Stakeholder Position Paper
Proposed New Medi-Cal Benefit: Long-Term Care at Home

July 9, 2020

Background and Introduction

The Long Term Care at Home ("LTC at Home") Proposal was first released as a "trailer bill" proposal in May and then introduced to stakeholders by the California Department of Health Care Services (DHCS) in June 2020. Development of this new statewide Medi-Cal benefit is being fast tracked, with implementation planned for early 2021, pending CMS approval.

The initial reason given for creating a new 1915(i) State Plan benefit was to "decompress" California's skilled nursing facilities, diverting an as-yet undefined set of Medi-Cal beneficiaries from hospital settings to home by providing alternative support. The proposal provided to the Long Term Services and Supports Subcommittee in late June indicated that the initial concept has expanded to include a broader set of goals. The proposal includes creation of a new licensure category through emergency regulations promulgated by the California Department of Public Health. Home health agencies and hospices would be categorically eligible to apply. Licensed LTC at Home agencies would be responsible for coordinating and delivering services to a limited group of Medi-Cal beneficiaries.

The medical care and home and community-based services (HCBS) to be provided through this proposed benefit would be determined by conducting person-centered assessments. While the proposal indicates that services will be tailored to individual needs, it is not clear what these services will entail nor whether this will include 24-hour health care and support as skilled nursing facilities do, as the full range of services available through this benefit has not been described.

Intended by DHCS to remain cost neutral, the proposed Long Term Care at Home benefit was initially described in state budget hearings as replacing CBAS (Community Based Adult Services) and MSSP (Multipurpose Senior Services Program), two effective LTSS program models deferring and/or avoiding institutional placement. Each represents over 40 years of expertise in the provision of community-based alternatives to skilled nursing facility placement, and deep expertise in serving medically and socially complex individuals in the community. CBAS is unique in that it is a licensed health facility that combines comprehensive daily health care and surveillance with increased social connection and community engagement, addressing social determinants of health. Both CBAS and MSSP are well rooted in their diverse communities and provide person centered services that are culturally and language specific.

CAADS stands in opposition to any action that would deny access to CBAS and MSSP for the more than 47,000 beneficiaries served across the state within these programs.

Recognizing that gaps in care have long existed, and the novel coronavirus pandemic has increased the urgency of this concern, CAADS stands ready to assist with the development of a realistic, meaningful Long-Term Care at Home benefit that builds upon and enhances the innovative LTSS programs that have paved the way in preventing over-utilization of nursing facility and hospital care.

CAADS' Recommendations:

1. Strengthen LTSS that are in place today by increasing access to and adding flexibility within existing licensure categories and LTSS programs to address the identified need.
2. Ensure a robust stakeholder process for LTC at Home to clarify purpose, identify gaps, and design solutions that work for the identified population(s) at greatest risk for institutional placement.
3. Preserve the LTSS safety net urgently needed by Californians most at risk to sustain local choices to meet a variety of needs.

CBAS Prevents Institutionalization

Community-Based Adult Services (CBAS) is a Medi-Cal Managed Care benefit based on the comprehensive adult day health care (ADHC) model and delivered by licensed and certified ADHC/CBAS providers (hereinafter called CBAS). CBAS offers a proven, cost-effective community-based alternative to placement in skilled nursing facilities or other forms of institutionalization for vulnerable adults (age 18 or older) with complex medical, cognitive and/or psychological conditions. Most CBAS participants are older adults with an extensive range of chronic health conditions and health disparities. The 256 programs across the state serve ethnically, culturally and geographically diverse populations. CBAS also serves developmentally disabled and younger adults. Approximately 40% of those served have been diagnosed with Alzheimer's disease or a related dementia. The average age is 77 years old making the vast majority dually eligible for Medicare and Medi-Cal. Ninety-six percent (96%) of all enrollees are Medi-Cal beneficiaries. The remainder are paid through other sources or private pay. Centers serve a diverse population with 13% African-American; 21% Latino; 23% Asian Pacific Islander and 22% White (21% other or not reported). Forty-four percent (44%) live alone.

To qualify for CBAS, people must be enrolled in a Medi-Cal managed care plan which then authorizes enrollment in CBAS after undergoing an eligibility review by a registered nurse. CBAS participants must demonstrate significant medical necessity for the nursing, maintenance and rehabilitative interventions, social services, therapeutic activities, and other supports that they receive for up to five days a week in a congregate program setting.

Working in partnership with participants, caregivers, physicians and other LTSS providers, the person-centered CBAS model fosters independence and supports the individual's choice to live in the community, while reducing social isolation. Most participants live alone or with their families, some live in residential care. When participants have caregivers assisting them, CBAS substantially alleviates caregiver strain by offering out-of-home respite, emotional support, and help with complex care needs, as well as strengthening participants' functional abilities, overall health and quality of life.

To accomplish this, CBAS centers all have interdisciplinary teams of health professionals who comprehensively address participants' health and psychosocial needs. The person-centered assessments and services tailored to address these needs are on-going, rather than episodic. Services include extensive nursing, such as diabetic and wound care, care coordination and medication management; physical, occupational and speech therapies; mental health services; case management, help to access resources and other social services; therapeutic activities; personal care and assistance with incontinence; specialized meals; nutritional counseling; and transportation to and from the participant's residence.

