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SPEAKERS

Jill Donnelly
Tyler Brennan
Kristie Kulinski
Michelle Wong
Neha Shergill
Natalie Allison
Ester Sefilyan
Gavin Ward
April Stewart

Jill Donnelly:

Hi, everyone. Thanks for joining. We're going to give it one more moment for people to jump on the call.

Okay, why don't we get started? Hello, my name is Jill Donnelly. I'd like to welcome you to our 7th CalAIM Community Supports Spotlight webinar. Before we begin, a few brief housekeeping notes. All participants will be on mute throughout the presentation. We'll have some time reserved for questions at the end of the webinar. If you have questions along the way, please submit them to the presenters via the Q&A feature on Zoom at any point. The PowerPoint slides and all meeting materials will be available soon on the DHCS website. It usually takes a couple of weeks, and we'll share details for where to access that information in the chat. A recording of the webinar will be sent out as well. Additionally, we have closed captioning available for this webinar. If you'd like to use this feature, please click on the closed captioning at the bottom of your screen and select subtitles.

Okay, so today we'll be hearing about personal care and homemaker services, as well as care caregiver respite. We'll start with some introductions. We'll hear about these Community Supports and promising practices from some of our presenters. As I mentioned, we'll also have some time for Q&A at the end. And with that, I will turn it over to Tyler Brennan at DHCS to introduce CalAIM and Community Supports.

Tyler Brennan:

Thanks, Jill. So we'll begin with a brief overview of CalAIM's Community Supports. Community Supports are medically appropriate cost-effective alternatives to services Medi-Cal managed care plans may provide In Lieu of Services traditionally covered by Medicaid. These services and or settings are designed to potentially decrease utilization of other Medi-Cal benefits such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. Managed care plans are strongly encouraged but are not required to provide Community Supports. CalAIM currently includes a robust menu of 14 pre-approved Community Supports to address the health needs of our members. This list of pre-approved Community Supports has been informed by the work and lessons learned under the Whole Person Care Pilot and the Health Homes Program. Managed care plan's selected Community Supports to offer when CalAIM went live on January 1st, 2022, and have the option to add new Community Supports every six months. Managed care plans in all counties are encouraged to offer at least one Community Support by January 1st, 2024. Next slide, please.

In Lieu of Services authority 101. The Community Supports are In Lieu of Services which are medically appropriate and cost-effective services or settings offered by a managed care plan as a substitute for a Medicaid state plan-covered service or setting. Under regulatory requirements, In Lieu of Services must be authorized and identified by plan contracts and offered at plan and enrollee options. This allows for Community Supports to cover a broad range of social and support services for eligible populations. Services are financed through the capita rates to plans in the same way as state plan services and do not require 1115 waivers savings. Next slide, please.

This slide here outlines the 14 pre-approved Community Supports. This particular webinar is intended to provide information about the personal care and homemaker services and caregiver respite Community Supports, and help inform you as you consider offering these supports to plan members and to patients. Next slide, please.

Managed care plan elections. At this time, 97 plans by county and 53 out of the 58 counties have elected to offer both the personal care and homemaker services and the caregiver respite Community Supports by January of 2024. So there's a lot of uptake on these. Next slide, please.

Together, the personal care and homemaker services and caregiver respite Community Supports are part of DHCS plan to build infrastructure over time and provide managed long-term care supports statewide in order to meet the needs of aging beneficiaries and individuals at risk for institutionalization. And with that, I'll pass it over to Kristie Kulinski from the Administration for Community Living who will provide us with an overview and some background on personal care and homemaker services. Kristie?

Kristie Kulinski:

Great. Thank you, Tyler. I'm Kristie Kulinski. I am with the Administration for Community Living. We are an operating division of the US Department of Health and Human Services, and I am a team lead in ACL's Office of Network Advancement. I'm really pleased to join you this afternoon to provide a summary of guidance on personal care and homemaker services, and I'd also like to connect the CalAIM guidance to the federal landscape with respect to ACL's investments and our priorities. Next slide, please.

So let's start with some basic definitions about the personal care and homemaker services community support piece. So the personal care services and homemaker services are provided for individuals who need assistance with activities of daily living, which are also known as ADLs. These include bathing, dressing, toileting, ambulation, or feeding, and can also include assistance with instrumental activities of daily living. We sometimes refer to those as IADLs, and those include meal preparation, grocery shopping, and money management.

So personal care and homemaker programs really aid individuals who otherwise would not be able to remain in their homes. It really enables community living. So this community support provides similar services to those offered through the In-Home Supportive Services or IHSS program. Those services can include help with house cleaning, meal preparation, laundry, grocery shopping, personal care services, accompaniment to medical appointments, and protective supervision for those who have mental impairments. Next slide, please.

So I'd like to frame personal care services and homemaker services in the context of the Older Americans Act. So ACL administers the Older Americans Act. It's a major vehicle for the organization and delivery of services that address health-related social needs for older adults and their caregivers. It's one of the authorizing statutes under which ACL operates. So through the Older Americans Act or the OAA, there's significant capacity across the country, including in California, to deliver home and community-based services such as personal care and homemaker services. You can see some of that context here on this slide.

Nationally, there are 600 area agencies on aging that are authorized by the OAA. And in California, there are 33 AAAs that are covering the state. Some of the core services that they're offering, as I indicated, home care, chore, personal care, but then also nutrition, transportation, and other services. So I wanted to frame that in the context that across the country and certainly within California, there's a network of organizations through the Older Americans Act, through the AAAs and their service providers that have the capacity to deliver these services in partnership with the managed care organizations. Next slide, please.

Who can provide these services? This list is provided as an example of the types of providers that Medi-Cal managed care plans may choose to contract with to provide the personal care and homemaker services community support, but it's not an exhaustive list of providers who may offer the services. So you can see here home health agencies, county agencies, personal care agencies, the area agencies on aging, which I just highlighted. And I would emphasize that providers must have experience and expertise with providing these unique services. Next slide, please.

