SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
SENIORS AND PERSONS WITH DISABILITIES (SPD) TECHNICAL WORKGROUP
Meeting #1 – Thursday, February 4, 2010
10:00am – 3:00pm
Sacramento Convention Center, Room 103

The meeting convened at 10:05 AM.

Attendance

Technical Workgroup members attending: Richard Bock, Molina Healthcare of California; David Ford, California Medical Association; Jonathan Freedman, Los Angeles County Department of Public Health (by phone); Dean Germano, Shasta Community Health Center; Mary Giammona, San Mateo Health Plan (by phone); Bradley Gilbert, Inland Empire Health Plan; Michael Humphrey, Sonoma County In-Home Supportive Services Public Authority (by phone); Jerry Jeffe, California Council of Community Mental Health Agencies; Lisa Kodmur, LA Care; Elizabeth Landsberg, Western Center on Law and Poverty; Jackie McGrath, California Council of the Alzheimer's Association; Christina Mills, California Foundation for Independent Living Centers; Santiago Munoz, University of California; Erica Murray, California Association of Public Hospitals; Chris Perrone, California Healthcare Foundation; Cheryl Phillips, On Lok Lifeways; Brenda Premo, Western University of Health Sciences; Jacqueline Ritacco, AltaMed Health Services; Deb Roth, SEIU; Leila Saadat, Alameda Alliance for Health; Rene Santiago, San Diego County, Health and Human Services; Margaret Tatar, CalOptima; Anthony Wright, Health Access California; Casey Young, AARP.

Others attending: David Maxwell-Jolly, Director, Department of Health Care Services (DHCS) and Chair, Stakeholder Advisory Committee; Gregory Franklin, Director of Medi-Cal Operations and Project Director, 1115 Demonstration Waiver Project, DHCS; Tanya Homman, DHCS; Luis Rico, DHCS; Don Fields, DHCS; Bob Martinez, DHCS; Bobbie Wunsch, Pacific Health Consulting Group, and Catherine Teare, Pacific Health Consulting Group.

Public in Attendance: 23 individuals attended in person, and 44 people called in on the listen-only telephone line.

Welcome and Introductions; Overview of the Purpose and Desired Outcomes of the SPD Technical Workgroup; Workgroup Structure and Process

David Maxwell-Jolly, Director, Department of Health Care Services (DHCS) and Chair, Stakeholder Advisory Committee opened the meeting. He recognized the California HealthCare Foundation for their support of the SPD Workgroup, and introduced Chris Perrone from CHCF, who is participating in the Workgroup.

David Maxwell-Jolly reviewed the SPD Workgroup's Charter (available at http://www.dhcs.ca.gov/provgovpart/Documents/SPD%20TWG%20Charter%20draft%202-

2%20_2_%20gf%20_3_.pdf). He said that questions the workgroup should address include whether the existing managed care infrastructure can handle enrollment of significant numbers of seniors and persons with disabilities, or whether the state needs to establish alternate structures. In other counties, what structures can be established to provide organized care for these beneficiaries? He recognized the wide variation of opinion on issues of mandatory enrollment of seniors and persons with disabilities and was looking forward to learning more about the workgroup's perspectives on the issues.

Bobbie Wunsch, Pacific Health Consulting Group, introduced the structure of the meeting, and welcomed participants on the phone.

- Future meetings of the workgroup will be held on February 28, March 11, and April 1. The February and April meetings will be in the Convention Center, Room 103; the March 11 meeting will be held at a location to be announced. At the February 28 meeting, the SPD TWG will propose several issues for the Stakeholder Advisory Committee (SAC) to consider at their March 10 meeting.
- Agendas and materials for future meetings will be sent out several days in advance of each meeting.
- The TWG meetings will be open to the public in three ways: a listen-only call-in capability through a conference line; limited seating at the actual meetings (as space permits) and a written summary which will be posted on the website within one week of each technical workgroup meeting. A summary of this meeting will be posted on the website by February 11, 2010.
- The members of the TWG were chosen by the DHCS Director with input from DHCS staff, the foundation partners and other stakeholders. TWG members may not send substitutes to represent them in the event of absence, though they are welcome to send a colleague to listen to the meeting. TWG members are expected to participate actively.

