NATIONAL INSTITUTE for MEDICAL RESPITE CARE

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ISSUE BRIEF

CalAIM Implementation of Recuperative Care Services: Lessons Learned

On Jan. 1, 2022, California began implementation of the California Advancing and Innovating Medi-Cal (CalAIM), a multiyear effort focused on transforming California's Medicaid program, which includes 14 new Community Support services to address health-related social needs of Medi-Cal beneficiaries. Recuperative care (also called medical respite care) is included as one of the Community Supports, which Medi-Cal Managed Care Plans (MCPs) have the option of providing to its unhoused members who need a place to recuperate following an inpatient hospitalization, emergency department (ED) visit or skilled nursing facility (SNF) stay.

Since then, data reports from California's Department of Health Care Services (DHCS) for CY2022 show that 2,400 people received recuperative care services from 170 recuperative care providers during 2022, the first year of implementation. During that time, existing programs needed to transition from being largely funded through hospitals to a claims/reimbursement-based system with MCPs, while newer programs were emerging into a rapidly changing environment. All programs were simultaneously expanding capacity and navigating new financing and workflow structures with new partners—all the while continuing to serve vulnerable people in need of post-acute care. Similarly, hospitals and managed care plans were also navigating new ways of conducting business and providing care.

The purpose of this issue brief is to document what is working well with the implementation of the CalAIM recuperative care service to date, what remains a challenge, action steps California should consider moving forward, and advice for other states looking to add a statewide Medicaid benefit for recuperative care.

This issue brief is based on interviews with leadership and staff at eight recuperative care programs, as well as several hospitals and MCPs from across the state (see appendix for list of participants). These interviews took place between June and August 2023, and their feedback is presented in the sections below.

BACKGROUND

While homelessness is a nationwide crisis, it is an especially large problem in California. The U.S. Department of Housing and Urban Development found that 582,462 people were experiencing homelessness on a single night in 2022—with 30% (171,521) of those people living in California. Further, California experiences a very high rate of unsheltered homelessness specifically, accounting for half of all unsheltered people nationally (115,491) and 67% of the state's total homeless population. A recent report from the Benioff Homelessness and Housing Initiative focused on homelessness in California found that 45% of those surveyed reported fair or poor health, 60% reported having a chronic illness, and 23% were unable to receive needed care in recent months.

This isn't unusual. People experiencing homelessness have significant health care needs, are hospitalized more often and for longer periods of time and have greater challenges to accessing needed health care services. Recuperative care programs offer hospitals a safe and legal discharge venue for vulnerable patients and provide a stable place to recuperate and receive ongoing services for those experiencing homelessness. Having those services funded through Medi-Cal can make this intervention more financially sustainable (as opposed to time-limited grants) and allow for integration into the larger health care system.

PERSPECTIVES FROM RECUPERATIVE CARE PROGRAMS

When asked what is working well with implementation, staff from recuperative care programs consistently mentioned four key areas:

1

BETTER RELATIONSHIPS WITH PLANS

Overall, program staff reported the opportunity to form better relationships with their MCP partners (though this was not a universal experience).

"CalAIM prompted a mutual understanding [with the plans] of the programs and how we can better serve clients. They were open to thinking outside the box. This was an opportunity to get to know each other and troubleshoot other problems."

"With [our MCP], we have a monthly meeting to discuss their members in our facility, the outcomes, and their status. I think that's great because it gives us the opportunity to let them know what's working and what's not working."

2

IMPROVED SERVICES TO PATIENTS

Program staff report MCPs are learning how to better serve beneficiaries who are experiencing homelessness.

"The plans are more involved in what happens to these particular patients. We can reach out to them and get assistance to get them into primary care, specialists, and linking them with ECM [enhanced case management] services for housing and what they actually need."

3

BETTER-INFORMED PARTNERS

Hospital and MCP staff are getting more education about recuperative care programs, as well as a better understanding of the realities of homelessness and how homelessness changes how vulnerable people interact with health care services and systems.

