input to incentivize and empower MCPs to improve quality.*

Quality Measurement

Developing contractual quality requirements with input from stakeholders, including consumers, institutional LTC providers, and MCPs, can increase the comprehensiveness of measures and possibly improve providers' understanding of and performance on the measures. As mentioned above, quality measures work best when they are consistent across MCPs.

- In Texas, legislation required the Texas Health and Human Services Commission to develop a quality-based system for nursing facilities that included incentives related to preventable hospitalizations, preventable use of institutional care, and overall improvements in quality. To support this, the state created an internal workgroup to develop potential measures for stakeholder input. After soliciting and integrating broad stakeholder feedback, the state shared revised measures with plans for feedback before those

measures were included in the state's contracts with MCPs to ensure that measures could be influenced directly by plans.[85]

- When Tennessee was selecting domains and measures for its VBP initiative, the state sought feedback from advocates, providers, service recipients, and caregivers. To support this process, the state launched a community forum that included sessions for nursing home residents and family members and sessions for providers. All forums focused on the concept of "what does quality mean from the perspective of the person receiving services?"[86]
- The California legislature recently has required all commercial plans in California to be accredited by the National Committee for Quality Assurance to standardize quality expectations; applying similar requirements in Medicaid has also been considered.[87]

Accountability and Oversight

While oversight and regulation of institutional settings fall to various departments within state and federal agencies, MCPs also have a responsibility to ensure that all of the providers in their networks are providing high-quality care and that their members are free from abuse and neglect. MCPs can use a variety of strategies to provide an additional layer of oversight to ensure the quality of their provider networks.

- In California, an innovative partnership between one LTCOP and several CMC plans led to jointly conducted unannounced visits to LTC facilities. The Ombudsman taught the MCP representative what to look for in residents' charts and how to conduct spot-checks to ensure that care plans were being followed, with a particular focus on identifying inappropriate use of **hospice**[88] and **antipsychotic drugs**[89], residents who did not need nursing facility care, and inappropriate hospitalizations and/or discharges.[90]
- The Veterans Administration, while not an MCP, is an example of a delivery system that adds an extra layer of oversight to its contracted facilities by conducting annual on-site audits to assess quality and environmental expectations.[91]
- Illinois enables MCPs to set forth additional quality expectations of nursing facility and HCBS providers that extend beyond state or federal requirements, limiting contracting to only those providers who meet those additional standards.[92]
- Advocates in Pennsylvania recently urged their state to hold MCPs accountable for the quality of their nursing home care. For example, if MCPs are allowed to contract with poor-performing facilities (e.g., one to two stars on **CMS's Nursing Home Compare**[93]) the state could require that those MCPs provide additional monitoring and support, such as more frequent in-person care manager visits or paying for additional staff in facilities that are understaffed.[94]
- National advocates have suggested including minimum staffing standards in MCP contracts for institutional providers in an effort to increase accountability. It has been suggested that MCPs can avoid placing their members in facilities that are understaffed by regularly examining quarterly **CMS Payroll-Based Journal data**.[95]

Quality and Financial Data Transparency

MCP care managers, hospital discharge planners, and consumers all have roles to play to help Medi-Cal members avoid entering institutions that are chronically understaffed or have a history of deficits, abuse, and poor quality. MCPs also should avoid contracting with facilities that have questionable financial practices. When nursing home quality data are published in easy-to-understand formats, it can help both MCPs and consumers make better choices.

- In California, the newly relaunched **Cal Long Term Care Compare**[96] website is a nonpartisan, public resource for quality data on all California nursing homes. MCPs can use the public data from this website to determine whether a facility is performing well enough to include it in their provider networks.
- In Oregon, the Department of Human Services publishes quality data in a **consumer-friendly website**[97] that can help those considering entering a facility avoid poor performers.
- In California, Governor Gavin Newsom recently signed into law S.B. 650, **The Corporate Transparency in Elder Care Act of 2021**,[98] which requires skilled nursing facilities to provide consolidated financial reports and documentation of corporate structure to the state and the public.[99] These financial statements can be examined by MCPs as they make determinations around what facilities they will contract with.

