JUNE 2023

CHCF Issue Brief

Lessons from the Field

How an Ad Hoc Stakeholder Network Is Helping Redefine Medical Respite Care in Los Angeles

Executive Summary

California Advancing and Innovating Medi-Cal (CalAIM), the groundbreaking, multiyear effort aimed at transforming California's Medicaid program, offers a variety of nontraditional services to help address some of the health-related social needs many of the state's 15 million Medi-Cal enrollees contend with daily.[1]

Among these available services, which are collectively known as Community Supports, is medical respite. Also called recuperative care, medical respite provides shelter and basic clinical care to people experiencing homelessness who may be too ill or too weak to recover from a hospital stay or emergency room visit on the streets but who don't require additional inpatient care. These patients frequently grapple with a high burden of illness, trauma, substance use, and mental illness.

By supporting safe places to heal, CalAIM's recuperative care option creates a means for interrupting the progression of cascading medical events often experienced by unhoused Californians. As such, the program offers a path for substantially reducing Medi-Cal costs tied to default emergency room care and hospital readmissions for those experiencing homelessness. In 2019, almost half of the patients experiencing homelessness in California visited the emergency department four or more times and were more likely than other adults with low incomes to be admitted to the hospital.[2]

Beyond improving care and reducing costs, medical respite also provides an opportunity for at-risk persons to engage with other social services more easily, including recovery programs and temporary and permanent housing. It consequently can serve as a powerful tool for helping disrupt the broader cycle of homelessness.

But while CalAIM promises to make recuperative care more accessible, offering medical respite services through managed care represents a significant change for both health plans and the state's recuperative care providers. Most of the latter are small, nonprofit, grant-funded agencies that have traditionally worked only with hospitals.

With those limitations in mind, a group of Los Angeles–area stakeholders coalesced in early 2021 to share best practices ahead of CalAIM's January 2022 rollout. They also sought to anticipate some of the barriers smaller provider organizations would likely face in the new environment.

The volunteer initiative became known as the Los Angeles Recuperative Care Learning Network (LARC) and was initially designed primarily to help medical respite providers contract effectively with managed care plans. But LARC quickly evolved into a more broad-based network that now includes not only providers but also representatives of health plans, hospitals, area government agencies, foundations, and other interested parties.

Today, the network serves as an ongoing forum for stakeholders to address a range of complex and difficult issues emerging with CalAIM's recuperative care implementation. In that respect, it functions as a working laboratory for assessing how the state's policy vision and program requirements are playing out in real-world settings. Equally important, the network is helping foster accountability among all stakeholders as CalAIM unfolds and evolves 14 months into its implementation.

Participants say that while substantial challenges remain, the network's collective efforts — along with the goodwill it has fostered — have strengthened and accelerated the medical respite rollout in Los Angeles and statewide. Accordingly, the network offers a potential model for other California communities interested in pursuing collaborative solutions, not only for medical respite but also around other elements of CalAIM's vast and complex Medi-Cal transformation.

And because Medi-Cal is one of the first Medicaid programs in the country to make medical respite and other social risk factor supports reimbursable services, policy experts nationwide are watching, and participating in, the learning network to inform similar efforts in other states.

The California Health Care Foundation (CHCF) provided grant funding to help establish the Los Angeles Recuperative Care Learning Network. A CHCF representative recently interviewed several LARC participants to better understand how the learning network formed, why it evolved, and the role it continues to play.

CalAIM's Pioneering Vision

California Advancing and Innovating Medi-Cal (CalAIM) is a far-reaching plan to transform the California Medicaid program over the next five years. Spearheaded by the state's Department of Health Care Services (DHCS), CalAIM creates a mechanism for health plans to provide nontraditional services that can help address social drivers of health, the matrix of socioeconomic and environmental factors that collectively influence health outcomes.[3]

Recuperative Care

One of the nontraditional services that health plans may offer, medical respite, helps fill the vacuum that many experiencing homelessness face following a hospitalization or an emergency room visit. Baseline medical respite care characteristics include 24-hour access to a bed, three meals a day, clean restrooms, transportation to medical appointments, connection to clinical care, care coordination, and daily wellness checks.[4] Settings can be freestanding facilities, homeless shelters, Federally Qualified Health Centers, nursing homes, and transitional housing.