So I'd like to highlight that community-based organizations are increasingly contracting with healthcare organizations to address health-related social needs. The passage of the Affordable Care Act and the shift to value-based care really created a rich environment for these partnerships, and CalAIM certainly presents another exciting opportunity. In recent years, we've seen a considerable increase in contracting as part of a network versus multiple contracts with individual community-based organizations. And the overarching rationale for this is that it's more efficient. So with fewer contracts, healthcare payers can access a service delivery system that covers a broader geography, includes a diverse set of partner organizations and available services, et cetera. I believe Ester with Partners in Care Foundation will be sharing more information about their CBO network.

I'd also emphasize that based on a request for information that I cited in the first bullet, Medicaid managed care organizations are the most common healthcare partnership for CBOs, particularly aging and disability CBOs across the country, and home care services are included in nearly one-third of contract packages. So there's a lot of opportunity here to establish and strengthen these partnerships. Next slide, please.

So let's take a look at some of the evidence supporting the personal care and homemaker services community support. These are really valuable life-impacting services. A Michigan study on personal care and homemaking programs found that the personal care services cost about \$18,000 per year, which is 74% less than nursing facilities and 54% less than annual assisted living costs. Individuals receiving personal care services were more than 20% likely to continue living in their home than those who did not receive personal care services. And that was an increase from 56% to 76%, and they had a 26% reduction in mortality rates when compared to those who weren't receiving the services. So we can see here really valuable, really life-impacting services that enable people to remain in their home, in their community of choice. So now I'll pass it over to Shel from the DHCS team who will take us through some more of the policy guidance.

Michelle Wong:

Hi. Thanks, Kristie. So there are a few applicable settings where personal care and homemaker services Community Supports can be used. PCHS can be used above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted. It can be used as authorized during any IHSS waiting period, though the member must already be referred to In-Home Supportive Services. Note that this approval time period includes services prior to and up through the In-Home Supportive Services application date. This support can also be used for members not eligible to receive In-Home Supportive Services to help avoid a short-term stay in a skilled nursing facility, not to exceed 60 days. As a final note on appropriate uses of personal care and homemaker services, similar services available through In-Home Supportive Services should always be utilized first. Personal care and homemaker services should only be utilized if appropriate and if additional hours or supports are not authorized by IHSS. Next slide, please.

So let's look at the eligible populations. Individuals who may be eligible for personal care and homemaker services community support include the following groups: individuals at risk for hospitalization or institutionalization in a nursing facility, individuals with functional deficits and no other adequate support system, and individuals approved for In-Home Supportive Services. The eligibility criteria for In-Home Supportive Services can be found on the California Department of Social Services website and we can also link that in the chat. Next slide, please.

The service limitations. Let's note a few limitations for this community support. Personal care and homemaker services cannot be utilized in lieu of referring to In-Home Supportive Services programs, and members must be referred to IHSS when they meet the referral criteria. Similar services available through In-Home Supportive Services should always be utilized first. Personal care and homemaker services should only be utilized if appropriate and if additional hours or supports are not authorized by In-Home Supportive Services. If a member receiving personal care and homemaker services has any change to their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. However, members may continue to receive the personal care and homemaker services community support during this reassessment waiting period. Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiaries through other state, local, or federally funded programs in accordance with the CalAIM STCs and federal and DHCS guidance. So now, I'll hand it over to Neha from DHCS to go over the caregiver respite services community support.

Neha Shergill:

Thanks, Shel. I'll now provide a summary of guidance on caregiver respite services. Next slide, please.

So what is caregiver respite? Respite services is not to be confused with recuperative care or medical respite, which is a different Community Support, but instead are provided to caregivers of members who require intermittent temporary supervision. Respite should be made available in instances where it can help to keep a person in their own home and preempt caregiver burnout. This support is intended to avoid institutional services for which the Medi-Cal managed care plan is responsible. These services are provided on a short-term basis because of an absence or need of relief for persons who are normally cared for and or supervise the member and are in non-medical in nature. Home respite services are

provided to the member in his or her own home or another location being used as the home while facility respite services are provided in an approved out-of-home location. As I mentioned, the service is distinct from medical respite and recuperative care. This program provides rest for the caregiver only. Next slide, please.

Respite service offerings. Respite services can include any of the following: services provided by the hour on an episodic basis because of the absence of or need for relief for persons normally providing the care to individuals; services provided by the day or overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals; or services that attend to the member's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines that would be ordinarily be performed by someone who normally cares for the member. Next slide, please.

So who's the eligible population? Members eligible for the caregiver respite support may include the following groups: individuals who live in the community and compromised in their activities of daily living, which we refer to as ADLs, who are dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement. Other eligible subsets may include children who previously recovered for respite services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, members enrolled in either California's Children's Services or the Genetically Handicapped Persons Program, and members with complex care needs. Next slide, please.

So going over the impact of caregiver respite programs. Research on caregiver respite programs shows significant impacts on caregiver well-being across several measures. A study on caregiver respite for caregivers of children with life-threatening conditions linked respite services to a 23% increase in caregiver psychological adjustment scores, 24% reduction in caregiver fatigue scores, and 11% increases in caregiver mental health quality of life scores. Move to the next slide, please.

The allowable providers. Caregiver respite providers must have experience and expertise providing these unique services. This list is meant to provide examples for the types of Medi-Cal managed care plans may choose to contract with. For complete list, we do encourage you to check out the program description in the Community Supports policy guide, and we can also drop the link in the chat. Note that the service can be provided in private residences or residential settings as well as in community settings. We can go to the next slide.

So talking a little bit about the service limitations and restrictions. In the home setting, these services in combination with any direct care services the member is receiving may not exceed 24 hours per day of care and their service limit is up to 336 hours per calendar year. Their service is inclusive of all in-home and in-facility services. Exceptions to the 336-hour per calendar year limit can be made with Medi-Cal managed care plan authorization when the caregiver experiences an episode including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit. Next slide, please.