Elizabeth Landsberg, WCLP raised concerns that the SPD Workgroup charter predetermines the direction the waiver will take, in significant ways. While the authorizing legislation for the waiver process (ABx4 6) mentions an organized system of care, it does not define that system. By contrast, the SPD workgroup charter seems to presuppose managed care. In the same vein, while readiness standards and requirements are critical for SPD populations, the managed care contracts are not necessarily only or best place for these to be contained, particularly as they are not public documents. Some pieces of these standards might better be contained in legislation or regulation.

David Maxwell-Jolly responded that it is no secret that DHCS would like to use the existing infrastructure to the extent possible, given the focus on coming up with a practical solution for delivering organized care. A focus on the existing managed care plans allows the workgroup to concentrate on what organized systems would be likely to deliver. He stated that he understood that many workgroup members likely had questions about the best way to provide services, and stated that the question is not closed.

Anthony Wright, Health Access concurred with Elizabeth Landsberg's comments, and asked whether it would be possible to add additional presentations to the agendas of subsequent meetings, or whether the agendas for those meetings were set. He raised in particular issues about consumer protections for patients in an organized system of care.

David Maxwell-Jolly responded that the agendas for all four meetings have been designed to cover an ambitious agenda, with the first three meetings focused on Care Management, Performance Measurement, and Managing Mandatory Enrollment, respectively. He asked whether the consumer protection issues and others could be brought up within the context of those three broad agendas, and if not, asked workgroup members to bring those issues forward.

Chris Perrone, CHCF suggested that relevant materials suggested by workgroup members be posted to the SPD section of the website, and Bobbie Wunsch agreed that this could be done. She will follow up on consumer protection issues with Anthony Wright, and said that members with other concerns should contact her or Tanya Homman, DHCS.

Anthony Wright, Health Access asked why the process was focused on contract standards, and not legislative or regulatory standards. David Maxwell-Jolly replied that contracts were the Department's main tool, and that it allowed for a specific and concrete discussion about how to operationalize the system.

Jerry Jeffe, California Council of Community Mental Health Agencies noted that the federal government has recently issued regulations regarding mental health parity. While it is too soon to know the impact on health plans and thus on the waiver process, he suggested that this might be an important discussion item for a future agenda.

Brenda Premo, Western University of Health Sciences said that individuals' rights need protection regardless of the system: HMO, FFS, or care coordination. People with disabilities need a single standard and a common set of rights across all delivery systems.

Michael Humphrey, *Sonoma County In-Home Supportive Services Public Authority* [by phone] said that discussion of linkage to home-based services was missing from the meeting agenda. He said that a discussion of the expectations of any organized delivery system, whether a managed care organization or a care coordinator, to provide linkage to community-based LTC services, should be part of the workgroup's plan.

David Maxwell-Jolly agreed that if such discussion was missing from the meeting agendas, it should be added, and that it could be discussed at the current meeting as part of the care coordination discussion.

Jackie McGrath, California Council of the Alzheimer's Association referred back to questions posed at the first Stakeholder Advisory Committee (SAC) meeting in January regarding performance data of managed care plans that enroll seniors and persons with disabilities. She suggested that such data would be directly relevant to evaluating whether existing contracts are adequate.

Mary Giammona, Health Plan of San Mateo [by phone] offered some data from HPSM's 23 years of enrolling SPD individuals. She specifically discussed the complications of Medi-Medi enrollment, and the high costs incurred by these dual eligibles, but said that intensive care coordination had reduced both ER utilization and hospitalization by more than over

40%. She raised the issue of adults with developmental disabilities being incorporated into the community health systems, saying that while social needs are often met by the Regional Center, there are not sufficient clinical resources in the adult health system to care adequately for health needs. Finally, she discussed efforts to take various categorical funds for seniors and people with disabilities and pool them to create a comprehensive system of care, with both health and social services following the patient regardless of the level of residential care required. *Tanya Homman* asked that HPSM provide recent data on their experience serving SPD in managed care to be shared with the workgroup. *Margaret Tatar, CalOptima* mentioned that CalOptima would be presenting data on the same issues at the February 25 meeting.

