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Medi-Cal Managed Care and Long-Term Services and Supports:
Opportunities and Considerations Under CalAIM

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About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

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Introduction

Millions of Californians live with disabling conditions or chronic illnesses that require them to seek assistance with common activities of daily living, such as bathing, dressing, and eating. Others need help with services such as transportation, housekeeping, meal preparation, or other assistance to live safely and independently at home. Some need these types of supportive services to thrive in a nursing home, assisted living community, or other facility setting.

To address these needs, a patchwork of programs across the state provides what are collectively known as long-term services and supports (LTSS); for many Californians with low incomes, some LTSS are provided through Medi-Cal, the state's Medicaid program.

California's Medicaid agency, the Department of Health Care Services (DHCS), seeks to improve the state's current approach to providing LTSS as part of its ambitious, multiyear set of reforms known as the CalAIM (California Advancing and Innovating Medi-Cal) initiative. The broad goals of CalAIM are to implement whole-person care approaches that address social drivers of health, improve quality outcomes, reduce health disparities, and create more consistent and seamless statewide Medi-Cal benefits that are easier for enrollees to navigate. One of the strategies that the state is using to achieve these goals is putting more responsibility for provision or coordination of services on its contracted Medi-Cal managed care plans (MCPs).

While a variety of approaches could help California achieve more standardized LTSS benefits and improve the enrollee experience, DHCS has stated its intent to move toward a delivery system referred to as statewide Managed Long-Term Services and Supports (MLTSS) by 2027. The CalAIM proposal defines MLTSS as "the delivery of long-term services and supports through capitated Medi-Cal managed care programs."[1] DHCS has not yet defined its vision for the full scope of LTSS services that would be the direct responsibility of Medi-Cal MCPs under statewide MLTSS, but has stated its intent to keep the In-Home Supportive Services (IHSS) program — the largest LTSS program — outside of managed care for the foreseeable future. It is likely that other LTSS benefits also would remain outside the managed care benefit, so Medi-Cal enrollees would receive some LTSS benefits through managed care and some outside the managed care system, with MCPs serving as the single point of accountability for referral, coordination, and delivery of services.

Through various reforms and programs, CalAIM increases the responsibility of MCPs for additional benefits, services, and populations that may increase the role of managed care in delivery of LTSS. Because of the sheer amount of activity under CalAIM, this report does not examine every CalAIM initiative that will impact MLTSS. However, it is important to understand that many components of CalAIM are interdependent, and many of these components increase the types of LTSS that MCPs can provide to enrollees. (See box titled "CalAIM Reforms Building Toward Managed Long-Term Services and Supports.")

This report explores some design options for implementing MLTSS that policymakers, agency leaders, advocates, and other stakeholders can consider as planning for this work unfolds. The information provided is based on research of existing LTSS in California and other states, more than 20 stakeholder interviews, and input from an advisory committee composed of regulators and subject matter experts (see Appendix A).

The report provides an overview of the challenges of the current system of supports and describes the potential benefits of statewide MLTSS. It also offers perspectives and lessons learned that can inform how the system could be developed, an overview of the improvements that a new system could provide,

as well as different scenarios for implementation. The analysis should help highlight viable options for the further development and implementation of statewide MLTSS in Medi-Cal managed care. The hope is to help ensure a smooth transition to this new approach to LTSS, and to advance and align with the larger goals of CalAIM.

CalAIM Reforms Building Toward Managed Long-Term Services and Supports

Following is a brief introduction to some of the related CalAIM components that impact MLTSS, which are in varying phases of implementation. Additional information can be found at the Department of Health Care Services' CalAIM web page.

- ***Institutional Long-Term Care Carve-In.*** Medi-Cal managed care plans (MCPs) statewide are responsible for institutional long-term care, starting with nursing facilities in January 2023, and other types of facilities in January 2024.
- ***Enhanced Care Management (ECM).*** ECM is a new Medi-Cal managed care benefit that is designed to address the clinical and nonclinical needs of specific populations of focus (e.g., high-risk, high-needs enrollees), who may require MCPs to deliver or coordinate additional LTSS to meet their needs.
- ***Community Supports (CS).*** Formerly known as "In Lieu of Services," CS include 14 medically appropriate and cost-effective alternatives to traditional Medi-Cal services that are optional for MCPs to offer and optional for enrollees to accept. Some CS are very similar to existing LTSS.
- ***Exclusively Aligned Enrollment (EAE) Dual-Eligible Special Needs Plans (D-SNPs).*** Beginning in 2023 in select counties and phasing in statewide by 2026, enrollees eligible for both Medicare and Medi-Cal will have the option to receive both program benefits from health plans from the same parent company. The goal of this model is to provide care coordination and wraparound services, including LTSS, through aligned Medi-Cal MCPs and Medicare Advantage plans known as Medicare Medi-Cal Plans.
- ***Population Health Management (PHM) Program.*** The PHM Program includes a road map that outlines the goals and requirements for MCPs to implement population health management strategies. A component of the PHM Program is the establishment of a PHM Service to provide access to comprehensive, timely, and accurate data to MCPs, providers, counties, and Medi-Cal members. MCPs will be required to use data from the PHM Service to identify gaps in care, focus on approaches that link members to social services and supports, utilize a standard member risk-stratification process, and improve care transitions across the delivery system for all Medi-Cal covered services.
- ***Standard Mandatory MCP Enrollment Policy.*** Nearly all Medi-Cal enrollees in the Seniors and Persons with Disabilities eligibility category are now required to enroll in an MCP for their Medi-Cal benefits statewide. This includes both those covered by Medi-Cal only and those enrolled in both Medicare and Medi-Cal (dually eligible enrollees). These MCP enrollment policies are intended to ensure that Medi-Cal enrollees have more consistent benefits and to reduce fragmentation of all Medi-Cal services, funding, and accountability through a single delivery system.