"Our managed care plan just hired someone who has a lot of experience in homeless services—that wouldn't have happened without CalAIM. It's creating awareness and collaborations across different systems of care that didn't exist before."

4

GREATER SYSTEM INTEGRATION

Staff reported that including recuperative care in CalAIM solidifies its role as a valuable health care intervention in both the local health care system and within the homelessness services system.

"The success in respite CalAIM reinforces that recuperative care is a solid, dependable program that is a backbone of a homeless response. We are core to the solution, and we deliver an excellent service."

Story and photo used with Roger's permission.

PATIENT STORY

Roger is a patient who successfully transitioned from a hospital stay to recuperative care to short-term post-hospitalization housing (another CalAIM Community Support) and then to permanent housing (with ongoing services).

Upon intake at the recuperative care program, Roger was very concerned about his health, legal problems, housing, and the denial of income from SSDI. During his stay, staff were able to help Roger with medication management, and obtain Medi-Cal coverage, a primary care provider, and vital documents. He was able to clear his warrants with the help of the homeless court and was matched to housing.

Roger was able to work on budgeting, stress management, and tenancy skills while in short-term post-hospital housing, and then successfully moved into an apartment with a housing voucher where he continues receiving tenancy and sustainability services.

HOWEVER, FOUR ISSUES REMAIN A CONSISTENT CHALLENGE:

1

SIGNIFICANT ADMINISTRATIVE BURDEN

Staff described substantial burdens to receiving/processing referrals, authorizations, claims, and reimbursements, as well as onerous data requests. More broadly, staff were frustrated with a fragmented health care system that uses separate and/or multiple IT systems and processes for each hospital and/or MCP. *[Notably, a program operated by the public health department acknowledged it did not have the same administrative burdens as their non-profit peers due to being part of a bigger system that already had substantive financial and information technology resources.]*

"There's no consistency — each plan has its own portal and referral process. We often get claims kicked back to us asking for info that we didn't have to provide for other patients — so it's been hard to routinize."

"We spend a significant amount of time on claims, processing claims, and getting claims paid on a timely basis. That's not where we should be directing our resources. I need to focus on my staff and the services I provide and not be focused on the back office work so much. Some of the smaller providers had to stop delivering care because they couldn't get paid. That's counterproductive to the whole system."

"We can't get a claims report from the plans so we can't see what claims we've submitted in their system. It makes it difficult to reconcile without doing a claim-by-claim analysis. It's like they are trying to find ways not to pay us."

2 LOW REIMBURSEMENTS

California is among the states with the lowest Medicaid reimbursement levels. Low reimbursement rates are causing concerns about program sustainability. Low rates translate into low wages, staff retention/recruitment challenges, and limits to the level of services offered. In turn, this leads to inadequate staffing and reductions in services.

"There was no conversation about what rate we needed to sustain our services. They [the plans] just went to one rate—there's no different rate, so the reimbursement isn't high enough to support the staff we have. Now we're not able to tailor the program by adding in more services."

"We had a food service with fresh meals every week but now we get frozen foods and things like that to cut costs. This is not anyone's preference. Patients obviously prefer fresh food to frozen food, and fresh food is easier to accommodate dietary restrictions, but we just can't afford it."

"I'm competing against Starbucks, which pays $18/hour and I'm paying $16.50. CA living wage is $21. We changed our line-staff positions to $18-$21/hour."

"The program is not sustainable with just CalAIM reimbursements. We have to have our supplemental grant from the hospital. Only 40% of our claims were reimbursable initially—and we do back-billing. If possible, we work to get people onto a plan while they are with us."

3 HIGH CLINICAL NEEDS

Hospitals frequently seek to discharge patients to the recuperative care program with higher clinical needs than the program is staffed to support. Whether due to workforce recruitment issues broadly—or limited reimbursement rates that curtail hiring more staff specifically—programs described being pressured to take higher needs patients than they were comfortable supporting. When programs declined to admit patients above their admission criteria, they noted receiving significant pressure from both the plans and the hospital to do so anyway. This dynamic presents significant stress on staff.