Existing Care Management Contract Standards and Coordination of Carve-Out Services

Susan McClair, Acting Chief, Medical Policy Section, Medi-Cal Managed Care Division gave a presentation on current contract standards and coordination of carve-out services. Her presentation, a COHS contract boilerplate document, and a related "crosswalk" document designed to assist readers in finding particular relevant topics within that contract boilerplate, are available at:

http://www.dhcs.ca.gov/provgovpart/Documents/PowerPoint_%20DHCS_%20%20Care%20Mgmt%20Contract%20Standards%20Coord%20of%20Carve-Outs.pdf (McClair presentation)

http://www.dhcs.ca.gov/provgovpart/Documents/COHS%20Contract%20Boilerplate%202009.pdf (contract boilerplate)

http://www.dhcs.ca.gov/provgovpart/Documents/Selected%20COHS%20Contract%20Requirements.pdf (crosswalk document)

An additional document, a November 2008 memo from the Center for Health Care Strategies (CHCS) summarizing the results of a survey of Medi-Cal health plans regarding case management/care coordination and disease management activities underway at the plans, was also discussed and is available at http://www.dhcs.ca.gov/provgovpart/Documents/CHCS%20Case%20Coordination%20Survey.pdf.

Deb Roth, SEIU asked how the presentation relates to the contract boilerplate. Susan McClair explained that the crosswalk document is designed as a map to the contract.

David Ford, CMA asked about contract requirements regarding network adequacy. Susan McClair responded that those requirements are included in the contract, but are not called out as an issue specific to SPD populations. *Chris Perrone, CHCF* noted that network adequacy will be discussed in the third SPD workgroup meeting. *Brad Gilbert, Inland Empire Health Plan* clarified that Knox-Keene requirements also control the provider network.

Jerry Jeffe, CCCMHA asked whether the Department's contracts would have to be amended to conform to new DMHC requirements for mental health providers, and Tanya Homman said that they would.

Brenda Premo, WUHS commended the Department's efforts to "map" the managed care contracts, but questioned the capacity of a "medical home" when the required ratio for primary care providers to patients is 1:2000. She asked how a single provider with 2000 patients could possibly provide comprehensive care to a patient with significant developmental disabilities who's just been put out of Lanterman. Bobbie Wunsch noted that medical home issues would receive more discussion, both through an upcoming webinar on February 26 sponsored by DHCS and a related meeting at the Capitol on March 2 sponsored by the Western Center on Law and Poverty.

Deb Roth asked Susan McClair to elaborate about the evaluation process for managed care plans, including audits. Susan McClair said that Medi-Cal managed care plans undergo audits by the Audits and Investigations Unit and DMHC (jointly), in which auditors review extensive documentation submitted by plans, conduct a random chart review, and do an onsite review of plan operations. *Brad Gilbert* detailed recent audits that IEHP has undergone.

Anthony Wright suggested that it would be useful to know how frequently the various audits and reviews take place. Tanya Homman provided additional detail on the audit and review processes.

Deb Roth asked about penalties and other enforcement measures; Brad Gilbert and Tanya Homman responded, describing DHCS's use of corrective action plan processes to correct deficiencies found during audits and investigations. Tanya Homman said that financial penalties were possible but rare, and Deb Roth asked for detail on any history of financial penalties imposed.

Jackie McGrath asked for detail on the Ombudsman program. Tanya Homman replied that the program has had staff shortages but is staffing up, with three new staff recently hired. There is no statutory requirement regarding response time, but the office tries to communicate with grievants within 24-48 hours. There is a process for immediate disenrollment when necessary. *Brad Gilbert* described IEHP's internal grievance process, and said that most issues were handled there. Jackie McGrath commented that one could expect a large increase in Ombudsman complaints in the event of SPD enrollment in managed care.

Mike Humphrey asked how ADA accessibility was monitored and evaluated. Susan McClair said that managed care plans are required to audit each provider site, using a tool developed by DHCS. MMCD's medical monitoring division also monitors provider sites.