Mounting evidence demonstrates that this focused attention significantly decreases the need for costlier interventions, including emergency room visits, hospital admissions/re-admissions, and skilled nursing facility placements.[1] The powerful peer and provider engagement facilitated through CBAS is proven to combat social isolation, which the Centers for Disease Control (CDC) indicates significantly increases the risk of premature death from all causes. The risks posed by social isolation may rival those of smoking and obesity and are associated with about a 50% percent increased risk of dementia.

Since 2012, CAADS' partner organization, the Alliance for Leadership and Education (ALE), has piloted and sustained a heightened CBAS model known as the Community Based Health Home (CBHH). CBHH adds an additional RN – a Nurse Navigator -- to work outside the four walls of the CBAS center to address at-risk elements of the participant's home situation and health status. Through active engagement with components of their medical care such as their personal physician, Nurse Navigators ensure that CBAS participants at highest risk due to the acuity of their health conditions, or other psychosocial factors, can remain stable and avoid skilled nursing facility placement.

This eight-year project, which draws upon nationally identified best practices, has achieved stellar outcomes, including a statistically significant reduction in emergency department visits (48.4% to 38.4% over 1 year). With additional flexibility, the learning garnered from this project could now be applied through CBAS Temporary Alternative Services (TAS) and CBAS to further the goal of preventing nursing home placements.

CBAS Response to the Public Health Emergency: Temporary Alternative Services (TAS)

At the outset of the coronavirus pandemic, Governor Newsom deemed CBAS to be an essential service that protects those who are most at risk from COVID-19 due to age and underlying health conditions. Since the issuance of the Governor's March 19, 2020 Executive Order, CAADS' leadership and members have worked extensively with the California Department of Aging (CDA), in coordination with the California Departments of Health Care Services and Public Health, in the rapid design of a Temporary Alternative Services (TAS) model. Tailored to sustain the safety and well-being of CBAS participants while congregate services are suspended in order to combat the spread of COVID-19 among the program's at-risk participants, TAS ensures each center has the appropriate staffing and interventions to meet the needs of those enrolled.

[1] Sadarangani, et al, A Mixed-Methods Evaluation of a Nurse-Led Community-Based Health Home for Ethnically Diverse Older Adults with Multimorbidity in the Adult Day Health Setting, Policy, Politics and Nursing Practice, Aug. 2019. https://doi.org/10.1177%2F1527154419864301

Through TAS, 37,000 vulnerable individuals across California who need to be protected at home are receiving essential care and direct support. CBAS centers are utilizing their in-depth knowledge of participants' psychosocial and medical concerns to innovate ways to sustain their well-being. This is being accomplished through the combination of telehealth services, COVID-19 screening and wellness checks, care coordination, therapies, therapeutic activities, virtual education and exercise programs, meal preparation and food delivery, as well as the provision of supplies, including PPE and medical equipment such as blood pressure cuffs and thermometers. TAS is thereby helping to keep participants and their families safe while sustaining participants' overall health, alleviating stress and isolation, and reducing the risk of institutionalization. The centers are also able to offer support to caregivers, who are experiencing increasing stress levels as their access to out of home respite is diminished.

This rapid, creative and skillful pivot in CBAS centers' approach to care was accomplished in close coordination with the California Department of Aging (CDA) and Medi-Cal managed care plans, who have worked diligently with CBAS providers over the past four months to ensure that critical needs are met during this extraordinary time. CAADS has provided weekly webinars since March, demonstrating leadership and a remarkable commitment to ensuring quality and clarity. CBAS centers approved by CDA to provide TAS have had the opportunity to participate in more than 30 hours of training in the new guidelines (March 2020-July 8, 2020).

LTSS Partnerships

For decades, CBAS and the Multi-Purpose Senior Services Program (MSSP) have been successful at providing long-term services and supports (LTSS) in the community and at home to older persons with advanced medical and social needs. As noted, CBAS and MSSP have demonstrated benefits and clearly defined models that resulted from extensive research and evaluation, as well as ongoing refinement through years of experience. Where co-existing in communities, CBAS and MSSP coordinate with one another and other LTSS, such as the California Community Transitions (CCT) program, Caregiver Resource Centers, and PACE, to name a few, to ensure that participants needing a broader level of assistance to sustain them are able to remain in their homes. These efforts are continuing as CBAS and MSSP adapt to the COVID-19 crisis. Were the proposed Long Term Care at Home benefit to be substituted for CBAS and MSSP and these programs eliminated, it would destroy services that have been and are continuing to work effectively during the pandemic emergency to keep vulnerable elders and people with disabilities safe while maintaining function and health.

Summary of Concerns and CAADS' Recommendations

A new state plan benefit certainly has the potential to help California's older adults and people with disabilities to remain in the community and live at home, however the LTC at Home proposal is worrisome. It rushes to create a complex, untested benefit on behalf of individuals in the state who are most vulnerable to COVID-19 without clearly defining the problem it seeks to address nor the population it targets. The vague goal is to "decompress" the NF population; however, nominal input was sought from stakeholders who are experts in this arena, including LTSS providers, prior to advancing the idea publicly.