"We have one staff person on shift at night and on weekends—but from a safety and management perspective, that's very stressful because we have 25-30 patients who do all sorts of stuff that is super challenging to manage."

"Hospitals are so desperate to discharge they'll just send [patients] anywhere—whoever is the first one to answer the phone."

"It's already challenging to find staff to work with this population, but it's difficult to stay competitive with other organizations who are larger and offer more benefits and pay. We have a lot of turnover in staff because of this."

WORKFORCE STRATEGY

In Orange County, an MCP partners with a workforce training organization and pays health care staff to work at the recuperative care program. This has enabled more targeted recruitment and hiring, though challenges still exist with LPNs, RNs, therapists, and SUD counselors.

4

LIMITED LENGTHS OF STAY AMID SCARCITY OF HOUSING OPPORTUNITIES

Staff in some areas described limited authorizations that did not allow sufficient time for patients to recuperate and connect to needed services, such as specialty care or get established with primary care in the community. However, even programs who got extended authorizations said there was no housing in their area, which severely limited the goal of discharging patients into permanent, stable housing placements.

"Our biggest frustration here is there simply isn't enough housing to accommodate our clients. Homelessness is only increasing and there's actually less housing. It's only getting worse."

"Staff are doing everything they can to use additional days to find housing or another place [for patients] to go but there's no place to discharge them."

"About half of my patients could use another 90 days after their initial 90 days expires. An extra 90 days would give us more time with the patient and more of an opportunity to plan a transition into housing."

"We were only able to discharge 10% of our patients into housing directly from recuperative care, but once we added the 6months of short-term post-hospital housing [another CalAIM Community Support service], we've seen the number of people discharged to housing go up to 20%."

PERSPECTIVES FROM HOSPITALS

Hospital staff appreciated that the broad number of new services added to CalAIM generally—and recuperative care specifically—will be reducing hospital (re)admissions for people experiencing homelessness. However, staff at hospitals raised three challenges that remain:

1

ADMINISTRATIVE BURDEN WITH PLANS

Similar to the feedback from staff at recuperative care plans, hospitals are experiencing significant administrative burdens and are frustrated by the fragmentation caused by the introduction of so many new administrative processes and workflow changes. The requirement to obtain authorizations delayed referrals and the significant changes to established practices created numerous challenges. They asked for the process to be standardized and simplified (drawing on their experiences partnering with recuperative care programs prior to CalAIM).

"Every payer is different and that's a huge challenge. There also hasn't been the best ability to see real-time where people are going, and what beds are available."

"Because there's no consistency across counties, we still have to create unique approaches in each region—but that doesn't allow for consistent evaluation, and we don't know what data is being collected or how it is being evaluated."

"With CalAIM, it's all different processes, forms, people to reach out to—it's challenging to figure out who does what, who provides what service, what form should I use, how long it should take—and everyone has different answers."

"If we could standardize referrals and authorizations and share databases across hospitals and plans and programs—that would be a tremendous benefit. We don't need perfection—just to get a balance here."

2

ADMISSION BARRIERS

Admission barriers with recuperative care programs: Similarly, hospital staff felt some recuperative care programs have onerous eligibility restrictions.

"The recuperative care program is not able to provide care to the most at-risk patients because they have strict criteria for who they can take—patients can't be in a wheelchair, they can't be using substances, they can't have a lot of things. We need the recuperative care facilities to be staffed with clinical folks—especially mental health workers."

"The programs have limited hours of admissions so if it's the middle of the night, we can't admit from the ED [emergency department]."

"If someone has a criminal background, the program doesn't have to take them. It just lends itself to discriminatory practices that are not appropriate. So, our biggest issue is cherry-picking."

3

DELAYS IN AUTHORIZATION

Long wait times to receive authorization from MCPs for referrals delayed placements and increased lengths of hospital stays, undermining policy goals.