4. Promotion of Equity in Long-Term Care

People of color have historically received lower quality care and experienced worse health outcomes across all systems of LTSS when compared to their White counterparts.[100] But research demonstrates that racial disparities are especially pronounced in institutional settings:

- Lower quality of care is often seen in LTC facilities that are racially segregated — serving a higher concentration of residents of color — versus those that serve a lower concentration.[101] In particular, research has found that Black residents in LTC facilities receive less pain management, are subject to more physical restraints, and are less likely to receive a flu vaccine than White residents.[102]
- Hospital readmission rates are higher for Black and Latinx residents in nursing facilities compared to White residents.[103]
- Residents of color have been found to be more likely to file complaints to their LTCOP related to residents' rights compared to White residents.[104]
- Racial disparities also have been demonstrated during the COVID-19 pandemic, where outbreaks were worse in nursing homes with higher proportions of non-White residents.[105]

Racial disparities in access to HCBS also impact institutionalization risk.

- One study showed that when states invest more dollars in HCBS, it results in less institutionalization for White people with dementia, but not for Black people.[106] This study suggests that there may be factors that inhibit access to HCBS that could make it more difficult for Black Californians to transition out of nursing homes.

Design of an Institutional LTC Carve-In that Elevates Equity

While considerable evidence demonstrates the pervasiveness of racial disparities in health care settings, research on effective interventions to ameliorate disparities in LTC settings is limited. That said, more comprehensive data collection to monitor disparities and increase consumer engagement is a logical preliminary approach.

- In their recently released **Comprehensive Quality Strategy 2022**,[107] DHCS outlines a health equity road map, including data collection, workforce development, and direct efforts to improve health care disparities (e.g., inclusion of health equity metrics in VBP approaches). As DHCS refines its health equity road map, it can consider specific elements and applications in consideration of the institutional LTC carve-in to managed care.
- State agencies and departments with responsibility for the care of residents of institutional settings can update their data collection and reporting on race and ethnicity to ensure that inequities and disparities are identified and remediated.

One structural approach to eliminating disparities is to ensure that institutional LTC facilities meet minimum staffing levels considered necessary to prevent harm or jeopardy to residents. Facilities that serve a higher percentage of residents of color have been found to have fewer financial resources and are more likely to have insufficient staffing, with a related higher number of care deficiencies and poorer direct care.[108] In particular, these facilities are more likely to have lower staffing by registered nurses (RNs) and tend to be staffed by workers with less clinical training.[109]

In 2001, CMS found a clear association between nurse staffing ratios and nursing home quality of care, and established the importance of specific staffing levels: a minimum of 0.75 RN hours per resident day, 0.55 licensed vocational nurse/licensed practical nurse hours per resident day, and 2.8 to 3.0 certified nursing assistant hours per resident day, for a total of 4.1 nursing hours per resident day to prevent harm and jeopardy for long-stay residents.[110] These standards have since been verified in other studies[111] and have been endorsed by professional associations and experts.[112]

- Advocates in Pennsylvania have recommended increasing staffing ratios to the recommended 4.1 nursing hours per resident day in order to address the fact that nursing homes with mostly Black or Latinx residents tend to be understaffed, leading to poorer outcomes.[113]
- Disparities in staffing and quality deficiencies can be monitored by MCPs using the quarterly Payroll-Based Journal reports that nursing homes are now required to submit to CMS and are made publicly available on CMS's website to **compare nursing homes**[114] and other kinds of providers.

Additionally, a variety of MCP-oriented strategies could be employed to address systemic inequities. Health equity accreditation is one approach:

- In California, commercial plans within the marketplace are required to obtain a health equity accreditation; DHCS may consider a similar approach for Medi-Cal plans.[115]

Additionally, one analysis of Pennsylvania nursing homes highlighted a series of potential approaches for addressing racial and ethnic disparities for MCP members in institutional settings,[116] including:

- Revise underlying MCP contracts to codify expectations for addressing disparities in nursing home care.
- Require MCPs to develop quality improvement plans related to addressing and mitigating disparities in nursing home care.

- Send MCP-based care coordinators to visit nursing home residents regularly to monitor safety and outcomes, especially those that are understaffed and/or have a high proportion of residents of color.
- When members are residing in lower quality nursing homes that are part of the MCP provider network, require MCPs to supplement nursing home staff with additional contracted staff resources.
- Require MCP staff involved in nursing home placements to demonstrate bias-free, quality-based guidance to choose an appropriate, high-quality nursing home.