Characteristics and Challenges of the Current Medi-Cal LTSS System

Detailed information about the current system of Medi-Cal LTSS can be found in the CHCF fact sheet, "Long-Term Services and Supports in Medi-Cal."[2] In addition, below are a few key points about the existing delivery system that are important to understand at a high level as California moves toward statewide MLTSS.

California has flexibility in designing its approach to LTSS. Medicaid programs across the country are jointly financed by states and the federal government. The Centers for Medicare & Medicaid Services (CMS) sets broad requirements for each state to develop its own Medicaid program through a Medicaid State Plan, which CMS both approves and monitors.[3]

States may request additional flexibility in designing their Medicaid programs through the formal approval of federal waivers.[4] Under the waivers, states can receive approval to deliver an alternative benefit plan, such as offering certain benefits to only a subset of Medicaid beneficiaries, implementing Medicaid managed care programs or restricted networks, and extending coverage to enrollees beyond those defined under Medicaid rules. This structure makes each state's Medicaid program unique and provides flexibility for California in its current approach to LTSS and how it could design its statewide MLTSS program.

Today's complicated system can make it difficult for people to get the care they need. Currently, California delivers most Medi-Cal LTSS through a complex patchwork of programs authorized through its Medicaid State Plan and several home and community-based services (HCBS) waivers. The ability of Medi-Cal enrollees to access these services can depend on waiver availability and/or capacity, the scope of services, and where enrollees live. This patchwork of program types and authorities means that California's current LTSS delivery system is fragmented, and services are not available consistently across the state. Medi-Cal enrollees who need services in the community or in a facility must navigate a complicated system, without a coordinated approach to support. Inefficiencies and inconsistency in the system can result in enrollees either not receiving care or accessing it in more costly settings, such as a hospital. Some of the program design issues that impact access to LTSS include:

- Fragmented accountability, oversight, and financial responsibility among the state, counties, and MCPs
- Regional differences in networks
- Varying waiver availability and eligibility criteria
- Long wait-lists, resulting in disparities in access
- Multiple intake/screening processes, making it difficult to determine the most appropriate program/waiver
- Program enrollment processes that can be difficult for people needing care (or their caregivers) to navigate
- Difficulty identifying available LTSS providers, especially providers willing to serve the Medi-Cal population
- Lack of robust data sharing across the LTSS system, impeding the delivery of person-centered care

More LTSS are moving under managed care through CalAIM. MCPs have responsibility for providing a subset of LTSS, including care delivered in long-term care facilities (expanded statewide under CalAIM), Community-Based Adult Services (or CBAS, an adult day health program that operates

in 28 counties),[5] and Enhanced Care Management benefits. Additionally, MCPs have the option to offer various Community Supports services. (See Appendix B for more details on the LTSS provided through MCPs.)

The remaining Medi-Cal LTSS are "carved out" of the MCP benefit. A carved-out benefit means that the MCP does not pay for or administer the services, which are accessed through a complicated system of waivers and other programs. (See Appendix C for more detail on current LTSS provided outside of the MCP benefit.)

Moving from LTSS to MLTSS: Federal and State Roles

No single path or prescribed format exists for a state to create an MLTSS program. CMS will consider a state's existing LTSS benefits and program structure as it evaluates and negotiates each MLTSS program one by one for compliance with Medicaid requirements. Once a state creates its MLTSS design, CMS and the state can identify the appropriate combination of waiver and State Plan authority necessary to meet the program's goals, given the requirements and limitations for each waiver and State Plan option.

CMS has broadly outlined the following key components that the department expects states to include in an MLTSS program design:[6]

1. Adequate planning
2. Robust stakeholder engagement
3. Enhanced provision of home and community-based services
4. Alignment of payment structures and goals
5. Support for beneficiaries
6. Person-centered processes
7. A comprehensive, integrated service package
8. A network of qualified providers
9. Participant protections
10. Quality assurances

Additionally, the state legislature will play a role in allocating funds from the state budget for the MLTSS program. Depending on the program's scope, statutory authority may be needed to implement the benefits statewide. Once CMS gives its approval and the state completes its legislative deliberations, states must adequately document — through managed care contracts, for example — the requirements and expectations of MCPs in providing and coordinating MLTSS.

Preparing for MLTSS: Integrating Lessons Learned from Past Efforts

California is not entirely new to MLTSS. Through a demonstration project known as the Coordinated Care Initiative (CCI), California attempted to move more LTSS under the responsibility of MCPs in seven counties. These experiments with MLTSS were met with considerable challenges. Specifically, two programs — In-Home Supportive Services (IHSS) and the Multipurpose Senior Services Program (MSSP) — were "carved in" to managed care for a few years, but were carved back out due to implementation challenges, unmet cost savings expectations, and significant opposition from key stakeholders.