"People [at the recuperative care program] are on speed dial so we don't have a problem with getting a bed—it's the authorization for the services through [the plan]—sometimes it takes so long to get an auth that we have to pay for it ourselves."

"More people should be eligible for recuperative care than are being authorized. We're looking at this data now—how many referred, why/why not admitted—bring back to payers and ask about where to correct us. We refer more patients than get admitted."

PERSPECTIVES FROM MANAGED CARE PLANS

Staff from MCPs said the regular meetings with programs to discuss member care help improve services and inform the need for workflow changes. They also emphasized that adding recuperative care as a reimbursable service under CalAIM allows people experiencing homelessness to receive better care, realize improved health outcomes, transition more successfully between care venues, achieve greater stability, and better prepare for housing.

"We now have the ability for more vulnerable members to have a place to be taken care of post-acute care stays. This has allowed us to move members into safe spaces sooner rather than later. This benefits hospitals too since it's faster, the recovery time is shorter, and frees up hospital beds for acute level care."

"We appreciate that CalAIM services like recuperative care have allowed more of an upstream focus on health. It's the right thing to do and we hear how helpful this is on a daily basis."

HOWEVER, STAFF AT MCPS ALSO RAISE THREE ONGOING CHALLENGES

1

NEED FOR GREATER PROGRAM CAPACITY

MCP staff also discussed needing more recuperative care programs with higher bed capacity in order to meet the broad needs of patients needing care.

"Capacity is a huge issue. There aren't enough [recuperative] providers. When you don't have enough providers and you pick and choose which patients you want—it's easier to pick the easier patients to serve."

2

BARRIERS TO SKILLED CARE

Staff expressed frustration that it is difficult to get patients experiencing homelessness admitted to skilled nursing care facilities, which then limits appropriate care options.

"We get referrals from hospitals for people who are sex offenders or current IV drug users, so they can't go to a SNF [skilled nursing facility]. If they can't go there, they can't go to the shelter. Recuperative care is not a replacement for a SNF, and it's the lowest level of care—but the hospitals are referring people inappropriately."

"We fax to 40 SNFs and no one will admit because it'll be a custodial care admission. We need funding to pay for board and care or assisted living for members who could get services in that venue. This would decrease the number of people on the street—especially for elderly folks. They deserve the dignity of a roof over their head."

3

LACK OF HOUSING

Similarly to the feedback from recuperative care staff, MCP staff consistently pointed to the critical need for housing so that patients had a discharge option, as well as an ongoing stable place to receive ongoing care. One mentioned how the dearth of housing impacts staff retention.

"Housing capacity is insufficient to meet the need. We are constantly looking at building capacity of housing navigators and better understanding how we can support good tenant-landlord relationships through tenancy supports providers. Housing is the #1 issue."

"What do you do with a fragile member who has nowhere else to go and has medical conditions that continue to be an issue? What's the next step when there is no housing?"

TRUST: A THEME FOR HOSPITALS AND MANAGED CARE PLANS

Successful partnerships between payers and community-based providers start with establishing trust. Numerous staff from hospitals and MCPs raised the issue of trust during interviews, and specifically described the work being done to better understand their partners' needs, and the changes they are making to better facilitate trusting relationships.

HOSPITAL FEEDBACK

"The plans need to trust us that we are doing what's in the best interest of the patient. Hospitals were doing this before CalAIM so we have experience with recuperative care. Trust that we'll do this well—that's what we need to work on together as plans, hospitals and providers."

"The relationships with health plans —and how health plans engage with hospitals and communities— all goes back to how will we work together as a team and how we can trust each other."

PLAN FEEDBACK

"I trust our recuperative providers and our hospitals to move members appropriately to the right space. We want to make sure we support that transition and we weren't getting in the way of that transition. That takes a level of trust because we're not requiring that monitoring—we don't feel the need to oversee every aspect of that transition."