The benefits of recuperative care for patients are substantial. Ready access to a stable, post-acute environment can lead to quicker recoveries and better outcomes. Engaging with medical respite can also help engender patient trust while supporting streamlined enrollment in other services, including primary care, behavioral health, substance use recovery programs, and — perhaps most crucially — temporary and permanent housing.

For hospitals and payers, medical respite care creates a reliable discharge option that can reduce length of stay and/or preclude or delay readmissions, thereby dramatically reducing costs. At least one study shows that medical respite can lead to a 50% reduction in the likelihood of readmission at 90 days post-discharge and a 24% reduction in readmission in the 12 months following a respite stay.[5] Because the cost of an average medical respite day, at between $225 and $250, is typically just 5%–10% of the average inpatient day, the cumulative reduction in the total cost of care is significant.[6]

Medical Respite Provider Spearheads Learning Network

The impetus for an educational consortium that could help Los Angeles' recuperative care providers adapt to a post-CalAIM world emerged from one of the area's medical respite care leaders, the National Health Foundation (NHF). Operated by the Hospital Association of Southern California (HASC), the nonprofit in late 2017 established the Pico-Union Recuperative Care Facility, a 60-bed medical respite center in the Pico-Union neighborhood of central Los Angeles.

With CalAIM rapidly approaching in 2021, Kelly Bruno-Nelson, then NHF's chief executive officer, and Danielle Cameron, then the chief strategy officer, brainstormed how best to position their organization for the impending inclusion of recuperative care as a reimbursed service.

"It was during our initial conversations about CalAIM that Danielle said, 'Wouldn't it be great if we could bring together all the recuperative care providers, so we could present one united voice in our negotiations with the health plans?'" recalled Bruno-Nelson, who now serves as executive director for Medi-Cal and CalAIM with CalOptima Health, a managed care plan based in Orange County. Cameron is currently CalOptima Health's director of program development for CalAIM.

NHF was well positioned to lead such an effort, having previously recruited a veteran managed care executive and health care consultant, Pamela Mokler, to pursue pre-leased agreements for Pico-Union beds with both hospitals and managed care plans in the area.

The Learning Network Takes Shape

Informal soundings of area medical respite providers revealed broad support for the learning network concept, and the California Health Care Foundation quickly provided seed funding to get the idea off the ground. From the foundation's perspective, an important objective for the network was to help as many providers as possible contract with managed care plans ahead of CalAIM. To that end, Mokler, Bruno-Nelson, and Cameron worked to educate small nonprofits about health plans' often extensive credentialing, contracting, claims, and reporting requirements.

At the same time, the Nashville-based National Institute for Medical Respite Care (NIMRC) became involved to share national best practices and to provide guidance about CalAIM's provider-facing provisions.

"From the outset, we have served as kind of a neutral third party or honest broker with skin in the game," said Julia Dobbins, director of programs and services with NIMRC. "As excited as we are about seeing medical respite become a reimbursable service, we had some concerns about providers moving into partnership with managed care plans, especially around logistics, oversight, and admin capacity."

Mokler, who took charge of the learning network's contracting assistance efforts, echoed these sentiments: "It's a heavy lift to go from a nonprofit that survives for the most part on grant funding to working with a health plan, where you have to do reporting, submit claims to get paid, and provide outcomes for what you're doing," she said. "It was a brand-new world for a lot of them."

As the network gained traction and Mokler and Dobbins took increasingly hands-on roles, NHF's Bruno-Nelson and Cameron stepped back from leadership positions.

"We felt if we were the ones leading this effort, there might be a perception that we weren't representing everyone's needs," Bruno-Nelson said. "We very much wanted to continue to participate, but just as providers. Plus, we had a track record with Pam [Mokler]. As a former managed care executive, we realized she was ideally suited to provide a bridge between providers and health plans."

Finding a Collective Voice

Pooja Bhalla, co-chief executive officer of the Illumination Foundation, an Orange County–based medical respite provider, said that in the network's early days, many of the provider participants who had long competed against each other for tight grant and hospital dollars were reluctant to give away too much information.

"But I think everyone realized pretty quickly that we were all struggling with the same issues, that our programs were very similar in the way we ran them, and that this was an opportunity to share best practices," she said. "The network gave us a collective voice to have honest conversations with each other — and then, pretty soon, with the health plans, the hospitals, and the state."