The service is only to avoid placements for which the Medi-Cal managed care plan would be responsible. Respite services cannot be provided virtually or via telehealth. As with personal care and homemaker services, Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other state, local, or federally funded programs. Next slide.

Just talking about the pricing guidance now. The Non-Binding ILOS Pricing Guidance outlines a high-level per diem pricing approach reflecting typical staffing ratios and service intensity. For more information, the suggested pricing guidance for the personal care and homemaker services and caregiver respite services supports, please take a look at the pricing guidance document, which we can also drop in the chat. And with that, I'll hand it back over to Jill to introduce our guest speakers for today.

Jill Donnelly:

Thanks, Neha. All right, we've got some great folks from the field to talk about how things are going with these Community Supports. We'll first hear from a managed care plan. I'd like to introduce Natalie Allison, manager of Healthcare Services and Community Supports at Molina Healthcare. Natalie, I'll hand it over to

you.

Natalie Allison:

Sounds good. Thank you so much for having me. So I am from Molina Healthcare. I'm a manager here with Healthcare Services for Community Supports, and I just want to review what we've learned and best practices, what's working, some barriers we've come across for personal care homemaker, as well as respite services. Next slide.

So as stated before, with Community Supports, we know that it can be combined with ECM, the Enhanced Care Management, and it focuses on the medical and social determinants of health and must be cost effective. Next slide.

Here's a chart of Molina's Community Supports that we're currently offering in each county. And highlighted, you can see the respite services as well as personal care and homemaker services we are offering in all counties except for LA at this time. But we did start a pilot program for personal care homemaker in LA on 1/1/22. So we were able to still be in that county for some of these services. Next slide.

Here's some of our personal care homemaker and respite service providers. We're currently working with 24 Hour Home Care, AccentCare of California, Cambrian Homecare, and beginning 1/1/23, will be Access TLC. Next slide.

Being that, we've also been doing personal care homemaking and respite services through our care plan options program for our Medicare members as well as our many members. We have been doing this for a while, so here's what's been working: developing a diverse network of providers. We want to make sure we meet the location differences of where our members are in each county and the different needs that members have. So we do like to have our network diverse in a wide range of providers.

Building on member's current support system and adding additional support for member to successfully and safely remain in the home, which we refer to as layers of support. So we want to utilize what the member already has at home, whether it's their friends and family, neighbors, IHSS caregiver, and then add to supplement that, what they need in the home to meet their needs. Open communication and a good working relationship with providers. We have a great working relationship with our providers through, we do quarterly meetings. We have had in-services by our providers, which is great for our team, and just being able to really tell them what the member needs and seeing what their capacity is to provide those services for our members. Next slide.

Some of the best practices we feel as we've been doing this. We know each member's case is unique. We know each member has different circumstances, different conditions, and different needs, so we try to always meet the member where they are at and take a member-centric approach. We try to get all the details we need from the referrer to make sure we are able to provide that to the provider to ensure those needs are met for each member. So we do take each case very different separately from the case before, from the case after. We really focus on the member where they're at that time.

Another best practice we've been working on is collaboration between the referrer, the member, and IHSS. We want to make sure, which kind of goes into the third one, is looking for a permanent solution for the member. We try to encourage the referrer to really work with a member and for the member to really work with IHSS, get that application in, get the reassessment going, get the health certification form in. Because we know there can be limitations to the community support, so we always want to make sure we're looking for a permanent solution for the member. Next slide.

Some of the barriers we've come across: Some of our members may live in remote areas, so the coverage in those areas can be difficult. We've actually, to date, never have had an issue, but we know that can be a barrier based on the coverage and caregivers being available to go out into those areas. We know too that some of the members may have a fear of having unfamiliar individuals in their home, whether it's from the past couple years of COVID or just in general having a new person in their home, getting to know them, building rapport. So we know that can be a barrier sometimes. The communication,

which can include language and culture, and then as well as complex health conditions. So again, each member is very different, very unique situations and needs. So we definitely work with our providers to ensure we can meet all those needs. Next slide.

Some of the lessons we've learned in the past year and prior to that with care plan options: The more details we can get on the member's situation and needs, the more, the better, the more we can provide to our potential provider to say, "Hey, this is what the member is going through, this is what they need. They need help with ADLs or IADL, cooking, laundry, bathing." So we try to really get a good picture, an overall picture of this member and what they need. So when the caregivers go into the home, they can really focus on that member.

The second one is encouraging the referrer to work with member to ensure IHSS process has started and timeframes are being met. We want to get a timely response from the referrer so we can help the member in a timely manner. But again, this goes back to finding a permanent solution for the member. We just had a recent case where IHSS was through, but IHSS couldn't get ahold of the member and the member wasn't answering the calls. So we work with the referrer to work with the member to ensure she's answering those calls to get that evaluation and get those hours started for her. Next slide.

Here's Molina's referral process. We do have a dedicated mailbox, and there's an underscore in there, MHC_CS@molinahealthcare.com. We have about four to five people running this mailbox. We have a great team. We try to turn around the referrals within a day or two to get those services started for our members. But our coordinators will review the referral and ensure the member meets criteria. And as I stated before, we really work to get that big picture of the member. So we will reach out to the referrer and we will ask questions. What does the member need? What is the member's preferred language? What days and times would assist them the most? Or do they have any special requests that we could try to accommodate? And then upon the acceptance, we will provide the authorization. And then if we need to extend that service, we would request a new referral form to be submitted to see if anything's changed with the member or what additional services they might need or how long this process will continue for. Next slide. And that's all I have. Thank you so much.

Jill Donnelly:

Great, thank you Natalie.

Natalie Allison:

Mm-hmm.

Jill Donnelly:

All right, we're going to move on to our next presenter. I would love to introduce Ester Sefilyan, vice president of Network Services at Partners in Care Foundation. I'll hand it to you, Ester.

Ester Sefilyan:

Thank you, Jill. Good afternoon, everybody. As Jill mentioned, I'm Ester Sefilyan, VP of Network Services at Partners in Care, a community-based organization or a mission-driven community-based organization located in Southern California but covered statewide services. Our mission has been to align social care and healthcare to address the social determinants of health and equity disparities affecting diverse and underserved and vulnerable populations.