As the state embarks on a pathway to defining and operationalizing statewide MLTSS, experiences from past efforts such as CCI can inform the work.

Making clear and consistent policy decisions. For the statewide MLTSS initiative to be successful, stakeholders need clear expectations and policy decisions to support their planning and implementation processes. During CCI, shifting policies (such as the carve-in and subsequent carve-out of IHSS and MSSP) created challenges for MCPs and their partners; these changes led to uncertainty and confusion about the benefit structure and the role of MCPs, which resulted in frustration and distrust among stakeholders and made it difficult for MCPs to provide the integrated and coordinated care envisioned in the initiative. For MLTSS, early, clear, and consistent articulation of expectations and policy decisions can help prevent this type of confusion.

Engaging providers. Communicating with impacted providers about the benefit and policy changes can help alleviate some of the confusion and opposition to enrollee transitions and the role of managed care. DHCS could work with plans and providers that have had success under previous pilots and existing MLTSS programs to create resources and trainings about developing relationships between MCPs and LTSS providers and how to build up expertise for statewide MLTSS implementation. These supports could address provider capacity for the reporting, invoicing, and data sharing necessary to support an effective network, and ability to coordinate excluded services. Proactive engagement and collaboration between DHCS, MCPs, and LTSS providers leading up to expanded MLTSS could help identify and reduce some barriers and integrate solutions that would support a broad network of LTSS providers. Those steps, in turn, could help improve coordination across the continuum of care.

Supporting the LTSS workforce. DHCS could use statewide MLTSS as a mechanism to implement policies that lead to a more robust LTSS provider network and increased options for Medi-Cal enrollees. Based on past efforts to improve LTSS networks and workforce retention, California stakeholders could consider the following approaches:

- Standardize and increase the use of telehealth and other virtual platforms to provide some LTSS virtually, which would help reach more people with the current workforce, especially in rural parts of the state.
- Create career pathways for LTSS providers. For example, one organization noted that it trains interested janitorial staff and others in entry-level positions so that they can move into direct care roles, and increases reimbursement when providers complete a certificate or training or when they otherwise demonstrate increased capabilities.
- Consider the value of creating different reimbursement structures and tiers based on enrollee needs, so that providers are paid adequately for the required workload.
- Provide a stipend to enrollees so that they could pay their LTSS provider directly, and at a consistent amount each month, rather than having provider incomes fluctuate based on hours worked.

Focusing on person-centered, sustainable services. Another key lesson is to center the design and implementation of MLTSS on providing person-centered care that enables Medi-Cal enrollees to receive high-quality care in the setting most appropriate for them, rather than focusing primarily on cost savings. While LTSS can be less expensive than higher-intensity care alternatives, person-centered LTSS provided in the community may not result in significant or immediate cost savings to the system and may result in an appropriate increase in the use of other services, such as primary care and prescription drugs. But the potential positive outcomes include improved health and a better enrollee

experience, especially when the enrollee is actively involved in their health care decisions. Under the CCI, the requirement to achieve cost savings to continue the program was one of the major roadblocks to the sustainability of those MLTSS.[7]

Exploring next steps. As the state moves into planning for MLTSS, stakeholders can consider models that other states already use to inform program design. The CHCF series titled "CalAIM for Seniors and People with Disabilities" includes examinations of efforts to integrate care in other states.[8]

Beyond information from past efforts, stakeholders will need to engage in constructive dialogue about program design options. One venue could be DHCS's CalAIM MLTSS and Duals Integration Workgroup,[9] where the state engages a broad group of stakeholders in planning for current and upcoming reforms. To date, this group has primarily focused on more immediate CalAIM implementation issues, and discussions of MLTSS have focused mainly on the carve-in of institutional long-term care and implementation of Enhanced Care Management and Community Supports. Focused discussions on achieving statewide MLTSS throughout the Medi-Cal landscape will be essential to creating stakeholder support and identifying best practices. Lessons from past experiences with MLTSS should be evaluated and integrated into these discussions and into the future program design. Another venue for learning and planning is DHCS's Home and Community-Based Services (HCBS)/MLTSS Gap Analysis and Multi-Year Roadmap process. (See box titled "Gap Analysis and Road Map.")

Gap Analysis and Road Map

In July 2021, the Department of Health Care Services (DHCS) received approval from the Centers for Medicare & Medicaid Services for $5 million in supplemental funding to engage in a statewide Home and Community-Based Services (HCBS)/MLTSS Gap Analysis and Multi-Year Roadmap for its HCBS and MLTSS programs and networks. The gap analysis is intended to highlight how the road map can be designed to reduce inequities in access and services, meet enrollee needs, increase program integration and coordination, improve quality, and streamline access. The results of this gap analysis will inform the development of MLTSS in Medi-Cal and impact the scope of federal authority needed to implement this program. DHCS is holding quarterly stakeholder meetings to provide updates and will be completing semiannual reports on activities and milestones.[10]

Potential Benefits of Expanding MLTSS

Given the complexity and inconsistency of the current LTSS system, the intention to expand MLTSS is an important part of making Medi-Cal benefits more consistent statewide under CalAIM. MLTSS is just one program design option for creating a more standardized system and is not a panacea for all of the system's current challenges. But since California has chosen this pathway, stakeholders should consider and seek to realize the potential benefits of this approach.