Brenda Premo said that the Department's ADA tool is too weak, but that four managed care organizations (IEHP, LA Care, Molina, and Health Net) have jointly developed a better tool that really ensures the accessibility of provider sites, and which LA Care has written a report about. The Department's tool and instructions for its use are posted at http://www.dhcs.ca.gov/provgovpart/Documents/Site%20Review%20Survey.pdf (site review survey) and http://www.dhcs.ca.gov/provgovpart/Documents/Site%20Review%20Survey%20Guidelines.pdf (site review survey guidelines); the tool developed by the plans will be posted on the SPD TWG main page (http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupSPDs.aspx) under "Resources" within several days.

Discussing this new accessibility tool, *Richard Bock, Molina Healthcare of California* said that nurses carry it as software on their computers and use it to document accessibility standards as part of the facility site review. The site review is also an educational opportunity, allowing plans to tell providers about tax credit opportunities for improving accessibility standards. *Lisa Kodmur, LA Care* said that they have now been using the tool for over four years, and that results of their evaluations are publicly available on LA Care's website.

Christina Mills, California Foundation for Independent Living Centers asked whether provider site review also includes medical home standards and cultural competency. Susan McClair responded that site reviews by health care plans of their contracted providers include medical record review, looking for care coordination, appropriate assessments, etc. If providers do not reach at least 80% compliance, plans issue corrective action plans and plans are responsible for following these up. The penalty in event of noncompliance is termination of contract by the plans. Cultural competency is assessed by a separate tool.

Elizabeth Landsberg, WCLP noted that the Ombudsman's office – and particularly the capability to immediately disenroll individuals – has been critically important in many cases, including for pregnant women and foster children. Regardless of the system used, the Department must think through how these processes are available to consumers in multiple languages and quickly.

Casey Young, AARP asked how best to figure out what standards are currently included in the contract. Tanya Homman suggested that the crosswalk document was designed for this purpose. *Deb Roth* asked if the crosswalk could be rewritten with hyperlinks to the relevant sections of the contract, and Greg Franklin, DHCS said that the contract is not designed as an educational document, and suggested that if members of the workgroup have questions, they contact him or Tanya Homman for help.

Anthony Wright suggested that most consumers don't want to read the contract, and asked what other documents were available to patients seeking to learn about their rights and responsibilities. Tanya Homman referred to the Health Care Options booklet, the Medi-Cal application, and the Choice packet.

Recommended Care Management Standards and Coordination of Carve-Out Services

Moira Forbes, The Lewin Group gave a presentation on recommendations for care management standards and coordination of carve-out services contained in a report entitled *Performance Standards in Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions* (November 2005). The report was sparked by a 2005 Administration proposal to expand mandatory managed care for people with disabilities. In response, the California HealthCare Foundation assembled a consulting team made up of three different organizations that together facilitated an extensive process to solicit public input and feedback in eight areas: enrollment and member services, network capacity, accessibility, benefit management, care management, quality improvement, performance measurement, and coordination of carve-out services. Central to the process was the work of a 28-member advisory group, which met intensively to develop the recommendations contained in the report. The advisory group took a practical approach, and sought recommendations that were enforceable, measurable, and reasonable in the overall context of the Medi-Cal managed care program. They focused on contract and purchasing specifications, and sought to define what providers and plans could do, and how the state could support and oversee those functions. In addition to reviewing existing contracts, they examined other states' practice and the relevant literature.

Materials are available at

http://www.dhcs.ca.gov/provgovpart/Documents/Lewin%20Group%20Presentation.pdf (Forbes presentation)

http://www.dhcs.ca.gov/provgovpart/Documents/CHCF%20Medi-Cal%20Performance%20Standards%20Recommendations.pdf (Performance Standards paper)

http://www.dhcs.ca.gov/provgovpart/Documents/DHCS%20Response%20to%20CHCF%20Recommendations.pdf (DHCS response to Recommendations)

Moira Forbes discussed the report's recommendations in two areas: care management standards and coordination of carve-out services:

Care Management Standards

In the area of care management standards, the group's findings included the following:

- Compared to other states, the California contract is very general on the topic of care management – saying only that it must happen, and that the PCP is primarily responsible. Other states provide more detail about, for instance, what has to be in the written care management plan, and the qualifications for care managers.
- Many participating plans said that they provide significant care management, even if it's not specifically included in their contracts.