"We are interacting with organizations who have never worked with a plan before and they don't know what it means to work with us. Trust was already there with our recuperative partners we've worked with for decades, but getting new providers to work with us to ensure warm handoffs required new relationships and trust."

"If it wasn't for trust, our recuperative care project would not be as successful. We're building more trust as we place more people and prevent them from returning to the ED [emergency department]. Trust has to be #1. You have to build the relationship and then you can do anything because you are working together."

COMMON AGREEMENT: LEARNING GROUPS ARE KEY TO SUCCESS

As the feedback in prior sections of this issue brief illustrate, the first year of implementation was especially challenging in part because key stakeholder groups did not have a venue for sharing emerging issues and determining solutions. In particular, recuperative care programs (which are often small, non-profit organizations) felt they were not on equal ground with large hospital systems and managed care plans, which have more resources, political power, and decision-making authority. While health plans and hospitals are familiar working with each other, staff at the program level were acutely conscious of the power imbalance. One program staff described it as follows:

RECUPERATIVE CARE FEEDBACK

"They will want it their way. If you say no, they write you off. You have to fight back on their inappropriate referrals. DHCS needs to do more oversight of the health plans—look at their policies and procedures, work flows, who are they accepting /denying, what criteria they use. Right now it's the other way around, they all report to DHCS and we have no idea what they are reporting."

In response to a clear need for communication and a space for problem-solving, the largest group of recuperative care programs in the Los Angeles area created the Los Angeles Recuperative Care (LARC) Learning Network as a venue to bring together recuperative care providers, health plans, hospitals, and other health care leaders to build relationships, with an emphasis on the contractual relationships and protocol surrounding the newly reimbursable recuperative care service under CalAIM. Staff from recuperative care programs, hospitals, and MCPs all reported this was helpful and should be replicated elsewhere:

RECUPERATIVE CARE FEEDBACK

"The LARC allowed for honest dialogue between the recuperative care providers and health plans to discuss challenges and come up with joint solutions."

HOSPITAL FEEDBACK

"The LARC created a space to work hand in hand with programs and see where there are needs in different areas. It's helped lift up the challenges being faced to ensure there's true support from the payers to understand the complexities and how referrals worked in the past."

PLAN FEEDBACK

"Having the LARC as a venue to openly talk about the challenges that we're experiencing and the opportunities for improvement allowed us to develop a strong base to build off of. I can't say enough about the LARC."

MOVING FORWARD IN CALIFORNIA: ACTIONS TO CONSIDER

Staff at both hospitals and recuperative care programs all agreed that five specific changes moving forward would improve the implementation of this CalAIM-covered service:

1. Reduce the administration burden by establishing uniform policies and procedures across all plans and hospitals and automate routine reports and claims. (Note: DHCS has committed to standardizing some procedures by Jan. 1, 2024—see the box on the next page.)

2. Increase reimbursement rates so programs can hire much-needed staff, offer more services, and operate more sustainable programs.

3. Implement a presumptive eligibility policy for recuperative care and authorize longer lengths of stay when 90 days is not enough. (Note: some plans eventually moved to presumptive eligibility, which also shortens hospital length of stay.)

4. Require only the minimum amount of information needed to make a referral and/or receive reimbursement.

5. Prioritize policies and initiatives that increase the availability of permanent housing so there is a safe and stable discharge option, and so clients are able to exit homelessness.

POLICY GUIDANCE

Importantly, DHCS issued policy guidance in July 2023 outlining changes in response to some of these challenges:

- MCPs must follow all Community Supports Service Definitions
- MCPs must remove any previously approved restrictions or limitations and adhere with the full Community Supports service definitions by 1/1/2024
- MCPs will no longer have the option to narrow the eligibility criteria or impose additional limitations on the service definitions (which include eligibility criteria), geographic or otherwise
- MCPs do not need to actively report on cost effectiveness for Community Supports at the MCP or individual level for the purposes of rate setting or compliance with federal requirements. Consistent with federal regulations, DHCS has determined the preapproved Community Supports to be cost-effective and medically appropriate substitutes for covered Medi-Cal services or settings

[Note: DHCS also issued a "cheat sheet" that summarizes the guidance linked above.]