A statewide MLTSS program is expected to result in more uniform benefits and more consistent program requirements. While the state still needs to define which specific LTSS will be paid for and covered by the MCPs under statewide MLTSS, MCPs

are positioned to play a vital role as the single entity responsible for providing and/or coordinating all covered LTSS for Medi-Cal enrollees. This approach will require close collaboration between MCPs and LTSS providers, which is essential to integrate and coordinate these services and reduce confusion for Medi-Cal enrollees. Implementing a statewide system could also provide an opportunity to evaluate where requirements for reporting and other administrative burdens can be streamlined or reduced and could help plans and providers work more effectively and efficiently to serve Medi-Cal enrollees. Additional potential benefits of statewide MLTSS are explored below.

Increased Accountability and Oversight

Under a statewide MLTSS program, MCPs would be the entities singly responsible for the referral to, delivery of, and coordination of services. Having MCPs in this role would allow the state to establish a standard monitoring and oversight role, rather than overseeing a variety of waiver programs with different requirements. This consistent approach should help streamline monitoring and improve transparency.

As part of its monitoring and oversight, DHCS could begin to collect both qualitative and quantitative quality metrics to evaluate health outcomes and enrollee satisfaction with Medi-Cal LTSS. The data could be made publicly available and shared with enrollees, their trusted messengers (including providers, local community organizations, and social service agencies), and other stakeholders, to create a feedback process that iterates on program design to improve outcomes. (See box titled "LTSS Data Dashboard.")

DHCS could use this information to strengthen oversight in collaboration with MCPs and other stakeholders, to assess changes over time, and to identify gaps and bright spots in key areas, such as access, outcomes, quality, and equity across the LTSS delivery system. This could help ensure that resources are not simply transferred from one delivery system to another with no change in the experience and outcomes for enrollees.

LTSS Data Dashboard

One component of California's Home and Community-Based Services Spending Plan includes Department of Health Care Services (DHCS) implementation of an LTSS Data Dashboard to improve the transparency of LTSS data on service use, quality, and cost. The dashboard also should be able to inform statewide MLTSS accountability and oversight. DHCS and its dashboard development partners have been examining which demographic, utilization, access, quality, and equity metrics should be included in the dashboard and working with stakeholders to identify data priorities and how data will be used to monitor and improve care. The first iteration of the dashboard was released in late 2022, and it will be periodically updated with more comprehensive data. This public reporting tool provides some transparency on program use and could inform DHCS's development of key metrics and goals for statewide MLTSS.[11]

Reduced Disparities in Access to Services

California currently provides limited public data on who receives LTSS, the specific benefits provided, where enrollees access services, and inequities in access to services based on race, age, geography, and other factors. Over time, this should improve through the LTSS Data Dashboard. (See box above.) Establishing MLTSS across the state provides an opportunity to aggregate data on the delivery and

coordination of services at the plan level, which has the potential to improve data collection and better inform strategies to reduce known disparities in access. (See box titled "Importance of Culturally Appropriate Care" for more information on the importance of culturally appropriate LTSS.)

Examples of disparities in access have been well-documented. For example, a national study of dually eligible enrollees found that HCBS spending for Black enrollees was lower than spending for White HCBS recipients. Meanwhile, Black enrollees had the highest rates of avoidable hospitalizations, and this greater spending on hospital care did not correlate with better outcomes.[12] A study of staffing levels in nursing facilities showed that facilities with a population of majority-White residents had registered nurse staffing levels that were 34% and 60% higher, respectively, than majority-Black and majority-Latino/x facilities. Furthermore, these disparities were not entirely accounted for by variables including the residents' medical conditions, the facility's percentage of Medicaid-eligible residents, and whether the facility was in an urban or rural environment.[13]

Importance of Culturally Appropriate Care

Person-centered LTSS should be delivered in a way that respects and reflects the cultural differences among the Medi-Cal population. As eligibility is expanded to cover additional populations, such as undocumented Californians age 50 or older, it is increasingly important to ensure care is delivered in a culturally appropriate manner and in the preferred language of the enrollee. Existing disparities could be exacerbated if enrollees are unaware of the benefits for which they are eligible due to cultural or language barriers, and unable to access LTSS that meet their cultural and linguistic needs.

By consolidating responsibility for LTSS under MCPs, California has an opportunity to centralize data collection and reporting and use these data to better identify and address these types of disparities. For more information about data gaps and opportunities specific to HCBS in California, see CHCF's report *Using Data for Good: Toward More Equitable Home and Community-Based Services in Medi-Cal*.[14]

The CalAIM waiver approval includes a requirement for DHCS to ensure that contracted MCPs submit encounter data and supplemental reporting on health outcomes and quality metrics at both a local and aggregate level to assess equity of care. Where possible, the data must be stratified by age, gender, race, ethnicity, and language spoken. Under statewide MLTSS, additional standardized data should be available to plans as a result of increased requirements to coordinate across the delivery system, even if particular services are not specifically included under the MCP benefit.