Chris Perrone clarified that after these recommendations were released, CHCF sponsored a project in which DHCS worked directly with other states on certain issues related to SPD enrollment. The CHCS survey of health care plans was part of that process.

Stuart Levine, Health Care Partners: asked about disease management (DM) versus care management (CM), and asked why the CHCF advisory group distinguished between the two. Moira Forbes replied that they looked at it because DM was part of the current contract, but that many in the SPD population have multiple issues and that DM is not designed to address that.

Coordination of Carve-Out Services

Moira Forbes reported that the coordination of carve-out became its own subgroup, with active participation by state staff. The advisory group was keenly aware of the extent of complaints about carve-out from California beneficiaries and providers. California has done a good job of identifying what's carved out, which is a start, but has not created systems to assist in coordination between plans and other agencies and programs, or defined what CHHS, as the umbrella, should be doing. Other states do not provide outstanding examples, unfortunately. The advisory group considered and rejected a number of approaches:

- Patient notebooks, used by a lot of plans in particular for children with special health care needs, were too specific a solution to be included as part of a contract.
- Quality Improvement programs in which plans and outside agencies are required to work together did not necessarily get to the root of the problem.
- Global solutions such as training or consumer navigation were likely to make the contract even more complex.

Brenda Premo, who participated in the Advisory Group, discussed the difficulty with Disease Management (DM) both for multiple problems – a person with diabetes, for whom DM is defined, who also has a spinal cord injury and uses a wheelchair – and for "orphan disabilities," specific and unique issues that affect small numbers of individuals.

Jackie McGrath, who also participated in the Advisory Group, mentioned three issues:

1) Need for more systematic, earlier assessment of need for care management, not reliant solely on a review of utilization data.
2) Focus on the role of the caregiver, both in recognizing their importance as a partner in care and in assessing their capacity to provide assistance. Many caregivers have health care issues of their own.
3) Need to assess patients' functional and cognitive status. Dementia a major cost-driver for Medi-Cal – the cost of care for someone with dementia is 2.5 times the typical amount, according to a UCSF study. Not including cognitive status as a qualification for care management would be short-sighted, but given the tremendous underdiagnosis of dementia – only 19% of people with dementia or Alzheimers actually have it noted in their medical record – there is a need for periodic assessment of cognitive status as people age.

There was a short lunch break, and the meeting reconvened at 12:45.

Existing Practice of Care Management and Coordination of Carve Out Services (panel discussion)

Peggy Hoover, Health Services Director, Partnership HealthPlan of California described Partnership HealthPlan's care management system for seniors and persons with disabilities. Her presentation is available at http://www.dhcs.ca.gov/provgovpart/Documents/PowerPoint_%20PHP_%20Coordination%20of%20Care%20for%20SPDs.pdf.

Partnership HealthPlan of California (PHC) is a COHS serving a four-county area in Northern California. 31% of its members are seniors and persons with disabilities.

PHC has a complex case management (CCM) program that serves people with chronic conditions, often seniors.

- Following an extensive (90-minute) interview, if a member is referred for CCM, s/he works with an Intensive Case Manager (RN) who develops an individualized care plan and coordinates services with the member's PCP.
- Some CCM members (those with complex conditions that prevent easy access to a PCP, or who are homebound) have access to a home nurse practitioner (a contracted position) as necessary. The home visiting NP has been a significant success for PHC. She is available 24/7, and can provide prompt treatment of exacerbations, avoiding many ER visits. Her current caseload is 60 patients.
- PHC is beginning a Care Transitions program this spring, which will focus on creating a smooth transition as a member moves from one level of care to another. It will target people most likely to be readmitted.
- Referrals to the CCM and other care management programs come from a variety of sources, primarily internal data reports, prior authorization and concurrent review staff, and PCPs/other clinical providers. Members can also self-refer.
- While PHC does have an end-stage renal disease program, it is moving away from DM toward a more "patient-centered" care management model.

Cheryl Phillips, On Lok Lifeways, stated that, from the perspective of a geriatrician, it can be difficult to have outside care management that is not well integrated with the primary care delivery team, and asked how Partnership's system handles that issue. Peggy Hoover said that the Home Nurse Practitioner or Intensive Case Manager will occasionally accompany the patient to an appointment, and also have frequent contact with the PCP, with the NP sending all their visit notes to the PCP. A key goal of Partnership's system is to maintain communication with all providers, in effect managing communications with providers on the patient's behalf.