CBAS and MSSP, California's legally sound, federally approved alternatives to institutionalization, were thoughtfully designed to play this role and are widely recognized as integral to California's LTSS system. These programs and others in the LTSS panoply are playing important roles in meeting the urgent needs created by the pandemic. Overlooking four decades of expertise in serving multi-faceted, fragile populations across this diverse state to focus on new program development quite simply does not make sense. The appropriate response in a time of pandemic would be to support and expand assistance utilizing the existing infrastructure with the flexibilities already granted, and more.

Most importantly, rushing a new LTC at Home service mode into action in the middle of the COVID-19 pandemic while failing to integrate it with the existing LTSS would place vulnerable populations at higher risk. Such massive system change clearly necessitates a broader, more robust stakeholder process than simply bringing it to the Master Plan on Aging Stakeholder Advisory Committee's LTSS Sub-Committee. Californians with disabilities across the age spectrum; caregivers; community-based organizations; consumer advocates; and provider advocates must all be included; and so, should hospitals, skilled nursing facilities, and managed care plans.

CAADS' recommendations are therefore to:

1. **Strengthen LTSS that are in place today by increasing access to and adding flexibility within existing licensure categories and LTSS programs to address the identified need.**

   The proposed LTC at Home program appears to duplicate (and otherwise ignores) the effective services California is already providing through CBAS and MSSP, as well as other LTSS. CAADS recommends that the state commit to utilizing and building upon existing programs to facilitate additional skilled nursing facility transitions to home, including CBAS, MSSP, California Caregiver Resource Centers, In-Home Supportive Services, the California Community Transitions (CCT) program, the Program for All Inclusive Care for the Elderly (PACE), and others. All have many years of experience in successfully serving high needs populations at home and in the community. These programs could be innovated and expanded to address the need for NF decompression.

   The LTC at Home proposal calls for the development of a new set of licensure requirements for Long-Term Care agencies, and only Home Health agencies and Hospice agencies are presently identified as meeting pre-qualification requirements for licensure. This proposed provider network misaligns with the experience and scope of work of CBAS and MSSP providers and differs from the Administration's budget hearing testimony. Creation of a new agency without past experience in addressing social determinants of health in an individualized, person-centered manner seems costly and inadvisable at this time. CAADS and other colleagues question whether the state needs a new licensure category with its associated cost and bureaucracy, however, if the state is authorized to create a new licensure category, we suggest that LTSS providers with experience in serving the target population be utilized and involved in the development of the licensure process.

2. Ensure a robust stakeholder process for LTC at Home to clarify purpose, identify gaps, and design solutions that work for the identified population(s).

The current LTC at Home proposal and trailer bill provide no defined model or standards of care, treatment protocols, or self-directed/person centered care specificity; nor is the process identified by which these components will be developed. This lack of clarity is of tremendous concern at a time when effective action is critically needed to prevent further harm from the health emergency created by the COVID-19 pandemic.

Overall, the level of integration of medical and social services and LTSS presently addressed in the proposal, trailer bill language, and DHCS' benefit design paper appears to be minimal. Longtime advocates, providers and consumers are already identifying multiple problem areas, including this one, and are deeply worried about the haste with which this proposal is being driven forward. Stakeholders are being asked to respond rapidly to a proposal about which there is limited information.

A robust stakeholder process, with defined goals for measuring success, must be implemented. In its final Report, the Long-Term Services and Supports Subcommittee notes that system change must be rooted in equalizing access to HCBS as a core component for meeting LTSS needs, in addition to ensuring that HCBS are fully integrated with necessary medical care.

At present, Californians are often unable to access necessary services and supports due to restrictive standards that prevent system flexibility and a lack of available options. This directly harms the people who rely on these services, exacerbating social inequities and health disparities and impeding their ability to avoid institutionalization. For this to change, the knowledge and experience of stakeholders must be valued and incorporated into the design of the benefit.

3. Preserve the LTSS safety net urgently needed by Californians most at risk to sustain local choices to meet a variety of needs

CBAS programs are an irreplaceable element of California's safety net for tens of thousands of Californians and have been for decades. The multiple services provided daily in CBAS centers, including person-centered nursing care, skilled therapies, personal care, and safe supervision, would be difficult to offer on either a short or long term basis in a home setting, and the cost would be prohibitive. Most importantly, these centers do far more than monitor and provide care; they help participants connect to others and to their communities and provide respite to caregivers to sustain their health and energy.[2] The powerful peer and provider engagement provided through CBAS is proven to combat social isolation and motivate participants to work towards improved health. Many other LTSS are also providing invaluable ongoing support. Any efforts undertaken to address gaps in the safety net must not create additional harm through the destruction of effective solutions which are already in place.

[2] Zarit, S., et al The Effects of Adult Day Services on Family Caregivers' Daily Stress, Affect, and Health: Outcomes from the Daily Stress and Health (DaSH) Study. Gerontologist. 2014 Aug; 54(4): 570–579.