Some key informants suggested this equity-focused analysis could begin prior to the implementation of statewide MLTSS, and that both qualitative and quantitative data could inform pre-implementation policy decisions. The state could explore several key questions to assess and address disparities in the delivery of LTSS as it pursues a more standardized, coordinated, and accountable system that better serves Medi-Cal enrollees. (See box titled "Key Questions to Assess and Address Inequities in LTSS.")

Streamlined Enrollment and Assessment Processes

Statewide MLTSS could create a standardized structure for LTSS eligibility and benefits, which would make it easier for MCPs to refer and coordinate LTSS, even if a particular service is not part of their contracted benefits. The structure could improve a

Key Questions to Assess and Address Inequities in LTSS

- Who receives a service and how do they access the service?
- How are enrollees educated and/or contacted regarding benefits that they are eligible to receive?
- Which Medi-Cal populations are underrepresented in the current use of LTSS or HCBS?
- What impact do eligibility processes and criteria have on who receives LTSS?
- How does the assessment process track enrollees' need for access or referrals to services?
- How does the state document enrollees' preferences for services and settings for receiving care?
- Which metrics demonstrate that enrollees are getting services in their preferred setting?
- Is a mechanism in place to identify Medi-Cal enrollees who need LTSS but may not be receiving care because of barriers to access or other reasons?
- What kinds of data are available to help providers more effectively identify and work with local populations in need of services?
- How can data be used to ensure that LTSS is offered through contracts with providers that can deliver culturally appropriate services and services in the language of the population they serve?
- How can the state take advantage of the DHCS Comprehensive Quality Strategy to ensure adequate attention to equity in LTSS?
- How will DHCS study subgroups of the population to monitor changes in equity and access during implementation of MLTSS?

plan's ability to help enrollees access a consistent and coordinated set of services. This standardized structure also could eliminate or greatly reduce the number of individual waiver assessments that enrollees must undergo to qualify for services. DHCS also could integrate stronger requirements and oversight through MCPs as the single accountable organization to ensure that referrals to LTSS are occurring across the continuum of care.

Designating MCPs as the single accountable organization could lead to the development of standard workflows related to LTSS delivery and referrals. Because current LTSS benefits and waiver programs are administered by various state departments, enrollment and reporting processes are not standardized. This patchwork system leads to manual processes that rely on individual expertise and knowledge of available programs.

The ability to develop standard workflows could increase referrals to LTSS both within and outside of the MCP benefit, which would help support the financial sustainability of LTSS providers by providing a steady pipeline of referrals. Additionally, streamlined assessments and standard criteria should address gaps in care for enrollees with temporary disabilities, who often struggle to navigate the eligibility criteria for different waiver programs.

Improved System Navigation and Care Transitions

Under MLTSS, MCPs would be expected to help their members transition between care settings (e.g., skilled nursing facility to home) or between LTSS programs, and to navigate the entire LTSS system. CalAIM reforms more broadly require MCPs to coordinate and contract with community-based organizations (CBOs) and other social service providers

to meet members' needs. Through the combination of these programs and MLTSS, plans will have the opportunity to implement whole-person care approaches and demonstrate improved outcomes related to access to and delivery of these services. Having a single point of contact and continuous support for all LTSS, regardless of whether a particular service is included under managed care or not, should make it easier for the enrollee to navigate the system and any transitions between care settings.

Stakeholders, however, may want to consider realistic expectations of what MCPs can achieve as they support enrollees who continue to receive some LTSS outside of the managed care benefit. To successfully support transitions and system navigation, MCPs would need the cooperation of contracted and non-contracted LTSS providers for coordination and access to information on their members. Since MCPs do not have the authority to compel non-contracted providers or social services to share data or to engage in care coordination activities, clear expectations or requirements may need to be established by the state. DHCS can consider how MLTSS could serve as a mechanism to engage MCPs, counties, LTSS providers, and CBOs to ensure effective coordination across the continuum of care.

Strengthened Data Exchange

Plans and LTSS providers require robust infrastructure, training, and resources to receive and digest data in ways that meaningfully impact care delivery. Because the LTSS system is not integrated and significant barriers exist for sharing data among LTSS providers, counties, and MCPs, the move to a standardized MLTSS benefit presents an opportunity to improve data exchange and ensure that plans and providers have access to the information needed to best support Medi-Cal enrollees.

Because some LTSS benefits will remain outside of MCP responsibility, addressing current data sharing barriers will require significant stakeholder engagement and agreement about which data should be shared and how to share data consistently across the Medi-Cal program. Improved data flow and information sharing would allow MCPs to engage in appropriate care coordination, identify duplication of services, create more robust care teams, ensure adequate referrals and access to services, and better transition enrollees to more appropriate levels of care. If MCPs have greater insight into all enrollee needs under statewide MLTSS, they could better identify and address gaps in LTSS, such as food insecurity, loneliness, and other social determinants of health.

However, MCPs will not be able to coordinate services in isolation. Coordination will require engagement and formal relationships among MCPs, counties, and LTSS providers. These relationships will be key to statewide goals for MLTSS integration and coordination and can assist with the transition to MLTSS even in the absence of robust statewide data exchanges, which may take years to establish. DHCS could consider CalAIM and statewide MLTSS to be important opportunities to create stronger requirements not just for MCPs but also for providers and counties to share data and information about enrollees. More robust data sharing could promote a more integrated system and hold all LTSS providers accountable for helping coordinate care.