In response to a question from Bobbie Wunsch, *Cheryl Phillips* said that there was no single model that was considered a best practice. While Partnership's system sounded great for some people, On Lok's PACE (Program of All-inclusive Care for the Elderly) program, which integrates the entire care team, has been recognized as a success for frail elderly. PACE physicians have a panel of approximately 100 patients, and meet with an interdisciplinary team including a social worker, nutritionist, and others daily to plan and exchange information.

Christina Mills asked about dental care and about transition coaching (giving patients the chance to talk about options outside what the physician recommends), and Peggy Hoover said that Partnership offers dental coverage for patients who have Medicare Advantage and occasionally through a special needs fund within the Plan, but does not currently offer a transition coaching alternative

In response to a question from *Brenda Premo* about challenges that Partnership faces, Peggy Hoover said that outside of funding, the biggest challenge is building trust with patients, some of whom have had multiple negative experiences with health care and other systems and do not easily build these new relationships.

Brad Gilbert, MD, CEO, Inland Empire Health Plan introduced IEHP's care management/care coordination services. His presentation is available at http://www.dhcs.ca.gov/provgovpart/Documents/PowerPoint_%20%20IEHP_%20Care%20Management-Care%20Coordination.pdf.

IEHP is a Joint Powers Agency, non-for-profit public entity that currently serves over 435,000 members, of whom 364,000 are Medi-Cal beneficiaries and 20,000 are Medi-Cal seniors and persons with disabilities.

IEHP identifies members for care coordination through encounter and pharmacy data which is "queried" for diagnoses and medications that suggest chronic illness; through internal member contact through a variety of portals (member services, utilization management, etc.); or through referrals from physicians. Brad Gilbert said that IEHP needs to work on identifying people who need care management earlier, and was struck by the lack of consistency or identified best practices in care management for these populations, as evidenced by the CHCS survey.

Care management/care coordination at IEHP includes assessment, and individualized care plan, and a multi-disciplinary care team. The member is assigned a primary contact from the care team based on multiple factors including illness, psychosocial issues, and relationships. All members of the care team are IEHP employees. The plan itself, and not the PCP, does much of the care management for Medi-Cal members. In part, this is because solo or small-office practitioners who are PCPs have none of the resources – nutritionists, social workers – that they need to meet the care management responsibilities of a medical home. This is not necessarily the case for large clinics that are more likely to have the staff they need.

Lessons learned include:

- Placement of a social worker at the Inland Regional Center has greatly improved care of members who also receive services at that facility
- Chronic pain has required IEHP to develop multi-disciplinary pain programs that are still evolving
- Development of a CCS database that tracks CCS authorizations and denials has greatly improved coordination between CCS and the plan
- Relationships with the two County Behavioral Health units has been critical to facilitating behavioral health care in a time when county resources are stretched thin.

Carve-outs remain challenging for IEHP. As of this month, the plan has brought behavioral health in-house for Healthy Families and the Medicare SNP.

In response to a question from *Christina Mills,* Brad Gilbert said that IEHP has been working with local Independent Living Centers (ILC) both through a disability collaborative and through a contract under which ILC staff counsel individuals who are leaving long-term care (LTC) and rolling into FFS.

In response to a question from *Jerry Jeffe,* Brad Gilbert said when providers believe that a Medi-Cal patient needs a mental health assessment, they do the assessment in-plan and then refer to the county's behavioral health intake units as needed.

Elizabeth Landsberg asked about physicians' response to the care management program. Brad Gilbert said that they do not receive nearly as many referrals from MDs as he had expected. While physicians have sometimes had problems with their disease management programs, which they may see as overly prescriptive, the care management program does not seem to feel like an infringement on their practice. The care plan is more about members' access to care and coordination, and less about medical practice.

Workgroup members continued the discussion of identification strategies. *Jackie McGrath* stated that since screening for dementia is often weak, but since people with dementia often have one or more other conditions (high blood pressure, diabetes) that are more frequently screened, there could be an opportunity to add dementia screening to the assessments triggered by these other conditions. Brad Gilbert said that IEHP screens for depression, but should look at adding a cognitive screen, possibly stratified by age. *Stuart Levine* said that everyone over age 65 enrolled in HealthCare Partners is screened for dementia.