Key Takeaways

Synthesis of key informant interviews with stakeholders, and examples of best practices and lessons learned from California and other states, point to the following key considerations for different stakeholder groups:

State Medicaid agencies. State Medicaid agencies can play a key role in ensuring accurate, fair rate-setting that incentivizes the use of HCBS, when appropriate. Additionally, states can set consistent and statewide quality, payment, payment timeliness, and equity expectations between MCPs and contracted providers; these expectations can be set forth in model contract parameters that MCPs use as they go through routine procurement processes with institutional and HCBS providers. Additionally, states can act as a neutral convener of stakeholders as the carve-in implementation begins to adjust and respond, as needed, to promote access, quality, equity, and rebalancing to HCBS. Over time, states can determine the appropriate balance to strike as MCPs take on a more active role in oversight and accountability of the quality of care provided by their networks.

Medi-Cal managed care plans. MCPs have a tremendous, arguably lead role to play as institutional LTC is carved in to managed care. MCPs can employ creative payment incentives and other financial levers to attract high-quality LTC providers and incentivize providers to ensure that beneficiaries are served in the most appropriate setting. MCPs have a responsibility to ensure the quality of care provided by their provider networks; they can use quality and staffing data to avoid placing members in low-performing facilities or provide more oversight for their members who are in facilities with a history of low staffing levels or quality deficits. This is especially important in facilities that are racially segregated and serve higher proportions of residents of color. MCPs can leverage relationships with community-based organizations that are experts in providing support and advocacy for institutionalized seniors and people with disabilities and helping them with transitions to lower levels of care, where appropriate. MCPs also clearly have a key role to play in operationalizing other CalAIM initiatives, such as Population Health Management, Community Supports, and Enhanced Care Management, and ensuring alignment between those programs' efforts to promote access, quality, and rebalancing and the institutional LTC carve-in.

Institutional LTC providers. Institutional LTC providers are operating in a payment and operational context that is largely externally defined and monitored, but they can take proactive steps to promote high-quality care. For example, nursing facilities may play a proactive role in identifying and communicating to MCPs the kinds of reimbursable services and supports that would help them provide higher quality care to MCP members, including those with the most complex care needs. Nursing facilities will need to collaborate closely with MCPs both before members are admitted, during their stay, and during the discharge process to ensure that the member receives quality care and is well supported during and after discharge.

Advocates, consumers, and caregivers. Advocates, along with consumers and caregivers as they are able and willing, have a tremendously important training and partnership role to play with MCPs and LTC providers to orient both entities to their obligations in a managed care setting. It may also make sense for some advocacy organizations to take on some aspects of monitoring and accountability on behalf of the state or MCPs. Caregivers and families also can play an important role as members of care teams, paying particular attention to the desires of their loved ones and ensuring that care transitions happen at appropriate times. The availability of public-facing quality data can help consumers and their caregivers understand the available choices and better advocate for the care they need in the setting of their choice.

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Appendix B. Institutional Long-Term Care Facilities, by County and Model

Table B1. Type and Number of Institutional Long-Term Care Facilities, by County

COUNTY	MODEL	SKILLED NURSING FACILITY (SNF)	SUBACUTE FACILITY		INTERMEDIATE CARE FACILITY		
			ADULT	PEDIATRIC	ICF/DD	ICF/DD-H	ICF/DD-N
Alameda	Two Plan	73	5	0	0	27	10
Alpine	Two Plan	0	0	0	0	0	0
Amador	Regional Expansion	1	0	0	0	0	0
Butte	Regional Expansion	9	0	0	0	2	4
Calaveras	Regional Expansion	1	0	0	0	0	0
Colusa	Regional Expansion	2	0	0	0	0	0
Contra Costa	Two Plan	29	2	0	0	16	13
Del Norte	COHS Expansion	1	0	0	0	0	0
El Dorado	Regional Expansion	4	0	0	0	0	0
Fresno	Two Plan	33	2	0	0	22	20
Glenn	Regional Expansion	1	1	0	0	0	0
Humboldt	COHS Expansion	5	0	0	0	2	0
Imperial	Imperial	3	0	0	0	3	0
Inyo	Regional Expansion	2	0	0	0	0	0
Kern	Two Plan	19	1	0	0	15	13
Kings	Two Plan	3	0	0	0	0	0
Lake	COHS Expansion	3	0	0	0	0	0
Lassen	COHS Expansion	1	0	0	0	0	0
Los Angeles	Two Plan	384	56	3	6	157	72
Madera	Two Plan	6	0	0	0	0	6
Marin	COHS	13	0	0	0	5	0
Mariposa	Regional Expansion	1	0	0	0	0	0
Mendocino	COHS	4	0	0	0	0	0