An immediate challenge to sharing LTSS data across the continuum of care is the lack of a consistent approach to data exchange throughout the system. As a result, plans and providers have been hesitant to invest in significant information technology improvements. Interviewees suggested that DHCS could identify a common data exchange platform and require entities to use it, as well as provide funding or grants to those organizations required to make significant investments to comply with the

chosen platform. Greater resources would make it feasible for more organizations to participate.

Additionally, DHCS could assess whether LTSS providers have the capacity for the data exchange needed for MLTSS, and then identify the resources it would take to coordinate the entire LTSS system. MLTSS could help foster this work through a coordinated statewide approach and strategy for LTSS data exchange.

Scenarios for Designing the MLTSS Program

While MLTSS is not the only way to improve outcomes throughout the LTSS system, since it is the path that the state is exploring, it could be helpful to consider different scenarios about how the program could work. DHCS has several years to develop and implement the program, which provides an opportunity to be thoughtful about exploring the impacts of different policy and design options. Table 1 on page 14 outlines some potential options for MLTSS program design and the impact that each approach could have on the delivery system. These scenarios could inform stakeholders considering these and other options. (See box titled "IHSS Contract Mode" for unique considerations specific to the IHSS program.)

IHSS Contract Mode

Currently, no more than 5% of the total In-Home Supportive Services (IHSS) recipients in a county may receive their IHSS services and providers through a qualified agency that employs IHSS caregivers, rather than directly hiring their own provider. Known as IHSS Contract Mode, this model can be especially useful for IHSS recipients who need assistance identifying and securing a provider, those who have too few IHSS hours approved to recruit a provider on their own, or those who are between providers or are hiring one for the first time and need temporary assistance.

IHSS Contract Mode has been implemented in several counties in the past, but it is currently only available in San Francisco. As DHCS moves to statewide MLTSS, it could explore an expanded pilot of the IHSS Contract Mode to gain insights into how coordination with IHSS could be enhanced under MLTSS even if not integrated under the MCP. (IHSS and MLTSS will be the topic of a future paper in this series.)

Table 1. Potential Options for and Impacts of MLTSS Program Design

OPTIONS:

Limited MLTSS

Maintain the status quo: Continue a limited MLTSS program that includes institutional LTC, CBAS, ECM, and optional Community Supports, and the renewal of the current LTSS waivers as carved-out benefits that are not available statewide.

Make LTSS consistent statewide: Continue with the status quo but move HCBS waivers into a statewide structure in which benefits and services are available to all eligible Medi-Cal enrollees but remain excluded from the MCP benefit.

Pilot a greater inclusion of LTSS in managed care: Explore new opportunities to test additional LTSS offerings through MCPs in certain geographic locations.

Integrate additional services (except IHSS) into statewide managed care benefits: Continue to include statewide institutional LTC, CBAS, ECM, and optional Community Supports under MCPs. Move HCBS waivers into a statewide structure in which the benefits and services are available to all eligible Medi-Cal enrollees and include all LTSS benefits, except for IHSS, under the MCP benefit.

Full MLTSS

Integrate services into a statewide MCP benefit, including IHSS: MCPs would offer statewide MLTSS benefits for all services, including IHSS. (This option is not currently under consideration by DHCS but is included for illustrative purposes.)

IMPACTS:

	Maintain the status quo	Make LTSS consistent statewide	Pilot a greater inclusion of LTSS in managed care	Integrate additional services (except IHSS) into statewide managed care benefits	Integrate services into a statewide MCP benefit, including IHSS†
Increases integration of LTSS		X*	X *May only increase integration in pilot geographies*	X	X
Creates a consistent and statewide benefit		X	X *Would not address current patchwork of waivers*	X	X
Shifts the focus from cost savings to person-centered care		X	X	X	X
Expands access to new enrollees in current service areas		X	X		X *Does not guarantee that current IHSS providers would contract with MCPs*

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* X indicates that the policy option has the potential to influence the delivery of MLTSS.

† This option is not currently under consideration by DHCS but is included for illustrative purposes.

Notes: *CBAS* is Community-Based Adult Services; *DHCS* is Department of Health Care Services; *ECM* is Enhanced Care Management; *HCBS* is home and community-based services; *IHSS* is In-Home Supportive Services; *LTC* is long-term care; *LTSS* is long-term services and supports; *MCP* is managed care plan; and *MLTSS* is managed long-term services and supports.

Source: Developed by authors based on stakeholder interviews, literature review, and consideration of potential scenarios/approaches.