Dean Germano, Shasta Community Health Center echoed concerns about chronic pain management, particularly for persons with disabilities, and the difficulty in coordinating behavioral health interventions. Brad Gilbert agreed that chronic pain is an example of an area in which carve-outs get in the way, so that Medi-Cal providers are left with only pharmaceutical options for treating pain.

Stuart Levine, MD, Corporate Medical Director, Health Care Partners discussed the care management provided by that plan. His presentation is available at http://www.dhcs.ca.gov/provgovpart/Documents/PowerPoint_%20%20HealthCare%20Partners_%20CA%201115%20Waiver%20SPD%20Workgroup.pdf.

Among the key points about Health Care Partners care management plan:

- HCP takes full risk, with a goal of redirecting every dollar to patients. This allows for the provision of coordinated care. HCP is MD-owned, and has no utilization management, only care management.
- All care is team care – all PCPs have a care manager there at least ½ day a week, so patients always have an advocate.
- HCP has a central data warehouse. The dashboard is available to everybody, and there are MD portals, patient portals, and a built-in care management program with two different electronic health records (an IPA EHR and a staff-model EHR that meet in the data warehouse).
- Long term contracts with hospitals mean long term relationships. HCP relies on hospitalists – every patient has to be seen by a hospitalist in the ER.

- HCP focuses extensively on Advanced Care Planning, and provides a lot of palliative care and ACP training to physicians and others.
- The care management program is built for frail seniors. HCP has about 90,000 seniors enrolled, and 650,000 other patients.
- One challenge is that HCP is big, and slow to market. They are working on breaking up into regions and allow each to work as own delivery system. One is the R&D.

In lieu of the *small group discussion* that had been scheduled, the Workgroup as a whole addressed the following key questions:

- What, if any, requirements should be added to promote effective care management for the SPD population?

- What, if any, requirements should be added to ensure effective coordination of carve-out services?

Jacqueline Ritacco, AltaMed Health Services discussed the need to standardize the definition of “medical home,” and define the role of the PCP. These definitions should be clearly stated in the Medi-Cal contracts.

Erica Murray, CAPH agreed with the medical home issue, and asked how we can better facilitate coordination between providers and the overlaying infrastructure. She referred to earlier discussion about the great range of levels of care available at various provider sites, from individual providers to large clinics, and the need to be flexible in what we require from these different sites.

Anthony Wright, Health Access asked how to structure reimbursement, particularly in the context of current budget realities. If the best way to incentivize care management is through reimbursements, what is the best rate methodology? In response, Tanya Homman and Brad Gilbert said that each aid code grouping receives a single rate. However, *Brad Gilbert* said that those beneficiaries who would be mandatorily enrolled are not necessarily similar to those who have voluntarily chosen managed care in Two Plan and GMC counties. He added that the same managed care program may not be best for every Medi-Cal member. *Lisa Kodmur, LA Care,* pointed out that while the plan receives one rate for each person in a given aid category, and pays the same to each IPA and medical group, from there the amount that flows to individual physicians can vary greatly.

Margaret Tatar, CalOptima, linked the carve-out issue to the rate issue, saying that what happens to the system in the carve-out situation is a loss of efficiency. She said that every plan has its own workaround to deal with the difficulties created by carve-outs, and that development of standards and protocols would be helpful in not requiring so many individual solutions. *Peggy Hoover* said that the primary problem with coordinating services is being responsible for payment without control over care coordination, as in the CCS example. *Dean Germano* said that, in his service area (which remains fee for service), carve-outs are still a very big issue, with many pediatricians frustrated with CCS.

Several members (*Cheryl Phillips, Erica Murray, Chris Perrone, Margaret Tatar*) cautioned that the system should be mindful of the diversity on the ground, and allow for local decisions, not a single solution. The standards would remain the same, but the construct might be locally determined.

Chris Perrone returned to the 2005 recommendations, urging that they be used as a model for the integration of SPD populations, and reminding the group that the report also includes a number of recommendations for the state, particularly on the Agency level. Tanya Homman responded that the Department appreciates the work that went into the recommendations, but that only 11 of the 53 have been implemented, largely due to lack of resources.