Indeed, it was apparent nearly from the outset that extending participation beyond just providers would be critical.

"We felt that to really make this work, we had to engage all of the different parties and create a space where we could collectively address questions like how do we pay for recuperative care, how do we drive quality, how do we ensure our members and patients can connect with it?" Mokler said.

Differing Perspectives Across the Medical Respite Care Landscape

Mokler initiated a fact-finding process to assess where Los Angeles County stakeholders stood regarding CalAIM's recuperative care benefit. Over many weeks, she conducted more than 50 in-depth interviews with representatives from managed care plans, hospitals and health systems, medical respite providers, and area government agencies, including the Los Angeles Homeless Services Authority and the Los Angeles County Department of Health Services. She also interviewed leaders with local, regional, and national funders and foundations.

The takeaways from this process, which were compiled by Mokler and shared with both CHCF and DHCS, reflected a variety of concerns about CalAIM's mechanisms and impact.[7] Most of the issues focused on reimbursement rates, payment responsibilities, and referral eligibility. The feedback also highlighted the unique complexities of the Los Angeles Medi-Cal managed care market.

Multiple Wins

While some of the challenges stakeholders identified in the interviews conducted two years ago remain, most observers agree that the learning network has proven an essential conduit for bringing these difficulties to light and has, in recent months, helped foster and accelerate important advances in both Medi-Cal and managed care plan policies.

Chief among these has been an acknowledgment by state planners that greater uniformity around health plan referral and eligibility standards is essential to alleviate confusion and uncertainty among hospitals and medical respite providers.

At the same time, the county's largest Medi-Cal managed care plan, L.A. Care, has indicated it intends to fundamentally overhaul its approach to medical respite in response to widespread concerns expressed by learning network participants. Finally, the learning network played a central role in shortening medical respite authorization windows and has helped ensure that providers across California are paid in a timely fashion.

Health Plan Fears

For health plans, key concerns surrounding the medical respite benefit focused from the outset on determining who should be responsible for paying for medical respite care, how much providers should be paid, and what referral criteria should look like. While reimbursement for providing the CalAIM Community

Supports is theoretically baked into the capitation rate the state pays the plans, Mokler said making the numbers work hasn't been a given for some managed care plans.

Part of the challenge reflects the complexities of plan-provider agreements in the Los Angeles area. The county's two principal health plans, L.A. Care and Health Net, subcontract with a total of four other plans. These organizations and the two larger plans, in turn, have entered into a wide variety of risk-sharing arrangements with medical groups and individual practice associations across the county.

The resulting variances in the division of financial responsibility between plans and providers affect who is financially at risk and therefore who is ultimately responsible for paying for medical services, from hospital readmissions to medical respite care. Hammering out workable arrangements is further complicated by the differing levels of service and specialization various recuperative care providers offer. In simple terms, no single rate applies for recuperative care.

More fundamentally, Mokler said, health plans have worried that — irrespective of the downstream total-cost-of-care savings that can accrue from medical respite — CalAIM creates an opportunity for hospitals to shift all the cost burdens of recuperative care onto the plans, costs that until now have largely been borne by hospitals under SB 1152. The 2018 legislation required hospitals to assist people experiencing homelessness in identifying and transitioning to an appropriate post-discharge destination.[8]

"Determining who should pay — plans or hospitals — is a legitimate concern, because these are costs the plans were not paying before," Mokler said. "But by the same token, plans need to understand that medical respite will save them a lot of money in the long run."

Provider and Hospital Worries

Just as health plans have struggled to make CalAIM work from their perspective, so too have medical respite providers and the hospitals that refer patients to them. Among the most vexing issues for both has been the broad latitude granted to plans around eligibility criteria. With only general guidelines provided by the state, different plans have implemented different referral exclusions. As a result, determining who can be referred to recuperative care and under what circumstances has proven problematic.

"I attended a Hospital Association of Southern California meeting that included more than 200 hospital discharge planners, and I got an earful about how difficult it was for them to navigate all the different requirements to make referrals," Mokler said. "For them, it's been a nightmare trying to figure out who goes where and why."