Table 1. Potential Options for and Impacts of MLTSS Program Design (continued)

	Maintain the status quo	Make LTSS consistent statewide	Pilot a greater inclusion of LTSS in managed care	Integrate additional services (except IHSS) into statewide managed care benefits	Integrate services into a statewide MCP benefit, including IHSS†
Includes new or expanded service areas		X *Workforce capacity may be a limiting factor*	X *Workforce capacity may be a limiting factor*		X *Does not guarantee that current IHSS providers would contract with MCPs*
Requires current LTSS providers to make significant changes		X	X	X *MCPs' requirements for data sharing, reporting, and billing may be burdensome for some providers*	X
Requires new federal waivers and approvals		X	X	X	X
Has significant impacts to the state budget		X	X	X	X
Disrupts the lives of enrollees currently receiving LTSS				X *Potential disruption from providers not contracting with MCPs/benefits not matching current waiver services*	X *Enrollees may be required to change providers and processes for receiving services*

* X indicates that the policy option has the potential to influence the delivery of MLTSS.

† This option is not currently under consideration by DHCS but is included for illustrative purposes.

Notes: *CBAS* is Community-Based Adult Services; *DHCS* is Department of Health Care Services; *ECM* is Enhanced Care Management; *HCBS* is home and community-based services; *IHSS* is In-Home Supportive Services; *LTC* is long-term care; *LTSS* is long-term services and supports; *MCP* is managed care plan; and *MLTSS* is managed long-term services and supports.

Source: Developed by authors based on stakeholder interviews, literature review, and consideration of potential scenarios/approaches.

Conclusion

The pathway to statewide MLTSS will be complex, as it requires building on a fragmented patchwork of programs while aligning the overall policy and financing goals of CalAIM and other related state health care initiatives. Stakeholders can leverage the lessons learned from pilots and the current LTSS delivery system to create a thoughtful and strategic implementation plan to increase coordination and improve the enrollee experience through more person-centered and equitable care delivery.

With robust stakeholder engagement and the development of standard data sharing and care coordination expectations along the continuum of care, statewide MLTSS has the potential to improve the enrollee experience and increase access to services through a more coordinated and consistent statewide benefit. However, large-scale system changes take time. DHCS, state policymakers, and LTSS advocates could take advantage of the years leading up to MLTSS implementation by 2027 to begin addressing existing barriers and identifying innovative solutions that will lay the groundwork for more effective and sustainable statewide MLTSS.

Appendix A. Advisory Committee Members

Organization	Representative
Anthem Blue Cross	Beau Hennemann
California Association for Adult Day Services	Lydia Missaelides
California Department of Health Care Services	Anastasia Dodson
Justice in Aging	Tiffany Huyenh-Cho
Partners in Care Foundation	Anwar Zoueihid

Appendix B. Medi-Cal Long-Term Services and Supports Provided Through Managed Care Plans

Institutional Long-Term Care Services — statewide for nursing facilities by January 1, 2023, and other facilities by January 2024.	Inpatient stays in an institutional setting, such as a skilled nursing facility, intermediate care facility, or subacute facility Source: *CalAIM Long-Term Care Carve-In Transition*, California Department of Health Care Services (DHCS), accessed October 12, 2022.
Community-Based Adult Services (CBAS) — 28 counties	▸ Individual assessments ▸ Professional nursing services ▸ Physical, occupational, and speech therapies ▸ Mental health services ▸ Therapeutic activities ▸ Social services ▸ Personal care ▸ Meals ▸ Nutritional counseling ▸ Transportation between a participant's residence and a CBAS center ▸ Emergency response services Because CBAS is only available in 28 counties, the Department of Health Care Services (DHCS) requires managed care plans (MCPs) to "arrange for the provision of unbundled services based on the assessed needs of the Member eligible for CBAS if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area." Source: *Community-Based Adult Services*, DHCS, last modified September 8, 2022.
Enhanced Care Management A statewide benefit available to select "Populations of Focus," ECM is designed to address clinical and nonclinical needs of the highest-need enrollees through intensive coordination of health and health-related services.	Populations of Focus include: ▸ Individuals and families experiencing homelessness ▸ Adults, youth, and children who are high utilizers of avoidable emergency department, hospital, or short-term skilled nursing facility services ▸ Adults with serious mental illness or substance use disorder ▸ Children and youth with serious emotional disturbance, identified to be at clinical high risk for psychosis or experiencing a first episode of psychosis ▸ Adults and youth who are incarcerated and transitioning to the community ▸ Adults at risk of institutionalization and eligible for long-term care ▸ Adult nursing facility residents transitioning to the community ▸ Children and youth enrolled in California Children's Services (CCS) with additional needs beyond CCS ▸ Children and youth involved in child welfare (including those with a history of involvement in welfare and foster care up to age 26) ▸ Individuals with intellectual/developmental disabilities (I/DD) ▸ Pregnant and postpartum individuals; birth equity population of focus Source: *California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management Fact Sheet*, DHCS, last modified January 18, 2023; and *CalAIM Enhanced Care Management Policy Guide*, DHCS, last modified December 2022.

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Appendix B. Medi-Cal Long-Term Services and Supports Provided Through Managed Care Plans (continued)

Community Supports Community Supports can be provided by MCPs as cost-effective alternatives to traditional medical services or settings and are designed to address social drivers of health. Community Supports are optional for both MCPs to provide and for enrollees to accept, and availability varies by plan and by county.	Community Supports include: ▸ Housing transition navigation services ▸ Housing deposits ▸ Housing tenancy and sustaining services ▸ Short-term post-hospitalization housing ▸ Recuperative care (medical respite) ▸ Habilitation programs ▸ Caregiver respite services ▸ Nursing facility transition/Diversion to assisted living facilities ▸ Community transition services/Nursing facility transition to a home ▸ Personal care and homemaker services ▸ Environmental accessibility adaptations (home modifications) ▸ Medically supportive food/Meals/Medically tailored meals ▸ Sobering centers ▸ Asthma remediation Source: *CalAIM Community Supports — Managed Care Plan Elections*, DHCS, accessed November 28, 2022.