For over 25 years, we have been a nationally recognized leader working at the regional, state, and national levels to disseminate models of care that address social determinants of health for different populations, specifically older adults and vulnerable populations. We have been pioneers in conceptualizing and developing home and community-based services, the network of those community based services, and recognized for leading the work to advanced the concept in California and across the country. I do want to note, we are NCQA accredited, and today I will showcase our community care hub and how it supports our private duty services. Next slide, please.

Before I get into that, just real quick, some background around Partners in Care and how this all ties in. We identify ourselves as the social determinant of health innovators, the specialists. Our work over the years has really served as a bridge between medical care and what a person can accomplish in their own home. We heard from Kristie some statistics around cost savings of not being institutionalized, staying in the home setting. We believe in the home setting, and our work has been really around models to support that. We create, test, adapt and disseminate evidence-based models of care that are applied to social care management for community living and really aging and well.

We deliver services to improve chronic disease self-management, identify and resolve dangerous medication errors through our HomeMeds program, which does prevent falls and costly ER use or hospitalization. Thus, we have homeless prevention, nursing home placements through in-home care coordination services. We do provide a lot of care management, both brief and long-term, as well as consumer empowerment through our evidence-based workshops to enhance health self-management skills and behavior changes. So all of that as being root to why the private duties ties very well with this work. Next slide, please.

So again, linking all around social determinants, social care and private duty services around the Community Supports being root of that is, over the years, we collaborate with hospitals, physician groups, health plans, other community-based organizations and government agencies to deliver services that support diverse adults and families with complex health and social needs, as well as their caregivers and families. So emphasis on caregivers here for this service. We do this across different payers, so Medicaid, commercial health plans, health systems, all types of lines of business, to try to really shift the emphasis from endless care to preventative care, and reduce cost and improve quality of life for those with chronic conditions. Our engagement tools allow us to continue to work throughout the pandemic in a telephonic fashion, as well as now we have really moved into the back to home setting and we were able to reach a lot of people and connect them to services that were needed. Next slide, please.

So how do we do this? We have care management, we have evidence-based programs under CalAIM Enhanced Care Management and Community Supports. And a lot of this work is done through our what we call the Community Care Hub. As part of our SDOH strategy, we realize that local services are the best approach to meeting individuals where they are at. As a result, our Community Care Hub was created. We are the lead network entity for this Community Care Hub. Our network, or as we call it now the Community Care Hub, was created almost 10 years ago and it covers the state of California and currently operates as a division of Partners in Care.

We have over 30 different network providers or partners ranging from folks that do personal care, respite services, so private duty agencies, non-medical home agencies, to care management agencies, 1115 waiver providers, Meals on Wheels providers, you name it, across the state of California that provide a variety of specialty services under our hub. So we contract with the payers and then they come through the hub, and then the hub passes on the work to the community organizations that are rooted in those regions to cover and provide those services. Again, our network of providers do a variety of different services. So lot of emphasis around short-term care management and care transition programs, community wellness programs, as well as engagement center or call center that helps to outreach and enroll a lot of folks in a variety of different programs that provides educational information as well.

But with expansion of Medicaid under CalAIM, the Medicaid reform here in California under CalAIM's Community Supports being added, we expanded our hub services to include private duty, the non-medical respite personal care that we've been hearing throughout the discussion. So I will go into a little bit more detail how we do that. And we are fortunate, as I mentioned before, to be able to have variety of different contracts to provide these services. Our payers really rely on us to help reduce healthcare costs by minimizing the need for expensive hospitalization, emergency department, and nursing home care. Next slide, please.

So what does the Partners at Home or Partners in Care's Community Care Help mean? As part of our national work through the partnership to align social care, we have really worked on defining as well community care hubs. And in a nutshell, a community care hub helps organize and support a network of

community-based organizations providing specialty services, specific services to address health-related social needs. So in this case, our personal care and respite agencies that the hub has organized and brought together, which centralizes the administrative functions and operational infrastructure that include but are not limited to contracting with healthcare organizations, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection and reporting.

We have trusted relationships with these specialty CBOs across the state as well as through our many years of working with the healthcare organizations. This model really helps foster cross-sector collaborations. So we focus on getting the contracts, working with the payers to have one contract that streamlines and provides a large geographic footprint. For some of our payers, especially on their CalAIM, they cover more than one region, multiple regions, multiple counties. So it becomes like a one-stop shop for them where they could access our community care hub and we bring in this specialty providers through this one contracting with healthcare.

It's a win-win for healthcare. So they'll have one streamline reporting, one streamline billing, one streamline intake referral process that we as the hub handle, and then pass it on to the providers, manage the providers, vet and curate the providers in the given areas that they are covering, ensure they're in compliance, and then aggregate the information back to the payer. This way, the providers don't all have to have individual contract, which we know could get expensive. Legal is expensive in working with health plans and a variety of different ways. So this helps streamline all of those processes, and it brings a lot of that geographic coverage and processes into more of a seamless process in general. We do the administrative functions, the backend office stuff, so our providers could really focus on the delivery of services. Next slide, please.

Who we are, we are the hub, Partners in Care is the hub who has engaged home care organizations. And home care organizations, as we call them our private duty providers. Our providers are licensed under the California Department of Social Services. They provide the non-medical care to support a member's or patient's needs around activities of daily living, instrumental activities of daily living, and to give some relief to caregivers for respite as well. This is provided through their home care aide. So the non-medical or home care agencies have home care aides that are registered through the State of California Home Care Services Bureau. There's ongoing training with these home care aides, as well as they have to be registered home care aides. So there's a lot of oversight and constant training through the home care organizations as well. But then the hub adds another layer of compliance oversight, quality assurance on top of that as well. Next slide, please.