The variances in eligibility requirements have also raised questions about the apparent gap between CalAIM's policy intent and the reality of recuperative care implementation. For example, L.A. Care, the largest Medi-Cal plan in the county, initially declined to authorize medical respite referrals from the emergency room.

L.A. Care's exclusions meant that thousands of patients who presented in the emergency room or were discharged with less-than-acute issues have been unable to access recuperative care, a reality seemingly at odds with the goals of CalAIM. Similar eligibility exclusions were not imposed by Health Net, L.A. Care's primary managed care counterpart in the county. From the start, Mokler said, Health Net deferred to hospital discharge planners and social workers in authorizing recuperative care. In essence, she said, Health Net has green-lit medical respite if the hospital staffer believes the patient would benefit from it.

L.A. Care Changes Course

The good news is that, thanks to feedback from network participants, L.A. Care recently agreed to begin authorizing referrals from the emergency room, effective July 1, 2023. Mokler said the health plan also intends to make other immediate changes in its eligibility criteria, including assessing member needs on a case-by-case basis and then determining which facility can best address those requirements.

Referrals Accelerated

Another issue providers and hospitals struggled with, at least initially, was the length of time health plans were taking to approve referrals. State policies gave health plans five business days to make a referral decision, but this interval often stretched to seven days over a weekend. For hospitals, this meant costly inpatient care had to be extended; and for medical respite providers, admissions were often delayed or reduced.

As the holdups mounted through the early months of the CalAIM rollout, Mokler conveyed providers' and hospitals' concerns to DHCS. She was told the matter would be investigated; not long afterward, Medi-Cal announced that, effective immediately, health plans would be required to expedite authorization and make referral decisions within 72 hours.

Mokler hasn't been shy about pointing out problems and holding all stakeholders to account. In another example, after multiple providers complained they hadn't been paid by L.A. Care for claims submitted months earlier, Mokler approached the plan's chief executive officer, John Baackes, following a presentation at a California Association of Health Plans meeting and informed him of the problem.

"He had told us we should come to him with unresolved issues," Mokler recalled. "So I did. I told him we needed his help. And the problem was resolved."

One network participant said the incidents underscore how essential it is to have a qualified and capable third party like Mokler leading the effort.

"I frankly can't think of anyone else who could provide the leadership that Pam has," said Bhalla of the Illumination Foundation. "It really has been exceptional. She sees what we're up against as providers, but because she's worked for managed care plans, she also understands how they need to operate. So I think we all feel like we have an honest broker and advocate leading this effort, someone who will listen to everyone."

A Turning Point

In late March 2023, the learning network — created at the height of the pandemic — conducted its first ever in-person forum. Among those in attendance was Jacey Cooper, the state's Medi-Cal director. According to Mokler, the daylong gathering gave stakeholders a chance to convey their observations and concerns to other participants and to the state. Cooper also addressed the gathering.

Among the key takeaways from the gathering, Mokler said, was the declaration by L.A. Care that the health plan was in the process of significantly restructuring its CalAIM operations. Some weeks later, the plan announced that it would begin accepting referrals from the emergency department by July 1, 2023.

For her part, DHCS's Cooper acknowledged that CalAIM was a work in progress and that the state was learning alongside participants. She addressed a number of specific stakeholder concerns and said that in light of the numerous problems that have emerged around authorizations and plan variance, DHCS intended to standardize managed care plan requirements as they relate to key aspects of the medical respite support, including eligibility.

New Tools and Collaborations

Susan Philip, the DHCS deputy director of health care delivery systems, observed that the learning network has supported the rollout of medical respite. Philip is responsible for overseeing Medi-Cal managed care plan contracts and CalAIM components related to the Community Supports initiative.

"I think the network has added value, particularly given the size and complexity of the Los Angeles market," she said. "It's a lot for community-based organizations to navigate, and it's been helpful to have a forum for folks to come together, plan what they need to do, and share best practices and lessons learned."

She noted that a new state initiative has been created to provide stakeholder guidance around a range of CalAIM implementation issues. Called Providing Access and Transforming Health (PATH), the effort — launched this past January — is providing up to $1.85 billion in state and federal dollars to help community-based organizations contract with third-party vendors for technical assistance related to capacity, infrastructure, contracting, and other operational issues.