Appendix C. Medi-Cal Long-Term Services and Supports Provided Outside of Managed Care Benefit

In-Home Supportive Services (IHSS) — Benefit Under California's Medicaid State Plan	▸ Housecleaning ▸ Meal preparation ▸ Laundry ▸ Grocery shopping ▸ Personal care services, such as bathing and grooming ▸ Accompaniment to medical appointments ▸ Protective supervision for the mentally impaired ▸ Paramedical services Source: *In-Home Supportive Services*, California Welfare and Institutions Code, § 12300 (2021); and *Overview of the IHSS Program*, California Department of Social Services, November 2020.
Services Provided Through Home and Community-Based 1915(c) Waivers The following list represents an inclusive set of services offered through various 1915(c) waivers, including the Home and Community-Based Alternatives (HCBA) waiver, Multipurpose Senior Services Program (MSSP), and the Assisted Living Waiver (ALW). Availability of each service depends on the specific waiver or program, and access may be limited based on unique waiver/program criteria and geographic limitations.	Services may include: ▸ Case management — services that help people gain access to needed medical, social, educational, and other services ▸ Community transition services — services that help people locate, secure, and coordinate affordable housing, adaptive equipment, or a care provider, and create a plan to return to community living ▸ Private-duty nursing — one-on-one nursing care ▸ Family training — education, support, and resources for family members and other caregivers about how to provide care ▸ Home health aides — health care workers who provide personal care and light household support to people in their homes ▸ Life-sustaining utility reimbursement — help paying utility bills to ensure enrollees maintain water or power service ▸ Habilitation services — services and devices that assist people in regaining full or partial skills and functioning to the maximum extent practical ▸ Respite care (in-home and out-of-home) — short-term care for patients as a relief to the primary caregiver ▸ Personal care services — care provided by an unlicensed individual who is employed by a Home Health, Employment, or Personal Care Agency that meets the HCBS waiver provider requirements ▸ Environmental accessibility adaptations — home modifications, such as ramps, grab bars, doorway widening, stair lifts, specialized electric and plumbing systems, and wheelchair-accessible bathrooms and showers that reduce the risk of accidents ▸ Minor home repair(s) ▸ Personal emergency response system (PERS) or communication device ▸ Protective supervision — supervision in the absence of the usual care provider to people in their own homes who are very frail or otherwise may suffer a medical emergency, to prevent immediate placement in an acute care hospital, nursing facility, or other 24-hour care facility ▸ Meal services — congregate living facility or home-delivered ▸ Social reassurance/therapeutic counseling — periodic telephone contact, visiting, or other social and reassurance services, to verify that the individual is not in medical, psychological, or social crisis; or to offset isolation ▸ Money management — activities related to managing money and the effective handling of personal finances ▸ Communication services — includes translation and interpretation Source: *Medi-Cal Waivers*, California Department of Health Care Services, last modified January 6, 2023.

Endnotes

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3. "State Plan," Medicaid and CHIP Payment and Access Commission (MACPAC), accessed September 1, 2022.
4. "Waivers," MACPAC, accessed September 1, 2022.
5. "List of Community-Based Adult Services Providers," California Department of Aging, accessed October 12, 2022; "1915(c) Home and Community Based Services Waivers," DHCS, accessed July 21, 2022; and "Community-Based Adult Services," DHCS, accessed July 20, 2022.
6. *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long-Term Services and Supports Programs* (PDF), Centers for Medicare & Medicaid Services, May 20, 2013.
7. Senate Bill 1036 (Chapter 45, Statutes of 2012) and Senate Bill 1008 (Chapter 33, Statutes of 2012); and *The Coordinated Care Initiative: A Critical Juncture*, Legislative Analyst's Office, February 27, 2017.
8. "CalAIM for Seniors and People with Disabilities," CHCF, accessed July 25, 2022.
9. "CalAIM Managed Long-Term Services and Supports and Duals Integration Workgroup," DHCS, accessed July 22, 2022.
10. "Gap Analysis and Multi-Year Roadmap of Medi-Cal Home and Community-Based Services and Managed Long-Term Services and Supports," DHCS, accessed October 11, 2022.
11. "Home and Community-Based Services Spending Plan," DHCS, accessed October 11, 2022; and "California Long-Term Services and Supports Dashboard," DHCS, accessed December 13, 2022.
12. Rebecca J. Gorges, Prachi Sanghavi, and R. Tamara Konetzka, "A National Examination of Long-Term Care Setting, Outcomes, and Disparities Among Elderly Dual Eligibles," Health Affairs 38, no. 7 (2019): 1110-1118.
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14. Amber Christ and Tiffany Huyenh-Cho, *Using Data for Good: Toward More Equitable Home and Community-Based Services in Medi-Cal*, CHCF, December 3, 2021.