So what do we do? You've heard already throughout the presentation around ADLs, IADLs, the purposes of Community Supports for personal care and homemaker services as well as caregiver respite services. Really, it's all non-medical care to support the activities of the living such as bathing, dressing, feeding, and instrumental activities of the data living such as meal prep, laundry, medication reminders. So what we do is we really try to match the home care aide to meet the needs of the recipient needing services, so the members that are being referred from the health plans, or Enhanced Care Management providers that are referring members for their own members for Community Supports specifically for these services. We match the language, the culture, the preferences of the home care aide to that of the member who's to be receiving those services.

We provide the payers with findings, summary of findings. We are like the quarterbacks in some ways and being the eyes and ears. So our home care aides are the eyes and ears in the home. If there's issues, findings, that is routed back to the hub, and as the hub working with the payers, we take that information back to the payers. Or being a community-based organization ourselves that has our own 1115 waiver programs like multipurpose senior services programs, we have our own Enhanced Care Management as well and a variety of different community wellness programs of different services that we could tap into to get individuals that need extra support enrolled in as well, if they're not already. And working with the plans in collaboration to ensure that the patient is getting that more long-term.

We heard Natalie mentioned having long-term setup in some way. So that is ideal. Community Supports

might be a little bit of a short-term get in, provide some support, but there might be a long-term plan needed, and that's where we could be of assistance as well in helping that get set up. And then we provide additional level, like I said, of daily support. And supervision is provided by the home care organization, but then we add another layer of that. Next slide, please.

I'll kind of go through quickly through these because we already heard about the different types of services under Community Supports that fall under this umbrella. Respite services in a nutshell is to provide break for family caregivers. So it's to give relief to help prevent burnout for family caregivers. It allows a caregiver to take some time from carrying their loved one for time for themselves without compromising the quality of care for the individual that they were providing that care for. This really provides support for family caregivers. Many times in our line of work there's so much burnout. We see the sandwich generation who have their own kids and then older adult family members are taking care of. There's demands in life, and burnout is real. This provides them some relief to get that break, recoup, come back, and take care of their loved one again. Next slide, please.

As part of the respite services, so it's a wide range of caregiving services provided by the professional caregivers through our home care organizations, so the home care aides, and they could be specialty services too, like dementia care, somebody who has specialty in dementia care. It really is the substitute of temporarily for family caregiver duties. Some of those common tasks are around the laundry. So around more of the IADLs services that we just mentioned. Next slide, please.

Personal care being the other. So caregiver respite is one community support, and then personal care/homemaker services, it's kind of grouped into the second. So personal care is really, I see this as the helping with the activities of daily living, bringing in that professional individual to support somebody in the home with activities of daily living that we just discussed, bathing, transferring, and that sort of things that we have listed initially. This is an expert that is able to assist with those tasks, including some physical assistance as well. It's to keep the individual safely and comfortably and at home. And again, that home is the emphasis, keeping individuals at home. Next slide, please.

And the last of the Community Supports homemaker services. Unlike personal care, this is seen more as the IADLs, instrumental activities of daily living. Again, focus of keeping people safely at home and to help ensure that they don't lose independence without having that professional support, professional home care aides, to be able to do some of these activities for them, so in order to help continue living a little independently at home. And these are, again, experts provide essential assistance with non-physical tasks. So that's homemaker services, and we've already got a lot of detail from the prior presenters on those areas. So next slide, please.

Okay, some metrics. One of our payers, actually, this is right out of one of our payers. We have right now six community support contracts. A couple of them are already signed, are going live January, but majority have started. Some of them began January 1, 2022. We provide community support services for those health plans across California. Some are more regional and some are statewide. So we do both through our community care hub. This is one of the metrics from one of the payers that I pulled out. Just looking at the level of information that the payers are turning to us to ensure that we're in compliance. These are our standard level agreements, our SLAs, so we have to make sure that we meet these timelines, deliverables.

One of the things that is part of this is satisfaction with services that are being surveyed through the patients, the members are being surveyed for satisfaction of services. And that's the bottom line in light blue, that you see that overall average of 8.4. So really high scores, but being new. Obviously, Community Supports rolled out this year. By the time got it going, we didn't see a lot of movement until really more so Q3, which then this is a Q2 data, so little by little was picking up. So next slide, please.

So benefits and opportunities as being a community care hub, I mentioned before, just to summarize, it allows the experts like our home care organizations and their home care aides to really focus on delivering care and services and not to worry about the backend office work that we as the hub will take on, have taken on. It streamlines contracting, reporting, and billing, like the functions that I mentioned earlier, for both the payers and the providers. So it's both ways. It really provides inclusion of smaller community

organizations to be involved. Sometimes it's a lot harder, and this is throughout our years of being a hub and working with a variety of different size community-based organizations, for them to directly have contracts with payers. So it allows them an avenue to come through a hub that could provide that infrastructure for them. It helps standardize workflows as well as provides a large geographic coverage area.

For some opportunities for improvement, if we could increase the referrals from payers, there's been a whole infrastructure that's been set up. We brought in all these providers through different counties, different areas, and we want to keep them going. So feeding them referrals is a way to keep them going, and keep them knowing what the processes are. So we're working with our payers that we are, as the hub, responsible for to ensure that we could streamline more referrals down to those counties that we've really stood up and brought in those providers. And then how could we, across different health plans, we've seen this as well, there's a different referral criteria and a little bit different authorization processes. So that's the long ways to go, but that's ideally how do we streamline the processes around referrals going to provide community care hubs or directly to private duty providers. Next slide. And that's my contact information, and I think I'm on track with my time.

Jill Donnelly:

Absolutely. Thank you so much, Ester.

Ester Sefilyan:

Thank you, Jill.

Jill Donnelly:

We're going to move on to our next presenter. We'll now hear from Gavin Ward, who is the director of Strategic Partnerships at 24 Home Care. Gavin?

Gavin Ward:

All right, Jill, thanks so much. Good afternoon, everybody. Again, Gavin Ward with 24 Hour Home Care. Thank you Natalie and Ester for your great presentations. My colleague April Stewart will also be joining me in just a moment in sharing some great information on how these services benefit Medi-Cal and the beneficiaries. So let's go and move to the next slide, please.