Brad Gilbert said that he has a bias towards managed care for most Medi-Cal members, and believes that many of the Lewin recommendations are achievable, but cautions that he could not have said this even five years ago. He also stated that IEHP has room for improvement in paying differentially, and needs to continue work in that area.

Lisa Kodmur stated that the Lewin recommendations should be aligned with NCQA standards for care management. In LA Care's research on development of a patient-centered medical home, they have discovered that two things are essential: 1) payment reform, to allow for a medical home with care management and case coordination as its beating heart; and 2) significant investment in health information technology (HIT) – not necessarily electronic health records, but some way for providers can communicate.

Cheryl Phillips issued a reminder to start with the person receiving care: the real medical home should be the patient's address.

Christina Mills said that lack of choice is always an issue for people with disabilities. Training for physicians, staff, and administrators on disabilities is essential. The IEHP partnership with ILC is working well, and similar partnerships should be established and that partnership would be great to see elsewhere. Where possible, transition specialists should themselves be people with disabilities. Disability cultural competency should be part of the state's definition of cultural competency.

Jerry Jeffe raised several points. 1) Mental health disabilities are different from other types of disabilities, and should be considered separately. 2) Carve-outs are currently a fact of life and the pros and cons should be carefully defined. 3) We need more data to know if managed care "works" for the SPD populations.

Margaret Tatar mentioned the challenges of accountability.

Stuart Levine raised concerns that the "medical home" not be defined only in a "doctor-centric" way, and that system definitions and person definitions be considered as well. He said that focusing on reducing hospitalization rates was the way to save money. He stated that carve-outs never need to exist, even for serious mental illness.

Elizabeth Landsberg urged that programs be targeted differently based on patient circumstances and conditions. Early assessment of patients needing care coordination is critical – frequent user programs, which target high levels of service, come too late to help many patients, and miss those who are under-utilizing care. Assessments by the enrollment broker should be considered, and plans for re-assessments should also be included. Care management outside the MCO model should be thought about, and linguistic access and care competency must be part of the discussion as well.

Jackie McGrath expressed concern about the lack of specificity in California contracts as far as the definition of care coordination. The plan should be designed for the patient with the highest needs and most complex conditions, and then backed out for patients who need less attention. The financial piece – the need for more investments in order to achieve improvements, and thus efficiencies -- is a tension with the Administration, which wants to save up front. Carve-outs are fundamentally flawed, bifurcating people and their health care, and it's a delusion to carve out the most expensive services and they say that we're controlling costs in managed care. She hopes the waiver will represent the elimination of carve-outs.

Casey Young raised oversight, enforcement, and market incentives. We need not only the right incentives, but enough money to make them effective.

Brenda Premo said that she hadn't heard any discussion about where she, as a person with disabilities, fits in the process. Will people with disabilities be part of their own care coordination? Patients and their families must be involved in their own care plans and in the design of support services. Medical issues cannot be considered in a vacuum, but as part of overall life goals and plans – education, work, technical training. If care coordination is to work, it must take account of these other aspects of individuals' lives – even though the plan does not pay for these aspects – and plan accordingly. The quality of the people interacting with patients is what makes any of this successful, and they must be well-trained.

Leila Saadat, Alameda Alliance echoed the call for local solutions, and said that Alameda Alliance continued to work closely with local advocates.

David Ford, CMA returned to the definition of a "medical home," and said that it was important to figure out what we want to achieve and what we're willing to pay. The goal is to do better by this population, not just save money off this population, and a successful medical home model entails gain-sharing with providers.

Richard Bock, Molina Healthcare, said that contracts must include support for transportation needs, physical access in the primary care environment, and specific requirements for coordination of care. In addition, investments in HIT are critical for this population.

Next Meeting and Feedback on Today's Meeting

Bobbie Wunsch said that future agendas would limit presentations to allow more time for discussion of specific issues. Future agendas will be revised to focus on specific questions, with background materials to support these discussions.

She thanked DHCS staff, CHCF and Chris Perrone, and those who presented at the meeting.

The meeting was adjourned at 3:05 PM.