Table B1. Type and Number of Institutional Long-Term Care Facilities, by County, *continued*

COUNTY	MODEL	SKILLED NURSING FACILITY (SNF)	SUBACUTE FACILITY		INTERMEDIATE CARE FACILITY		
			ADULT	PEDIATRIC	ICF/DD	ICF/DD-H	ICF/DD-N
Merced	COHS	10	0	0	0	3	7
Modoc	COHS Expansion	2	0	0	0	0	0
Monterey	COHS	15	1	0	0	2	0
Napa	COHS	6	0	0	0	1	0
Nevada	Regional Expansion	5	0	0	0	0	0
Orange	COHS	73	14	2	2	79	40
Placer	Regional Expansion	10	1	0	0	0	3
Plumas	Regional Expansion	2	0	0	0	0	0
Riverside	Two Plan	55	4	0	1	52	23
Sacramento	GMC	37	2	0	0	12	11
San Benito	San Benito	2	0	0	0	0	0
San Bernardino	Two Plan	54	8	2	0	61	37
San Diego	GMC	84	10	1	1	74	20
San Francisco	Two Plan	18	1	0	0	0	0
San Joaquin	Two Plan	26	1	0	0	20	18
San Luis Obispo	COHS	7	0	0	1	7	3
San Mateo	COHS	17	1	0	0	21	12
Santa Barbara	COHS	14	0	0	1	6	1
Santa Clara	Two Plan	52	3	2	0	9	24
Santa Cruz	COHS	7	0	0	0	0	0
Shasta	COHS Expansion	10	0	0	0	7	7
Sierra	Regional Expansion	1	0	0	0	0	0
Siskiyou	COHS Expansion	1	0	0	0	0	0
Solano	COHS	9	0	0	0	11	7

Table B1. Type and Number of Institutional Long-Term Care Facilities, by County, *continued*

COUNTY	MODEL	SKILLED NURSING FACILITY (SNF)	SUBACUTE FACILITY		INTERMEDIATE CARE FACILITY		
			ADULT	PEDIATRIC	ICF/DD	ICF/DD-H	ICF/DD-N
Sonoma	COHS	20	1	0	0	8	5
Stanislaus	Two Plan	19	0	0	0	1	0
Sutter	Regional Expansion	4	0	0	0	0	4
Tehama	Regional Expansion	2	0	0	0	0	0
Trinity	COHS Expansion	1	0	0	0	0	0
Tulare	Two Plan	17	2	0	3	1	18
Tuolumne	Regional Expansion	3	0	0	0	0	0
Ventura	COHS	19	3	0	0	21	11
Yolo	COHS	6	1	0	0	1	6
Yuba	Regional Expansion	1	0	0	0	0	0
	Total	**1,207**	**120**	**10**	**15**	**646**	**395**

Table B2. Total Number of Institutional Long-Term Care Facilities, by Medi-Cal Managed Care Model

MODEL	SKILLED NURSING FACILITY (SNF)	SUBACUTE FACILITY		INTERMEDIATE CARE FACILITY		
		ADULT	PEDIATRIC	ICF/DD	ICF/DD-H	ICF/DD-N
COHS Expansion	24	0	0	0	9	7
GMC	121	11	1	1	86	31
Imperial	3	0	0	0	3	0
Regional Expansion	49	2	0	0	2	11
San Benito	2	0	0	0	0	0
Two Plan	788	83	7	10	381	254
Total	**1,207**	**116**	**10**	**15**	**646**	**395**

TABLES B1 AND B2:

Note: *COHS* is County Organized Health System, *GMC* is Geographic Managed Care, *ICF/DD* is intermediate care facility/developmentally disabled, *ICF/DD-H* is intermediate care facility/developmentally disabled-habilitative, *ICF/DD-N* is intermediate care facility/developmentally disabled-nursing.

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