All right, so just like you folks out there, all the Community Supports providers, ECM providers, and whoever else is on the call today, we all have our whys at our organizations, and for us, we impact lives by making a difference every day. With this new benefit, we've already seen the opportunity to benefit so many lives already. And I'll share a little bit more about how 24 Hour Home Care impacts thousands of lives each and every year. But let's move on to the next slide, please.

All right, so some objectives of the next few minutes is a little bit more information about why we're offering personal care homemaker and respite benefits. We're going to share a little bit more detail about the scope of services. And often when we hear of home care, as Ester and Natalie have alluded, sometimes people get confused with home health. So we'll dive in a little bit deeper on what the scope of services is. And then April will share a little bit about the service and the impact to Medi-Cal systems and members. And then at the end, we'll share our team and contacts. Next slide, please.

All right, so a few of our partners. So we are across California, and we're very fortunate to work with so many health plans in Southern, Central, and Northern California. So today, I know Natalie had mentioned we are one of their providers there at Molina. We actually work with 10 other health plans that are either live today or are starting in January. You can also see on our list that we also work throughout the state in all 58 counties with all 21 of California's regional centers and the VA and many other California hospitals and health systems.

So if you're not familiar with our organization, we've been around for about 14 years. As I mentioned, we

are across the state, we're also in Arizona. We are the home care organization. What's a little bit different about 24 Hour Home Care besides the time that we've been in business is our size and scale. One of the reasons that the 11 health plans have contracted with us is we are in all 58 counties. I've been with the organization for about 11 years. April, who you'll see momentarily, has been with the organization about eight years. And we are fortunate to be here pretty much early in the game.

One thing that I had shared with my contacts early on in the 2010 decade was, I believe that Medicare, not Medi-Cal, but I actually said I believe that Medicare will fund what we are doing because it's so important to how personal care, homemaker, and respite, the work that our caregivers are doing, but we're often not necessarily a part of the care continuum formally. So in 2019, not sure if you folks know, but Medicare Advantage plans were actually able to also fund personal care, homemaker, and respite. We started to pick up some momentum, and our organization at 24 Hour Home Care had the privilege to work with some health plans on the Medicare side. And now here in 2022, as I mentioned, we're contracted with 11 health plans and we have the ability to scale. We have the contracting systems in place, and we're just really, really excited to work with many of you here on the call today. I'm going to pass it over to April and let's advance to the next slide.

April Stewart:

Thanks, Gavin. Hi everybody, nice to meet many of you virtually. I am April Stewart, I'm the director of Government Relations with 24 Hour Home Care. So what I do is our advocacy, as well as drive the new design of programs to both drive the outcomes that we're looking for specific payers as well as make sure that our programs are modified wherever needed to meet the clients criteria of our payer system as there are different nuances everywhere. So I'm going to talk to you a little bit about our program.

So first I just wanted to cover some benefits to Medi-Cal members by offering personal care, homemaker, and respite services. So there was actually some research done on the living preferences of people that we serve in our communities, and they did come out and say that 88% of adults prefer to age at home. Now granted that may not mean it's appropriate for everybody, however, that does show us that there's a huge demand for home care services to make that a possibility for those that it does make sense and we're able to connect to the right services and supports. However, only 16% feel confident in their ability to pay for long-term care. CalAIM and these service lines are a huge way to impact that because Medicaid through CalAIM can now pay for some of these services and bridge some of the gaps that IHSS couldn't fill before.

And then 11%, that's a very small number, have discussed these ongoing living assistance preferences with doctors. That's likely because Medicaid and Medi-Cal in the past couldn't pay for these types of services. So there weren't quite as many options. But CalAIM opens that up, and we're hoping to partner with all of you to make this more of a discussion between the entire integrated health network to determine what is the best setting for this individual and have those wants and needs heard so that people can choose the most appropriate living preference and setting for themselves. If we go to the next slide. Thank you.

So another benefit is that this offers a very person-centered approach to healthcare. So we often, in the medical model, look at the needs of a person, their basic living needs, medical and emotional support. What's really awesome about CalAIM is that we are also now adding in a larger element of choice, the wants, and that is choice, control, and cultural competence. And as we partner together with the standard medical system, we together are able to elevate our ability for person-centered approaches to healthcare. Next slide, please.

What this ultimately leads to is, as a system, we are not saying that everybody needs to choose to receive services in the home. All of the models that we have, facility-based care, senior communities, and the option to use home care to age in place are all critical elements to be able to provide that choice, control, and cultural competence. Next slide, please.

All right, so just a second to load there. I won't spend too much time on this slide because I think the previous presenters did an amazing job explaining what these service lines are, their goals, service, and

supports, as well as the limitations. We put this in here because you will be receiving a copy of these slides so we can go ahead and move forward.

All right. And as Gavin mentioned, sometimes there is some confusion when we enter the healthcare world about what is the difference between home care versus a medically based home health service. So this is on a very high level what the home care scope of services is. It includes ADLs and IADLs, although not everybody is familiar with those terms, especially when we start speaking directly to members, so this is kind of how we high level describe our services. We can provide personal care; healthy meal preparation; medication reminders; transportation, if your plan allows it, some plans are allowing transportation and others are not; supervision and socialization; and some lighthouse keeping. However, if your members have a medical need such as wound care, medication administration, or medical equipment and devices, certain ones need a nurse or therapies, that would need to be done with a home health provider with in mind that if that's only a portion of their care, there's oftentimes that somebody does have home health for a couple hours a week and then uses home care for the other needs that don't need medical assistance. Next slide, please.

All right, we were asked to share a little bit about how this process is going, what's working, what needs for their collaboration? So first we're excited to share some of the successful collaboration that we have, and I think we should just take a moment to celebrate that we actively are serving members in this service, both us and Partners in Care and many others within the provider networks. And it's taken so much collaboration to have this happen. We are new to the payer space in Medi-Cal, not for other payer spaces, but being able to get these programs understood by Medi-Cal, by our members and people accepting the services, has just taken so much collaboration, and those first few admissions into our services were just a huge celebration for our entire system.