ADVICE FOR OTHER STATES SEEKING TO ADD A STATEWIDE RECUPERATIVE CARE BENEFIT

Recuperative Care programs offer the following 10 points of advice for those looking to add a statewide benefit in other states:

1. Streamline/standardize as many forms, processes, and portals as possible to reduce inefficiencies
2. Ensure reimbursement rates reflect the true cost of care and support the level of services needed
3. Offer capacity-building grants to give programs a chance to adapt to claims-based systems and/or make a "reserve" fund available for programs to borrow against when cash flow may be temporarily low.
4. Form a planning group (like the LARC Learning Network) ahead of time to provide a platform for programs, hospitals and plans to map out processes for referrals and claims submissions, as well as establish parameters and timelines for reimbursements
5. Balance structure with need for flexibility
6. Establish stronger state monitoring of managed care plans to ensure their practices align with state goals and policies
7. Hold regular client-focused meetings between recuperative care programs and MPCs
8. Establish trust between partners by focusing on the joint missions to address the needs of vulnerable unhoused people
9. Ensure all partners (especially staff at MCPs) are educated about homelessness and the realities of homelessness that make engagement in health care different from other groups
10. Ensure access to permanent housing to enable discharges and better outcomes

Hospital staff offer the following supplementary advice:

1. Put client navigators in the emergency department to identify those likely to benefit from recuperative care and facilitate care transitions
2. Identify programs and services that can serve higher needs patients, such as those who are older, those with behavioral health conditions, and those needing palliative care
3. Prepare to change based on feedback from partners

Finally, staff from MCPs recommended taking time to learn what's really needed, and they lifted up the need to ensure reimbursement rates include all the services being offered to ensure an adequate network of providers.

CONCLUSION

Implementing a wide range of new Community Support services into Medicaid is a tremendous challenge under any circumstances. After 18 months, California's recuperative care providers, hospital systems, and MCPs are still working through a transition complicated by administratively burdensome processes, low reimbursement rates, a fragmented health care system, medically complex patients, and a dearth of permanent housing. At the same time, those interviewed for this issue brief point to the importance of providing these services to a vulnerable population, the improvements in care and health outcomes, and the value of continuing to work together to make this service work well for all parties. Many pointed to the importance of building trust between partners in order to make changes and better meet community needs. Moving forward, California policymakers should encourage (or require) a more streamlined, consistent approach to many of the administrative aspects of providing a reimbursable service while also increasing the availability of permanent housing. Those in other states looking to California as an example of how to add a recuperative care benefit to their Medicaid waiver should note the feedback from these stakeholders and adjust their own process accordingly.

FOR FURTHER READING ON CALAIM AND RECUPERATIVE CARE

- National Health Foundation: Los Angeles Recuperative Care (LARC) Learning Network
- Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide (July 2023)
- California Health Care Foundation (CHCF): Lessons from the Field How an Ad Hoc Stakeholder Network Is Helping Redefine Medical Respite Care in Los Angeles (June 2023)
- Hospital Association of Southern California (HASC): Recuperative Care Forum Spurs Collaboration, Action (March 2023)
- CHCF: Supporting Statewide Expansion of Medical Respite in California (January 2022)
- CHCF: Medical Respite: Post-Hospitalization Support for Californians Experiencing Homelessness (July 2021)
- National Health Foundation: Planning for a Learning Network Among Los Angeles Medical Respite Payers and Providers (July 2021)

PARTICIPANTS IN THIS PROJECT

Medical Respite Care programs
Illumination Foundation, LifeLong Medical Care, San Francisco Medical Respite Care program, Housing Matters, National Health Foundation, HOLA Recuperative Care, The Gathering Inn, Golden State Recuperative Care

Hospitals/Health Care Systems
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