PATH likewise is taking another page from the Los Angeles Recuperative Care Learning Network with the creation of 25 regional collaboratives statewide. Run by impartial, state-designated facilitators, the effort is designed to pull in a wide range of stakeholders to identify gaps within the community, identify and resolve implementation issues related to CalAIM Enhanced Care Management and Community Supports, and disseminate and share best practices.

As for the challenges Los Angeles–area stakeholders have encountered to date with recuperative care, Philip acknowledged the difficulties relating to the variance in medical respite authorization policies. She reiterated that the state intends to release new standardized requirements within the next few months. But she pointed out that with a policy effort as sweeping as CalAIM, it's important that the rules not be overly prescriptive.

"You need to allow for appropriate variation where it makes sense, and you don't want to inhibit innovation and flexibility," she said. "So it's always going to be a balancing act."

Looking Back and Looking Ahead

Mokler said uncertainties remain for all constituencies and more work needs to be done, particularly in the areas of streamlining workflows and improving access to short-term post-hospitalization housing. Nonetheless, she said momentum has been steadily building since the LARC meeting in March.

"I think there is a lot of optimism that wasn't there before about how we can collectively move this forward," she said. "The bottom line is L.A. Care and the other managed care plans are responding to feedback from the network and are willing to make changes, as appropriate, to ensure members have access to recuperative care based on their needs."

As for the role the learning network has played in helping drive recuperative care progress, Dobbins — the national expert who's been involved in the learning network from the outset — said she's been struck by the commitment participants have shown.

"Frankly, I was initially skeptical that people would or could come together to work on these issues," she said. "And it has been bumpy, and there have been a lot of candid and sometimes difficult conversations about what's working and what's not. But the stakeholders have kept coming to the table and kept communicating to figure out how to make this work. The health plans didn't need to be there. It's really been pretty impressive."

Jennifer A. Lloyd, senior vice president for population health and clinical operations with managed care plan

Health Net, agreed that the learning network has provided an essential vehicle for advancing the complex requirements of CalAIM.

"The learning network has been critical in rolling out the recuperative care community support program in LA," she said. "It's provided a forum for open discussion to address real-time issues and explore identified best-practice processes with other stakeholders. The network also facilitates working meetings to align processes among health plans to decrease the burden on providers working with numerous health plans."

What can other communities working to implement CalAIM's programs take away from the Los Angeles effort?

Mokler says it's about communication and respect.

"CalAIM requires payers and community organizations to be open to understanding each other's perspectives, processes, and workflows, and to be willing to compromise and change the way they operate," she said. "The success and sustainability of these partnerships can only be achieved if all parties feel like they're equal partners."

She added, "I see my role as an advocate for all stakeholder groups, including Medi-Cal beneficiaries. Everyone wins if we work together to serve our most vulnerable individuals."

About the Author

Bonar Menninger is a veteran business and health care writer who has worked for a range of publications since 1984 and is a three-time Pulitzer Prize nominee. Menninger was a reporter for both the Kansas City Business Journal and Washington D.C. Business Journal and has covered health care and technology for numerous online and print publications.

About the Foundation

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

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. *Baseline Report* [unwinding eligibility and enrollment data] (PDF), California Department of Health Care Services (DHCS), April 20, 2023.
2. Shannon McConville et al., *How Hospital Discharge Data Can Inform State Homelessness Policy*, Public Policy Institute of California, September 2022.
3. Sanne Magnan, *Social Determinants of Health 101 for Health Care: Five Plus Five*, National Academy of Medicine, October 9, 2017.
4. "The State of Medical Respite Care," National Institute for Medical Respite Care, last updated May 2023.
5. Stefan G. Kertesz et al., "Post-Hospital Medical Respite Care and Hospital Readmission of Homeless Persons," *Journal of Prevention & Intervention in the Community* 37, no. 2 (2009): 129–42.
6. *Recuperative Care in Los Angeles County: Strengths, Gaps & Opportunities* (PDF), UniHealth Foundation, July 2020.
7. *Planning for a Learning Network Among Los Angeles Medical Respite Payers & Providers* (PDF), National Health Foundation, July 2021.
8. "SB-1152 Hospital Patient Discharge Process: Homeless Patients," California Legislative Information, October 1, 2018.