We've also seen success with strong communication channels being built throughout the health network, both with MCOs, ECMs, and all the other points that we need to integrate with. We've been able to establish trust and collaborative partnerships. Like today, we're seeing a lot of co-learning opportunities. We've gotten to learn through these forms about other services. We're getting to share about our services. And then the IPP and grant funding. We did receive an IPP grant, and we are using part of that to actually expand our services into 14 different languages to drive health equity. So those are all really key successes.

Things that we're still collaborating on, and I want to be clear that these are all kind of in process. It's just things that, as you move through, you come up with more things that need to be clarified and worked out together. And we do have those partnerships and we're excited to move forward with these. So member eligibility, we have seen as we get the first few referrals in that some people aren't eligible, we're having to clarify some of the processes as we go. And that's okay. We're going to refine these processes as we move forward.

We are seeing some different referral processes between plans, and we hope that we can collaborate as we move forward to kind of unify what that structure looks like for efficiency on all ends. System integrations, we use very different systems than physicians, and health plans use very different systems than say our regional center partners. So system integration is still taking place. We are working with plans and the state to determine what kind of data and outcome metrics you'd like us to track long term. And then of course, full systemic service familiarity to understand what our services are. Today is a huge step towards that. Next slide, please.

All right. And then you guys may be familiar with DHCS put out some information on different areas that they would love to see CalAIM impact through offering these services. So there are six that I wanted to highlight that are services, personal care, homemaker, and respite touch. The first is having multiple systems that people have to work with. And that can be a challenge especially when people need IHSS because there is a time gap to become eligible. So while they still need to use IHSS because our services are to supplement IHSS, not supplant, it does help with getting faster access to services while they're in that waiting period and bridges that gap. Driving health equity is another huge one. Home care services provide an opportunity to get culturally competent services with a one-on-one provider in the person's

home. That is someone that they can truly connect with. We're able to address complex needs. A caregiver in the home is someone that truly can bridge the gap to help them manage their care between medical appointments. Next slide, please.

All right, and then three more to highlight. We do also hope to impact high utilizers, people that are going to the hospital for things that maybe could have been stabilized in the home. Caregivers can assist with that. Reducing hospital readmissions by having a caregiver there to make sure that they're following their post hospital care plan so that they don't end up readmitted. And then high cost settings. I was kind of surprised to learn this when I started learning about the Medi-Cal system and the CalAIM space, that over two-thirds of patient days in California long-term care facilities are actually Medi-Cal members. And our hope as we go into 2023 is to allow more people to have the choice to receive care and agent place at home instead of only having the option of facility-based care. Next slide, please.

And lastly, just some other areas that we're touching. We talked about this earlier, so I'll go through this fast. We're elevating our choice, control, and cultural competency through person-centered benefits and choices. There is proof, you guys heard about it earlier in the presentation, that services are cost effective. We're also helping with capacity building. When we add another layer and option for care, it means that that leaves community open beds for those who need that higher level of care. And then just taking a step towards health equity, we're able to meet people where they are in their home and offer options to underserved populations. Gavin, if you want to go ahead and wrap it up.

Gavin Ward:

Sounds great. Next slide, please. All right, so in the last couple minutes here, we'll just share a little bit more about our team and how to reach us. So you can see here, this is our dedicated Community Supports leadership team. Now, while we're a new team in 2022, none of us are new to home care or new to 24 Hour Home Care. Our team has an average of about eight years with the organization. So for the health plans out there or the ECMs or other CS providers, when you reach out to us, you'll likely get a hold of lesser fee, which you can see there on your left hand side. And they're able to answer immediately in English and Spanish. And then if you have members who reach out to us or you reaching out to us and need other language assistance, we're able to tap into translation services as needed. And as April mentioned, we should have documents translated into 14 different languages relatively soon in the near future, thanks in part to the IPP funding.

All right, we are down to our last slide, if we can go to the next slide please. This is how you reach us. So this is how to reach us. You can see the information there. I think we're all set and we'll pass it off.

Jill Donnelly:

Great. Thank you, Gavin and April, and a big thank you to all of our presenters today. We really appreciate it. We do have a couple thoughts here on frequently asked questions. It has been mentioned already but wanted to reemphasize that DHCS has provided non-binding pricing guidance for all of the Community Supports, which can be found on the DHCS website and we can link to that. Ultimately, it's up to managed care plans and service providers to negotiate final rates. If you are on the call and interested in becoming a Community Supports provider, the best thing to do is to reach out to your local health plans to determine the provider application process for that plan.

In terms of referrals, patients can be referred to Community Supports by many different sources. You don't have to be a Community Sports provider to refer a member in. So please, again, reach out to that member or client's managed care plan if you think you have a client who would benefit from these services. Any questions around eligibility can be answered by looking at the DHCS Community Supports policy guidance.

All right. We've had a few questions come in through the chat, so why don't we spend a few moments here walking through those? Neha, perhaps I can throw this first question your way. There's a question around limitations for Community Supports. Can these services be combined with other Community Supports, such as nursing facility transition or assisted living community transition services?

Neha Shergill:

Sure. Yeah, I can take this one. Yes. So in instances where the member is eligible for more than one community support services and they would benefit from receiving more than one, the member may receive those Community Supports simultaneously.

Jill Donnelly:

Okay. Great. And then to follow up on that, can caregiver respite services be provided to members in assisted living facilities where they're living or at other community facilities like adult day health centers?

Neha Shergill:

Yeah, great question. So the answer is also yes. Caregiver respite services can be provided in a couple of ways. So we have, the home respite services are provided to the member in his or her own home or another location being used as the home, whereas facility respite services are provided in an out-of-home location. And the Community Supports policy guide definitely provides more of an in-depth list of potential service providers who can offer the support, which includes a lot of home and community-based providers. And that list isn't exhaustive, but it could give you definitely a good sense of where these services can be provided. So definitely, if someone from our team can add the link to the chat.

Jill Donnelly:

Great. Yep. We'll get someone to throw that link in the chat.

Neha Shergill:

Thank you.

Jill Donnelly:

This next question, maybe Shel, you can answer this one. On the limitation slides for respite services, it said that these services can't be provided virtually or via telehealth. A telehealth-based provider who's able to provide services in person, can they provide in-person respite services?

Michelle Wong:

Yeah, so that's a great question, and I can clarify a little bit. So the services may not be provided virtually, but a telehealth-based provider may contract to offer these services as long as the services themselves are provided in person.

Jill Donnelly:

That's great. And then another question here. This one is about the overlaps between personal care and homemaker services support and IHSS. The question is, do individuals have to qualify for IHSS in order to receive personal care and homemaker services? And if a member is receiving services through both IHSS and Community Supports, how does that interaction work?

Michelle Wong:

Yeah. I can answer both parts of that. So members do not need to be approved for IHSS in order to be eligible for personal care and homemaker services. That's just one path for eligibility. But other members at risk of institutionalization and those who have functional needs and no other adequate support can also qualify. To answer the second part of the question, if similar services are available through IHSS, those are meant to be used first. The personal care and homemaker services community support can be used to fill in gaps for those receiving IHSS, like during the waiting period or when a member's IHSS benefits are exhausted. Generally speaking, Community Supports are meant to supplement rather than supplant the other program.

Jill Donnelly:

Great, thank you. Here's a question for Neha. We have a question about rates here. Since the pricing guidance includes recommended hourly rates, so can managed care plans set hourly service rates above those listed in the pricing guidance? Or is that kind of a cap?

Neha Shergill:

Yeah, no, managed care plans definitely can offer rates that are different from those outlined in the document. Just a reminder that the pricing guidance is designed to serve as a tool to support discussions regarding rates, but it's not binding. And again, we can share a link in the chat.

Jill Donnelly:

Okay, great. Oh, and Elizabeth is already on it. So on a related note, another question asked more about what funding opportunities exist to help new providers. And I know some of these came up in some of the presenter presentations as well. Can you say a little more about what funding opportunities exist?

Neha Shergill:

Yeah, definitely a really, really good question we're excited to talk more about. But there are several different funding opportunities that may be relevant to different folks on the call today. So we have the Providing Access and Transforming Health, which we refer to as PATH, and definitely a wonderful initiative which offers several streams of funding to providers. So for the providers who are contracted or in the contracting process with health plans, there are existing PATH funds that they can apply for directly. And for those organizations who are not that far into the process and may need support getting to that point, we're really excited that there'll be more of a technical assistance marketplace launching in January. We also have the Incentive Payment Program, or IPP, which many of the speakers talked about today, but this is run through the health plans, and you can reach directly out to the MCPs in your areas to learn more. We've actually developed a cheat sheet that explains these funding opportunities more in detail. So if somebody could please provide that in the chat as well.

Jill Donnelly:

Okay, great. Yep. We can throw that in the chat. It's there already. Okay. So a lot of different funding streams, some of them through the plans, some of them through DHCS, really helpful.

Okay. Here is a question maybe I'll direct at Shel. Maybe we can take a step back and answer a question about referring patients to these supports. Does someone have to be a Community Supports provider in order to refer a client for caregiver respite or personal care or homemaker services? If they have an eligible client, who do they reach out to?

Michelle Wong:

Sure. So to answer the first part of the question, no, you do not have to be a contacted community support provider to refer someone in. The referral process is based on a no wrong door approach. So any community support provider, any provider, and even members themselves can submit a referral. The best place to start if you think you might have a client or a patient who is eligible for the Community Supports is to reach out to the member's health plan to learn more about how to make the referral.

Jill Donnelly:

Okay, great. Let's answer another question about how providers can contract to offer services. So for organizations that already offer similar services like support with ADLs, IADLs, or let's say they provide relief to caregivers but they're not currently contracted with any of the MCPs for Community Supports, how do they start? Where do they start? How do they join the program?

Michelle Wong:

Yeah, I can take this one also. So for organizations that are interested in becoming a community support provider, we recommend to reach out to your county's medical health plan to determine the provider application process. So you can also review the Managed Care Plan County Elections document, which is publicly available on the DHCS ECM and Community Supports website to see which plans operate in your county and have elected to offer these Community Supports. And if someone can be kind enough to drop that link into the chat also.

Jill Donnelly:

Of course. Okay. I've got one for Tyler. Tyler, we have another question about the contracting process that came up. The question asks, for providers interested in offering Community Supports that don't have a state level enrollment pathway, what are the requirements from the managed care plans that they'd have to meet?

Tyler Brennan:

Sure. I can help answer that. So there is some guidance on this topic that's available on the ECM and the Community Supports FAQ document that's available on our website, but instead of running through that in detail, maybe somebody can link it here in the chat while I describe it at a little bit of a higher level. So at a high level, in situations where there is not a state level enrollment pathway, which is the case for many Community Supports providers being as they can be novel services in a lot of areas, providers still have to be vetted by the managed care plan they're working with. So we recently updated the FAQ document in August, and you can find out more details about what criteria managed care plans might consider using for enrollment pathways for new providers. And in terms of getting to the point of contracting, most plans do have their own individual application processes.

Jill Donnelly:

Okay. All right. Great. I think we got through most of these, so we can wrap up a little bit early. I want to thank everyone who asked questions through the Q&A. We'll send up a follow-up message to all of you once the recording and slides have been posted online. We also wanted to just again thank all of our presenters. Our next Community Supports webinar is on December 8th. This is our final one. We're really excited about it. We're going to be covering the intersection between Community Supports and pediatric populations. So come back December 8th at 1:30, we'll have a registration link that comes out as well. And as always, if you have any questions, please submit them to the CalAIMECMILOS@dhcs.ca.gov mailbox, and they'll get your response. Thank you all for joining and have a wonderful rest of your day.